



AGING IN THE SAN JOAQUIN VALLEY: PRESENT REALITIES AND FUTURE PROSPECTS

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The Central California Institute for Healthy Aging acts as a catalyst for regional change to enhance the quality of life and physical, social, emotional and economic well-being of elderly residents in the Central California region, through research and evaluation, education, training and related community service activities, resource development, technical assistance and curriculum development.

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INTRODUCTION

This report presents an overview of the demographic, economic, health and social characteristics of the San Joaquin Valley's aging population. This report is a first step in describing the issues and concerns of the older population. In order to meet current needs and future demands, it is imperative that we understand the aging population and lay the framework for developing policies and programs to meet their needs. A major goal of this report is to raise awareness concerning the impact that an aging population will have on the families, seniors, and health and social service providers in the San Joaquin Valley. A second major goal is to gather recommendations to help guide policy makers, providers, and the public as we begin our efforts to understand the challenges and opportunities of an aging population.

The United States is experiencing an unprecedented aging of the population. For the first time in the nation's history, over 13 percent of the population is aged 65 or older. By 2050, 70 million Americans or over 20 percent of the U.S. population will be 65 or older. The older population in the United States is growing at a pace that is three times faster than that of the young. Life expectancy is also increasing; people who are 65 today can expect on average to live 18 more years (Federal Interagency Forum on Aging Related Statistics, 2000).

California is also experiencing unprecedented population shifts. The 2000 Census reveals that 3.6 million adults age 65 or older reside in California (U.S. Census, 2000 a, c). Even though this constitutes a small percentage of the population, California still has more older adults than any other state. It is estimated that by 2050, eleven million Californians will be over the age of 65 (Lee, Miller, & Edwards, 2003). By far the fastest growing segment of older adults in the state are those age 85 or older. Currently there are roughly 425,000 adults age 85 or older; by 2050 estimates indicate that there could be between 1.6 million and 2.7 million oldest-old (Lee, Miller, & Edwards, 2003). The oldest-old are most likely to experience physical and cognitive impairments and have lower incomes. These elders are also most likely to require nursing home care, medical treatment and home and community-based services.

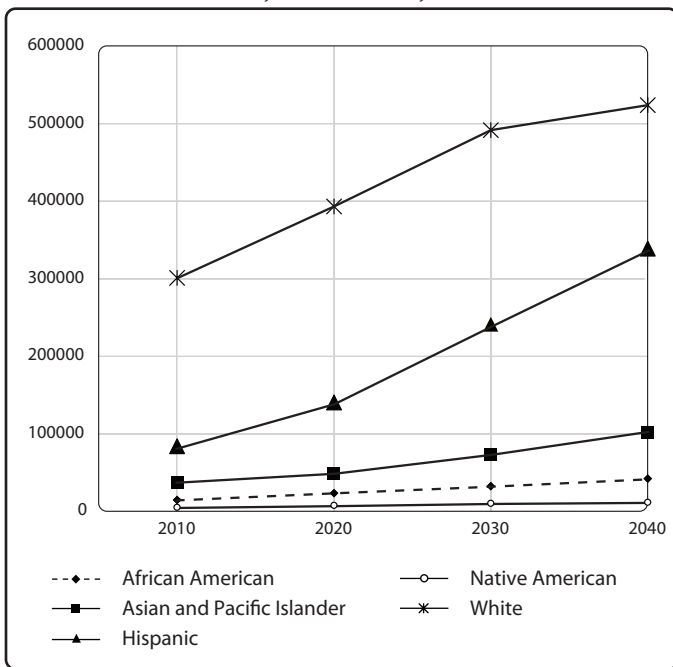
With respect to a racially and ethnically diverse population, California is also ahead of the national curve. Currently, about 70 percent of the elder population is non-Hispanic white; 40 years from now, over 50 percent of the elder population will consist of Hispanic and other non-white elders (Lee & Villa, 2000). The majority of non-white elders will be Hispanic. The state of California will need to continue to develop culturally appropriate and linguistically competent social and health care services. It is obvious the state of California, like the United States, has both sobering realities and exciting opportunities to consider in responding to the changing age profile of its citizens.

According to the 2000 Census, the population of the six-county Central San Joaquin Valley is 2,292,197. As one of the agricultural areas in the nation, the region is one of the most culturally diverse in the nation, with more than 70 ethnicities and 105 languages spoken. Along with this great diversity, 44 percent of residents in the Central Valley (totaling 998,960) are of Hispanic origin, compared with 32.4 percent statewide. While the Central Valley is predominantly rural, there are large urban populations, too.

CHARACTERISTICS OF CENTRAL VALLEY'S ELDERS

Elders 65 and older constitute 9.3 percent of the population in the San Joaquin Valley. Currently, there are approximately 335,505 elders (U.S. Census, 2005a-h) in the San Joaquin Valley. One-third of these elders are non-white, 17 percent are Hispanic, 7 percent are Asian and Pacific Islander, 2 percent African American and almost 1 percent Native American (CHIS, 2005). However, projections through 2040 indicate that Caucasians will be the slowest growing group of elders. Estimates based on the aforementioned racial/ethnic groups indicate that by 2040 there will be just over 1 million older adults who comprise 15 percent of the population. Caucasians will barely comprise half of the elder population (51 percent). Hispanics will comprise 33 percent; Asians and Pacific Islanders, 10 percent; African-Americans, 4 percent; and Native Americans 1 percent. Every county will experience at least a 350 percent increase in the growth of the elder Hispanic population; however, Kern and Stanislaus

Figure 1: Central Valley Population Projections:
65 and Over by Race/Ethnicity: 2010-2040



Source: Counting California (1998)

counties will experience an unprecedented increase, 469 percent and 435 percent, respectively. Stanislaus County will also have the greatest percent increase (425 percent) of Asians and Pacific Islanders. These projections use the most recent decennial census, and are based on past trends of fertility, mortality and migration as well as on assumptions of how these factors will develop in the future. Several projection scenarios are produced and the series using the middle assumption for each component is the most common. Figure 1 shows the growth in real numbers for the most populated ethnic/racial groups in the Central Valley.

Of adults age 65 or older in the Valley, 55 percent are female. Over half (56 percent) of all elders are married, approximately 40 percent are widowed, the rest have never been married (2.3 percent), or live with a partner (CHIS, 2005). Only 32 percent live alone. A significant proportion (28 percent) do not possess a high school education, 37 percent have a high school degree, 17 percent have some college or vocational training, 8 percent have a bachelor's degree and 6 percent have some postgraduate education or a graduate degree. Table 1 presents a demographic overview of county

rankings on population, living arrangements and poverty. California's 58 counties are ranked on population, living arrangements and poverty, providing a comparative look at how counties are performing relative to one another. Elders in counties ranking closer to the top on poverty and living alone are faring worse on average than elders in counties ranking closer to the bottom. However, there are fewer elders in counties with higher rankings on population (Indicators A and B). This table suggests that even though there are fewer elders in the San Joaquin Valley, more of them are living in poverty than in other California counties.

In the Central Valley, the challenges of serving the older population are compounded by rurality. In California, 15 percent of all elders reside in rural areas; however, 29 percent of all Valley elders reside in rural areas (CHIS, 2005). Elders in rural areas are more likely to have health care needs, nutritional risk, and higher incidence of chronic health conditions than elders in non-rural areas. Service use in rural communities is often hampered by geographic inaccessibility, lack of transportation, limited service availability and the inability on the part of older adults to pay for needed care. In short, elders who reside in rural areas have poorer access to care, poorer health status, and require greater levels of care compared to their urban counterparts (Porell & Miltiades, 2002).

INCOME AND POVERTY

Older people in the San Joaquin Valley face high rates of poverty, and this is notably true for non-whites. Nationally speaking, the current generation of elders has more disposable income than prior generations. Poverty among older Americans is at an all time low of 9.8 percent (Federal Interagency Forum on Aging Related Statistics, 2006). In California 11.5 percent of older adults are below the federal poverty level (CHIS, 2005). Although on the surface it appears that a small percentage of elder Californians are in poverty, a closer examination reveals that poverty rates are much higher for elders who reside in the Central Valley.

Out of the 58 counties in California, Tulare and Fresno counties are ranked 7th and 8th, respectively, as having the highest percentage of elders living below poverty. The Federal Poverty Level (FPL) is based on income thresholds

Table 1: County Rankings on Key Demographic Indicators

Indicators	Fresno	Kern	Kings	Madera	Merced	San Joaquin	Stanislaus	Tulare
% Population 65+	45	52	58	35	50	37	38	47
% Population 85+	39	52	57	46	51	33	36	41
% 65+ Live Alone	41	42	52	44	46	30	40	43
% 65+ <Poverty	8	16	19	11	15	22	28	7

Source: California Association of Adult Day Services (2002)

for different family sizes. For a married couple with a householder aged 65 or older in 2006, the poverty income threshold for 100 percent of the FPL was \$12,186 (U.S. Census Bureau, 2007). In the Central Valley, 17 percent of elders are below the FPL. Twenty-seven percent are considered near poor and are between 100-199 percent of the FPL. Fewer than 40 percent are classified as high income households and are at 300 percent or more above the poverty level. In contrast, 57 percent of elders in the Bay Area are at 300 percent above the FPL, and only 11 percent are below the FPL (CHIS, 2005).

Other elders may have considerable difficulty making ends meet. According to Wallace and Molina (2008), who have developed an index of basic costs of living for elders in California, “the federal poverty guideline, ...covers less than half of the basic costs experienced by adults age 65 and older.” For example, they estimate that an elderly couple in Fresno without a mortgage who are receiving an average Social Security payment would need an additional \$6,000 a year to meet their basic needs (www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=247). Older adults who rely primarily on Social Security and

Supplemental Security Income are the most financially vulnerable to economic change. Social Security is a federal retirement program. To qualify for Social Security as a worker, one must be age 62 or older, or disabled and be “insured” by having enough work credits. Social Security work credits are based on total yearly wages or self-employment income. Up to four credits can be earned each year. The amount needed for a credit changes from year to year. In 2005, for example, one credit was earned for each \$920 of wages or self-employment income. In California, the average annual income from Social Security for retired workers in 2004 was approximately \$1,003 a month, a dollar higher than the national average (Office of Research, Evaluation, and Statistics, 2007).

Almost 53,000 older adults in the Central Valley received Supplemental Security Income (SSI) payments from the federal government in 2005. SSI makes monthly payments to people with limited income and resources who are age 65 or older, blind, or disabled. SSI payments are not based on prior work history and are funded by General Revenue. In California, SSI recipients are eligible for Medi-Cal and food stamps. The average

Table 2: Social Security Recipients by County, 2005 (65 Years and Older)

County	OASDI Recipients	SSI Recipients	% of 65 or Older SSI Recipients	SSI Recipients Also Receiving OASDI	% of 65 or Older SSI & OASDI Recipients
Fresno	74,370	14,867	18.3%	17,255	21.3%
Kern	61,175	8,940	13.8%	14,529	22.4%
Kings	9,370	1,576	15.3%	2,328	22.6%
Madera	13,895	1,813	12.4%	2,505	17.1%
Merced	19,155	3,655	17.9%	4,730	23.2%
San Joaquin	55,410	8,559	14.2%	10,365	17.1%
Stanislaus	45,245	6,556	13.9%	8,694	18.4%
Tulare	34,670	6,820	18.7%	9,639	26.4%

Source: Social Security Administration (2005a) and Social Security Administration (2005b)

federal payment was \$515; this is supplemented by the California State Government and provides up to \$233 for eligible low-income seniors and \$568 to couples (Office of Research, Evaluation, and Statistics, 2007; California State Government, 2007). For many older adults this is a significant, if not the only, source of income. Older adults on Social Security may qualify for SSI payments if they are still below the federal poverty line. Almost 9 percent of Social Security recipients in Kern county also qualify for SSI. Fresno and San Joaquin counties have the lowest percentage (3 percent) of Social Security recipients who also receive SSI. See Table 2 for SSI and Social Security recipients by county.

LIVING & HOUSING ARRANGEMENTS

Housing arrangements also vary when comparing California's elders to the nation's older adult population. Nationally, 66 percent of older adults owned their home in 2000 (U. S. Census Bureau, 2000d). Homeownership rates are comparable in the San Joaquin Valley; most older adults own their own home. The lowest rates of homeownership are in San Joaquin and Tulare counties. Approximately 70 percent of older residents own their home. Over 80 percent own their own home in Fresno, Kern and Madera counties (CHIS, 2005). Homeownership does not differ significantly by race/ethnicity. Approximately 84 percent of Caucasian elders own a home, compared to 79 percent of elders from all other racial/ethnic groups. Elder Latinos have lower homeownership rates at approximately 70 percent. In general, older adults are more likely than younger adults to own homes built before the 1960s. These homes are more likely to need repair and the value of these homes is lower than the national average (Office of Policy Development and U.S. Department of Housing and Urban Development, 1999).

THE INTERPLAY OF MEDICARE AND MEDI-CAL

Dually eligible seniors are those seniors who qualify for both Medicare and Medicaid, known as Medi-Cal in California. One-sixth of the nation's dual eligibles reside in California (Fineman et al., 2005). Seven percent of Central Valley seniors rely on Medicare only; 67 percent have Medicare and supplemental insurance; 24 percent receive Medi-Cal and Medicare (CHIS, 2003). Given the poverty statistics, it is not surprising that out of the 58 counties in California, Tulare and Fresno counties are ranked 5th and 6th, respectively as having the highest percentage of dually eligible seniors (CAADS, 2002). The percentage of older adults receiving Medi-Cal ranges from 18 percent in Madera to 26 percent in Tulare.

Table 3: *Medi-Cal Recipients (65 Years and Older)*

County	Number of 65 or Older Medi-Cal Recipients	% of Total 65 or Older Medi-Cal Recipients	County Rank*
Fresno	19,099	24.1%	6
Kern	11,728	18.9%	28
Kings	2,168	22.7%	29
Madera	2,524	18.6%	18
Merced	4,725	23.6%	13
San Joaquin	11,381	19.0%	19
Stanislaus	9,529	20.4%	17
Tulare	9,175	25.5%	5
Total			
San Joaquin Valley	70,329		
California	681,211		

Source: California Association of Adult Day Services (2002)

*County Ranking is based on the 58 Counties of California

San Francisco county has more dual eligibles than any other county in California; 32 percent of seniors are dually eligible. The other counties in the Bay Area range from a low of 6 percent (Marin County) to a high of 21 percent (Santa Clara county). For county rankings of Medi-Cal recipients see Table 3.

In 2005, 80 percent of Central Valley seniors had some type of prescription drug coverage (CHIS, 2005). Since then, Medicare Part D was implemented on January 1, 2006 and was intended to help seniors save money on

Table 4: *Nursing Home Statistics, 2006 (San Joaquin Valley)*

County	No. of Homes	No. of Beds	No. of Residents	No. of Filled Beds	Accepts Medicare	Accepts Medi-Cal	No. Non-Profits Homes	No. For Profit Homes	No. of Gov. Homes
Fresno	37	3383	2990	88%	29	37	9	26	2
Kern	18	1743	1533	88%	18	17	4	12	2
Kings	3	322	268	83%	3	3	0	3	0
Madera	5	390	366	94%	5	5	1	3	1
Merced	10	686	630	92%	8	10	3	7	0
San Joaquin	29	2731	2444	89%	28	29	6	23	0
Stanislaus	20	2063	1879	91%	18	20	3	16	1
Tulare	16	1676	1426	85%	15	16	1	13	2

Source: U.S. Department of Health and Human Services. (2006a-h)

prescription drug costs. Many seniors were automatically enrolled, however, enrollment of low-income seniors (LIS) has been slow. Low-income seniors fall below 150 percent of the federal poverty level and are eligible for a subsidy to pay the cost of coverage under Medicare Part D. The characteristics of LIS eligible for extra subsidies include: non-English speaking elders, ethnic/racial minority elders, elders in fair or poor health, elders with cognitive decline and homebound elders. Many may not realize they are eligible for Medicare Part D. It is estimated that 9 percent of the 439,000 LIS in California reside in the Valley. Even after Part D implementation, more than 25 percent of seniors do not have prescription drug coverage in some San Joaquin Valley counties. Enrollment may be in part complicated by the numbers of seniors who do not speak English. Thirty-seven percent of San Joaquin Valley seniors do not speak English well. Over half of Latino elders do not speak English well (CHIS, 2005).

Seniors in the Central Valley are in poorer health than their counterparts in other California counties. Half of California elders aged 65-79 have a disability caused by a long-lasting physical or mental condition. The corresponding number in the Central Valley is 56 percent. At ages 80 and older, 67 percent of Californians claim a disability, whereas 72 percent of San Joaquin elders have a disability. In the Bay Area, 42 percent of elders, ages 65 and older, are in excellent or very good health, while only 35 percent of elders in the Central Valley are in good health. The discrepancy is even more apparent when observing elders in fair or poor health. Thirty percent and 38 percent of Bay Area and Central Valley seniors,

respectively, describe themselves as being in fair or poor health (CHIS, 2005).

NURSING HOMES AND RESIDENTIAL CARE FACILITIES

Nationally, five percent of seniors ages 65 or older reside in nursing homes and/or residential care facilities. Across the state of California, 3 percent of seniors reside in nursing homes (Henry J. Kaiser Family Foundation, 2005). In the Central Valley, approximately 10,000 or

Table 5: *Residential Care Facilities, 2002*

County	Number of Providers	Number of People Being Served
Fresno	143	1,950
Kern	66	1,182
Kings	5	61
Madera	17	129
Merced	36	415
San Joaquin	80	1,797
Stanislaus	68	1,654
Tulare	53	868

Source: California Association of Adult Services. (2002)

2.8 percent of elders live in nursing homes (U.S. DHHS, 2006a-h). The majority of nursing homes in the San Joaquin Valley are for-profit homes. Out of the 37 homes in Fresno, 70 percent are for-profit. Many older adults who need indefinite long-term care, use Medi-Cal as the primary payer. In the San Joaquin Valley, every nursing home accepts Medi-Cal. The percentage of beds that are

filled ranges from a low of 83 percent in Kings County to a high of 94 percent in Madera County (U.S. DHHS, 2006c-d). The percentage of nursing homes that accept Medicare ranges from a low of 78 percent in Fresno County to a high of 100 percent in Kings and Madera counties. Medicare payments are primarily for skilled or rehabilitative nursing home care. On average, there are fewer filled beds in the Bay Area than in the Central Valley. The percentage of filled beds ranges from a low of 73 percent in Sonoma to a high of 93 percent in Napa. Unlike the Central Valley, not every nursing home accepts Medi-Cal. See Table 4 for a detailed comparison of nursing home types and insurance coverage accepted for the San Joaquin Valley and the Bay area.

There are also numerous residential care facilities (RCFEs) in the Central Valley. RCFEs assist with activities of daily living. Some provide limited medical care. Assisted living facilities, retirement homes and board and care homes fall under the category of an RCFE. Approximately 8,000 elders reside in the 468 RCFEs in the Central Valley; 24 percent of these elders are in Fresno County (CAADS, 2002). Across the state of California, approximately 130,500 elders reside in RCFEs (CAADS, 2002). For a count of RCFEs and elders served per county see Table 5.

Although relatives shoulder the lion's share of elder support, the government will need to continue to bear a measure of responsibility by maintaining a safety-net of entitlements, benefits and services for older adults. Meeting the health and long-term care needs of older adults is especially challenging given the fiscal conservancy and attempts by the federal government to control spiraling Medicare and Medi-Cal costs. Health care reform and managed care will continue to have a dramatic impact on the shape and form of needed services for vulnerable populations. The state of California will face difficult choices regarding the financing of long-term care.

ADULT DAY AND DAY HEALTH CARE PROGRAMS

There are two types of day programs for older adults in California. Adult day care programs are community-based and provide personal care and assistance to older adults who have difficulties with activities of daily living. Adult day health care centers are licensed by the California

Department of Health Services and are certified by the Department of Aging for Medi-Cal reimbursement. The programs provide a variety of health, therapeutic

Table 6: *San Joaquin Valley Adult Day Programs*

County	Adult Day Health Care	Adult Day Care
Fresno	9	21
Kern	3	28
Kings	n/a	5
Madera	n/a	5
Merced	2	6
San Joaquin	2	23
Stanislaus	2	9
Tulare	1	12

Source: California Department of Aging. (2006)

and social services in attempt to delay nursing home placement. Eighty-five percent of the day programs in the San Joaquin Valley are adult day care programs. The majority of adult day health care centers are in Fresno county. Kings and Madera Counties do not have any adult day health care centers and Tulare County only has one. Kings and Madera Counties only have five adult day care programs (CDDS, 2003 a-h). For the number of programs per county see Table 6.

IN-HOME SUPPORTIVE SERVICES

In-home supportive services (IHSS) provide services to eligible low-income older, blind and/or disabled

Table 7: *Annualized County Distribution of IHSS* Recipients, 2003 (San Joaquin Valley)*

County	Total IHSS	IHSS per 1,000 Population	IHSS Hourly Wages and Benefits
Fresno	13,183	16	\$9.80
Kern	5,211	7	\$8.55
Kings	1,506	11	\$8.60
Madera	1,602	12	\$7.50
Merced	3,000	13	\$8.10
San Joaquin	6,221	10	\$9.53
Stanislaus	5,271	11	\$8.85
Tulare	2,896	8	\$8.10

Source: Legislative Analyst's Office. (2007)

*In-Home Supportive Services

persons who are unable to live alone without assistance. Typical services provided can include housework; meal preparation; personal care services, such as bathing, dressing, grooming, ambulation; and medical transportation. Elders who rely on IHSS may delay nursing home placement. Hourly wages for IHSS workers range from a low of \$7.50 in Madera to a high of \$9.80 in Fresno. Only 14 counties in California have higher wages than Fresno. Paying providers above minimum wage helps ensure that elders receive needed services. IHSS recipients in Fresno receive more service hours than IHSS recipients in any other county. The average hours per case in Fresno is 101. The average hours per case in California is 84. Fresno County averages 11,000 monthly cases (LAO 2007). An annualized county distribution of IHSS recipients is found in Table 7.

OLDER VALLEY SENIORS AS RESOURCES

Although many older adults develop new roles after retirement, some continue to contribute to the labor force. Recent changes in federal policy should encourage higher numbers of older adults to seek employment. In April of 2000, former President Clinton signed into law the repeal of the earnings limit for Social Security beneficiaries between the ages of 65 and 69. No longer will beneficiaries in that age bracket be penalized for remaining in the work force. That group can continue to remain employed full time and still collect the full amount of their Social Security benefits. Workforce

participation among older adults has been steadily climbing since the 1980s. According to the Bureau of Labor Statistics, some 23 million (or 37 percent) 55-plus Americans are now working. In the San Joaquin Valley, approximately 20 percent of men and 10 percent of women continue to work full or part-time after age 65 (CHIS, 2005).

Many older persons provide invaluable support to their families. One example is the growth of grandparent-headed households. Nationally, 2.4 million grandparents are raising their grandchildren in the absence of the children's parents. In California, almost 295,000 grandparents live in multigenerational households, and of these households, 25 percent of the grandparents are solely responsible for raising their grandchildren (U.S. Census, 2000c). In Fresno, almost 11,000 grandparents live with their grandchildren; of these families, almost 4,300 have sole responsibility for their grandchildren (U.S. Census, 2004). Thirty-eight percent of these families are in poverty, 60 percent of the grandparents are married, and less than 30 percent are retired (U.S. Census, 2004). Most grandchildren reside with their grandparents due to their parent's inability to provide care for reasons such as divorce, substance abuse, mental health problems, incarceration and poverty. Grandparents raising grandchildren face various obstacles including the possibilities that retirees may not be financially prepared to raise another generation. Older grandparents may also have chronic illness and grandparents who are not legal guardians have difficulties placing their grandchildren on their health insurance and enrolling their grandchildren in school. Oftentimes, affordable housing that can jointly accommodate both younger and older generations is extremely scarce. See Table 8 for a listing of grandparents raising grandchildren by county.

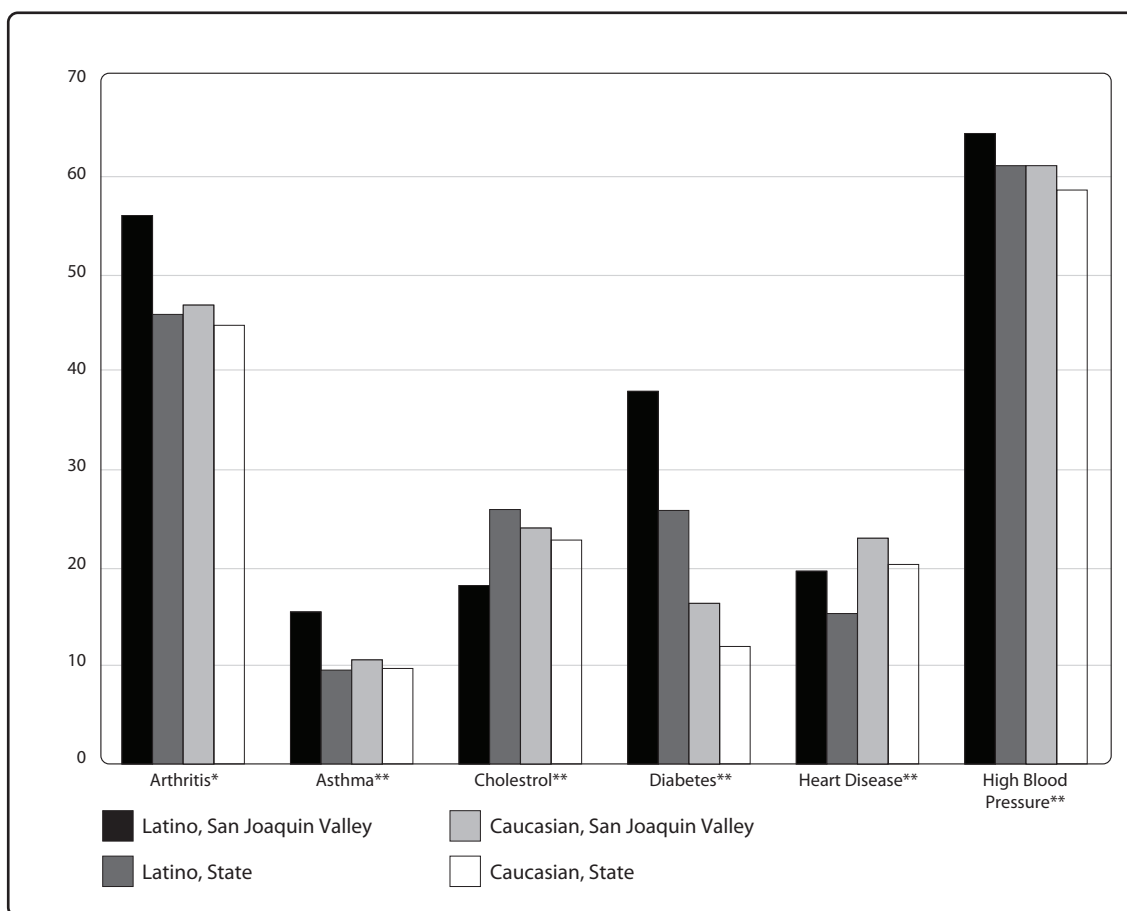
Table 8: *Grandparents Responsible for Grandchildren Under 18, San Joaquin Valley*

County	Number of Care Providers	Responsible Five or More Years
Fresno	9,433	3,589
Kern	9,427	2,835
Kings	1,734	821
Madera	1,254	337
Merced	2,704	539
San Joaquin	6,807	2,134
Stanislaus	3,917	1,555
Tulare	4,307	1,464
Total Central Valley	39,583	13,274
United States	2,458,806	912,011

Source: U.S. Census Bureau. (2005 a-h)

LATINO ELDERS

Given that 23 percent of the elders in the San Joaquin Valley are Latino, and that the Latino group is the fastest growing, it is imperative to consider the demographics of the Latino population. In general, Latinos in the Central Valley have fewer economic resources than their white counterparts; however, Latinos in the Central Valley are also more disadvantaged than Latinos who reside outside

Figure 2: Chronic Disease in the Latino and Caucasian Elder Population

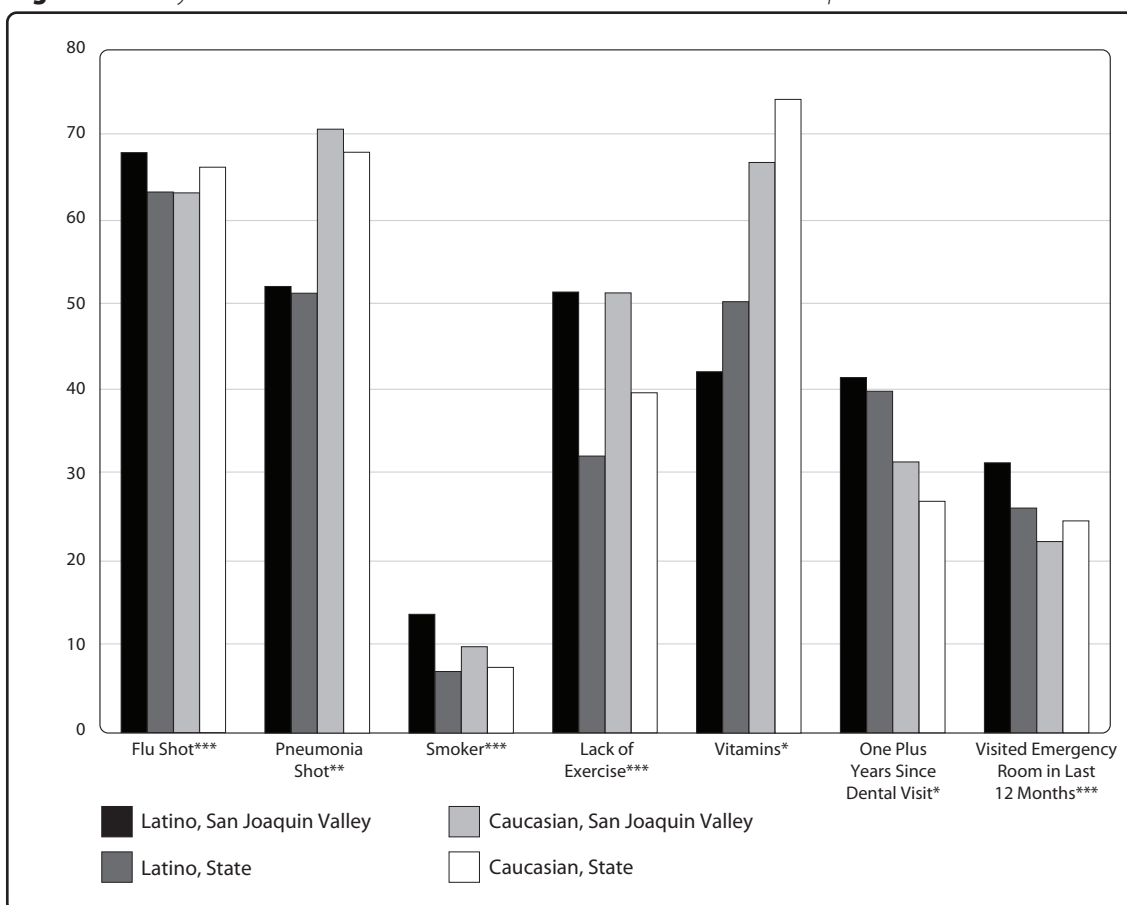
Source: *California Health Interview Survey (2001) **California Health Interview Survey (2005)

the Central Valley. A significant number (46 percent) of elder Latinos in the Valley are between 0-99 percent of the Federal poverty level, compared to 39 percent of non-Central Valley Latinos. Food insecurity is another issue that elder Valley Latinos face, 36 percent have difficulty affording food, whereas 21 percent of non-Valley Latinos cannot afford food (CHIS, 2005).

Central Valley elder Latinos are in poorer health than their non-Central Valley counterparts and Caucasian Central Valley elders. Fifty-seven percent of Central Valley Latinos report fair or poor health, compared to 34 percent of Caucasian Central Valley seniors and 52 percent of California Latinos. They make more frequent use of emergency rooms than California Latinos. One-third of Central Valley Latinos have visited an emergency room within a year's time period. Almost one-third require special equipment or someone to assist them

with activities of daily living. Only 18 percent of other California Latinos require such assistance. Fifty-three percent are covered by Medi-Cal compared to 45 percent of Latinos throughout California.

Diabetes is one of the most pressing health concerns facing elder Valley Latinos; Forty-four percent have been diagnosed with diabetes as compared to 30 percent of elder Latinos across the state of California (CHIS, 2005). Only 19 percent of Caucasians in the Valley have a diagnosis of diabetes. Heart disease is the second most pressing health issue; 23 percent of elder Valley Latinos have heart disease compared to 18 percent of non-Valley Latinos. Asthma is yet another health issue faced by 18 percent of Central Valley Latinos, compared to 11 percent across the state (CHIS, 2005). Figure 2 contains detailed information on health and chronic diseases.

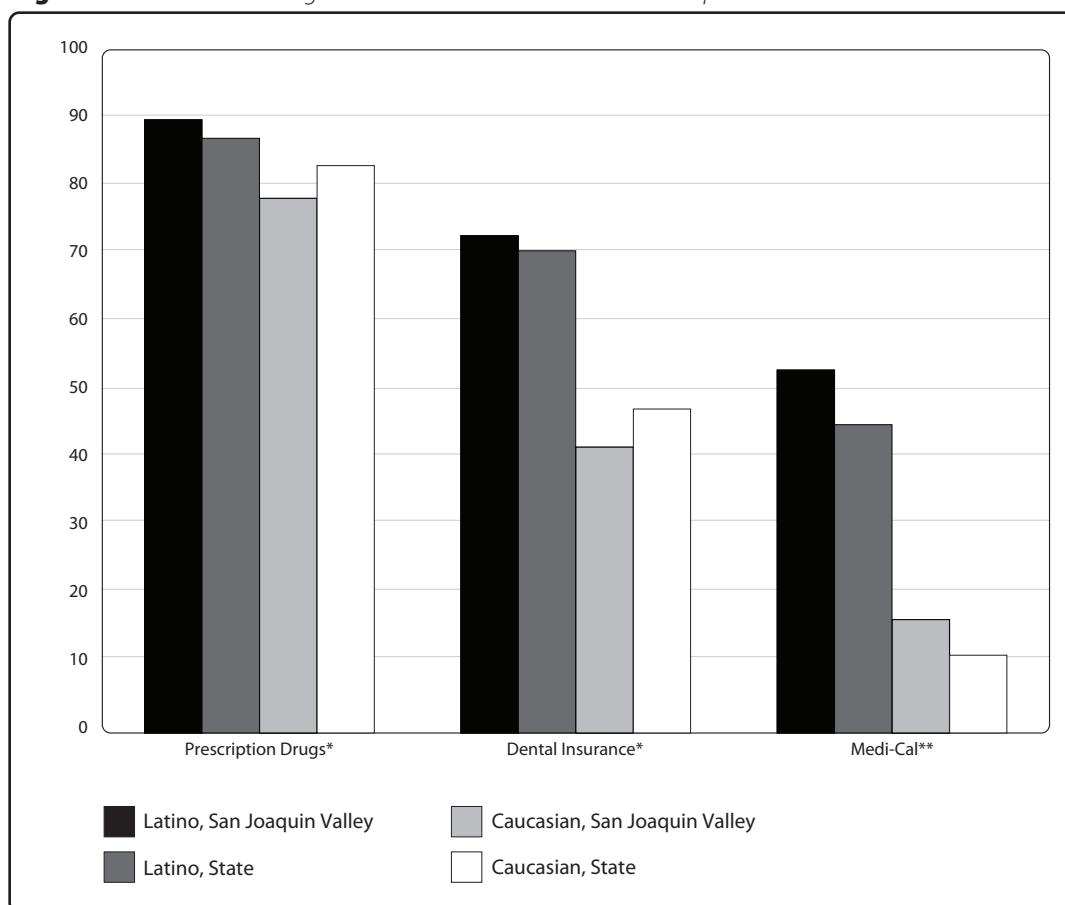
Figure 3: Lifestyle and Preventive Behavior in the Latino and Caucasian Elder Population

Source: *California Health Interview Survey (2001)
 **California Health Interview Survey (2003)
 ***California Health Interview Survey (2005)

Rates of preventive care and healthy lifestyle behaviors for Central Valley elder Latinos are similar to rates for elder Latinos across the state. However, when compared to Central Valley elder Caucasians, elder Latinos in general have lower rates of preventive care and higher rates of unhealthy lifestyle behaviors. Although flu shot rates are similar at about 65 percent, the percentage of Caucasians receiving pneumonia shots is 20 percent higher than rates for elder Latinos. Sixty percent of elder Latinos do not participate in physical exercise, compared to 43 percent of Caucasian elders. Caucasian elders are less likely to utilize emergency rooms and more likely to visit a dentist on a regular basis. Whereas two-thirds of elder Caucasians in the Valley take supplemental vitamins, only 42 percent of elder Latinos do. Elder Latinos will visit another country for health care (7 percent), most often Mexico, whereas elder Caucasians receive their medical care in the

United States. Figure 3 contains detailed information on preventive and lifestyle behaviors (CHIS, 2005).

Over half of elder Latinos in the Valley are covered by Medi-Cal. The Medi-Cal program provides a set of basic services, including hospital inpatient and outpatient care, skilled nursing care, doctor visits and laboratory tests. California also covers many optional services, including prescription drugs, dental and eye care. Thus, the majority of elders (90 percent) have prescription drug coverage and over 70 percent have dental insurance. Only 63 percent have their eye examinations covered (CHIS, 2005). See Figure 4 for a comparison of insurance coverage.

Figure 4: Insurance Coverage in the Latino and Caucasian Elder Population

Source: *California Health Interview Survey (2003)

**California Health Interview Survey (2005)

SOUTHEAST ASIAN ELDERS

Almost two million Southeast Asians live in the U.S.; more live in California than any other state (Niedzwiecki, & Duong, 2004). Southeast Asians predominately come from Laos, Thailand, Vietnam and Cambodia. People from these countries suffered through the Vietnam War and experienced resettlement as refugees in America. Many of the former soldiers who were middle-aged when they came to the U.S. in the 1970s and 1980s are now elderly. In addition, in 2004 more than 5,000 new Hmong refugees resettled in California from the Wat Tham Krabok Camp in Thailand, several hundred of whom were older than 65. These Hmong and Lao elders have a high incidence of mental illnesses, with Post-Traumatic Stress Disorder and depression reported to be 10 times higher than among similar populations in Thailand (The California Endowment, 2006a).

In the Central Valley alone, there are an estimated 80,000 Hmong (The California Endowment, 2006b) and over 15,000 Lao (Niedzwiecki, Yang, & Earm, 2003). Although the Central Valley has the largest concentrated population of Lao and Hmong refugees in the United States, there are no medical or social services targeting mental health issues in these populations (The California Endowment, 2002). Additionally, there are very few health care providers who have a cultural and linguistic understanding of these communities. There is only one Hmong physician who is still in residency training and one dentist in the Central Valley (Esparza, 2005). The only Adult Day Health Care Center for Hmong and Lao in the Central Valley operates four hours a day during the week. It is not surprising then that a recent study found that mental health needs were identified by Hmong in the Central Valley as being one of their most pressing issues (Yang, 2003).

A high percentage of Hmong (71 percent) and Lao (63 percent) elders are disabled. A third of Hmong and 23 percent of Lao elders live in poverty. Since over 95 percent reside in family households, they are critically dependent on their younger family members for their well-being (Niedzwiecki et al. 2003). However, although both cultures respect their elders, family members are also refugees and may be burdened by the process of adapting to Western culture and assisting dependent family members. Due to cultural beliefs and lack of familiarity with the Western medical system, family members may not understand the medical implications of later life illnesses, or have the knowledge about, or resources to seek treatment for older family members. Finally, these elders are often isolated due to lack of acculturation, language and transportation, increasing the risk of health disparities (Kue, Redo, & Yang, 1995).

AFRICAN AMERICAN ELDERS

Information on African-American elders was obtained through the California Health Interview Survey (2001). Most of the information was statistically unstable, therefore only a few key demographics can be reported. Sixty percent of older African-Americans report a yearly income level of \$5,000 to \$20,000; most of these householders are female. Almost 60 percent report fair or poor health; Over 70 percent of women report such poor health. A significant number of these elders also report chronic and debilitating health conditions. The majority (74 percent) report arthritis, 67 percent have high cholesterol and over half report diabetes. It is of

importance to note that the percentage of older African-Americans with these health conditions is significantly higher than their Latino and Caucasian counterparts.

LEADING CAUSES OF DEATH

The leading causes of death among elders 65 and older in the San Joaquin Valley are similar to the death rates in California and nationally. The leading cause of death for all races/ethnicities, except American Indians in the Valley, is heart disease. Forty-percent of African-Americans die from diseases of the heart compared to 29 percent of American Indians. Cancer is the second leading cause of death, except for American Indians where it is the first. Asians and Pacific Islanders have higher rates of death from strokes (11 percent), whereas American Indians have a higher percentage of deaths (17 percent) due to chronic respiratory disease. Latinos have a higher percentage of deaths due to diabetes (8 percent). For a

Table 10: *Causes of Mortality, California*
(Total California Population Over 65: 3,927,830)

Cause	Population Affected
Diseases of the Heart	284,707 (40.60%)
Malignant Neoplasms (Cancer)	186,902 (26.65%)
Cerebrovascular Diseases (Stroke)	77,792 (11.09%)
Chronic Lower Respiratory Diseases	56,400 (8.04%)
Accidents	36,478 (5.20%)
Diabetes Mellitus	28,078 (4.00%)
All Others	30,912 (4.41%)
Total	701,269 (100%)

Source: NCHS (2004b)

Table 9: *Causes of Mortality, San Joaquin Valley*

Cause	African American	American Indian	Asian or Pacific Islander	Hispanic or Latino	White	TOTAL
Diseases of the Heart	274 (40.2%)	17 (28.8%)	237 (34.3%)	709 (32.1%)	4907 (35.5%)	6144 (35.2%)
Malignant Neoplasms (Cancer)	144 (21.1%)	18 (30.5%)	140 (20.3%)	454 (20.5%)	2860 (20.7%)	3616 (20.7%)
Cerebrovascular Diseases (Stroke)	56 (8.2%)	2 (3.4%)	79 (11.4%)	184 (8.3%)	1232 (8.9%)	1553 (8.9%)
Chronic Lower Respiratory Diseases	36 (5.3%)	10 (16.9%)	32 (4.6%)	101 (4.6%)	1052 (7.6%)	1231 (7.0%)
Accidents	5 (.7%)	1 (1.7%)	22 (3.2%)	34 (1.5%)	243 (1.8%)	305 (1.7%)
Diabetes Mellitus	41 (6.0%)	2 (3.4%)	30 (4.3%)	180 (8.1%)	379 (2.7%)	632 (3.6%)
All Others	126 (17.6%)	9 (15.3%)	151 (21.9%)	550 (24.9%)	3149 (22.8%)	3985 (22.8%)
Total	682 (100%)	59 (100%)	691 (100%)	2212 (100%)	13822 (100%)	17466 (100%)

Source: NCHS (2004 a)

detailed comparison of mortality rates by race/ethnicity in the Valley see Table 9. The death rates for the state of California are in Table 10.

LIMITATIONS

The information for this report was drawn from multiple sources including government reports, private foundations, regional agencies and secondary data sources. Of note is that different sources presented conflicting information. This calls into question the reliability and validity of the information. Similarly, locating information on the older population in the Central Valley proved challenging. There are few research studies on the regions older population. Some of the information is outdated and therefore inaccurate and unreliable. Information in general was limited and not detailed. Information on ethnic and racial elders was limited, and for some groups non-existent. Furthermore, data collected by the CHIS is often statistically unreliable for ethnic groups and even for detailed analysis using the Caucasian population. Despite these limitations pooling multiple sources allows us to begin to understand the characteristics and needs of the older population in the Valley.

SUMMARY OF KEY FINDINGS

Changing Demography

There are two main demographic trends predicted for the aging population. First, there will be an exponential growth of elders between the years 2010 to 2040, from approximately 441,600 older adults to over 1,018,000 older adults. The fastest growing group will be adults ages 85 and older. Second, the older population will become increasingly ethnically and racially diverse. The fastest growing group will be elder Latinos.

Racial/Ethnic Health Disparities

Health disparities are readily apparent across racial/ethnic elders. As compared to their Caucasian counterparts, elder Latinos are more likely to have asthma or diabetes and less likely to use preventive services such as dental care. Elder Hmong have high rates of Post Traumatic Stress Disorder and depression. Almost 60 percent of African American elders are in poor health (CHIS, 2005).

Community Services

Given the rural nature of the Central Valley, in-home services are crucial in allowing older adults to remain independently in the community. A need exists to better advertise and market existing services. Diverse population needs call for bilingual and culturally competent service providers.

Health Services

There is an increasing need for health service providers. Some counties in the Central Valley do not have Adult Day Health Care Centers. With the exception of Kings and Madera counties, most nursing homes are at least 90 percent occupied. The occupations with the most job openings are in health fields and include RNs, nursing and home health aides and medical assistants. Home health aides, medical assistants and RNs are also the fastest growing occupations.

Emerging Trends; Grandparenting

About 9 percent of Central Valley elders are raising their grandchildren. Of these grandfamilies, approximately one-third have been together for five or more years.

Prescription Drug Coverage

Almost 40,000 elders in the Central Valley are identified as low-income seniors and qualify for subsidized Medicare Part D. It is estimated that 25 percent of Valley seniors do not have prescription drug coverage.

Employment and Volunteering

Older adults will continue to participate in the workforce. Approximately 15 percent of adults 65 and older are currently employed. Organizations seeking older volunteers face recruiting challenges. Outreach efforts targeting older adults and linking their assistance to improving local communities prove to be effective recruiting strategies.

STAKEHOLDER RESPONSE

On February 19, 2008, community leaders, advocates, organizational representatives and researchers met to review and discuss this report. They were asked to identify, based on their own experience in the field of aging, the most important findings/conclusions of the report. They also identified some of the commitments and strategies needed for building sustainable communities for

our elders. Lastly, the discussion groups addressed how to best connect academic and community efforts to improve the well-being of our elders.

Many common themes emerged from the discussion groups.

- A frequent concern among the community members was the paucity of data that currently exists on Central Valley elders. They discussed the need for longitudinal, in-person surveys to accurately depict the health status and well-being of the older population. They further noted the need to publicize such studies in order to highlight the disparity that exists, particularly among ethnic minority and immigrant groups in the Valley.
- Participants also identified the need for provider surveys. Provider surveys are seen as a way to better understand programs and services, as well as the population served. One concern is the under enrollment in programs such as Medicare Part D, Medi-Cal, SSI, IHSS and other similar serving programs. Participants stressed the need to network available resources and to develop outreach programs to underserved elders.
- Another common theme was the need for community engagement. This included the need to increase volunteerism in programs critically dependent on volunteers to provide services to seniors. Such programs include transportation programs, Meals on Wheels, and the Friendly Visitor program.
- Similarly, participants expressed the need for California State University, Fresno to collaborate with community agencies and local programs. Examples of collaboration include; using the Institute for Healthy Aging as a resource in grant writing, partnering on resource projects, and providing networking opportunities and open forums to discuss community issues on aging.
- Participants also identified service and programmatic needs in the community. Many of these needs reflect the rural nature of the Valley and the difficulty seniors experience accessing services due to geographic disparities. Lack of transportation services, the need for bilingual providers, affordable housing for low-income and homeless seniors, caregiver education and support,

training for emergency and police responders and services for grandfamilies were all identified as pressing concerns. It was noted that reputable service programs for some of the identified needs exist in other counties and states. These could be replicated. Additionally, it was pointed out that multiple funding streams create duplication of services. These services should be unified, so that programmatic growth can occur.

- Many participants stressed the need for advocacy on behalf of elders. Raising public awareness is a first step to creating a culture change, where elders are seen as valuable contributors to society and have the resources to age successfully.

RESEARCH RECOMMENDATIONS

This report identifies several gaps in the existing literature and knowledge concerning older adults in the San Joaquin Valley. Research in the following areas is needed in order to increase our understanding of the older population.

- A detailed population analysis of the older population
- Basic research on Asian/Pacific Islanders, South East Asian elders and African-Americans
- Research on the demands faced by grandparents raising grandchildren
- Research on immigrant elders and the process of adjusting to life in the Central Valley
- Research on the use of health and social services by elders, including emergency room use
- Research on economic well-being, retirement planning and long-term care planning by elders
- A community survey of health and social service providers, including estimates of unmet need and service adequacy
- Research on undocumented elders and migrant older workers

POLICY RECOMMENDATIONS

The following recommendations are based on the available data and may provide guidelines for policy

development and community-based research and organizational action.

- The continual aging of San Joaquin Valley residents and the increasing diversity of the older population is anticipated. Efforts to meet diverse social and cultural needs will improve quality of life and enhance elders capacity to productively engage with and contribute to society.
- Older adults should be viewed as integral to the functioning of society. Forthcoming generations of elders will be healthier and more active. Companies should consider policies and strategies to encourage employment, such as flex-time, job-sharing and part-time positions. Similarly, volunteer opportunities should be provided. It is estimated that older adults provide an average of 3.3 volunteer hours a week and older persons contribute approximately \$71.2 billion dollars of volunteer time nationwide (Saxon-Harrold, McCormack, & Hume, 2000).
- Policies created to assist elders benefit not only the older adult, but families and their caregivers. As such, policies should not be solely focused on vulnerable elders. A general policy of prevention is needed in order to improve societal welfare and strengthen the social and health care economy. Such policy should focus on preventive health care, nutrition and various retirement options.
- Increasing community-based and home-based care as an alternative to nursing home care or hospital stays will ultimately reduce long-term care costs. This strategy calls for creative designs in service products, delivery, agency partnerships and funding. Such an orientation to service provision will also be responsive to the overwhelming preference by older adults to remain in the familiar surroundings of their own homes and communities for as long as possible (Hooyman, & Kiyak, 2002).
- Transportation is a crucial issue for many older adults who may be forced to relinquish driving due to physical or cognitive health decline. Transportation in the San Joaquin Valley is even more difficult to obtain given the rural nature of the area. It is important to develop an individualized economically sustainable transportation service which allows older adults with health care needs to be transported efficiently and with minimal stress to health care providers and other agencies. As the need for transportation increases, multiple methods for service delivery and partnerships with nonprofit organizations should be explored.
- Policies and programs aimed at serving older adults who are geographically dispersed in rural areas will require innovative strategies. High-technology services delivered in the homes of older adults are becoming increasingly available. Providers of durable medical products and technologies can be expected to assume increased importance in the years ahead. Other technologies that are increasingly available include: personal emergency response systems, telemedicine and telehealth computer technology, home robotics and numerous other smart house applications. It is readily apparent that the boundaries between home and hospital are becoming increasingly blurred. However, the effective and efficient provision of these services require well-trained personnel able to insure that elders and their relatives are comfortable with and properly and safely use such technology. Other options for improving service delivery are likely to increasingly grow out of partnerships among nonprofit, public and proprietary organizations.
- Sophisticated community service networks that include formal service providers, nonprofit organizations, and the family must emerge to encourage comprehensive and reliable support for older adults in need. Policies and programs need to be implemented in response to the specific needs of elders. Services in health and nutrition, housing, income security, and social, cultural and leisure activities are all necessary for sustaining quality of life. Only the creative and innovative minds of well educated health and human service planners and providers will insure that services are soundly designed and delivered by organizational enterprises that are sensitive to consumer need while simultaneously being fiscally sustainable.

- Counties in the San Joaquin Valley need to develop a streamlined process to assess the needs of older residents and to identify services best suited to meet those needs. Centralized information and one-stop shopping is available through The Fresno County Network of Care but this award winning Web site needs to be expanded and continually updated. Additionally, many older adults do not have access to the Internet. One-stop shopping and assessment curtails costs and ensures that older residents receive appropriate services in a timely manner. The challenge of standardized assessment, of course, is to insure that such a process is adequately sensitive to the unique and personal situations, differences, and complications that often drive the need for service use. Additional challenges include networking social service and health care providers.
- In order to provide services for older adults, agencies will need an increasing number of workers and better training. To prevent turnover in long-term care and service facilities, employees must be offered competitive wages, salaries and benefits.

CONCLUSION

Overall, government and societal institutions have been slow to respond to the demographic imperative of an aging society. For the past 20 years, population forecasters have warned us to prepare for an aging population. Institutions of higher learning will certainly be pressed into service by the call for expanding numbers of well trained public administrators, health care managers, human service planners, nurses, and social workers needed to serve the older population. Shortages in some professions in the state are already severe (e.g., nursing, long-term care workers). Educators, alongside business leaders, health care providers, government officials and families need to prepare themselves for the elder cohort of tomorrow. The “new aged,” those entering later life now and in the future, will be an increasingly diverse population. Their diversity, economic, social and racial/ethnic will transform the societal institutions that have been established to meet the needs of an aging San Joaquin Valley. The health and human service sectors will be pressed to serve the dramatically rising number of elders and family members caring for frail elders. The Valley must prepare now to respond to the challenges of an aging San Joaquin Valley and create opportunities for elders to realize their full potential.

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