Assessing the Needs of Older Adults in the Greater Richmond Area: A Report to the United Way Services Older Adult Action Council and Older Adult Partnership

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Acknowledgements

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I. OVERVIEW OF PROJECT

United Way Services (UWS) of Greater Richmond/Petersburg is acutely aware of the growing needs of the older adult population. As the population ages the needs of older adults will only increase. Unfortunately, as compared to the two other UWS focus areas of children, youth, and families, and homelessness, there is not the same level of information readily available to inform strategies to address older adult needs. UWS, as part of their community indicators project, identified five impact goals for older adults. Attempts were made to identify indicators and data sources to monitor each. The impact goals and indicators are listed in Table 1.

Table 1 - UWS Older Adult Impact Goals and Indicators / Indicator Status in 2003

Impact Goal	*Indicator to Monitor Impact Goal*
1. Older adults are able to meet their basic needs.	Percent of people 65 years of age and older below the poverty line.
2. Older adults are as healthy as possible.	Number of fall-related injury hospitalizations for people 65 years of age and older.
3. Older adults have safe, affordable housing.	No data available for indicators related to this impact goal.
4. Older adults are socially and emotionally supported in the community.	Number of reported cases of abuse and neglect against people 60 years of age and older.
5. Caregivers will have the skills and supports needed to care for older adults.	No data available for indicators related to this impact goal.

Source: UWS. (January 2003) Community Conditions Report: Social Indicators for Greater Richmond and Petersburg

The purposes of this pilot project, funded by DataShare Richmond, were to 1) identify data that are accessible through existing data sources, 2) manipulate the existing data so its useful to the UWS staff and partners, and 3) develop a community survey instrument that could be used to collect data that are otherwise not available at the local level.

The UWS Older Adult Action Council (OAAC) and the Older Adult Partnership (OAP), both committees comprised of community stakeholders that are working toward assuring the health and well-being of older adults in the Greater Richmond area, will use the data generated through the pilot project to monitor the health and well-being of older adults in the community, identify the most pressing needs, and develop and support effective programs to address them. Ultimately, the data will be used to help prioritize funding decisions of the Older Adult Action Council for 2004-05 and used to inform the development and direction of the Older Adults Partnership, which seeks to mobilize the community around addressing system barriers impacting the lives of older adults in the Greater Richmond area.

II. STRUCTURE OF REPORT

This report includes data sections on the five UWS impact goals: 1) older adults are able to meet their basic needs, 2) older adults are as healthy as possible, 3) older adults have safe, affordable housing, 4) older adults are socially and emotionally supported in the community, and 5) caregivers will have the skills and supports needed to care for older adults. Efforts were made to compile and analyze data from publicly available data sets for the following localities: Charles City, Chesterfield, Goochland, Hanover, Henrico, New Kent, Petersburg, Powhatan, and Richmond City. Throughout this report, unless otherwise noted, these counties / cities are collectively referred to as the Greater Richmond area.[1] Following the data presentation, there is a section that contains a summary of findings and then a section on recommendations for future work by the UWS in the older adults focus area. The recommendations are derived from the use and analysis of the existing data sets.

[1] Petersburg is sometimes identified as being outside of the Greater Richmond area. In order to be consistent with localities identified in the United Way Community Conditions Report, Petersburg data were utilized in this pilot project. For purposes of brevity, Petersburg is considered within the Greater Richmond area.

III. OLDER ADULTS ARE ABLE TO MEET THEIR BASIC NEEDS

The first impact goal is that older adults are able to meet their basic needs. The UWS indicator for this impact goal is the percent of people 65 years of age and older below the poverty line. This section includes related indicators that can be applied to this impact goal. The data for this impact goal are derived from the decennial census and available through the United States Census Bureau's American FactFinder website.

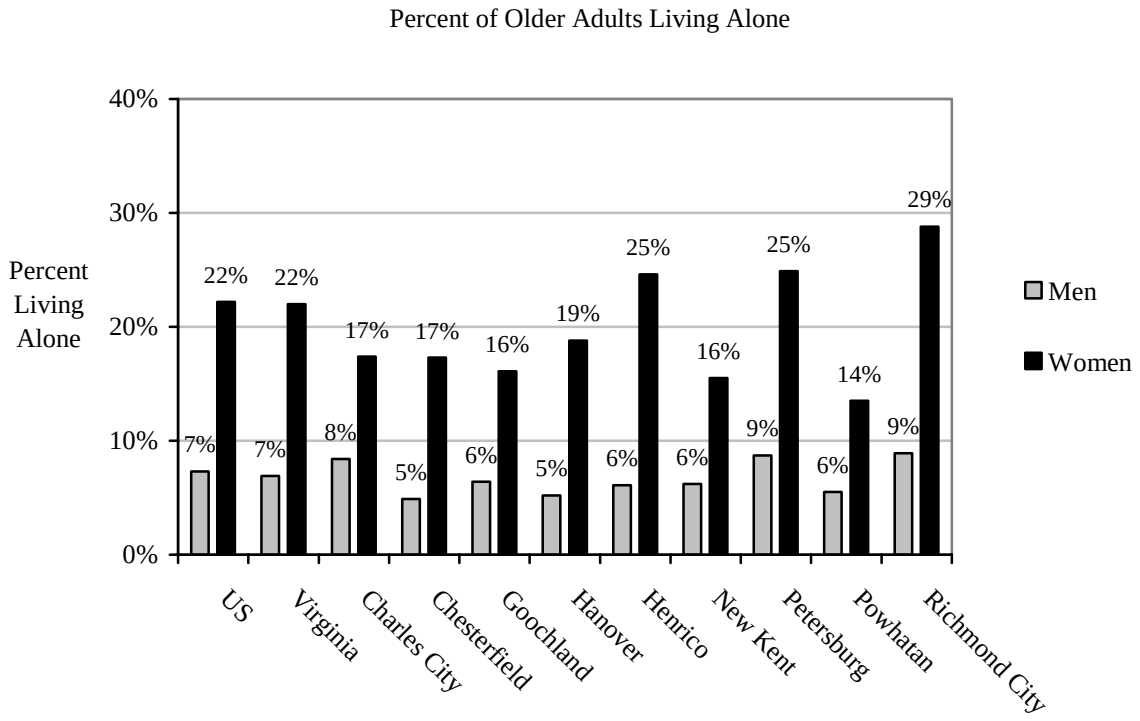
A. Decennial Census Data

1. Older Adults Living Alone. Across the nine counties and cities in the Greater Richmond area, between 21% and 36% of households contain one or more individuals 65 years of age and older.[2] However, not all older adults live with other people. Household structure can impact a person's well-being. Older adults that live alone can be at risk for reduced quality of life if there are co-existing conditions such as poverty, lack of vehicle availability, and/or illness, disease, or disability. Figure 1 illustrates the percent of older adults living alone by gender. The differences between the percent of men and women living alone are striking in all counties / cities within the Greater Richmond area; however, these findings are not dissimilar to those seen statewide and nationwide.

2. Poverty. UWS used decennial census data to describe the percent of older adults in the Greater Richmond area living below the poverty level, by county / city. The relationship between financial status and well-being and quality of life is well established and measures of poverty are clearly relevant to the impact goal of older adults being able to meet their basic needs.

2 Census 2000. Table DP-1. Profile of General Demographic Characteristics.

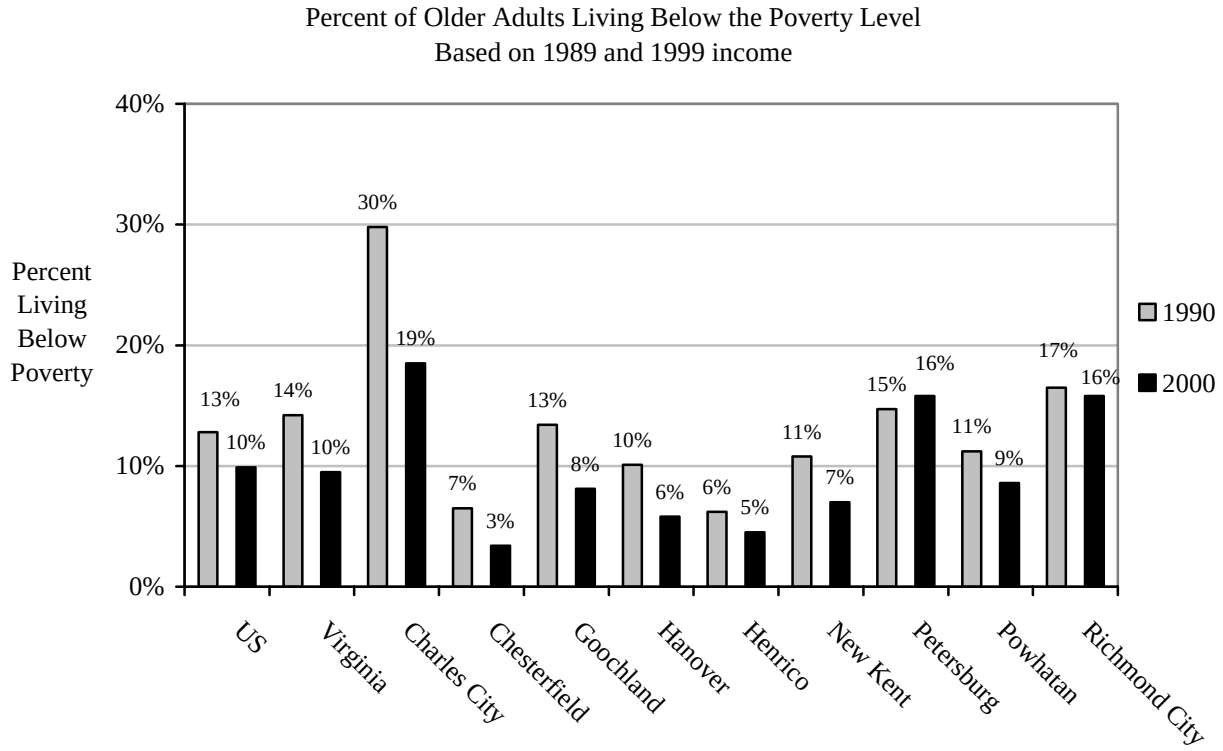
Figure 1 - Older Adults Living Alone



NOTE: Limited to older adults 65 year and over.
SOURCE: Census 2000. QT-P11 (SF1).

The percent of older adults living below the poverty level in the Greater Richmond area range from a low of 3% in Chesterfield County to a high of 19% in Charles City. It is encouraging that nationwide, statewide, and within counties / cities in the Greater Richmond area (with the exception of Petersburg City), the percent of older adults living in poverty has decreased during the past decade. Figure 2 illustrates this finding.

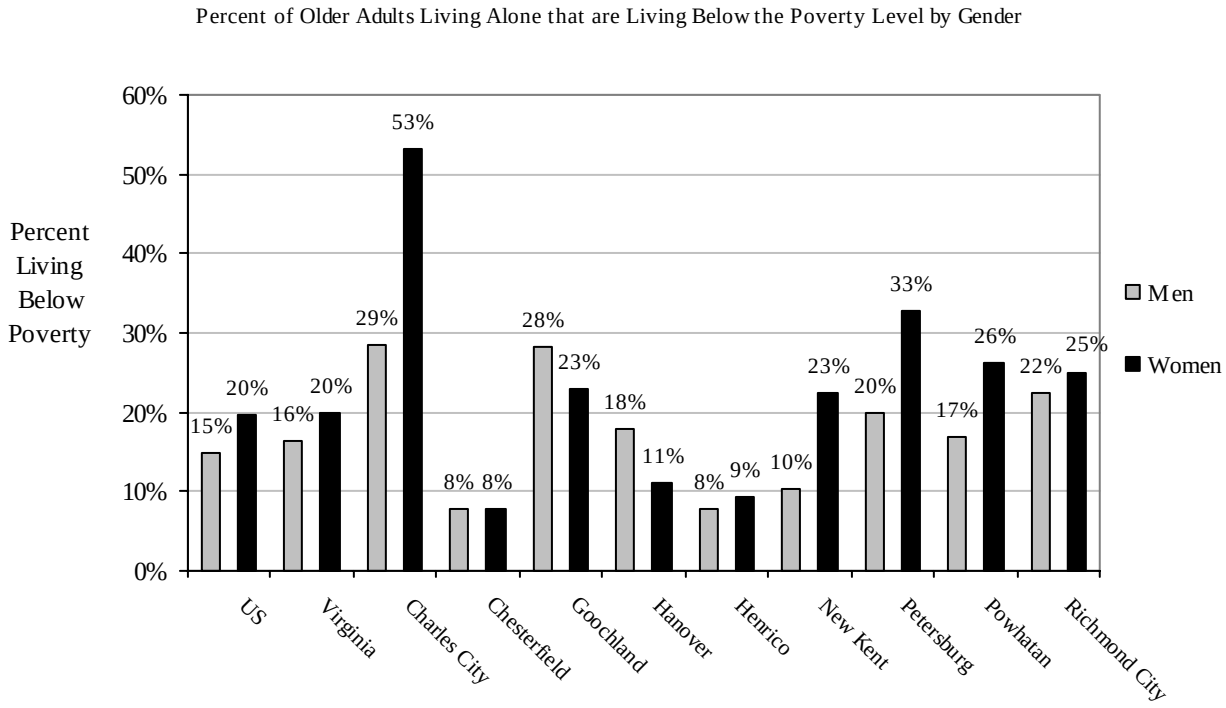
Figure 2 - Older Adults Living Below the Poverty Level (1990, 2000 Comparison)



NOTE: Limited to older adults 65 year and over.
SOURCES: Census 2000. QT-P34 (SF3) and Census 1990. DP-4 (STF3).

Disparities based on gender are not uncommon in today's society. Figure 3 illustrates the percent of men and women living alone in the Greater Richmond area that are living below the poverty level. In all cities / counties except Goochland, Hanover, and Chesterfield, a higher percent of older adult women living alone are living below the poverty level as compared to their male counterparts.

Figure 3 - Older Adults Living Alone and Living Below the Poverty Level by Gender

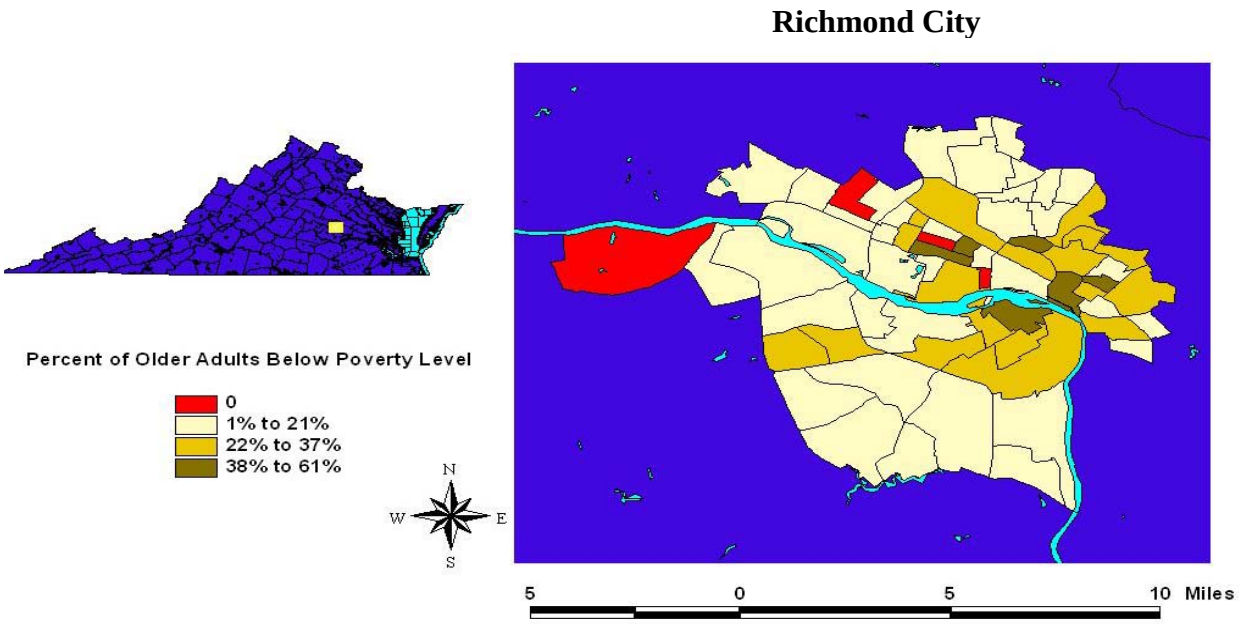


NOTE: Limited to older adults 65 years and over.
SOURCE: Census 2000. QT-P34 (SF3).

Finally, poverty at the sub-county / city levels can be explored. In Richmond City, 16% of older adults live below the poverty level. However, there are census tracts within Richmond City that have older adult poverty rates as high as 61%. Figures 4 through 12 illustrate census tract level poverty data for older adults in each of the nine counties / cities within the Greater Richmond area.[3] Figure 13 illustrates census tract level poverty data for the Greater Richmond area as a whole.

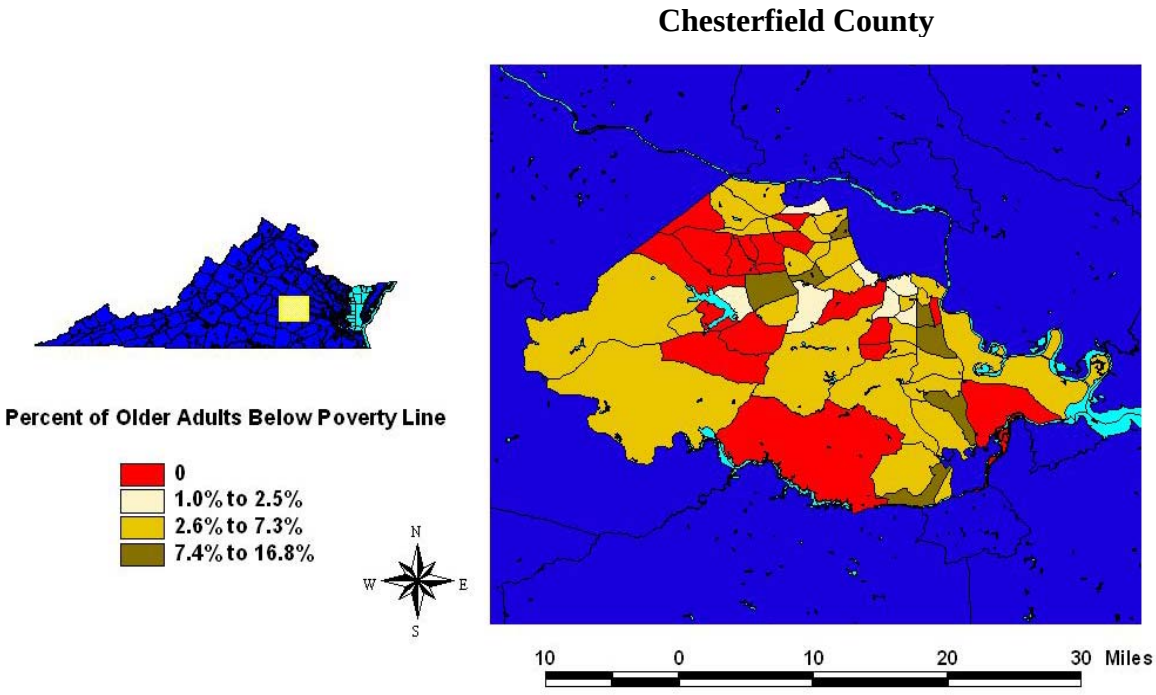
[3] Poverty data are derived from the decennial census long-form questionnaire that is sent to approximately one out of every six households in the United States. Census data estimates based on long-form data are less stable at lower levels of geography because of the reduced sample size. When limiting the analysis to older adults, the sample size is further reduced and the sampling error further increased. In some census tracts, it might appear that there are no older adults living below the poverty level. However, this should be interpreted cautiously because it might be the result of sampling methodology rather than the true socioeconomic circumstances of older adults. That is, the long-form questionnaire might have been sent to only households with individuals under the age of 65. This example applies, conceptually, to all long-form data (SF3, SF4) including that presented throughout this report with regard to telephone availability, vehicle availability, and disability.

Figure 4 - GIS Analysis of Older Adults Living Below Poverty (Richmond City)



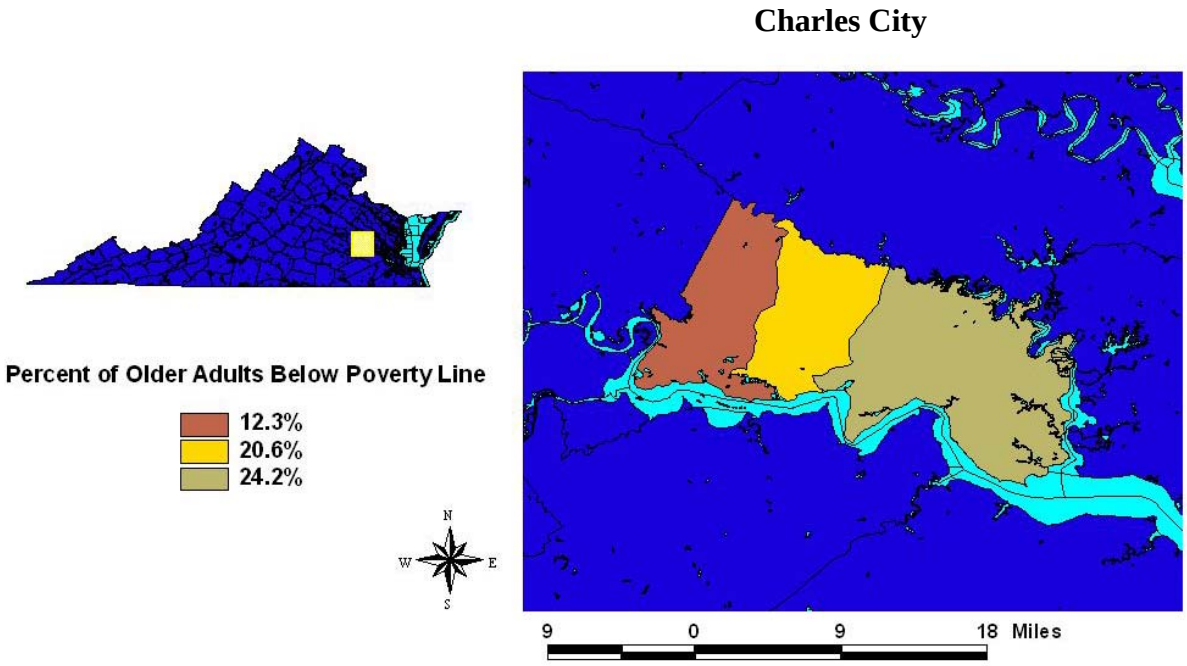
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 5 - GIS Analysis of Older Adults Living Below Poverty (Chesterfield County)



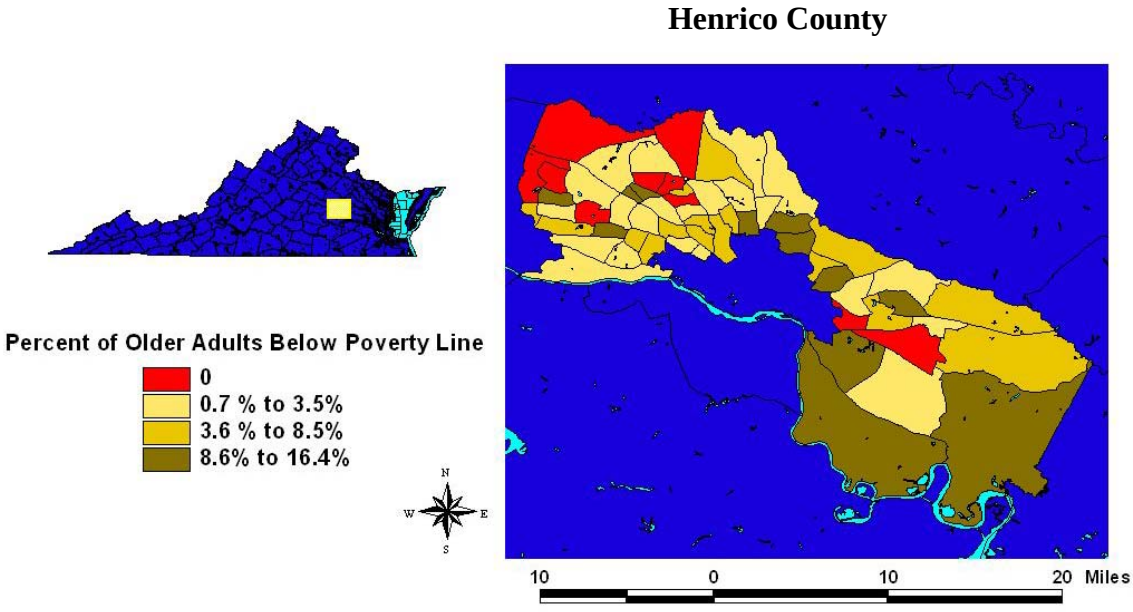
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 6 - GIS Analysis of Older Adults Living Below Poverty (Charles City)



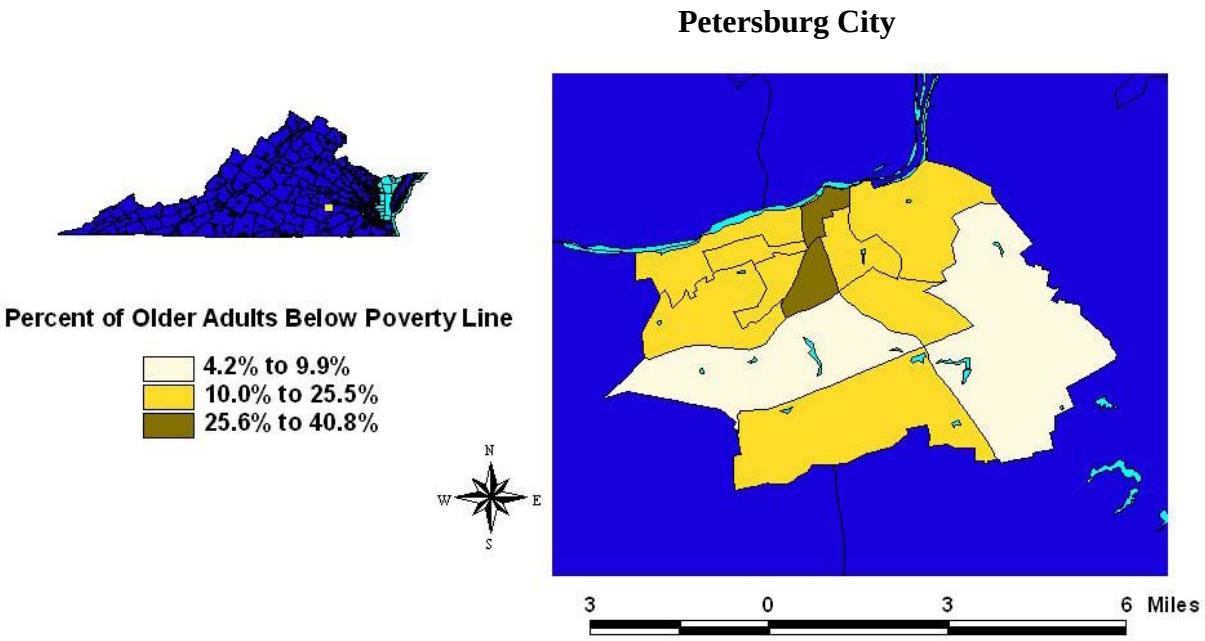
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 7 - GIS Analysis of Older Adults Living Below Poverty (Henrico County)



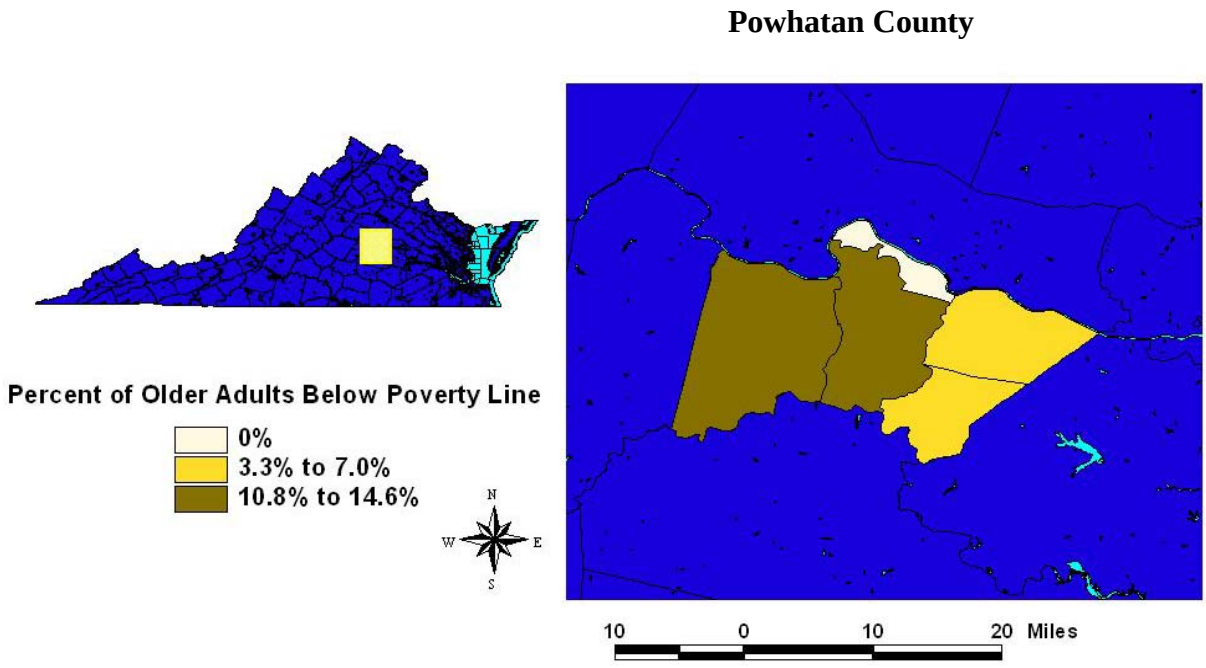
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 8 - GIS Analysis of Older Adults Living Below Poverty (Petersburg City)



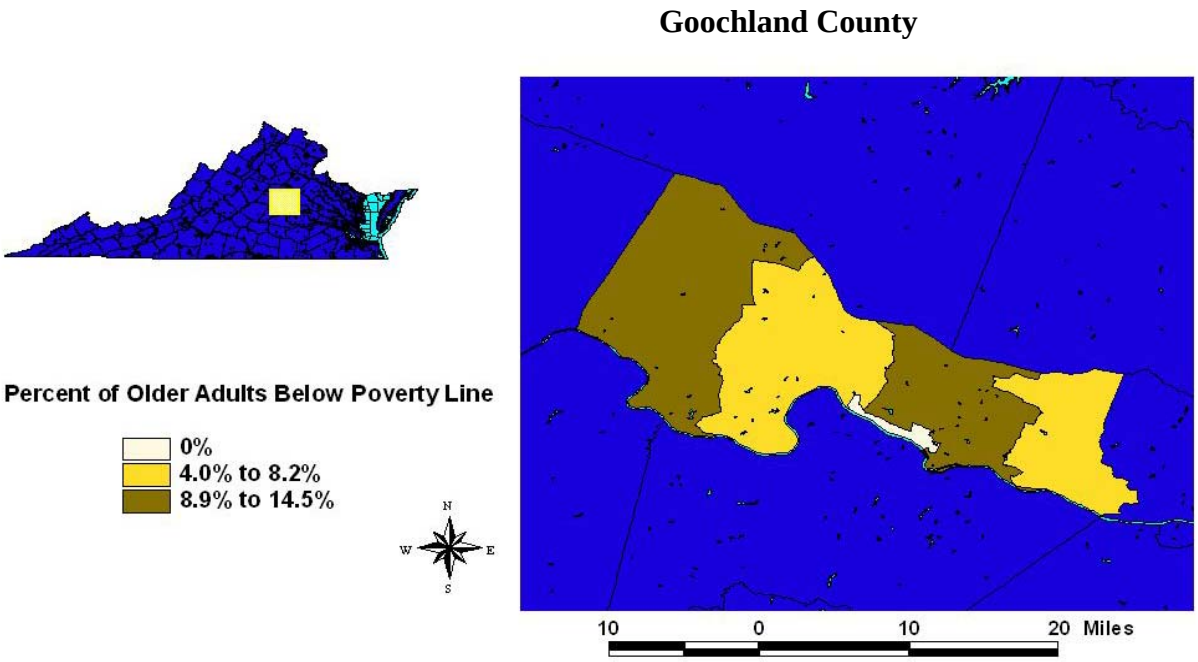
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 9 - GIS Analysis of Older Adults Living Below Poverty (Powhatan County)



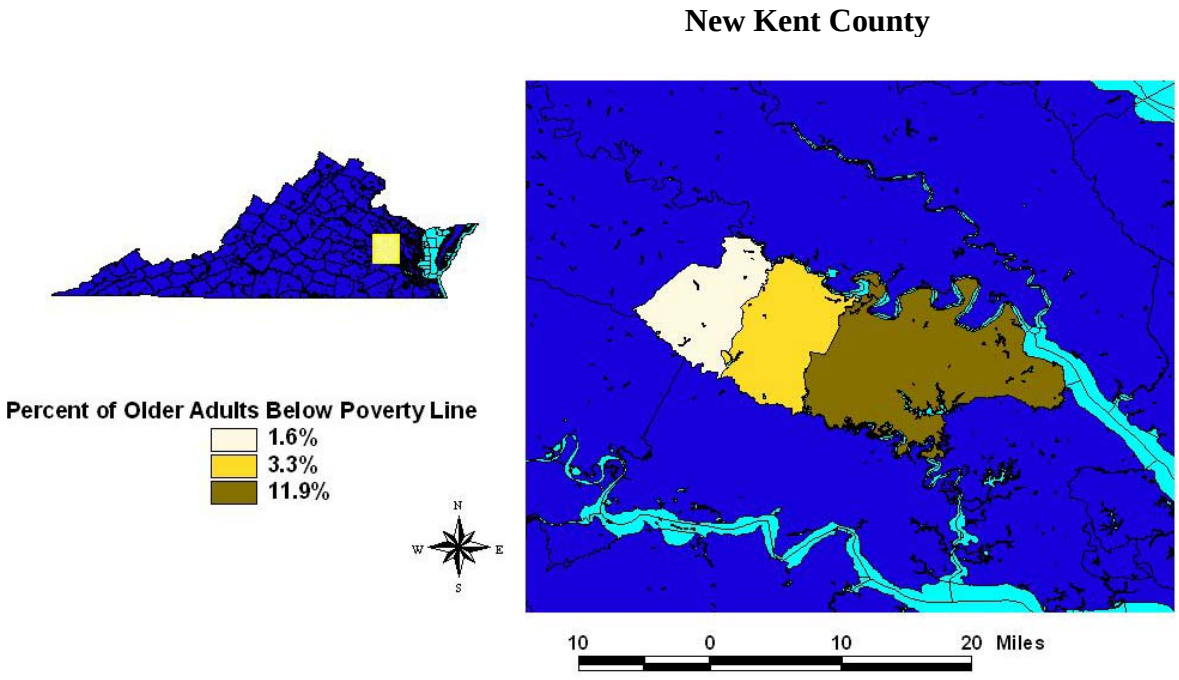
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 10 - GIS Analysis of Older Adults Living Below Poverty (Goochland County)



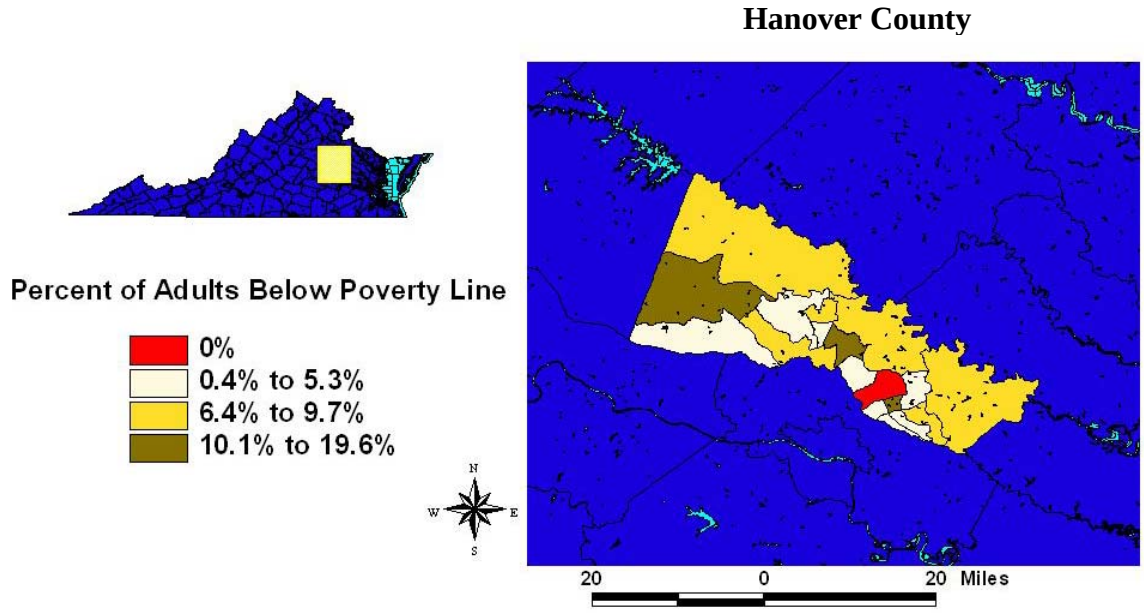
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 11 - GIS Analysis of Older Adults Living Below Poverty (New Kent County)



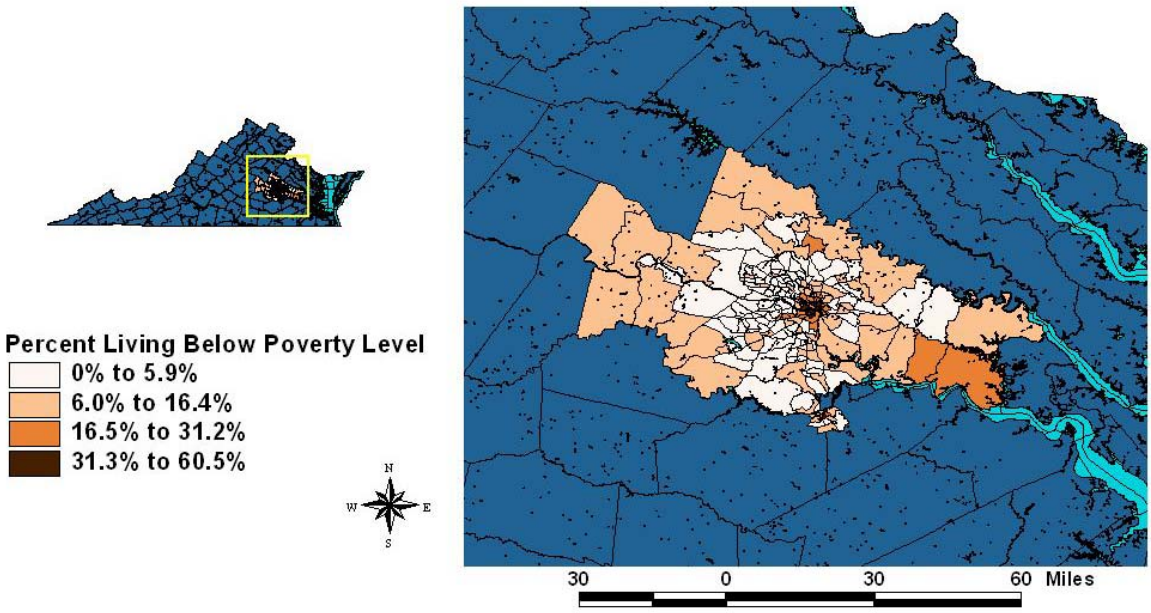
SOURCE: Census 2000. Table DP-3 (SF3).

Figure 12 - GIS Analysis of Older Adults Living Below Poverty (Hanover County)



SOURCE: Census 2000. Table DP-3 (SF3).

Figure 13 - Older Adults Living Below Poverty Level at the Census Tract Level within the Greater Richmond Area



SOURCE: Census 2000. Table DP-3 (SF3).

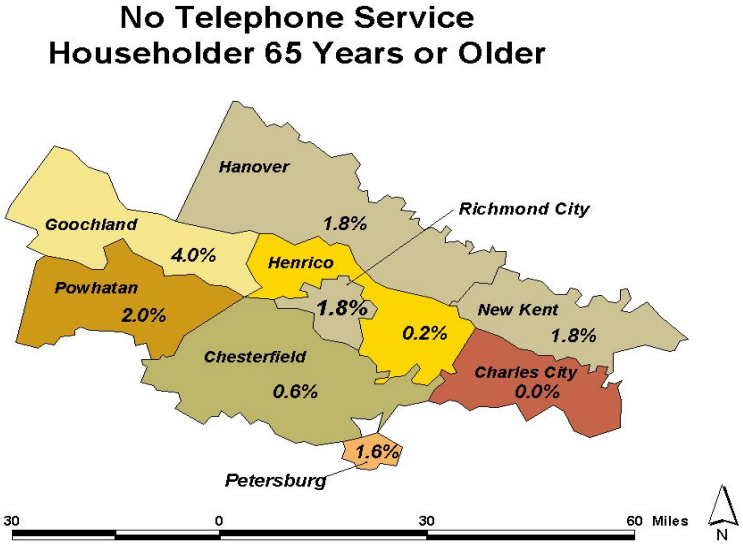
Mapping data using GIS can be an effective tool when trying to understand the distribution of various social and demographic characteristics among a population. Further analyses could be conducted to see if poverty varies by the number of nursing homes or group homes in a particular locality. This type of analysis is beyond the scope of the pilot project, but it is a recommendation for future consideration.

There are additional data elements that can be examined to create a more detailed profile of the extent to which older adults are able to meet their basic needs. The following are a few examples of data that can be used to help inform, in part, the impact goal of older adults being able to meet their basic needs.

3. Telephone Availability. Individuals receiving the decennial census long-form are asked the following: "Is there telephone service available in this house, apartment, or mobile home from which you can both make and receive calls?" The response category is yes / no. For many older adults, telephone availability is a critical link to the outside world; and for some older adults, it could be the only link to the outside world.

Figure 14 illustrates the lack of telephone service, at the county level, for households where the householder is 65 year of age or older. The values range from a low of 0% in Charles City to a high of 4% in Goochland. In Virginia, as across the United States, 1.3% of householders' age 65 and older lack telephone services.

Figure 14 - Telephone Service and Older Adults



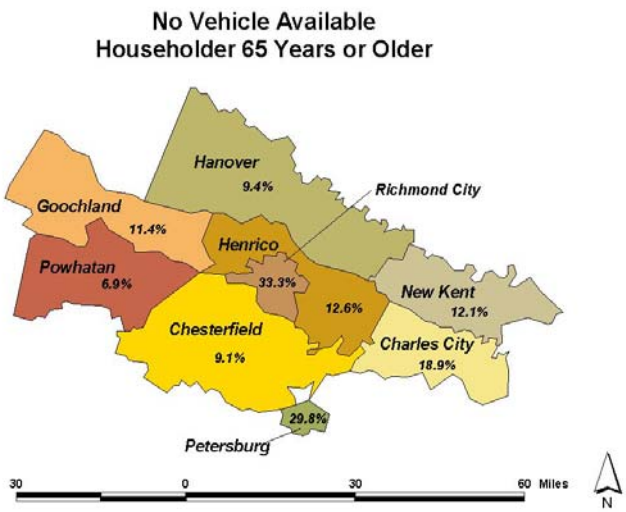
SOURCE: Census 2000. Table QT-H10 (SF4).

4. Vehicle Availability. Similar to telephone availability, access to a vehicle can facilitate older adults' involvement in the community and interaction with other community members. Lack of a vehicle might result in social isolation and difficulty accessing basic necessities such as food and medical care. The Federal Interagency Forum on Aging-Related Statistics[4] identified "gathering information on the impact of transportation needs on the quality of life of older Americans" as one of the key areas in which more data are needed for research and policy. Individuals receiving the decennial census long-form are asked the following: "How many automobiles, vans, and trucks of one-ton capacity or less are kept at home for use by members of your household?"

Figure 15 illustrates vehicle availability at the county level for households where the householder is 65 years of age or older. Values range from a low of 9.1% in Chesterfield to a high of 33.3% in Richmond City. This is in comparison to 15.7% statewide and 17.5% nationwide.

[4] Federal Interagency Forum on Aging-Related Statistics. Older Americans 2000: Key Indicators of Well-Being (Washington, D.C.: Federal Interagency Forum on Aging-Related Statistics, 2000) p. 52. Available at http://www.agingstats.gov/chartbook2000/default.htm.

Figure 15 - Vehicle Availability and Older Adults



SOURCE: Census 2000. Table QT-H10 (SF4).

The findings about vehicle availability should be considered within a geographic context. Although Richmond City has the highest percent of older adult householders without vehicle availability, it is also an urban area with a large public transportation system. The negative impact of lack of vehicle availability might not be felt as much by older adults in Richmond City as compared to older adults in a less urbanized area such as Goochland County.[5]

[5] Although some decennial census data are readily available via the web, using it and applying it within a local context can be challenging for community-based organizations. Long-form data such as those presented in the tables, figures, and maps above can be downloaded into Excel spreadsheets. However, some manipulation of data is often required to determine rates and percents. Further, in order to use GIS to visually illustrate the data, expertise in preparing .dbf files and joining them with existing GIS .shp files is required.

In this report, data about older adults living alone and older adults without telephone availability are provided separately. This is a limitation of tables available through American FactFinder. Decennial census PUMs data could be analyzed to determine if there is a relationship between household structure and telephone availability.[6]

IV. OLDER ADULTS ARE AS HEALTHY AS POSSIBLE

The second UWS impact goal is that older adults are as healthy as possible. The indicator selected to inform this goal is the number of fall-related hospitalizations for persons 65 years of age and older. Although this is one indicator of health, there are other sources for health-related data and other indicators that can inform this impact goal. The data sources described in this section include the Behavioral Risk Factor Surveillance Survey (BRFSS), decennial census data from the long-form, and data from the Virginia Department of Health.

A. Behavioral Risk Factor Surveillance Survey (BRFSS). BRFSS is a population-based telephone survey conducted in all 50 states as well as the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. BRFSS, a collaborative project of the Centers for Disease Control and the states and territories, measures behavioral risk factors in the adult population 18 years of age or older living in households. BRFSS was initiated in 1984.[7]

[6] Since 1960, the United States Census Bureau has released 1% and 5% public use microdata files following each decennial census. These microdata files contain 1% and 5% of all the long-form records respectively. The files are released in ASCII format, by state. SPSS syntax can be accessed through the Interuniversity Consortium for Political and Social Research (ICPSR) to convert the flat ASCII files into working SPSS data files. State-level files can then be concatenated to create a multi-state or a national level file. The hierarchical PUMs files are valuable because they contain individual records that can be explored at the person-level, family-level, or household level. The PUMs file contains all non-identifying, person-level information collected on the decennial census long-form questionnaire. Weighting variables are provided as well as variables containing information about data imputation. Also, importantly, household and family identifiers are provided so that cases can be rolled-up to create a household-level or family-level file. Alternatively, analyses can be conducted at the person level. By using the PUMs file, researchers are able to look at relationships between variables that are not otherwise available in the geography-based tables available via the US Census Bureau's American FactFinder website. Virginia's 5% PUMs file contains 351,485 person-level records that represent 156,800 households (unweighted counts).

[7] SERL has conducted the BRFSS for the Virginia Department of Health since 1989.

BRFSS consists of three sections. The core is a standard set of questions asked by all states. In 2002 there were 18 core sections including health status, family planning, women's health, tobacco use, diabetes, and demographics. Optional modules contain topic-specific questions that states can add at their discretion. Finally, state-added questions are, as the name implies, questions that are created by or acquired by the state and added to the state BRFSS. Content in the core and in the optional modules can change from year to year.

BRFSS data from 1997 to 2002 were analyzed to identify health trends among older adults in the Greater Richmond area. Also, for comparative purposes, Greater Richmond older adult data were compared to data from older adults living within Virginia but outside of the Greater Richmond area. In addition, older adult data from the national BRFSS file (2002) were analyzed so that the reader, if desired, can place the findings within the context of the larger population of older adults.[8] Finally, where applicable, Healthy People 2010 (HP 2010) targets have been provided.[9]

The following section highlights the findings from the BRFSS analysis. Throughout the section, data are limited to adults 65 years of age and older. All counts, unless otherwise noted, are unweighted and percents are weighted.

1. Demographic Profile. Older adults in the Greater Richmond area were similar to those outside the Greater Richmond area with regard to gender, marital status, and education. Greater Richmond older adults were more likely to be African-American as compared to their counterparts outside of the Greater Richmond area. Table 2 provides a demographic profile of the respondents.

[8] The Virginia BRFSS file was delimited to include data from 1997 to 2002. Cases under the age of 65 were excluded. In order to have the 'n' necessary to yield meaningful results, descriptive analyses were conducted on questions that were asked across a number of years. The national BRFSS file for 2002 was downloaded as an ASCII file from the Centers for Disease Control website and imported into SPSS and made into an analysis file. Similar to the Virginia file, the national file was delimited so that cases under
the age of 65 were excluded. The result was a Virginia BRFSS file that contained records for 3,306 adults 65 years of age or older, 341 of which resided in the Greater Richmond area. The 2002 national BRFSS file contained 51,082 records for adults 65 years of age and over.

[9] Additional information about Healthy People can be found at www.healthypeople.gov.

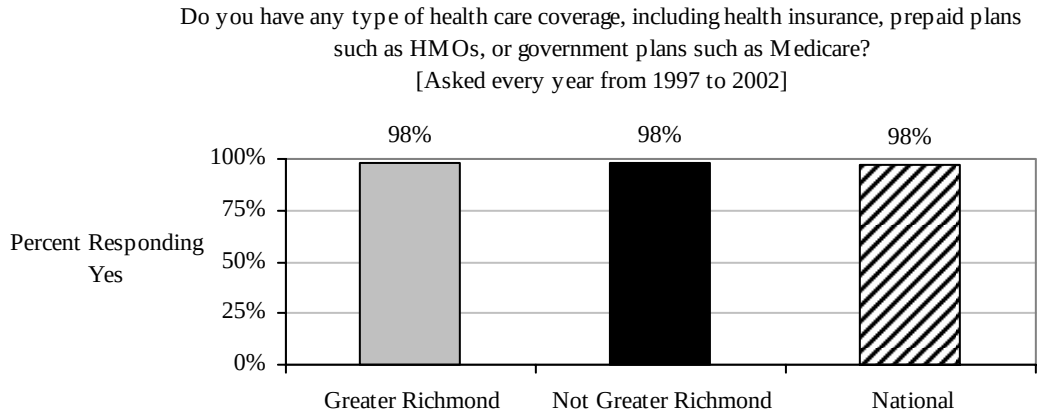
Table 2 - Demographic Characteristics of Older Adults (65 years of age and older)

	Greater Richmond (n=341)	*Not Greater Richmond (n=2,965)*
Gender		
Male	40%	41%
Female	60%	59%
Marital Status		
Married	56%	58%
Divorced	6%	7%
Widowed	34%	31%
Separated	1%	1%
Never married	4%	3%
Unmarried couple	---	<1%
Race		
White	79%	86%
Black	20%	12%
Other	1%	3%
Education		
Less than high school	10%	15%
Some high school	15%	11%
High school diploma or GED	76%	74%

2. Health Care Coverage and Access. Since Medicare is an entitlement for adults 65 years of age and older[10], it is not surprising that the majority of BRFSS participants in the Greater Richmond area, in the state as a whole, and in the nation reported having some type of health care coverage. Figure 16 illustrates this finding.

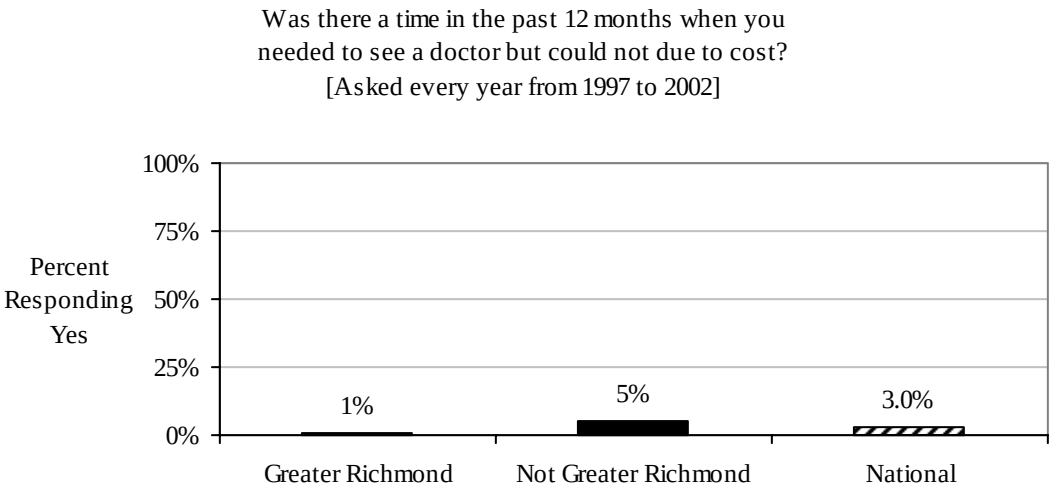
[10] Medicare Eligibility Tool. Available at: http://www.medicare.gov/MedicareEligibility/home.asp?version=default&browser= IE%7C6%7CWinXP&language=English

Figure 16 - Health Insurance Coverage



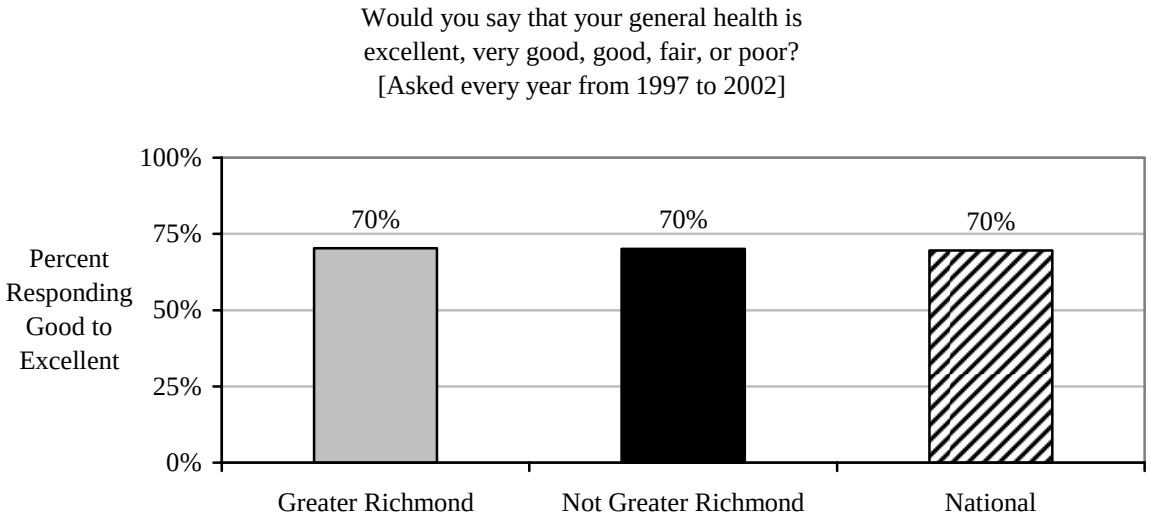
Health care coverage alone does not ensure access to medical care. Some medical services are not covered or are only partially covered by Medicare. Co-payments and cost of services can preclude some older adults from receiving medical care. It is encouraging that only 1% of older adults in the Greater Richmond area reported having had a time in the past 12 months when they needed to see a doctor but could not due to cost. This is lower than the statewide finding of 5% and the national finding of 3%. Figure 17 illustrates this finding.

Figure 17 - Access to Medical Care



3. Perceived Health. Perceived health is correlated with both morbidity and mortality. Adults who report better health tend to have fewer incidents of illness and disease and a better quality of life. Within Greater Richmond, within Virginia, and across the nation, 70% of older adults reported good to excellent general health. Figure 18 illustrates this finding.

Figure 18 - Perceived Health



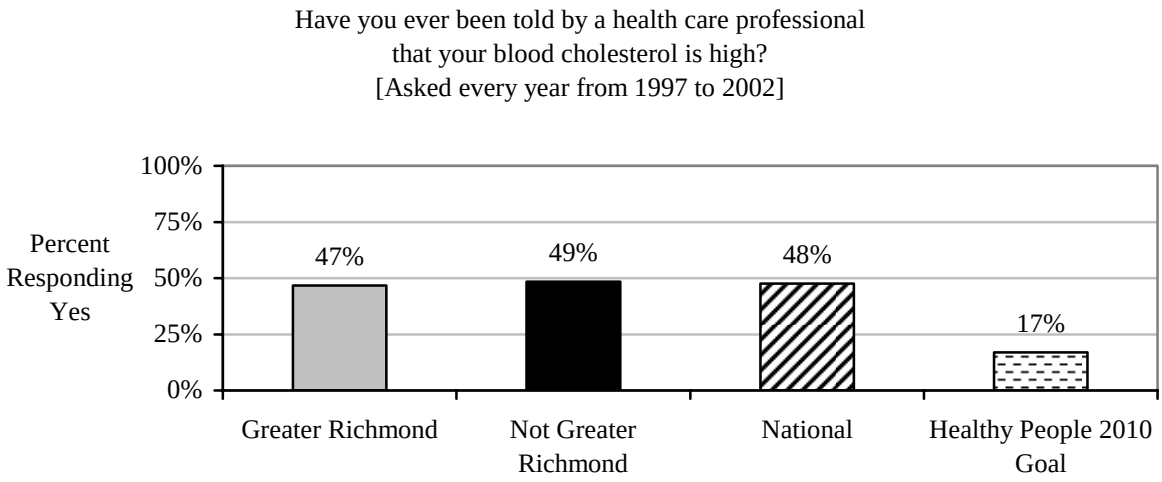
4. Physical and Mental Health. Questions about physical health and mental health have been asked every year since 1993. The findings suggest similarities between older adults in Greater Richmond and those outside of Greater Richmond. When comparing older adults in the Greater Richmond areas to those outside the Greater Richmond area, the average number of days per month of poor physical health and mental health are essentially the same. Table 3 illustrates these findings.

Table 3 - Perceived Physical and Mental Health

	Average number of days of	
	Poor physical health	*Poor mental health*
• *Greater Richmond Area*	4 days	2 days
• *Not Greater Richmond Area*	5 days	2 days
• *National*	5 days	2 days

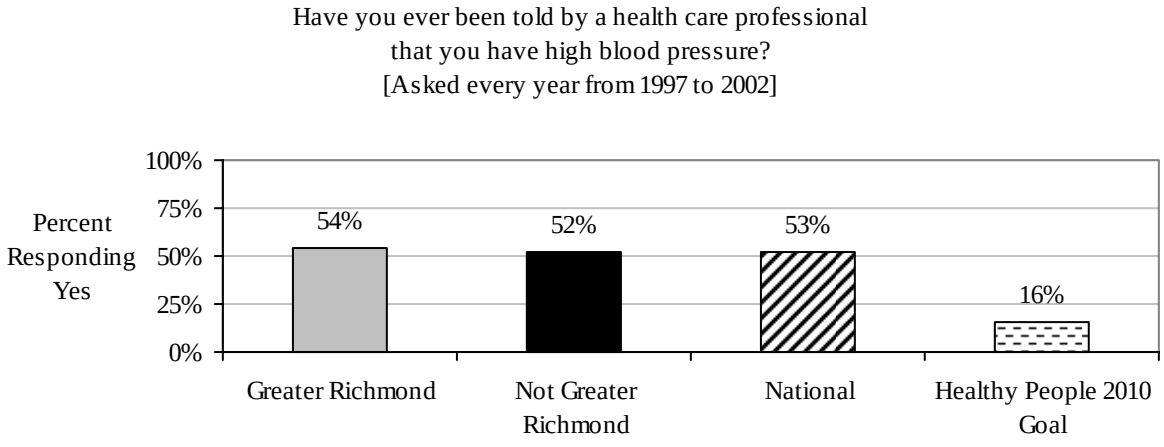
5. Blood Cholesterol and Blood Pressure. High cholesterol and hypertension are, in large part, preventable and/or controllable conditions that can lead to negative health outcomes such as heart disease and stroke. Approximately one-half of older adults in the Greater Richmond area, in Virginia, and in the nation have been told by a health care professional that they have high blood cholesterol and/or high blood pressure. Figures 19 and 20 illustrate these findings.

Figure 19 - Blood Cholesterol



Additional information about Healthy People can be found at: www.healthypeople.gov.

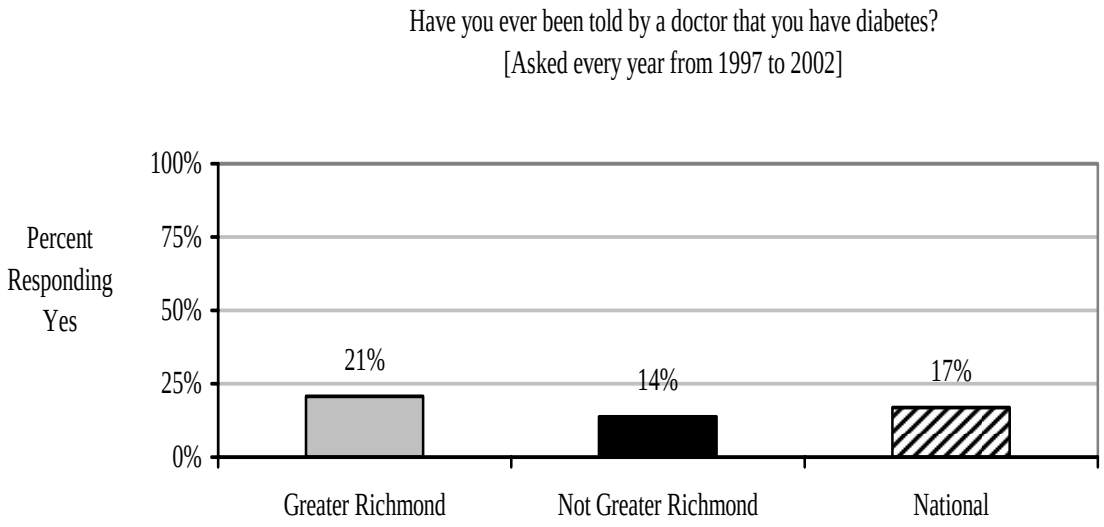
Figure 20 - High Blood Pressure



Additional information about Healthy People can be found at: www.healthypeople.gov.

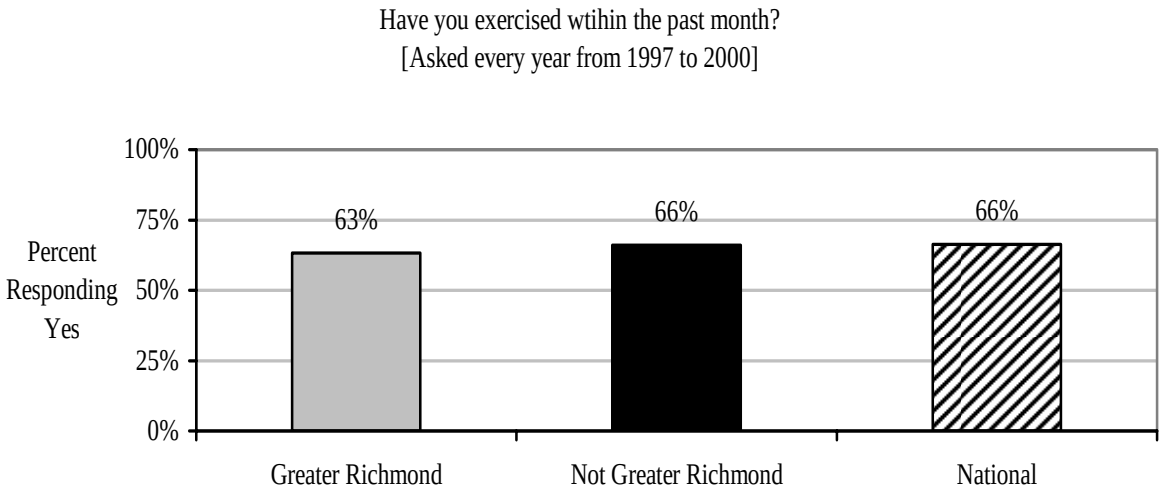
6. Diabetes. Diabetes is a chronic condition that requires frequent monitoring along with lifestyle changes. Diabetics are at increased risk for retinopathy, neuropathies, foot ulceration, amputations, and a host of other secondary conditions. Nearly one-quarter of Greater Richmond older adults have been told, at some point in time, that they have diabetes. As figure 21 illustrates, this is higher than the statewide finding of 14% and the national finding of 17%.

Figure 21 - Diabetes



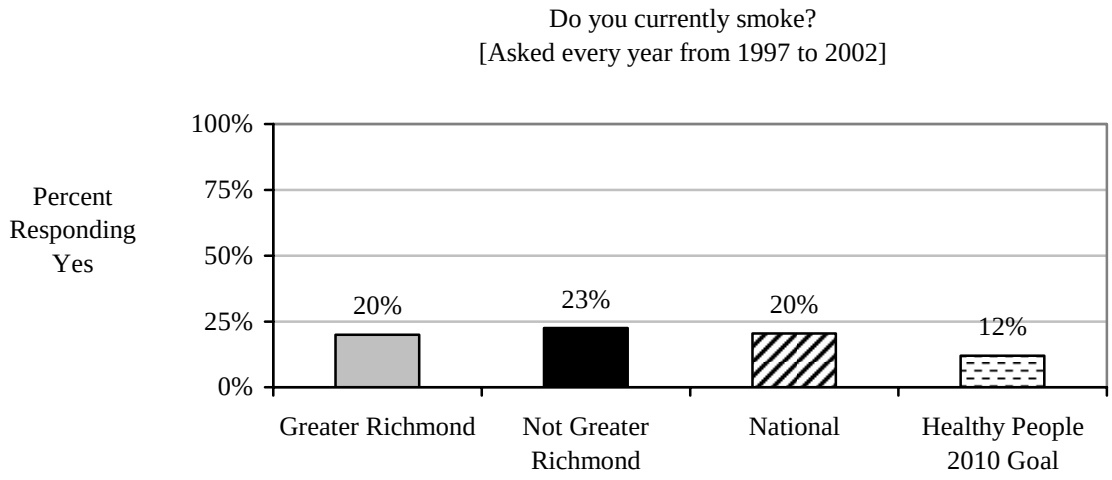
7. Physical Activity. Chronic conditions such as high blood cholesterol, high blood pressure, and diabetes, among others, can be managed, in part, through physical activity. Slightly more than 60% of older adults in the Greater Richmond area had exercised in the past month as compared to 66% state- and nationwide. Figure 22 illustrates this finding.

Figure 22 - Exercise Within Past Month



8. Smoking. While exercise can be helpful in the management of chronic conditions, smoking can be deleterious. Whereas the Healthy People 2010 goal is 12%, 20% of older adults in the Greater Richmond area currently smoke. This is similar to the estimate of 23% statewide and 20% nationwide. Figure 23 illustrates this finding.

Figure 23 - Smoking



Additional information about Healthy People can be found at: www.healthypeople.gov.

9. Breast Cancer Screening. BRFSS contains a number of questions related to the screening and early detection of cancer. Unfortunately, questions relative to prostrate cancer and colorectal cancer were asked in too few years to allow for meaningful analysis. However, questions pertaining to breast cancer detection were asked in a sufficient number of years to allow for analysis. The majority of women 65 years of age and older in the Greater Richmond area had a clinical breast exam *at some point in time* and the majority had their most recent one *within the past two years*. Figures 24 and 25 illustrate these findings.

Figure 24 - Ever Had A Clinical Breast Exam

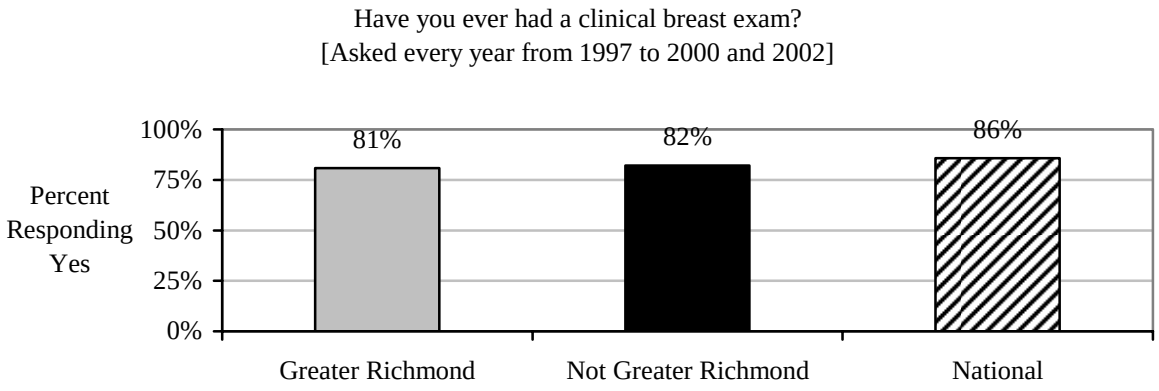
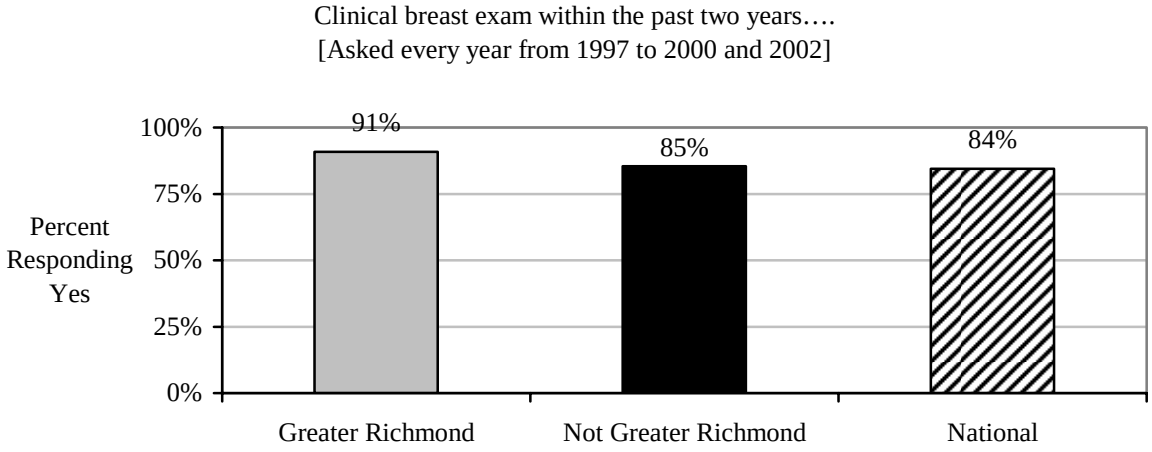


Figure 25 - Time Since Last Clinical Breast Exam



Mammography questions yielded similar results. The majority of older adult women in Greater Richmond had, *at some point*, received a mammogram and 84% received their most recent mammogram *within the past two years*. Figures 26 and 27 illustrate these findings.

Figure 26 - Ever Had A Mammogram

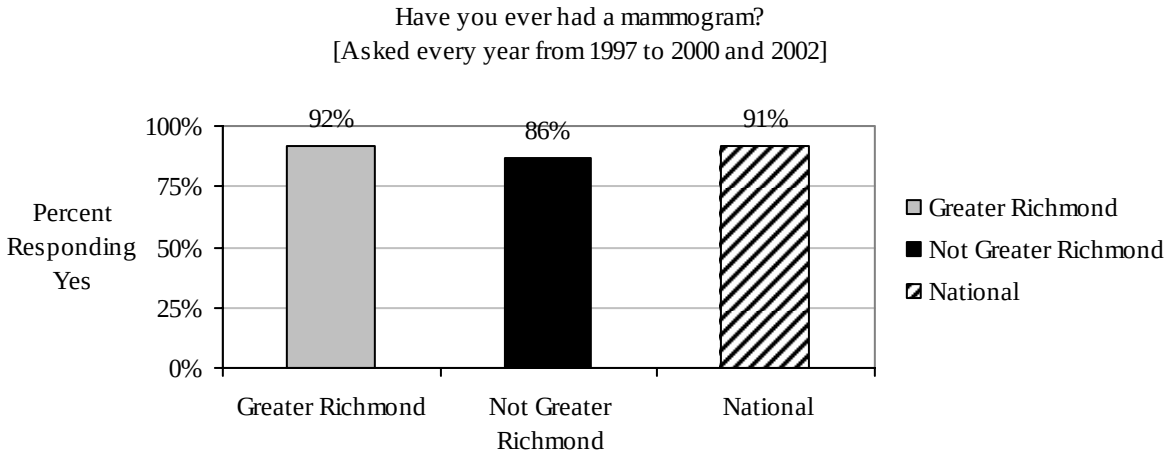
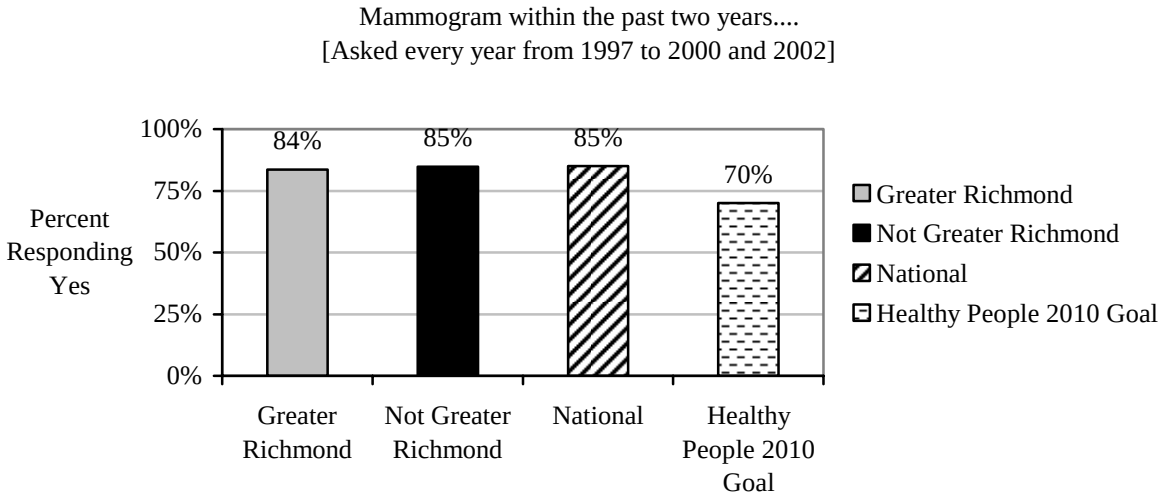


Figure 27 - Time Since Last Mammogram



Additional information about Healthy People can be found at: www.healthypeople.gov.

10. Implications of the BRFSS Analysis

The most significant finding from the BRFSS analysis is the similarity between older adults in the Greater Richmond area and older adults in Virginia and across the nation. The findings suggest that UWS can have some degree of confidence in using BRFSS-based statewide older adult data in the absence of Greater Richmond specific data.

The findings are encouraging in that they suggest that older adults, for the most part, view themselves as being in good to excellent health and appear to have little difficulty with regard to health care coverage or health care access. Older adults only reported two days on average, of poor mental health and four days on average of poor physical health within a 30 day period. Also encouraging is the fact that the majority of older adult women in Greater Richmond reported positive health behaviors with regard to breast cancer screening activities.

One area of concern is the prevalence of chronic health conditions. High blood cholesterol and high blood pressure were reported by approximately one-half of older adults living in the Greater Richmond area. This well exceeds Healthy People 2010 targets. Approximately 20% reported that they had been told by a doctor that they have diabetes. Smoking and lack of exercise are behaviors that interact negatively with chronic conditions. Twenty percent of older adults in Greater Richmond smoke currently and only 63% reported exercising within the past month. Chronic conditions and curtailing negative health behaviors might be an area of focus for UWS community health initiatives.

11. BRFSS Limitations

BRFSS does have limitations that should be considered by individuals using the data for program planning and policy purposes. The limitations relevant to this analysis are briefly described below.

1. First, BRFSS is a telephone survey of randomly selected households. One adult in each household is selected for participation. If there is an adult in the household that is 65 or older, but he/she is not the one selected for participation, his/her information would be unreported.

2. BRFSS is limited to households with telephones. In addition, there is no method in place for individuals with hearing-impairment to complete BRFSS via TTY. Individuals that are least well off tend to be underrepresented when using telephone survey methodology. The findings described above likely depict the best case scenario with regard to health.

3. As seen in this analysis, some of the questions are broad in nature. For example, a person might report that they have been told they have diabetes, but it is unclear if this is Type I or Type II diabetes. This distinction can be important in planning programs and interventions. BRFSS provides a general overview of the population's health. Specific information about certain disease conditions and/or risk behaviors would require additional study.

4. Since BRFSS content changes from year to year, some questions of interest might not be asked in enough years to allow for analysis. Prostate cancer and colorectal cancer questions are examples.

5. The data collected via BRFSS is self-report. Although respondents are asked about the presence of health conditions, there is no formal clinical examination to determine if these disease conditions truly exist.

6. Since the analysis was limited to older adults and no one year contained a sufficient number of cases of older adults, it was necessary to pool data across years. When pooling data across years, there are a few considerations. First, the number of cases each year could vary. As was done in this analysis, weights need to be adjusted to account for the difference in the number of cases each year.

Secondly, year to year differences might be obscured when averaging out data over a number of years. Third, there might be cohort effects when pooling data over years. For example, people who were 65 and older a decade ago might be different than those who are 65 and older now due to differences in experiences growing up. The two latter issues are addressed by pooling data over the fewest number of years possible.

7. There were an insufficient number of cases at the county / city level to conduct analyses at a level of geography smaller than the Greater Richmond area. Also, differences among a few counties / cities can get obscured when data are combined across nine different counties / cities. This can make neighborhood and community-level planning difficult.

B. Decennial Census Data. The United State Census Bureau is another source of information that can inform UWS's health-related impact goal for older adults. The decennial census long-form contains a series of questions related to disability.

1. Disability. The following disability-related questions are asked about each person in the household that has received the long-form[11]:

16. Does this person have any of the following long-lasting conditions:

    a. Blindness, deafness, or a severe vision or hearing impairment?
    b. A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying?

17. Because of a physical, mental, or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities:

    a. Learning, remembering, or concentrating?
    b. Dressing, bathing, or getting around inside the home?
    c. Going outside the home alone to shop or visit a doctor's office? (16 y/o and older)
    d. Working at a job or business? (16 y/o and older)

[11] Census 2000 Long-Form Questionnaire. Available at: http://www.census.gov/dmd/www/ 2000quest.html.

Each question has yes / no response categories and the person to whom the questions pertain can have a "yes" response to more than one question. Table 4 on the next page identifies the disability type based on the response to each question.

Table 4 – Disability Type Based on Question Response

If individual has....	*Then, they are classified as having a….*
• Blindness, deafness, or a severe vision or hearing impairment?	Sensory disability
• A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying?	Physical disability
• Learning, remembering, or concentrating?	Mental disability
• Dressing, bathing, or getting around inside the home?	Self-care disability
• Going outside the home alone to shop or visit a doctor's office?	Go-outside-home disability
• Working at a job or business?	Employment disability

There are some limitations that need to be considered with regard to decennial census disability questions. First, the questions are broad in nature and the results have little utility for planning disability-specific programs. For example, if one were interested in implementing a reading program for the visually impaired, it would be hard to determine the number of potential program participants based on decennial census data alone. The second limitation is that the long-form is sent to a sample of households, approximately one in every six. The result is that some households with persons with disabilities are missed. In large geographic areas, this probably has little impact on population estimates. However, estimates at lower levels of geography such as county and sub-county are less stable. Finally, the questions rely on self-report and are not verified by a medical professional. Some persons who are disabled might not view themselves as such and others that are quite functional could regard themselves as disabled.

While keeping the above caveats in mind, it is useful to consider disability data generated by the decennial census. As can be seen in Table 5, across the Greater Richmond area, the percent of older adults with at least one disability ranged from a low of 33% in Goochland to a high of 53% in Petersburg. In six out of the nine Greater Richmond counties, a higher percent of women than men had at least one disability.

Table 5 - Disability by Gender

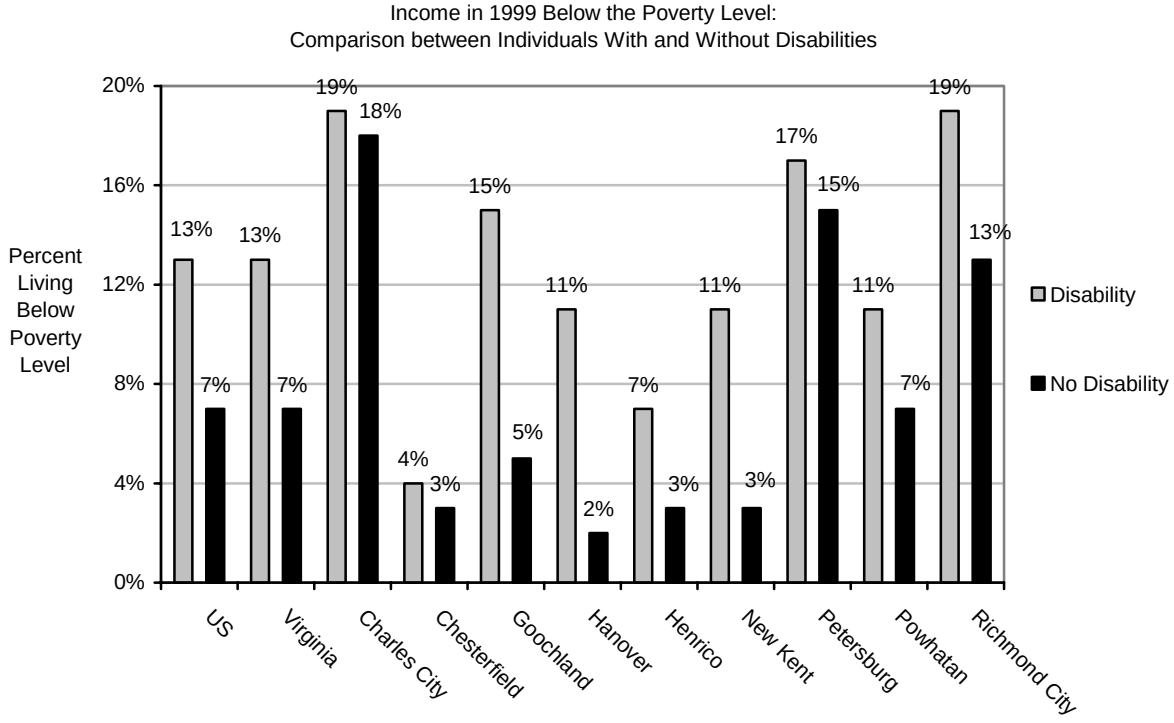
County / City	*At least one disability……*		
	Percent of Men	*Percent of Women*	*Percent of Men and Women*
Petersburg	50%	55%	53%
New Kent	42%	55%	49%
Richmond City	44%	50%	48%
Charles City	41%	44%	43%
Powhatan	43%	39%	41%
Hanover	36%	42%	40%
Henrico	37%	36%	36%
Chesterfield	34%	38%	36%
Goochland	36%	30%	33%
Virginia	*40%*	*43%*	*42%*
United States	*40%*	*43%*	*42%*

SOURCE: Census 2000. Table PCT26 (SF3)

Across all nine counties in the Greater Richmond area, physical disabilities were the most prevalent followed by disabilities that interfered with one's ability to go outside the home. The least prevalent disabilities were self-care and mental disabilities. Disability data are of interest because of the relationship between health and overall well-being. Decennial census data about disability and poverty[12] are available. Figure 28 illustrates that a higher percent of older adults with disabilities were living below the poverty level in all Greater Richmond counties / cities as compared to their counterparts without disabilities.

[12] From American FactFinder glossary available at www.census.gov: "To determine a person's poverty status, one compares the person's total family income with the poverty threshold appropriate for that person's family size and composition (see table below). If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered poor, together with every member of his or her family. If a person is not living with anyone related by birth, marriage, or adoption, then the person's own income is compared with his or her poverty threshold."

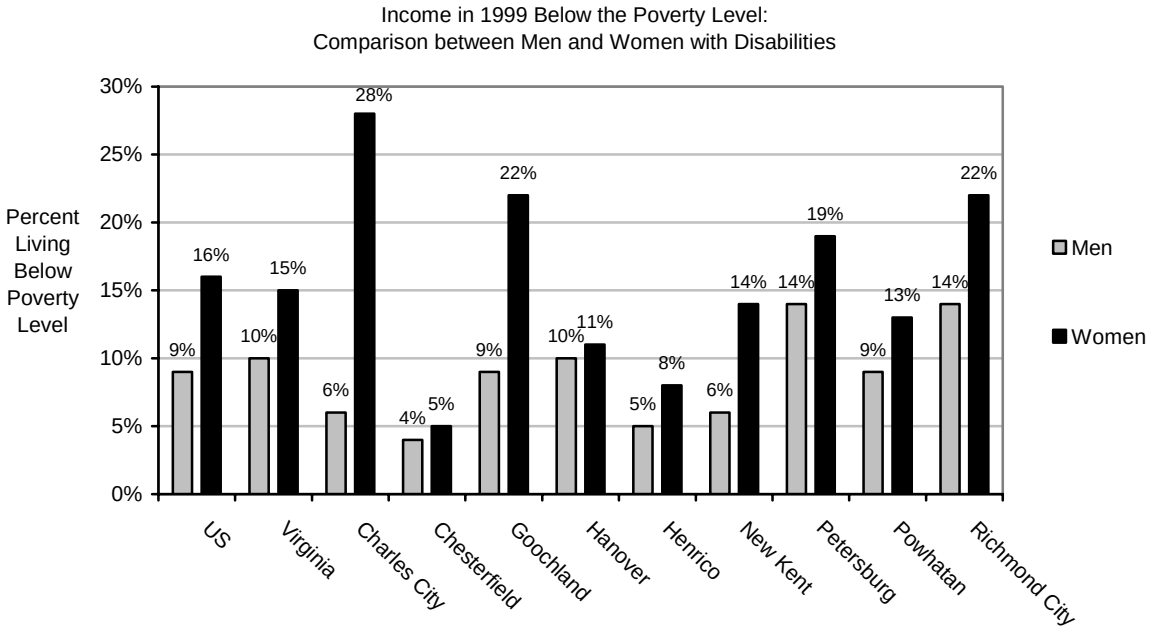
Figure 28 - Poverty and Disability



NOTE: Limited to older adults 65 years and over.
SOURCE: Census 2000. PCT34 (SF3).

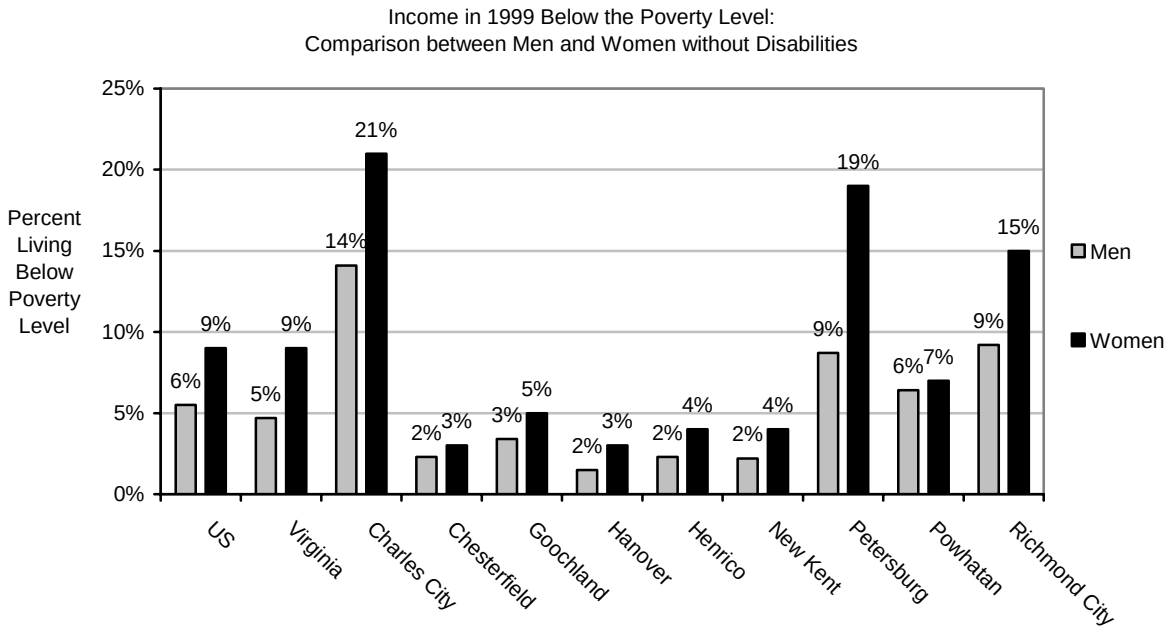
Disparities are seen not only between those with and without disabilities. When looking only at individuals with disabilities, women were more likely to be living below the poverty level than men. Figure 29 illustrates this finding. Figure 30 illustrates similar findings when comparing men and women without disabilities, but the differences between the two groups are less striking than those seen when comparing men and women with disabilities.

Figure 29 - Poverty Among Those <u>With</u> Disabilities Based on Gender



NOTE: Limited to older adults 65 years and over.
Figures displayed in graph have been rounded to the nearest whole number.
SOURCE: Census 2000. PCT34 (SF3).

Figure 30 - Poverty Among Those <u>Without</u> Disabilities Based on Gender



NOTE: Limited to older adults 65 year and over.
Figures displayed in graph have been rounded to the nearest whole number.
SOURCE: Census 2000. PCT34 (SF3).

C. Virginia Department of Health Data. The Virginia Department of Health releases county-level health data each year. Although the data are not provided by age group, there are some disease conditions that are more likely to occur in older age cohorts. Examples include heart disease and cerebrovascular disease.

1. Heart Disease and Cerebrovascular Disease. Although data from 2002 are available on the VDH website, data from 2000 are provided in Table 6 for heart disease and stroke in each county/city within the Greater Richmond area. Data from 2000 are presented because, unlike 2002 data, the 2000 data are age-adjusted to account for differences in age distribution across the different counties/cities.[13]

Table 6 - Death Rate per 100,000 for Heart Disease and Cerebrovascular Disease (2000)

County / City	*Death Rate per 100,000 Age-Adjusted* Data for 2000*	
	Heart Disease	*Cerebrovascular Disease*
Charles City	341.7	47.2
Chesterfield	188.6	72.9
Goochland	176.5	136.2
Hanover	246.7	72.5
Henrico	220.6	65.2
New Kent	301.0	118.5
Petersburg	319.8	68.1
Powhatan	213.5	89.9
Richmond City	295.4	96.1
Virginia	*244.5*	*67.0*
Healthy People 2010 Target	*208*	*48*

* Age-adjusting is a procedure designed to minimize distortions created by differences in age distributions when comparing rates for populations within localities with different age compositions.
NOTE: The most accurate death rate calculations are based on data collected over a number of years. However, based on availability, data for one year are presented in this table.
SOURCE: Virginia Department of Health. (2000). Virginia Health Statistics, Volume 1.
Additional information about Healthy People can be found at: www.healthypeople.gov

[13] Age-adjusted data were made available for 2000 in May of 2002 by the Virginia Department of Health. This illustrates one of the problems with regard to data access and utilization. Age-adjusted data are often released one to two years after it is collected. VDH can, upon request, perform special analyses. Requests should be made to VDH's Division of Health Statistics. There is a cost associated with special data runs.

Healthy People 2010 targets can be used to provide a context for interpreting the death rate data presented in Table 6. All counties / cities except Chesterfield and Goochland exceed the Healthy People 2010 target for heart disease, 208 deaths per 100,000. With the exception of Charles City, all counties / cities exceed the Healthy People 2010 target for cerebrovascular disease, 48 stroke-related deaths per 100,000.

Table 7 on the following page highlights newly identified health indicators that can be used by UWS's OAAC and OAP in their efforts to gauge progress in meeting the needs of older adults in the Greater Richmond Area.

Table 7 - Summary of Indicators Related to Health

Impact Goal: Older Adults are as Healthy as Possible			
Indicator	*Source*	*Status*	*Recommendations*
*Number and rate of falls resulting in hospitalization**	*VDH's Center for Injury and Violence Prevention*	*Collected and included in UWS Community Conditions Report*	----------
100% of older adults have health insurance coverage	Virginia's BRFSS	Data from 1997 to 2002 contained within this report. Healthy People 2010 target not currently met.	Continue to use BRFSS to track indicator
Older adults that currently smoke not to exceed 12%.**	Virginia's BRFSS	Data from 1997 to 2002 contained within this report. Healthy People 2010 target not currently met.	Continue to use BRFSS to track indicator
Older adults with high blood pressure not to exceed 16%.**	Virginia's BRFSS	Data from 1997 to 2002 contained within this report. Healthy People 2010 target not currently met.	Continue to use BRFSS to track indicator
Older adults with high blood cholesterol not to exceed 17%.**	Virginia's BRFSS	Data from 1997 to 2002 contained within this report. Healthy People 2010 target not currently met.	Continue to use BRFSS to track indicator

Impact Goal: Older Adults are as Healthy as Possible			
Indicator	*Source*	*Status*	*Recommendations*
Older adults that have had a mammogram within the past two years exceed 70%.**	Virginia's BRFSS	Data from 1997 to 2002 contained within this report. Healthy People 2010 target is currently met.	Continue to use BRFSS to track indicator
Determine extent to which older adults return home following hospitalization (as opposed to being discharge to alternative care settings).	VHI data	----------	UWS can purchase data file and conduct analyses or request special data runs from VHI.
Older adults with disability living in poverty.	Decennial census data	Data contained within this report.	Access decennial census PUMS files and explore relationships between disability and other socioeconomic indicators other than income.
Disparities in percent of older adults with disabilities based on gender.	Decennial census data	Data contained within this report.	
Reduce deaths due to heart disease to 208 per 100,000.**	VDH	Age-adjusted data for 2000 contained within this report.	----------
Reduce deaths due to cerebrovascular disease to 48 per 100,000.**	VDH	Age-adjusted data for 2000 contained within this report.	----------

*Current UWS indicator for the impact goal.
**Based on Healthy People 2010 targets. Additional information about Healthy People can be found at: www.healthypeople.gov
NOTE: There are a number of indicators that can be tracked through BRFSS data. However, the indicators in this table are reflective of those derived from responses to BRFSS questions that are likely to be asked each year. Indicators based on questions that are asked sporadically will have little utility in terms of monitoring yearly progress toward Healthy People 2010 targets.

V. OLDER ADULTS HAVE SAFE AND AFFORDABLE HOUSING

The third impact goal for the UWS Older Adults project is that older adults have safe and affordable housing. The UWS was unable to locate reliable data to measure this goal. This section outlines three viable sources that the UWS can pursue for safe, affordable housing data: The Virginia Center for Housing Research (VCHR) in the Research Division at Virginia Tech University in Blacksburg, the Virginia Department of Housing and Community Development (VDHCD), and the Virginia Housing Development Authority (VHDA).

A. Virginia Center for Housing Research Data. The VCHR considers affordable housing for the average family to be an average housing price that costs less than 25% of the median family income. Ownership costs are the principal and interest payments. Therefore, this definition of affordability does not include maintenance, insurance, taxes, or utilities. A January 2003 VCHR study found that "homeownership is affordable to the median income family in virtually all the housing market areas throughout the state", and the Richmond area was found to be one of the most affordable.[14] However, because the search for affordable housing is reaching further out, houses in the surrounding countryside are expected to become less affordable.

1. Housing Profiles. The VCHR created housing profiles of the state, counties, and independent cities. These profiles show for each geographical area the following data: area in square miles, total population, percent urban, total housing units, occupied housing units, number of units within structures, year structure built, vacancy status, gross rent, owner costs, owner value, household type, subfamilies, tenure (renters and homeownership rates), household size and crowding, substandard occupied units, cost burden for renters and homeowners, median income, poverty levels, adults with disabilities, and population in nursing homes. Appendix A contains the profiles for Virginia and the nine Greater Richmond localities of interest. The profiles contain the following data elements for adults 65 and older: homeownership rates, income below poverty level, disabilities, and population in nursing homes.

[14] Koebel, C. Theodore and Kelly M. Atkinson, "Homeownership Affordability in Virginia," A Report on Virginia Homeownership Affordability released jointly by the Virginia Association of Realtors and the Center for Housing Research (Virginia Tech Center for Housing Research, January 2003, p. 5) at www.arch.vt.edu/CAUS/RESEARCH/vchr/Otherreports.html.

As shown in Table 8, the homeownership rate for adults 65 and older in the nine Greater Richmond locales exceeds the overall state rate of 80% in all but three jurisdictions: Henrico (77%), Petersburg (72%), and Richmond City (64%). The other six locales have homeownership rates for adults 65 and older ranging from 87% in Goochland to 96% in New Kent. In each locality, homeownership rates are higher, and sometimes much higher, for adults 65 and older than other age groups.

Table 8 - Number and Percent of Homeowners and Homeownership Rates for Selected Age Group for Each Locality (2000)

Locality	*Percent Urban*	*Number and Percent of Homeowners (all ages)*		*Ownership Rate for 25-34 Year Olds*	*Ownership Rate for 35-44 Year Olds*	*Ownership Rate for 65 and Older*
	%	#	%	%	%	%
Charles City	0%	2,268	85%	70%	76%	93%
Chesterfield	90%	75,874	81%	65%	82%	88%
Goochland	7%	5,334	87%	74%	84%	87%
Hanover	57%	26,233	84%	70%	85%	89%
Henrico	94%	71,089	66%	43%	69%	77%
New Kent	0%	4,369	89%	74%	88%	96%
Petersburg	97%	7,107	52%	25%	39%	72%
Powhatan	9%	6,448	89%	85%	88%	89%
Richmond City	100%	39,008	46%	27%	46%	64%
Virginia	73%	1,837,939	68%	46%	68%	80%

SOURCE: Virginia Center for Housing Research, 2000 Virginia Housing Atlas Profile Pages.

The federal standard for housing affordability incorporates the cost of utilities, which raises the cost burden threshold to 30% of the median family income. Table 9 summarizes the cost burdens for the localities of interest. The percent of owners paying 30% or more of their income for housing ranges from lows of 17% in Chesterfield and Hanover to highs of 26% in Petersburg and Richmond City. The state average is 20%. More importantly, the percent of owners with an income of less than $20,000 that are paying 30% or more of their income for housing ranges from a low of 49% in New Kent to a high of 73% in Richmond. The VCHR profile does not show cost burden data by the age of owner (or renters), but the UWS could consider contacting the VCHR for this level of detail.

Table 9 - Percent of Homeowners in Each Locality Paying 30% or More of Gross Income for Housing (Principal + Interest + Utilities)

County / City	*Median Family Income (all ages)*	*Number of Owners*	*Owners Paying 30% or More of Income (all ages)*	*Owners Paying 30% or More of Income with Income < $20,000*
Charles City	$49,361	2,268	20%	50%
Chesterfield	$65,058	75,874	17%	68%
Goochland	$64,685	5,334	20%	56%
Hanover	$65,809	26,233	17%	51%
Henrico	$59,298	71,089	19%	63%
New Kent	$60,678	4,369	18%	49%
Petersburg	$33,955	7,107	26%	63%
Powhatan	$58,142	6,448	18%	53%
Richmond City	$38,348	39,008	26%	73%
Virginia	$54,169	1,837,939	20%	56%

SOURCE: Virginia Center for Housing Research, 2000 Virginia Housing Atlas Profile Pages.

The proportion of renters paying 30% or more of their income on housing is higher than that of owners. As shown in Table 10, it ranges from a low of 26% of all renters in Charles City to a high of 44% of all renters in Richmond City. For renters with incomes less than $20,000, a majority is paying 30% or more of their income on housing. The range is from 69% in Charles City to 95% in Powhatan. Again, these data are not broken out by age group, and it is suggested that the UWS obtain more detailed data from the VCHR.

Table 10 - Percent of Renters in Each Locality Paying 30% or More of Gross Income for Housing (Rent + Utilities)

County / City	*Median Family Income (all ages)*	*Number of Renters*	*Renters Paying 30% or More of Income (all ages)*	*Renters Paying 30% or More of Income with Income < $20,000*
Charles City	$49,361	402	26%	69%
Chesterfield	$65,058	17,898	34%	89%
Goochland	$64,685	824	40%	85%
Hanover	$65,809	4,888	35%	83%
Henrico	$59,298	37,032	35%	87%
New Kent	$60,678	556	30%	89%
Petersburg	$33,955	6,692	41%	75%
Powhatan	$58,142	810	35%	95%
Richmond City	$38,348	45,541	44%	76%
Virginia	$54,169	861,234	37%	78%

SOURCE: Virginia Center for Housing Research, 2000 Virginia Housing Atlas Profile Pages.

2. Nursing Home Population. The VCHR housing profiles also show the number of adults 65 and older in nursing homes, the number and percent of adults 65 and older below poverty level and the number of adults 65 and older with disabilities. Nursing home populations are displayed in Table 11.

Table 11 - Number of Adults 65 and Older Residing in Nursing Homes for Each Locality

County / City	*Nursing Home Population*
Charles City	-
Chesterfield	819
Goochland	69
Hanover	272
Henrico	2,714
New Kent	-
Petersburg	284
Powhatan	-
Richmond City	1,109
Virginia	35,154

SOURCE: Virginia Center for Housing Research, 2000 Virginia Housing Atlas Profile Pages.

The poverty levels and prevalence of disabilities that are also summarized in VCHR profiles are not discussed further in this section because they were covered in detail in the preceding section that addressed the impact goal of older adults are able to meet their basic needs.

B. Virginia Department of Housing and Community Development / Virginia Housing Development Authority

1. Housing Needs. In March and April 2001, VDHCD and the VHDA jointly conducted regional housing forums as part of a statewide assessment of housing needs. In addition to the small group discussions, housing and economic data were drawn from 2000 Census and a statewide inventory of federal and state assisted rental housing was conducted. The report[15] summarizes the priority housing issues and needs for the Richmond area. For the purposes of their report, the Richmond market area was defined as follows:

[15] Analysis of Housing Needs in the Commonwealth, a joint report of the Virginia Department of Housing and Community Development and Virginia Housing Development Authority, November 2001, 368.

Housing Market Description	*Localities Included*
Older core localities	Hopewell, Petersburg, and Richmond Cities
Other urban and suburban localities	Chesterfield, Hanover, Henrico, and Prince George Counties; Colonial Heights City
Outlying localities	Amelia, Charles City, Dinwiddie, Goochland, King William, New Kent, Powhatan, and Sussex Counties

While the report does not provide the data by locality or by age group within the Richmond market area, UWS can contact the source to see whether special reports or data files can be obtained. The needs of older adults were addressed specifically[16] and some of the key findings directly relate to the older adult population in the Richmond market area:

- Tighter market conditions have exacerbated the large affordability gap for the lowest income households (i.e. those dependent on fixed public benefit payments or very low wages).
- Affordable and accessible housing is very limited for people with disabilities.
- Deep subsidy rental housing for the elderly is highly concentrated in core localities (e.g. Richmond, Petersburg, Hopewell) but the population 75 and older is expected to decline in the core cities between 2000 and 2010 and to increase rapidly in the surrounding counties leading to a mismatch between the location of assisted senior housing and the location choice of elderly renter households.
- Discrimination due to race, age, or disability limits housing opportunities for both owners and renters and serious discriminatory practices continue against low-income, homeless, and disabled people.
- The lowest income populations – homeless people, people with disabilities, seniors depending primarily or exclusively on Social Security income, and minimum wage workers – all experience an extremely large gap between their limited incomes and the cost of adequate rental housing.

[16] Ibid., Part II A, pp. 2, 4, 5, 8.

In the Executive Summary to the full report, the authors identify as a statewide issue the unmet needs for housing linked to services for the disabled, elderly and homeless people.[17] Statewide, there is an anticipated elderly demand shift from independent living units to service-rich housing and assisted living facilities.[18]

Table 12 summarizes the status of new housing indicators for older adults.

Table 12 - Summary of Indicators Related to Safe and Affordable Housing for Older Adults

Impact Goal: Older Adults Have Safe, Affordable Housing			
Indicator	*Source*	*Status*	*Recommendations*
No data in Community Conditions Report			
% of older adults owning homes	VCHR	Data for 2000 in this report.	Establish benchmark and goal, use VCHR data to monitor
% of older adults in rental units	VCHR	Data for 2000 in this report.	Establish benchmark and goal, use VCHR data to monitor
% of older adults paying 30% or more of gross income for housing costs (ownership and rental)	VCHR	Data for all age groups in this report for 2000.	Contact VCHR for data by age groups, establish benchmark and goal, use VCHR data to monitor.
Availability of deep subsidy rental housing units for older adults	VDHCD/VHDA	General data for 2001 in this report.	Contact VDHCD or VHDA for detailed data.

[17] Ibid., Executive Summary, p. 4.
[18] Ibid., Executive Summary, p. 5.

VI. OLDER ADULTS ARE SOCIALLY AND EMOTIONALLY SUPPORTED IN THE COMMUNITY

The fourth impact goal is that older adults are socially and emotionally supported in the community. UWS obtained the number of reports of abuse and neglect from the Virginia Department of Social Services, Long-Term Care and Prevention Services. The Federal Interagency Forum on Aging-Related Statistics cites the need for national statistics on elder abuse and a better understanding of the risk factors involved[19]. Elder abuse can be defined in several ways and these definitions relate both to the nature of the act and the relationship between the victim and the offender. For example, elder abuse can be verbal or physical assaults perpetrated by a family member or scams perpetrated by a stranger.

The victimization data available through the Federal Bureau of Investigation's (FBI) National Incident-Based Reporting System (NIBRS) allows one to examine offenses committed against those 65 and older and to examine the relationship between the victim and the offender. A preliminary analysis is presented in this report.

A. NIBRS Victimization Data (2001). Virginia is one of the states certified by the FBI to submit incident-based data to the national reporting system. The advantage of working with NIBRS data is that much more information is reported through this system than through the FBI's Uniform Crime Reports. This includes the number and types of offenses that are included in the reporting and the level of detail about the incidents. For each incident, reporting from local law enforcement agencies includes information about the offender characteristics, the offenses and their characteristics, the victim's characteristics and injuries sustained, if any, the location (geographical and type of structure), date, and time of the incident. The most recent publicly available data file for use in this report was from 2001.

[19] Federal Interagency Forum on Aging-Related Statistics, p. 52.

Offenses Against the Elderly. The 2001 NIBRS offense data for incidents in which the victims were aged 65 or older was examined by looking at the most serious offense reported during the incident. Because an incident can consist of more than one offense, it is common to examine only the most serious offense when working with large numbers of cases. For this analysis, the most serious offenses were grouped by major category of offense – person or property[20]. In each locality, a substantial majority of offenses reported to law enforcement officials by victims aged 65 and older were offenses against property. As shown in Table 13, the proportion of property offenses relative to person offenses was very high, ranging from a low of 89% in Petersburg to 100% in Charles City and Goochland.

Table 13 - Most Serious Offense Committed Against Victims 65 and Older

	Person Offenses		*Property Offenses*		*Total Offenses*	
Locality	*#*	*%*	*#*	*%*	*#*	*%*
Charles City	-	-	3	100%	3	100%
Chesterfield	42	8%	497	92%	519	100%
Goochland	-	-	13	100%	13	100%
Hanover	9	8%	93	92%	102	100%
Henrico	39	5%	760	95%	799	100%
New Kent	1	5%	21	95%	22	100%
Petersburg	33	11%	274	89%	307	100%
Powhatan	1	4%	26	96%	27	100%
Richmond City	94	7%	1265	93%	1,359	100%
Virginia (< 65)	106,706	33%	213,080	67%	319,786	100%
Virginia (all)	107,836	32%	226,881	68%	334,717	100%

SOURCE: FBI National Incident-Based Reporting System, 2001 Data File

[20] Person offenses include the following crimes: assaults (aggravated, simple, and intimidation), homicide, kidnapping/abduction, and sex offenses (rape, sodomy, sexual assault with an object, fondling of a child, incest, statutory rape). Property offenses include robbery, burglary, motor vehicle theft and related offenses, destruction of property, embezzlement, fraud, forgery, and larceny/theft.

For victims under the age of 65 statewide, the percentage of property offenses reported drops to 67% and the percentage of person offenses increases to 33%. The proportion of person crimes to all crimes reported by victims age 65 and older is relatively low, ranging from a low of 0% in both Charles City and Goochland to a high of 11% in Petersburg. This is substantially lower than the 33% reported statewide for victims *under* the age of 65.

In summary, persons 65 and older who reported being the victim of a crime were substantially more likely to report being the victim of a property crime than a person crime. Persons 65 and older also were much less likely to be victims of any type of crime than were persons 64 or younger.

2. Victim Characteristics. There was a fairly even split of male and female victims in most localities; the exceptions were Charles City, New Kent, and Powhatan, each with about two-thirds male victims. Statewide, for all incidents for victims of all ages, there was an equal proportion of male and female victims. The majority of victims were Caucasian in all localities except Charles City, Petersburg, and Richmond where the majority were African-American. Statewide, for victims of all ages, almost two-thirds of the victims were Caucasian and almost one-third were African-American. This was true also for incidents in which the victims were age 64 or younger across the state. (See Table 14)

Table 14 - Victim Gender and Race for Victims 65 and Older for Each Locality

Locality	*Victim Gender*		*Victim Race*			
	Male	*Female*	*Caucasian*	*African-American*	*Other*	*Unknown*
	%	*%*	*%*	*%*	*%*	*%*
Charles City	66%	33%	33%	66%	-	-
Chesterfield	52%	48%	89%	9%	1%	1%
Goochland	54%	46%	85%	15%	-	-
Hanover	53%	47%	91%	9%	-	-
Henrico	47%	53%	78%	19%	1%	3%
New Kent	64%	36%	73%	23%	-	4%
Petersburg	52%	48%	35%	65%	-	-
Powhatan	63%	37%	82%	18%	-	-
Richmond	49%	51%	34%	62%	1%	3%
Virginia (<65)	50%	50%	63%	32%	1%	4%
Virginia (all)	50%	50%	63%	31%	2%	4%

SOURCE: FBI National Incident-Based Reporting System, 2001 Data File

3. Victim-Offender Relationship. The Federal Inter-Agency Forum on Aging notes that one of the data needs, nationwide, is estimates on elder abuse. One way to begin to look at elder abuse in more detail is to examine the relationship between the victim and the offender in the context of the types of offenses reported. A comprehensive analysis is beyond the scope of this report, but a preliminary look at the relationships between the victims and the offenders was conducted with the NIBRS data.

In the majority of localities for which victim-offender relationship data are available, the victim knew the offender in the majority of incidents (see Table 15).[21] The exceptions to this were Richmond City where in 55% of the incidents the relationships were recorded as "relationship unknown" and in Chesterfield County where 49% were recorded as "relationship unknown". It is possible that this reflects a greater reluctance in divulging information when the victim knew the offender or it could reflect differences in coding at the local level. Statewide, victims of all ages reported knowing the offender in almost 75% of the reported incidents; for victims under the age of 65 the findings were the same.

In four localities – Chesterfield, Hanover, Henrico, and Petersburg – the percentage of incidents with victims 65 and older in which the offender was a family member exceeds both the percentage reported for incidents in which the victims were 64 and younger statewide as well as the statewide percentage for all ages. (In New Kent and Powhatan, all victims reported the offender was a family member but the number of incidents is only one each.) In Chesterfield and Hanover, the victims in about one-half of the incidents indicated that the offender was a family member, and in Henrico and Petersburg about one-third said the offender was a family member. For victims 64 and younger in incidents statewide and statewide for all age groups, a family member was reported as the offender in only 28% of the reported incidents.

[21] The victim-offender relationship categories of "familial" and "known" in the FBI's coding scheme are defined as follows: Familial relationships include spouse, common-law spouse, parent, sibling, child, grandparent, grandchild, in-law, stepparent, stepchild, stepsibling, or other family member. For outside the family but "known" to the victim, the following categories are used by the FBI: acquaintance, friend, neighbor, babysittee, boyfriend/girlfriend, homosexual relationship, ex-spouse, employee, employer, otherwise known.

Table 15 - Victim-Offender Relationship for Victims 65 and Older for Each Locality

Locality	*Victim-Offender Relationship*					
	Familial	*Known, Not Family*	*Stranger*	*Unknown Relationship*	*Total Count*	
	%	*%*	*%*	*%*	*#*	*%*
Charles City	-	-	-	-	0	-
Chesterfield	47%	4%	-	49%	49	100%
Goochland	-	-	-	-	-	-
Hanover	57%	-	7%	36%	14	100%
Henrico	35%	26%	28%	11%	54	100%
New Kent	100%	-	-	-	1	100%
Petersburg	38%	42%	12%	8%	24	100%
Powhatan	100%	-	-	-	1	100%
Richmond	15%	28%	2%	55%	189	100%
Virginia (<65)	28%	45%	11%	16%	112,324	100%
Virginia (all)	28%	45%	11%	16%	113,730	100%

NOTE: The FBI does not require a victim-offender relationship designation on all crimes. This column shows the count of the number of incidents for which it was required and coded. This is the base for the percentages.
SOURCE: FBI National Incident-Based Reporting System, 2001 Data File

Further analyses of the NIBRS data could explore the relationship between the types of offenses, the victim-offender relationship, and the location of the incidents. Table 16 summarizes the status of new indicators for older adults being socially and emotionally supported in the community.

Table 16 - Summary of Indicators Related to Older Adults Being Socially and Emotionally Supported in the Community

Impact Goal: Older Adults are Socially and Emotionally Supported in the Community			
Indicator	*Source*	*Status*	*Recommendations*
Number of reported cases of abuse and neglect against people 60 years of age and older.	VDSS	Data included in Community Conditions Report.	
% of adults 65 and older who are victims of person crimes	NIBRS	Data for 2001 in this report.	Establish benchmark and goal, use NIBRS data to monitor
% of adults 65 and older who are victims of property crimes	NIBRS	Data for 2001 in this report.	Establish benchmark and goal, use NIBRS data to monitor
% of victims aged 65 and older who are victimized by family members or members of same household	NIBRS	Data for 2001 in this report.	Establish benchmark and goal, use NIBRS data to monitor
% of adults 65 and older who are fearful of becoming victims of crime	National Crime Victim-ization Survey or BRFSS	No data included in this report.	Consider adding questions to BRFSS or using NCVS data

VII. CAREGIVERS HAVE THE SKILLS AND SUPPORTS NEEDED TO CARE FOR OLDER ADULTS

The fifth impact goal is that caregivers will have skills and supports needed to care for older adults. Unfortunately, SERL was unable to locate any publicly available datasets that provided direct indicators of this impact goal. However, the Central Virginia Health Planning Agency Community Needs Assessment (2002) does provide some valuable information and is a potential resource for the future.

A. Central Virginia Health Planning Agency Community Needs Assessment (2002). The Central Virginia Health Planning Agency did community needs assessments in 1999 and 2002. In 2002, phone surveys were done with 3,000 residents across 27 counties and 4 planning districts. The results of the community needs assessment are available on the CVHPA website.

For much of the data, there are comparisons between planning districts and comparisons between survey years. In some cases, comparisons are made between counties / cities. However, in the summary report, there are no data provided by age group; in other words, data specific to older adults is not readily available.

1. Long Term Care and Caring for the Elderly. Despite the limitation in data access, there are two interesting findings from the 2002 Community Needs Assessment Survey that might be of interest to UWS, the OAAC, and OAP. First, 31% of respondents believed that long-term care for the elderly was a serious issue. This is an increase from 29% in 1999. Second, 22% of respondents believed that caring for the elderly was a serious issue. Interestingly, this is a decrease from 25% in 1999. In planning district 15, the district containing all Greater Richmond counties / cities except Petersburg City, there was no greater concern about elderly care as compared to the other three planning districts. It is unclear how the OACC and the OAP would use these findings. On the one hand, the percents might seem and might reflect a lack of awareness about critical needs in terms of elderly care. If that is the case, the OACC and OAP could focus on community education as a means to increase awareness and involvement. On the other hand, these findings might be in line with what is expected and efforts can be placed on activities that extend beyond community awareness.

Table 17 - Summary of Indicators Related to Caregivers Having the Skills and Supports Needed to Care for Older Adults

Impact Goal: Caregivers Having the Skills and Supports Needed to Care for Older Adults			
Indicator	*Source*	*Status*	*Recommendations*
No data in Community Conditions Report			
% of adults viewing long term care as an important issue	CVHPA	Data from 2002 survey in this report.	Work with CVHPA to include this and related questions in next community survey
% of adults viewing caring for the elderly as an important issue	CVHPA	Data from 2002 survey in this report.	Work with CVHPA to include this and related questions in next community survey

VIII. SUMMARY OF FINDINGS

This section highlights the project findings for each impact goal that resulted from the analysis of existing data (with a parenthetical note of the original source as referenced to in the body of this report). As noted in the previous sections, there are limitations to the interpretations of the data findings. These limitations are the result of the decisions made by the original data collectors and holders about purposes, methods, and data structures, which is not uncommon when secondary data sources are used.

A. Impact Goal 1: Older Adults Are Able To Meet Their Basic Needs

- 21% to 36% of the households in the nine localities in the Greater Richmond area have one or more individuals 65 years and older (Census 2000)
- In these localities, the number of older adult women living alone is anywhere from two to five times greater than the number of older adult men living alone (Census 2000)
- The percent of older adults living in poverty ranges from a low of 3% in Chesterfield to a high of 19% in Charles City and these percentages have decreased since 1990 for each of the nine localities (Census 2000 and Census 1990)
- In the localities except Goochland, Hanover, and Chesterfield, a higher percentage of older adult women living alone are living below the poverty level as compared to older adult men living alone (Census 2000 long-form questionnaire)
- In all the localities except Charles City, there are households with householders aged 65 and older with no telephone service (.2% to 4%) (Census 2000 long-form questionnaire)
- In all localities, there are households with householders aged 65 and older with no vehicle available (9% to 33%) (Census 2000 long-form questionnaire)

B. Impact Goal 2: Older Adults Are As Healthy As Possible

- 98% of adults aged 65 and older in the Greater Richmond area report having some type of health care coverage (BRFSS survey)

- 1% of the adults aged 65 and older in the Greater Richmond area report having had a time in the last 12 months when they needed to see a doctor but could not due to cost (BRFSS survey)

- 70% of the adults aged 65 and older in the Greater Richmond area report good to excellent general health (BRFSS survey)

- The average number of days of poor physical health (4 days) and poor mental health (2 days) reported by adults aged 65 and older in the Greater Richmond area compares favorably with both Virginia outside of the Greater Richmond area and the national average (BRFSS survey)

- Approximately 50% of the adults aged 65 and older in the Greater Richmond area have been told by a medical professional that they have high blood cholesterol and/or high blood pressure, both of which well exceed the Healthy People 2010 goals (BRFSS survey)

- Over 20% of the adults aged 65 and older in the Greater Richmond area have been told by a doctor that they have diabetes, which exceeds both the national and the not Greater Richmond area findings (BRFSS survey)

- 20% of the adults aged 65 and older in the Greater Richmond area report that they currently smoke; this exceeds the Healthy People 2010 goal of 12% (BRFSS survey)

- Over 80% of the adult females aged 65 and older in the Greater Richmond area report having had a clinical breast exam and over 90% report having had one within the last two years (BRFSS survey)

- Over 90% of the adult females aged 65 and older in the Greater Richmond area report having had a mammogram and over 80% report having had one within the last two years, which exceeds the Healthy People 2010 goal (BRFSS survey)

- A higher percentage of men and women aged 65 and older with disabilities in the Greater Richmond area are living below the poverty level than those without disabilities, and women with disabilities are more likely than men with disabilities to be below the poverty level (Census 2000 long-form)

- Of the nine localities, all cities / counties except Chesterfield and Goochland exceed the Health People 2010 target of 208 deaths per 100,000 for heart disease (VA Department of Health)

- Of the nine localities, all cities / counties except Charles City exceed the Healthy People 2010 target of 48 stroke-related deaths per 100,000 for cerebrovascular disease (VA Department of Health)

C. Impact Goal 3: Older Adults Have Safe and Affordable Housing

- The homeownership rate for adults aged 65 and older is greater than the overall state rate of 80% in six of the nine localities: Charles City, Chesterfield, Goochland, Hanover, New Kent, and Powhatan (VCHR)

- The homeownership rate for adults aged 65 and older is less than the overall state rate of 80% in the three localities that are the *most urban*: Henrico, Petersburg, and Richmond City (VCHR)

- The homeownership rate, ranging from 64% to 96%, for adults aged 65 and older is greater than that of the adults less than 65 years of age in all nine localities (VCHR)

- The lowest income populations, which includes seniors depending primarily or exclusively on social security income, experience a large gap between their income and the cost of adequate rental housing (VDHCD and VHDA Analysis)

- The percent of owners (of all ages) with gross incomes less than $20,000 that are paying 30% or more of their income on housing (principal + interest + utilities) ranges from 49% to 73% in the nine localities (VCHR)

- The percent of renters (of all ages) with gross incomes less than $20,000 that are paying 30% or more of their income on housing (rent + utilities) ranges from 69% to 95% in the nine localities (VCHR)

- There is an anticipated shift in the relative numbers of adults 75 and older from the core cities to the surrounding counties between 2000 and 2010 leading to a potential mismatch between the location of deep subsidy rental housing for the elderly and their location of choice (VDHCD and VHDA Analysis)

D. Impact Goal 4: Older Adults Are Socially And Emotionally Supported In The Community

- Adults aged 65 and older in the nine localities were much more likely to be the victim of a property crime than a person crime if victimized (NIBRS 2001)
- Adults aged 65 and older in the nine localities are much less likely to be the victim of any crime than adults aged 64 and younger (NIBRS 2001)
- Adult victims of crime aged 65 and older in the nine localities were much less likely to be the victim of a person crime than adult victims of crime aged 64 and younger (NIBRS 2001)
- Of the nine localities, with the exception of Richmond City and Chesterfield, the adult victims of crime aged 65 and older were much more likely to report that the offender was someone they knew (family member or otherwise known to them) than a stranger (NIBRS 2001)

E. Impact Goal 5: Caregivers Have The Skills And Supports Needed To Care For Older Adults

- Long-term care for the elderly is considered a serious issue by 30% of the adult respondents (CVHPA Community Needs Assessment survey)
- Caring for the elderly is considered a serious issue by 22% of the adult respondents (CVHPA Community Needs Assessment survey)

IX. RECOMMENDATIONS

This section summarizes the recommendations related to each of the impact goals. These recommendations are based upon the data sources analyzed and cited in this report. There are many sources of national, state, and local data and information that can be used to shape and understand older adult issues. However, there are substantially fewer resources that provide useful data about older adults in each of the nine localities in the Greater Richmond area that are of interest to the OAP and OAAC. Key data sources that were located required data manipulation and analysis.

A. Impact Goal 1: Older Adults Are Able To Meet Their Basic Needs

Decennial census data is a very viable option for monitoring the ability of older adults to meet their basic needs.

- Use decennial census data to monitor the ability of older adults to meet their own needs based on analysis of income and poverty, prevalence of disability, and vehicle and telephone availability.

- Exercise caution when drawing inferences about older adults at sub-county/city geographic levels since data on income and poverty, disability, and vehicle and telephone availability are derived from a sample of households and the estimates will be less stable at smaller levels of geography.

B. Impact Goal 2: Older Adults Are As Healthy As Possible

One of the most significant resources available to UWS is Virginia's BRFSS data, collected by SERL on behalf of VDH since 1989. Analyses can provide valuable information about the health of older adults in the Greater Richmond area as compared to those outside of the Greater Richmond area. The descriptive analyses of BRFSS data presented in this report indicate that there is little difference between those living in the Greater Richmond area and those residing outside of the Greater Richmond area with regard to selected health variables. Given this fact and in the absence of locality specific data, UWS and the OACC and OAP may consider using statewide BRFSS data as proxy data for the Greater Richmond area. It is recommended that UWS use BRFSS data to monitor the following indicators:

- 100% of older adults having health insurance coverage.
    - The Healthy People 2010 target is not currently met.

- Number of adults currently smoking not to exceed 12%.
    - The Healthy People 2010 target is not currently met.

- Number of older adults with high blood pressure not to exceed 16%.
    - The Healthy People 2010 target is not currently met.

- Number of older adults with high blood cholesterol not to exceed 17%.
    - The Healthy People 2010 target is not currently met.

- 70% of older adult women having had a mammogram within the past two years.
    - The Healthy People 2010 target has been met.

Virginia Health Information is a rich source of data about hospital admissions and discharges. Primary and secondary diagnoses, hospital procedures, and discharge dispositions can be tracked. Also, repeated admissions can be tracked. This can be important when considering older adult issues since some may lack access to adequate medical care. VHI data costs money. The patient-level data file can be purchased or special data runs can be requested.

The decennial census data is a good source of data on income and poverty, disability, and vehicle and telephone availability. In the absence of a valid measure of one's ability to meet his/her basic needs, UWS should explore the use of proxy variables that when considered in combination provides a picture of older adults in the community of interest.

C. Impact Goal 3: Older Adults Have Safe And Affordable Housing

Three viable sources of housing data and analyses are: The Virginia Center for Housing Research (VCHR) in the Research Division at Virginia Tech University in Blacksburg, the Virginia Department of Housing and Community Development (VDHCD), and the Virginia Housing Development Authority (VHDA). The VCHR, established in 1989, is recognized for its expertise in housing issues in the Commonwealth. Among other research and consulting projects, the VCHR tackles the research needs identified in the State's Comprehensive Housing Affordability Strategy (CHAS). CHAS is the official housing plan for Virginia.

Regional housing assessments have been conducted by the VDHCD and VHDA. The UWS could contact both of these agencies for detailed data and analyses specific to the older adult population in the nine localities in the Greater Richmond area that are of interest.

- Establish benchmark and goal for the percent of older adults owning homes and percent of older adults in rental units, and use VCHR data to monitor.
- Establish a benchmark and goal for the percent of older adults paying 30% or more of gross income for housing costs (ownership and rental) and use VCHR data to monitor.
- Contact VDHCD or VHDA for detailed data regarding the availability of deep subsidy rental housing units for older adults in each of the geographic areas of interest.

D. Impact Goal 4: Older Adults Are Socially And Emotionally Supported In The Community

Regarding the social and emotional support of older adults in the community, the National Incident Based Reporting System (NIBRS) is very valuable for examining older adult victimization. It is recommended that the UWS contact the Virginia State Police and/or the Department of Criminal Justice Services Statistical Analysis Center to pursue continued support in data analyses. A website at www.jrsa.org/ibrrc was created by the Justice Research and Statistics Association to provide a thorough introduction to NIBRS data structure and how to work with the file segments. One section provides examples specific to the analysis of elderly victimization data.

- Establish benchmark and goal to monitor the percentage of adults 65 and older who are victims of person and property crimes and the percentage who are victimized by family members or members of the same household.

Another potential source of victimization data is the National Crime Victimization Survey, although this is a nationwide sample of 43,000 households annually so decisions would have to be made about its utility given the number of relevant cases, geographically and age-wise. (More information about this survey is available at www.ojp.usdoj.gov/bjs/cvictgen.htm.) Certainly, fear of crime and victimization questions might be pursued through the BRFSS.

- Consider adding questions to BRFSS or using NCVS data to determine percentage of adults 65 and older to measure fear of crime.

E. Impact Goal 5: Caregivers Have The Skills And Supports Needed To Care For Older Adults

The CVHPA Community Needs Assessment data could be a valuable resource for UWS.

- Discuss with the CVHPA the feasibility of obtaining a combined file that contains data from both 1999 and 2002. This might yield enough cases to disaggregate results by age group (under 65 and 65 and older). Another option, in the future, might be for the UWS to consult with CVHPA about an oversampling of older adults.

- Discuss with the CVHPA the inclusion of additional questions in the next community survey regarding specific long term care issues, including workforce impacts.

As part of the DataShare pilot project proposal, UWS and SERL initially planned to develop a community survey to address persistent gaps in data relative to older adults. As a result of the data collection and data analysis activities undertaken during the last several months, the development of a community survey is thought to be inappropriate for the following reasons: 1) the data needs are diverse, 2) capturing the data of interest on one survey would be very challenging, and 3) there is a strong desire to learn about the needs of older adults that are not currently receiving services or accessing community programs. A mail survey such as the one conceptualized at the outset of this project would not be the best method to collect data from this group of individuals. Therefore,

it is recommended that UWS pursue a federal grant that would provide the necessary financial resources to design a responsible methodology, develop appropriate instrumentation, and collect data in a manner that results in analyses that are both valid and reliable. The SERL staff is pleased to work collaboratively with UWS in this regard should UWS decide to pursue this strategy.

REFERENCES

Analysis of Housing Needs in the Commonwealth, a joint report of the Virginia Department of Housing and Community Development and Virginia Housing Development Authority, November 2001.

Community Needs Assessment, Central Virginia Health Planning Agency 2002.

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Census 2000 Profile of General Demographic Characteristics United States and Virginia/prepared by the U.S. Census Bureau, 2001.

Census 2000 Summary File 1 United States and Virginia/prepared by the U.S. Census Bureau, 2001, Table QT-P11.

Census 2000 Summary File 3 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table QT-P34.

Census 2000 Summary File 3 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table DP-4.

Census 2000 Summary File 3 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table DP-3.

Census 2000 Summary File 3 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table PCT26.

Census 2000 Summary File 3 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table PCT34.

Census 2000 Summary File 4 United States and Virginia /prepared by the U.S. Census Bureau, 2001, Table QT-H10.

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Koebel, C. Theodore and Kelly M. Atkinson, "Homeownership Affordability in Virginia," A Report on Homeownership Affordability released jointly by the Virginia Association of Realtors and the Center for Housing Research, Virginia Tech Center for Housing Research, January 2003.

U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division, Uniform Crime Reporting Program, National Incident Based Reporting System, 2001 Data File.

Virginia Health Statistics, Volume 1. Center for Health Statistics, Virginia Department of Health, 2000.

Virginia Housing Atlas Profile Pages, Virginia Center for Housing Research, 2000.

ADDITIONAL RESOURCES

Behavioral Risk Factor Surveillance System (BRFSS), National data, Center for Disease Control website – http://www.cdc.gov/brfss/index.htm

Department of Health and Human Services, Centers for Medicaid and Medicare Services, Medicare Eligibility Tool - http://www.medicare.gov/MedicareEligibility

Interuniversity Consortium for Political and Social Research (ICPSR) - http://www.icpsr.umich.edu

Justice Research and Statistics Association, Incident-Based Reporting Resource Center - http://www.jrsa.org/ibrrc/

Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services - http://www.healthypeople.gov

United States Census Bureau – http://www.census.gov

United States Census Bureau's American Fact Finder website - http://factfinder.census.gov

United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Crime and Victims Statistics, Bureau of Justice Statistics criminal victimization data collections - http://www.ojp.usdoj.gov/bjs/cvict.htm#ncvs

Virginia Center for Housing Research, Center Reports - http://www.arch.vt.edu/CAUS/RESEARCH/vchr/Othereports.html

APPENDIX A

Virginia Center for Housing Research

Housing Profile Pages for Charles City County, Chesterfield County, Goochland County, Hanover County, Henrico County, New Kent County, Petersburg City, Powhatan County, Richmond City, and Virginia

retrieved online at:

www.arch.vt.edu/caus/research/vchr/2000%20Atlas%20profiles%20to%20put%20on%20website%20pdf.pdf