

HEALTH EQUITY SERIES:

OLDER ADULT HEALTH DISPARITIES IN MISSOURI

OCTOBER 2014



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Missouri Foundation for Health is a resource for the region, working with communities and nonprofits to generate and accelerate positive changes in health. As a catalyst for change, the Foundation improves the health of Missourians through partnership, experience, knowledge, and funding.

The Health Policy Portfolio complements the Foundation's grantmaking efforts to address health issues from a systemic perspective. Health Policy supports education, advocacy, and analysis on issues significant to the health of uninsured, underinsured, and underserved Missourians.

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The world's population is aging at a rapid pace.

ISSUE STATEMENT

The number of people worldwide age 65 and older is expected to triple between 2010 and 2050—from 524 million to 1.5 billion.¹ In the United States, there will be approximately 72.1 million people (19 percent of the total U.S. population) over age 65 by 2030, more than twice the amount in 2000.

Missouri shows a similar trend in the projected growth of older adults. In 2011, there were 854,652 Missourians age 65 or older (14.2 percent of the population). This age demographic is projected to reach 1,414,266 people (21 percent of the population) by 2030.² Older adults account for the largest percentage of health care spending. The Centers for Medicare and Medicaid Services (CMS) report that health care spending by older adults grew 3-times that of 18 to 64 year olds in 2010.³ As Missouri continues to age, attention must be given to the health needs of this population, as well as the availability and cost of services.



Data highlighted in this report, include:

- The Center for Disease Control (CDC) reports that 80 percent of older adults have at least one chronic condition and 50 percent have at least two.⁴
- Ninety percent of flu-related deaths and more than half of flu-related hospitalizations occur in people age 65 and older.⁵
- In 2011, there were 17,571 reports of elder abuse in Home and Community-Based Settings (HCB) in Missouri. Of these reports, 72.9 percent were substantiated after investigation.
- The number of Missourians over 65 with Alzheimer's disease will increase between 2010 and 2025, from 110,000 to 130,000.
- In 2011, the number of certified geriatricians in Missouri was 139. Assuming that only the most vulnerable older adults need to be treated by a geriatrician (30 percent of the total older-adult population), the projected number of geriatricians needed in 2030 would be 558.⁶
- Older adults comprise 9 percent of Missouri's Medicaid enrollees, but account for 19 percent of Missouri's Medicaid spending.⁷
- Current statistics show that approximately 70 percent of people over the age of 65 will require some kind of long-term care services during their lifetime.⁸ AARP reports that the ratio of potential caregivers to adults over 80 will fall from 7-to-1 in 2010 to 4-to-1 in 2030 and less than 3-to-1 in 2050.
- Missouri ranks 33rd overall in the United Health Foundation's Senior Report, a measure of various health determinants and outcomes. Specific measures include percentage of older adults visiting the dentist in the last 12 months (ranked 47th), obesity (ranked 32nd), premature deaths (ranked 38th), and multiple chronic conditions (ranked 31st).⁹

WHAT ARE

HEALTH DISPARITIES



The National Institutes of Health (NIH) defines health disparities as “the difference in the incidence, prevalence, morbidity, and burden of diseases and other adverse health conditions that exist among specific population groups.” This report aims to address the most prevalent health disparities faced by older adults in the state of Missouri and nationally. The topics addressed do not constitute an exhaustive list, but are an overview of some of the most pressing health concerns faced by this growing population.

For the purposes of this report, the term “older adults” refers to individuals age 65 and older, unless otherwise noted, since that is the age bracket in which much of the data is reported. However, the precise definition of “old age” is up for debate. As more people continue to lead active lives into their 70s, 80s, 90s, and beyond; a

One’s age does not automatically limit one’s ability to remain an active, contributing member of society.

one-size-fits-all definition does not work. One’s age does not automatically limit one’s ability to remain an active, contributing member of society. Many older adults continue to work, volunteer, and

pursue a wide variety of interests into later life. While productive and healthy aging is a possibility for many, the disparities outlined in this report represent another side to this story.

PHYSICAL HEALTH

CHRONIC DISEASE

Chronic disease, or chronic illness, is broadly defined as a non-communicable illness that lasts one year or more, requires ongoing medical attention, and can limit activities of daily living. Chronic conditions are generally incurable but some are preventable. Some examples of chronic illness include heart disease, diabetes, and arthritis. Risk factors for chronic disease are both modifiable and non-modifiable. In addition to heredity, one of the strongest unmodifiable risk factors is advanced age.

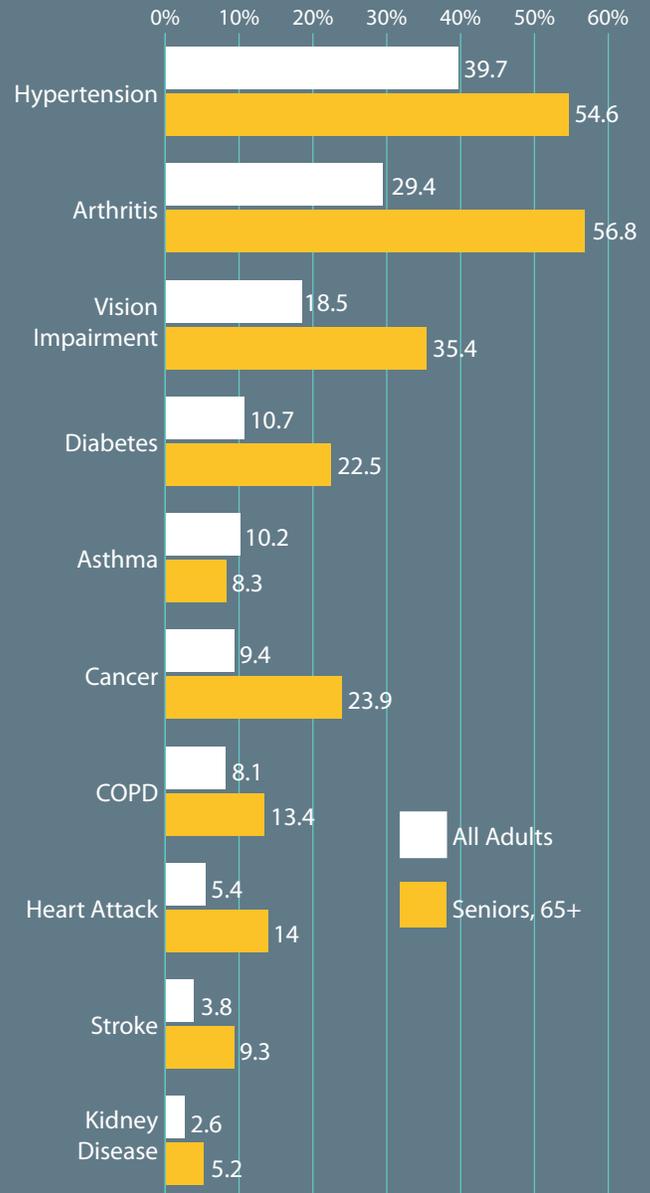
Americans are living longer than ever before, creating conditions for an increased prevalence of chronic conditions. Advancements in medicine have extended life expectancy, in part through the successful treatment of infectious diseases that were once incurable. Diseases like tuberculosis and small pox, at one time devastating in their scope and impact, were essentially eradicated in the 20th century due to widespread vaccinations. While infectious disease is still of concern, increased life expectancy and the resulting increase in chronic and degenerative diseases has marked an “epidemiologic shift” occurring worldwide.¹⁰

The CDC reports that 80 percent of older adults nationwide have at least one chronic condition and 50 percent have at least two.¹¹ In a survey of older Missourians, about 95 percent were found to have one of 13 chronic diseases and conditions, more than 80 percent had at least two, and about 65 percent had at least three.¹² Cost of care is a major concern related to the increase in chronic illness. More than 75 percent of health care costs are due to chronic conditions.¹³

The shift in prevalence from infectious diseases to long-lasting chronic conditions requires a new way of thinking about the prevention, management, and treatment of illness.

Prevalence of Chronic Diseases & Conditions 2011

AMONG ALL ADULTS & SENIORS IN MISSOURI





INFECTIOUS DISEASES

While chronic disease accounts for the majority of disability and fatality among older adults, infectious diseases can also be life-threatening in this population due to weakened immune systems. Additionally, older adults do not always present with typical symptoms when suffering from an infection. Common symptoms of an infection, such as fever and leukocytosis (above average white blood cell count), are sometimes absent, making diagnosis a challenge. Instead, subtle changes or symptoms may be present, including cognitive impairment or delirium.¹⁴

Influenza and Pneumonia

Older adults are at a higher risk of being infected by influenza (flu), a contagious respiratory virus. Another infectious disease that can result from the flu is pneumonia, a treatable lung infection that can be caused by bacteria, virus, or fungi. While most healthy people recover from the flu or pneumonia, it can be fatal for vulnerable populations including older adults. An estimated 90 percent of flu and pneumonia-related deaths and more than 60 percent of flu-related hospitalizations occur in people age 65 and older.¹⁵ Flu consistently ranks among the top 10 causes of death for older adults.¹⁶

There are vaccines available for flu and pneumococcal pneumonia (a type of pneumonia caused by the strep bacteria).¹⁷ The CDC recommends that people over 65 receive both of these vaccinations. Missouri ranks slightly higher than the national average for the percentage of older adults who receive flu vaccinations. Data from 2012 show 67.3 percent of older adults in Missouri and 59 percent of older adults nationally receive the vaccine.¹⁸ The cost of one flu shot per season is completely covered by Medicare Part B.

Shingles

Shingles, or herpes zoster, is a virus that affects the nerves in adults, causing moderate-to-severe pain

and blisters. It is caused by the same virus that causes chickenpox (varicella-zoster). Once a person has had chickenpox, the virus remains in the body and can be reactivated later in life causing shingles. Shingles is very rarely life-threatening (less than one per 1 million people), but it can result in chronic, untreatable pain even after the resulting rash has disappeared.

The incidence of shingles for the general U.S. population is approximately 4 cases per 1,000 U.S. people annually, while the incidence among people 60 years of age and older is about 10 cases per 1,000.¹⁹ There is a shingles vaccine that is recommended for people 60 and over which is covered by most private insurance plans and is generally covered by Medicare Part D (prescription drug plan).

FALLS

In the U.S., the leading causes of injury deaths for older adults are slips and falls.²⁰ In addition to fatal injuries, falls can cause fractured and broken bones, head injuries, and other complications that can lead to hospitalizations, chronic pain, reduced functional ability, and loss of independence. Older adults are at higher risk for falls due to several factors, including: loss of muscle strength, pharmaceutical side effects or interactions that may cause drowsiness or dizziness, vision problems, or balance issues.

Missouri's rate of falls among older adults is 31 percent higher than the national average.²¹ Following the lead of a national fall prevention effort by the National Council on Aging and its partners in 2008, Missouri began working on a state plan of its own by organizing key stakeholders. A coalition was created called "Show Me Falls Free Missouri" which identifies best practices and coordinates awareness activities around the state. In the past five years, fall prevention awareness activities have reached 24,800 people throughout Missouri.²²

The importance of fall prevention is being recognized at the national level. The NIH and the Patient-Centered Outcomes Research Institute (PCORI) have made a joint award to fund a clinical trial aimed at identifying and evaluating evidence-based strategies for preventing falls that can be adopted across health care systems. The study will include 6,000 older adults (age 75 and older) at 10 trial sites across the country. The award will total approximately \$30 million over five years. First-year funding (\$7.6 million) was awarded in June of 2014.²³

ELDER ABUSE

The term "elder abuse" can refer to many types of abuse: neglect, financial or material abuse, physical abuse, sexual abuse, emotional abuse, and self-neglect. It is unclear how many older adults are victims of abuse, but recent major studies indicate abuse rates as high as 1-in-10²⁴ (these numbers may be low due to under-reporting). The National Center on Elder Abuse explains that older adults, "may be reluctant to report abuse themselves because of fear of retaliation, lack of physical and/or cognitive ability to report, or because they do not want to get the abuser (90 percent of whom are family members) in trouble."²⁵

In Missouri, alleged abuse and neglect victims are all ages, but the likelihood of being abused increases with age.

Elder abuse can occur at home, in community-based settings, or in institutional care. A 2000 study interviewed 2,000 nursing home residents about their experience with abuse. Of those surveyed, 44 percent said they had been abused and 95 percent said they had been neglected or seen another resident neglected.²⁶

In Missouri, the Department of Health and Senior Services (DHSS) responds to and investigates reports of

abuse, neglect, and exploitation of individuals over age 60. In 2011, there were 17,571 reports of elder abuse in HCB settings. The number of those cases that were found to be substantiated after investigation, meaning investigators found a “reason to believe” or “suspect” the allegations to be true, was 72.9 percent.²⁷

DHSS reports that an individual’s circumstances or environment was the largest contributing factor in reports of abuse in FY2011. Such circumstances can include lack of heat, air conditioning, or running water.

HUNGER

Food insecurity is defined by the United States Department of Agriculture (USDA) as having limited access to adequate food due to a lack of money and other resources. In 2012, food insecurity affected 8.8 percent of American households (2.8 million) that included one or more older adults, and 9.1 percent of households (1.1 million) comprising older adults living alone.²⁸

In a 2013 report, 15.5 percent of Missourians over the age of 60 were food insecure, ranking Missouri 34th out of all states (with 50th being the state with the highest percentage of food insecurity).²⁹

Missouri has 10 Area Agencies on Aging (AAAs), created under the 1973 amendments of the Older American’s Act. These AAAs provide many services to older Missourians, including free or low-cost congregate and home-delivered meals. In FY2013, Missouri’s AAAs served over 2.2 million congregate meals to older adults and delivered over 3.4 million meals to older adults in their homes.

MENTAL HEALTH AND BRAIN HEALTH

DEPRESSION

In *Older Americans 2012: Key Indicators of Well-Being*, the Administration on Aging reported that 11 percent of men and 16 percent of women over the age of 65 experience depression. In breaking down these statistics further, the percentage of those with depression increases with age: 19 percent of men and 18 percent of women over age 85 exhibit depressive symptoms. Depression in older adults often goes untreated as it is mistaken for other illnesses or assumed that depression is a normal part of the aging process.³⁰

The second highest rate of suicide in the nation is that of individuals over the age of 85. Males commit suicide at a rate that is consistently 4-times greater than women.³¹



The 2006 Missouri Senior Report noted that 6 percent of Missourians receiving in-home long-term care may suffer from major depression, while 19 percent may suffer from lesser depression, of which 40 percent were persistently depressed over one year. Older persons in nursing facilities experience even higher rates of depression.

ALZHEIMER'S DISEASE AND DEMENTIA

The term "dementia" is an umbrella term that encompasses a wide-range of symptoms associated with the decline in mental ability, such as memory and other thinking skills. An estimated 35.6 million people are living with dementia worldwide, a number that is expected to double every 20 years.³² There are different types of dementia and different diseases for which dementia is a symptom, including: Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease, and others. Alzheimer's disease is the most common form of dementia, accounting for 60 to 80 percent of cases.³³

Alzheimer's disease is the 6th leading cause of death in the U.S. (the 5th leading cause of death for older adults) and the only cause among the top 10 without a cure or a way to slow its progression. Deaths from Alzheimer's disease are rising: an increase of 68 percent was seen between 2000 and 2010. Meanwhile, deaths from other major diseases, including heart disease (the number one cause of death), have decreased. Although there are cases of younger-onset Alzheimer's, it is estimated that over 95 percent of cases affect older adults.

In Missouri, there are 110,000 people with Alzheimer's disease, and that number is expected to increase to 130,000 by 2025. Those with the disease are far from the only ones affected. There are an estimated 390,000 caregivers in Missouri who commit a total of 351 million hours of unpaid care each year. If one were to give a value to the care provided by these informal caregivers, the amount would total over \$4 billion.

In Missouri, 390,000 family caregivers provide 350 million hours of unpaid care to individuals with Alzheimer's. This unpaid care is valued at \$4 billion.

ACCESS TO CARE

LACK OF GERIATRIC DOCTORS

There is a current shortage of geriatricians—doctors who specialize in the care of older adults—and that shortage is expected to grow dramatically in future years. It is estimated that each geriatrician can care for approximately 700 patients. In 2007, there were 7,128 physicians certified as geriatricians (one for every 2,546 older adults). It is predicted that 36,000 geriatricians will be needed in 2030, but that the number will only grow to 7,750 (one for every 4,254 older adults). Some believe that current trends suggest that the number of geriatricians could even decrease over time.³⁴

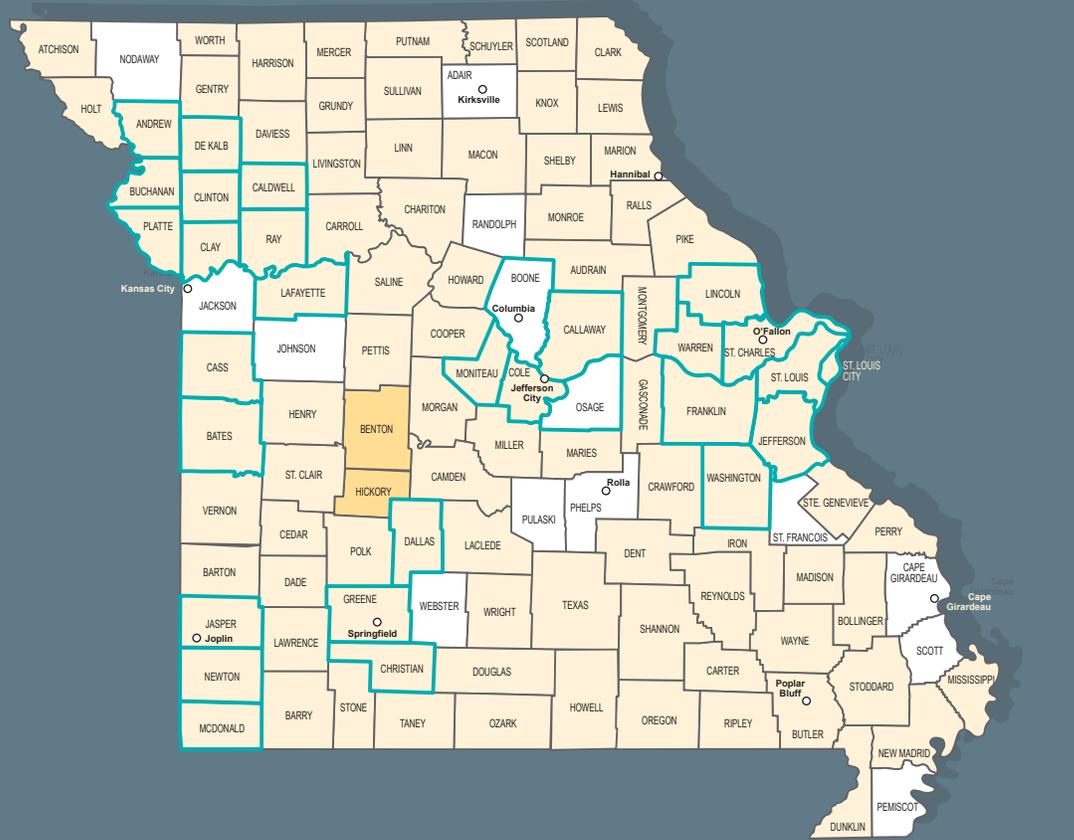
This shortage of geriatric specialists extends to other medical fields as well. There is currently one geriatric psychiatrist for every 11,372 older adults. By 2030 that number is predicted to rise by less than 100, meaning only one for every 20,195 patients.³⁵ Geriatric specialties in other fields are low as well: only 4 percent of social workers and less than 1 percent of physician assistants.³⁶

It is certainly viable that other health care professionals, not just geriatricians, have the capacity to treat older adults. There are concerns, however, that medical

Older Adults

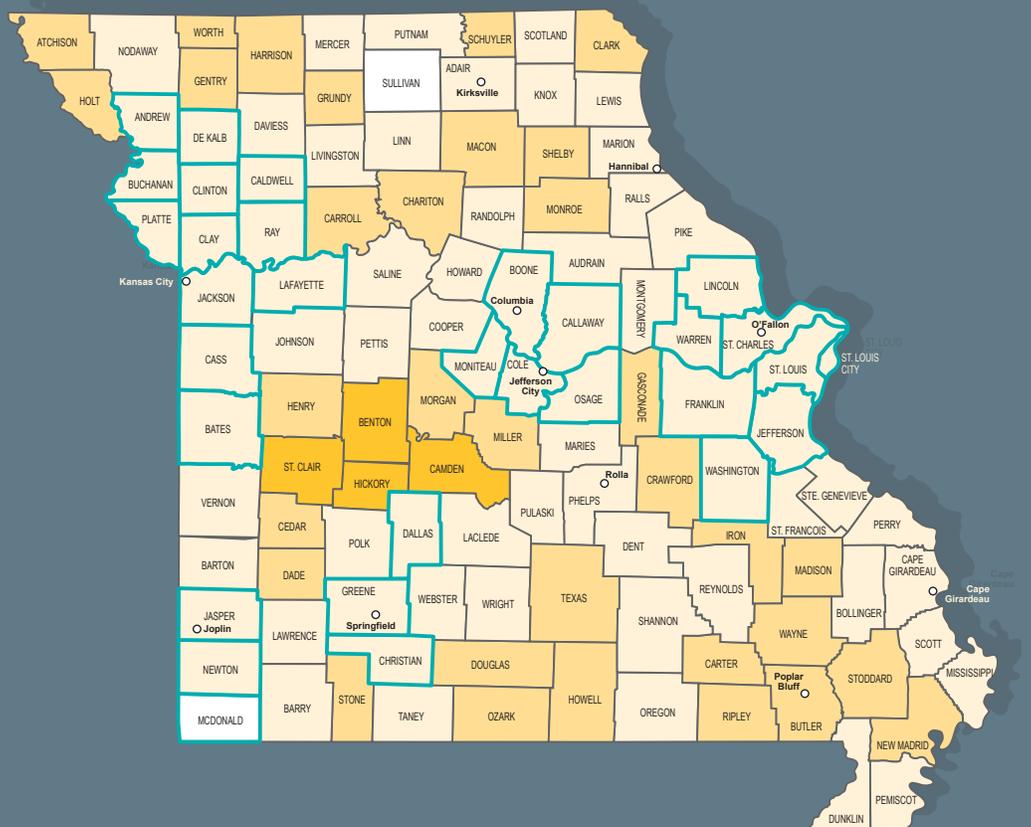
AS A PERCENTAGE OF THE POPULATION

2010



2030

(PROJECTED)



- 5.0 – 15.0%
- 15.1 – 25.0%
- 25.1 – 35.0%
- > 35.1%

RURAL COUNTY

URBAN COUNTY

training across the board lacks a sufficient amount of geriatric care education. A 2007 American Association of Medical Colleges survey of graduating medical students found that only 23 percent of students strongly agreed that they were exposed to expert geriatric care. Less than 1 percent of registered nurses and pharmacists are certified in geriatrics.

In 2011, the number of certified geriatricians in Missouri was 139. Assuming that only the most vulnerable older adults need to be treated by a geriatrician (30 percent of the total older adult population), the projected number of geriatricians needed in 2030 would be 558.³⁷

RURAL RESIDENTS

Rural Missouri suffers from a shortage of providers across all areas of health care. While 37 percent of Missourians reside in rural counties, only 18 percent of the state's primary care physicians are located there. The federal government designates an area as a Health Professional Shortage Area (HPSA) where there is one physician or less for every 3,500 people. Twenty-nine rural Missouri counties qualify as HPSAs. Additionally, the Office of Primary Care and Rural Health reports that 75 rural Missouri counties either have no dentist or fall below the federal standard of one dentist for every 3,000 residents.

The alarming nature of these provider shortages is compounded by the fact that rural Missouri counties are projected to account for a larger percentage of older adults than urban Missouri counties in the decades to come. As rural counties age, and older adults need more services, the shortage of providers will be more acute than ever before.

TRANSPORTATION

Transportation is often assumed to be a rural-only problem. As mentioned in "Spotlight on Rural Missouri" on the next page, transportation can certainly be a major challenge for older adults when trying to access

health care services. The distance individuals must travel, the scarcity of health care providers, and a lack of public transportation all contribute to transportation challenges in rural Missouri.

The lack of reliable transportation can be a barrier to health care access for urban residents as well. Despite the presence of public transportation, these options can be unaffordable, inconvenient, or otherwise difficult to navigate for some urban-dwelling older adults.

There are a variety of issues that can make transportation more complicated for older adults, including:

- Waiting at bus stops in extreme cold or hot temperatures,
 - Vehicles not equipped with wheel chair lifts,
 - Limited mobility impeding some seniors' ability to get from their house to the curb or bus stop, and
 - Bus stops potentially being a long walk from a final destination.
-

INTERSECTING IDENTITIES

No person can be defined by their age alone: each person has multiple identities that have the potential of affecting their health and health care access in many ways. We use the term "intersecting identities" to define when a person's various identities—age, gender, race, sexuality—meet and overlap. Health disparities experienced by older adults are often affected and magnified by their other identities. The following section discusses four identities that intersect with age: race, gender, sexual identity, and ability status.



SPOTLIGHT ON RURAL MISSOURI: PUTNAM COUNTY

Putnam County, population 4,979, lies in the middle of Missouri's northern border (2010 census). The percentage of Putnam County residents over age 65 is 21.8 percent, higher than the national average of 13 percent. Putnam County Senior Services provides daily meals to older adults living in Putnam County, both at the senior center in the county seat of Unionville, and delivered to the homes of older adults who are homebound.

PUTNAM COUNTY SENIOR SERVICES PREPARES AND SERVES 134 MEALS A DAY, 252 DAYS A YEAR.

Putnam County has a land mass of approximately 518 square miles, resulting in a population density of only 10 people per square mile. The distance between homebound older adults requires PCSS staff to travel many miles roundtrip each week to deliver meals. Lack of transportation is also a serious barrier to health care access for older adults who live long distances from doctors' offices and hospitals. OATS, Inc. is a non-profit transportation service that provides non-emergency medical transportation to individuals in 87 Missouri counties, including Putnam County. Older adults must schedule their trips in advance on one of only two available days per month for each destination (Kirksville or Centerville).

Women

The majority of older Americans, and older Missourians, are women. Life expectancy in the U.S. is 81.1 years for women and 76.3 years for men.³⁸ Since women—on average—live longer than men, women are more likely to face the health challenges unique to older adults. In 2011, Missourians over 65 years old included 56.8 percent women and 43.2 percent men. The gender breakdown for the projected population in 2030 is not expected to change drastically, with older women comprising 54.2 percent and older men comprising 45.8 percent of older Missourians.³⁹

Older women are more likely to live in poverty than older men. One reason for this is the likelihood that a woman will outlive her male partner and live in a one income house into her later years. Women in heterosexual relationships tend to marry men who are older than they are. Seven out of 10 baby boomer

women (born between 1946 and 1964) are expected to outlive their husbands, potentially resulting in a one income household for the widow.⁴⁰

Race and Ethnicity

Older adults of color experience even greater disparities relative to their health outcomes compared to other older adults. The Office of Minority Health reports that, in 2009, African Americans were 30 percent more likely to die from heart disease than non-Hispanic white men. African American men are more than twice as likely to die from prostate cancer as white men, while African American women are 40 percent more likely to die from breast cancer than white women (but 10 percent less likely to be diagnosed).⁴¹

The rate of cancer in older African American Missourians is greater than white Missourians (see table). Deaths among African American Missourians from heart disease and stroke are one-fourth to one-third higher than that

Gender Disparities in Rate of Poverty

AMONG OLDER ADULTS IN THE U.S.

2011



for whites, and rates were also higher for heart disease and stroke related hospitalizations.⁴²

The National Cancer Institute at NIH reports that cancer health disparities are multifactorial, but that the most obvious factors are lack of health care coverage and low socioeconomic status (SES). SES is a term used to describe income, education level, occupation, and other factors. Individuals from underserved communities are less likely to seek early treatment of cancer and are therefore more likely to be diagnosed with late stages of disease.⁴³

Death rates are another way to measure disparities in health status. From 2000 to 2004 the overall death rate for African American Missourians ages 65 – 74 was nearly

Lesbian, Gay, Bisexual, and Transgender (LGBT)

In 2011, the National LGBT Health and Aging Center released findings from the first federally-funded study to examine LGBT aging and health. A total of 2,560 LGBT adults from across the nation, ages 50 to 95, participated in the study.

An important issue highlighted by the study is the fear of accessing services that LGBT people experience due to their sexual identity. The study found that more than one in ten (13 percent) of LGBT older adults reported that they were denied health care or provided inferior care because of their sexual orientation, and 4 percent have experienced this discrimination three or more

2010 Cancer Registry Incidence

RESIDENTS OF MISSOURI

Age	White		Black/African American	
	Number	Rate	Number	Rate
65–74	7,590	1859.6	702	1962.8
75–84	5,386	2136.7	488	2524.7
85 and over	2,153	2027.7	162	2333.6

MICA data, Rates per 100,000

40 percent higher than for whites, and was 20 percent higher for those age 75 – 84. It is only at age 85 and older that death rates were nearly equal.⁴⁴

Older adults of color are also more likely to live in poverty, which can seriously compound health issues. In 2012, the Census Bureau reported that 7.9 percent of older whites live in poverty, while 18.3 percent of blacks and 7.9 percent of Hispanics live in poverty.

times in their life. Among the respondents, transgender older adults were much more likely to have been denied health care or received inferior care compared to other participants—40 percent of transgender respondents compared to 11 percent of lesbians, bisexual women and men, and gay men. Additionally, although there are available lists of LGBT-friendly health care providers, the study found that 8 percent of respondents stated that they even fear accessing health

care within the LGBT community. Overall, 15 percent of respondents fear accessing services outside the LGBT community.

In addition to barriers related to the access of health care, LGBT adults are more likely to face another risk to their health: violence and victimization. A 2010 survey of 459 LGBT St. Louis residents found 61.6 percent of respondents had experienced violence and victimization due to homophobia during their lifetime. Violence and harassment, in addition to being a health risk in its own right, can also lead to a victim being reluctant to access health care or supportive services for fear of experiencing a similar incident.⁴⁵

Older Adults with Disabilities

An intellectual disability is defined as one that originates before the age of 18 and which limits both intellectual functioning and adaptive behavior.⁴⁶ The term “developmental disabilities” describes disabilities that present before age 22, are severe and chronic, and can be intellectual or physical in nature.⁴⁷ Due to advances in medicine, individuals with intellectual and developmental disabilities (I/DD) are living longer, healthier lives than ever before. Subsequently, the portion of the population with I/DD age 60 years and older is projected to nearly double in size from 641,860 in 2000 to 1.2 million by 2030.⁴⁸ As a result, physicians and community agencies need to learn to identify and accommodate the unique needs of older adults with these conditions.

Due to their disabilities, limited access to adequate health care, and other compounding factors, adults with I/DD are more likely to develop chronic conditions than the general population. In addition, aging issues can be syndrome-specific. For example, an older adult with Down syndrome typically experiences health complications

such as accelerated aging in the form of conditions such as hearing loss, osteoporosis, hypothyroidism, and an increased risk of Alzheimer’s disease.⁴⁹ The need for additional training for physicians related to aging and I/DD has been on the national radar for more than a decade, but little improvement has been made.

More than one in ten (13%) of LGBT older adults reported that they were denied healthcare or provided inferior care because of their sexual orientation.

Another concern for the aging I/DD population is available care options in later life. Of individuals with I/DD, 75 percent live in a community without any formal disability services. Of the 25 percent that are receiving services, over half live with and receive care support from their families.⁵⁰ As adults with I/DD live longer and potentially outlive their parents or other family caregivers, alternative quality care options will be needed.

COST OF CARE

Although older adults make up only about 12 percent of the U.S. population, they account for approximately 26 percent of all physician office visits, 47 percent of all hospital outpatient visits with nurse practitioners, 35 percent of all hospital stays, 34 percent of all prescriptions, 38 percent of all emergency medical service responses, and 90 percent of all nursing-home use.⁵¹

Nearly all older Americans receive health insurance benefits through Medicare. Medicare is the federal health insurance program for individuals age 65 and

over, individuals under 65 with certain disabilities, and individuals of any age with End-Stage Renal Disease. Medicare beneficiaries included 40.4 million older adults in 2011.⁵²

According to the Congressional Budget Office, the Medicare budget is projected to nearly double in the next 10 years, from \$586 billion in 2013 to over \$1 trillion in 2023.⁵³ Despite its sizeable budget, Medicare does not cover all health care costs for enrollees, and beneficiaries have significant out-of-pocket expenses like co-pays and deductibles. Many Medicare beneficiaries are on a fixed income with modest assets. In 2012, half of all beneficiaries earned incomes of less than \$22,502 and had savings of less than \$77,482.⁵⁴ A 2012 study by researchers at Mount Sinai School of Medicine found that “as many as a quarter of Medicare recipients spend more than the total value of their assets on out-of-pocket health care expenses during the last five years of their lives.”⁵⁵

These substantial out-of-pocket expenses do not appear likely to decrease; rather the percentage of older adults’

income spent on health care is projected to rise. The Urban Institute estimates that annual out-of-pocket expenses for older adults will more than double between 2010 and 2040, from about \$2,600 to \$6,200 (in constant 2008 dollars), while household income will increase more slowly. Given the difference in the rate of increase between cost of care and income, the median share of household income spent on health care by older adults will increase from 10 to 19 percent by 2040.⁵⁶

THE COST OF LONG-TERM CARE

In addition to co-pays and deductibles, one of the greatest out-of-pocket costs for older health care consumers is long-term care, which is not covered by Medicare. Many are unaware that Medicare does not cover the cost of long-term care facilities (unless it is required for rehabilitative care, and then only up to 100 days). The largest share of long-term care costs is paid by Medicaid, the government-funded health insurance program for the poor, and only after an individual has spent nearly all of his/her personal assets.

Long-term care is a broad term representing medical and non-medical care that helps individuals with Instrumental Activities of Daily Living (IADLs) or Activities of Daily Living (ADLs). People may still be able to live independently who need help with a few IADLs (e.g., cooking, shopping, managing finances). Others requiring more intense care may need to move to a facility where they can receive more continuous help with their ADLs (e.g., bathing, toileting, eating). There are many community-based efforts to assist older adults with IADLs, with the goal of enabling them to remain in their homes and communities longer.

Current statistics show that approximately 70 percent of people over the age of 65 will require some kind of long-term care services during their lifetime.⁵⁷ AARP reports that the ratio of potential caregivers to adults over 80 will fall from 7-to-1 in 2010 to 4-to-1 in 2030 and less than 3-to-1 in 2050.

Average Costs of Care

ANNUALLY IN MISSOURI

Nursing Home	Single Room - \$58,035 Shared Room - \$52,830
Assisted Living	Private, one bedroom - \$27,450
Adult Day Care	\$18,200 (based on five days per week)
Home Health	\$41,184 (based on 44 hours per week)

While paid caregivers can supplement the help needed to keep older adults at home and in their communities, sometimes a decision is made that a person needs to live in a facility where he/she can receive around the clock care. The cost of such a facility is substantial; a shared room in a nursing home facility in Missouri costs an average of \$52,830 annually.

The cost of long-term care constitutes a disproportionate amount of Missouri's Medicaid budget. Older adults comprise only 9 percent of the state's Medicaid enrollees, but they account for 19 percent of Medicaid spending. The cost of receiving care at home is approximately one-third the cost of nursing home care. The state allows individuals to apply for a waiver to use their Medicaid funds at home. Home and Community Based Services (HCBS) waivers allow low-income older adults to receive a variety of health-related services in the home. Currently, Missouri's Consumer Directed Services (CDS) program grants HCBS waivers to older adults who are able to direct their own care, meaning that they have the cognitive ability to hire, train, and supervise their care attendants. However, HCBS waivers through the CDS program are not currently available in Missouri for older adults who are unable to direct their own care due to limited mental capacity, including dementia and Alzheimer's patients.

POLICY OPTIONS

There are many existing policies that attempt to address health disparities experienced by older adults, and there is room for additional policies as best practices become evident. Some key policy options are detailed below.

Physical Health

The physical and economic burden of chronic disease is something that must be addressed before the percentage of older adults in Missouri reaches its peak. As discussed, some risk factors for chronic disease are unmodifiable. Others risk factors, however, have the potential to be addressed by public health campaigns and community health initiatives.

The Better Choices, Better Health® Workshop is one popular example of an evidence-based chronic disease self-management program developed by Stanford University in which participants learn:

- 1 Techniques to deal with problems such as frustration, fatigue, pain, and isolation;
- 2 Appropriate exercise for maintaining and improving strength, flexibility, and endurance;
- 3 Appropriate use of medications;
- 4 Communicating effectively with family, friends, and health professionals;
- 5 Nutrition;
- 6 Decision making; and
- 7 How to evaluate new treatments.

Three risk factors that can be addressed are smoking, physical inactivity, and obesity. Missouri ranks in the bottom half of states for obesity, and the bottom third of states for smoking and physical inactivity; there is opportunity for improvement related to these factors.

In addition to preventing chronic disease, managing existing conditions must also be considered. Since chronic conditions can produce symptoms lasting for years, individuals can and must learn to manage and alleviate symptoms themselves through their day-to-day choices, behaviors, and habits. Physicians, community organizations, and support groups can aid individuals in these efforts and equip them with knowledge and action steps.

In 1996, over 1,000 individuals with chronic conditions participated in a study which measured the outcomes of the Better Choices, Better Health® Workshop. After three years, results of the study showed that workshop participants spent fewer days in the hospital and

demonstrated significant improvements in a number of areas, including exercise, cognitive symptom management, communication with physicians, self-reported general health, fatigue, and more.⁵⁹

Missouri has a history of implementing chronic disease self-management programs with federal grant dollars since 2010. In that year, the Administration on Aging awarded a grant to Missouri (along with 44 other states,

Puerto Rico, and the District of Columbia) to deliver evidence-based chronic disease self-management programs. The program—titled the *Communities Putting Prevention to Work: Chronic Disease Self-Management Program*—had 1,592 participants, and funding ended in March of 2012. Fifty-nine percent of participants were 65 years or older, and the rest were adults with disabilities.

A similar program was funded by Prevention and Public Health Funds that picked up where the previous program left off. *Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs* began in September of 2012 and will be funded through August 2015. As of March 2014, the program had reached over 1,100 Missouri adults.

Mental Health and Brain Health

As the home of several major research institutions, including the world-renowned Knight Alzheimer's Disease Research Center at Washington University, Missouri is in a unique position to be a world leader in Alzheimer's disease research. In 1987, the Missouri General Assembly voted into law the Alzheimer's Disease and Related Disorders Research Program. This program provided seed funding for local researchers to then subsequently attract larger grants from other sources. Between 1987 and 2005, the \$2.5 million invested in this program funded 120 research projects related to Alzheimer's and dementia and yielded over \$20 million in additional revenue. Funding for the program was cut in 2005 and has not been reinstated.

While working towards finding a cure for Alzheimer's disease is an important goal, the care of those currently facing the disease is also of the utmost importance. Currently, Missouri does not allow individuals with diminished mental capacity to take advantage of the CDS program HCBS waivers (allowing individuals to use Medicaid funds to receive services at home from the caregiver of their choice) because they are unable to manage their own care. Other states, however, allow individuals to use these services by having a family



Policy recommendations to address the physical health of older Missourians include:

- Continue to support and implement public health initiatives that target older Missourians and address the issues of smoking, physical inactivity, and obesity.
- Continue to pursue federal grants that support the implementation of chronic disease self-management programs. Identify best practices in these small-scale programs and implement them state-wide.

Policy recommendations to address the mental health and brain health of older Missourians include:

- Reinststitute funding for the Alzheimer’s Disease and Related Disorders Research Program, which has a demonstrated record of attracting federal and independent grant funds to Missouri while advancing research on these diseases.
- Allow Alzheimer’s and dementia patients to qualify for CDS HCBS waivers; assess other states’ programs for successful policies which include this population.



member or other caregiver represent them. As of 2007, there were 11 states that have consumer-directed programs serving individuals with dementia. Using these states’ challenges and successes as examples, Missouri would be free to craft its own policy regarding who could be the consumer’s representative, what kind of training they would need to receive, and what kind of quality assurance measures would be put into place. It costs less to care for people at home than in a facility, and many people wish to remain at home as long as possible.

Access to Care

Many older Missourians face barriers when attempting to access health care. The cost of care, including those expenses not covered by Medicare, such as co-pays and deductibles, can be more than many older adults are able to afford on a fixed income. While some very low-income seniors qualify for MO HealthNet, Missouri’s Medicaid program, others may have incomes that are just over the limit for this program. An older adult living alone must

make less than \$9,919 (85 percent of the federal poverty level (FPL)) in order to qualify for MO HealthNet.

One benefit available to older Missourians who do not qualify for MO HealthNet is the Medicare Savings Program. These programs are federally and state funded, and help older adults pay for their health care expenses. These programs do have income limits, but they are higher than that of MO HealthNet (135 percent of FPL vs. 85 percent of FPL).

Even if older adults are able to afford their care, geriatric health care professional shortages will exacerbate access issues in the future. There are many different health care professionals that interact with older adults, from social workers and nurses to doctors and specialists. As the population of older adults grows in the coming decades, it is essential that training in all health care fields includes the competencies necessary to accurately and skillfully treat older adults. Geriatricians, doctors that specialize in treating older adults, have very little

financial incentive to enter this specialty. In 2010, the median salary for a geriatrician in private practice was \$5,879 less than the average family physician, despite the fact that they train for at least one year longer than other primary care doctors.⁵⁹ Creating incentives for students to enter the specialty of geriatrics is important to prevent a severe shortage in the future.

Policy recommendations to address older Missourians' access to care include:

- **Maintain financial assistance programs for older adults such as the Medicare Savings Programs. Promote these programs to ensure full participation in the program by older adults in need.**
- **Create programs for loan forgiveness and scholarships for medical students who choose to become geriatric specialists.**

CONCLUSION

For many reasons, both biological and environmental, older adults are at risk for a wide variety of serious health challenges. Intersecting identities, such as race, gender, disability status, and others, can increase those risk factors. As the population of Missouri, the United States, and much of the world shifts to include a greater percentage of older adults, policies and services must be implemented to support the health needs of this demographic.

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