ACKNOWLEDGEMENTS

This assessment engaged individuals and service providers, gathering input in a variety of ways, including holding a forum attended by over 50 community members and agency staff to address issues of senior health. Focus groups and key informant interviews were conducted with staff, seniors, and community professionals. Thank you to the people who provided their time, expertise, and information for this assessment. Their input provided a perspective not always identified or available in the quantitative data. Staff and community representatives are recognized at the end of each chapter in which their contributions are included. Special thanks to our community partners listed below for their input into the assessment, providing direction and information as well as reviewing draft documents.

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May 2007

Dear Providers of Care:

As the baby boom generation ages, so will the proportion of senior citizens living in our community.

In anticipation of this change, the Spokane Regional Health District (SRHD) in partnership with Aging and Long Term Care of Eastern Washington (ALTCEW) and Spokane County United Way conducted a senior health assessment. The information within this report, Aging with Care in Spokane County, will help these partners develop policies and funding priorities and address the issues identified through the assessment. We hope that other agencies will find great value in this report as well.

The purpose of the assessment was to compile available data on people aged 60 years or older living in Spokane County and where possible make a comparison to Washington State data about the same age group. The assessment concentrates on issues that affect the health status of seniors and concerns stated by seniors and providers in the community. Community issues with potential solutions are identified within this document.

This assessment, Aging with Care in Spokane County, provides a snapshot describing the current status of senior's health. It also will lead to further discussions about the identified challenges. As a community, we must reach our vision of providing for our seniors' needs to improve the quality of the aging process.

Sincerely,

Larry Jecha, MD
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EXECUTIVE SUMMARY

Improved environmental conditions, medical care, prevention efforts, and lifestyles have expanded life expectancy in the United States. As a result, the proportion of the population who are 60 years of age or older has increased. Many of the improvements have also advanced the quality of life for seniors. On the other hand, with the leading causes of death in seniors changing from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses, a growing number of seniors experience debilitating conditions that require long-term caregiving from family, friends, or institutions. The increasing senior population and longevity with changing health issues affects the community as a whole, including the capacity to care for seniors through the aging process.

Public health improves and protects the health of the community through education, prevention of injury and disease, and monitoring. Community health assessments are conducted to define local priorities by:

- Describing the health of a population;
- Identifying disparities in health;
- Identifying gaps in capacity to address those health issues; and then
- Developing or strengthening community programs and policies.

*Aging with Care in Spokane County* is the result of a senior health assessment conducted by staff from Spokane Regional Health District in partnership with the Aging and Long Term Care of Eastern Washington and Spokane County United Way. Methodology for the assessment included a literature review; a community forum to prioritize health issues; focus groups with staff, seniors and professionals in the field; interviews with key service providers; and compiling primary and secondary data.

Spokane County seniors discussed some of the perks of getting old with the staff, expressing that acceptance of the aging process is important to keeping a positive perspective. The seniors most often mentioned the following benefits of being 60 years of age and older:

- Volunteering in the community
- Family and grandkids
- Senior privileges and discounts
- Travel
- Not having to work

The seniors also expressed challenges of the aging process. This assessment focuses on those issues. In 2006 in Spokane County, 15.9% of the population was 60 years of age or older. The projected senior population for 2016 is 20.4%, increasing to 24.2% in 2026. In 2004-2005, about one-third of seniors in Spokane County said they had a disability, which is defined as being limited in any way in any activity because of a physical, mental, or emotional problem. In 2004, almost 25% of all seniors were employed with 22% living at or below 200% of the Federal Poverty Level.

One-quarter of the Spokane County population in 2026 will be 60 years of age or older.
Behavioral Health Factors
In general, 41% of seniors reported they had very good or excellent health. However, one-quarter of seniors had eight or more days of poor physical health. Increasing the focus on healthy aging was stressed by many of the agency's staff who worked with us on this assessment. Half of seniors are either overweight or obese; 37% are moderately physically active; 25% eat the recommended fruits and vegetables per day; and 9% smoke cigarettes.

Many conditions affect the nutrition seniors receive, such as cost, mobility, and health conditions. Oral health can affect the ability to eat nutritious foods. One-third of seniors are missing all of their teeth with another third missing more than six teeth in the upper or in the lower arch.

Morbidity and Mortality
The most common chronic conditions among seniors are arthritis (63%), hypertension (55%), and high cholesterol (46%). Over one-third mentioned having back problems, trouble hearing, chronic allergies, and trouble seeing. The leading causes of hospitalization are unintentional injury (51%), heart disease (39%), respiratory disease (24%), digestive system disease (21%), and cancer (14%). In 2004, 3,700 hospitalizations were due to unintentional injuries of Spokane County residents aged 60 years of age or older with an average charge of $25,311 per hospitalization. Thirty-two percent of the unintentional injury hospitalizations were due to falls. One-half of all deaths were from heart disease and cancer.

Healthcare
In Spokane County, 97% of seniors had medical insurance in 2005, but 6% did not have a personal healthcare provider and about 5% were unable to see a healthcare provider because of cost. Medicare coverage options are complex, so the benefits are not always fully utilized, including the new prescription drug plan. The largest percentage of the cost of medications for Medicare beneficiaries was for cardiovascular agents (25%) with two-thirds of seniors purchasing this type of medication. In 2005, 40% of seniors did not receive a flu shot in the last year and 37.5% had never had a pneumonia shot. In 2004, 61% of senior males had received a prostate specific antigen (PSA) test in the last year. About one-quarter of senior females said their last Papanicolaou (PAP) test was five or more years ago, although two-thirds had received a mammogram within the previous year. Colorectal cancer screenings had similar participation by men and women.
Mental Health
Data regarding mental health is limited. However, senior’s mental health was prioritized as a top concern by individuals at the community forum. Individuals and groups repeatedly talked about access to services being limited for seniors. Mental health is related to many other health issues. For seniors, there is still a stigma around seeking help for mental health issues and people who need help do not always recognize that they need help. Dementia, loneliness, depression, and suicide were the most often mentioned conditions. From a survey, 8% of seniors reported in the last 30 days having had 14 or more days of poor mental health with 19% currently reporting depression, anxiety, or other mental health problems. Males over 60 years of age have the highest rate of suicide in Spokane County. There is limited data around elder abuse, which should be explored further.

Environment
Most seniors (86%) live independently in Spokane County with a higher percentage living in the suburban neighborhoods than the urban core of Spokane City. As functional limitations increased, seniors were more likely to begin transitioning to community housing with services and then to long-term care facilities. At any given time, less than 5% of seniors live in a nursing home. Issues raised in the interviews with key service providers included: concerns over quality of care; lack of assistance and services to keep seniors in their own homes; the difficulty in deciding when to transition to assisted living; and more. Affordable, safe housing and public transportation for seniors were raised as issues in the community discussions.

Caregiving
Most care is provided by an informal caregiver, even as a senior’s limitations increase. A recent survey of employees working in two large businesses in Spokane County indicated that 19% of the staff provided care for a senior. The most cited services provided by informal caregivers were companionship, shopping, transportation, phone calls, home repairs, and managing finances. Formal caregivers are usually necessary as the functional limitations of seniors
increase. Concern was expressed by the community about the quality of formal caregivers. Washington State does not have a regulatory body that oversees private providers of home healthcare. Providers who receive public funds are required to maintain a specified level of trained staff.

Planning for Long-term Care
Planning for long-term care and end-of-life issues are intricately related and should involve both family and medical providers. Estimates indicate that between 50-70% of Americans experience a long, slow decline before they die. Almost 38% of seniors die in a nursing home with 29% dying at home and 27% in a hospital. Thoughtful planning ahead of time can improve a senior’s continuum of care based on their individual needs. Without a long-term care plan in place, fragile seniors are more likely to become dependent on their family to make decisions for them.

Government and Other Support
Many organizations and programs in Spokane County strive to assist seniors in living a healthy life. Coordination between the various community entities is important in helping seniors address their health issues. However, public programs for seniors face ongoing funding issues, even as the senior population continues to increase. The reauthorization of the Older Americans Act in 2006 continued federal support for senior programs and enhanced the system to empower consumers to manage their own care and make choices that will allow them to avoid institutional care. The proposed 2007-2009 budget for the Washington State Office of the Governor contains funding for some programs that focus on senior health issues.

In anticipation of the increasing number of seniors, how can we as a community plan to, at the very least, maintain the current level of services for seniors in the future? As we plan, the current capacity of the community and government systems needs to be considered as well as information needs identified. During the discussions with the community, staff heard repeated suggestions regarding improving consumer and provider education; improving access to resources and information; and increasing senior advocates.

Vision for the Future
Aging with Care in Spokane County includes a section on a vision for the future. Tomorrow's seniors are described as having to take a bigger role in their health. To begin a discussion on next steps, community suggestions are provided throughout the document with some additional ideas on page 72 of this chapter. When the community mobilizes, action happens.

Let us take the challenge to make something happen.
PURPOSE OF ASSESSMENT

A community health assessment identifies the local perspective on an issue and assists with defining local priorities. Concepts for community health assessments conducted by Spokane Regional Health District (SRHD) are rarely developed in isolation of program staff and community partners. For several years, there has been discussion by staff and the community about the aging population. Expressed was a need to know more about the senior population. As the senior population continues to grow, it is important for a community to understand what factors affect the process of healthy aging.

In 2006, SRHD staff discussed the concept of a community health assessment of seniors in Spokane County with staff from Spokane County United Way and Aging and Long Term Care of Eastern Washington (ALTCEW). This partnership identified strategies for conducting a community health assessment that would describe the general health of Spokane County seniors and the availability of community support for healthy aging. The strategies included identifying topics that impact seniors’ health, evaluating data for these topics, and examining services and resources for seniors. To be consistent with the Older American Act of 1965, the project classified seniors as those age 60 years or older. In some cases, the only available data involved individuals age 65 years or older.

SRHD invited community members to share their expertise and experiences about what factors impact the health of seniors. This information provided:

- **insight** into the leading health concerns of seniors;
- **suggestions** for improving these areas; and
- **ideas** for changes in the community that might help improve senior health.

**Methodology**

To learn the current status of conditions and issues faced by seniors in our community, a mixed qualitative and quantitative methodology was used. Staff conducted a literature review, focus groups, and interviews. Existing local-level data on the issues were reviewed where available. Whenever possible, local data were compared to state and national data. Data were examined by certain demographic factors for the purpose of identifying disparities among the senior population, when possible. Information is presented by age groups when available and appropriate. Stratification by other demographic areas, like race, was not possible for several reasons, including: sample sizes that were too small and secondary data sources that did not provide the information broken out by demographic categories.

This report incorporates health status data and the community perspective regarding the needs that should be addressed as the senior population continues to grow.

**Literature Review**

A preliminary literature review indicated that the health issues facing seniors in Spokane County would likely include falls, poor nutrition, lack of physical activity, and the need for affordable medicine and health care. In order to confirm these preliminary findings, focus groups with SRHD staff and a community forum were conducted.
Focus Groups and Interviews
The qualitative component of our assessment methodology consisted of convening two focus groups with program staff of the Spokane Regional Health District (N = 14), one community forum for service providers (N = 53), five focus groups involving seniors (N = 43), and interviews with individuals (N=18) working with seniors. Additional qualitative data was collected through four focus groups (N=26) in assisted living centers. These additional focus groups addressed built environment concerns, such as availability of safe places to walk.

The initial list of health issues identified in the literature review laid the foundation for the questions posed to SRHD staff focus groups (Appendix A: SRHD Focus Group Questions). Participants confirmed the findings of the literature review and helped identify mental health as an important issue for seniors in our community.

The community forum provided the opportunity to bring a wide variety of service providers together to discuss the needs of the senior community and to prioritize those needs (Appendix B: Community Forum Agenda). The prioritization process revealed that senior’s mental health issues were the greatest concern for our community partners (Appendix C: Prioritized List of Health Issues).

The prioritized list was merged with the list of issues created through the literature review and the SRHD focus groups (Appendix D: Combined List of Issues). The combined list of issues is the focus of the Senior Health Assessment report.

Focus groups with seniors were conducted to determine whether the merged list of identified issues (Appendix D) correlated with the issues seniors themselves identified as important (Appendix E: Focus Group Questions). Findings were consistent across focus groups and supported the applicability of the merged list of issues in Appendix D.

Interviews were conducted with 18 key representatives from a wide variety of service providers in the community. The interviews were conducted to identify the capacity of our community to provide the services necessary to address the identified health concerns of seniors (Appendix F: Service Provider Questions). A secondary purpose of these interviews was to identify possible solutions to the issues raised. The health concerns identified by the service providers were similar to those of the other groups involved in the assessment.

Results of the focus groups and interviews are summarized under the headings “What We Heard,” in each section of this assessment. Reported case studies demonstrate the inter-relatedness of the range of conditions identified in the assessment.

Database Research and Surveys
The quantitative component of our assessment methodology consisted of analysis of population-based and survey based databases. Published data from several sources were also used.

Staff used three population-based data sources: death certificates, hospital discharge data, and the Washington State Cancer Registry. Information from these sources is representative of seniors in Spokane County and Washington State.

The 2000 U. S. Census provides the most comprehensive source of demographic information available. However, since this information is becoming outdated, other reliable sources were used. One such source is the Washington State Office of Financial Management (OFM) Forecasting Division. The OFM is responsible for providing population estimates on which Washington State policy makers can base their decisions. This report uses OFM’s estimates for growth in the senior population to predict future needs in Spokane County.

In addition, the results of three phone surveys were used in this assessment: the Behavioral Risk Factor Surveillance System (BRFSS), the Washington State Population Survey (WSPS), and the American Community Survey (ACS). The BRFSS is a national survey administered throughout the United States by state health departments with support from the Centers for Disease Control and Prevention (CDC). The WSPS is a survey specific to Washington State administered by the Office of Financial Management.
The ACS is a national survey administered by the U.S. Census Bureau. All the surveys are conducted by phone using a random, digit-dial selection. The surveys exclude people who do not live in a private residence and those who do not have a standard telephone. In some instances, survey results from multiple years were aggregated to stabilize the statistic.

Other information provided in this report comes from surveys or secondary data sources, which are cited accordingly.

In 2006, the SRHD’s Oral Health program conducted a survey of seniors aged 60 years or older in Spokane County (N=346). The survey collected information about senior oral health and health history. The results of this survey provided information about the prevalence of oral and physical health conditions among Spokane County seniors age 60 years or older. This survey was completed by volunteers and over-represents low income seniors. Approximately 40% of survey respondents were living below 100% Federal Poverty Level compared to approximately 6% of seniors in the county.

The Senior Nutrition program at SRHD conducted a survey among participants of meals offered at senior centers, community centers and through the Meals on Wheels home-delivery program (Appendix H: Senior Nutrition Survey). The survey results are not representative of Spokane County, but provide information about the people who use these services and those who took the survey (N=404).

SRHD also conducted an on-line survey in 2006 of two large healthcare agencies in Spokane County (N=286). The survey looked at the burden of caregiving on current employees.
Bill is 89 years old, divorced, and living alone in a small two-room trailer. His income is below federal poverty guidelines but he refuses to “go on the dole and accept welfare.” Since his divorce six years ago, he has displayed symptoms of depression. He is very proud, pessimistic, angry and distrustful of others, and views asking for help as a sign of weakness. He has many health problems including cardiovascular disease, emphysema, and highly limited mobility. Bill has no identified healthcare provider. The only medical care he receives is through the emergency room when he has a health crisis.
Demographics Overview

The demographic makeup of a senior can make a big difference in their physical and mental health, their physical ability, and their desire to utilize services. For many seniors, it is important to them to stay healthy and connected to the community. As seniors age, differences are seen in various demographic categories such as sex, employment, socio-economic status, and marital status. Taking these differences into account is important when reading the information contained in this assessment. For example, the issue of unintentional injury, specifically falls, is predominant in this assessment. Senior falls happen far too frequently, are very expensive, and are preventable. Falls are directly related to the age and the income of seniors. As seniors age they are more likely to experience a fall. If seniors have adequate resources they are more likely to have improvements done to their homes that decrease the likelihood of a fall.

Living in poverty is a concern to seniors who retire from the workforce or become too debilitated to work. Without ample financial savings, seniors may find themselves living on a fixed income that does not meet their needs or they may have no income at all. Although all seniors are eligible for Medicare, the coverage mainly addresses acute healthcare needs. Seniors without employer-supplied health insurance must pay out-of-pocket for some medical services. They may also have to buy supplemental insurance to cover other healthcare needs, such as long-term care.

Age, Gender, Race/Ethnicity

In 2005, there were 74,105 Spokane County residents age 60 years or older. The age distribution of seniors in Spokane County was similar to that of Washington State. Over the last 30 years, approximately 15-16% of the population in Washington State has been age 60 years or older. In the next 20 years, the number of seniors in this age group is projected to increase to 24% of the population. The Office of Financial Management projects that in the year 2026, the Spokane County population will include 137,866 residents who are 60 years or older.

Census data show that there are more males than females between the ages of 60 to 74, but by age 75 or older, there are more females than males. In 2003, the average life expectancy in Spokane County was 78.3 years; 75.8 years for men and 80.7 years for women.
The number of minority seniors in Washington State is projected to increase by 6.5% over the next 20 years (2005 to 2025). The number of non-Hispanic Whites is expected to decrease from 89.7% of the population in 2005 to 83.2% in 2025. According to the Office of Financial Management, in 2004, 3.3% of Spokane County seniors were born in a country other than the United States.

**Education and Employment**

In Spokane County, 9% of seniors had attained less than a high school diploma, while 30% held a high school diploma or GED, 30% had some college, and 30% had a four-year college degree or greater.

**WHAT WE HEARD**

Seniors reported that society’s perception of older people is often stereotyped and many feel as though they are “invisible” to the community and feel undervalued. They also noted that it is difficult for seniors to find a job. These realities can be hard for seniors who spent their whole life as active, respected, contributing citizens in the community to accept and address.
Of all seniors age 60 or older, 25% were in the workforce in 2004 and most of those were employed. The proportion in the workforce decreased as age increased, yet 9% of seniors age 75 years or older were employed in 2004. Individuals not in the workforce are not seeking work because they may be, for example, retired or disabled. Unemployed individuals are able and wanting to work, but are not employed.

Poverty
Limited financial resources decrease the options available to meet one's basic needs, such as safe, accessible housing; caregiver aid; healthy food; and medication. These are basic necessities that allow seniors to maintain their health and have a good quality of life.

Nationally 30 years ago, 19.4% of seniors age 65 years and older lived below 100% Federal Poverty Level (FPL). By 2005 that percentage had decreased to 9.8%. Spokane County showed a similar decline from 10.9% in 1990 to 8.4% in 2005. In 2006, five percent of seniors in Spokane County lived at or below 100% of FPL, while 16.9% lived between 101% and 200% FPL and 78.0% lived above 200% FPL. In 2006, 100% FPL represented $9,800 for one person and $13,200 for a two-person family. The percentage of seniors living in the lower income categories may be undercounted because people living in group quarters, such as nursing homes were not included in the data collection. The total income needed for two seniors, living in one home, to meet their basic needs in Spokane County is 114% of FPL, detailed in Table 1.

Marital Status
Most seniors in Spokane County were married (65.7%), while 11.6% were separated or divorced and 25% were widowed. Not surprisingly, as seniors age, the proportion who are either married or separated/divorced decreased and the proportion of widowed increased. This is true for each sex, although the proportions vary greatly between the sexes.

Table 1.

<table>
<thead>
<tr>
<th>Monthly Cost of Basic Needs for a Family of Two Seniors in Spokane County, 2006</th>
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<tbody>
<tr>
<td>Food</td>
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<td>Housing</td>
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<td>Utilities</td>
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<td>Transportation</td>
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</tr>
<tr>
<td>Personal &amp; Household Expenditures</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Monthly cost of basic needs was determined by the following:

- Food costs are estimated by the U.S. Department of Agriculture. The June 2006 U.S. average for the low-cost food plan was used as a sustainable measure of basic food needs.
- Housing costs were based on the taxes for a house with an assessed, taxable value of $150,000 in the City of Spokane, since most seniors live in the community.
Utility costs were a combination of energy and telephone services. According to Qwest in 2006, basic telephone service with no additional amenities was approximately $22.50 per month, including taxes. Energy costs, updated by using a cost of living calculator from www.aier.org, were $103 in 2006.

Transportation costs were based on the family having one car and assumed there was no car payment. The cost of gas was calculated for driving 20 miles per day at 20 miles per gallon at a cost of $2.50 per gallon of gasoline ($76). Basic car insurance costs were estimated at $60 per month for a 2002 car. A minimal amount of maintenance ($30) was also included.

Health insurance cost was calculated by using Medicare insurance premiums. Medicare part A covers inpatient hospital care and has no monthly premium if Medicare taxes were paid during employment. Medicare part B covers outpatient and other medical services. The premium for part B is based on income. An income of $80,000 or less requires a $93.50 monthly premium. Medicare part D covers prescription drugs. Monthly premiums range from approximately $25-$70. This calculation used the low estimate of $25. Not taken into account were the co-payments and deductibles.

Personal and household expenses were calculated at 15% of all costs.

WHAT WE HEARD

Key representatives from social services and service providers expressed concern about seniors living in poverty or on the edge of poverty who are struggling to meet their basic needs. As the cost of living continues to increase, seniors on a fixed income face increasing bills. These increases may be in the form of rising medication costs or property tax increases.

Suggestions for helping improve the financial stability of seniors included the following:

- cap property taxes for seniors living on a fixed income;
- create subsidies for property taxes and utility bills; and
- allow tax-deductible contributions to a senior subsidy program that could be offered by the tax assessor and utility offices. The program would automatically add a pre-determined contribution to an individual’s utility bill, if requested.
Raising Children's Children

Data from the 2000 U. S. Census indicates that nearly six million children in the U.S. live with grandparents or other relatives as their primary caregivers. According to the Washington State Department of Social and Health Services, more than 35,000 grandparents or other relatives are raising children in Washington State. In recent years it has become more commonplace for grandparents to be the primary caregiver of their grandchildren.

The Washington State Institute for Public Policy identified the following characteristics of Washington kinship caregivers:

- 73% are grandparents;
- 87% are women;
- the average caregiver age is 53 with about a quarter of caregivers over age 60;
- the average age of the children in kinship care is nine years;
- the average caregiver has been caring for the child for an average of almost six years; and
- about half of the caregivers care for two or more children.

As one caregiver grandparent noted in an interview for a recent journal article: “The emotional impact of raising children when you are past that life cycle event is a big issue. It is an enormous adjustment for a person whose energies, developmentally, are beginning to turn inward, to suddenly have to turn outward to meet the demands of caring for a child or children again—the physical care, the homework help, and so forth. Many of these grandparents are emotionally exhausted.”

Another issue facing seniors raising grandchildren is dealing with their own children. As parents, they may feel angry and resentful that their children are not caring for their own young children. Many seniors may feel guilty, because they wonder if their own parenting may have contributed to their child’s inability to care for the grandchildren.

If the grandparent has a grandchild with special medical, educational, developmental, or emotional needs, it may be difficult to obtain services for the child since many agencies require that the natural parent obtain these services. In 2005, Washington State passed a bill that allows relative caregivers the legal right to give informed consent for medical care.

Most kinship arrangements in Washington State do not involve the state’s child welfare system. A Washington State Institute for Public Policy (WSIPP) survey revealed that there are nine informal kinship care arrangements for every formal arrangement. Financial assistance was determined to be the most significant unmet need of kinship caregivers across Washington State. This often involves needing assistance to obtain food, clothing, shelter, and transportation.

CHAPTER ACKNOWLEDGEMENTS

Pam Almeda, Spokane Valley Meals on Wheels
Dan Jordan, Spokane Neighborhood Action Program
Wade Knutsen, Spokane North Community Services Office
Billie Malcolm, Washington State Department of Social & Health Services
Mike Midkiff, Washington State Department of Social & Health Services
Sue is 84 years old, widowed, and until recently lived in her own home. Ten years ago, she fell and fractured a hip. Since then she has received assistance with yard work and heavy housework. She has not driven since her fall. She has a circle of friends she talks with daily and who provide her with transportation. Lately, she feels her circle of friends and family is shrinking as she is outliving those around her. Sue has begun experiencing muscle weakness and being tired after short walks. She has also been falling down and having difficulty getting back up. Sue is less able to prepare her meals, manage household tasks, and perform personal care. Within a month of first noticing weakness, Sue moved in with her daughter who performs the household chores and helps Sue with personal care. Her daughter recently returned from work to find Sue disoriented and lying on the floor, where she had apparently been for hours. Sue has been admitted to the hospital and diagnosed with anemia. Upon discharge from the hospital, Sue will need skilled nursing, occupational therapy, and physical therapy services.
Behavioral Health Factors Overview

As seniors age, changes in behavior that affect the body systemically may make a person vulnerable to a cascade of events that lead to poor health outcomes. For example, a senior might change her diet because she has trouble eating due to dention issues, or perhaps she cannot get to a store as often as she would like, or maybe she just doesn't feel like eating. Poor nutritional intake might make her dizzy, which could lead to a fall and a broken bone.

Sensory perception tends to decrease with age, which may limit what or how much a senior can do. For example, if a senior has decreased vision, he might not be able to drive to the grocery store or might not be able to see well enough to prepare a healthy meal. Lack of adequate nutrition can lead to additional physical or mental distress.

A senior might limit social contacts for a variety of reasons including poor physical health; a partner who requires a lot of caregiving support; limited resources to get to social activities; or not feeling safe when walking or driving. The resulting isolation may affect mental health status, which leads to further behavior changes. Without assistance, these behavioral and mental changes may create a serious cyclical pattern that leads to increasingly worse health outcomes.

Health Status

Although the risk of disease and disability clearly increases with age, poor health is not an inevitable consequence of aging. Healthy behaviors and preventive screenings may reduce a person’s risk for many chronic conditions or disability. The Washington State Department of Health lists nine steps to healthy aging:

1. Be physically active.
2. Eat a diet high in fruits, vegetables, and whole grains and low in saturated fats.
3. Avoid tobacco use.
4. Get enough calcium.
5. If you drink alcohol, drink only in moderation.
6. Take care of your teeth and visit a dentist regularly.
7. See a healthcare provider regularly to find out about screening tests and immunizations you might need.
8. If you take medications, make sure you are taking them properly.
9. Be socially active with friends and family and be involved with your community.

In Spokane County, 41% of seniors reported they had very good or excellent health; 43.5% of seniors statewide reported similarly. In Spokane County, as well as statewide, fewer than 40% of the seniors surveyed experienced one or more days of poor physical health in the month before the survey. However, 25% of seniors in Spokane County had eight or more days with poor physical health, compared with 19.4% of seniors statewide. Those seniors who reported one or more days of poor physical health in the previous month indicated the average number of days of poor health was 15.7 in Spokane County and 14.2 statewide.

Figure 7

Self-reported Health Status Among Seniors

* Data Source: BRFSS 2004 and 2005
** Data Source: BRFSS 2005
Of those seniors who participated in the SRHD oral health survey, 35.1% reported uncorrectable vision problems in one or both eyes; 37.3% reported trouble hearing. Other physical ailments and limitations were noted as well and are summarized in Figure 8. The physical health conditions of seniors may affect their quality of life. Knowing which conditions many seniors experience provides information about what to consider when working with or planning events for seniors.

\[\text{Data Source: SRHD Senior Oral Health and Health History Assessment}\]

\[\text{Figure 8}\]

**Current Medical Conditions Among Seniors Spokane County, 2006**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of 60+ Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>63.0</td>
</tr>
<tr>
<td>Back problems</td>
<td>37.6</td>
</tr>
<tr>
<td>Trouble hearing</td>
<td>37.3</td>
</tr>
<tr>
<td>Chronic allergies</td>
<td>35.1</td>
</tr>
<tr>
<td>Trouble seeing</td>
<td>35.1</td>
</tr>
<tr>
<td>Limited use of a limb</td>
<td>28.5</td>
</tr>
<tr>
<td>Asthma</td>
<td>16.0</td>
</tr>
<tr>
<td>Skin rash</td>
<td>12.6</td>
</tr>
<tr>
<td>Migraines</td>
<td>7.6</td>
</tr>
</tbody>
</table>

\[\text{Percent of 60+ Population}\]

“\text{It takes gold to keep the Golden Years alive.}”

- Senior Focus Group Participant

**WHAT WE HEARD**

Key representatives from healthcare, services providers, and social services emphasized that healthy aging is facilitated by healthy habits, such as not smoking, not drinking excessively, using safety measures, and staying physically active. They felt that healthcare providers should promote preventive care.

Suggestions for improving healthy behaviors among seniors included encouraging assisted living facilities to promote exercise in a way that makes it easy, fun, and social.

Many commented that they felt healthcare providers are rushed to provide care and do not have the time or desire to listen to problems other than those of immediate medical necessity. Participants identified a need for more compassionate, comprehensive care.

Seniors commented that deteriorating vision and incontinence are problems. Some seniors may not be able to accomplish daily activities, like bathing or cooking, and some experience loss of balance. Of particular concern were dental issues. They also noted that it costs more to live healthily, and declining health is much more expensive than in the past.

Participants in both the built environment and senior community focus groups noted that one of the greatest joys of aging is interaction with children. Participants in the built environment focus groups indicated that they particularly enjoy watching children play outside and they would go to extra effort to be able to do so.

Suggestions for improving the ability of seniors to feel safe in taking walks for exercise included the following:

- fix sidewalks so they are smooth;
- clearly mark crosswalks;
- create walking volunteer programs so seniors have someone with whom to walk; and
- install walk signals that stop all traffic at the busiest intersections.

Seniors who participated in focus groups about the built environment frequently commented that they enjoy outdoor walks and that the ability to participate in this activity is important to them. However, fear of falling, lack of a level ground to walk on, lack of clearly marked crosswalks, and a shortage of others to walk with were common concerns. Participants were asked to prioritize their concerns about the built environment; one participant’s response captured the most prevalent concern. She stated, “The sidewalks aren’t level. You expect sidewalks to be smooth. In this city, a lot of sidewalks are uneven and not smooth.”

Participants in both the built environment and senior community focus groups noted that one of the greatest joys of aging is interaction with children. Participants in the built environment focus groups indicated that they particularly enjoy watching children play outside and they would go to extra effort to be able to do so.

Suggestions for improving the ability of seniors to feel safe in taking walks for exercise included the following:

- fix sidewalks so they are smooth;
- clearly mark crosswalks;
- create walking volunteer programs so seniors have someone with whom to walk; and
- install walk signals that stop all traffic at the busiest intersections.
Health Behaviors

An important aspect of senior’s health is engaging in healthy behaviors and avoiding behaviors that contribute to negative health consequences.

Being active and eating a healthy diet can help improve a person's health status at any age. In Spokane County, surveys show that more than half of all seniors are either overweight or obese; fewer than 20% engage in vigorous activity for at least 20 minutes three times a week; 37.1% participate in moderate physical activity for at least 30 minutes five times a week; and 25% eat fruits and vegetables five times per day.

A good diet helps keep the body healthy, but as people age, they may experience barriers to healthy eating, such as decreased appetite, limited access to healthy food, and inability to prepare food. Fruits and vegetables can help maintain a healthy weight and help reduce the risk of some chronic health conditions.

Smoking cigarettes is associated with poor health outcomes. Fewer than one in 10 Spokane County seniors smoke (9.0%) cigarettes. Among adults younger than 60 years of age, one in four individuals smoke cigarettes.

Nutrition

For many people, eating a healthy diet can be difficult due to cost, time limitations, or food preferences. Seniors may have additional barriers, such as mobility or transportation limitations. Seniors may have chronic health conditions and are more vulnerable to changes in their health, making adequate nutrition important. Some health conditions can affect digestion or nutrient absorption, while others impact the ability of seniors to eat adequate food, such as poor dentition. Additionally, food insecurity may affect the mental health of seniors. Food insecurity occurs when the availability of or the ability to acquire food is limited or uncertain.

In a 2003 BRFSS survey of Spokane County residents, very few seniors (2.9%) reported cutting the size of their meal or skipping a meal because they didn't have enough money to buy food. Cost is only one issue in ensuring proper nutrition. The Spokane Regional Health District has a program that provides meals to seniors at several locations in the community where people can congregate to both eat and socialize with others. More than 1,400 people participated in this program in 2005 with 94,995 meals served. Additionally, Meals-on-Wheels delivers meals to home-bound individuals. Nearly 900 people received this service in 2005 with 134,901 meals served. The SRHD nutrition program includes many community partners. There are also “private pay” programs available in Spokane County. The number of individuals served and number of meals provided from these programs is unknown.
Among participants of SRHD congregate meals or home delivered meals, 42.4% have used the program for at least three years. Nearly three quarters (73.9%) report the meal program is their main meal of the day. These programs make it possible for 85.6% of participants to have enough to eat and assists with the difficulties mentioned in Figure 11.2 In 2004, 7% of Second Harvest’s food bank clients were age 62 years or older.12

**Figure 11**

**Difficulties Associated With Proper Nutrition Among Seniors Spokane County, 2006**

<table>
<thead>
<tr>
<th>Percent of Senior Meal Participants</th>
<th>70</th>
<th>60</th>
<th>50</th>
<th>40</th>
<th>30</th>
<th>20</th>
<th>10</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking a meal</td>
<td>48.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping for groceries</td>
<td>47.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning up after making a meal</td>
<td>34.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choosing nutritious food</td>
<td>33.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying for food</td>
<td>27.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: SRHD Senior Nutrition Meal Program Surveys

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**WHAT WE HEARD**

Interviews with key representatives from social services, public health, and service providers identified that proper and adequate nutrition is important for seniors, the lack of which may lead to premature institutionalization or hospitalization, thus increasing health care costs. Several factors affect the ability of seniors to have proper nutrition. Seniors are at risk for dehydration brought on by medications, which is complicated by the fact that the perception of thirst diminishes as people age. Issues affecting meal preparation included the fact that some seniors may not have the resources to purchase adequate food, they may have difficulty shopping or preparing a meal, or they may not feel hungry. Some seniors may get into a routine about what they eat because of price, ease of preparation, or personal preference.

There is much interest among seniors in having fresh produce. When coupons were available for a farmer’s market, many seniors took advantage of this opportunity. There are food services available to seniors, but many seniors are unaware they are eligible, or they don’t know how to access the services.

Meals-on-Wheels provide meals to homes of people who are unable to provide a nutritious meal for themselves. Some people believe that the program serves only low-income individuals, which is an incorrect perception. The program is also for people without the social resources to help with meals. For example, if someone is recovering from an illness or injury, they may be placed in a rehabilitation facility if they don’t have someone who can help them grocery shop or cook meals. Delivered meals, even for a short time, could allow the person to recover at home.

Funding for senior meal services, either home delivered or at congregate meal sites, does not meet the demand for meals. The City of Spokane has a waiting list to participate in its meal program. Spokane Valley Meals-on-Wheels does not have a waiting list, but demand for services has meant that they have had to use their reserve fund the last two years. These programs rely on volunteers to help deliver meals. Rising gas prices have affected the ability of some to volunteer. Of special concern are the people these programs do not reach, who may not know about the services, do not ask for them, or who may not want to go to a meal site. Therefore, no one may know they are not eating well.

Suggestions for improving this area included the following:

- increase awareness of Meals-on-Wheels services among the medical community;
- increase funding for this basic need, which is also a protective factor for health;
- inform the community about the need for these services;
- continue coupons for the farmers market;
- improve quality of meal sites (variety of meals and activities); and
- encourage creation of community gardens and distribute produce to seniors.
Sexual Health

Seniors expressed a need to continue to have their sexual health addressed. Many seniors are sexually active and can have age-specific sexual health concerns. Issues seniors should consider relate to both physical enjoyment and health concerns of sexual activity.

The risk for cancer of the reproductive organs increases with age. Seniors should discuss cancer screenings with their physician. Early detection of cancer leads to better health outcomes.

Seniors experience physiological changes that may affect their sexual activity. More than half of men over the age of 40 years have erectile dysfunction. Causes of erectile dysfunction include heart disease, high cholesterol, high blood pressure, diabetes, prostate problems, depression, and the use of certain medications. Prescription medications are available to help with erectile dysfunction. For women, symptoms of menopause include thinning of the vagina and vulva and decreased ability to produce as much lubrication during sexual arousal.

The number of seniors diagnosed with sexually transmitted diseases (STDs) in Spokane County every year is small. (Please see Figures 12 and 13, which show the combined data of 12 years.) As age increases, the rate of seniors diagnosed with STDs decreases.

WHAT WE HEARD

Seniors reported many women aren’t using protection because they are post-menopausal. They feel they are not at risk for STDs because they are too old.

“We’ve wanted to address sex and aging and we can’t find anyone who is willing to address the issue.”

- Senior Focus Group Participant

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Pam Almeda, Spokane Valley Meals on Wheels
Dr. Robert Bray, Spokane Physician
George Brower, Aging and Long Term Care of Eastern Washington
Dan Jordan, Spokane Neighborhood Action Program
Wade Knutsen, Spokane North Community Services Office

Billie Malcolm, Washington State Department of Social & Health Services
Mike Midkiff, Washington State Department of Social & Health Services
Linda Petrie, Spokane Neighborhood Action Program
Lynne Quimby, Spokane Regional Health District
Al is 72 years old, widowed, and lives alone in a small apartment. While walking down the stairs of his apartment leading to the laundry facility, he suffered a fall that fractured his hip. Al called his son from the hospital, but he was out of town on business. Being unable to get out of bed, Al was sent to a rehabilitation center. When Al's son came to see him in the rehab center, he learned that after arriving, Al had developed pneumonia, which was causing Al's heart rate to drop so dramatically that he required a pacemaker. Al's son made several phone calls to find another facility in which to place his father, alternating those calls with ones to Al's insurance company, trying to untangle the maze of what amount of his stay and various procedures would be covered by insurance.
**Morbidity and Mortality Overview**

Disease and physical ailments can affect the lifestyle to which a senior is accustomed. As seniors age, they are likely to develop one or more conditions that may limit their functional status. Some ailments may be medically managed and may interfere minimally with the lifestyle of a senior. Other ailments may lead to functional limitations that require the use of an assistive device or finding someone who can assist a senior with some activities. Without consideration for both the medical and functional needs, a senior may have a poor health outcome.

This section looks at morbidity (illnesses among seniors) as well as mortality (causes of death). Chronic conditions, such as diabetes and cancer, oral health issues, and hospitalizations, are also addressed.

**Chronic Conditions**

As individuals age, they are more vulnerable to the health impacts of chronic medical conditions. As the senior population increases, there will be more demand for health care services related to chronic conditions. Some conditions, such as diabetes, require long-term medical maintenance. Other conditions, such as cancer, require acute treatment followed by subsequent monitoring.

In 2006, more than one-half of Spokane County seniors who participated in the senior oral health and health history assessment reported they had been diagnosed with arthritis and hypertension. Slightly less than one-half had ever been diagnosed with high cholesterol. The effects of these conditions may be tempered by medications or lifestyle changes.

In 2004, just 2% of the senior population in Spokane County was newly diagnosed with cancer. The leading types of cancer were prostate cancer among males and breast cancer among females. Sex-specific cancers were followed by lung and bronchus cancer and colorectal cancer. These four leading types of cancer for each sex accounted for 57.5% of all new cancer diagnosed among Spokane County seniors in 2004.

The risk of developing diabetes increases with age. This disease requires both medical maintenance and attention to personal care. Diabetes can affect a person’s vision; however, a senior may attribute a change in vision to the aging process instead of identifying it as a side effect of...
Oral Health

Oral health and dental status are affected by many factors, such as use of dental services, behaviors, education, and income. As people age, physical frailty and the use of multiple medications may also have a negative effect on oral health. Older adults with fewer teeth may experience discomfort and embarrassment when eating and thus limit their social contacts. Additionally, difficulty chewing or eating limits food choices, which affects nutritional status.³

The oral health and health history assessments among Spokane County seniors age 60 years or older identified that about one-third of respondents are missing all of their teeth.¹ Another one-third are missing fewer than six teeth on either their upper or lower arch. According to a geriatric dentist, missing six or more teeth in one arch is typically when people begin to have problems eating.¹ About one-third (35%) reported having trouble biting or chewing any kinds of food and one in five reported that his or her teeth or gums hurt.

Only one-half of seniors participating in the oral health assessment had seen a dentist in the previous year.⁶ The greatest reason cited for not having seen the dentist in the last year was that there was no reason to go; either they had no problems or had no teeth.

People should be encouraged to visit their dentist regularly, even if they have few or no teeth. The survey results indicate that seniors may need more education about the benefits of visiting a dentist. Benefits include the fact that the dentist can help maintain good functionality of full or partial dentures as well as screen for oral cancers. In Spokane County, seniors are nearly five times more likely than adults younger than 60 years to be diagnosed with oral or pharyngeal cancer.⁴

Among the seniors who participated in the oral health assessment, the second most common reason for not visiting the dentist in the last year was cost.² Of those surveyed, 28% had dental insurance (Medicare does not cover dental treatments). Survey results indicated that 25% of seniors felt they needed to see a dentist in the last year, but did not, and 40.7% felt they were currently in need of dental treatment.
Hospitalizations

Hospitalizations provide a glimpse of the more severe morbidity in the community. Knowing the leading causes helps identify which medical resources are needed. Some hospitalizations may be preventable, such as hospital stays for treating injuries. More medical and personal resources are used when someone is hospitalized for a condition compared to resources needed to help prevent the conditions leading to the hospitalizations. Additionally, if the conditions could be prevented with interventions, the seniors would not have to suffer physically.

In 2004, the leading cause of hospitalization among Spokane County seniors age 60 years or older was unintentional injuries, with a rate of 50.9 injuries per 1,000 seniors. Falls were the most common cause of injury (32%). Involvement in motor vehicle crashes accounted for less than 2% of unintentional injuries; poisoning accounted for 1%. The leading cause of hospitalizations among seniors in Washington State was heart disease (41.6 cases per 1,000 seniors), followed by unintentional injuries (39.7 cases per 1,000 seniors). Other leading causes of hospitalization were chronic diseases and cancer.

When examined by age group, the five leading causes of hospitalization in Spokane County were similar. However, as age increased, hospitalization rates and the proportion of injury hospitalization from falls also increased. Fractures were the ninth leading cause of hospitalization among seniors. More than one-half (54%) of those cases were hip fractures.

Falls pose a threat to independence for many older adults. Many seniors have a great fear of falling because they see the fall as the beginning of the end.

- Senior Falls Prevention Guide

In 2004, unintentional injuries resulted in more than 3,000 hospitalizations for Spokane County seniors. The average charge for an unintentional injury hospitalization was $25,000 for a total of more than $93 million. The average charge for an unintentional injury hospitalization specifically due to a fall was nearly $19,000, totaling more than $21 million. Hospital charges for the leading causes of hospitalizations among seniors are listed in Table 2.

Table 2.

<table>
<thead>
<tr>
<th>Leading Causes of Hospitalization</th>
<th>Number of Hospitalizations</th>
<th>Average charge</th>
<th>Total charges for all hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Unintentional Injuries</td>
<td>3,700</td>
<td>$25,311</td>
<td>$93,652,072</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>2,809</td>
<td>$29,917</td>
<td>$84,036,640</td>
</tr>
<tr>
<td>Respiratory Disease</td>
<td>1,710</td>
<td>$16,440</td>
<td>$28,111,500</td>
</tr>
<tr>
<td>Digestive Disease</td>
<td>1,528</td>
<td>$18,668</td>
<td>$28,525,302</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,031</td>
<td>$23,475</td>
<td>$24,202,498</td>
</tr>
</tbody>
</table>


Falls are particularly threatening because the data show that two-thirds of older adults admitted to hospitals for fall-related injuries are discharged to nursing homes or assisted living care centers rather than sent home. Programs are available in Spokane County that provide education for older adults to help reduce the chance of falling and fall-related injuries. Program components include information on the following: an exercise program aimed at improving strength, balance and flexibility; improvements to home safety; review and management of medications that affect balance; physician referral for chronic health problems associated with falling; discussion on topics related to balance and gait, such as nutrition, proper footwear, vision, hearing, memory, and outdoor safety.
Functional Status and Disability

Functional status is defined as the “ability to perform self-care, self-maintenance, and physical activities.” It affects the ability to interact with others and the environment. Functional impairments or disabilities may need to be addressed before a person can live a healthy lifestyle. According to BRFSS, one-third of seniors in Spokane County (34.0%) say they have a disability, which is defined as being limited in any way in any activities because of a physical, mental, or emotional problems. This proportion of disabled seniors is similar to findings for Washington State (33.0%). There was no significant difference in disability status by age or sex among Spokane County seniors. Significantly, more seniors in Spokane County (21.1%) use special equipment, such as a cane or wheelchair, than do seniors statewide (14.9%).

The largest percentage of functional status limitations reported were physical, meaning a condition that limited activities, such as walking, climbing stairs, reaching, or lifting. Other limitations reported were sensory, a long-lasting condition such as blindness, deafness, or a severe vision or hearing impairment; or were concerned with activities of daily living (ADLs), such as experiencing difficulty in dressing, bathing, or getting around inside the home.

WHAT WE HEARD

Key representatives from service providers commented that seniors may not always recognize the physical limitations that may accompany the aging process. Even simple tasks may lead to an unintentional injury. As one representative summarized, “In people’s minds, they are younger than their body.” Several representatives observed that seniors tend to have an “I can do it” mindset and do not want to ask for help.

Seniors commented that they are concerned over the possibility of falling and its consequences. As one senior summarized, “Falling is the beginning of the end for most people.”

WHAT WE HEARD

Seniors reported that many physical chores have become too difficult for them to complete because of reach or strength limitations.
Mortality
The leading causes of death among seniors in Spokane County were similar to those reported for Washington State. In 2004, there were 2,999 deaths among Spokane County seniors age 60 years or older. Almost half of these deaths were due to heart disease or cancer. Most of the conditions that lead to death in seniors often require extensive medical maintenance, monitoring, or treatment before death occurs. This is not true, however, for death caused by unintentional injury. Of such deaths in Spokane County in 2004, 69% were caused by a fall and 13% by motor vehicle accident. The percentage of deaths attributed to falls was significantly higher in Spokane County than statewide, which was 55.6%. (OR 1.76, p=0.01).

Table 3.

<table>
<thead>
<tr>
<th></th>
<th>Spokane County % of All Deaths</th>
<th>Washington State % of All Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>25.1</td>
<td>26.1</td>
</tr>
<tr>
<td>Cancer</td>
<td>23.2</td>
<td>24.6</td>
</tr>
<tr>
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<tr>
<td>All other causes</td>
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</table>

*Not among the top 10 causes of death.
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificates.
Mildred is 78 years old, widowed, and lives alone in a one-bedroom apartment in the Spokane Valley. Her only child (a daughter) lives several states away and is in poor health and seldom visits. Mildred has poor eyesight, congestive heart failure, mobility problems, and difficulty completing housekeeping tasks. She has difficulty getting to her doctor appointments and has stopped going to church. She tells her apartment manager that she has been feeling worthless, unable to sleep, and fears that she will be forced to leave her apartment. Mildred's apartment manager reports that she looked into Mildred's apartment and was frightened by the filth and debris. She relates that Mildred was always “clean and tidy.”
Healthcare Utilization

As people age, they become more susceptible to specific chronic and acute conditions. Having medical insurance provides a level of access to services and assistance with lowered associated costs. Use of preventive care services can improve health or minimize the physical and financial consequences of an illness.

To be eligible for Medicare, an individual must be either disabled or age 65 or older. In Spokane County, 97.3% of seniors age 60 years or older in 2005 had medical insurance. Among seniors age 65 years or older, 98% had Medicare.

Medicare has four parts: A, B, C and D. Part A is hospital insurance. It covers hospital stays, skilled nursing, home healthcare, and hospice-related expenses. Medicare Part B is medical insurance. It covers physician visits, diagnostic testing, and more. Part B is optional, and those who choose to enroll in Part B pay a $93.50 premium each month. If their income is over $80,000 the seniors pay a higher premium. If a Medicaid enrollee’s income qualifies them as eligible, DSHS will cover their monthly premium. If individuals enroll in Part B after their initial enrollment period has ended, they may be required to pay a penalty.

Healthcare and Mental Health Overview

Seniors may require health maintenance services as they age and their bodies become more frail. Having a medical provider to oversee their care and to help manage medical issues can provide a certain level of stability for their health.

Use of preventive screening for identification of cancer is an important service. Early detection of cancer provides a better opportunity for treatment. A senior who does not have a personal healthcare provider may not know where to receive this service, or they may be unaware of the importance of the screenings.

Many health conditions are managed with medications designed to ease specific symptoms. Some health conditions require multiple healthcare providers who offer specialized treatment. Coordinating the prescribing of medicines for seniors who have multiple healthcare providers can be difficult. Pharmacists provide consultation on medications, but if a senior uses multiple pharmacies, the various pharmacists may not have a record of all the medications the individual might be taking. Communication with a senior regarding his or her medications is important in ensuring an appropriate medication regimen.

In addition, medication is costly. A senior who has limited financial resources may have to balance choices about personal health care with the need for basic living items, such as food and heat. Physical mobility, access to transportation, and cognition level may also affect how a senior follows medical recommendations. The outcome of having to make these choices may be that a senior does not seek care from a medical provider, they do not get the medication they need, or they do not take the medication as recommended.
Medicare Part C is the Medicare Health Plan (formerly Medicare Advantage). Different insurance companies contract with Medicare to cover medical services through a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) system of delivery.

Medicare Part D is the prescription drug program. Insurance companies vie for business to pay for medications only. There typically involves a monthly premium, with deductible and co-pays. Those living under 135% of the Federal Poverty Level can qualify for help to pay these costs through the federal Extra Help program.

Medicare covers two types of long-term care: nursing home benefits, limited to post-acute care (immediately following hospitalization for injury or illness); and a home health benefit. The home health benefit is limited to skilled nursing care (such as help with medications, care for bandages or wounds, etc.) at home on an intermittent basis, or for specific therapies (such as physical or speech therapy).

Medicare parts A, B, C, and D do not cover costs of all procedures, medically-related equipment, care and/or medications. There are many limitations. It is recommended that patients consult with their healthcare providers in order to pre-authorize services in advance, if possible, so that there are no surprises.

There are also Medicare supplement programs available for purchase to help protect the patient from additional costs incurred through premiums, deductibles, co-pays, and plan limitations.

A full list of what is not covered by either Medicare Part A or Part B is found in Appendix G.

The cost of healthcare is affected by several factors, but generally, the cost increases as individuals get older.
Some U.S. military veterans can access CHAMPVA, a medical insurance program administered through the U.S. Department of Veteran Affairs. To be eligible for CHAMPVA, a veteran must have a service-related disability and be younger than 65 years, unless a person turned 65 on or before June 5, 2001. CHAMPVA is a secondary payer to Medicare. One-third of Spokane County seniors had served on active duty in the military. Some of these veterans may be eligible for CHAMPVA.

Seniors age 65 years or older are eligible for Medicare. There is a concern in the community about the availability of physicians who are willing to accept the Medicare reimbursement rates and who are willing to accept new patients with Medicare insurance. In 2005, about 6% of seniors in Spokane County did not have someone they thought of as their personal healthcare provider and about 5% were unable to see a healthcare provider because of cost. Statewide survey results were similar.

**Affordable Medication**

As people age, the number of maintenance medications they must take tends to increase. The cost of these medications can become significant, especially for seniors with a low or fixed income. Before 2006, Medicare did not have a prescription medication plan. In 2006, Medicare Part D, a prescription drug plan, became available to help with the cost of medications.

In 2003, the average cost of prescription medications per Medicare beneficiary was $1,774 annually with an average cost per prescription of $64. Most Medicare enrollees (90%) purchased at least one prescription drug in 2003.

### WHAT WE HEARD

**Key representatives from healthcare and social services** talked about the need for more geriatric physicians. Currently, there are very few of these specialists in Spokane County. Geriatric physicians are trained to understand and treat the medical needs of aging patients. Other physicians can treat seniors too, but may need to refer to the geriatric specialists when an older patient has increasing or complex medical needs.

**Key representatives from academia, healthcare, service providers, and social services** commented that confusion about Medicare seems to be common among the seniors they serve. Medicare is a complex insurance program, they noted, and seniors need more education on how to use their benefits. There was also concern expressed about having enough physicians who accept Medicare clients.

**Healthcare provider representatives** pointed out that the Medicare reimbursement is low, making it unaffordable for them to accept more than a certain percentage of Medicare clients. Healthcare providers are expected to provide all services for their patients, they said, even if they don’t get paid for those services.

* A suggestion for improvement included increasing the reimbursement rate for Medicare for both physicians and long-term care staff.

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*Data Source: BRFSS 2004 and 2005
**Data Source: BRFSS 2005*
Among Medicare beneficiaries in 2003, 29% had no other health insurance, 55% had supplemental private insurance, and 16% had other public insurance. Still, 51% of the costs of prescription medications were paid out-of-pocket. Those with supplemental insurance paid a smaller proportion of the cost of medication out-of-pocket.4

The largest percentage of the cost of medications for Medicare beneficiaries was for cardiovascular agents (25%). Two-thirds of beneficiaries purchased this type of medication in 2003.4

Key representatives from social services, academia, and service providers reported that access to affordable medication and other medical services is important for health maintenance. The cost of medication for seniors is a concern. If medicine is too expensive, seniors may not go to appointments or fill their prescriptions. Seniors might have to decide what is more important: eating, paying the energy bill, or taking care of their medical needs. Although these basic needs are important as well, taking medicine inappropriately or not going to the doctor may endanger their health.

Key representatives felt that the recently available Medicare prescription drug plan (Part D) would change the out-of-pocket cost for medications among seniors. In the short term though, it has caused problems in getting medications due to the complexity of the system.

“Prescriptions can be very expensive. Some [people] can’t afford to take their needed medications. One guy spends $500 a month just on healthcare and $300 on prescriptions alone.”

-Senior Focus Group Participant
Medication Management

Proper use of medication can decrease the burden of illness or disability by helping seniors maintain their health, recover from an acute health problem, or control symptoms of a chronic disease. However, there can be potential challenges for seniors in managing their medication appropriately. Seniors are at greater risk for adverse reactions to medications than are younger adults. Adverse reactions such as dehydration, loss of appetite, or dizziness may lead to other health problems including falls, confusion, and malnutrition. There is also a risk of improper medication dosing because the aging process affects how the body absorbs, uses, and eliminates medication. Additionally, memory or sensory problems, like poor vision, may make it difficult to follow a complex medication schedule.

Among Medicare enrollees age 65 years or older, the average annual number of filled prescriptions in 2000 was 30. This was an increase from an average of 18 prescriptions filled in 1992. The number of prescriptions filled increased as the number of chronic conditions increased. Chronic conditions included cancer, stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions.

Medications change often. You don’t know what you’ll get. Some docs just don’t care to explain.” - Senior Focus Group Participant

Source: Older Americans 2004: Key Indicators of Well-Being
Key representatives from social services, healthcare, and academia noted that as some seniors get older, health problems can multiply, which may require the use of multiple medications. This can be confusing for some seniors to manage. Interview participants expressed concern about seniors not taking the right dose or frequency of medication for a variety of reasons, such as having a lack of resources to acquire the medication; lack of education about the importance of a proper medication regimen; or lack of assistance to get and take medication properly. Seniors also may not know who to ask about their medication regimen, or whether it is even alright to ask. Compliance in taking medication appropriately is also affected by mental health issues, such as forgetfulness.

Another barrier to proper medication management happens when healthcare professionals are unaware of all the medications a senior is taking. This may occur when an individual has multiple physicians, which may be appropriate for specialty care needs. Without knowing all the medications a person is currently taking, a physician may prescribe additional medication that may be contraindicated, duplicative, or unnecessary. Pharmacists review medications when a prescription is filled and receive referrals on concerns about medications. If prescriptions are filled at multiple pharmacies, the pharmacist may not know all the medications someone is taking and so cannot advise about contraindications.

Medicare Part D recently added coverage for medication therapy management to help improve participants' knowledge about the medications they are taking. Pharmacists can be reimbursed for time spent with a patient twice each year at the rate of $65 each time in Spokane County.

Suggestions for improving medication management for seniors included the following:

- developing a referral system from providers to pharmacists for certain patients;
- using blister packs for medication;
- having pharmacies fill medications a week at a time and having each day’s dosage packaged separately (like a pill box);
- having seniors develop a list of medications they are taking to give to the pharmacy;
- designing health cards that note medications and treatment plans;
- providing medication case management;
- creating a central pharmacy system or developing a common computer system or interface between systems;
- promoting medication education to seniors in multiple ways: one-on-one with a pharmacist, phone consult, group settings, or various media; and
- reimbursing pharmacists for education time with patients.

Seniors expressed a need for assistance in understanding their medications.

Over-medicating was felt to be a significant problem as well, although the MediTech system (see page 52 describing the system) helps to regulate the dispensing of medication.

“People aren’t intentionally over medicating, whether it is the physician or the patient, it just seems to be a communication problem.”

- Senior Focus Group Participant
Preventive Care

Influenza and pneumonia are among the top 10 leading causes of death for seniors. Seniors are particularly at risk for complications from these vaccine-preventable illnesses. However, among seniors in Spokane County, 39.7% did not receive a flu shot in the last year and 37.5% have never had a pneumonia shot.\(^1\) Statewide, a similar proportion of seniors did not have a flu shot (41.2%), but a significantly higher proportion had never had a pneumonia shot (43.4%).\(^8\)

Cancer is the second leading cause of death among seniors, accounting for nearly a quarter of all deaths. Preventive screenings for early detection of cancer can help identify cancer at earlier stages. Early detection of cancer allows more treatment options and better outcomes for elimination of the cancer.

Prostate Cancer

The CDC supports the use of both a prostate specific antigen (PSA) test and digital rectal exam (DRE) for detection of prostate cancer.\(^9\) Screening recommendations for men are to offer the PSA and DRE annually, starting at age 50 years. There are limitations in the tests, so patients should discuss screening decisions with their physician.

In 2004, three quarters of senior men in Spokane County and Washington State reported ever having a PSA test, and of these, most had received it within the last year (61% in Spokane County and 67% statewide).\(^10\) Nearly 90% of senior men in Spokane County and Washington State reported ever having a DRE, and of these, more than half had received it within the last year. Among men age 60 years and older, 7.2% in Spokane County and 9.0% statewide reported ever having prostate cancer.
Colorectal Cancer

There are several methods of screening for colorectal cancer. Recommendations for both men and women are to receive the screenings periodically beginning at age 50 years. An annual fecal occult blood test (FOBT) is recommended, while a flexible sigmoidoscopy and a double-contrast barium enema are recommended once every five years. A colonoscopy is recommended once every 10 years.

In 2004, 59.8% of seniors surveyed in Spokane County and 65.1% statewide reported every having had a FOBT. This difference was not statistically significant. Of these, fewer than one-half had received the test within the last year. Two-thirds of seniors in both Spokane County and statewide reported ever having had a sigmoidoscopy or colonoscopy. Most reported they had received the test within the last five years.

Cervical and Breast Cancer

Women should receive screenings for cervical cancer, using a Papanicolaou (PAP) test once every three years beginning by at least age 21. Approximately half of women who develop cervical cancer have never had a PAP test. Women should also be screened for breast cancer by using mammograms, clinical breast exams, and breast self-exams. A mammogram is the best screening tool for detecting breast cancer in its early stages. Recommendations are to have a mammogram every one to two years, beginning at age 40.
Mental Health – Socialization, Isolation, Loneliness, and Elder Abuse

Mental health issues are a top concern for seniors in Spokane County. This topic emerged and was discussed at most of the project’s focus groups, meetings, and interviews with key representatives. Mental health covers a broad range of issues from hospitalizations for acute mental health episodes to the ability to access outpatient services for chronic conditions or periods of psychological distress due to life circumstances. Another related issue is the ability to access medications for acute and chronic mental health conditions. Certain situations are emotionally stressful for most seniors: the loss of a spouse or partner, family members, and friends; the loss of independence and mobility; and the feeling that their world is growing smaller and more socially isolated.

Access to mental health services for an individual on Medicare is limited and must meet stringent criteria. Medicare Part A covers grief counseling for people with a terminal illness (less than 6 months to live) when they are receiving Medicare-approved hospice care. It will also cover inpatient mental healthcare in a psychiatric hospital, but is limited to 190 days in a lifetime. Medicare Part B will cover some mental health outpatient care with certain limits and conditions. Part B pays for 50% of fees associated with approved outpatient mental healthcare.11

Seniors have traditionally been grossly underserved by mental health providers, although, diagnostically, this target group suffers from mental health disorders, such as depression, anxiety, late-life schizophrenia, paranoia, bi-polar disorders, dementia, and similar disorders, as well as physical health and cognitive problems. The symptoms are serious and persistent and create problems such as disturbed sleep, changes in appetite and weight, irritability, agitation, aggression, hallucinations and delusions, suicidal ideation, and more.12

Hospitalizations for mental health issues are one way to look at the prevalence of these issues in the senior population in our community. In Spokane County, between 1993 and 1998 there was an increase in the rate of hospitalization for all psychoses for males 60 years of age or older. Since 1998, there has been a steady and significant decrease in the rate of hospitalizations for all psychoses among both males and females 60 years old or older.
Since 1993 in Washington State, there has been a significant upward trend in hospitalizations in both senior males and females for dementia, including Alzheimer's. The Spokane County rate of male and female hospitalizations for dementia was significantly lower than the rate for Washington State in the 2002-2004 time period.

In Spokane County, there has been a significant downward trend in the rate of senior females being hospitalized for depression since 1993. Among Spokane County males age 60 or older, the rate of hospitalization for depression stayed stable from 1996 through 2001 and dropped slightly in 2002-2004. The decline was not significant.

"With dementia comes the inability to be a good reporter. Reporting what their needs are and learning what the needs of the other spouse, without dementia, is difficult. You might assume the husband knows how to wash the clothes and the wife with dementia can't tell you any different."

-Senior Focus Group Participant
Seniors account for a disproportionate percentage of suicides. During the 10-year period of 1996-2005 in Spokane County, 22.2% of all suicides were committed by seniors aged 60 years or older, while they comprised just 15% of the total population. Among senior suicides, 85% were committed by males. Male seniors are at the highest risk of suicide when compared to other ages or groups in Spokane County:

- For males 60 years or older, the suicide rate is 40.6 suicides per 100,000 population, compared to males age 15 to 59 years with 28.4 suicides per 100,000 population.
- For females 60 years or older, the suicide rate is 5.3 suicides per 100,000 population, compared to females age 15 to 59 years with 7.9 suicides per 100,000 population.

Neither male nor female Spokane County mortality rates for suicide were significantly different from Washington State rates.

Females tend to have a higher rate of suicide attempts, but males have a higher rate of completion. For the 2001-2003 time period, senior females in Spokane County were significantly more likely than those in Washington State to be hospitalized for a suicide attempt (27.4 and 17.0 per 100,000 population, respectively). There are no significant differences in male hospitalizations between Spokane County and Washington State rates (24.7 and 21.3 per 100,000 population, respectively).

The number of attempted suicides reported above is based on hospitalization records for suicide attempts; the actual number of suicide attempts is likely higher.

From 1996 to 2004, there was a downward trend in the rate of hospitalizations for schizophrenia in Spokane County for females aged 60 years or older. In the 1996-1998 time period, the hospitalization rate of females for schizophrenia was significantly higher than in Washington State.

From 1993 to 2004, there was a significant upward trend in schizophrenia hospitalizations in men age 60 years or older in Spokane County, as well as statewide. There was no significant difference between Spokane County and the state in the rate of hospitalization of senior males for schizophrenia.13

A recent study conducted by the SRHD Community Health Assessment program evaluated the capacity of both the private and public mental health systems to serve various populations in Spokane County. Providers were asked to indicate the percentage of their caseload that was comprised of specific populations. According to the responses received from providers, seniors comprise 10% of the caseload of publicly funded providers and 5.3% of private provider caseloads.14 Seniors account for approximately 15-16% of the population in Spokane County.15
In 2006, of those Spokane County seniors age 60 years and older who participated in a health history assessment, 5.2% reported ever being told by a healthcare provider that they had mental health problems. Yet, 29.8% reported ever being told they had depression. One in five (19.2%) reported currently having depression, anxiety, or other mental health problems.16 This proportion was similar to findings from the 2005 BRFSS survey for Spokane County, in which 21% reported having one or more days of poor mental health in the last 30 days and 8% reported having 14 or more poor mental health days in the last 30 days. Those who reported at least one day of poor mental health experienced 12.2 days of poor mental health in the last 30 days on average.

There are two primary public systems that fund mental health services. The Washington State Department of Social and Health Services (DSHS) funds mental health services for Medicaid-eligible seniors as well as for some seniors who are not eligible for Medicaid but meet other criteria. Regional Support Networks (RSNs) contract with licensed community mental health providers to supply mental health services to eligible individuals. Mental health providers include community inpatient evaluation and treatment centers, community services from mental health providers who treat and manage on an outpatient basis, and state hospitals.

As seniors suffer multiple personal losses, they tend to become highly resistant to intervention and services. They respond to interrelated losses, such as physical, emotional, social, cognitive, economic, and supportive, and subsequently decline in functioning by minimizing and/or denying the existence or severity of their problems. They may isolate themselves. This results in feelings and behaviors such as disabling levels of fear, anxiety, suspicion, shame, anger, or depression, which are symptoms of mental illness. Left unserved, this population has the potential to deteriorate and utilize more costly services including:12

- hospital emergency rooms;
- community emergency response systems such as 911, law enforcement, or the fire department;
- psychiatric inpatient care (often involuntary); and
- nursing homes.

In the fiscal year July 2003 to June 2004, 2% of seniors in Spokane County received mental health services from DSHS. The cost per client was nearly $6,000 for a total cost of more than $6 million. The utilization rate and per client expenditure for mental health services were higher in Spokane County than statewide.17

### Table 4

| State-Funded Mental Health Service Use and Expenditure Among Seniors, July 2003 to June 2004 |
|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Use Rate                                        | Per Client Spent | Total Spent     |
|                                                | Spokane County  | Washington State| Spokane County  | Washington State| Spokane County  | Washington State|
| Community Inpatient Evaluation & Treatment      | 0.0%            | 0.0%            | $1,064          | $2,722          | $17,018         | $767,662        |
| Community Services                              | 1.8%            | 1.4%            | $865            | $1,329          | $863,329        | $12,935,283     |
| State Hospitals                                 | 0.2%            | 0.1%            | $47,933         | $70,740         | $5,176,797      | $24,405,247     |
| TOTAL                                           | 1.9%            | 1.4%            | $5,904          | $3,842          | $6,057,144      | $38,108,192     |

Data Source: Washington State Department of Social and Health Services, Client Data
Key representatives from social services, healthcare providers, service providers, and academia reported that the mental health of seniors is of great concern. Seniors may have mental health issues due to a variety of health and social circumstances. Seniors may not seek mental health treatment because there is a stigma associated with mental health. They don’t want to be seen as “crazy” or weak. There needs to be resources for the seniors for impulse control, depression, dementia, and other mental health concerns.

During our interviews, healthcare providers indicated that when they identify mental health issues and behavioral problems in seniors, they often don’t know where to refer the seniors or don’t have the resources to arrange referrals themselves.

We also heard that loneliness is a big obstacle for seniors. Friends and spouses may have died. Moving to a new neighborhood isolates seniors from the friends they had where they previously lived. They may have no one to talk to and may deteriorate rapidly when they don’t have the ability to get out in the community. It is not just physical limitations that keep seniors from going out, but they may feel they need to have the proper clothes or have their hair done in order to go out. Loneliness as an issue among seniors does not seem to receive much attention. There is no organized, county-level program to check on seniors, but some churches have programs with outreach programs for seniors who are alone.

Gambling is an activity in which many seniors we talked to participate in. This may be of concern if it is uncontrolled or interferes with finances. Alternatively, it is an activity that fills time and seniors are treated well, welcomed, and respected in gambling facilities.

Suggestions for improving mental health in seniors included:

- promotion of neighborhood support programs.

Elder Abuse

National data on the abuse of adults aged 60 or older indicates a 19.7% increase from 2000 to 2004 in the combined total of reports of seniors and vulnerable adults who are abused or neglected. However, state statistics vary widely because there is no uniform reporting system to document elder abuse. For example, in the 2004 national survey sponsored by the National Center on Elder Abuse, Washington State was not able to separate abuse reports where the victim was at least 60 years old. Therefore, the national data does not include information from Washington State.

In 2004, national elder abuse reporting rates ranged from a low of 0.4 per 1,000 seniors age 60 years or older (Oregon) to a high of 24.5 per 1,000 seniors (Connecticut). The average substantiation rate for states that provided both investigated and substantiated reports was 46.7%. The substantiation rates ranged between 7.2% (Arkansas) to 72.4% (Texas). The large range in rates is attributed to differences between states in definitions and procedures used to substantiate.

In 2006, Washington State Adult Protective Services received 13,134 allegations of mistreatment of vulnerable adults. Vulnerable adults are defined as:

- anyone who is 60 years of age or older who does not have the functional, mental, or physical ability to care for him or herself; or
- who has a developmental disability as defined by statute.

There were over 1,100 reported cases in Spokane County in 2006. Approximately 63% of these cases were for individuals aged 60 or older.

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Linda Petrie, Spokane Neighborhood Action Program
Pam Sloan, Elder Services
Dr. Megan Undeberg, Washington State University Pharmacotherapy Department
Spokane Regional Health District Employees
Ralph is 80 years old, divorced and living in a run-down, one-room dwelling in rural Spokane County. His indoor plumbing hasn’t worked for two years and he has been using his front yard as a toilet. He has multiple frayed electric cords and heats his home with a space heater. His bed is in the middle of the room, but he can’t sleep on it because it is piled with dirty clothes. He has anxiety, depression, and moderate dementia. He drives without a driver’s license and spends his limited monthly income on pull-tabs. He owes a water bill of $800, because of a leak in his water pipes. He eats hot dogs at the small convenience store where he buys the pull-tabs. He has a son who lives in town but is dying of cancer. He also has a daughter from whom he is estranged. He has no close friends or acquaintances.
Environment Overview

The environment in which we live consists of many aspects. For example, consider the structure of a home. How many stairs are required to get into and out of the home? Do stairs have to be navigated within the home? How accessible are the various living spaces? Another factor would be the location of the home. Is it on a bus route? Are there areas easily accessible for outdoor enjoyment and exercise? Are there opportunities for community involvement and socialization? The environment we live in either encourages us to maintain our state of health or it challenges our ability to stay healthy. It has been said, “We rely on healthcare when genetics and our environmental or social policies have failed us.”

The characteristics of the community we live in can affect overall health by influencing physical activity; however, the built environment also can affect social capital, mental health, exposure to hazards, and unintended injuries.

Issues discussed in this chapter range from transportation to various needs of seniors in order to stay in their own home. Each of these areas affects the health of the senior either directly or indirectly.

The cost and political feasibility to implement changes that would facilitate the development of senior-friendly communities is beyond the scope of this report.

Living Arrangements

Most seniors live independently in the community (86.3% in Spokane County). Where seniors live depends on the circumstances of the individual and may be based on such factors as income, access to services, proximity of family, or social settings, among others. It is important that a variety of affordable, safe housing options be available.

In Spokane County, suburban neighborhoods have a higher percentage of those age 65 years or older than does the small urban core in downtown Spokane or the more rural areas of the county. However, “trends indicate that seniors are returning to the city because of increased access to services and recreational amenities in urban settings, a desire to avoid the isolation associated with rural living, and decreased functioning (e.g., health status, physical ability, disability).”

Several family arrangement scenarios could have seniors serving as the primary caregivers to children younger than 18 years old. In 2004, an estimated 212 (0.3%) Spokane County seniors were living with, and responsible for, grandchildren. However, approximately Figure 32

Distribution of the Senior Population by Neighborhood Spokane County, 2000

Source: U.S. Census, 2000
one in 20 seniors (4.7%) reported children younger than 18 living in the household. 

According to the 2000 U.S. Census, 6.9% of seniors age 65 years or older resided in group quarters, meaning they did not live in individual housing units. Group quarters are comprised of nursing homes (4.1%), non-correctional institutions such as hospitals (0.5%), and non-institutional group quarters such as community-based group homes (2.2%). Little information about health, lifestyle, and behavior is available on this population because they generally are not included in random household surveys.

Among Spokane County seniors age 65 years or older who do not live in group quarters, approximately half live in a family household with two or more people. The remainder lives in a non-family household, either alone or with non-relatives. Among households of seniors age 65 years or older, three-quarters are owned by the householder.

### Household (HH) Size and Tenure*

Among Seniors by Age Group, 2005

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Source: American Community Survey, 2005

* Tenure defined by the U.S. Census: Refers to the distinction between owner-occupied and renter-occupied housing units.

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### WHAT WE HEARD

Key representatives from academia, social services, healthcare, and service providers reported on how housing choices and availability of services may affect the health of seniors, as summarized below:

Options for living arrangements vary depending on the needs and resources of each senior. In general, there is a lack of knowledge by individuals about the various level of care available in group facilities. There is a belief that people go to nursing homes to die. Nursing homes generally offer a rehabilitation ward and a custodial ward. The goal for residents in the rehabilitation ward is to regain the independence needed to return home. Residents of the custodial ward can no longer care for themselves and in fact, many are likely to die there.

The quality of care in an assisted living facility is an expressed concern. Assisted living facilities are not regulated, so there is a broad spectrum of definitions for “assisted living.” Additionally, a shortage of qualified caregivers (nurses and assistants) puts stress on the facilities.

Services are available to help keep seniors in their own homes, but there are not enough funds or services to meet the demand. People want to maintain their independence and maintain control over their life.

As medical or caregiving needs increase, seniors are often moved from facility to facility, in order to meet their evolving needs. It is not always clear when someone should transition to a different living environment. Some seniors are rushed to move from an assisted living facility to a facility that provides full, skilled nursing care. Frequent moves tend to be difficult for the senior. When safety becomes an issue, doctors can be at odds with the independent living goals a senior might have for staying in his or her home. If seniors are in their home, many cannot afford or find 24-hour care when they need it; nor can they get specialized medical care.

Seniors may feel isolated in the housing that is available to them because they don’t feel safe going out of their building. In rural areas, problems are made worse by distance, remoteness, and lack of resources. Often appropriate dwellings and services are not situated near the location of individual seniors.

The senior population tends to be segmented by income through housing options ranging from low-income housing to gated senior condominiums. Consideration should be given to making mixed income communities available. Many areas of the country are offering senior housing for mixed incomes and common areas of interest.

Senior focus group participants reported that many seniors don’t want to leave their homes, but are unable to take care of themselves. It is important to get the message out to the community and seniors that living in retirement centers can be beneficial and rewarding.
Another housing option is assisted living facilities. Some facilities rent units, while others offer the option to purchase a unit and refund a portion of the purchase price upon vacancy. In 2005, there were 2,608 beds in assisted living facilities in Spokane County. Aggregate information about occupancy rates by age group was not available. If assisted living facilities were at full capacity and occupied solely by individuals 65 years or older, then 5% of this age group would reside in assisted living. That percentage probably overestimates the true percentage due to the underlying assumptions.

National statistics of living arrangements among seniors were similar to those for Spokane County. The majority (92.7%) live in the community with the general population. Another 5% live in a long-term care facility, while 2.4% live in community housing that offers services. When looking at the national statistics on community housing that offer services, the most available service was meal preparation (85.8%), followed by housekeeping or cleaning services (80.4%), laundry services (68.2%), and help with medications (46.6%). Nearly one-half of the seniors living in community housing with services have those services included in their housing cost (46.7%). Another 37.9% have some of the services included in the housing cost with others billed separately. The remaining 15.4% pay for all services separately from their housing. More than one-half can continue living in the facility if they need substantial services (53.0%). Similar data are not available for Spokane County.

Information about functional limitations experienced by people living in different settings was available nationally. Seniors with more limitations tend to live in places where they can receive assistance. Limitations may be related to activities of daily living (ADLs), which include bathing, dressing, eating, getting in or out of chairs, walking, or using the toilet. Another category of limitations is instrumental activities of daily living (IADLs), which include using the telephone, light housework, heavy housework, meal preparation, shopping, and managing money.

![Image of seniors in a residential setting](image)

Figure 34: Residential Setting and Functional Limitations Among Seniors United States, 2002

Source: Older Americans 2004: Key Indicators of Well-Being
Affordable, Safe Housing

Many seniors are on a fixed income and may not be able to afford increasing property taxes and the cost of maintenance associated with home ownership. Under Washington State law, property owners who are either 62 years old in the tax year, or are disabled, may be exempt from residential property tax if the combined family income (including Social Security) is less than $35,000. In 2006, approximately 13,500 senior/disabled persons received a property tax exemption in Spokane County. However, the Spokane County Assessor's office was not able to distinguish the percentage of those tax-exempt individuals who were aged 60 or older. 

Safe housing encompasses conditions both inside and outside the house. A safe house may decrease the chances of unintentional injury, which is a leading cause of hospitalization and death among seniors. Living in a safe neighborhood is also important, since it affects the senior's ability to enjoy physical activity and social interaction in the neighborhood.

WHAT WE HEARD

Key representatives from service providers and social services reported that more affordable living arrangements need to be available for seniors. The need for affordable housing is higher than the supply of such facilities. As the senior population increases, so will the demand for housing options.
Transportation

Public transportation is a vital resource for many reasons and for many different groups of people. Many seniors prefer to use public transportation because they may be uncomfortable with driving or are unable to drive. They may also find it financially beneficial to take a bus rather than pay to maintain a vehicle.

Having some form of transportation is important in meeting needs and staying connected to the community. In Spokane County, it may be difficult to find housing that is within easy walking distance of the community places people frequent, such as grocery stores, medical offices, parks, churches, and other social or service places. Public transportation helps seniors access these locations.

In Spokane County, the Spokane Transit Authority (STA) provides public transportation. In addition to the regular bus system, there is a paratransit service available. To be eligible for paratransit, an individual must be determined by a physician to be unable to travel on the regular bus system due to the effects of a medical condition or disability. The application, signed by the physician, is reviewed by the STA eligibility department who determines if the applicant meets the criteria for service.

Paratransit is a shared system and eligible users of the service must schedule their trip one to seven days in advance. The service does not run on a regular schedule and therefore riders must be flexible in their time requests. The paratransit system provides 1,800 to 1,900 trips each day.

Another program, offered through Elder Services, is the Care Cars program. This volunteer transportation service is available to frail elderly or cognitively impaired seniors who are unable to drive due to health problems.

“If you can’t take a bus or car you can’t get around. You could always walk, but many seniors cannot walk due to health problems.”

- Senior Focus Group Participant
citizens over the age of 60. Individuals may be eligible to use the service if they are unable to drive or use public transportation to make essential medical appointments. This service is different from services provided by STA in that the driver stays with the consumer throughout the trip. The service will provide transportation to and from two medical appointments per week."

"I drive 6 miles to the bus stop because it is the closest one to my house."
- Senior Focus Group Participant

WHAT WE HEARD

Key representatives of service providers, social services, and public health reported that seniors need transportation for both medical and social purposes. Transportation in rural areas of Spokane County is more difficult than in the urban core. Seniors without transportation delay going to doctors’ appointments and thus end up using the emergency room. However, a mobile medical clinic is available to provide healthcare services to seniors before their health difficulties result in a visit to the ER. The mobile clinic is a for-profit medical group that takes Medicare and Medicaid payments.

Barriers to using STA public buses include the physical mobility and location of a senior. Regular bus service is not suitable for the very frail and is difficult for people with walkers and those in wheelchairs. The public bus system was also reported as difficult to use. STA has eliminated some of the most important routes for seniors. For example, it is very complicated to get to the Veterans’ Administration (VA) hospital.

“Public transportation is receding as the need is expanding,” stated one focus group participant.

Suggestions for improving this area included the following:

- continued funding for volunteer services (Care Cars);
- increased availability of mobile medical clinics; and
- have a liaison who could aid in arranging transportation.

Seniors reported that it can be difficult to lose their drivers license and have to find another means of transportation. They would like to see a better system for riding buses, such as free or discounted rides for people who have a medical card.
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Spokane Regional Health District Employees

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Helen is 65 years old and recently widowed. She and her husband had discussed retirement options and decided to move from Texas to Spokane to be closer to their son and his young family. Helen's son agreed to this and bought a house that was big enough for that purpose. Before they could move, however, Helen's husband fell ill. Helen provided care to her husband through an extended time, but he did not recover and passed away. Helen now lives in Spokane without her husband of 39 years and away from her lifelong friends. Helen is in good health but struggles with bouts of sadness. Seeing her young grandchildren daily helps her to feel happy. Assisting around the house with some light chores and watching her grandchildren occasionally helps Helen to feel needed. Helen does not have financial worries due to planning for retirement and she is able to travel every few months to Texas to see her other son and her friends.
Informal Caregivers

Most seniors come to rely heavily on an informal support system composed of family, friends, neighbors, or church members. These informal caregivers provide unpaid care out of love, respect, obligation, or friendship. The number of informal caregivers in the U.S. far outnumbers formal caregivers. According to testimony offered in a 2005 Congressional hearing: “Nearly 60% of elderly persons receiving long-term care assistance rely exclusively on unpaid caregivers, primarily children and spouses. Only 7% of the elderly rely exclusively on paid services.”

Nationally, the percentage of seniors age 65 years or older who receive personal care for a chronic disability decreased from 14.6% in 1984 to 10.7% in 1999. Among those who received care, most received it informally. This was true even as the number of limitations a person experiences increased.¹

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Informal Caregiving Overview

As seniors age and become increasingly frail, their dependence on others grows. The fortunate ones have an informal or formal support system that can help with the small things that enable the senior to stay in his or her home. Such support includes transportation to and from the grocery store, medical appointments, and social engagements; help with buying groceries; and making sure there is food in the house that is nutritious and easy to fix. Even providing yard work and maintenance and upkeep on the house can make the difference between whether a senior can remain in his or her home or not.

Nationally, the percentage of seniors age 65 years or older who receive personal care for a chronic disability decreased from 14.6% in 1984 to 10.7% in 1999. Among those who received care, most received it informally. This was true even as the number of limitations a person experiences increased.¹

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Figure 35

Distribution of Care Received for a Chronic Condition Among Seniors Age 65 Years or Older United States, 1984-1999

Figure 36

Distribution of Care Received by Level of Limitation Among Seniors Age 65 Years or Older United States, 1999

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¹ Source: Older Americans 2004: Key Indicators of Well-Being

IADL – Instrumental Activities of Daily Living (e.g. shopping and cooking)

ADL – Activities of Daily Living (e.g. bathing and dressing)
There are many factors that need to be taken into account when an informal caregiver is considering providing care to a loved one who has either an acute or chronic condition. Some of these include the following:

- the amount of time needed to care for a disabled person;
- the need to balance a job with the demands of caregiving;
- the need for medical supervision of the disabled person;
- the physical demands of moving the patient; and
- the issue of the dignity and privacy of the caregiver and the disabled person over changing dirty diapers or helping in the bathroom with toileting and bathing.

Most people who provide informal caregiving do so without training or counseling. According to the report on caregiving, surveys and studies consistently find depression as a major problem for full-time informal caregivers. It is important for informal caregivers to access services in their community that can help them to get training, counseling, respite care, and assistance with providing care.

The services of unpaid caregivers do not come without a toll. In a recent survey of two large health agencies in Spokane County, one in five employees (19.4%) reported they had family responsibilities for caring for someone 60 years of age or older. This percentage reflects the estimated 20% of the total population nationally who provide part-time or full-time care for adult loved ones. Nearly 50% of survey respondents providing care in Spokane County were caring for a loved one who was 80 years or older. The majority of the individuals being cared for were a parent (70.9%), while 7.3% were caring for a grandparent.
The length of time the respondents reported having been the caregiver was almost equally divided among categories from less than one year to over five years (Figure 38).

The services provided to loved ones support the findings that there is an increasing reliance on caregivers for some of the more common and basic needs of life (Figure 39).

Figure 38
Length of Caregiving Responsibilities
Spokane County, 2006

<table>
<thead>
<tr>
<th>Percent of Caregiver Respondents (n=66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6 Months</td>
</tr>
<tr>
<td>6-11 Months</td>
</tr>
<tr>
<td>1-2 Years</td>
</tr>
<tr>
<td>3-5 Years</td>
</tr>
<tr>
<td>&gt;5 Years</td>
</tr>
</tbody>
</table>

Data Source: Caregiver Survey Completed by Spokane Regional Health District and INHS, 2006

Figure 39
Type of Services Provided by Caregivers

- Companionship: 87.3%
- Shopping: 76.4%
- Ride to medical appointments: 67.3%
- Making phone calls: 56.4%
- Home repairs: 54.5%
- Managing finances: 52.7%
- Arranging outside help: 47.3%
- House cleaning: 43.6%
- Cooking: 41.8%
- Receiving phone calls: 36.4%
- Laundry: 36.4%
- Assistance with medical treatment or therapies: 34.5%
- Providing medication: 32.7%
- Direct financial support: 29.1%
- Personal Care (e.g., dressing, bathing, toileting, transferring): 18.2%
- Other: 10.9%
- Moving around the house: 7.3%

Data Source: Caregiver Survey Completed by Spokane Regional Health District and INHS, 2006

WHAT WE HEARD

Key representatives of social services reported that having some type of support system helps seniors as their needs increase. Concerns raised included the issue of caregiver burnout; seniors who outlive their support system; and seniors who live in isolation and who may lack a support system altogether.

Key representatives from academia reported that families providing care for a senior don’t know enough about adult day centers. Adult day centers provide respite for families, which may alleviate stress and help to avoid the need to place the senior in a nursing home.

A suggestion for improving this area included the following:

- promoting the availability of caregiver support opportunities by letting people know about the day centers and respite care programs available in Spokane County.

“Families desert seniors. A lot of them are put in a nursing home and people just forget about them. Some people even end up with no one left to help them.”

- Key Representative

Families desert seniors. A lot of them are put in a nursing home and people just forget about them. Some people even end up with no one left to help them.”

- Key Representative
While these services are basic, the effect on the caregiver of providing this informal care is apparent in the responses given. The areas that are affected the most are emotional and social/leisure time activities.

Caregiving is not as basic as it used to be. In today’s technological age, there are efforts to enhance human caregiving duties with mechanical devices. These devices might include special computer systems for communication, equipment to help with mobility, remote vital sign monitoring, or remote oversight monitoring.

Telehealth is one such technology. There are many telehealth products available to seniors in Spokane County. Telehealth products generally allow for two-way communication between the patient and the formal caregiver, who may be a nurse or a physician. Examples of clinical uses of telehealth technologies include transmission of medical images or medical data for diagnosis or disease management; groups or individuals exchanging health services or education live via videoconference; advice on prevention of diseases and promotion of good health by patient monitoring and follow-up; and health advice by telephone in emergent cases.

Home Health agencies provide various types of in-home healthcare.

Finding quality caregivers is an ongoing challenge. Currently in Washington State there is not a regulatory body that oversees private providers of home healthcare. Only providers who provide publicly funded care are required to maintain a certain level of training in order to be paid.

Formal Caregivers
Caregiving is not as basic as it used to be. In today’s technological age, there are efforts to enhance human caregiving duties with mechanical devices. These devices
There are many health issue measures that should be followed by caregivers, such as how to:

- use techniques for lifting and moving the patient so the caregiver avoids injuring either themselves or the patient;
- use bedpans and maintain good sanitation;
- prevent bedsores;
- deal with incontinence;
- provide proper skin care;
- maintain personal hygiene with a disabled person;
- properly use devices, modifications and systems designed to help with disabilities;
- maintain good oral hygiene and oral health;
- help older women avoid yeast infections;
- provide emotional and spiritual comfort;
- prevent falls in seniors;
- provide proper nutrition; and
- provide foot care and hygiene, especially with diabetic patients.

The level of caregiving needed can be divided into three categories: acute care, chronic care, and individuals with permanent mental impairment requiring supervision. Acute care is often necessary to recover from a hospital stay or serious injury, in cases where the individual is expected to recover in a matter of time. Chronic care is provided when an individual has an ongoing disease or disorder, or an injury that results in disability. The condition is often permanent and chronic care is needed for longer than a few weeks or months. With mentally impaired seniors, the need for care may continue for many years. While many seniors who are mentally impaired are cared for at home, many more are being cared for in specialized facilities.

Residing in an assisted living facility can be costly—financially, emotionally, and socially.
Key representatives from social services and service providers reported that most seniors want to stay in their own homes. They also discussed issues that support or impede the ability of a senior to stay at home.

Seniors are more comfortable and feel more independent in their own home, surrounded by familiar things. As we age, more and more things move beyond our control. When seniors leave their homes, they have to face the fact that they need help and have lost some of their independence.

For the community as a whole, it is more cost-effective for seniors to stay in their own homes. However, most individual families don’t have the money to provide the resources many seniors need to remain independent. Sometimes, however, small services, such as minor home maintenance, yard work, housekeeping, or daily visits can enable seniors to stay longer in their own homes.

One key representative said “There used to be a wonderful program called CHORE that provided assistance to people living in their homes.” CHORE volunteers shopped for groceries, cleaned the home, or transported the elderly person to medical visits. The program was state funded, but was eliminated and replaced with the Medicaid Personal Care Waiver programs, Community Options Program Entry System (COPES), and Medicaid Personal Care (MPC) services, which are funded by a 50/50 state/federal match.

Eligibility requirements for the programs are becoming more stringent. To qualify for the Medicaid-funded programs, an individual must qualify financially and need assistance either medically or with a personal care need, such as bathing, dressing, or being moved from a chair to the bed. The increased requirements have made services unavailable to seniors needing minimal assistance, such as transportation for shopping or medical appointments. People who are not highly functionally disabled, needing help with one or two things instead of many things, find it difficult to get the help they need.

The wage of in-home workers has recently been raised, which reduces the number of hours a senior can afford to have help. Additionally, 24-hour care is no longer available through government-funded programs. This means seniors are home alone for longer periods of time. An average plan of care covers 4-6 hours per day. However, 24-hour care is provided in adult family homes, boarding homes, and assisted living facilities, as well as in nursing homes.

Suggestions for improving this area included the following:

- increase the number of volunteers available to help seniors with tasks; and
- increase the number of programs offering low-cost home repair and yard work.

One public health employee reported the following experience regarding the quality of caregivers: “I’ve had sad experiences with caregivers; in-home caregivers need to have background checks. Once, I hired a person that came recommended. I got a call from my husband who thought he was alone. I went home and the caregiver guy was there, but he had just shot up heroin and was passed out on the couch.”

A need reported by seniors was to increase the availability of people to accomplish such in-home tasks as cleaning and cooking. Another issue discussed was the difficulty in finding home care for an individual with multiple health issues. One senior related the story that she had been turned down for home care because of a history of shakiness and strokes.
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Jack and Betty have been married for 42 years. Betty developed dementia three years ago and Jack assumed total caregiving responsibilities. Jack is very depressed, feels overwhelmed, and states that the future “offers no hope, just more pain, loneliness, and isolation.” Jack refuses to involve his children stating, “They have enough to worry about.” He states that he promised his wife he would never put her in a nursing home. However, he relates that he cannot continue to handle the stress of caregiving. He has given up all his hobbies and friends to care for Betty. He implies that both of them would be better off free from the constant pain and misery.
Planning for Long-term Care Overview

Planning for long-term care and end-of-life issues are intricately related. Estimates indicate that between 50 and 70% of Americans will experience a long, slow decline before they die. The case study for this chapter is not uncommon. Many of us can tell similar stories of loved ones who have experienced the same slow decline.

The more prepared we are individually, the better off our families and communities will be. As the senior population grows and the resources to provide care continue to be stretched thinner and thinner, it is increasingly important for individuals to prepare for long-term care.

This chapter will look briefly at some of the common long-term care planning issues. The topic is very broad and there are many resources dedicated to assisting people with the personal and legal ramifications of long-term care planning.

One definition of long-term care is:

When a person requires someone else to help him/her with his/her physical or emotional needs over time.

Some of the activities or needs that healthy, active people might take for granted when thinking about providing for long-term care include the following:

- Walking
- Bathing
- Dressing
- Using the bathroom
- Helping with incontinence
- Managing pain
- Preventing unsafe behavior
- Preventing wandering
- Providing comfort and assurance
- Providing physical and occupational therapy
- Attending to medical needs
- Counseling
- Feeding
- Answering the phone
- Meeting doctor's appointments
- Providing meals
- Maintaining the household
- Shopping and running errands
- Providing transportation
- Administering medications
- Managing money
- Paying bills
- Doing the laundry
- Making repairs to the home
- Maintaining a yard
- Removing snow

People are living longer than ever before. The fastest growing segment of our population is the “very old” (people older than 85 years). Over half of the people who are over 85 years old require long-term care. The older a person gets, the greater his or her chances are of developing Alzheimer’s disease. It is critical that as a community we begin to openly address long-term planning at the individual level.

We are humbled by aging.”

- Key Representative
Thinking Ahead

Research has shown that 70% of Americans would prefer to be at home with loved ones when they die, yet statistics show this does not happen for most people. More than one-third (37.8%) of Spokane County seniors die in a nursing home, although at any given time fewer than 5% of seniors live in a nursing home. The rest of seniors die during a hospital inpatient stay (27.3%) or at home (29.2%). A lower proportion of seniors in Spokane County died in a hospital than did seniors statewide. Differences in location of death occurred in Spokane County by age and sex (Figure 42).

Among the common long-term care planning issues is the need to decide which type of care facility is most appropriate to an individual’s situation. There are three options: a nursing home, a retirement center/assisted living facility, or in-home care. As shown in the case study at the beginning of this section, the options can cover a continuum based on need, especially if thoughtful planning has taken place prior to the need for care.

The cost of long-term care is high. An excerpt from a 2005 Congressional hearing by the House Ways and Means Committee highlights this fact:

In 2004, approximately $135 billion was spent on long-term care for the elderly. Sixty percent of this amount was financed through Medicaid and Medicare, one-third through out-of-pocket payments, and the remainder by other programs and private insurance. This funding excludes the significant resources devoted to long-term care by informal caregivers (primarily spouses and children).

Estimates that attempt to quantify the equivalent cost of informal care run as high as $300 billion or more per year. The toll on informal caregivers is not only financial, it is also mental and physical.

WHAT WE HEARD

Key representatives from service providers reported that people need a mindset on how to prepare for an unknown future, including finances.

- A suggestion for improving this area included proposing hypothetical situations to seniors to encourage thinking about and planning for aging issues.

Family Dependency

Without a long-term care plan in place, fragile seniors are more likely to become dependent on their family. This is in direct conflict with what seniors in our community said they want and is similar to what most surveys of seniors have found. Seniors say they want to 1) remain independent and make decisions for themselves, 2) maintain good health and have access to adequate healthcare, and 3) have enough money to cover their everyday needs and not outlive their assets.

* Includes dead on arrival, hospice, unknown, and other
Source: Washington State Department of Health, Center for Health Statistics

* Includes dead on arrival, hospice, unknown, and other
Source: Washington State Department of Health, Center for Health Statistics
Although seniors with more financial resources may have more choices than other seniors about their future, all aging individuals should consider their options. Any senior who has not made decisions about his or her future may have to live with decisions made by the family. Understanding available options and expressing the desired option to family members can ease the burden on both seniors and their families, especially during a time of crisis. The National Care Planning Council’s Guide to Long-Term Care Planning includes a seven-step process. The steps walk through 1) understanding the process of planning, 2) understanding care settings, 3) understanding government long-term care programs, 4) knowing who to contact for help, 5) creating sources of funding to pay for services, 6) strategies to preserve assets, and 7) creating a long-term care plan.

The eventual need for long-term care is 600 times more likely than the risk of having a home fire, yet few elderly spend money or time planning for long-term care. Without proper planning, the need for long-term care can result in the single greatest crisis in an elderly person’s life.

The first step toward planning for the end of life is to ask oneself the following questions:

- Where do I want to die? At home? In a hospital or medical facility?
- Do I want to move to be closer to relatives, friends, or other loved ones?
- What kind of medical treatment do I want? What don’t I want?
- Who do I want to take care of me when I can no longer care for myself?
- What do I think is a “good death?”
- What kind of funeral service do I want?
- Where and how do I want to be buried?
- Do I want to be cremated? If I want to be cremated, what do I want done with my ashes?

Other considerations include providing a copy of advanced directives to medical providers to help in medical decisions should the individual become unable to participate in decision-making; having a will to guide family member decisions about an estate; and making arrangements for either a burial or cremation, letting family members know which is preferred.

End of Life

Conversations about end-of-life issues should occur while seniors are still middle-aged and should include their family and others who are involved, rather than waiting until they are facing end-of-life decisions.

WHAT WE HEARD

Key representatives from service providers reported that families need to strategize on how to prepare for aging parents.

Suggestions for improving this area included developing a common database of resources.

WHAT WE HEARD

One participant in the senior focus groups shared the following story: Before his wife passed away from breast cancer, she told him that she did not want to be resuscitated if she ended up in a coma; however, when the situation occurred, the doctors did not believe the husband. He had to locate and provide her living will for the caregivers to agree to comply with her wishes. Some seniors said they were upset that such things have to be written down for doctors to believe them.

CHAPTER ACKNOWLEDGEMENTS

Gail Goeller, Senior citizen and founder of senior directory
Government and Other Support

Maria is 69 years old, widowed, and lives alone in her own home. She has a son in town but he visits rarely because he works two jobs and is raising a family. They have never had a close relationship. Maria has been suffering from depression due to multiple losses, including the loss of her spouse. Lately, she has been having suicidal ideation and relates she has medication from her family physician that she would use to commit suicide.
**Government and Other Support Overview**

Many organizations and programs in Spokane County strive to assist seniors in living a healthy life. These efforts include meeting basic needs, providing health management services, assistance in staying independent, or providing information on topics that affect the health of seniors. Community members who assist seniors include healthcare workers, program specific staff, and volunteers.

Coordination between, or at least knowledge of, the various senior support services is important in helping seniors address their health issues. That way, when a senior reaches out for aid, they will receive appropriate assistance or referrals. However, even though the senior population continues to increase, public aid programs are facing funding decreases or restrictions.

**Aging Services**

Area Agencies on Aging (AAA) were established by the 1973 amendments to the 1965 Older Americans Act (OAA). There are approximately 700 of these agencies across the nation. They are part of what is known as the "Aging Network." This network includes the Administration on Aging (AoA) at the federal level, State Units on Aging in each state, Area Agencies at the local level and such other public and private agencies as senior centers and nutrition project sites, all working together to serve the nation’s elderly.

The organizational and funding flow to the agencies begins with Congress, which enacted the OAA, the Social Security Act, and other laws focused on older persons and others in need of long-term care. These acts are amended periodically and Congress appropriates federal funds. The Washington State Legislature enacted the Senior Citizens Services Act in 1976 and appropriates state funds for various programs. The Senior Citizens Services Act was passed by the Washington State Legislature to help people remain independent in their own homes for as long as possible. Washington was the first state in the country to devote state dollars to home-based services for the elderly. The Washington State Department of Health and Human Services (DSHS) and the Administration on Aging

**Figure 43**
**Organizational and Funding Flow of the Aging Network**
Aging (federal) develop regulations and procedures for implementing the OAA and awarding funds to the state. The Washington State DSHS Aging and Disability Services Administration (ADSA) administer federal funds on behalf of the state. ADSA develops a state plan on aging every four years, which is updated every two years. They develop policies and procedures for implementing the federal OAA, the State Senior Citizens Services Act, and other programs. They also oversee Area Agencies by reviewing and approving plans, awarding funds, and monitoring and evaluating performance.

The Older Americans Act was originally signed into law by President Lyndon B. Johnson on July 14, 1965. In addition to creating the Administration on Aging, it authorized grants to states for community planning and services programs, as well as for research, and demonstration and training projects in the field of aging. Later amendments to the act added grants to Area Agencies on Aging for local needs identification, planning, and funding of services. Eligible services include community and homebound nutrition programs; programs that serve Native American elders; services targeted at low-income minority elders; health promotion and disease prevention activities; in-home services for frail elders; and services that protect the rights of older persons, such as the long-term care ombudsman program.

The OAA Amendments of 2000 added a new program, the National Family Caregiver Support Program, which helps family members who care for ill or disabled older loved ones.

In September of 2006, Congress passed the 16th reauthorization of the OAA, which was signed into law by President Bush. The National Council on Aging supported the reauthorization and stated, “The legislation reauthorizes and strengthens services offered under the Older Americans Act, the chief federal law governing the organization and delivery of many vital services for older Americans.” Assistant Secretary for Aging, Josefina G. Carbonell, said, “The OAA embodies our nation's compassion toward ensuring the dignity and independence of our older citizens by promoting older Americans' full participation in society, and supporting their overwhelming desire to remain living in their own homes and communities for as long as possible.”

Reauthorization of the OAA 2006 continued federal support for all of the OAA’s basic programs. This will mean that these important services will continue, benefiting millions of older Americans, many of whom have limited income and resources (See Appendix H for details).

The newly reauthorized OAA provides for enhancement of the current Aging Network by modernizing community-based and long-term care systems to empower consumers to manage their own care and make choices that will allow them to avoid institutional care and live healthy lives in the community.
Coordination of Systems

Twenty-three years ago, Aging and Long Term Care of Eastern Washington (ALTCEW) and Spokane Mental Health (SMH) combined funding, resources, and mandates to form a comprehensive system of service delivery (Elder Services) designed to locate and serve frail, vulnerable, moderately to severely impaired, and community-dwelling elders. The issues supporting the need for an integrated system included the fact that SMH was not identifying and locating high-risk elders who had mental health needs, and ALTCEW was identifying elders whose co-morbidity required more than social services to help them remain living at home. Although at high risk of losing their independence, the identified target population often denied having problems and resisted help. Unlike other age groups, at-risk older adults suffered from multiple interrelated problems demanding a comprehensive, integrated approach. Understanding this to be true, the Elder Services partnership was formed.

Elder Services is designed to help older adults described by the Federal Council on Aging as “frail and vulnerable” and by Spokane Mental Health as the “moderately to severely dysfunctional.” This includes moderately to severely impaired elders living in their own homes, whose complexity of problems places them at risk of involuntary inpatient psychiatric treatment and premature institutionalization as well as premature and untimely death.

Elder Services utilizes an innovative, nationally acclaimed and replicated case-finding model called “Gatekeepers.” This systematic, community organization effort actively involves all aspects of the community in identifying and locating high-risk, isolated elders. This ensures that elders from the target population will be identified and located, as less than 1% of the target population refer themselves for services (See Healthcare and Mental Health Chapter page 26 on Mental Health issues).

When a system of care identifies and locates a population with multiple, interrelated problems, it must have clinical case management and ancillary services designed to be relevant to the needs of the population. The Elder Services' program is configured to meet the needs of the target population by evaluating and addressing the complexity of their problems. This includes:

The Elder Services model, which has won nine national awards, is recommended by the federal government, American Association of Retired Persons (AARP) and the Centers for Disease Control and Prevention (CDC). The issues that initially supported the need for an integrated system of service delivery still exist, supporting the need to preserve the Elder Services’ model and the ALTCEW/SMH partnership.
• operating an access point comprised of highly trained/skilled information and assistance triage screeners;
• utilizing a multi-disciplinary approach by teaming nurses, social workers, pharmacists, and Psychiatrists to complete comprehensive in-home assessments;
• providing in-home clinical case management and follow-up services;
• providing 24-hour, face-to-face, on-call crisis response and intervention; and
• providing family and support system education and in-home supportive therapy.

Elder Services has ancillary resources such as respite for caregivers (Respite Care), specialized transportation services for elders who cannot use STA or Special Mobility Services (Care Cars), caregiver support (Family Caregiver Support program), and peer counseling (Senior Peer). These ancillary services promote timely case stabilization combined with case management to form a highly relevant, comprehensive system of care.

The ALTCEW and SMH partnership combines the mental health system (major mental illness) and the aging network (activities of daily living/social services) creating a relevant, clinically efficient and cost effective system. This system provides case managers with the tools and resources necessary for case stabilization; the whole is far greater than the sum of its parts.

Funding
Many publicly funded programs are restricted in how the funds are spent based on a variety of eligibility requirements.

During the period of July 2003 through June 2004, 13.7% of seniors in Spokane County received public assistance from the Washington Department of Social and Health Services (DSHS). As shown in Table 5 on page 65, an average of $14,219 was spent per client in Spokane County. The utilization rate and amount spent per client was higher in Spokane County when compared to Washington State.

WHAT WE HEARD
Key representatives from healthcare, service providers, social services, and academia commented on the senior service systems in Spokane County. They felt services offered by various agencies are often duplicative with excessive administrative requirements reducing the time for actual client contact.

Some felt that when seniors are referred to a service that service, should follow-up with the referral source to determine whether the referral system is working appropriately. If the system is not working, the issues could be identified and fixed. Development of a standardized referral process would facilitate referrals. Likewise, coordinated referral to programs having similar eligibility requirements would help seniors take advantage of the programs intended for them. For example, if a senior qualifies for the Spokane Neighborhood Association Program (SNAP) services, they might also qualify for a lower utility rate.

Conceptually, we have a good continuum of care with home care, assisted living, group home, and nursing home options—there just aren’t enough of them.

Suggestions for improving this area included the following:

• aging and mental health partnerships are important, but the administrative responsibilities of case workers could be streamlined; and
• cooperative efforts between systems need to continue.
The proposed 2007-2009 budget from the Office of the Governor contains the following items specifically related to the needs of seniors:

- Support for relative caregivers to meet the needs of children in their care;
- Improve compliance of long-term care facilities to decrease client abuse;
- Rate increase for boarding homes and adult family homes;
- Wage increase for home-care workers; and
- Increase on affordable, safe housing.

WHAT WE HEARD

Key representatives from social services, public health, and service providers commented on the restrictions associated with some types of funds. Comments included recommending that funding sources allow recipient agencies the freedom to customize and design programs that address specific problems for individual communities. Seniors with low to moderate incomes often do not qualify for services. Seniors in this income bracket may have to choose between purchasing necessities, such as medications, food, and heat. This type of situation could be alleviated if there was more flexibility in how Medicaid and Medicare money could be used.
**Population Growth Impact**

As the senior population increases, there will be an increase in the demand and need for services to assist with healthy aging. Currently, there are a variety of agencies and services addressing the needs of seniors. They range from medically-oriented to basic needs assistance to quality-of-life services. Most service agencies and programs report that funding is always a concern. They would like to be able to do more for current participants and be able to reach other seniors in need.

In order to help readers understand the implications of the increasing population of seniors and their needs, a simple projection on the impact of falls (a preventable, unintentional injury) is presented here. This projection combines available information on the prevalence and cost of falls with the official population estimates for the year 2026.

As reported in the demographics section, over the next 20 years, seniors are projected to increase to 24% of the population in Washington State.

On page 23 of the Morbidity and Mortality chapter, information is provided regarding the prevalence of hospitalizations due to unintentional injury (50.9 injuries per 1,000 seniors) and identified that falls were the most common cause of unintentional injury hospitalizations (30%) is provided. In 2004, the number of hospitalizations specifically due to a fall was 1,116 with an average hospital charge of nearly $19,000, totaling $21 million.

Using these averages and estimated future population, 137,866 seniors in Spokane County and 2,105 of those seniors will experience a hospitalization due to a fall. It is likely that the average charge of an unintentional injury hospitalization will be higher than $19,000. Applying the current average charge to these hospitalizations, a total of $40 million dollars will be spent on hospitalizations from preventable falls injuries. This is close to double the 2004 amount of $21 million. This example describes the factor of cost due to the increasing population, but does not consider the hospital bed capacity needed to accommodate just this one health issue.

As a community, how can we plan to meet the level of service needed to accommodate the increasing numbers of seniors in the near future?

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**WHAT WE HEARD**

Key representatives from social services, service providers, and academia reported on some issues the community should consider as our population ages. There is a need for case management from private companies and publicly funded organizations. There are very few geriatric care managers in Spokane. They are very helpful in providing assistance to seniors and their families on a range of issues, but provide the service to those with the ability to pay their fee. Public case managers cannot fulfill this function; rather, they tend to focus on more specific needs, generally restricted by the organization they represent. We need people who understand available resources and all areas of living, versus specialists who only know one area.

Organizations that provide services to seniors should incorporate a planning component into their programs to identify the current and changing needs of seniors. Learning why seniors are not accessing services must be identified before access issues can be improved. The younger senior population has different needs and wants than the older senior population. When defining policy and practice guidelines, seniors’ needs should be addressed separately from other populations as they may have different characteristics and needs than, for example, people with disabilities. Currently, aging and disability services are grouped together.
General Strategies to Assist Seniors

During discussions with service providers and seniors, some themes emerged that expressed strategies meant to assist seniors with their health concerns. The themes fell into three categories, including:

- increasing education for consumers and providers;
- improving access to resources and information; and
- expanding advocacy programs for seniors.

Key representatives from healthcare, service providers, academia, and public health as well as focus group participants commented on the need among seniors for education about issues affecting their lives, such as accessing services. There seemed to be a lack of available educational material on how to use the social service system for seniors. In addition, participants noted that it can be difficult to determine who is eligible for various services.

Key representatives from social services and healthcare commented that as our community ages, healthcare providers will increasingly need to receive education about the health issues and needs of seniors. Topics could include mental health, substance use, end-of-life issues, support systems, and more. Many students and professionals in health-related fields are not exposed to medically complex seniors or those with complicated socioeconomic barriers. Education is needed for healthcare providers in hospitals, home health, and nursing homes to recognize “geriatric syndromes” and understand how to manage symptoms and keep the senior comfortable. The University of Washington’s Physicians Assistant program in Spokane County uses a geriatric curriculum for one quarter. During this quarter, students experience what it is like to be aged by participating in an experiential activity. This type of program helps prepare medical professionals to have a greater understanding of the needs of the elderly.

Suggestions for improving consumer and provider education included the following:

- instituting a local educational program to enhance independence for seniors (there is curriculum available for seniors nationally);
- prevention education readily available through libraries, Parks and Recreation programs, provider offices, faith-based efforts, and others;
- more community training offered with Continuing Medical Education (CME) credits to increase provider attendance; and
- increased training on elderly issues within medical school programs.

One focus group participant made the following comment, which summarized the feelings of other participants: “I have lost my dad, mom, and mother-in-law in the past few years. I have learned so much from this conversation and I learned about all the mistakes I made. Educating families on how to do things and care for your elderly relative isn’t available. Education is greatly needed.”

Education for Consumers and Providers

Any person has the right to call ALTCEW; they will help you find out where to go for help and answer all of your questions. I tell all my friends to call there if they need something.”

-Senior Focus Group Participant

WHAT WE HEARD

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Key representatives from healthcare, service providers, social services, academia, and public health reported on the systems and methods for providing information about senior issues to people who need the information. When it comes to finding information, seniors generally fall into one of two categories: those who seek information and services, often when a crisis arises; and those who may need help and/or services, but won’t seek out information or ask for assistance. Those in the second group may not want to admit to themselves or to others that they need help; or they may be reaching the point of dysfunction where they don’t recognize they need help. Income and resources do not appear to determine into which category any particular senior may fall.

Seniors, healthcare providers, caregivers, and gatekeepers need to know what information is available and who to call for assistance with specific problems. The homebound do not get out; therefore, they have a difficult time getting information that is available in the community. It can be hard for seniors to figure out how to get help. We need to find a way to get information to those who need it the most.

Seniors reported they would like to see libraries and senior centers have an “Aging Resource Center” with a volunteer available at specific times and days. Then the word would need to get out to the community that a person will always be there to help identify resources at that time. They suggested that offering one phone number to call to get health information would be very useful. One senior summarized the voices of many by saying, “Years ago there was an 'Ask-A-Nurse' line, but the funding was cut and it was shut down.” This program was well received and many would like to have it again.

The representatives also noted that marketing of services could be improved by considering how seniors will perceive the message and how to distribute the message to reach all seniors. Multiple methods are needed to inform seniors and promote resources. Technological dissemination of information needs to be simple. If using television or radio to get the word out, the message must be entertaining and relevant to a senior’s situation. Use of giveaways, drawings, and coupons entice seniors to participate in educational functions.

Another summary comment from the focus groups was: “Some seniors just don’t want to go places and do things. If they have always liked being by themselves, how do you make them do things they don’t want to do?”

The Spokane Directory for Seniors and Their Families was described as a good way to get information out about resources and other issues. Seniors often give the directory to each other. A list of Spokane senior resources is provided in the 'Resources' chapter. Some agencies listed specialize in providing referral information.

Additional suggestions for improving this area included the following:

- extend distribution of the ALTCEW brochure of useful numbers for seniors;
- encourage seniors and their families to access information;
- station outreach workers at healthcare clinics; and
- collaborate with groups, such as neighborhoods, Association for the Advancement of Retired Persons (AARP), churches, and service providers to help ensure all seniors are aware of the available services.
Key representatives from social services reported how an advocate can aid seniors. When seniors are in a crisis, they need help to navigate the system. Without an advocate it is very hard, if not impossible, for them to use the system on their own. The oldest and most isolated seniors are the ones who need assistance the most.

Spokane uses a “gatekeeper” system where community members look out for seniors. These gatekeepers are people who have regular contact with a senior, such as a mail carrier or hair stylist, who may notice when things do not seem right with the senior. They can then refer aging services to check on the senior. The gatekeeper program is a promising practice. Gatekeepers are especially important for seniors whose ability to manage on their own has eroded. They become afraid and do not seek help.

Seniors discussed some of the effective ways to ensuring good communication with their healthcare provider. They noted that it would be useful for seniors to write down what they want to ask the healthcare provider before going to the appointment. Seniors can have an active role in their health care decisions and should also know their consumer rights, such as the right to ask for a second opinion. It might also be helpful, they said, to ask a caregiver or other trusted person to go with them to the appointment. Having someone accompany them to the visit will help ensure that the healthcare provider receives all the pertinent health information and that the patient correctly interprets the healthcare provider’s recommendations.
Victor is a dynamic gentleman of 63 years old, in late November 2006, Victor walked into the Community Health Assessment office ready to add his thoughts to the project. The responses Victor gave to our questions mirrored those of other Spokane seniors. The best parts of Victor’s life as he ages have been having grandchildren, his spouse, and his lifetime of memories. Victor faces many challenges including health and healthcare; limited funds, loss of family and friends, and loss of independence. His personal health issues include a laryngectomy, chronic obstructive pulmonary disease (COPD), hypothyroidism, and hearing loss. Victor feels that seniors need to accept themselves and their limitations. Seniors need to reach out to help others more to stop feeling sorry for themselves. On the flip side, the public needs to realize how valuable seniors are—for their experience, ideas and wisdom—and should act accordingly.
Vision for the Future Overview

The goal of *Aging with Care in Spokane County* was to provide information to the community about issues that affect the health of seniors. Throughout this report, many issues have been discussed using both health data and information provided by people and organizations from our community.

The information describing the vision for the future of Spokane County seniors was compiled from responses to the question: “With a growing senior population, do you have a vision of how services will meet the demand?”

A vision of how our community could look if actions are taken to address the concerns is presented. Again, the suggestions for action came from all of the wonderful people who gave their time to this project through participating in focus groups, the community forum, and the key informant interviews. As a community, we must decide what changes can be made to our system, within our community, and personally to improve the lives and the overall health of current and future seniors.

Tomorrow's Seniors

Seniors of the future may be very different from today's seniors. The generations living today that will be tomorrow's seniors will have had more opportunity to live longer, healthier lives than previous generations. Few of tomorrow's seniors will have had childhood polio or other debilitating childhood diseases. However, rates of diabetes and high blood pressure are increasing faster now and may negatively affect the health of future seniors.

Tomorrow's seniors may be more outspoken about their needs and have a greater sense of entitlement than seniors today. They may be more willing to speak up for themselves and to play a more active role in managing their healthcare.

Tomorrow's seniors are likely to be more active and eager to participate in community advocacy and volunteerism. They will expect services to be well marketed to seniors. As a whole, they will be far more technologically savvy than previous generations of seniors.

“We’re beautiful physically and spiritually. Life is seen in the lines of our faces.”

- Senior Focus Group Participant
Seniors will have financially planned for their retirement and health care needs, finding themselves relying less on family support to fill the gaps. Their plan will not outpace their individual savings and exceed the limits of their insurance coverage.

**Tomorrow’s Service Providers**

Nationally and locally, funding for senior programs will become a higher priority and stabilize to meet the need as it grows.

Service provider guidelines will be broadened for more seniors needing assistance to qualify for services. The fear of turning seniors away, rationing services, or requiring seniors to pay a larger share of the cost will not be realized.

Tomorrow’s service providers will be able to retain well-trained staff with an increased system capacity to meet the population growth.

Many social support programs will have strong volunteer programs to meet the need of serving a greater caseload.

Tomorrow’s service providers will put a greater emphasis on prevention and healthy aging initiatives.

**The Future When the Community Mobilizes**

Even though our hopes for tomorrow’s seniors and service providers was positive, many of the project’s discussions held about the future were not.

*The following strategies were suggested by individuals and are provided as examples and ideas for further discussion. Other suggestions were made throughout this document. There are many more potential actions our community could take to help with current senior health issues and to prepare for the future.*

- Each of us must take personal responsibility for planning for our senior years.
- Community gardens could be commonplace and efforts could be made to solicit, encourage, and support senior participation in planting, caring, and partaking of the produce from the gardens.
- Through neighborhood programs, seniors could be looked after and community service programs could assist seniors who needed minor home maintenance.
- More opportunities could be created through the utility companies to help pay for seniors’ utility bills. Property taxes on seniors’ homes could be set at the rate they were when the individual retired and began living on a fixed income. All seniors could be exempt from any property tax increase.
- City planners could work through a lens that always asks the question: “How can this new project be developed and engineered in a way that encourages physical activity and social participation for our senior population?”
- Agencies could plan together and develop a unified system of care. Bureaucratic restrictions could be loosened and cross-pollination of efforts could prevent silo funding. Primary and ancillary care could be available in one place.
- Programs to help seniors could be implemented in high schools, requiring youth to meet community volunteer requirements for graduation. A portion of the required volunteer curriculum could address senior issues and caregiving. This approach could create a dual opportunity for community involvement and an increased awareness of personal future needs.

Taking action on some or all of the feasible suggestions within this document would lead to healthier, happier, more active, and socially integrated seniors in our community. The positive vision for tomorrow’s seniors would then come true.

**Let us take the next step!**
RESOURCES

2-1-1 (Washington Information Network)
PH DIAL 2-1-1 or 877.211.WASH (9274) • www.211WA.org
24 hours seven days a week
Trained local specialists are available to help you find a number of services including: assisted living, child care, children’s services, counseling/support, drug treatment, education/literacy, financial help, food, housing, legal assistance, medical care, medical coupons, recreation, rent and utility assistance, senior services, teen services, temporary shelter, transportation and tutoring. 2-1-1 is here to help every day and to provide information in times of disaster.

American Association of Retired Persons (AARP)/Senior Employment Program*
PH 509.325.7712 • www.aarp.org • 1801 W. Broadway, Spokane, WA 99201 • M-F 9am-4pm
Free. Assists those low-income individuals, 55 years and older, who are looking for employment. Provides work experience and job referrals. Clients are placed for 20 hours a week at minimum wage in a non-profit or public service agency where they receive work experience and upgrading of their marketable skills.

Adult Protective Services (DSHS)**
PH 1.800.459.0421 TTY 509.568.3086 FAX 509.458.3558
APS protects vulnerable adults by investigating allegations of abuse, neglect, abandonment, and financial exploitation when the person lives in his/her own home. APS conducts an investigation at no charge and without regard to the income of the alleged victim. Some protective services may be provided without cost. Contact them any time you suspect a vulnerable adult living in his/her own home may be being harmed.

Aging and Long Term Care of Eastern Washington (ALTCEW)*
PH 509.458.2509 TTY 509.477.4442 • www.altcew.org
1222 N. Post, Spokane, WA 99201 • M-F 8:30am 5pm
Aging & Long Term Care of Eastern Washington (ALTCEW) is one of 13 publicly funded area agencies on aging in the State of Washington that serves as a conduit for state and federal funds designated to help seniors and others needing essential community long-term care services in Ferry, Stevens, Pend Oreille, Spokane, and Whitman counties. Programs and services offered through ALTCEW and its subcontractor network to support families and individuals with caregiving and other needs including: information and assistance/case management, transportation services, Title XIX medicaid personal care, and COPES Personal Care Program; home care quality authority registry; nutrition services; health appliances; minor home repair; registered nurse consultant services; respite services; family caregiver support services; bathing assistance/limited home care; Title V senior employment; legal assistance; Statewide Health Insurance Benefits Advisors (SHIBA); fundamentals of caregiving training; continuing education classes; WSDA Outreach Program; falls prevention; Long Term Care Ombudsman Program. ALTCEW also provides an online resource directory that allows users to find aging services throughout Eastern Washington. The resource directory can be found at: http://www.altcew.org/res-rd.asp

Alzheimer’s Association* (Inland Northwest Chapter)
PH 509.473.3390 • www.inwalza.org • 910 W. 5th Ave, Ste 256, Spokane, WA 99204 • M-F 9am - 5pm
Free. The Inland Northwest Chapter of the Alzheimer’s Association is a non-profit, charitable, tax-exempt organization dedicated to education, patient and family services, advocacy, and research support. Our service area includes 16 counties in Eastern Washington and 10 counties in Northern Idaho. Our services include support groups, education seminars, a newsletter, a help line, and a bracelet identification program to safely return people with Alzheimer’s to their home when they wander. We have just opened a 24-hour contact center at 800-272-3900 that provides information and care consultation to family members and professional caregivers.

(The) Directory for Seniors: Information and Resources for Seniors and Their Families
PH 509.838.7475
http://spokanewa.seniorlivingstrategies.com/index.asp
This publication contains information about issues seniors need to consider as they age and where they can find assistance with these matters. It is published yearly and is available free of charge on-line at the above web address. Print versions are also available at a variety of organizations that provide services to seniors.

DominiCare In-Home Support Services*  
**PH 509.935.4925 • 303 E. King Street**  
Chewelah, WA 99109 • M-F, 8am - 4:30pm  
Sliding fee scale. Assists independent living by providing personal care, respite-care, and homemaker, seven days a week, for elderly and functionally impaired persons living in the Tri-County area (Stevens, Ferry, Pend Orielle) and Northern Spokane County.

**DSHS (Washington State Department of Social and Health Services) Aging & Disability Services Administration**  
**PH 1.800.459.0421 TDD 1.800.737.7931**  
The Aging and Disability Services Administration assists children and adults with developmental delays or disabilities, cognitive impairment, chronic illness and related functional disabilities to gain access to needed services and supports by managing a system of long-term care and supportive services that are high quality, cost effective, and responsive to individual needs and preferences.

**Elder Services - Spokane Mental Health*  
**PH 509.458.7450 TDD 509.835.1282 • www.smhca.org**  
5125 N. Market, Spokane, WA 99217 • M- F 8am - 5pm  
Medicaid priority. Clinical case management to at-risk elderly living in their own homes. Strives to prevent premature or unnecessary hospitalization or nursing home placement. Services include in-home assessment, psychiatric care, respite care, senior peer counseling, family caregiver support, and a 24-hour Information and Assistance line for elders.

**Family Caregiver Support Program (DSHS)**  
**PH 509.458.7450**  
The Family Caregiver Support Program supports unpaid caregivers of older adults and grandparents or relative caregivers of children. Services are free or low cost and generally include: information and help getting services; caregiver support groups and counseling; caregiver training and education; and respite care so caregivers can have a break. Staff with the FCSP program can provide information, support, and services that can be a lifesaving resource.

**Friend to Friend*  
**PH 509.483.1600 • 4620 N. Regal, Spokane, WA 99207**  
Wed 8am - 12pm  
Free. A volunteer program providing friendship to lonely, isolated residents of long term and assisted living care facilities. To be eligible clients must seldom have any visitors. Training of volunteers is provided at orientation at St. Peter Lutheran Church.

**Holy Family Adult Day Centers*  
**PH 509.252.6600 (South Hill) • www.hfadc.org • 4827 Palouse Hwy, Spokane, WA • M F 8am - 4:30pm**  
Sliding fee scale, Medicaid. Provides rehabilitation, physical and mental health monitoring, socialization and activities for impaired adults and the elderly. Services are provided in a structured group setting for individuals with dementia, physical impairments, including strokes. Centers are located on the South Hill at 4827 S. Palouse Highway and near Holy Family Hospital on 6018 N. Astor Street.

**Home and Community Services*  
**PH 509.323.9400, INTAKE 509.323.9409**  
www.aasa.dshs.wa.gov • 1427 W. Gardner, Spokane, WA 99201 • M-F 8am - 5pm  
Medicaid eligibility required for most services. Arranges or provides a variety of services for elderly, functionally disabled and vulnerable adults. Services include: 1) Long-term care financial (anyone can apply) 2) Functional, nursing and medical needs assessments in hospital, residential and home settings 3) In-home personal care and services 4) Residential placement into assisted living facilities, enhanced adult residential care facilities, adult residential care facilities; adult family homes; and nursing homes 5) Residential care case management 6) Adult Protective Services (APS) for vulnerable adults who are abused, neglected, exploited, or abandoned. (No financial eligibility required) 7) COPES: In-home services, assisted living, or adult family homes.

*Resources from the 2004-2005 Spokane Community Resource Directory, you can find it online at www.iel.spokane.edu/crd  **Resources from http://www.aasa.dshs.wa.gov*
**Hospital Equipment Loan***
**PH 509.747.0899 • 1108 W. Riverside, Spokane, WA 99201 • M-F 9am - 4pm,**
**Almoner in T-Th 10am - 12pm**
Free. Medical equipment available for up to 30 days. Assistance dependent on equipment needed and availability. Call Clem for interview and more information. Sponsored by the Scottish Rite.

**Kinship Care in Washington State (DSHS)**
http://www1.dshs.wa.gov/kinshipcare/
Serving grandparents or other family members raising a relative’s child.

**Long Term Care Ombudsman Program***
**PH 509.456.7133 • www.snapwa.org • 500 S. Stone, Spokane, WA 99202 • M-F 8am - 5pm, CLOSED 12 - 1pm**
Free. Washington State LTCOP is an advocacy program for the rights of residents in nursing homes, adult family homes, and boarding homes. Spokane Neighborhood Action Program (SNAP) trains and certifies volunteers who visit and monitor long-term care facilities.

**Needy Relative, In Loco Parentis, and Legal Guardian Grant**
https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/non_needy_relative_grant.asp
Offers financial and medical assistance for children who are in the care of a relative of specified degree or a legal guardian or custodian. Adults who act "in loco parentis," or in the place of a parent, may also be eligible.

**Parenting a Second Time Around (PASTA)**
http://www.parenting.cit.cornell.edu/pp_pasta.html
A program that provides support, parenting skills, critical legal information, and communication skills to grandparents, as well as other relatives raising children. PASTA covers child development, authoritative discipline, rebuilding a family, legal issues and advocacy, mental health concerns, how to discuss sensitive issues, and how to access legal, medical, social, and educational services.

**Paratransit (Spokane Transit)**
**PH 509.328.1552 • TDD 509.327.6055**
www.sppokanetransit.com/ridesta/paratransit.asp
1230 West Boone Ave., Spokane, WA 99201
Paratransit is a wheelchair-accessible shared ride transportation service for individuals whose disability prevents them from using the regular fixed-route buses. This means that a person must be unable, because of a disability, to get to or from the bus stop, get on or off a lift or ramp equipped bus, or successfully travel by bus to or from the destination.

It is necessary to complete an application form if you wish to use the paratransit vans. Applications are available on the website, by phone, or by writing to the above address.

**Relatives as Parents Program**
www1.dshs.wa.gov/pdf/Publications/22-996.pdf
A resource guide for relatives raising children in Washington state.

**Revised Fundamentals of Caregiving Training***
**PH 509.458.2509 • www.altcew.org • 1235 N. Post, Spokane, WA 99201 • M-F 8:30am - 4pm**
Fees vary. Two to three trainings monthly are held at Aging and Long Term Care of Eastern Washington to provide the 28 hours of mandated training for in-home care providers. This training is also available to unpaid family caregivers at no charge. The training classes take place over four days, with dates changing each month. Reservations are required. Attendance is limited to 35 persons. There are also a variety of classes offered each month so providers may meet continuing education requirements. Please call for more information.

**RSVP (Retired and Senior Volunteer Program) of Spokane County***
**PH 509.344.7787 • www.ymcaspokane.org • YMCA Building • 507 N. Howard, Spokane, WA 99210 • M-F 8am - 5pm**
Free. RSVP provides seniors 55+ with meaningful opportunities for community involvement through volunteer service. Volunteers are matched according to interest and skills in over 100 non-profit and public organizations in Spokane County that address priority community needs. Project Warm-up, one RSVP program, provides hand knitted items for low-income families. Another program, RSVP Reading Corps, involves volunteers as tutors and to read to children. RSVP membership benefits include insurance coverage, transportation reimbursement for low-income volunteers, recognition events and awards, and free subscription to Senior Times.

Senior Centers*
Corbin Senior Activity Center
PH 509.327.1584 • 827 W. Cleveland
Deer Park Seniors
PH 509.276.2411 • 316 E. Crawford Rd (lower level of Deer Park City Hall)
East Central Senior Center
PH 509.625.6693 • 500 S. Stone
Hillyard Senior Center
PH 509.482.0803 • 4001 N. Cook (NECC)
IEL (Institute for Extended Learning) Seniors Program
PH 509.533.4756 • Community Colleges of Spokane
Mid-City Senior Center
PH 509.747.3257 • 1222 W. 2nd
North Star Senior Center
PH 509.466.6350 • 8415 N. Wall St.
Sinto Senior Activity Center
PH 509.327.2861 • 1124 W. Sinto
Southside Senior Activity Center
PH 509.535.0803 • 3151 E. 27th
Valley Senior Center
PH 509.926.1937 • 11423 E. Mission

Senior Energy Outreach Program*
PH 509.495.4086 or 509.495.4074 • www.snapwa.org
PO Box 3727, Spokane, WA 99220 • M-F 8am - 5pm
Avista customers, 60 years and older on a limited or fixed income, may contact Avista CARES to facilitate referrals for energy assistance. Applications for energy assistance are processed by Spokane Neighborhood Action Program (SNAP) offices based on client zip code area, on a first-come, first-served basis until funds are depleted.

Senior Nutrition Program, Spokane Regional Health District (SRHD)*
PH 509.324.1532
www.srhd.org/health/seniors/nutrition.asp
1101 W. College, Rm 190, Spokane, WA 99201
M-F 8am - 5pm
Donation requested, $2.50 per meal. Provides hot meals at noon in 11 congregate meal sites in Spokane County. Call for locations and meal schedules. Homebound seniors over age 60 may be eligible for hot or frozen home-delivered meals. This is a federally assisted program under Title IIIC, Older Americans Act, via ALTCEW.

Senior Services*
PH 509.328.8400 • www.catholiccharitiesspokane.org
1212 W. Sharp, Ste 3, Spokane, WA 99201
M-F 8am - 5pm
Free. Volunteer Chore Services: Volunteers provide basic assistance with housework, laundry, transportation, yard work, snow removal, light maintenance, wheelchair ramps; assistance with moving, and communications and monitoring to low-income elders and adults with disabilities who do not qualify for help from other agencies. The goal is to assist low-income seniors and low-income adults with disabilities with chores in order that they might live longer in their homes and avoid premature institutionalization.

Senior Nutrition: Designed to provide a nutritious meal, socialization, and education for low-income seniors and adults with disabilities at the Delaney Apartments, House of Charity, and Deer Park Senior Center.

Senior Times Newspaper*
PH 509.924.2440 • 523 N. Pines, Spokane, WA 99206
Community owned, independent newspaper. Published monthly for seniors. Self-sustaining.

Seniors-Up & Go
PH 509.324.1596 • 1101 W College, Room 401, Spokane, WA 99201
Provides education on preventing falls. This program is available to residents of Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman counties in partnership with the Spokane Regional Health District and the East Region EMS and Trauma Care Council. Seniors–Up & Go presentations can be scheduled in senior centers, community centers, at luncheons, and other social functions.
www.eastregion-ems.org/committees/IPPE/Programs/IPPEseniorsupgo.htm

Spokane Valley Foundation*
PH 509.924.0507 • 1212 N. Pines, Spokane, WA 99206
M- F 9am - 5pm
Provides services for the elderly in Spokane Valley. Transportation Monday - Friday, 9:30 a.m. to 3:30 p.m. (Doctor appointment, shopping, hair appointment, anything needed within our boundaries) need 48 hour notice minimum. Cards and lunch offered on Wednesdays only ($2 donation). For those over 60 years old, call for service area.

Spokane Valley Meals on Wheels
PH 509.924.6976 FAX 509.926.4606
www.spokanevalleymealsonwheels.com
321 S. Dishman-Mica Rd., Spokane Valley, WA 99206
For almost 30 years, Spokane Valley Meals On Wheels has been providing hot, nutritious meals to elderly and disabled persons in our community. Our mission is to prolong the ability of elderly and disabled persons in the Spokane Valley to remain living independently in their own homes by providing nutritious meals. Referrals to other services are provided as needed. Serve clients from Havana Road to Starr Road, 4800 blocks north and 4800 blocks south. Our 250 volunteers deliver to 23 routes, serving approximately 6,000 meals per month!

Title V Senior Community Service Employment*
PH 509.458.2509 • www.altcew.org • 1222 N. Post, Spokane, WA 99201 • M F 8:30am - 5pm
Free. A program sponsored by Aging and Long Term Care of Eastern Washington with funding by the Older Americans Act. Designed to provide, foster, and promote useful part-time work activities for economically disadvantaged persons who are 55 years of age or older, the program provides on-the-job training in community service or non-profit organizations. Enrollees are expected to seek unsubsidized employment while in this subsidized workplace. To be eligible for this program, applicants must want to work; be at least 55 years of age; be unemployed; be a resident of the State of Washington; and have income not exceeding 125% of the Federal Poverty Level guidelines.

University Legal Assistance*
PH 509.323.5791 • 721 N. Cincinnati, Spokane, WA 99258 • M- F 8:30am - 5pm
Free to seniors 60 and older. Provides legal representation and counseling without charge to individuals over 60 years of age focusing on the needs of the low-income elderly. Representation includes civil legal matters, guardianship, public entitlement, housing, consumer affairs, and domestic relations. This project also facilitates access to a low cost panel of attorneys on issue of wills, and similar matters.

Washington State Dental Association WDSA Outreach Program*
PH 509.458.2509 TTY 509.477.4442 • www.altcew.org
1222 N. Post, Spokane, WA 99201 • M- F 8:30am - 5pm
Fees vary. Provides reduced dental rates to anyone 65 years or older with a single-person annual income of less than $23,275 or family annual income less than $31,225, who are not covered by dental insurance or Medicaid coupons that cover dental care. No fees charged by ALTCEW for screening. ALTCEW serves as the primary entry point for those seeking care under the program by establishing the eligibility of the prospective patients. Services are provided in cooperation with the Washington State Dental Association. Formerly known as the Dental Access Program.

APPENDIX A: SRHD Focus Group Questions

Spokane Regional Health District Staff Focus Group Questions

1. If you serve seniors clients, what issues are you seeing that are important to the health of seniors?

2. In your personal experience, what issues do you feel are important to the health of seniors?

3. Are there built environment concerns for seniors? (safety, walkability…)


5. Who do you refer to in the community that addresses senior health issues?

6. What strengths have you found in services for seniors and the ability to meet the needs of seniors?

7. What gaps have you found between the needs of seniors and the availability of services for seniors?

8. Looking toward the future, what additional issues do you think will need to be addressed?

9. Who do you feel should be invited to the community forum?
# APPENDIX B: Community Forum Agenda

## Community Health Assessment of Adults 60 and Older

*Tuesday, June 13, 2006*  •  *3:00-5:00 pm*

*Spokane Regional Health District, Auditorium*  •  *1101 W. College Avenue*

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic &amp; Tasks</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00 pm</td>
<td>Welcome and Focus of Project&lt;br&gt;Interest in Assessment</td>
<td>Dr. Kim Thorburn&lt;br&gt;Nick Beamer&lt;br&gt;Vic Forni</td>
</tr>
<tr>
<td>3:15 pm</td>
<td>Introduction of Community Health Assessment Services and Staff</td>
<td>Lyndia Vold</td>
</tr>
<tr>
<td></td>
<td>Background on Community Based Participatory Community Health Assessment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Why are we all here?</td>
<td>Alicia Thompson</td>
</tr>
<tr>
<td></td>
<td>• What are we doing?</td>
<td></td>
</tr>
<tr>
<td>3:25 pm</td>
<td>Community Process - Breakout into Small Groups&lt;br&gt;• Tell us your story&lt;br&gt;• What are the needs and priorities?</td>
<td>All</td>
</tr>
<tr>
<td>4:25 pm</td>
<td>Research on Topic&lt;br&gt;• Literature Review and SRHD Focus Groups&lt;br&gt;• Data Sources&lt;br&gt;• Data Gaps&lt;br&gt;• What data or resources can you share?</td>
<td>Alicia Thompson&lt;br&gt;Amy Riffe</td>
</tr>
<tr>
<td>4:45 pm</td>
<td>Plan of Action&lt;br&gt;• Next steps&lt;br&gt;• How do you want to be involved?&lt;br&gt;• Please fill out form before you leave</td>
<td>All</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Closing</td>
<td></td>
</tr>
</tbody>
</table>

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*Sponsored by*

[Spokane Regional Health District]<br>[[Long-Term Care]]<br>[[United Way]]
## APPENDIX C: Prioritized List of Health Issues

<table>
<thead>
<tr>
<th>Issue #</th>
<th>Health Issue</th>
<th>Total</th>
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<tbody>
<tr>
<td>5</td>
<td>Mental health</td>
<td>75</td>
</tr>
<tr>
<td>2</td>
<td>Not having access to health care / not accepting Medicare</td>
<td>54</td>
</tr>
<tr>
<td>9</td>
<td>Education for doctors and seniors</td>
<td>53</td>
</tr>
<tr>
<td>25</td>
<td>Assistance to stay in home</td>
<td>45</td>
</tr>
<tr>
<td>3</td>
<td>Lack of preventive care</td>
<td>42</td>
</tr>
<tr>
<td>15</td>
<td>Proper prescription use / medication management</td>
<td>35</td>
</tr>
<tr>
<td>17</td>
<td>Healthy, successful aging</td>
<td>34</td>
</tr>
<tr>
<td>18</td>
<td>Transportation</td>
<td>34</td>
</tr>
<tr>
<td>31</td>
<td>Affordable, safe housing</td>
<td>34</td>
</tr>
<tr>
<td>12</td>
<td>Information and dissemination that works for seniors</td>
<td>33</td>
</tr>
<tr>
<td>13</td>
<td>Nutrition access - understand needs</td>
<td>33</td>
</tr>
<tr>
<td>8</td>
<td>Referral system</td>
<td>29</td>
</tr>
<tr>
<td>10</td>
<td>Under Medicare - no dental, eye, hearing</td>
<td>29</td>
</tr>
<tr>
<td>22</td>
<td>Poverty</td>
<td>28</td>
</tr>
<tr>
<td>28</td>
<td>Affordable medications</td>
<td>25</td>
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<td>4</td>
<td>Need for home visits</td>
<td>21</td>
</tr>
<tr>
<td>16</td>
<td>Planning for long-term care</td>
<td>20</td>
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<tr>
<td>27</td>
<td>Decreasing funding</td>
<td>19</td>
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<tr>
<td>21</td>
<td>Chronic conditions</td>
<td>17</td>
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<tr>
<td>23</td>
<td>Isolation / loneliness</td>
<td>17</td>
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<tr>
<td>11</td>
<td>Geriatric physicians</td>
<td>16</td>
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<tr>
<td>20</td>
<td>Elder abuse</td>
<td>16</td>
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<tr>
<td>29</td>
<td>Capacity to provide a continuum of care</td>
<td>16</td>
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<tr>
<td>34</td>
<td>Environmental accessibility</td>
<td>15</td>
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<tr>
<td>37</td>
<td>Advocacy - senior issues and disability</td>
<td>15</td>
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<tr>
<td>14</td>
<td>Dental care</td>
<td>13</td>
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<tr>
<td>30</td>
<td>Respite care and support for caregivers</td>
<td>13</td>
</tr>
<tr>
<td>26</td>
<td>Medicare accountability at client level</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>Substance abuse</td>
<td>11</td>
</tr>
<tr>
<td>19</td>
<td>Kinship care</td>
<td>10</td>
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<tr>
<td>44</td>
<td>Quality and experienced care givers / adequately paid</td>
<td>9</td>
</tr>
<tr>
<td>39</td>
<td>Injuries - prevention</td>
<td>8</td>
</tr>
<tr>
<td>42</td>
<td>Home environmental health issues</td>
<td>8</td>
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<tr>
<td>38</td>
<td>Lack of intellectual opportunities</td>
<td>7</td>
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<td>7</td>
<td>Identifying populations within a population</td>
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<tr>
<td>36</td>
<td>Stigma accessing services</td>
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<tr>
<td>1</td>
<td>Lack of utilization - individuals put off care</td>
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<td>35</td>
<td>Intergenerational communities</td>
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<td>Self-advocacy</td>
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<td>33</td>
<td>Alternative work options</td>
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<td>24</td>
<td>Care for special needs populations</td>
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<tr>
<td>43</td>
<td>Alternatives to traditional medications</td>
<td>3</td>
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<tr>
<td>32</td>
<td>Immigration / refugee status posing barriers</td>
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<tr>
<td>40</td>
<td>Poisoning</td>
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</tbody>
</table>
### Senior Community Health Assessment Topics

#### Chronic Conditions
- Arthritis
- Cancer
- Dementia
- Diabetes
- Heart Disease
- Incontinence
- Stroke
- HIV/AIDS

#### Demographics
- Age
- Gender
- Race/Hispanic ethnicity
- Employed
- Education
- Income per person
- Poverty
- Immigration/refugee status, poses barriers

#### Environment
- Built environment issues
- Accessibility
- Home environment issues

#### Family Issues
- Caregivers
- Raising Children’s Children
- Respite care & support for caregivers
- Kinship care

#### Financial Security
- Fixed Income
- Planning for long-term care

#### Functional Status & Disability
- Activities of daily living
- Activity limitations
- Instrumental activities
- Physical functioning
- Physical impairments (vision, hearing)
- Summary measures
- Need for home visits
- Quality experienced caregivers, adequately paid
- Care for special needs population

#### Healthcare Expenditures
- Hospitalizations
- Long-term care

#### Health Insurance
- Medicare - no dental, vision, hearing
- Provider acceptance
- Resources needed

#### Hospitalizations
- Injury
  - Crashes
  - Falls
  - Hip fractures
  - Homicide
  - Poisoning
  - Suicide
  - Vulnerable Adult Abuse
  - Prevention measures

#### Living Arrangements
- Assisted Living
- Relative Care
- Residential setting
- Affordable safe housing
- Assistance to stay in home
- Intergenerational communities

#### Mental Health
- Access based on income
- # days poor mental health
- Depression
- Narrowing of service qualifications
- Not seeking - stigma

#### Mortality
- Life Expectancy

#### Nutrition
- Can’t prepare own meals
- Eating alone/isolation
- Food insecurity/hunger
- Access
- Understand needs

#### Oral Health
- Dentition status
- Access to services

#### Perceived Health Status
- # unhealthy days
- Self reported health status

#### Risk Factors
- Fruit/vegetable consumption
- Prescription medication
  - Conflicting meds
  - Use of meds (timely, proper use, etc.)
  - Who is administering
  - Medication management
  - Affordability

*Continued on next page.*
Healthcare Utilization
- Emergency Room
- Homecare/Hospice
- Hospital Inpatient
- Nursing Home
- Physician
- Access issues (dental, meds, etc)
- Screenings/preventive care
- Vaccinations/immunizations
- Veterans Health Care (VA svs)
- Referral system
- Stigma accessing services
- Lack of utilization, put off care
- Alternatives to traditional medicine

Identifying populations within population

Healthy Successful Aging
- Obesity & overweight
- Physical activity
- Smoking
- Substance use

Social Participation
- Engage in social activity
- Volunteering
- Isolation/loneliness
- Lack of intellectual opportunities
- Alternative work options

Special Equipment Use

Transportation
- Driving
- Access to services
- Cost

Community Issues
- Education for doctors & seniors
- Information & dissemination that work for seniors
- Decreasing funding for services
- Geriatric physicians
- Capacity to provide a continuum of care

Advocacy
- Senior issues
- Disability
- Self-advocacy
APPENDIX E: Senior Focus Group Questions

Senior Community Health Assessment Focus Group Questions

1. What is the best part about aging?
2. What are the challenges with aging?
3. What are some of your worries and concerns as you age?

The next few questions address health issues:
4. What are some common health issues you or your friends face?
5. What do you think are the greatest needs of seniors?
6. Where do you think seniors can go for their needs?
7. What are some reasons seniors can't get their needs met?
8. What do you think needs to be done to help seniors?

The next few questions get your thoughts on how to get information in the community:
9. What health issues would you like to know more about?
10. How could we get health information to you?
11. Which newspapers or magazines do you read?
12. Is there anything else you would like to add?

Please let us know if you would like to share your story or experience with us?

Please provide contact information
Senior Community Health Assessment - Community Key Informant Representative Questions

1. From your perspective, what do you think are the greatest needs of seniors in our community?

2. From the community forum that we held in July, one of the priority areas was ____________________________. Can you tell me why you think this came out as a priority?

3. What do you think needs to happen to improve this priority area?

4. What are the gaps between needed and available services for seniors?

5. Do you have any suggestions for ways to resolve the current service gaps?

6. With a growing senior population, do you have a vision of how services will meet the demand for additional services?

7. Who else should I talk to about this topic?
Medicare does not cover everything. Items and services that are not covered include, but are not limited to the following:

- Acupuncture
- Chiropractic services
- Cosmetic surgery
- Custodial care at home or in a nursing home
- Deductibles, coinsurance, or copayments when you get certain healthcare services
- Dental care and dentures
- Diabetic supplies
- Eye care (routine exam), eye refractions and most eyeglasses
- Foot care routine such as cutting of corns or calluses
- Hearing aids and hearing exams for the purpose of fitting a hearing aid
- Hearing tests that haven't been ordered by your doctor
- Long-term care, such as custodial care in a nursing home
- Orthopedic shoes
- Physical exams
- Prescription drugs
- Shots
- Tests (screenings)
- Travel
APPENDIX H

Older American Act–General Provisions

- Five-year reauthorization: 2006-2011;
- Funding formula: 1) hold harmless at 2006 levels; 2) guaranteed “growth factor” phased out in five years.

Administration on Aging–New/Expanded Provisions

- Authority to Implement “Choices for Independence” (Aging & Disability Resource Centers; self-directed care);
- Enhanced responsibility to coordinate long-term care services through Interagency Coordinating Committee on Aging within the Federal departments of government;
- Expanded responsibility to coordinate elder abuse prevention programs and services (Elder Justice) and expand definitions;
- Enhanced coordination responsibility for public awareness, prevention and treatment of mental disorders among older persons;
- Senior Employment Program (Title 5) revisions: 1) two-year limit with some exceptions; 2) “underemployed” now eligible; 3) retains age eligibility at 55, but adds a priority population provision of 65 and older; 4) higher placement goal of 25% (now 20%) phased in over five years; 5) sets performance standards with penalties if not met; 6) hold harmless at 2000 levels for funding with additional provisions in play for amounts greater than 2000 levels for national and state contracts;
- Research grants:
  1. Focus on evidence based health interventions, independence, aging in place including naturally occurring retirement communities (NORCSs)
  2. Assistive technologies
  3. Transportation innovation
  4. Multigenerational and civic engagement activities.

State Units on Aging (SUA) and Area Agencies on Aging (AAA)–New or Expanded Provisions

- Programs and services
  1. Develop and implement a long-term care system of in home and community-based services including Aging and Disability Resource Centers (information, personal counseling and access to programs);
  2. Mental health services coordination, public awareness;
  3. Pension and benefits counseling information added;
  4. Evidence-based health promotion and disease prevention;
  5. Voluntary contributions allowed for all services and encouraged for people with incomes above 185% of the Federal Poverty Level;
  6. Family Caregiver Support Program: The age of eligibility for grandparents has been reduced to 55 years old and authorization increased to $187 million over five years.
- Planning:
  1. Increased support for community planning to assess the “aging readiness” of communities over a 10-year planning horizon and to advise government officials on preparing for the long-term care needs of the baby-boom generation;
  2. Develop emergency preparedness plans.
- Target criteria for recipients of services have been expanded to include individuals with limited English proficiency and people at risk for institutional placement;
- Area Agency on Aging Advisory Council makeup is expanded to include family caregivers, service providers, and business representatives.
GLOSSARY

Age-specific or age-limited rate:
An age-specific rate is a rate in which the number of events and population at risk are restricted to an age group (e.g., the birth rate of women age 15 to 19; death rate for people age 45 to 64).

Aggregate:
Grouping is used to increase the size of the numerator and denominator, which stabilizes the rates. Grouping can be done by combining multiple years of data, using larger geographical areas, and combining groups of people.

Community housing with services:
Applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, or other similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications.

Confidence interval:
A confidence interval is a statement of two values between which we believe the true proportion is found; a range of values that is normally used to describe the uncertainty around a point estimate of a quantity; for example, a mortality rate. Therefore, confidence intervals are a measure of the variability in the data. Generally speaking, confidence intervals describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. Confidence intervals are calculated with a stated probability, so we say that there is a 95% chance that the confidence interval covers the true value. When comparing two rates, if the confidence intervals do not overlap, the difference in the rates is considered “statistically significant.”

Denominator:
In calculating rates, the denominator is the number of people in a specified population. Everyone in the denominator must be eligible to be counted in the numerator. The denominator is often called the “population at risk.”

Federal Poverty Level (FPL) Guidelines:
The poverty guidelines are a federal poverty measure. They are issued each year in the Federal Register by the U.S. Department of Health and Human Services (HHS). The guidelines are used for administrative purposes; for instance, determining financial eligibility for certain federal programs.

Rate:
A rate is a measure of the frequency of an event per population unit. The use of rates, rather than raw numbers, is important for comparison among populations, since the significance of the number of events depends, in part, on the size of the population.

Statistical significance:
Testing for significance is an objective approach to evaluating the difference or change in a population. Confidence intervals are used to determine significance.

For more information on these or other terms, please reference Washington State Department of Health, Assessment Operations Group, www.doh.wa.gov/Data/Guidelines/guidelines.htm
This report meets several of the standards for public health in Washington State through:

1. analyzing health data to compare existing services to the projected need for services. This information can then aid in developing recommendations for policy decisions, program changes, or other actions (1.2L) (6.2L);

2. sharing local health data with appropriate organizations (1.4L);

3. documenting community and stakeholder involvement in recommending priorities (3.1L);

4. making health data available for the public (2.7L); and

5. an additional standard will be met when the results of this community health assessment are presented to stakeholders (3.2L).