Meeting the Challenge of an Aging Population in Greater Cincinnati

Prepared for The Cincinnati Foundation for the Aged

by The Health Foundation of Greater Cincinnati

November 2001
# Table of Contents

Table of Illustrations ........................................................................................................ v

For More Information ........................................................................................................ vii

Introduction ....................................................................................................................... 1

Effect of the “Baby Boom” Generation on the Elderly Population ................................. 3
  Projected Impact of the Baby Boom Generation on the Elderly Population .................. 6
    Minorities in the Baby Boom Generation ...................................................................... 8
  Family Caregiving and the Baby Boom Generation ....................................................... 9
    Baby Boomers as Family Caregivers ............................................................................ 9
    Baby Boomers as Recipients of Family Caregiving ..................................................... 10

Concerns of the Elderly ..................................................................................................... 11
  Maintaining Well-Being ................................................................................................. 11
    Medicare and Health Insurance .................................................................................. 12
  Physical Health ............................................................................................................ 13
    Local Statistics on Physical Health Status .................................................................. 13
    Disability .................................................................................................................... 14
  Mental Health ............................................................................................................... 16
    Depression .................................................................................................................. 16
    Alzheimer’s Disease ................................................................................................. 17
  Substance Abuse .......................................................................................................... 19
    Alcohol Abuse .......................................................................................................... 19
    Prescription Drug Misuse and Drug Interactions ....................................................... 20
    Addressing Behavioral Health Needs ......................................................................... 21
  Elder Abuse ................................................................................................................. 21
  Living Environment ..................................................................................................... 24
    Remaining at Home .................................................................................................... 24
    Home Maintenance and Management Assistance ..................................................... 24
    Adult Day Services .................................................................................................... 25
    Non-Home-Based Residential Living ........................................................................ 27
  Poverty .......................................................................................................................... 30
  Prescription Drug Costs .............................................................................................. 32
  Transportation ............................................................................................................... 33
  Social Networks .......................................................................................................... 36
  Nutrition ....................................................................................................................... 36
  Ethnicity and Healthcare ............................................................................................ 37
  Specific Concerns of Local Seniors ............................................................................. 39
    Hamilton County ....................................................................................................... 39
    Boone, Campbell, and Kenton Counties ...................................................................... 41
## Contents

**Caregivers and Caregiver Support ................................................................. 43**
- Informal Caregivers of Older Adults ................................................................. 43
- Support for Informal Caregivers ....................................................................... 44
  - Gender Differences Among Informal Caregivers ............................................ 47
- Older Adults as Informal Caregivers for Grandchildren ................................. 48
- Paid Caregiver Workforce Issues .................................................................... 51

**Today’s Seniors ....................................................................................................... 53**
- Ohio and Hamilton County .............................................................................. 53
- Kentucky and Boone, Campbell, and Kenton Counties ....................................... 55
- Gender, Poverty, and Ethnicity .......................................................................... 56
  - Gender ........................................................................................................... 56
  - Poverty .......................................................................................................... 58
  - Ethnicity ........................................................................................................ 60

**Tomorrow’s Seniors and Services ....................................................................... 61**
- Closing Service Gaps .......................................................................................... 61
- Expanding Services to Meet the .......................................................................... 63
- Increasing Number of Baby Boomers .................................................................. 63
- Incorporating New Knowledge ............................................................................ 63
- Conclusion ........................................................................................................... 64

**References ............................................................................................................ 67**

**Appendix A ........................................................................................................... 71**

**Appendix B ........................................................................................................... 77**

**Appendix C ........................................................................................................... 81**
# Table of Illustrations

- **Figure 1**: The projected number of elderly in Ohio, Kentucky, and Indiana ........................................... 3
- **Figure 2**: The effect of the baby boom generation on the U.S. population ................................................. 5
- **Figure 3**: The effect of the baby boom generation on the U.S. elderly population ................................... 7
- **Figure 4**: The increase of ethnic diversity in the elderly ........................................................................... 8
- **Figure 5**: Disability rates of Northern Kentucky seniors ........................................................................ 15
- **Figure 6**: Local prevalence of elder abuse .............................................................................................. 23
- **Figure 7**: Monthly Medicaid spending on home care and nursing homes ............................................. 26
- **Figure 8**: Local monthly spending on home care and nursing homes .................................................... 26
- **Table 1**: Demographics of older Americans living below 125% of FPL .................................................... 31
- **Table 2**: Costs of common prescription medications ............................................................................ 33
- **Table 3**: Top five concerns of Tri-State seniors ...................................................................................... 39
- **Table 4**: Needs of Northern Kentucky seniors ...................................................................................... 41
- **Table 5**: Local financial impact of unpaid caregiving ............................................................................ 47
- **Figure 9**: Population of Ohio’s older adults, by age, in 1995 and projected for 2010 ............................ 54
- **Figure 10**: Population of Hamilton County’s older adults, by age, projected for 2000, 2005, and 2010 ............................................................. 55
- **Figure 11**: Hamilton County’s elderly population by age and gender, in 2000, 2005, and 2010 ........... 57
- **Table 6**: Northern Kentucky’s elderly female population, by age ........................................................... 58
- **Figure 12**: Poverty rates for Northern Kentucky seniors by age, gender, and living arrangements........ 59
- **Figure 13**: Ethnic populations of Greater Cincinnati older adults ......................................................... 60
In 2000, The Health Foundation of Greater Cincinnati entered a partnership with the Cincinnati Foundation for the Aged to assess the healthcare needs of older adults in four Greater Cincinnati counties. These four counties are part of the Health Foundation’s service area (see figure below).

The Cincinnati Foundation for the Aged (CFFA) makes grants to enable aged persons without private or public resources to enter nursing homes or to receive home services. The CFFA is not currently seeking proposals.

Marilyn C. Anderson, Associate Professor in the Department of Nursing at Miami University, and Sondra Britton, former Director of Adult Protective Services at Cincinnati Area Senior Services, served as authors of this paper. Jennifer Bartos, Joseph Snyder, and Health Foundation staff served as editors.

The Health Foundation invests in projects that fall into four focus areas:

- Strengthening Primary Care Providers to the Poor
- School-Based Child Health Interventions
- Substance Abuse
- Severe Mental Illness

For additional copies of this paper, please call our Publications Ordering Line at (513) 458-6658 or visit our web site at http://www.healthfoundation.org/publications. For more information about the Health Foundation or our grantmaking interests, please contact us at (513) 458-6600. You can also reach us toll-free at (888) 310-4904. This report and others, as well as information about the Foundation’s grantmaking programs, can be found on The Health Foundation of Greater Cincinnati’s web site: http://www.healthfoundation.org.
Introduction

In the United States, we have come to expect that with some careful planning, the “golden years” should be one of the best times of our lives. And, the truth is, many seniors enjoy an abundance of good years.

However, the longer we live, the more likely we will deal with some of the less desirable consequences of aging—illness, loneliness, diminished capacity, loss of independence, loss of social connections, and dwindling financial resources—the things that most of us choose not to talk about. Yet as we age, these consequences can make meeting basic needs challenging and at times overwhelming.

While we may not be able to stop aging, we may be able to slow its course. New research demonstrates that, in part, we can control our aging through the lifestyles we choose. However, there are changes that we cannot control. How much these changes affect our quality of life, in great part, depends on the external supports available. For example, the average 90-year-old person does not have the same physical health as the average 30-year-old person. However, with external supports such as reading glasses, canes, help around the house, and transportation, the 90-year-old can maintain an acceptable quality of life.

The availability of external supports will become particularly important around 2011, when the “baby boomer” generation begins turning age 65. After 2011, the elderly population will grow rapidly, potentially taxing the already limited supports for the elderly. For the community, the challenge is to discover and then make available the external supports that are needed to make the lives of seniors livable. Putting these supports in place now will improve the quality of life for today’s seniors and for tomorrow’s.

This paper will explore the population of the elderly and the supports available to this population. The data proceed from a national level to a state level, and, when possible, to a regional or county level, specifically targeting Hamilton County in Ohio and Boone, Campbell, and Kenton.
Counties in Kentucky. Finally, the paper suggests ways to meet the identified needs of local seniors and recommends best practices for meeting those needs.
Effect of the “Baby Boom” Generation on the Elderly Population

Between 1930 and 1945, the American population experienced a decline in birth rates due to the Great Depression and World War II (WWII). Immediately after WWII, birth rates increased dramatically, giving rise to the “baby boom” generation. This generation consists of people born between 1946 and 1964—approximately 76 million people (Morgan, 1998).

Just as the members of the baby boom generation influenced pediatrics when they were children, they will have a great effect on geriatrics and gerontology in the coming decades. In 2011, the first of the “baby boomers” will turn 65, and the population of older adults in the U.S. will skyrocket (see Figure 1).

![Graph showing the projected number of elderly in Ohio, Kentucky, and Indiana from 1995 to 2025.](source: U.S. Census Bureau, 2001)

The years leading up to 2011 may be considered a grace period, as projected increases in the elderly population will be relatively small. Social service systems for the elderly can use this window of opportunity to put in place the necessary infrastructure to meet the period of rapid growth projected between 2011 and 2030.

Although the rapid growth of the elderly generation caused by the baby boomers will taper off beginning in 2050, the
The size of the elderly population will not suddenly decrease. The baby boom generation will directly influence the number of people in the generations that come after it. While people in the baby boom generation had fewer children per person than their parents had (Pillemer and Suitor, 1998), the population of later generations has grown merely because
there are more people in the baby boom generation to have children (see Figure 2).

![Figure 2: The effect of the baby boom generation on the U.S. population](image)

Source: Morgan, 1998
Projected Impact of the Baby Boom Generation on the Elderly Population

By 2010, the population of people aged 65 and over is projected to be just over 39 million. Between 2010 and 2030, that population will increase by more than 75%, growing to over 69 million. Once the baby boomers reach near age 85 and over, the elderly population will grow 14% between 2030 and 2050, reaching 79 million (Administration on Aging [AOA], 1996). The rapid growth caused by the baby boom generation will also cause major increases in the population of the “oldest old”—those aged 85 and over (see Figure 3).
These rapid increases will especially complicate service systems that assist the elderly with disabilities. The Administration on Aging (1996) predicts that the number of elderly adults with severe or moderate disabilities will more than triple between 1986 and 2040, even if increases in longevity and disability ratios are held constant at today’s rates. Furthermore, if current trends in nursing home utilization remain constant, the population of elderly people...
in nursing homes could double or even triple by 2030, with the segment aged 85 and over tripling during that time.

**Minorities in the Baby Boom Generation**

The rapid increases in the elderly population will also occur with increasing ethnic diversity among the elderly. As will be discussed later (see the section entitled “Today’s Seniors” for more information), the percentages of Americans from ethnic minority groups is expected to grow in the near future, causing similar increases in the demographics of the older population (see Figure 4).

![Figure 4: The increase of ethnic diversity in the elderly](image)

The sudden population growth caused by the baby boomer generation will cause similar growth in the older populations of ethnic minority groups. Health status and healthcare access vary widely among people of various ethnic groups, and providers to the elderly will have to take into account ethnic variations as they plan for the future increases.
Family Caregiving and the Baby Boom Generation

While the baby boomers will share many of the concerns about aging that the current elderly population has (see “Concerns of the Elderly” for more information), the baby boom generation will face unique challenges with family caregiving as they age. Many of these challenges have resulted from the changes in family philosophy from one generation to the next.

For example, the majority of people in generations before the baby boom held the philosophy that parent-child relationships were born out of obligation and a sense of filial responsibility—that is, the children would automatically take care of the parents when the parents became older. Since the baby boom, this philosophy has changed in the United States. Children become independent sooner, expectations of filial responsibility are less clearly articulated, and parent-child relationships are chosen, not obligated (Pillemer and Suitor, 1998).

Another change that will affect family caregiving and the baby boomer generation is the notion of “family.” There are many more family forms today than before the baby boom generation was born: one-parent, two-household, step-family, grandparent-led, foster family, etc. In addition, the mobility of the current U.S. society has meant that relatives live farther away from each other than before. These changes will have a significant impact on baby boomers as they age and look to family caregivers for assistance.

Baby Boomers as Family Caregivers

By serving as caregivers to and assisting their aging parents, the baby boom generation is getting a unique look at the assisted-living and other service systems for elderly populations long before they will have to navigate these systems themselves. And the baby boomers have plenty of time to get this look: they can share 30 or more years of adulthood with their parents.

While baby boomers are getting experience navigating service systems that may help them when they reach age 65 and older, they are also getting experience with the
frustration of trying to navigate a fragmented system. They are watching their parents struggle with decisions about living at home, staying independent, and staying healthy with often inadequate community resources to do so. Once the sudden spike in the elderly population hits when the first of the baby boomers reach age 65, however, these systems will become more fragmented and inadequate unless something is done ahead of time.

**Baby Boomers as Recipients of Family Caregiving**

Changes in family structure will especially affect baby boomers when they become the care recipients rather than the caregivers. One significant change is in the number of children per family. Parents of baby boomers had an average of three children who survived until the age of 40 per every married woman; baby boomers have under two (Pillemer and Suitor, 1998).

Baby boomers also had their children much later in life than their parents did, meaning their children could be 40-50 years old when the baby boomers turn 80 (Morgan, 1998). During these “middle age” years, the children of baby boomers will most likely have some child-rearing responsibilities of their own on top of any informal caregiving they might provide to their parents.

Given these two factors, aging baby boomers may not be able to rely on informal caregivers as much as their parents did. In addition, the baby boom generation had a much higher divorce rate than the generations before it. Divorce can have a significant affect on parent-child relationships, which could translate into fewer opportunities for baby boomers to have a family caregiver.
Concerns of the Elderly

As people age, maintaining familiar lifestyle patterns becomes challenging as basic life requirements (i.e. food, shelter, etc.) take priority. Many seniors become concerned with such issues as failing health, insufficient financial and social resources, inadequate community resources, and age discrimination. As a result, a plethora of needs arise.

A frequent concern of older people is becoming disabled, making them a burden to others. The hope for many is that they can live in an environment where, despite disability, their abilities are maximized. Being matched with the right level of care preserves abilities while compensating for disabilities. Seniors need accessible, acceptable, and affordable community resources to maintain life quality. These resources include a range of services offered in the community to address the needs of its residents.

Healthcare issues are often a major focus for seniors, who receive healthcare across a spectrum of settings from hospital to home. Changes in health may require a change in daily living environment, and these transitions often result in personal gains and losses for seniors. For example, an older person may have to give up treasured possessions and a familiar neighborhood to gain necessary support and help with day-to-day living that an assisted living facility can provide.

Maintaining Well-Being

Most elderly adults consider themselves in excellent or good health and live in their own homes. It is only when their ability to carry out valued activities is threatened that they begin to consider themselves “sick.”

For “well elders”—people who consider themselves to be in good health—continued well-being is a critical issue. Exercise; maintaining a healthy diet; decreasing high-risk behaviors; stress reduction; seeking social support; having regular check-ups, screenings, and flu shots; and other behaviors are the primary factors to remaining well as one ages. However, at least locally, seniors are not taking...
Concerns of the Elderly

The advantage of the preventive measures that can help keep them well. The Greater Cincinnati Community Health Status Survey (The Health Foundation of Greater Cincinnati [HFGC], 1999), a survey of adults in 20 Greater Cincinnati counties, reported that of the population aged 65 and over:

- 8.7% had not had their blood cholesterol checked for three or more years, and an additional 6% had never had their blood cholesterol checked;
- 41% had not had a flu shot in the past 12 months, and 9% reported having the flu during the past fall or winter;
- 24% of women had never had a mammogram;
- 7% of women reported that they had never had a Pap test, and 24% had their last Pap test five or more years ago;
- 2% of men had never had a rectal or prostate exam, and 21% had their last rectal or prostate exam three or more years ago;
- 18% of people were unable to exercise, 29% exercised less than one time a week, and 41% exercised 3–7 times a week; and
- 25% ate high-cholesterol or high-fat foods every day, such as fatty meat, cheese, fried foods, or eggs.

Medicare and Health Insurance

Another factor in staying well is access to healthcare, which is made easier by health insurance. Medicare insures the majority of older Americans. Among Greater Cincinnati residents aged 65 and over, only 2% reported in The Greater Cincinnati Community Health Status Survey (HFGC, 1999) that they did not have health insurance or coverage at some time during the last 12 months, compared to 17.5% of the general population of adults surveyed. However, nearly 10% reported that in the past 12 months there was a time when they personally thought that they needed medical care but did not get it or delayed getting it. The most frequent reasons for not getting or delaying care were “being stubborn” or “waiting for [the problem] to go away.” Greater Cincinnati residents aged 65 and over were the least likely of any age group to report that a member of the household did not receive a doctor’s care because the household needed the money to buy food or clothing or to pay for housing.
However, Medicare does not cover all healthcare services, and when it doesn’t, the picture is quite different. For example, Medicare does not cover dental care. Nearly 44% of seniors in the Greater Cincinnati area reported that it had been more than three years since they last visited a dentist or dental clinic for any reason (HFGC, 1999). The high cost of prescription drugs is another well-described out-of-pocket expense for most seniors.

The Commonwealth Fund (2000) reported in 1999 that the typical Medicare beneficiary pays $2,600 in out-of-pocket healthcare expenses each year, or nearly 20% of his or her annual income. In comparison, non-elderly families spend about 8% of their annual income on out-of-pocket healthcare expenses.

**Physical Health**

Like many factors, chronic illness adds to the complex picture of aging. Chronic illnesses are characterized by being long-term, irreversible, and medically or financially burdensome for individuals, their families, and the healthcare system. They can have a dramatic effect on quality of life and may require people to make changes in their living environments or settings of care (Phipps, Sands, and Marek, 1999). Arthritis, hypertension, heart disease, hearing impairments, orthopedic impairments, cataracts, sinusitis, and diabetes were the most frequently occurring health conditions in the nation in 1995 (American Association of Retired Persons [AARP], 1999; AOA, 1999). Each of these conditions is chronic in nature.

While the problems associated with chronic illness may change, they usually do not completely disappear (Phipps, Sands, and Marek, 1999; Strauss, 1984). How well seniors manage chronic illness is associated with their ability to get the support they need. In addition, most seniors have one or more chronic conditions, further complicating their management (AARP, 1999; AOA, 1999).

**Local Statistics on Physical Health Status**

According to The Greater Cincinnati Community Health Status Survey (HFGC, 1999), area adults at greatest risk of having physical health limitations included those who were: elderly, female, white Appalachian, poor, educated at less
than a high school level, covered only by Medicaid, widowed, living in a household with no children, and living in a household with one adult. Key findings from this survey that relate directly to the elderly included:

- The conditions most common at the national level (arthritis, hypertension, heart disease, and diabetes) were ranked similarly at the local level.
- Adults aged 65 and over were most likely to indicate that they had been diagnosed with heart trouble or angina, diabetes, cancer, and stroke.

**Disability**

An important measure of physical health for older adults is the level of disability they experience. During 1994–1995, 52.5% of the senior population reported having one or more disabilities, and the prevalence of disability increases with age (AARP 1999; AOA, 1999). In Ohio, research indicates higher rates of severe disability among women of all ages (Mehdizadeh, Kunkel, and Applebaum, 1996).

For older adults, disability is measured by their ability to be independent in activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL are basic activities such as bathing, dressing, eating, and getting around the house. Almost 15% of seniors (4.4 million) had difficulty in carrying out ADL. IADL include preparing meals, shopping, managing money, using the telephone, doing housework, and taking medications. Over 20% of seniors (6.5 million) reported having difficulty with IADL (AARP 1999; AOA, 1999).

The ability to carry out ADL greatly influences quality of life. The chronic conditions of aging limit the basic activities that are critical for independent living. Nationally, over 36% of senior adults reported limitations due to chronic conditions in 1996 (AARP 1999; AOA, 1999).

**Hamilton County.** In both Ohio and Hamilton County, the size of the severely disabled population is projected to change only slightly between 1995 and 2010. It was estimated that Hamilton County had 38,233 disabled seniors in 1990 and that 34% (12,986 seniors) fit into the
severely disabled category (Mehdizadeh, Kunkel, and Applebaum, 1996).

It is interesting to note from this study the difference in the numbers of people in various age groups who have no disabilities. In the year 2000, 79% of Hamilton County seniors aged 65–69 had no disabilities compared to only 15% of seniors aged 85–89. People aged 85 and older are the only group estimated to increase in the percent with moderate and severe disability during the next ten years.

**Boone, Campbell, and Kenton Counties.** The best indicators of disability among seniors in Kentucky were mobility and self-care, which are both representative of ADL. As in the nation, the increasing age of Kentucky residents results in increased limitations in mobility and self-care. While the counties start with a similar level of disability for men and women at age 65 and over, by age 75 and over, Boone County has the highest disability rate for women (40.2%), while Campbell County has the lowest (33.3%) (see Figure 5).

![Figure 5: Disability rates of Northern Kentucky seniors](source: Rowles et al., 1996)
Mental Health

Healthy aging is influenced by mental health, and difficulties with mental health can begin at any age. For some seniors, mental illness had its onset in the teens, twenties, or thirties. By the time the person has reached age 65, he or she usually has acquired an approach to coping with the illness that is acceptable to himself or herself and others. Mental health problems can also develop with age and may take their toll in the form of depression or other illnesses, such as Alzheimer’s disease, that may have catastrophic results. Diagnosing mental illness can be problematic for a clinician, as it can be difficult to accurately detect mental or emotional problems within the array of physical symptoms that accompany aging and its chronic illnesses. And although the mental health problems experienced by the elderly can be managed and treated through community-based interventions, the mental health needs of many elderly people are not being met.

Another obstacle in detecting mental health problems is that physical health problems are usually given priority by families and physicians. Additionally, seniors are often reluctant to seek care from mental health professionals because of the powerful stigma associated with forms of treatment for mental illnesses that seniors heard of when they were younger (Hogstel, 1996). Accurately identifying mental health problems is further complicated by the fact that many mental problems, such as depression and Alzheimer’s disease, have such similar symptoms in early stages that one mental problem is sometimes mistaken for another.

Approximately 20% of Americans ages 55 and over experience specific mental disorders in any given year. The most common disorders, in order of prevalence, are: anxiety disorders, severe cognitive impairment (e.g. Alzheimer’s disease), and mood disorders. Schizophrenia and personality disorders are less common. Individuals ages 65 and over account for 20% of all suicides, representing the highest rates of suicides in the U.S. (AOA, 2001).

Depression

As people age, they experience losses and increased dependency, which lead to feelings of hopelessness, helplessness, and a loss of sense of self—each a symptom of
depression (Hogstel, 1995). Depression can have an impact on general well being, causing physical illness, greater functional disability, social isolation, and increased use of healthcare resources. Greater difficulty can be expected if the symptoms are left untreated. Severe depression may lead to suicide.

Although women aged 65–84 have more severe depressive symptoms than men do, after age 85, the prevalence of depressive symptoms is similar between men and women. The prevalence of depression increases for those who live in long-term care facilities (Hogstel, 1995).

Depression is a treatable illness and is the most common type of mental illness in older adults, and the prevalence of depression increases with age. Of the 34 million older adults in the U.S., 2 million suffer from some form of depression (National Institute of Mental Health [NIMH], 2001). In 1998, 15% of people aged 65–79, 21% of people aged 80–84, and 23% of people aged 85 and over were diagnosed with depression (Federal Interagency Forum on Aging Related Statistics, 2000).

**Alzheimer’s Disease**

Alzheimer’s disease, characterized by plaques and tangles in the brain, is the most common form of dementia. The disease has a long course of 2–20 years, with an average duration of eight years from the onset of symptoms. The prevalence of people with Alzheimer’s disease is expected to continue to increase, especially as more people live into their 90s.

Because the onset of the disease is often hidden, the disease has usually progressed several years before it is diagnosed. Those with Alzheimer’s disease often experience devastating losses over the course of the illness, including the loss of communication skills and bowel and bladder function, as well as the abilities to walk, recognize others, and sit up or swallow. Data on Alzheimer’s disease include:

- About 4 million Americans have Alzheimer’s disease (Evans, 1990). In the 27-county area served by the Greater Cincinnati Chapter of the Alzheimer’s Association and Related Disorders Association, Inc., it is estimated that there are more than 23,000 persons
Concerns of the Elderly

diagnosed with Alzheimer’s disease (Alzheimer’s Association and Related Disorders Association, Inc. [AARDA], 1998).

- About 14 million Americans are projected to have the disease by the middle of this century unless we learn how to cure or prevent the disease (Evans, 1990).
- One in 10 people over age 65 and nearly half of those over age 85 have Alzheimer’s disease (Evans, 1989).
- The U.S. spends at least $100 billion a year on care for Alzheimer’s disease. Neither Medicare nor most private health insurance covers the long-term care most patients need (Rice, K. P., et al., 1993).
- More than 7 out of every 10 people with Alzheimer’s disease live at home, and almost 75% of home care is provided by family and friends. The remainder of home care is “paid” care that costs an average of $12,500 per year. Families pay almost all of this out-of-pocket (United States Department of Health and Human Services [USDHHS], 1982; United States Congress, Office of Technology Assessment [OTA], 1987; Brody, 1990).
- Alzheimer’s disease is the third most expensive disease in the United States, after heart disease and cancer (Kane, 1994).

The issues that arise from living with Alzheimer’s disease present daily challenges for the affected people and their families, who find they know little about the disease or how to care for the affected person. Concerns of family members include:

- differences and similarities between Alzheimer’s disease and other forms of dementia;
- communication challenges;
- managing behavior;
- how to find programs and services;
- general safety issues, such as the person driving, wandering, and other issues;
- home safety issues;
- legal and financial issues;
- advanced directives and durable powers of attorney;
- transitions across settings of care; and
Concerns of the Elderly

- emotional support, stress relief, and respite care (AARDA, 1998).

Caring for a person with Alzheimer’s disease exacts a great physical and psychological toll on families. When families have exhausted all other options, they usually turn to nursing home placement, which can exact a great toll itself (see the chapter entitled “Caregivers and Caregiver Support” for more information on family caregivers). Special units and entire facilities have been constructed or redesigned to meet the needs of people with dementia.

Substance Abuse

Substance abuse among seniors is a significant problem that takes on new meaning for this population. Usually, substance abuse is considered the abuse of alcohol and illicit drugs. Alcohol abuse and misuse is the major substance abuse problem among older adults in the U.S. Older drinkers may have begun their drinking earlier in life (early onset), or the problem may have begun when they were in their 50s or 60s (late onset) (Britton and Stephan, 1995). The majority of older drinkers in treatment are early onset drinkers. “Drug abuse” by older adults is generally prescription drug misuse, which can be just as dangerous as illicit drug abuse.

Alcohol Abuse

The ability to tolerate alcohol changes with age (Britton and Stephan, 1995), and age-related increases in sensitivity to alcohol may result in negative effects with even relatively low consumption of alcohol (USDHHS, 1998). Risk factors for alcohol abuse include gender (older men are more likely to have the problem), loss of a spouse, other losses such as impairments or mobility problems, substance abuse in earlier life, a mood disorder diagnosis (depression and bipolar disorders), and a family history of alcohol problems.

Alcohol use combined with age-related illnesses are also problematic for older persons. Prescription and over-the-counter medications can be dangerous for older adults who consume alcohol. Alcohol consumption can also increase the risk of falls and accidents. In addition, if older adults have mental impairments, their ability to self-monitor their alcohol intake is diminished (USDHHS, 1998).
There is debate among professionals regarding the adequacy of the criteria in diagnosing older adults with alcohol problems. Since the criteria for the medical diagnosis of substance abuse were designed for younger patients, healthcare providers frequently overlook substance abuse in seniors. Moreover, seniors are more likely to hide their substance abuse and less likely to seek treatment than other age groups, probably because heavy drinking was more socially acceptable when these seniors were younger. To further complicate matters, older adults may be involved in fewer activities, which may make detection of problems by others more difficult. At times, healthcare providers also can mistake the symptoms of substance abuse for dementia, depression, or other problems.

**Prescription Drug Misuse and Drug Interactions**

Prescription drug misuse is prevalent among seniors. Generally, seniors have more health problems than younger people, and therefore are more likely to be taking many medications at the same time. The more kinds of medication a person takes, the more likely he or she is to have an adverse drug interaction (i.e., when two drugs act differently in combination than individually intended). The body's reaction to these adverse interactions is also more severe in seniors than in younger people, as changes in body chemistry that accompany aging also affect the way drugs are processed in the body. Adverse drug interactions can result from drug overuse or misuse and from the differences in how drugs act in an older body. Risk factors for adverse drug interactions include being female, living alone, having multiple diseases, taking multiple drugs, and having poor nutrition (Gomberg, 1996).

Noncompliance is also an important issue regarding prescription drug misuse among seniors. Gomberg (1996) identified several different categories of noncompliance, including:

- nonuse, or not obtaining the medication;
- partial use, or stopping taking the medication before directed by a physician;
- incorrect dosage, or taking more or less than prescribed;
- improper timing or sequencing of the medication; and
- sharing medications.
While there may be several reasons for noncompliant behavior, such as avoiding undesired effects of the medication, the cost of purchasing the medications can also be a significant contributing factor. Although Medicare has made healthcare affordable for the majority of older Americans, prescriptions are not a Medicare benefit. Without additional coverage, some seniors are unable to pay for the cost of their prescriptions (see the section entitled “Prescription Drug Costs” in this chapter for more information).

**Addressing Behavioral Health Needs**

Addressing the substance abuse needs of the elderly is complex. In 1998, the Mental Health and Aging Coalition identified that the behavioral healthcare needs—such as mental health and substance abuse disorders—of the elderly frequently go unnoticed by professionals in the aging field because of their lack of substantive knowledge of behavioral health. At the same time, behavioral health providers are also unfamiliar with issues relating to the aging process and services available to the elderly in the community, which results in fragmentation in service delivery.

**Elder Abuse**

Abuse of older adults is a significant problem in the U.S., where an estimated 59% of the senior population is mistreated each year (Cincinnati Area Senior Services [CASS], 2000). However, this may be an underestimation, as there is general consensus that gross underreporting of elder abuse occurs. It is also estimated that only 1 out of 14 domestic elder abuse incidents (excluding self-neglect) are reported (United Way, 2000). Results of the 1996 National Elder Abuse Incidence Study (AOA, 1998) also supported this underreporting by showing that four times more incidents of elder abuse, neglect, or self-neglect were unreported than were reported to, and substantiated by, adult protective service agencies.

The three categories for reporting abuse as defined by the national Adult Protective Services Law are abuse, neglect, and exploitation:

- **Abuse**: The infliction upon an older adult, by self or by others, of injury, unreasonable confinement,
intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.

**Neglect (also known as self-neglect):** The failure of an older adult to provide for himself or herself the goods or services necessary to avoid physical harm or mental anguish, or the failure of a caretaker to provide such services.

**Exploitation:** The unlawful or improper act of a caretaker who uses an older adult or adult's resources for monetary benefit, personal benefit, profit, or gain (CASS, 2000).

More than one type of abuse can happen at once. For example, there may be indications of self-neglect (i.e., an older adult refuses to wash himself or herself although able) in addition to unauthorized use of the older adult's bank account by a family member. When a senior is in an abusive situation, other problems may arise such as substance abuse, inadequate housing arrangements, financial burdens, caregiver stress, etc. To prevent elder abuse, factors such as inadequate financial support, poor housing arrangements, and lack of caregiver support may need to be addressed.

Elder abuse is also associated with disability. The most likely victim of elder abuse is a middle class woman, aged 75 and over, who is severely disabled (mentally or physically) and dependent on others for daily care (CASS, 2000).

Personal and situational risk factors for elder abuse include:

**Personal risk factors**
- Isolation—having no family close by or having no family and having few social contacts
- Family status—being unmarried, divorced, widowed, or childless
- Physical impairment
- Mental impairment
- Being homebound
- Being bedridden

**Situational risk factors**
- Sudden dependency
- Mental illness
Concerns of the Elderly

- Advanced age or frailty
- Needing constant care
- Living alone
- Overburdened family resources
- Family conflict
- Substance abuse (CASS, 2000).

Local data are available about elder abuse (see Figure 6).

Figure 6: Local prevalence of elder abuse

In addition, 60% of people aged 85 and over who are abused are women, and 34% of people aged 70 and over who are abused are women (United Way, 2000).

Available local data also point to a definite need for abuse prevention services. The number of elder abuse reports in Hamilton County increased 150% between 1986 and 1996, a reflection of both the growing senior population and...
the shrinking number of available caregivers (United Way, 2000).

**Living Environment**

Although many impaired older adults live in nursing homes, seniors who are equally as impaired are living in the community. A variety of living environments can sustain seniors at any disability level, as long as the environments have the appropriate supports and care for seniors’ needs.

**Remaining at Home**

Presently, there are two programs designed to assist local seniors in staying at home despite their disabilities. The Pre-Admissions Screening System Providing Options and Resources Today (PASSPORT) is a national program which gives low-income older adults and their families the option of receiving services at home rather than in a nursing home. To qualify for PASSPORT, the cost of the in-home services must be less than the cost of care in a nursing home and can not exceed an established cap.

The Elderly Services Program (ESP) is a local program using Hamilton County property tax levy funds to provide a variety of services to Hamilton County residents aged 60 and older. Such services include homemaker, personal care, respite, and supportive services not covered by Medicare, Medicaid, or private insurance. Registered nurses and social workers assess the needs of the seniors by telephone and connect seniors to appropriate services (CASS, 2000).

**Home Maintenance and Management Assistance**

Minor home repairs, housekeeping, shopping, bill paying, and yard work can become difficult for seniors to do alone. Even simple tasks such as reaching for something on a high shelf can result in hip-breaking falls. Having some assistance with household tasks can help seniors live at home longer. This assistance can come from a volunteer or a paid professional.

If a person needs the services of a paid professional, a home care aide is one option. However, the demand for health aides exceeds the supply of workers, putting many of those who need assistance on waiting lists. In Northern Kentucky,
there are currently 81 seniors on the waiting list for home care or home health services, such as home-delivered meals, housekeeping, meal preparation, personal care, and respite care (Northern Kentucky Area Development District [NKADD], 1999). In Hamilton County, the number of seniors waiting for home care aides grew to 204 seniors between June 1999 and February 2000.

**Adult Day Services**

Also called “day care,” adult day services are an alternative to non-home-based residential living for those who either cannot afford it or do not wish to use it. Adult day services allow highly impaired older people to remain in their own homes by providing care and socialization for the older person and respite for the caregiver.

Services may include mental stimulation, therapeutic groups, supervision, transportation, hot lunch, and snacks. Most importantly, day care provides respite for caregivers who are “on duty” 24 hours a day. The services are cost-effective for many families, ranging from $25 to $50 per day in the counties addressed in this paper. Seniors enrolled in the PASSPORT Program may qualify for some free adult day services (CASS, 2000; Senior Services of Northern Kentucky [SSNK], 2000).

The need for adult day services exceeds the availability of the service. For example, in Boone, Campbell, and Kenton Counties, only 6.5%, 1.8%, and 4.8% of the respective needs for adult day services are being met (Rowles, et al., 1996).

Despite the fact that more disabled older adults live at home in both Ohio and Kentucky, the amount of monthly
Concerns of the Elderly

Medicaid spending directed to home care in these states is below the national average (see Figure 7).

![Figure 7: Monthly Medicaid spending on home care and nursing homes](chart)

Source: United Way, 2000

Locally, fewer Medicaid long-term care funds go to home care in Ohio than in Kentucky (see Figure 8).

![Figure 8: Local monthly spending on home care and nursing homes](chart)

Source: United Way, 2000
If asked, many seniors would express a preference to use their capabilities and remain as independent as possible for as long as possible, and living in their own homes is one way of doing this. Given the pattern of spending on nursing home care and the desire of older persons to stay in their own homes, policymakers and systems serving older adults need to ask and answer some hard questions: Why are limited community resources being directed toward more expensive and less desired nursing home care? What can be done at the local level to offset the disparity in home care vs. nursing home care funding? What can make strongly preferred in-home assistance a reality for seniors?

Non-Home-Based Residential Living
Seniors with serious illnesses or disabilities who cannot remain at home have two levels of assistance available to them: assisted living facilities and nursing homes. Although the types of services offered at facilities within these levels may vary, facilities in each level share certain characteristics.

Assisted Living. When personal needs exceed an in-home caregiver or adult day service agency’s ability to meet needs, the older person usually moves to a more service-intensive but more personally restrictive environment. In the not-too-distant past, people moved from their homes directly into nursing homes. Assisted living facilities now bridge the gap between home and nursing home and offer both healthcare and socialization benefits.

Each state has developed guidelines for the management of assisted living facilities. In Ohio, for example, assisted living facilities are licensed by the Ohio Department of Health as Resident Care Facilities. As such, they must provide accommodations for 17 or more adults unrelated to the facility’s owner(s). Additionally, they must provide supervision and personal care services (bathing, grooming, dressing, feeding, etc.) for at least three residents and supervision of special diets or medications to at least one resident (CASS, 2000).

In the past 10 years, the construction industry for assisted living facilities has boomed, with the number of assisted living facilities doubling between 1995 and 1997 (Applebaum, Mehdizadeh, and Straker, 2000). In
Northern Kentucky, some counties still need both assisted living and nursing home beds. Boone, Campbell, and Kenton Counties, however, are not among those counties listed as underserved regarding the number of assisted living and nursing home beds (Rowles, et al., 1996).

**Nursing Homes.** Nursing homes offer the most intensive array of healthcare and personal services in a residential setting. Although some people use nursing homes as a place for rehabilitation and recuperation after a serious injury or major surgery, the majority of people in nursing homes will spend the remainder of their lives in this setting.

Nursing homes may be owned and operated by a philanthropic or non-profit organization or by a proprietary, for-profit corporation, family, or individual. Philanthropic facilities are not necessarily less expensive than proprietary nursing facilities, and many facilities of both types have long waiting lists, interfering with access to this type of care.

Nursing homes have changed in recent years. In the past, these facilities were designed both physically and programmatically to meet the needs of people with physical impairments. More recently, there have been increased numbers of people with mental impairments. The most frequent cause of mental impairment among seniors in nursing homes is dementia, whose most frequent cause is Alzheimer’s disease. Half of all nursing home residents suffer from Alzheimer’s disease (AARDA, 1998).

To be admitted to a nursing home, an elderly person must have a Pre-Admission Screening Resident Review (PASRR). This is a state-required service for those entering a Medicaid certified nursing service in Ohio. PASRR assesses physical functioning and mental health deficits. A Universal Pre-Admission Review may also be conducted to evaluate options for the most appropriate long-term care, including community-based programs (CASS, 2000).

There are many complex financial and legal decisions that should be made before nursing home placement. Pre-planning is critical for families. Annual nursing home costs average $42,000 per year but can be as high as $70,000 per year in some parts of the U.S. (AARDA, 1998). Locally,
nursing home costs average between $29,200 and $62,780 per year, depending on the degree of care and privacy of the room (NKADD, 2001). Many nursing home residents rely on Medicaid to pay for their care, but strict rules govern when and what Medicaid will cover. In order to qualify for Medicaid assistance for long-term care, a person must first “spend down” his or her assets, paying for his or her care until personal assets dip below a certain level. Elder care attorneys can help a family work through the regulations regarding spend down.

Being eligible for Medicaid does not guarantee nursing home care, however. Facilities licensed to accept patients with Medicaid must give a certain percentage of beds to Medicaid residents. Remaining beds can be filled by private pay or Medicaid patients at the facility’s discretion. Because Medicaid payment rates are lower than private payment rates, not all nursing homes provide care for residents who rely on Medicaid. Those that do often limit the number of Medicaid beds they provide, sometimes creating extensive waiting lists (CASS, 2000).

Medicaid also does not pay for all available services in a nursing home. For example, Medicaid will not pay for personal comfort or convenience items (such as shampoo, tissues, or newspapers) unless medically necessary and ordered by the doctor. Private duty nursing, nonessential or experimental services, beauty or barber services, rest home or custodial care, continued stay in a facility if the resident’s level of care does not match the facility’s certificate level, and alternative placement are not covered by Medicaid. Dry cleaning and transportation to visit families and friends are also not covered. Medicaid residents in Ohio are allowed to keep $40.00 per month as a personal needs allowance. From this allowance, the resident must pay for personal comfort and convenience items. They must also buy all items that permit them to be a giver such as birthday gifts, candy for a visiting grandchild, or a plant for a sick neighbor.

Some older adults may qualify for Medicare coverage, which is also limited and is applicable only in Medicare-certified nursing homes. Medicare pays for the first 20 days and $96 per day for days 21-100 per benefit period if the patient:

- has been hospitalized for at least three days,
Concerns of the Elderly

- needs skilled nursing care for a condition treated in the hospital, and
- is admitted within 30 days of leaving the hospital and has a doctor’s authorization.

Medicare will also pay for up to 210 days of hospice care for persons who are terminally ill (SSNK, 2000). A person who does meet these requirements is responsible for the rest of the payment.

Poverty

Income determines access to goods and services, which in turn determines function and quality of life. People with lower incomes are more likely to have health problems that are more difficult and costly to treat (Summer, 1999). A recent study showed that nearly 50% of older Americans would experience at least one year of living near or below the federal poverty level (FPL) after age 60. For African Americans, people who were not married, and people with less than 12 years of education, the percentages increased sharply (Everding, 1999).

In 1999, the median annual income for older adults was $19,079 for men and $10,943 for women. Approximately 10% of older Americans were below FPL that year and another 6.1% were “near poor” (AOA, 2000). The FPL for that year for one person over the age of 65 was
Concerns of the Elderly

Table 1: Demographics of older Americans living below 125% of FPL

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2005</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>living alone</td>
<td>not living alone</td>
<td>living alone</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40%</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>32%</td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>Female</td>
<td>41%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>35%</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>75-84</td>
<td>42%</td>
<td>27%</td>
<td>35%</td>
</tr>
<tr>
<td>85+</td>
<td>49%</td>
<td>46%</td>
<td>34%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>36%</td>
<td>17%</td>
<td>25%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>65%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Black and other</td>
<td>69%</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

1 Racial categories are defined as mutually exclusive categories.
Source: AOA, 1996

Once the increases in the elderly population arrive with the aging baby boom generation, the rates of poverty among older adults will most likely change. About 43% of baby boomers are confident that they will have enough retirement income. Women and parents in the baby boom generation are more concerned about not having enough retirement income than men. In addition, people born in the first half of the baby boom put more money into insurance and pensions than those born in the last half (Cutler, 1998). Actual projections of how many baby boomers will be living at or below the poverty level after age 65, therefore, are difficult to project.

Locally, older adults in Kentucky and Ohio also face poverty issues. In 1999, 12.6% of Kentucky’s population aged 65 and over and 8.1% of Ohio’s population aged 65 and over had incomes below the federal poverty level (AOA, 2000).

Meeting the Challenge of an Aging Population in Greater Cincinnati
Prescription Drug Costs

Older adults are the biggest consumers of prescription drugs, yet many seniors are unable to afford the cost of their medications. Not taking needed medications can lead to the development of new health problems or the exacerbation of existing ones. In 1997, it was reported that approximately 22% of seniors’ out-of-pocket healthcare expenditures was spent on prescription drugs (AARP, 1999; AOA, 1999). In southwestern Ohio, the average prescription out-of-pocket cost to seniors who receive home care is $732 per year (United Way, 2000). The national average is $590 per year (Statistical Abstract of the United States, 1997).

In 2000, the Working in Neighborhoods Senior Action Coalition (WINSAC) surveyed 190 senior citizen residents in the Greater Cincinnati area concerning health insurance and the costs of prescription drugs. WINSAC found that:

• 91% of respondents took prescription drugs on a regular basis, but only 11% said their insurance covered all costs for their prescription drugs;
• 23% reported that their prescription drug costs were not covered;
• 47% spent less than $50 per month on prescription drugs; and
• 19% spent over $151 per month on prescription drugs (WINSAC, 2000).

As of May 2001, Medicare does not cover prescription costs, which are one of the highest out-of-pocket expenses for the elderly. Without additional supplemental prescription coverage, some seniors are unable to pay for their medications. At the same time, the seniors least able to buy prescriptions are also less likely to have funds to purchase supplemental coverage that may help reduce the costs of their prescriptions. In addition, it is not unusual for a senior to be taking many prescriptions at once; for example, a senior may be taking medications for arthritis, hypertension, and depression simultaneously. The costs of one of these
medications alone can be quite expensive, and having to take two or more can put these medications out of reach (see Table 2).

<table>
<thead>
<tr>
<th>Medication</th>
<th>Common purpose</th>
<th># of tablets</th>
<th>Monthly cost</th>
<th>Yearly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celebrex (100 mg)</td>
<td>Arthritis</td>
<td>30</td>
<td>$46.39</td>
<td>$556.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60</td>
<td>$87.49</td>
<td>$1,049.88</td>
</tr>
<tr>
<td>HCTZ (25 mg)</td>
<td>Hypertension</td>
<td>30</td>
<td>$5.49</td>
<td>$65.88</td>
</tr>
<tr>
<td>Prilosec (20 mg)</td>
<td>Gastric Ulcer</td>
<td>30</td>
<td>$125.39</td>
<td>$1,504.68</td>
</tr>
<tr>
<td>Vicodin</td>
<td>Pain relief</td>
<td>30</td>
<td>$13.19</td>
<td>$158.28</td>
</tr>
<tr>
<td>Vioxx (25 mg)</td>
<td>Arthritis</td>
<td>30</td>
<td>$82.19</td>
<td>$986.28</td>
</tr>
<tr>
<td>Zoloft (50 mg)</td>
<td>Depression</td>
<td>30</td>
<td>$73.59</td>
<td>$883.08</td>
</tr>
</tbody>
</table>

Table 2: Costs of common prescription medications

Prices as of September 9, 2000. Prices are subject to change. Yearly costs are based on one tablet per day.
Source: Kroger Pharmacy

The expected closure of some HMOs locally is likely to add to the problem by leaving more seniors without prescription coverage. This will cost the individual more in the long term, and it will also cost the family, the community, and the healthcare system.

**Transportation**

Transportation is frequently identified as the number one need of seniors today (United Way, 2000). According to the Council on Aging of Southwestern Ohio (2000), an estimated 87% of seniors in the Elderly Services Programs (ESP) require assistance to get to locations beyond walking distance, and 91% of these ESP seniors are unable to shop for groceries without assistance.

Many seniors would opt to drive themselves were it not for the inevitable sensory deficits and cognitive impairments associated with aging. Between 1969 and 1990, the number of licensed drivers aged 65 and over increased by more than 50%. However, as the number of older drivers increased, the frequency of driving decreased (TransSafety, Inc., 1997). This may be due to the limitations imposed by disability. Whatever the reason, it appears evident that alternate forms of transportation for seniors need to be developed. Seniors can stay in their homes and be
Independent longer if they have access to responsive, reliable transportation.

Transportation services for older adults can be either curb-to-curb (CTC) or home-to-door (HTD). CTC transportation requires that the rider be able to walk from house to curb to enter the vehicle. HTD service assists or carries the rider from the home to the vehicle and through the door of the destination. To reduce liability, most agencies offer only CTC services. When an older adult or small group needs help getting to and from medical appointments, shopping, or banking, some transportation services provide escorts to accompany them.

Most transportation services are offered at low or no cost to seniors. In many instances, a suggested donation ($0.50–$1.00 each way) is sufficient to cover the cost of the service. Under Title III of the Older Americans Act, some transportation to congregate meal sites and senior centers within a three-mile radius of the site can be provided. Under Title XIX of the Social Security Act (Medicaid), transportation of Medicaid patients for medical services is provided. The national PASSPORT program may also authorize transportation for enrollees.

In Hamilton County and Northern Kentucky, there are a number of transportation services available to older adults provided by community, public, and private agencies. Most will transport seniors to and from community senior centers, shopping trips, and medical appointments. For example, ESP in Hamilton County provides funding for eligible clients for transportation to medical services. However, some agencies, particularly hospital-based and routine ambulance services, transport for medical purposes only. All of the agencies provide transportation during the day, although hours of operation vary slightly across agencies. With the exception of routine ambulance and public transportation (i.e. Metro, TANK, Yellow Cab, etc.), few agencies offer services on evenings, weekends, or holidays. While there is typically no waiting list for services, most agencies require that services be scheduled 24–48 hours in advance. Some agencies require as much as two to three weeks advanced notice.
Although local transportation services for seniors appear adequate, there are some significant limitations:

- Of the 20 community agencies offering transportation services to seniors in the Hamilton County and Northern Kentucky area, 18 do not offer transportation services on evenings, weekends, or holidays. One agency, the American Cancer Society, will transport cancer patients on evenings and weekends only if a volunteer driver is available. The Wesley Community Services, serving West/Northwest Hamilton County, provides transportation for area residents to some Saturday medical appointments.

- Some community and public transportation service agencies do not have wheelchair accessible vehicles. Of the 29 community and citywide transportation service agencies in the Hamilton County and Northern Kentucky area, nine do not have wheelchair accessible vehicles and therefore can only transport ambulatory older adults.

- Community agencies have a limited number of vehicles available for transporting seniors. Of the 20 community agencies offering transportation services to seniors in the Hamilton County and Northern Kentucky areas, half have three or fewer vehicles.

- Although there are a number of agencies providing transportation services to seniors, most have a limited service area. Most community agencies will transport only within each agency’s own community, discouraging trips outside the community. Most Hamilton County agencies do not serve residents of Kentucky, although some will transport Hamilton County residents to Kentucky when necessary. Citywide public transportation has the largest service area, but because it serves the masses, accommodation for individual needs is often lacking.

The lack of safe, affordable, and reliable transportation can have significant consequences for seniors. Without appropriate transportation, seniors may not be able to adequately follow up on their healthcare needs. They may have limited opportunities for socialization and companionship, particularly if they live alone. They may be required to neglect or delay the purchase of necessary items,
such as food or medications. Finally, they may experience reduced self-esteem as a result of being overly dependent on others. Inadequate transportation services may lead to a reduced quality of life and poorer health status for today’s seniors.

Social Networks

The perspective of social psychology suggests that self-concept results from social interaction (Kinch, 1973), which can greatly influence how one perceives oneself. Older adults experience multiple losses within their social networks as a result of death and separation. They must cope with these losses as well as the losses that accompany other life events, such as changes in living arrangements, finances, or health status.

Loss is an antecedent to loneliness, which is widespread among the elderly in society (Alston, Small, and Whiteside, 1992). An estimated 31–34% of seniors aged 65 and over live alone in the Greater Cincinnati area (United Way, 2000). Consequences of loneliness may include physical and psychological problems, including depression (Alston, Small, and Whiteside, 1992). As stated earlier, of the 34 million senior Americans aged 65 and over, approximately 2 million suffer from some form of depression (NIMH, 2001).

Social isolation is a significant problem affecting the quality of life of today’s seniors. The challenge of accessing appropriate transportation likely contributes to this problem. Seniors participating in senior center activities have some opportunities for social interaction and peer support. However, these are primarily daytime activities during the week. Few activities are offered at senior centers in the evenings or on weekends. Furthermore, transportation to the center may not be available or affordable. Homebound seniors or seniors without access to senior centers have even fewer opportunities for social interaction.

Nutrition

Nutritional counseling has been identified as an unmet need in Ohio. According to a 1997 study, 54% of seniors in southwestern Ohio made changes in the way they ate because of an illness or medical condition, 64% ate their
meals alone, and 16% ate fewer than two meals per day (United Way, 2000).

According to a survey conducted by the Northern Kentucky Area Development District (1999), help with fixing meals was not a high priority item (Boone County 6%, Campbell County 4%, Kenton County 9.4%). It is not clear what percentage of these seniors was homebound or at what priority homebound seniors ranked this need.

Several of the homebound seniors surveyed in focus groups in Hamilton County expressed the desire for improvement in the quality (i.e., taste, temperature, etc.) and quantity of home-delivered meals (Anderson and Britton, 2000). These factors can be significant for seniors who are entirely dependent on these meals. Seniors may eat only a small portion of unappealing meals, leaving them without the vital nutrition they need. It is important that healthy, appealing meals are regularly provided to homebound seniors to prevent nutritional deficiencies and worsening health conditions.

**Ethnicity and Healthcare**

Ethnic and cultural variations can influence the health needs and concerns of older adults, as some diseases are more common among minority seniors. Diseases may also have different symptoms or follow a different course depending on the ethnic background of the individual. In addition, ethnicity can influence how and when people access healthcare.

The five most frequently reported chronic conditions are the same for African American and white older adults. However, African Americans are more likely than whites to have limitations in daily activities because of these conditions. This is particularly true of arthritis, the most prevalent condition among older people (Summer, 1999).

Other examples concerning aging and ethnic variation include the following:

- Non-Hispanic African Americans have increased stroke and hypertension than Hispanic white people
Concerns of the elderly also differ by race. In preparation for the White House Conference on Aging in 1995, tri-state agencies hosted a series of focus groups to identify the concerns of local seniors. Approximately 16% of the total number of respondents were African American. There were too few Asian and Pacific Islanders and American Indians to accurately report results. When responses regarding the top

- Alzheimer’s disease is the sixth leading cause of death among white women aged 85 and over, but the disease is less common among African American women or men (NCHS, 2000).
- Diabetes is the third leading cause of death among American Indian and Alaska Native men and women aged 65 and over, but it ranked fourth and sixth respectively as a cause of death for Hispanic men and women and Asian/Pacific Islander men (NCHS, 2000).
- African Americans who survive to older ages may be healthier than whites. African American women have slightly increased life expectancy after age 65 (NCHS, 2000).
- Minority seniors have greater health problems than the majority population. They may have worked in labor-intensive jobs and less safe workplaces, creating a higher risk of injury and disability (ASA, 1992).
- The health status of American Indian seniors has been considered the poorest of any ethnic group in the U.S. (ASA, 1992).

or non-Hispanic white people (National Center for Health Statistics [NCHS], 2000).
Concerns of the Elderly

Five concerns facing older adults were separated by race, differences were noted in the rankings of concerns (see Table 3).

**Table 3: Top five concerns of Tri-State seniors**

<table>
<thead>
<tr>
<th>Rank</th>
<th>General population of respondents (n=1,074)</th>
<th>African American respondents (n=199)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alzheimer's disease (59.4%)</td>
<td>Crime and personal safety (67.9%)</td>
</tr>
<tr>
<td>2</td>
<td>Crime and personal safety (54.8%)</td>
<td>Alzheimer's disease (50.0%)</td>
</tr>
<tr>
<td>3</td>
<td>Long-term care (42.3%)</td>
<td>Community-based/in-home care (32.1%)</td>
</tr>
<tr>
<td>4</td>
<td>Community-based/in-home care (34.1%)</td>
<td>Homelessness (31.5%)</td>
</tr>
<tr>
<td>5</td>
<td>Transportation/accessibility to services (33.5%)</td>
<td>Diseases related to aging (30.9%)</td>
</tr>
</tbody>
</table>

Both socioeconomic variables and culture may influence the concerns expressed by minority seniors. National data indicate that African American seniors have lower incomes, less education, lower occupational status, less adequate housing, and lower health status than white older adults. This picture is not expected to change perceptibly in the near future (Sayles-Cross, 1990).

Culture also influences what is accepted as “normal” to minority seniors. For example, long-term care was a concern of 42% of the general respondents in the local focus groups but did not appear in the top five concerns of African American respondents. This is probably because African Americans expect that family members will care for them, and they are not concerned by the thought of long-term care. Cultural differences like these negate a “cookie cutter” approach to aging concerns.

**Specific Concerns of Local Seniors**

Although seniors in the Greater Cincinnati region have the concerns already mentioned, the priority given to these concerns varies depending on geographic and demographic characteristics. A variety of services already exist to assist local seniors (see Appendixes A and B), but as this section will show, more services could be offered.

**Hamilton County**

To better understand the needs of Hamilton County seniors, Anderson and Britton (2000) developed two focus groups and a survey of older adults. One focus group was held at an urban senior center with nine seniors and the center director,
all of whom were African American. The second focus group was held at a suburban senior center with 11 seniors. Eight participants were white and three were African American. In addition, 22 homebound seniors receiving Meals-On-Wheels were also asked to complete a survey. Effort was made to choose seniors representing variation in age, ethnicity, and socioeconomic status. Neither the focus groups nor the survey should be considered to be a scientifically valid, generalizable study. They are useful only for their ability to identify what the issues are.

The results of the focus groups and survey indicated that the majority of participants gained information about available services and programs through friends, peers, and Meals-On-Wheels drivers. This raises the concern about the lack of networking opportunities for seniors who do not participate in senior centers or Meals-On-Wheels programs. Many seniors said that communication and companionship were primary needs not currently being met. They also shared that Meals-On-Wheels services could be improved by offering better quality and quantity of home-delivered meals. For future planning, the majority of participants suggested that providing transportation to places other than the doctor’s office would better meet their needs. All participants reported that they would look to family, friends, or church when needing assistance before turning to community agencies (Anderson and Britton, 2000).

It is important to note that the focus group participants appeared to be healthy older adults. Had the focus groups included more dependent seniors, the results may have been quite different. Further, the participants appeared to address the needs of seniors from a present rather than a future perspective. For example, although some comments were directed toward how a specific center might improve services, respondents did not project what their need for services might be in the future.

Although the above comments are from a small group, it was interesting to note that seniors with different ethnic backgrounds preferred different learning styles. The African American participants from the urban senior center reported that they learn best by discussing information, listening to presentations, calling information hotlines, or watching videos. The senior participants from the suburban senior
Concerns of the Elderly

center, a predominately white sample, preferred reading information, educating themselves, asking healthcare providers, or searching the Internet (Anderson and Britton, 2000). Future considerations in this area might include attempts to better understand the role of culture or ethnic background in the dissemination of information to seniors.

**Boone, Campbell, and Kenton Counties**

In 1998, the Northern Kentucky Area Development District conducted a needs assessment survey of people aged 60 and over who experienced more than one major health problem or limitation. In the survey, each participant was asked what assistance he or she needed. Although needs arose in a variety of areas, transportation appeared to be a leading concern across the three counties (see Table 4).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Boone County</th>
<th>Campbell County</th>
<th>Kenton County</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transportation to doctors and stores</td>
<td>Transportation to doctors and stores</td>
<td>Doing housekeeping tasks</td>
</tr>
<tr>
<td>2</td>
<td>Loneliness</td>
<td>Doing housekeeping tasks</td>
<td>Transportation to doctors and stores</td>
</tr>
<tr>
<td>3</td>
<td>Shopping for items such as food, clothing, etc.</td>
<td>Loneliness</td>
<td>Shopping for items such as food, clothing, etc.</td>
</tr>
<tr>
<td>4</td>
<td>Doing housekeeping tasks</td>
<td>Boredom</td>
<td>Hearing</td>
</tr>
<tr>
<td>5</td>
<td>Money problems (not enough to meet basic needs; i.e., food and heat)</td>
<td>Shopping for items such as food, clothing, etc.</td>
<td>Seeing</td>
</tr>
<tr>
<td>6</td>
<td>Finding opportunities to be with other people such as church, club, or social events</td>
<td>Hearing</td>
<td>Loneliness</td>
</tr>
</tbody>
</table>

**Table 4: Needs of Northern Kentucky seniors**

Additionally, survey participants reported that the services they would find most helpful would be assistance with doing home repair and maintenance tasks, acquiring additional financial resources, locating needed services or programs, and having meals delivered to the home (NKADD, 1998).
Caregivers and Caregiver Support

Caregivers are the keystones of the care system, and older adults may find themselves as both caregivers and care recipients. Caregivers may be unpaid (informal) or paid (formal) and may provide transportation, meal preparation, housework, money management assistance, general supervision, and personal and emotional care. The personal burden of providing care is very great for the caregiver no matter what his or her age. Declining health and stresses on a caregiver put both the caregiver and the person cared for at greater risk for abuse and neglect.

Caregiving is often a full-time job. While many people feel a sense of reward in caring for a loved one, all caregivers experience stress at times. Among the stresses felt by caregivers of any age are: personal limitations, competing responsibilities, emotional and physical demands of meeting the needs of the care recipient, family strain, and financial strain. Caregivers often put their own physical and mental health needs last. In fact, caregivers take more drugs for their mental health than do the people they care for. In addition to being physically and emotionally drained, caregivers are often isolated from sources of support for themselves.

Informal Caregivers of Older Adults

For the functionally impaired older adult, the caregiver is the key to survival. As disability increases, no factor is as critical for maintaining as normal a life as possible as having a caregiver. For older adults who are disabled, walking or driving may not be within the realm of possibilities: relying on others becomes a necessity.

Roslynn Carter in her Testimony before the Senate Special Committee on Aging on September 10, 1998 (Gutheil and Chernesky, 1999) noted, “One of my colleagues has said there are only four kinds of people in the world: Those who have been caregivers; and those who currently are caregivers; those who will be caregivers; and those who will need caregivers.”
There are over 22 million households in the U.S. with people providing care to someone 50 years of age or older. The average age of caregivers is 46, but 10% of caregivers are over 75 years of age, and those providing the most intensive care are more likely to be aged 65 and older themselves. Almost 75% of all caregivers are women and more than 40% of caregivers have children under the age of 18. Almost 66% of caregivers are working, with most working full time. The average duration of caregiving is 4.5 years (Gutheil and Chernesky, 1999).

In A Profile of Caregiving in America (1997), the Pfizer Journal noted that “Care is a job no one is trained to do until they have to do it” (Gutheil and Chernesky, 1999). According to Levine (1998), caregivers need better information, appropriate training, sensitive and caring recognition of their dedication and suffering, and help with decision making and role definition.

Not only do caregivers need better training, but also they need time and support to attend to their own needs. In 1992, over 33% of caregivers reported their health as fair or poor. Caregivers are three times more likely to be depressed, two to three times more likely to take psychotropic drugs, and 12% more likely to use alcohol to cope with stress than the general population. Other coping strategies include prayer, talking with friends or relatives, exercising, hobbies, and talking with counselors or other professionals.

Informal caregiving takes a financial as well as a physical toll on the caregivers. In 1996, the National Alliance for Caregiving and the American Association of Retired Persons conducted a telephone survey of 1,509 English-speaking family caregivers of people aged 50 and older. The survey found that 41% of caregivers who know how much of their own money they spend on caregiving spend an average of $171 monthly. This would total approximately $1.5 billion per month if applied nationwide (Gutheil and Chernesky, 1999).

Support for Informal Caregivers

Just as caregivers provide assistance, they also need assistance. The National Council on the Aging conducted a survey of 1,300 caregivers to learn what informal assistance caregivers
want. Using questionnaires and focus groups, the Council found that the most valued service was help in navigating the complex maze of services, with 69% of respondents indicating that locating local resources would be valuable. One such resource is the national Eldercare locator at (800) 677-1116. Other frequent answers included:

- monitoring of programs and benefits (64%),
- transportation arrangements (60%),
- shopping (58%), and
- household chores (54%).

Through the questionnaires and focus groups, informal caregivers also proposed actions they would find helpful, such as workplace policies that would support them. They asked for written information that could guide them and their families through the planning and implementation of caregiving. They need more affordable services, as well as resources to help with the evaluation of paid caregiver services (NCOA, 2000).

Although not cited as important by informal caregivers, respite care is a vital support. Respite care is designed to ease the burden on families who provide care for a person in need of extensive physical, mental, and medical attention. It is short-term relief provided either outside the home—by assisted living facilities, nursing homes, adult day care centers, or senior centers—or inside the home by a home health agency or visiting nurse or companion. Respite care results in reduced institutionalization for older adults and reduced stress for the caregiving family.

There are a limited number of providers of respite care in the Greater Cincinnati area. In Hamilton County, the Caregiver Assistance Network (CAN) and the United Home Care Respite for Seniors offer respite care services to relieve family members on an occasional basis (CASS, 2000). In Northern Kentucky, the Florence Park Care Center and Highlands of Ft. Thomas Healthcare Center provide admissions from three days to four weeks for short-term respite or to allow the caregiving family to go on vacation. St. Charles Care Center Lodge and Village has apartments available for temporary stays on a daily, weekly, or monthly basis, and Senior Services of Northern Kentucky has trained staff who can relieve caregiving family members (SSNK, 2000).
Although respite care is provided in the Greater Cincinnati area, there are some limitations to the services. First, most Medicaid recipients can expect to be placed on a waiting list for these services, and the waiting list is usually very long because of a shortage of Medicaid beds and low payment rates to agencies. Some agencies have no waiting lists but accept only private pay patients. Second, the level of care offered during respite varies depending upon the agency. Some agencies offer respite care supervised by professional nursing staff, while other agencies offer respite care services provided by trained volunteers. The level of education and training of the staff determines the level of care provided during respite. Third, immediate respite care is often not available through a nursing home because they require that a patient’s physician document a complete history and physical 48-72 hours in advance of stay (CASS, 2000).

Another example of a resource for the informal caregiver is a caregiver support group. However, despite availability, these support groups are not well attended. A study found that only 1.1% of informal caregivers in Cincinnati had ever attended such a group. Reasons for low attendance at the sessions included scheduling conflicts, not knowing about the sessions, and the stigma that may be associated with belonging to the group (United Way, 2000). In addition, informal caregivers may find it difficult to leave the care recipient in order to attend the support group meetings.

Despite the need for assistance, caregivers may not qualify for or be able to find appropriate services. Often, caregivers will be placed on waiting lists for long periods of time when they are in need of immediate assistance. The accumulation of sleep deprivation, burnout, lifetime family dynamics, and other stresses can lead to abuse of vulnerable elders or caregivers.

New products are at times a mixed blessing for the informal caregiver. For example, the invention of disposable adult undergarments has been helpful for dealing with incontinence. However, the average price for a pair of incontinence undergarments is $0.50 to $1.00, bringing the average daily cost to $2.50-5.00 (Gahring, Olson, and Albach, 1998). On a fixed income, this $1,800 annual expense can be insurmountable, resulting in the caregiver using less efficient and effective approaches.
In-home care by an informal caregiver is provided at personal cost to the caregiver but no apparent financial cost to the healthcare system. The United Way Older Adults Subcommittee Self-Sufficient Vision Council Report on Data (United Way, 2000) estimated that informal area caregivers save Hamilton, Boone, Campbell, and Kenton Counties over $873 million annually (see Table 5).

<table>
<thead>
<tr>
<th>County</th>
<th>Estimated # of caregivers</th>
<th>Estimated annual value of unpaid caregiving</th>
<th>Financial impact of a 2% reduction in unpaid caregiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton</td>
<td>22,446</td>
<td>$669,697,156</td>
<td>$13,393,943</td>
</tr>
<tr>
<td>Boone</td>
<td>1,409</td>
<td>$40,269,844</td>
<td>$805,397</td>
</tr>
<tr>
<td>Campbell</td>
<td>2,314</td>
<td>$66,100,187</td>
<td>$1,322,004</td>
</tr>
<tr>
<td>Kenton</td>
<td>3,397</td>
<td>$97,051,816</td>
<td>$1,941,036</td>
</tr>
</tbody>
</table>

Source: United Way, 2000

Despite the dollars that informal caregivers save society, they themselves receive little or no public support to assist them in their efforts.

The easiest way for an informal caregiver to get support is to place the care recipient into a residential facility. Frequently, caregivers will not turn to residential facilities until they have exhausted every known way of in-home caregiving in an attempt to give their family member or other care recipient as much independence for as long as possible. Factors most apt to lead to nursing home placement include incontinence, difficulty with mobility, combativeness, and nocturnal wandering, which especially leads to sleep deprivation of both the caregiver as well as the care recipient (USDHHS, 1982). One of the authors of this paper, a gerontological nurse, was familiar with a sleep-deprived caregiver of a husband with Alzheimer’s disease who wandered at night. The caregiver tied her wrist to her husband’s so she would be jerked awake when he got up at night.

**Gender Differences Among Informal Caregivers**

According to Lustbader and Hooyman (1994), there are key differences found among men and women as informal caregivers of adults.
Approximately three-fourths of all informal caregivers for people over 50 years of age are women. Many of these female caregivers are older spouses with chronic illnesses or physical limitations themselves. Ironically, they will outlive their husbands and have no spousal caregiver when they become dependent. They will most likely be cared for by a daughter or live in a nursing home.

Daughters are the next most frequent caregivers of the elderly after wives, with daughters outnumbering sons as caregivers 3:1. The daughter caring for a parent may also be caring for her own children and is “sandwiched” between two generations of competing demands. A female living in the United States can expect to spend 17 years caring for children and 18 years helping an aging parent (Guthel and Chernesky, 1999).

Working women may be penalized for taking unscheduled time off due to their caregiving roles. Not only do they lose income, but also they lose any pension, retirement account, or Social Security credits. Women who provide care while working in jobs with little flexibility find themselves pulled between competing demands. In addition, they may begin caregiving after a full day of work, leaving little time for themselves.

Men are more likely to assist with caregiving responsibilities by paying bills, doing home repair and maintenance tasks, or providing transportation. When men who have functioned primarily in a traditional role suddenly become informal caregivers, they may initially be overwhelmed by the experience. Men may also receive criticism from female siblings regarding the kind and amount of their participation in caregiving.

**Older Adults as Informal Caregivers for Grandchildren**

In the U.S., grandparents are increasingly being called upon to serve as parents for their grandchildren. When reunification with natural parents is not possible, grandparents provide familiar relationships and give children a valuable connection to their extended family.
Parenting a second family as one ages combines the challenges of aging with the challenges of child rearing. Often these informal caregivers are seniors who, by health or socioeconomic status, are at risk themselves for poor physical and mental health. Many grandparents make large sacrifices to raise grandchildren with few community resources to support them in this role.

In Ohio, 10% of grandparents have sole responsibility for the care of their grandchildren. Many seniors in this situation fall within a lower income group: 25% have an annual income less than $15,000, while 51% have an annual income less than $30,000 (Ohio Grandparents Raising Grandchildren Task Force, 1999). To put this into perspective, the federal poverty level for a family of two is $11,824 per year (U.S. Census Bureau, 2000).

Recognizing the special circumstances that often accompany the grandparent-grandchild parental relationships, the Ohio General Assembly formed a statewide task force in 1997 on Grandparents Raising Grandchildren. The task force determined the number of Ohio grandparents raising grandchildren, identified their major needs and concerns, developed a strategic plan to address those needs and concerns, and submitted a plan to the 123rd Ohio General Assembly (Ohio Grandparents Raising Grandchildren Task Force, 1999).

The task force found that of Ohio households with children, 32,340 households contained grandparents as the sole provider for their grandchildren. The task force also found that:

- the average age of the grandparent is 55, although 16% are 65 or older;
- over 50% of the grandchildren are age 6 or younger;
- 50% of the grandparents provide care for more than one grandchild;
- 87% of grandparents raising their grandchildren are female;
- 43% are not married;
- only 11% are legal guardians for the children, and only 9% have formal temporary custody;
9% of grandparents raising grandchildren receive child support, 14% receive financial support from public assistance, and 8% receive social security for the child; and

the care arrangement will last for approximately six years (Ohio Grandparents Raising Grandchildren Task Force, 1999).

The task force also identified major needs and concerns of grandparents, which included:

- **Legal relationships.** More than 75% of the grandparents who provide custodial care for their grandchildren have no formal agreement establishing them as legal guardians of their grandchildren. Nearly 66% admitted they had concerns pertaining to their legal rights. Without some mechanism that recognizes the existence of the legal relationship, the grandparent may be unable to enroll the grandchild in school or grant consent for medical treatment, including immunization.

- **Access to assistance.** Nearly 66% of grandparents raising grandchildren were worried about their financial ability to care for their grandchildren. Often, they were unaware of assistance for which they or their grandchildren may qualify.

- **Health needs of the child.** More than 75% of Ohio grandparents raising grandchildren expressed concern about their grandchildren’s health, and 62% say they were specifically concerned about their grandchildren’s healthcare coverage. More than 80% of Ohio grandparents raising grandchildren indicated they had concerns about their grandchild’s mental health, and over 66% considered the availability of counseling services important.

- **Physical health of the grandparents.** An important concern of grandparents raising grandchildren in Ohio was staying healthy enough to optimally accomplish the task of raising their grandchildren. More than 50% of Ohio grandparents raising grandchildren indicated concerns about their emotional health, and nearly 75% considered the availability of counseling services for themselves important.

- **Social activities.** Opportunities for recreational and social activities were an important service for
grandparents raising grandchildren: 81% rated such activities as important for their grandchildren, and 76% rated quality time in the form of joint recreational or social activities with their grandchildren as important to them both.

- **Increased financial assistance.** The financial assistance available to grandparents raising grandchildren in Ohio is generally much lower than that provided to non-related foster parents. Although federal regulations give states flexibility for foster care of children, Ohio grandparents receive, on average, $220 per month per child less than non-related foster parents. Though kinship placement is a preferable option for the effective raising of children, licensing requirements pose significant barriers to grandparents raising grandchildren. In the task force's findings, less than 3% of Ohio grandparents had legally adopted the grandchildren they were raising. About 25% expressed concern about the cost of adoption proceedings.

- **Grandchild care.** Given that 45% of the grandparents raising grandchildren were still employed and 56% of Ohio's grandchildren being raised by their grandparents were age 6 or younger, the need for child care services is significant. Grandchildren of school age require different kinds of care, including after-school care, transportation, and tutoring. Grandparents raising school-age children indicated that finances were the number one obstacle to obtaining these services. Tutoring and transportation services were deemed important by 70% and 54%, respectively, of Ohio's grandparents raising grandchildren.

Using these concerns, the task force submitted recommendations to the 123rd Ohio General Assembly (see Appendix C).

**Paid Caregiver Workforce Issues**

The growing number of seniors placed on waiting lists for home care or home health services is a problem for today's seniors, which may be due to insufficient funding, unresolved service delivery issues, or a limited number of available workers. Viable solutions need to accommodate the future widening of the gap between supply and demand for
paid caregivers as the baby boomers age and the number of the oldest old skyrocket.

There appears to be little incentive for people to become health aides. With health aides earning only slightly above minimum wage and receiving fewer benefits, recruitment and retention are understandably difficult (Bennett and O'Connor, 2000). Furthermore, health aides are at risk for work-related injuries and job stress (Grantmakers In Health [GIH], 2000). Nationally, the average compensation for a nurse's aide is just $7.46/hour, and 29% have no health insurance (GIH, 2000).

Employee turnover rates in nursing homes and home healthcare agencies are high. According to estimates from the U.S. Department of Health and Human Services (USDHHS), annual staff turnover rates are 70–100% in nursing homes and 40–60% in home healthcare agencies (Wilner, 1999). In Northern Kentucky, 25% of the positions for nurse's aids in nursing homes are unfilled (NKADD, 1999).

It is important for both private and public agencies to recognize the value of the services that nurse's aides and home care and home health workers provide. Policymakers and service agencies need to be aware that understaffing may cause noncompliance with federal mandates regarding staffing levels. Proposed standards require each resident in a nursing home to receive two hours of care each day from a nurse's aide (Rizze, 2000). If these standards were to go into effect, many nursing homes would be noncompliant and could lose licenses or Medicaid eligibility.
Today’s Seniors

National demographics on health status are plentiful, but there are usually fewer statistics available at the local or neighborhood level. Because healthcare is delivered locally, good local data are helpful. National data can then provide benchmarks for comparing local data. Painting the overall picture of today’s seniors involves looking at demographics, health status, and disability at national, regional, and local levels.

During the 1900s, the senior population of the U.S. grew steadily until 1990, when growth slowed. The slight decline in growth during the 1990s was attributed to the small number of babies born during the Great Depression of the 1930s.

Older segments of the senior population also expanded during the last century. The 65–74 age group contained 18.4 million people in 1998, eight times more people than in the early 1900s. The 75–84 age group had a 16-fold increase (to 12 million) and the 85-and-over a 33-fold increase (to 4 million) during this time period (AARP, 1999; AOA, 1998).

Ohio and Hamilton County

Ohio is one of nine states with the highest number of seniors (approximately 1.5 million) (AARP, 1999; AOA, 1998). Although the total number of older adults is expected
to remain relatively the same through 2010, the composition of that population will change (see Figure 9).

The numbers of the oldest seniors are projected to increase, and there continues to be a high proportion of female senior adults: in 2010, 62% of seniors will be women.

Projections are based on the 1990 census.
Source: Mehdizadeh et al., 1996

Figure 9: Population of Ohio’s older adults, by age, in 1995 and projected for 2010
Today's Seniors

Figure 10: Population of Hamilton County's older adults, by age, projected for 2000, 2005, and 2010

Hamilton County data resemble Ohio data (see Figure 10).

Analysts project that the senior population in Hamilton County will decline from 115,406 in 1990 to 105,600 in 2010. However, the oldest group (people 85 and over) will increase slightly from 12,506 in 1990 to 14,200 in the year 2010 (Mehdizadeh, Kunkel, Applebaum, Kolada, and Bridges, 1997).

After 2010, though, a massive influx of baby boomers will dramatically increase the numbers of the elderly. This will occur throughout the region and nation (see the chapter entitled “Tomorrow’s Seniors and Services” for more information on the rise in the elderly population).

Kentucky and Boone, Campbell, and Kenton Counties

Between 1980 and 1990, the state of Kentucky experienced a 13.9% rate of growth in its senior population, which was slower than the national average of 22.8%. However, the 30.9% growth in the 85-and-over population in Kentucky was greater than the 22.3% national growth rate (Rowles et al., 1996).
From 1980 to 1990, Boone, Campbell, and Kenton Counties increased in their rankings for the percent of the population aged 65 and over in the state of Kentucky. Seniors accounted for 8.3% of the general population of Boone County, 11.5% of Kenton County, and 12.9% of Campbell County.

The Northern Kentucky Area Development District (1999) projected that in 2000, Boone County seniors would total 7,014, Campbell County 11,513, and Kenton County 16,904. Neither actual figures nor projections were available beyond the year 2000.

**Gender, Poverty, and Ethnicity**

Gender, poverty, and ethnicity are three factors that should be considered when assessing the needs of the senior population. More than half of the senior population is female, and the number of seniors who are ethnic minorities is increasing. Poverty is also prevalent in both of these groups.

**Gender**

Gender significantly influences the national demographic picture. Older women (20.2 million) outnumbered older men (14.2 million) in 1998. Economically, women earn less than men during their lifetime and retire on smaller incomes than men do. Due to limited work histories, past wage discrimination, and biases in the distribution of Social Security benefits by gender, women are likely to have fewer and lower Social Security benefits (Rowles, et al., 1996).

Economic health, medical health, and social support are all factors that determine the living arrangements of the elderly and therefore influence their well-being and quality of life. In 1998, approximately 44% of women aged 65 and over live with their spouses, while 73% of men aged 65 and over live with their spouses. This difference may be because women live longer than men and tend to marry older than themselves. Almost half of all older women in 1999 were widows (45%), and there were over four times as many widows (8.4 million) as widowers (1.9 million) (AOA, 2000).
**Hamilton County.** As shown in Figure 11, women are projected to make up the majority of the senior population in Hamilton County in the coming years. By 2005, women will comprise over 80% of the total population aged 90 and over (Mehdizadeh, et al, 1997).

![Graph of Hamilton County's elderly population by age and gender, in 2000, 2005, and 2010](source: Mehdizadeh et al., 1997)

The Scripps Gerontology Center (1998), using 1990 U.S. census data, reported that 83% of people aged 85 and over living by themselves or with no relatives were women. In addition, 80% of people aged 75 and over living in poverty were women.
Boone, Campbell, and Kenton Counties. Collectively, Boone, Campbell, and Kenton Counties contained slightly more than 21,000 women aged 65 and over in 1999 (see Table 6).

<table>
<thead>
<tr>
<th>Age</th>
<th>Boone County</th>
<th>Campbell County</th>
<th>Kenton County</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>2,202</td>
<td>3,481</td>
<td>5,134</td>
</tr>
<tr>
<td>75-84</td>
<td>1,443</td>
<td>2,340</td>
<td>3,563</td>
</tr>
<tr>
<td>85+</td>
<td>526</td>
<td>927</td>
<td>1,425</td>
</tr>
</tbody>
</table>

Source: U.S. Census, 1999

Poverty

Poverty is a factor that influences every facet of quality of life, especially for senior women and minority seniors. As noted in the Greater Cincinnati Community Health Status Survey (HFGC, 1999), “socioeconomic factors, particularly poverty level, education, and home ownership status, appear to have the strongest and most consistent effect on the various health issues.”

Boone, Campbell, and Kenton Counties. Poverty extends across all age groups in Kentucky. The average poverty rate for Kentucky was 12.1% in 1999, slightly higher than the national rate of 11.8% (U.S. Census, 2000). Low educational levels and poor and limited employment opportunities (particularly for women) have put older Kentucky citizens at risk for poverty. The previous U.S. Census reported 91,000 elderly poor in Kentucky (U.S. Census, 1990).

In 1989, Boone, Campbell, and Kenton Counties had some of the lowest poverty rates for people aged 65 and over in the state, 11.0%, 12.9%, and 11.8% respectively. However, for people aged 75 and over, the poverty rate surpassed the national average. It has been noted that being connected to an urban area decreases poverty (Rowles et al., 1996). People aged 65 and over living in rural Boone County had a poverty
rate of 35.7%, nearly three times the national average (see Figure 12).

Source: Rowles et al., 1996
Ethnicity

Current county-specific data pertaining to aging and ethnic minority groups are not readily available, but some information is known (see Figure 13).

What is clear is that the population of ethnic minorities will increase more rapidly than the population of ethnic majorities (ASA, 1992). As ethnicity has an effect on the health concerns and needs of the elderly, more data on minority seniors are needed at both the national and local levels.

Hamilton County. Like other regions in the nation, the Greater Cincinnati region is becoming more culturally diverse. Asian Americans outnumber Hispanic Americans in Hamilton County (U.S. Census, 2000). However, the Hispanic culture is becoming more evident with the increase in Latin American stores and Spanish-speaking church services and the establishment of a Spanish-language newspaper.

Boone, Campbell, and Kenton Counties. In Boone County, Asian Americans also outnumber Hispanic Americans. However, in the past 10 years, Boone County had the largest percent gain in Hispanic people among the four counties studied for this paper. Increasing from 318 to 708, the population more than doubled (Conte, 2000).
Tomorrow’s Seniors and Services

In the future, aging services will have to meet three major challenges: closing existing service gaps, expanding services to meet the increasing number of baby boomers, and decreasing the time between knowledge development and knowledge use.

Closing Service Gaps

The preceding chapters of this paper have identified areas in which services are non-existent or do not meet demand. Seniors need seamless services. They often have multiple conditions, such as high blood pressure, glaucoma, and arthritis. Therefore, they require a complex package of services on a continuous basis. Several of the areas of need are transportation, home management, informal caregiving, raising grandchildren, access to information, treatment of substance abuse and depression, and medication costs.

- **Transportation** is the most pressing need, according to seniors themselves. Eyesight, physical frailty, and mental incompetence result in the loss of ability to drive or negotiate public transportation. Giving up one’s driver license is a marker event for the loss of independence. Buying groceries, going to medical appointments, and meeting family and friends become major tasks. Affordable, accessible, door-to-door, timely transportation ranks high as services that effect the quality of life of seniors.

- **Home management assistance** ranges from help with heavy household work to personal care assistance with daily activities. Poor pay, inadequate benefits, and lack of training lead to high turnover rates for providers of home management and personal care services for older persons.

- **Informal caregiver assistance** is needed on a continuous basis to support family and friends who assist frail older persons. Caregivers may be an elderly spouse, sibling, or younger family member. Caregivers are often isolated and do not receive information that would help them perform their jobs. They also need
the opportunity to care for themselves mentally, spiritually, and physically.

- **Assistance in parenting grandchildren** is an increasingly important need as more grandparents take on the responsibilities of grandchildren. Unfortunately, grandparents do not receive the support that foster parents do. Often they must stretch social security checks to feed, clothe, and house one or more grandchildren. In addition, grandparents have no formal agreements establishing them as legal guardians or covering the healthcare for these children. Grandparents often do not have the information, time, energy, or finances to take the difficult route to find the necessary resources.

- **Access to information** empowers people. While radio, television, and print sources may be familiar to older persons, newer technologies such as the internet may be used less frequently. In addition, changes in hearing and sight may require more inventive approaches even to familiar media for seniors.

- **Treatment of substance abuse disorders and polypharmacy** are also important considerations. Seniors are often perceived as immune from drinking problems. Because of this view, they are often not diagnosed and treated appropriately. Seniors use and, in some cases, misuse multiple medications. Often, through no fault of their own, they experience medication interactions that may compromise or even threaten their lives.

- **Treatment of depression** is another essential service. Situational and physiological changes put many seniors at risk for depression, which is treatable. Lack of diagnosis and treatment compromises the quality of life of seniors. In addition, depressed senior males have a higher risk for suicide than the general population.

- **Medication costs** remain a challenge for many seniors. In the United States in 1997, only 65% of seniors had insurance coverage for pharmaceuticals, compared with full coverage in Australia, Canada, France, Germany, Japan, New Zealand, and the United Kingdom (Anderson and Hussey, 1999). For seniors with hypertension, glaucoma, diabetes, etc., medications are essential to their well-being. Being unable to afford medication can have serious consequences.
Expanding Services to Meet the Increasing Number of Baby Boomers

As the population ages, older groups will continue to influence public policy, which sets the tone for the distribution of resources. In 1997, 12.5% of the U.S. population was 65 and older. However, 38% of the total health expenditures were for people 65 and older (Anderson and Hussey, 1999). Moreover, “the number of working-age people for every elderly person has declined steadily since 1960 and is projected to continue to decline through 2020” (Anderson and Hussey, 1999). Social security and Medicaid rely on the input of people who are working today to remain solvent. In sum, fewer people will support increasing numbers of older persons in the future. The older population will grow in absolute numbers, and this group consumes a high percent of resources, especially health expenditures. Therefore, there is a high priority in delivering highly efficient and effective services to large groups of older recipients.

As age increases, impairment also increases. Thus, the increased numbers of the elderly have great implications for service providers and policymakers. To plan for this, decision makers will need to carefully weigh today’s decisions in light of these projections and the impact these decisions will have on the lives of older adults (Mehdizadeh, Atchley, and Applebaum, 1996).

Incorporating New Knowledge

Researchers in aging are amassing a body of knowledge that can improve the lives of seniors. Recent research findings have demonstrated that many conditions such as muscle atrophy, decrease in bone density, and mental decline are frequently due to inactivity rather than a universal aging phenomenon. In addition, researchers have shown that in the absence of illness, these conditions are reversible with exercise, diet, and various other lifestyle changes. This information gives seniors some amount of control over their own aging process.

Product development also influences the health and function of older persons. New drugs decrease blood pressure, lower
cholesterol, and increase bone density. They can prevent more catastrophic conditions of stroke, heart attack, loss of vision, and fractured bones. Items such as “grabbers”, improved walkers, emergency call systems, and lift chairs have improved the function of seniors. New information must be continually translated into the daily lives of seniors. Information and making informed decisions empower seniors.

Conclusion

Today’s seniors can reflect on a world that has changed immensely. In increasing numbers seniors are raising their grandchildren. Furthermore, many seniors, especially women, care for an ill spouse.

Aging is a period of physical and functional decline. Loss of physical function increases as age increases, and this in turn causes a reduction in the quality of life. For example, the loss of eyesight can lead to the loss of driving a car. Being unable to drive a car can result in a person not being able to attend church, buy groceries, visit a friend, or go to a doctor’s appointment.

As people age they must rely more on the healthcare system. As the baby boomers swell the ranks of seniors, even more healthcare dollars will go to seniors. They are more likely to have healthcare coverage via Medicare than the young. Even so, the typical Medicare beneficiary uses nearly 20% of his or her annual income to pay for out-of-pocket healthcare costs, especially medication (Commonwealth Fund, 2000).

Most seniors prefer to remain in the community for as long as they are physically and mentally able. This may last for their entire lives for the majority of seniors. However, the key to remaining in the community is assistance, which may include help with heavy chores or weekly grocery shopping. Seniors who are more impaired need a full-time caregiver. Caregiving is a constant and demanding job. Caregivers save society millions and perhaps even billions of dollars. Despite the contribution they make, they receive little from the community to support their efforts.

The increasing number of older persons, the growing number of the oldest old, and the high use of public health
dollars make senior issues the center of many policy debates. Politicians know that seniors vote and even organize, which is evidenced by the membership in the American Association of Retired Persons.

In the Greater Cincinnati community, perhaps the most important timespan is between 2001 and 2011. These 10 years are a time for strategic planning and collaboration as the “baby boomer” generation turns 65. If we use these years wisely by filling in service gaps, developing capacity, and empowering ourselves with newly developed knowledge, we will have met the challenge of aging in our community.
References


Administration on Aging. (2001). Older Adults and Mental Health Fact Sheet.


References


Kroger Pharmacy (personal communication, Sept. 9, 2000).


References


References


Appendix A

Each year, Cincinnati Area Senior Services (CASS) updates the list of senior services available and prints a Cincinnati edition of the Resource Guide for Older Adults and Their Families. The following resources and services are available for seniors in Hamilton County.

**General Information & Referral, Community Outreach**
- Primary Resource Information and Referral Agencies
  - Area Agencies on Aging
- Senior Centers
- Home Delivered Meals (Meals on Wheels)
- Food and Grocery Resources
  - Grocers That Deliver
- Transportation
  - Handicapped Parking Card
  - Safe Driving Classes
  - Enhanced Medicaid Transport
  - CASS transportation
  - Citywide Public and Private
  - Hospital Provided
  - Routine Ambulance Transport

**Consumer Help & Information**
- Do’s and Don’ts of 911
- Discount Programs
- Education and Leisure
- Health Education and Wellness
- Employment
- Volunteer Opportunities
- Safety and Security
  - Alert and Watch Programs
  - Victim Assistance
  - Police Protection
- Finances and Estate Planning
  - Credit Counseling
  - Taxes
  - Professional Organizers
Appendix A

— Estate Planning
— Living Trusts vs. Wills

• Legal Health Care/Advance Directives
• Living Will Directive Form
• Funeral Pre-planning
• Advocacy, Legal, and Self Empowerment
  — Advocacy
  — Legal Resources
  — Legal Records
  — Elected Representatives
  — Voting
  — Veterans Services

Crisis, Mental Health & Caregiver Support Services
• Alzheimer’s Association Safe Return Home
• Social Services and Emergency Assistance
  — Elder Abuse and Neglect
  — Crisis Intervention
  — Community Support
  — Pastoral Assistance
  — Utilities Assistance
  — Telephone Assistance
• Companionship
  — Telephone Reassurance
  — Bereavement/Widow Support
  — Birthday/Anniversary Greetings
  — Pet Companionship
• Family Support Services
  — Grandparents Support
• Mental Health Counseling
  — Hospital Provided
  — Mental Health Home Care
• Caregiver Support and Respite
  — Professional Care Managers
  — Respite
  — Caregiver Resources
• Aging Web Sites
• Geriatric Assessment
Appendix A

— Geriatric Assessment Centers
• Alzheimer’s Services
• Adult Day Services

Social Security, Medicare, Medicaid & Medical Insurance
• Social Security
  — Limits on Benefits
  — SSI
• Medicare/Medicaid/Health Insurance
  — Patient’s Rights Under Medicare
  — Community Medicaid
  — Medicaid Spend Down
  — Benefits Resources
  — Medical Claims Assistance
• Quick Summary of 2000 Medicare Benefits and Medicare HMO Coverage
• Medigap Insurance
• HMO Insurance Options
  — Medicare Benefits through an HMO
  — Medicare HMO Checklist
  — Terms
• Long Term Care Insurance
  — Company Checklist
  — Policy Checklist
  — Terms
  — Viatical Settlements
• Long Term Care Insurance Comparison Checklist
• Caregiver Emergency Help Guide

Medical & Health Care Services
• Hospital Health Care Systems
  — Hospital Membership Programs
  — Urgent Care Physician Services
  — Community Clinics
  — Medical Phone Assistance
  — Pharmacies that Deliver
  — Prescription Assistance
  — Viatical Settlements
  — Visiting Physicians
Appendix A

- Home Health Care
  - Selecting an Agency
  - Range of Services
  - Questions to Ask
  - Terms
  - Benevolent Providers
- Home Health Care Agency Comparison Checklist
  - Companion Services
  - Additional Resources
- Important Documents Checklist
- Help at Home Checklist
- Hospice Care
- Medical Equipment and Adaptive Services
  - Medical Emergency Response Systems
- Disability and Rehabilitation Services
  - Vocational Rehabilitation
  - Visual Disabilities
  - Speech and Hearing Disabilities
  - Additional Accessibility Resources
- Health-related Agencies and Services
  - AIDS/HIV, Alcohol, Alzheimer’s, Disease, Arthritis/Lupus, Asthma/Allergy, Cancer
  - Cerebral Palsy, Dental, Diabetes, Drug and Poison, Epilepsy, Gastrointestinal Support, Heart, Huntington’s Disease
  - Kidney, Leukemia, Lung, Neuromuscular Diseases, Nutrition, Pain, Stroke

Housing & Skilled Healthcare Facilities
- Housing Options
  - Information and Referral
  - Household Sales/Disposition
  - Shared Living Homes
  - Questions to Ask
  - Senior Housing Terms
- “Is Staying at Home the Best Financial Alternative?” Chart
- Reverse Mortgage Loans
- Subsidized Housing
- Home Repair and Maintenance
  - Home Maintenance Resources
  - Chore Services
Appendix A

- Mobile Home Parks
- Nursing Facilities/Nursing Homes
  - Grievance Resources
  - Financial and Legal Pre-planning
  - Questions to Ask
  - Types of Long Term Care Facilities
  - Legal Terms
  - Medicare Coverage
  - Medicaid Coverage
- Independent/Assisted Living Checklist
- Residential Care/Nursing Facilities by Area
- “Is Nursing Home Placement the Correct Decision?” Chart
Appendix B

Each year, Senior Services of Northern Kentucky updates the list of senior services available and prints a Northern Kentucky edition of the Resource Guide for Older Adults and Their Families. The following resources and services are available for seniors in Northern Kentucky.

**General Information and Referral, Community Outreach**
- Primary Information and Assistance
- Senior Centers
- Food Resources
  - Private Delivery Services
  - Meals on Wheels
- Transportation
  - Private Services
  - Handicapped Parking
  - Routine Ambulance Transport

**Consumer Help and Information**
- Living Trusts vs. Wills
- Discount Programs
  - General
  - Fishing and Hunting Licenses
  - Park Admissions
  - Property Tax
  - Transportation
- Safety and Security
  - Alert and Watch Programs
- Finances and Estate Planning
  - Credit Counseling
  - Estate Planning
  - Taxes
  - Veterans Services
- Advocacy, Legal, and Self Empowerment
  - Insurance Advocacy
  - Government Information
  - Legal Resources
  - Legal Records
— Elected Representatives
— Voting
• Education and Leisure
  — Education
  — Publications
  — Outdoor Recreation/Special Events
  — Safe Driving Classes
  — Travel and Tourism
• Employment
• Important Documents Checklist
• Volunteer Opportunities
• Legal Health Care/Advance Directives
• Funeral Pre-planning
• Living Will Directive Form

Crisis, Mental Health, and Caregiver Support Services
• Social Services and Emergency Assistance
  — Crisis Intervention
  — Emergency Shelter for Men
  — Emergency Shelter for Women
  — Emergency Food and Clothing
  — Pastoral Assistance
  — Utilities Assistance
• Companionship
  — Telephone Reassurance
  — Bereavement/Widow Support
  — Birthday/Anniversary Greetings
  — Pet Companionship
• Family Support Services/Mental Health Counseling
  — Hospital Programs
  — Professional Care Managers
• Geriatric Assessment
  — Geriatric Assessment Centers
• Alzheimer’s Disease
• Adult Day Services/Respite Care
  — Day Treatment
  — Range of services
  — Caregiver Resources
• Caregiver Emergency Help Guide
Social Security, Medicare, Medicaid, and Medical Insurance

- Social Security and Health Care Insurance
  - Social Security
  - SS Income Limitations
  - Supplemental Security Income (SSI)
  - Medicare
  - Patient’s Rights under Medicare
  - For Low Income Beneficiaries
  - Medical Claims Assistance
  - Community Medicaid/Spend Down

- Quick Summary of 1999 Medicare Benefits and Medicare HMO Coverage

- Medical Insurance Options
  - Medicare Changes
  - Medicare Benefits through an HMO
  - Medicare HMO Checklist

- Medigap Insurance

- Long Term Care Insurance
  - Company Checklist
  - Policy Checklist
  - Terms

- Long Term Care Insurance Comparison Checklist

Medical and Health Care Services

- Home Health Care Agency Comparison Checklist

- Hospital Health Care Systems
  - Northern Kentucky
  - Cincinnati
    - Hospital Membership Programs
    - Pharmacy Delivery
    - Prescription Assistance

- Primary Health Care Services
  - Dental Services

- Home Health Care
  - Range of Services
  - Terms
  - Questions to Ask
  - Benevolent Providers

- Hospice Care
Appendix B

—Questions to Ask
• Medical Equipment and Adaptive Services
  —Medical Emergency Response Systems
• Help at Home Checklist
• Disability and Rehabilitation Services
  —Catalogs with Disability Products
  —Vocational Rehabilitation
  —Visual Disabilities
  —Speech and Hearing Disabilities
  —Additional Accessibility Resources
• Holistic Health and Wellness Programs
• Health-related Agencies and Services
  —AIDS/HIV, Alcohol, Alzheimer’s Disease, Arthritis/Lupus, Asthma, Cancer, Cerebral Palsy,
  Dental, Diabetes, Drug and Poison, Epilepsy, Heart, Huntington’s Disease, Kidney, Leukemia,
  Lung, Neuromuscular Diseases, Nutrition, Pain, Parkinson’s Disease, Stroke Support

Housing and Skilled Healthcare Facilities
• “Is Nursing Home Placement the Correct Decision?” Chart
• Housing Options
  —Information and Assistance
  —Section 9 Housing
  —Questions to Ask
  —Senior Housing Terms
• Independent/Assisted Living Comparison Checklist
• Family Care Homes
• Assisted Living
• Senior Housing Apartments
• Home Repair and Maintenance
• Reverse Mortgage Loans
  —Reverse Mortgage Lenders
  —Reverse Mortgage Counselors
• Skilled Nursing Facilities/Nursing Homes
  —Grievance Resources
  —Questions to Ask
  —Types of Long Term Care Facilities
  —Medicare Coverage
  —Medicaid Coverage
• Skilled Nursing Facilities by Area
• “Is Staying at Home the Healthiest or Best Financial Alternative?” Chart
Appendix C

The following are the recommendations that the Ohio statewide task force on Grandparents Raising Grandchildren made to the 123rd Ohio General Assembly (Ohio Grandparents Raising Grandchildren Task Force, 1999).

- Establish legal relationships between grandparents and grandchildren so that grandparents may act in the best interests of themselves and their grandchildren.
- Make grandparents raising grandchildren aware of policies and eligibility requirements for Ohio’s Temporary Assistance to Needy Families/Ohio Works First (OWF) and the Kinship Family Preservation Supportive Services Programs. Passed into law as H.B. 408 in 1997, OWF gives Ohio’s Department of Human Services the flexibility to use federal block grant money (via the 1996 Federal Work Opportunity Reconciliation Act) to serve the needs of the families in their communities. The Kinship Care Family Preservation Supportive Services program is available through county children services agencies to families caring for relative children.
- Ensure that grandparents know that all children below 200% of the federal poverty level qualify for health insurance, regardless of relation to parental authority.
- Ensure that all grandchildren raised by grandparents receive all necessary immunizations by easing the way for grandparents to give medical authorization.
- Increase recognition of the emotional needs of grandchildren raised by grandparents, as well as the availability of counseling services to them.
- Expand availability of health services to grandparents raising grandchildren.
- Expand services and resources promoting preventive and recuperative emotional/mental health services for grandparents raising grandchildren.
- Encourage intergenerational activities to strengthen family structures.
- Encourage the General Assembly to commission and fund a study of how best to increase financial assist to low-income grandparents.
- Provide accessible and affordable childcare for grandparents raising grandchildren.
- Expand childcare to encompass after-school care and tutoring.
- Increase support for grandparents willing to adopt their grandchildren. The Federal Assembly and Child Welfare Act of 1980 (P.L. 96-272) buttresses the belief that states should seek the most family-like setting for adopted children and that relatives are more likely than non-relatives to advance the best interests of the adopted child.