ELDER NEEDS IN CENTRAL MASSACHUSETTS

2014

Central Massachusetts Agency on Aging
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October 2013

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AREA PROFILE & NEEDS ASSESSMENT

Table 1. Central Massachusetts and Massachusetts Population Aged 60+ 2000 – 2020

	2000	2010	2020 est*
CMAA	126,956	150,280	201,326
MASS	1,096,567	1,273,271	1,632,168
% of MA 60+ Pop	11.6%	11.8%	12.3%

**Estimates from The Research Unit, Executive Office of Elder Affairs, based on MISER projections*

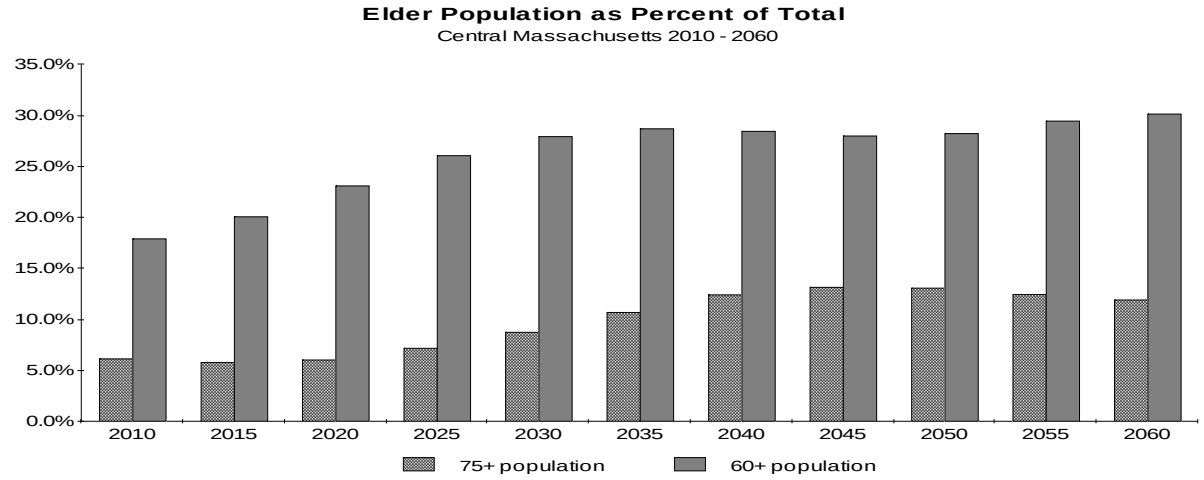
The 2010 census documents some trends that CMAA has observed over the past few years:

- The overall population of the Central Massachusetts region increased by 6.44%, more than twice the state increase of 3.13%.
- The 60+ population of Central Mass increased 18.4% to 150,280 in comparison to the statewide increase of 16.1%.
- This area now comprises 11.8% of the Massachusetts 60+ population, compared to 11.6% in 2000.
- Geographically, the communities bordering the I-495 belt in the northeastern part of the region and the Blackstone Valley have shown substantial gains in elder population.
- On the other hand, larger cities (such as Worcester and Fitchburg) and former factory communities (such as Clinton, Hopedale and Southbridge) have seen little or no change in 60+ population.

The increased geographic dispersal of the Central Massachusetts elder population may mean that community-based providers might experience increased transportation costs in reaching their elder clients in the future; a trend that CMAA continues to monitor.

Looking forward, MISER estimates that the 2020 elder population for Central Massachusetts will be 201,326. Barring substantial changes in migration patterns, we expect that the 60+ portion of the population of Central Massachusetts will increase from 17.8% of total population in 2010 to about 28% in 2030 due to the aging of the baby boomer generation. At the same time, we expect the 75+ portion of the population to remain approximately level or even decline somewhat from 2010 until 2021 when the baby boomers once again will produce rapid growth in this age cohort (see Figure 1).

Figure 1.



Since it is the population aged 75 and older that is most likely to need supportive services, we expect the demand for such services to level off to some degree for the next few years. However, if those over 75 years of age continue to live increasingly longer than in the past and if there is a greater emphasis on helping them to remain in the community, the "baby bust" legacy of the Great Depression will not lead to a decline in the demand for community-based support services.

Minority Populations

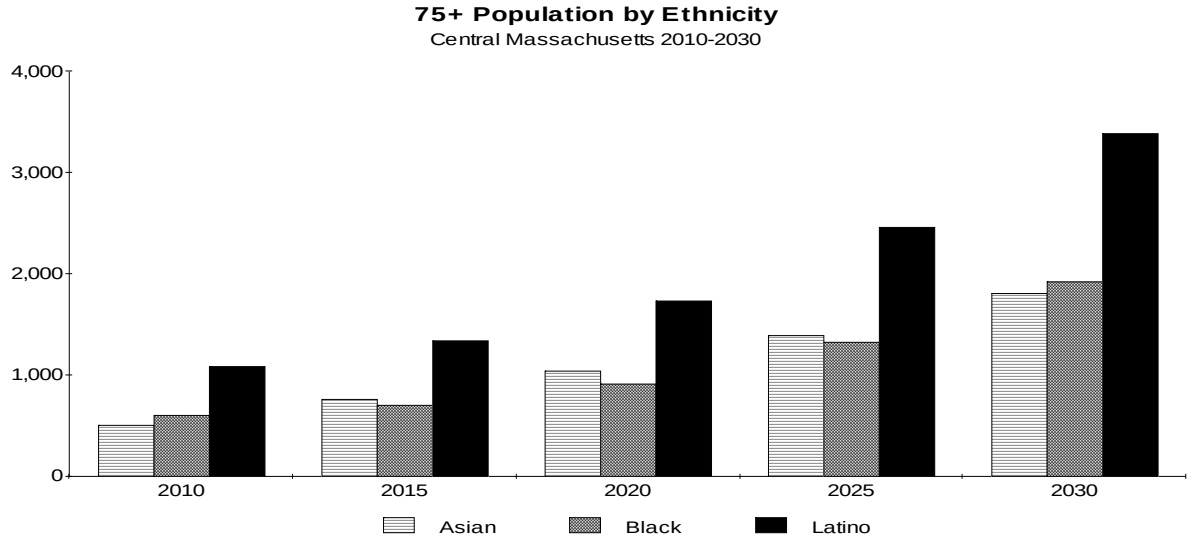
Based on the 2010 census, federally-defined minority groups (Black, Hispanic, Asian, Native American and Pacific Islanders), made up almost 7% of the elder population of Central Massachusetts compared to 4.4% in 2000. This is related to the significant immigrant component of all of these groups except Native Americans, who constitute 0.1% of the 60+ population. While in the past, the Black population was little impacted by immigration, this has changed since the 1990's with a substantial influx of people from Africa and the Caribbean.

Groups having a large immigrant base consistently have a younger age profile than the indigenous population. Also, Blacks have historically had a younger age profile in the United States due to documented health disparities. As a result, minority elders are comparatively fewer in number. Thus, while 17.8% of the overall population is aged 60+, 6.6% of the minority population in Central Massachusetts is 60 or older. As immigrant populations age in place we expect this proportion to increase.

We expect that the number of minority elders will approximately double from 2010 levels by 2025. This reflects a much faster growth rate than for the overall population, even with the aging of the baby boomers. By 2040 we expect that the age profile of these groups will begin to approximate that of the overall population of Central Massachusetts.

Over the next ten years we also expect that the minority population aged 75 and older, the age group that is most likely to need community-based support services, will more than triple for Asians and Latinos and more than double for Blacks (see Figure 2).

Figure 2.



Another trend is the movement of minority population, including elders, from urban centers to suburban towns. For the greater Worcester area, while the city itself saw an 89% increase in the number of minority elder residents, the nine surrounding towns collectively experienced a 140% increase in the number of minority elders. This was particularly pronounced in the Asian populations of Shrewsbury and Grafton.

The language and cultural issues that the aging of immigrants potentially pose for the elder service network in Central Massachusetts may be mitigated to some extent by the greater degree of acculturation to American society that these older elders are likely to present. In most cases they will have spent substantial portions of their adult lives in this country. At the same time, we should expect continued immigration of sufficient magnitude such that cultural and linguistic barriers will remain an issue for some elders.

Needs Survey

In the Fall of 2009 Central Massachusetts Agency on Aging undertook a survey of people aged 60 and older in the 61 communities comprising our service area focusing on demographic characteristics and needs. This survey followed the same procedure as earlier surveys in 1993, 1997, 2001 and 2005. Major findings included:

- Financial issues such as finding employment and help with financial assistance were much more important compared to earlier surveys. In addition, the poverty rate was higher than in any past survey and the percentage of self-identified caregivers reporting a financial burden due to their caregiving role showed an eight-fold increase.

- Residents of smaller communities reported less than half the poverty rate of larger communities as well as a generally lower level of both need and unmet need. The main exception to this pattern was in transportation.

- Compared to the 2005 survey results, there was an increase in the proportion of respondents indicating a high risk of depression. This may be related to economic circumstances.

- The Elder Economic Security Standard developed at UMass/Boston was used as a tool to look at the economic status of elders in Central Massachusetts. The data indicated that approximately one-third of Central Massachusetts elder households may fall below the EESS and thus face at least some degree of financial hardship.

- Compared to past surveys, the 2009 survey found higher rates of problems with one or more disabilities than in past surveys, even with the population being younger than in the past.

- In looking at nutritional status, the 2009 survey population showed a higher proportion of elders at an elevated level of nutritional risk, again with an younger population profile overall.

During the fall of 2012 CMAA conducted a series of eight focus groups targeting a range of elder populations that are not effectively accessed via broad-based surveys as CMAA undertook in 2009. These include:

- Deaf
- African American
- Southeast Asian
- Latino
- LGBT

The major Issues that cut across these sessions were:

- Transportation (8 groups) – little availability in some areas, accessibility issues in others.
- Housing (7 groups) – issues were: long wait lists, cost of non-subsidized housing, lack of ADA compliance in older units, acceptance issues (for LGBT elders, to a lesser extent ethnic minorities)
- Information on available services (5 groups) – this was related to communication barriers (deaf & linguistic minority), complicated health insurance, insufficient outreach.
- High cost of living (5 groups) – prices for food, housing, heating oil, etc. are rising faster than elders' incomes. Many elders had low incomes during their working years and thus have low Social Security checks.
- Communication barriers (4 groups) – These were all related to deaf or linguistic minority status, but also include cross-cultural misunderstandings. Such barriers complicate access to all other services.

Other specific points were made as well. These included:

- While medical care was perceived as good, LGBT elders have difficulty finding understanding and supportive providers. This is especially true for transgender elders who generally don't fit well with the larger lesbian & gay community.

- Discrimination is faced by LGBT and by minorities in various forms.

- Employment opportunities that pay a living wage are limited, especially for working class elders.

- Social isolation is often a problem. This can be due to lack of transportation, family members working during day, living in an unsafe neighborhood and other causes.

- There is a general shortage of mental health services (including age-appropriate substance abuse treatment) and of health care providers of any kind in some areas (e.g. rural western part of Central Massachusetts).

Limited English Proficiency (LEP)

The barrier to service accessibility posed by limited proficiency in speaking and understanding English is not limited to the Federally- defined minority elders. In fact there has been significant migration of various European ethnic groups to Central Massachusetts in recent years (e.g. Albanian, Polish, Russian). This is in addition to pockets of earlier immigrant groups (e.g. Portuguese, Italian, French). To the extent that elders from these groups have migrated with younger family members, language may limit access to needed services.

Of the Central Massachusetts communities with larger numbers of LEP elders, Worcester is the most complex, having notable elder populations speaking Greek, Russian and Albanian in addition to the largest Hispanic, Brazilian, Vietnamese and African populations in the CMAA Planning and Service Area. In addition, since the 2000 census there has been a rise in immigration from the Middle East, especially Iraq.

The Fitchburg/Leominster area has the largest Laotian and Hmong communities in the region in addition to a significant Hispanic population.

In Milford, the Portuguese community comprises most of the LEP elders. While there is a growing Brazilian presence, this is a recent phenomenon and the Brazilian population profile is much younger. This applies to the local Hispanic population as well.

In addition to the large Hispanic population in Southbridge there is a notable Polish community linked to the neighboring towns of Dudley and Webster as well as the largest Laotian community outside of Worcester and the Fitchburg/Leominster area.

Franklin has the largest Chinese population outside Worcester and the adjacent towns.

Finally, Shrewsbury has an established South Asian community as well as a growing East Asian and Southeast Asian population.

Related to this consideration of potential linguistic barriers, it was interesting to note that in a focus group of Latino elders in Worcester the consensus was that language was not a significant problem. The participants indicated that they had little difficulty finding services in Spanish. The

Hispanic community in Worcester has its roots in the late 1950's and early 1960's and after over a half century of growth, local insurance agencies, banks, health care providers, retailers, automotive services and so on frequently have staff who speak Spanish. Spanish-speaking elders can thus usually access what they need in a linguistically comfortable environment by patronizing those businesses and providers that are owned and operated by Latinos or have Spanish-speaking staff. Currently, this does not seem apply to the same extent elsewhere in the region (e.g. Fitchburg/Leominster, Southbridge) or for other language groups.

Income Characteristics

Based on needs assessment surveys of people aged 60+ in Central Massachusetts we can look at the distribution of income over time. The three income levels are defined as "low income" (less than $18,311 for 2009), "middle income" ($18,311 to $29,530 for 2009) and "high income" (more than $29,531 for 2009). Note that these levels do not conform with those used by the Census Bureau, but reflect the poverty level breakpoints for different household sizes.

Reviewing the information summarized in Table 2, the trend toward an increasing income gap between higher and lower socio-economic groups in the United States that characterized the 1980's and 1990's seems to persist.

Table 2. Percent Distribution of Central Massachusetts Survey Respondents by Income Category *

Income Category *	1997	2001	2005	2009
Low	24.9%	23.3%	25.3%	24.5%
Middle	25.7%	23.6%	20.9%	20.9%
High	49.4%	53.1%	53.8%	54.6%
Below poverty	10.9%	10.6%	8.1%	12.5%

** Income categories are based on the poverty level guidelines for different household sizes for the year prior to the survey.*

To the extent that we can generalize from this data, it appears that the trend is for most Central Massachusetts elders to be better off financially while those at the very bottom continue to fall further behind. The 50% increase in the proportion of elder households falling below the poverty level in the 2009 survey compared to the 2005 results is a significant development and probably reflects the impact of the recent Great Recession in the United States.

The statewide results for Massachusetts for the 1997 to 2005 period reflect a similar trend. As in Central Massachusetts, the proportion of the sample falling below the poverty line declined; from 14.5% in 1997 and 12.0% in 2001 to 9.9% in 2005. Generalizing from the Central Massachusetts results, we can anticipate that there may have been a similar increase in elder poverty levels statewide. However, given that the cost of living in Massachusetts is much higher than the national average, the poverty line standard arguably understates the real degree of economic need.

Elder Economic Security Standard

The Gerontology Institute at the University of Massachusetts/Boston has developed an *Elder Economic Security Standard* (EESS) for each county in Massachusetts based on 2006 data. This standard assesses the county-specific costs associated with paying for housing, food, health care, transportation and other miscellaneous expenses. Taking the result for Worcester County as a proxy for Central Massachusetts (52 of CMAA's 61 communities are part of Worcester County), and applying the income data from the 2005 and 2009 needs assessment surveys should provide a better picture of the economic status of elders in this area.

The *Elder Economic Security Standard* focuses on individuals and couples living independently. Therefore we only looked at these types of households in our review of the Central Massachusetts 2005 and 2009 survey data. In addition, there was no way to distinguish what proportion of homeowners are mortgage-free. Given the recent mortgage "bubble" and the number of vendors offering reverse mortgages, it is likely that at least some of these homeowners still have liens on their property.

Table 3. Percent of CMAA Survey Respondents Below the Elder Economic Security Standard for Worcester County – 2005 and 2009

	2005	2009
Elder Persons Living in Their own Homes	38%	48%
Elder Couples Living in Their own Homes	23%	11%
Elder Persons Living in Private Rental Housing	71%	50%
Elder Couples Living in Private Rental Housing	14%	25%
Elder Persons Living in Public Rental Housing	96%	95%
Elder Couples Living in Public Rental Housing	NA	100%

These results must be taken as an approximation since the income categories do not match exactly with those employed in the EESS. However, while recognizing the small sample size in some of the above categories, it is clear that, as we might expect, individuals are more economically vulnerable than couples. The data also indicated that approximately one-third of Central Massachusetts elder households may fall below the EESS and thus face at least some degree of financial hardship.

Perceived Health Status

The proportion of elders who rated their health as good or excellent has continued to increase (see Table 4). This seems to reflect improving health status among the overall elder population, a situation that has been widely recognized. The 2009 sample continues the pattern of a progressively younger average age of the sampled population compared to the 2005 and 2001 survey respondents. This result is probably related to the changing age structure.

In 2009 an increased proportion of elders living in the community rated their health status as "fair" while a smaller proportion characterized their health as "poor". Both are reversals of the prior trend of decreasing numbers in the "fair" category and increasing numbers in the "poor" group. However, collectively these two categories continue to represent a progressively smaller percentage of the elder population of the region.

Table 4. Distribution of Respondents by Self-Reported Health Status – 1997 to 2009

Health Status	1997	2001	2005	2009
Excellent	19.4%	20.0%	21.0%	25.3%
Good	52.6%	52.7%	55.5%	51.7%
Fair	24.3%	21.8%	17.6%	19.7%
Poor	3.4%	5.1%	5.9%	3.3%
don't know	0.3%	0.3%	0.0%	0.0%

2009 Needs Survey Summary

In an attempt to measure the relative importance of different identified needs, CMAA staff has historically used a "Need Index" that takes into account the level of need, the level of unmet need and the proportion of overall need that is unmet. Based on this ranking, the following categories were highlighted in the 2009 survey:

Financial Issues:

- help with applying for financial assistance (#1)
- preparing tax forms (#2)
- finding employment opportunities (#4)
- paying property taxes (#6)
- coping with large debt (#7)
- help with handling bills (#13)

Housing and Household Issues:

- home repairs (#3)

Social Support and Counseling Issues:

- finding volunteer opportunities (#5)
- coping with depression (#8)
- coping with disability (#9)
- finding exercise programs (#10)
- finding social opportunities (#12)
- access to education programs (#14)
- finding dating opportunities (#15)

Transportation:

- to medical appointments (#11)

Overall, issues related to personal finance are much more highly ranked than in the past. This is to be expected given the state of the economy in the Fall of 2009. A similar increase was evident in the 2001 survey which was also conducted during a time of financial hardship.

In addition, there was a notable increase in the proportion of respondents indicating they were experiencing problems coping with a sensory or physical disability. Considering that the sample population profile becomes progressively younger from 2001 through 2005 to 2009 this result was unexpected and seems inconsistent with the pattern of elders continuing to report better health status as noted above.

Another source of information on elder needs is elder contacts with CMAA's Information and Referral service, *SeniorConnection*. The most frequent requests during FY 2012 were:

- Information on home care services
- Public benefits
- Health & in-home services
- Housing issues
- Financial assistance
- Requests for general information from CMAA
- Legal issues
- Health benefits
- Transportation
- Institutional care

Collectively these accounted for over 92% of all I&R calls. In general, they parallel the issues highlighted by the needs survey.

Trends in Need Levels

Results from the *2009 Needs Assessment of People Aged 60+ in Central Massachusetts* are compared with past survey results in Table 5.

In every case the proportion of survey respondents needing assistance increased compared to 2005. This is a reversal of the downward trend from 2001 to 2005 and is most notable with respect to finance-related needs such as "employment opportunities", help with financial assistance" and "handling bills". The latter two also spiked up in the 2001 survey during the last recession.

Another trend reversal, as demonstrated above, is in the proportion of respondents reporting problems in dealing with a disability. The extreme degree of change from 2005 and the fact that the 2009 percentage is higher than the 1997 and 2001 surveys which had older population profiles demand some further research.

The picture is more mixed in terms of the level of unmet needs. In most cases the level of unmet need has declined over the years and the 2009 results show little change from this trend in many categories.

Table 5. Central Massachusetts Needs Assessment Results Comparison - 1997 to 2009

	% in Need				% w/ Unmet Need			
NEED:	**1997**	**2001**	**2005**	**2009**	**1997**	**2001**	**2005**	**2009**
Transportation								
medical appointments	11.9%	13.2%	6.1%	10.2%	3.7%	3.5%	1.7%	2.1%
social events	7.6%	9.7%	4.1%	5.7%	3.2%	3.0%	1.0%	1.1%
errands	9.3%	12.6%	4.1%	8.5%	3.2%	3.2%	0.3%	1.1%
Legal Assistance								
consumer issues	6.8%	5.7%	2.0%	2.6%	3.9%	2.5%	1.7%	1.5%
insurance issues	8.4%	5.9%	3.0%	2.9%	4.5%	2.1%	1.3%	1.5%
tenant rights	5.4%	4.4%	1.0%	1.1%	3.0%	1.8%	0.3%	0.4%
immigration issues	4.6%	3.1%	0.0%	0.4%	2.4%	1.5%	0.0%	0.0%
Home Repairs	12.2%	21.0%	10.3%	11.6%	4.6%	7.3%	6.5%	5.8%
Employment Opportunities	3.7%	3.1%	2.7%	7.2%	2.1%	2.3%	2.7%	5.4%
Volunteer Opportunities	6.0%	4.8%	3.0%	6.1%	3.6%	3.3%	2.0%	3.9%
Help w/ Financial Assistance	5.9%	10.4%	6.5%	15.2%	3.6%	6.2%	4.1%	7.4%
Preparing Tax Forms	15.4%	20.5%	15.3%	23.7%	3.2%	3.5%	2.0%	2.1%
Handling Bills	5.6%	9.5%	5.9%	9.8%	1.8%	1.7%	2.1%	1.4%
Problems with:								
confusion/forgetfulness	6.6%	9.1%	2.7%	4.7%	3.9%	2.7%	0.7%	0.7%
disability	8.7%	8.4%	3.8%	11.2%	3.2%	2.3%	0.7%	2.2%
abuse/neglect	3.6%	3.1%	0.6%	1.1%	2.1%	1.4%	0.3%	0.4%
Depression	7.4%	10.0%	n.d.*	10.6%	3.9%	2.3%	n.d.*	2.6%

* n.d. - This question was misprinted on the 2005 survey. As a result, the data was discarded.

The notable departures from this pattern relate to “employment opportunities”, “volunteer opportunities” and “help with financial assistance”. In the case of the first and last, these are clearly related to recent economic conditions. Many younger elders have been displaced from the workforce and the extent to which they have difficulty in finding new employment will have significant implications for their financial status in coming years. With the general shift from defined benefit retirement plans to defined contribution plans (e.g. 401k, 403b) a greater number

of retirees may find themselves facing financial hardship. This may put increased pressure on publicly-funded housing and other support systems.

Elder Needs in Small and Rural Communities

CMAA needs assessment research has included a focus on small and rural communities in Central Massachusetts. This research has contrasted these smaller towns with survey responses from elders living in larger urban and suburban communities.

Table 6 summarizes the contrast between the smaller ands larger communities in Central Massachusetts. For purposes of this study the small communities included:

Ashburnham	Ashby	Barre	Berlin
Bolton	Boylston	Brookfield	Douglas
East Brookfield	Hardwick	Hubbardston	Mendon
Millville	New Braintree	North Brookfield	Oakham
Princeton	Rutland	Sterling	Warren
Upton	West Brookfield		

Each of these communities had a population below 8,000 according to 2007 U.S. Census Bureau estimates and lacked within its boundaries one or more of the following: supermarket, pharmacy or doctor's office.

In general, levels of perceived need and unmet need were consistently lower among small community respondents. This pattern is similar to the one found during the 1998 CMAA survey of rural and small communities. Exceptions to this general picture were related to unmet need for transportation and assistance in dealing with depression. Both of these are probably related to a lack of locally-based service resources addressing these issues.

Some specific differences between rural and small communities and their larger neighbors include:

- Small community residents were twice as likely to report their health as being "poor" (5.4% to 2.7%). This is consistent with results from the 1998 CMAA survey of rural and small communities (6.6% to 3.2%). This difference cannot be explained by the age distribution which is largely the same for the two samples with the small community sample being slightly younger.

- Small community residents were also slightly more likely to report their health as "good" or "excellent" when compared to residents of larger communities (79.2% vs. 76.6%).

- In the 1998 survey the small community sample demonstrated a slightly higher poverty rate (11.9% to 10.6%) and had a larger proportion falling into the low income group (31.2% to 24.5%). This changed radically in the 2009 survey (see Table 7) with the small community sample having a much lower poverty rate (5.9% to 13.6%) and a notably smaller proportion of respondents falling into the low income group (18.6% vs. 24.5%).

Table 6.

Central Massachusetts Needs Comparison - Large and Small Communities - 2009

NEED:	In Need Large	In Need Small	% change Large to Small	w/ Unmet Need Large	w/ Unmet Need Small	% change Large to Small
Transportation						
Medical	10.7%	9.1%	*-15.0%*	2.1%	1.7%	*-19.7%*
Social	5.9%	4.2%	*-28.0%*	0.4%	2.5%	*505.1%*
Errands	8.8%	5.0%	*-43.1%*	0.8%	1.7%	*99.2%*
Legal Assistance						
consumer issues	2.6%	2.5%	*-1.3%*	1.3%	1.7%	*31.6%*
insurance issues	3.4%	2.6%	*-24.7%*	1.7%	1.7%	*0.4%*
tenant rights	1.3%	0.9%	*-34.5%*	0.4%	0.0%	*-100.0%*
immigration issues	0.4%	0.0%	*-100.0%*	0.0%	0.0%	*0.0%*
Home Repairs	12.6%	5.1%	*-59.3%*	6.7%	2.6%	*-61.9%*
Employment Opportunities	7.1%	5.2%	*-27.3%*	5.0%	4.3%	*-14.2%*
Volunteer Opportunities	6.3%	3.4%	*-44.8%*	3.8%	2.6%	*-31.0%*
Help w/ Financial Assistance	16.7%	9.1%	*-45.7%*	7.8%	4.5%	*-41.4%*
Preparing Tax Forms	24.4%	19.7%	*-19.3%*	2.0%	2.5%	*21.0%*
Handling Bills	9.9%	5.7%	*-41.9%*	1.2%	0.8%	*-33.6%*
Problems with:						
confusion/forgetfulness	4.2%	4.2%	*0.0%*	0.0%	0.0%	*0.0%*
Disability	11.8%	7.7%	*-34.9%*	2.1%	1.7%	*-19.0%*
abuse/neglect	0.9%	0.9%	*0.0%*	0.0%	0.0%	*0.0%*
Depression	9.9%	10.8%	*9.3%*	1.7%	3.3%	*93.3%*
large debt/credit card bills	5.1%	7.6%	*48.7%*	3.4%	4.2%	*23.9%*

Table 7. Income Level by Community Type – 2009

	Small Communities	Large Communities
High Income	61.0%	55.4%
Middle Income	20.3%	20.2%
Low Income	18.6%	24.5%
Below Poverty	5.9%	13.6%

1. Based on survey responses, older residents of smaller communities appear more likely to be looking for employment opportunities and less likely to be working full-time (see Table 8).

Table 8. Employment Status by Community Type – 2009

	Small Communities	Large Communities
Full Time	15.8%	17.3%
Part Time	13.2%	13.1%
Looking for Work	6.1%	3.8%
Retired	64.9%	65.8%

Regarding the provision of services in rural and small communities, we can make the following observations:

1. There is little access to **public transportation**:
- Little or no taxi service
- Local bus service rare or non-existent
- In most cases where people do not have access to transportation via their personal social network, they must rely on volunteer transportation programs operated by local organizations or do without.

2. **Distance from service providers** such as physicians, dentists, pharmacies, day care & other services can be a barrier to getting care.
- People often have to drive great distances to reach service providers.
- When service providers are in the area, they often do not accept medicaid patients.
- Access to prescriptions can be a problem, especially for elders who don't drive. Formerly, many local pharmacies offered prescription delivery service, but these have declined in number due to the expansion of national drug store chains. While mail order pharmacy services can fill this gap for monthly prescriptions, this is not very helpful for short-term or emergency prescriptions.

3. There is often a **lack of awareness of service availability** on the part of rural residents. The offices of most service providers are located in central places and our experience is that publicity regarding services is far more frequent in these core areas (that is where the bulk of potential clients are). There are often more limited means of reaching rural residents.

4. **Attitudes** in rural areas may also be a factor. Rural residents often feel they are more resilient than "city folks" and may deny the need for assistance, or believe they can get by without it. This is an adaptation to their reality. Often the needed assistance is not readily available for them.

5. **Social networks** are perhaps more critical in rural areas since neighbors and family are often the only local source of support and assistance. For those who are not part of the local social network, their isolation is compounded.

6. **Reimbursement rates** for service providers do not consider the greater time and transportation costs associated with service delivery in rural areas where the population is more widely distributed. Under current reimbursement systems that make no distinction regarding local geography, service provision in rural areas often puts providers in an untenable financial position with respect to providing services in these locations. *This may be the most important barrier to service provision.*

Nutritional Risk in Central Massachusetts

While not part of the 2005 survey, the 2009 survey re-assessed nutritional risk among respondents. Similar data on nutritional status was collected in the 2001 survey of Central Massachusetts elders. Based on these data, there are very real differences in the level of risk for different age and sex categories.

Comparing the results from 2001 and 2009, there has been an increase in the proportion of elders falling into elevated nutritional risk categories from 49% to 55%. Since taking 3 or more drugs is considered a risk factor, this increase may be partially related to a change in medical practice with physicians today being much more aggressive in prescribing anti-hypertensive and anti-cholesterol medications as well as daily sub-clinical aspirin to a much wider range of patients than in the past. A countervailing factor is that the age structure of the 2009 sample is younger than that for the 2001 survey. Given this demographic change, the increase in elevated nutritional risk is unexpected and worrisome. Economic factors may be playing a role, but 2001 was also at time of recession and financial hardship.

Women continue to be at higher levels of nutritional risk compared to men, but only marginally so (see Table 9). While men showed almost a 50% increase in the moderate risk category there was a slight decline in the proportion at high risk. For women, there was a decrease in those with a moderate level of nutritional risk that almost balanced out the increase in those showing a high level of risk.

A comparison of elders living alone with those who are not living alone (see Table 10) suggests that this gender difference is related to the much higher rate of nutritional risk among women. Older women are far more likely than men to be living alone. In the CMAA sample, 36% of women lived by themselves while only 12% of men lived alone.

Table 9. Nutritional Risk by Gender – 2001 & 2009

Nutritional Risk	Male Risk 2001	Male Risk 2009	Female Risk 2001	Female Risk 2009
Low	57.8%	47.1%	46.0%	45.1%
Moderate	25.2%	37.0%	33.3%	28.0%
High	17.0%	15.9%	20.6%	26.8%

Table 10. Nutritional Risk by Living Situation – 2009

Living Situation	Level of Nutritional Risk: High	Moderate	Low
Men Living Alone	43.8%	12.5%	43.8%
Women Living Alone	44.1%	23.7%	32.2%
Men Not Living Alone	12.4%	39.7%	47.9%
Women Not Living Alone	16.3%	30.8%	52.9%

Overall, the major risk factors for elevated nutritional risk are increasing age, low income and living situation. All of these factors apply to both men and women, however, women are more likely to be negatively affected by the latter two issues.

While overall, these results coincide with those from the 1997 and 2001 needs survey, the fact that risk levels are tending to increase even as the average age of 60+ population becomes younger is a concern. The 2009 increase in the proportion of elders below the poverty line in Central Massachusetts may indicate that an increasing financial gap between the "haves" and the "have nots" is having measurable nutritional consequences.

Disability

Reflecting national trends, the statewide proportion of elders reporting problems with a physical or sensory disability in needs assessment surveys showed a slight general decline from 1993 through 2001. In the 2005 survey there was a significant drop in reporting problems with a disability of this nature. For all of these years, the results for CMAA paralleled the statewide pattern. It was thus a surprise to see the substantial increase in elders reporting disability issues in 2009. The rate was higher, in fact, than that in 1993.

Table 11. Percentage of Elder Respondents with Problems Coping with Disability

	1993	1997	2001	2005	2009
Mass	10.4%	10.5%	10.1%	3.8%	no data
CMAA	10.0%	8.7%	8.4%	4.8%	11.2%
60-74	6.0%	5.2%	7.7%	4.1%	8.8%
75+	17.0%	16.1%	9.6%	7.1%	15.6%

A number of factors may be related to this result.

Some recent research has indicated that disability rates among non-institutionalized elders may be on the rise again after a steady decline since the 1980's.

Other research has argued that there is an increased rate of obesity among aging Baby Boomers with consequent increase in related health problems (e.g. diabetes, arthritis and other joint problems) that can produce activity limitations.

In recent years there has been a concerted effort to keep elders out of nursing homes and even return them to a community setting, often with government-funded support services. In Massachusetts the state home care program plays a major role in this endeavor. In addition, the availability of assistive technology can help overcome the limitations imposed by disability. Taken together, these factors can be expected to lead to an increase in elderly residents in the community with ADL and IADL limitations.

Even with all of these factors operating, the increase from 2005 to 2009 still seems extreme. However, the comparison with 2001 rates is less so. This implies that the 2005 survey results may be an aberration.

The long-term decline in reported disability nationally can be related to a number of factors. These include:

Diet & Lifestyle Changes

- Greater focus on healthy behavior linked to higher levels of education among the general public and increased awareness of health issues.
- Better access to health information via all media outlets and especially the internet which allows for individuals to better research their own health issues.
- Occupational changes have increased the number of people holding service and knowledge-related jobs that pose low risk for injury.

Improved Medical and Restorative Care

- Increased availability of joint replacement procedures.
- Organ transplants becoming are more common.
- Enhanced cardiac intervention options (e.g. stents, angioplasty)
- Vision procedures (e.g. cataract surgery)

Applied Technology

- Greater availability of scooters for mobility
- On-line shopping
- Direct deposit and electronic fund transfers
- Cell phones
- Specialized communication options for deaf and visually impaired elders.

All of these reduce the impact of physical limitations; particularly with respect to Instrumental Activities of Daily Living (IADLs).

Caregiver Needs in Central Massachusetts

CMAA research on Central Massachusetts caregivers has focused on those caregivers aged 60 and older.

- Approximately 9% of elder survey respondents identified themselves as having responsibility for providing housing, personal care, financial assistance or social/emotional support to an elder.

- Of these elders who are providing care, most indicate that they have no difficulty in providing the required care, while about 42% of elder caregivers indicate that they need assistance.

- Approximately one quarter of all caregivers aged 60 and older experienced some degree of intra-family disagreement over care giving decisions.

- In Central Massachusetts, 28% of elders who are caregivers report that a support group and discussion with other caregivers would be helpful.

- After the need for more information, the most frequently cited need of caregivers was the need for support from other caregivers or professionals, with 28% citing such a need.

- A quarter of those providing care responded that they were suffering from physical or mental health problems due to care giving.

- In 2005 2% of those providing care reported having financial problems due to care giving. In 2009 that percent grew to 16%. This probably reflects the financial strains that many families faced during difficult economic circumstances.

- Finally, caregivers may not always recognize that they are being impacted by the stress of their responsibilities. Caregivers need resources that may improve their loved one's quality of life, as well as their own.

Housing Issues

Affordable housing is an important component in promoting independence and avoiding premature institutionalization among elders that reside in Central Massachusetts. As the population ages, we must recognize the increasing need for supportive services. To promote the health, safety, and well being of the elderly critical supportive services must be established. Home care and community-based services will ultimately prolong independence. Currently, resources offered for home and community-based care are minimal in comparison to the resources dedicated to facility-based, skilled nursing care.

Based on 2012 focus group results we can identify some specific housing problems.

- There were many complaints about the lack of availability of senior housing and the consequent long waiting lists.
- The high cost of rental housing at market rates in "safe" neighborhoods can pose a problem for lower income elders. In many cases they cannot afford to live outside of areas where they feel threatened.
- A few elders reported that some older subsidized housing units are not ADA compliant and that this can pose problems for them.
- Both LGBT and minority elders can face acceptance issues in elder housing communities. In the case of the latter this is correlated with communication barriers and cultural differences. For the former, we can note that in general members of older generations are often less accepting of the LGBT population than younger people.

Public housing residents comprised 7.4% of 2009 survey respondents. Three quarters of these are female. Looking at the age distribution of respondents residing in public housing we find over half of these elders are 75 years of age or over. In total, over one third need assistance performing household chores. This reemphasizes the need for additional supportive services in public housing facilities.

Table 12. Percentage Distribution of Income Category by Residential Category – 2009

Income Category	Own Home	Family Member's Home	Private Rental	Public Housing
Low	16.6	25.0	28.6	85.7
Middle	18.6	42.9	28.6	14.3
High	64.8	32.1	42.9	0.0
Below Poverty	5.9	22.7	23.8	38.1

As expected, public housing residents were also more likely to face challenging economic circumstances. While elders living in their own homes were in the strongest financial

circumstances, those living with relatives or in private rental housing were only somewhat better off economically than those living in public housing.

Table 13. Percentage who "skipped" goods or services "due to shortage of money" by Residential Category – 2009.

Item:	Own Home	Family Member's Home	Private Rental	Public Housing
Food	5.8	3.7	16.7	11.8
Utilities	4.3	0.0	16.7	6.7
Gas	6.5	8.0	20.0	15.4
Rent or Mortgage	3.5	0.0	12.5	5.6
Medical Appointment	4.3	0.0	17.6	11.8
Prescription Drugs	7.4	0.0	20.0	17.6
Dentist	14.3	7.7	21.1	35.3
Hearing Aid	8.5	4.3	25.0	44.4
Eye Glasses	8.1	7.4	25.0	16.7
Social Opportunity	8.5	8.3	15.4	23.1

However there was a clear difference between those living with family and those in public housing in terms of relative access to goods and services. Those living with family members generally had lower levels of deprivation than those living in their own homes (see Table 13). This is probably due to their families making sure they received what they needed even if the elder involved did not have the necessary financial resources.

Mental Health

The survey included a screening tool to assess risk of depression. While the proportion of elders at moderate risk remained essentially the same, the proportion at high risk is almost one-third higher than in 2005.

Table 14. Percentage of Survey Respondents at Elevated Risk for Depression 2005 and 2009

Risk Level	2005	2009
High Risk	9.4	13.5
Moderate Risk	8.3	8.1
Total at Elevated Risk	17.7	21.6

Interestingly, economic characteristics did not predict elevated risk overall, but lower income respondents were much more likely to be at a high level of risk for depression.

Table 15. Percentage of Survey Respondents at Elevated Risk for Depression by Elder Economic Security Standard (EESS) Level – 2009

Risk Level	<EESS	>EESS
High Risk	21.1	7.1
Moderate Risk	4.8	19.0
Total at Elevated Risk	25.9	26.2

This seems to imply that the current economic difficulties may be the cause of this increase in risk level.

Transportation

While many elders have a need for assistance with transportation, based in survey responses the level of unmet need is relatively low on a percentage basis. However, based on discussions with local service providers and focus groups, for those who have an unmet need this need is significant.

A major obstacle in addressing this issue is the cost of providing service. In this regard, volunteer driver programs are an efficient and effective way to provide transportation to older adults. Paid drivers programs often have to operate at a high cost to provide services to older adults. According to the Beverley Foundation, the average cost per ride for a paratransit program nationally is $37.94 and the average cost per ride for a volunteer driver program is $7.74. There are currently few transportation options for older adults in the Central Massachusetts area. Many of the available transportation options are expensive or do not provide the level of support services that older adults may need; such as escorted or door through door assistance. Volunteer driver programs can be an effective solution to these transportation problems.

LGBTI Issues

There are three major circumstances that make successful aging more difficult for Gay and Lesbian older adults.

1. The effects of social stigma, both past and present, real or perceived. That what happens in earlier stages in one's life will have an impact on the late stages of life as well.
2. The reliance on families, defined by the government and society as biological family and marriage, to provide informal care, social connections and support for older adults in our society.
3. The laws and programs currently in our country that treat Gay and Lesbian older adults differently and unfairly and do not address or may actually create extra barriers for Gay and Lesbian older adults.

In general Gay and Lesbian older adults seem to be more likely to live alone, not be partnered, and have no children when compared to their heterosexual peers. They are less likely to have

close family to call for help. Those living in small towns are more likely than their urban peers to lack any type of companionship. All of these factors are risk factors for social isolation.

Gay and Lesbian older adults often do not feel comfortable accessing social activities through mainstream programming. In one survey, 72% reported that they were tentative about utilizing Older Americans Act services and only 19% reported that they had some involvement with their local senior center. They often feel unwelcome at senior centers, volunteer centers and places of worship. This was true for participants in focus groups held in both Worcester and Boston where individuals stated that they did not feel comfortable going to their local senior centers.

Social isolation is a serious concern. Those older adults who feel isolated are three times less likely to report very good or excellent health and experience significantly more depressive symptoms compared to those who do not feel isolated. Social isolation can also lead to premature death among older adults.

Internalized homophobia affects the health, careers and social life of Gay and Lesbian individuals and those over the age of 80 have the highest rate of internalized homophobia. Older Gays and Lesbians came of age in a time when being such was considered a crime, sin and/or a mental illness. This discrimination and stigma over the years can lead to chronic stress, or what is sometimes referred to as “minority stress”. This stress leads to higher levels of depression, psychological problems and is found to increase loneliness. Gay and Lesbian older adults have shown higher rates of disability, and are more likely to smoke and drink in excess. One study of Gay and Lesbian individuals over the age of 50 shows these individuals reporting problems such as diabetes at rates similar to those decades older. Their health may be in further jeopardy because Gay and Lesbian older adults often put off seeking care and receiving tests and screening. Older lesbian woman are far less likely to get a pap smear than their heterosexual peers. Many Gay and Lesbian older adults receive needed care in the emergency room setting. Many also report being denied care or receiving inferior care because of their sexual orientation.

Older Lesbians and Gay men often have experienced discrimination in employment. Historically there was no legal barrier against such discrimination and, as a result, many older Gay and Lesbian adults had limited job options, jobs with lower incomes, and fewer opportunities to obtain employer health insurance and pension plans. In addition, government programs have discriminated against Gay and Lesbian couples. Now that the federal government is moving to recognize same sex marriages, this situation will be mitigated to a significant extent. However, the legacy of past discrimination will still play a role in the financial circumstances of many older Gay and Lesbian adults. Also, there are still a range of discriminatory state laws in effect around the nation so the impact of this court decision will vary depending on locality.

While Transgender and Intersex (persons born with a reproductive or sexual anatomy that doesn’t fit the typical definitions of female or male) people are clearly not the same, there are some similarities in life experience that distinguish them from Gay and Lesbian older adults.

Both can be subject to medical and/or surgical intervention for gender assignment. For Transgender people this is generally an adult decision, but for Intersex individuals this treatment is sometimes undertaken during infancy or childhood. If the gender assignment/reassignment is

done early in life there is a substantial risk that this will be contrary to the individual's identification in adulthood. Overall, Transgender and Intersex people often experience difficulty in receiving health care that is understanding and supportive.

Both Transgender and Intersex people often find it difficult to fit into either Gay/Lesbian or heterosexual social environments. American society does not have social categories that readily accommodate them and recognize their place in the social milieu. This can lead to social isolation and the health consequences related to "minority stress" as discussed above.

In addressing the needs of these two populations, service providers need to adopt an accepting and understanding perspective. Providers need to train staff to create a "safe space" for Transgender and Intersex older adults to talk about their experiences. Instead of assessing them through a lens of disorder and dysfunction, there needs to be a focus on what it means to be a healthy and functioning Transgender or Intersex person in a society with rigid sex and gender norms.

In a similar vein, Bisexual individuals often find a lack of acceptance in both gay and straight communities. In both contexts they may be perceived as sexual "tourists" who are unlikely to be able to maintain committed relationships. In the face of this, Bisexual elders may feel that they have two "closets" – both a straight and a gay one. A June 2013 Pew Research Center survey of LGBT adults found that bisexual individuals are far less likely to be "out" to their family members and co-workers than gays or lesbians, reflecting a fear of social prejudice and stereotyping. As a result, bisexual people can also experience the health effects of "minority stress".

It is important for elder service workers, health care providers and other professionals who interact with LGBTI elders to become informed regarding the issues and barriers that exist as well as means to overcome these barriers if appropriate care is to be delivered to these populations.

Aging of the Baby Boom Generation

As noted in the CMAA population estimates (Figure 1), the "Baby Boom" generation has already begun to reach early-retirement age, and by 2020 they will begin to turn 75. With the higher disability rates for the Boomer generation, this is beginning to pose significant challenges to the community-based elder service system. These challenges will include:

- A growing number of elders with disabilities due to increased longevity of both persons born with disabilities and those who acquired disabilities during their non-elderly years.

- A growing racial and cultural diversity among elders.

It is important to note that, in general, the social characteristics and traits of the baby boomer generation will vary to some degree from those traditionally associated with elderly people. A significant proportion of the baby boomer population are likely to bring expectations for

lifestyles and services that accommodate individual choice as well as a focus on preventative health care, healthy lifestyles, good nutrition, and adequate and flexible community-based activities and services.

As indicated in the results of Central Massachusetts and statewide needs assessment surveys from 1993 to 2009, a large proportion of older people are likely to be well, healthy, mobile, and financially stable, disability rates notwithstanding. Based on this pattern, it is likely that in succeeding groups of older people, the number of individuals who will wish to remain integrated as active, participating, productive members of their communities will grow. We anticipate a growing need to balance the issues of the well-elderly and frail-elderly. Therefore, ways must be found to utilize the talents, skills, and experience of this elder cohort.

On average, Baby Boomers are better educated than their parents and have a greater familiarity with technology. In addition, Boomer women are more likely than their parents to have retirement assets of their own. These characteristics will have implications for both service delivery and household financial status.

However, we also need to recognize that Baby Boomers are distributed across all socioeconomic categories. Popular publications generally focus on the top socio-economic tier of the Boomer generation but a significant portion also fall into lower income categories. These are people who held working class jobs throughout their employment history and often, due to the long-term physical stresses placed on them, are forced to take social security at less than full retirement age, thereby settling for lower social security benefits. Those falling into this circumstance are also less likely to have substantial retirement assets and will thus face financial difficulties as they age. Based on our past survey work, we can estimate that this will affect approximately one quarter to one third of the elder population with single and widowed individuals particularly vulnerable.

Because of their numbers, the baby boomer cohort can be expected to place demands on society as consumers of both public and commercial services.

Boomers, on average, have fewer children than their parents. As a result, we can expect that the family-based support network for them will be less extensive than is the case for their parents, thus increasing demands placed on community-based supports. This may lead to an increased need to train both agency staff and direct service workers (such as health care workers, teachers, bank tellers…) in aging issues and effective communication with elderly people.

To competently respond to the greater diversity among older consumers there may be a demand for providing specialized training to specific worker and professional groups to assure that the needs of aging persons and people with disabilities can be met.

As this group ages we will see increases in the prevalence of chronic diseases and disabilities, chronic physical and mental health conditions, and the long term consequences of occupation-related diseases and injuries. This, in turn, will increase the demand for information and assistance, case management, long-term care insurance products, supportive assistance and long-

term care services (both institutional and community-based), informal and formal caregivers, and housing modifications.

Socially, baby boomers differ from prior generations. Changes in traditional family structures and configurations have characterized the past three decades, affecting the dynamics of family and intergenerational interactions as well as the dynamics of the workplace. In addition to the more traditional households types such as those living alone because of divorce or spousal death, those never married and childless couples, the number of less traditional households and families has grown. These include:

- elderly and non-elderly unmarried cohabiting couples;
- grandparents as custodial parents;
- three- and four generation families in a household;
- lesbian and gay households;
- those married multiple times with multiple sets of extended family members, step children, and aging parents;
- households made up of groups of unrelated individuals;
- elderly parents caring for elderly adult children with developmental and other disabilities.

Each of these types of households will have specific needs that may fall outside those of more traditional household forms.

Addressing this complex of issues may require:

- Customizing programs, services, products, forms, information, and communication to fit the growing diversity in terms of household type, language, race, ethnic culture, disability, and other circumstances that will characterize the elder population.

- Increasing reliance on various existing and new technologies as efficient and effective methods of improving communication and interaction with elders. This may require targeting education and personal assistance to facilitate elders' ability to use/access the Internet and other technologies

- Recognizing the need to adapt technological solutions and tools to the age, language, racial, cultural, educational, and disability characteristics of elders paying special attention to reliability, security, and privacy issues associated with the Internet and data-sharing technologies.

- Increasing the availability of specialized/adaptive services needed by frail elders (i.e. transportation, housing, in-home, community support, rehabilitation, mental and health promotion).

- Making greater use of the talents and skills of retirees by providing accommodations to permit them to remain in the workforce longer and by expanding adult continuing education programs to prepare older people and retirees to work in needed occupations.

- Developing innovative and affordable housing that will increase the availability of options that provide supportive services in the least-restrictive environment for elders.

Impact of Recent Recession on Elders

Major impacts of the recession on Elders and older Americans:

- Job losses – decreased earnings during peak earning years
- Stock market losses – drop in retirement savings
- Housing price decline – effect on net worth
- Social issues – expectations, mental health, abuse
- Lower tax revenue – cuts in government supported services

The recession has had a significant impact on employment among older workers. On average, older workers (aged 55+) who lose their jobs take longer than younger people to find new ones and when they do find new jobs it is more likely to be at a significantly lower earning level.

In some cases older workers are forced to take social security at 62 rather than waiting for full retirement age due to economic circumstances. This reduces their monthly income permanently compared to what they might have received had they been able to work longer.

Based on Federal Bureau of Labor Statistics data, the rate of labor force participation among the 65+ population has increased (see Table 16). In considering this trend it is important to note that Baby Boomers did not begin to turn 65 until 2011. This pattern may reflect an attitudinal change about working later in life, economic necessity, or perhaps some other factors.

Table 16. Massachusetts Labor Force Participation Rate by Year for Those Aged 65+

	2007	2008	2009	2010	2011	2012
Percent in labor force	15.6	16.5	17.6	18.9	19.1	19.9

The change in workforce participation may be related to the altered financial circumstances faced by many older workers. Although most people with retirement assets suffered substantial losses during the collapse of the stock and bond markets, since March 2009, these markets have rebounded substantially. This has allowed those who remained invested to make back all or at least a significant part of their losses. However, those who sold out during the decline may have missed this rebound in asset prices.

Another major component of financial security is home ownership. While home prices have started to rebound in many areas, they remain substantially lower than during the real estate boom of the early 2000's. The decline in home prices can have an impact in terms of the money elder homeowners can take from the sale of their property or in the amount available through a reverse mortgage.

Summary

While many of the broader trends we have identified are beyond the capacity of an Area Agency on Aging to address, it is important to recognize the broader context within which we have to operate. Understanding these broader trends will help us to better prepare for future service needs.

Based on the information presented here we conclude that the primary supportive service needs identified in the CMAA needs assessment process fall into a few broad categories. These include:

- **Access Issues** such as transportation, language barriers and lack of information about service availability.
- **Housing Issues** such as long wait lists for elder housing, high costs and home repair.
- **Financial Issues** such as finding employment, managing financial affairs and dealing with increased costs of living (e.g. food, fuel).

In addition, under the Older Americans Act there are specified needs that must be addressed:

- **Legal Services** targeting the needs of vulnerable elders (e.g. public benefits issues, eviction).
- **Nutrition** including both congregate and home delivered meals.
- **Health Promotion and Disease Prevention** addressing significant local health needs or gaps in available health promotion programming.
- **Caregiver Support** to assist family caregivers to better provide assistance to elders.