REPORT OF THE VIRGINIA DEPARTMENT FOR THE AGING IN COMPLIANCE WITH THE CODE OF VIRGINIA §2.2-703.1

Virginia's Four-Year Plan for Aging Services

Across the Continuum — Across the Commonwealth

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Dear Reader:

This State Plan differs from previous studies and reports on aging services in several dimensions, in part, because the aging of Virginia has become so pronounced that we are all older Virginians. Building plans predicated on "them" instead of "us" makes less sense. At the same time, we have grown in our understanding of human aging and a State Plan should incorporate this fuller, more comprehensive and more positive perspective.

One of the most significant breakthroughs in our understanding is that, as we grow older, we tend to grow less alike. This hallmark of aging seems counter-intuitive. After all, there are fairly common changes in the shapes of our bodies – our hair often grows grey or goes away, most of us need glasses, and so on. These, however, are relatively minor commonalities. On virtually every important dimension, from health to income to acquired skills and experience, aging increases the variety within each generation. Simply put, there is greater variability in characteristics and function among 75 year olds than among 45 year olds.

Viewing later life on a continuum, the vast majority of us will be healthy, active contributors to our communities. Most of us will need information; some will need intermittent services; fewer still will need coordinated long-term services to delay or prevent institutionalization; and a smaller number will require facility-based care.

Often government reports focus almost exclusively on older adults in need, an understandable priority, yet ignoring us also as resources, as volunteers, as experienced employees, as caregivers, as grandparents raising grandchildren, and as citizens actively engaged in the civic structure. Older Virginians with time and talent are, in many ways, an untapped resource, waiting to be activated.

Recognizing the great variability among older Virginians, this Plan focuses on the continuum from most to least able – both resource and need. It avoids the inclination to label individuals as independent or dependent, recognizing that none of us is ever fully independent. From childhood on, we have depended on others in our family and community. We may strive for autonomy, the ability to choose and execute our own decisions, but we do so with the help of others. Even those in need of assistance may still desire to manage that assistance. Thus, the goal is to maximize autonomy or "assisted autonomy" for all older Virginians – wherever we are across the continuum of aging.

This State Plan offers a framework for action, recognizing the interaction or interdependence between older Virginians and our communities, and incorporating recommendations for both Optimal Aging by individuals and creating communities that help us Age in Place. This Plan asks and answers the question: What can each of us, our local communities and the Commonwealth do to enable us all to continue our development across the life course.

— The Four-Year Plan Work Group

EXECUTIVE SUMMARY

As the Baby Boom generation races toward traditional retirement age, the number of older adults in Virginia will reach 1.8 million by 2030 – more than double that population in 2000. In just two decades, almost one in every five Virginians will be age 65 or older, with the over 85 age group being the fastest growing segment of the population. Recognizing the coming "Age Wave," the 2008 Virginia General Assembly expanded the duties of the Virginia Department for the Aging by mandating a four-year planning process for aging services. Numerous prior studies have already documented issues in serving Virginia's older adults. This Plan however, attempts to present a comprehensive picture of where we are now and where we need to go to effectively meet the needs and leverage the human resources of Virginia's rapidly aging population.

This report recognizes the broad continuum of aging and describes the current informal and formal array of supports and services utilized by older Virginians – and begins to layout a plan for how that system must change in order to meet future demands. It begins by underscoring the value of older Virginians as vital resources to our families and communities, stressing the power and responsibility each of us has in shaping our later years, and introducing the concept of "Optimal Aging." It also recognizes that some of us require a level of assistance beyond what can be provided with informal supports or paid for with private means. Therefore, the Plan goes on to discusses how the Commonwealth, communities and public and private services can be designed to help us all remain safe and autonomous to the greatest extent possible, enabling us to "Age in Place" through the development of "Livable Communities."

In addition to discussing how most individuals can help shape their later years through maintaining their physical and mental health to the greatest extent possible, remaining engaged in the social and civic life of their community, and planning for their financial future; this Plan recognizes that there are some special populations whose unique challenges call for particular consideration and targeted supports. These special populations include adults with lifelong disabilities, grandparents raising grandchildren, aging immigrants, and older prisoners.

Virginia is not alone in facing the coming age wave and there are transformational changes underway across the nation in aging services. These changes are being driven by both desire and necessity. Seniors overwhelmingly report they want to stay in their homes and communities and policy makers recognize that we simply cannot sustain the current system as the huge baby boom generation approaches their later years. As a result, the nation is moving from a cultural mindset of institutional care for the elderly to supporting individuals at home with the necessary level of care to thrive and contribute as members of the community.

Unfortunately, most communities developed over the past several decades are not conducive to "Aging in Place." The vast majority of us live in suburbs - often in homes that present barriers as we

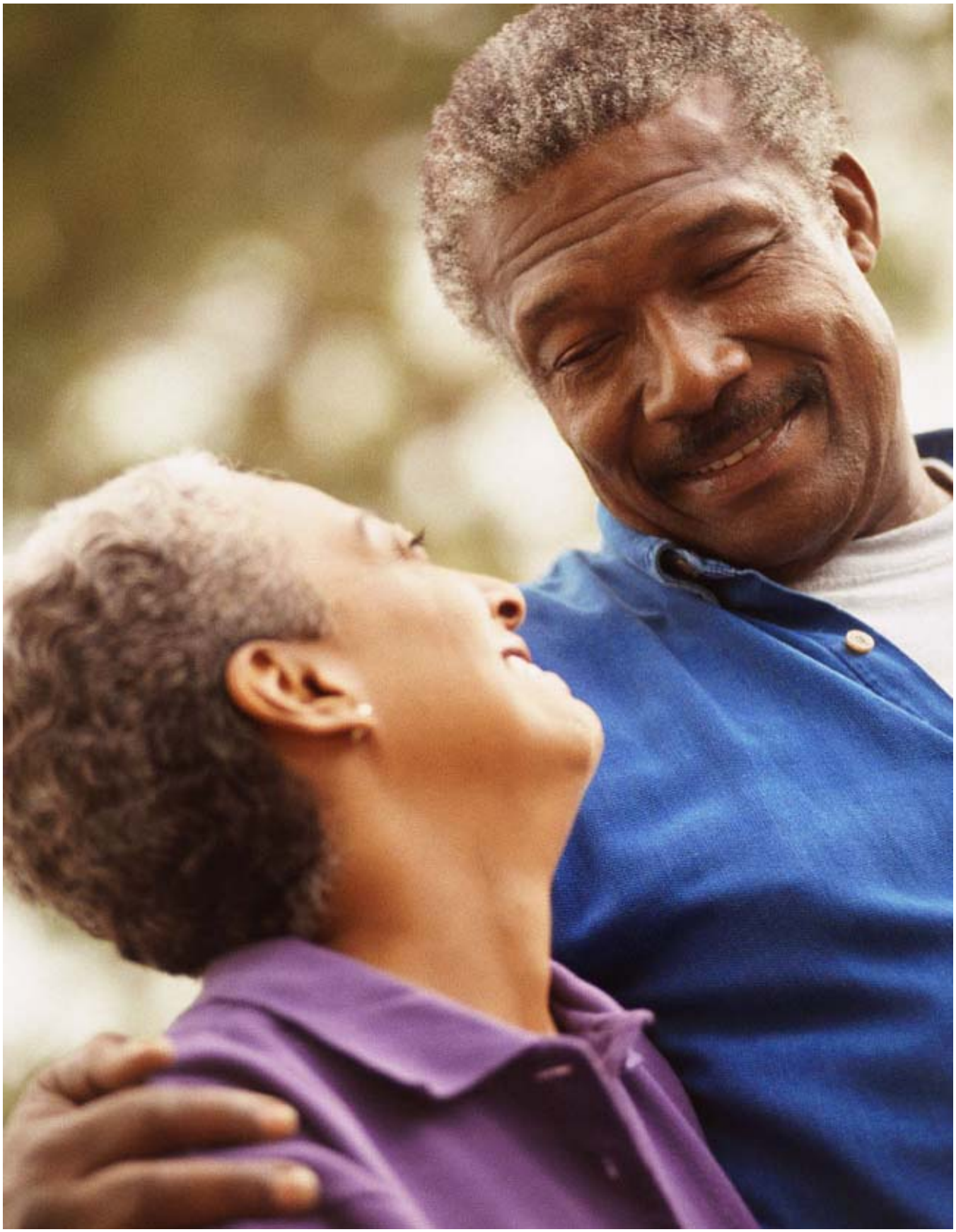
age and located outside of public transit routes. When driving is no longer an option, we become isolated from grocery stores, pharmacies and medical services, and even friends and family.

Fortunately, there are models and resources available to help communities not just survive the impending demographic shift but actually seize the opportunity to create aging-friendly or "livable communities" for all ages. Such a community addresses the needs of older adults for safety and security, accessible and affordable housing, mobility options, home and community-based services, and accessible health care and medical-related supports. Livable communities that support older adults aging in place tend to also support healthier lifestyles for people of all ages. This report delves into each of these essential areas, discusses Virginia's strengths and challenges, and presents recommendations for pathways to success.

Change is inevitable. If we ignore the signs, it will catch us unprepared and drive us to react in crisis. This Plan is the beginning of a comprehensive, inclusive and proactive approach to the coming change. The recommendations herein are the collective voices of policy makers, service providers, researchers, planners, and advocates. Although many of the recommendations focus on the most vulnerable citizens, others are more universal in nature with a goal to assist all older adults to remain as autonomous as possible given their unique circumstances.

Currently, the recommendations are not prioritized but rather categorized by topics. Arguably, some, such as health care workforce development are particularly urgent because of the years it will take to educate and develop the number of professionals and direct service workers needed to support the coming wave of older Virginians. Some recommendations are detailed because the necessary research is available to guide and support specific strategies. Others are broad-based, acknowledging the need for additional information to determine the proper approach. Many recommendations will necessitate funding and must be addressed as the economic climate improves. Finally, many recommendations will only come to fruition through collaborative efforts. It will be necessary to break through historical silos and build on existing and develop new creative partnerships, leveraging the strengths of both the public and private sectors. Wherever possible, this Plan recognizes and supports the recommendations of current collaborative efforts.

The primary goal of this first planning effort is to establish a structure and process that will serve as a solid foundation from which future efforts to assess Virginia's network of aging services can evolve. Public input must be solicited, additional relevant data collected, some issues explored further, desired outcomes defined, recommendations prioritized and made actionable, benchmarks for measuring progress established, and a process for evaluating effectiveness designed and implemented. The most important change needed however, is not contained in this Plan – for state and local leaders to move the aging of Virginia near the top of the public policy agenda. There is obviously much to do and little time to prepare. The future is almost here.

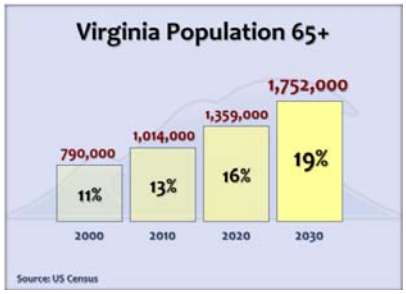


INTRODUCTION

In 2008 the Virginia General Assembly passed legislation expanding the duties of the Virginia Department for the Aging (VDA) by mandating a four-year planning process for aging services. (See Appendix A for § 2.2-703.1). This document constitutes the first Four-Year Plan for Aging Services, submitted to the Governor and the General Assembly in November, 2009.

Numerous prior reports have documented the issues involved in serving Virginia's seniors both today and tomorrow. These include studies by the Secretary of Health and Human Resources in 1992, the Joint Commission on Health Care in 1998, and the Joint Legislative Audit and Review Commission (JLARC) in 1999. More recently, the 2006 session of the General Assembly required all state agencies to prepare annual reports in response to the 2006 JLARC study: Impact of an Aging Population on State Agencies. This Four-Year Plan is not just a newer version of previous reports but instead begins to layout a comprehensive picture of where we are now and where we need to go, in order to effectively meet the needs and leverage the human resources of Virginia's rapidly aging population.

In order to develop this first Four-Year Plan for Aging Services the Virginia Department for the Aging assembled a diverse planning team of experts from state agencies, boards and councils, non-profits, community programs, service providers and advocacy groups. (See Appendix B for list of work group members). The Plan represents their knowledge and insight, incorporates current national and state data from recent studies and reports, and presents recommendations for action that will move the Commonwealth forward in serving older Virginians now and in the future. (See Appendix C for a list of all recommendations).



Members of the Silent Generation (born between 1910 - 1925) who reached age 65 were rewarded with an average life expectancy of 12 more years. Baby Boomers (born between 1946 - 1964) who reach 65 will likely live another 20-25 years – almost twice as long as their parents.

Some reports state that today the average Baby Boomer has more living parents than children.

The Coming Age Wave

While few claim to have foreseen the depth and breadth of the current economic downturn, there is another societal change we can all clearly see coming – if we choose to look. Like the recession, the impact will be felt in all sectors of society and will create long lasting fundamental changes in our world. But unlike the fiscal crisis, this change will not only bring challenges but will offer exciting opportunities as well. Virginia, like most of America, is aging and aging rapidly. As the Baby Boom generation (born between 1946 and 1964) reaches traditional retirement age, the number of Virginians over age 65 will reach 1.8 million by 2030 – or more than double the number in 2000. In just two decades, almost one in every five Virginians will be age 65 or older, with the over 85 age group being the fastest growing segment of the population.

However, the future population of older Virginians will not just differ in size. While the current 65+ population in Virginia is less diverse than the overall population (21 percent compared to 33 percent), the number of older Virginians who are Hispanic or non-white will continue to grow in the coming decades. In addition, experts tell us that baby boomers will be fundamentally different than their parents in their expectations and demands for services and supports. Just as this massive generation has changed society as it moved through the decades, boomers are likely to change what it means to grow old. These trends will require that cultural competency increasingly becomes a part of the provision of senior services and likely require the development of new programs and service delivery models.

Where We Are

This report attempts to describe the formal and informal array of supports and services that are in place today to address the needs and resources of older Virginians – and to begin to describe how that system must change in order to meet future demands. It is, of course, impossible to catalogue all the resources available to us as we age, largely because most are provided by individuals through private means or by our families and informal social networks. For the most part, this vast informal system of support works very well with no link to any organization, no government oversight, and no data collection or reporting – and represents the preferred choice for most of us.

The more formal system of long-term services provides vital support to thousands of individuals but is also criticized by many. In Virginia, publicly funded long-term services are administered by a variety of state and local agencies; although VDA is the only state agency with the specific mission of serving individuals age 60 and over (See Appendix D for agency responsibilities). The separation of these programs is often described as fragmented and difficult to under-

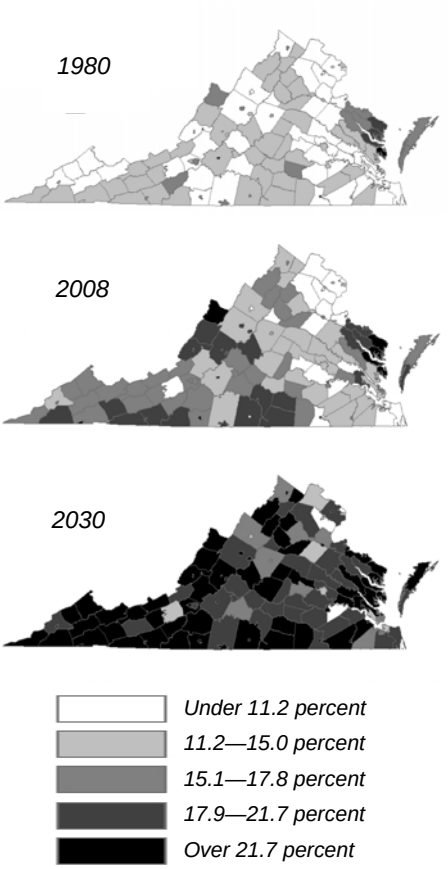
stand or access, driven primarily by different funding streams, with a focus on services available rather than the individual's needs. Fortunately, there are initiatives at the national level designed to transform aging services that are rapidly taking hold here in the Commonwealth. The influence of these exciting trends can be seen emerging in services today and influence the recommendations presented in this report.

Virginia's Four-Year Plan for Aging Services

Most of us not only remain active but continue to contribute to our communities and assist others (parents, children, friends, and neighbors) well beyond retirement. For us, the primary assistance necessary to help maintain a healthy and fulfilling life may simply be information – about wellness, health care, personal finances, planning for our future, and available services and supports, should we need more. This Four-Year Plan therefore begins by underscoring the value of older Virginians as vital resources to our families and communities and the power and responsibility each of us has in shaping our later years.

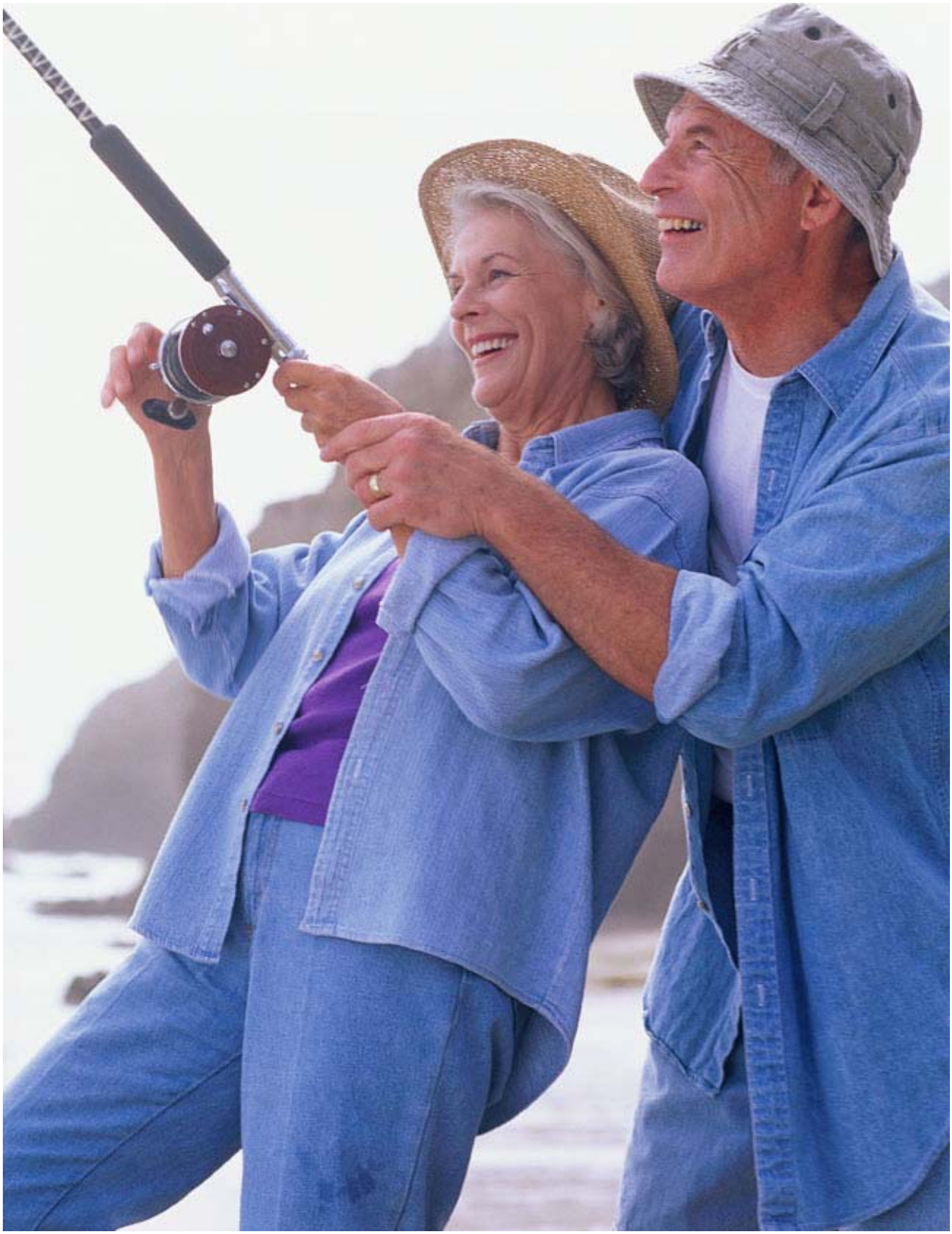
There are times however, when an individual requires a level of assistance beyond what can be provided with informal resources or paid for with private means. Therefore, this Plan goes on to discuss how the state, communities and public and private services can be designed to help us all remain safe and autonomous to the greatest extent possible. The challenge, of course, is to ensure that the right services and supports are easily accessible no matter where we are on the continuum – from the need for minimal guidance to intensive daily support. If we can be smart in how we plan to serve the growing numbers and meet the diverse needs, and wise in how we spend our resources, the Commonwealth will be an even better place for both young and old alike.

Percentage of Virginians 65+



70 percent of older Virginians live in metropolitan areas but rural Virginia has the highest proportion of seniors, resulting from a combination of younger generations moving away and older adults moving to rural settings for retirement.

In 2000 there were 50,454 centenarians in the United States compared to the 1990 census, which reported 37,306.



OPTIMAL AGING — INDIVIDUAL

Although each of us experiences aging from a unique perspective, we generally agree that we would like to maintain our quality of life as we grow older. By avoiding or managing chronic disease, maintaining high cognitive, mental and physical health, engaging in life, and planning for our future, we are playing an active role in our aging process. "Optimal Aging" embraces the philosophy that we can optimize our capabilities and our satisfaction with life, regardless of age or health status. While our goal may be to avoid or at least deter disease and related disabilities, this approach suggests that even in a chronic-disease state, we have the choice to maximize our life.

Optimal Aging is a pathway that measures success not just by health status but also by connection to others, contributions to humankind, and creative and productive energy. By focusing our capacity to function across many domains – physical, functional, cognitive, emotional, social, and spiritual – Optimal Aging goes beyond good health and longevity and takes root in the concept of adaptation. In short, it proposes that changes across the lifespan offer opportunities to adjust, adapt, learn, and grow. Optimal Aging is good for us, for our loved ones, and our communities. As we add years, we also add experiences and knowledge, which can be used to teach and mentor others. With age, each of us develops a reservoir of skills and expertise. By offering access to our wealth of knowledge, skills and experiences, we can maximize our quality of life and raise the quality of life for others as well.

By the year 2030:

- *More than one out of every three Boomers will be considered obese.*
- *More than half of all Boomers will be living with a chronic condition such as diabetes or heart disease.*
- *Nearly 1 out of very 2 Baby Boomers (more than 26 million) will be living with arthritis.*

After a 12-week session of "Stand Tall, Don't Fall" exercise program offered by the Prince William Area Agency on Aging, 77 percent of participants showed improved balance.

Maintaining Physical Health

Given that we all age differently, what should we expect of our bodies as we grow older? According to a longitudinal study by the National Institute on Aging, "normal" aging should be distinguished from a "disease-state." Although people's bodies change and decline over time, debilitating and life-threatening disorders such as diabetes, hypertension or dementia are prompted by disease and are not considered part of the "normal" aging process. Admittedly though, diseases are much more prevalent in later life. In fact, 85 percent of individuals over 65 have at least one chronic health condition.

Chronic Disease

Six of the seven leading causes of death among older adults are chronic diseases. While it is true that we don't choose our parents and genetics may foster predisposition for a particular disease, many chronic diseases associated with later life can be modified or even prevented with positive behavioral interventions. Lack of regular exercise, poor eating habits and smoking are the three biggest contributors to disease-related declining health. Although advances in medicine continue to increase longevity overall, proper disease management and healthy lifestyle decisions are significant factors in determining an individual's lifespan.

Secondary Factors

Lack of education and low income can be secondary factors influencing our health. Living at a lower economic level can mean that nutritious foods have been less accessible for some or all of our life. Additionally, growing older in poverty may present economic and geographic barriers to accessing regular health and dental care or may present environmental hazards such as poor air quality or greater exposure to waste products.

Just as poverty can contribute to poor health, chronic declining health can have a significant economic ripple effect. Research shows that adults 50 and older who begin exercising just 90 minutes a week can save an average of $2,200 per year in medical costs. Collectively, it has been estimated that, if all 39 million Medicare recipients followed suit, over $3 billion dollars of unnecessary health care costs could be avoided. Exercise can also prevent more than just disease. There is mounting evidence that regular exercise is one of the biggest factors in preventing falls by improving strength, flexibility, balance, and endurance. Simply translated, a prevented fall can mean a prevented trip to the hospital, prevented x-rays and treatment, and prevented rehabilitation or nursing home placement. Ultimately, it can mean preventing thousands of deaths and millions of dollars in health care spent each year as a result of falls.

Another ripple effect to an individual's declining health is the impact on family caregivers. The longer an individual can live autonomously, the shorter the period of dependence on loved ones. As the aging population continues to mushroom and the health and financial burdens on caregivers multiply, the benefits to reducing morbidity can mean a better quality of life for several generations.

Prevention

Beyond exercise, other preventive measures such as vaccinations help to support and extend good health. While vaccination rates for all older adults have increased overall in recent years, it is not true for all sectors of the population. Hispanics and non-Hispanic blacks are 20 percent less likely to receive a flu shot than non-Hispanic whites. A healthful diet at any age is also valuable but in later years it is especially important to decrease sodium, saturated fat, added sugar and alcohol because of changes in metabolism. Obesity has reached epidemic proportions among all ages; however in older adults it can cause additional complications when combined with arthritis, osteoporosis, or mobility restrictions.

Clearly, preventative measures can go a long way in reducing morbidity but when health issues do arise, it is important to have access to health professionals who understand the complexity of physical, emotional and environmental factors that collectively impact health diagnosis and treatment for older adults. Access to care is a challenge for older adults – not so much because of lack of insurance but moreover due to workforce shortages. Generally speaking, health professionals are not trained to specifically address challenges unique to older age. For instance, the fact that the body absorbs, distributes and metabolizes medications differently is often over-looked when prescribing medications for seniors. Additionally, adverse drug reactions are often mistaken for a new disease in older adults – prescribing additional medications to treat the new symptoms creates a reaction or "cascade effect."

According to the National Institute on Aging, "Years ago we didn't talk about disease prevention for seniors. Now we see that disease and disability are not inevitable consequences of aging." With a rapidly growing senior population, a self-directed boomer population and a growing dependence on family caregivers, the need to educate and assist consumers to support healthy lifestyle choices is compelling. While much needs to be done to bolster the geriatric health professions workforce, older adults and family caregivers must also take an active role in preventative care, diagnostic processes, and medication and treatment management. Aging is a lifelong process. Good health in later years begins with good choices – the sooner the better – but research shows it is never too late to start.

In 2009, at the age of 82, Joy Johnson completed her 22nd consecutive New York City Marathon. According to Running USA, since 2003, the number of finishers 80 and above for all road races has risen 23 percent compared with 16 percent for all age groups.

At 107 years of age, Larry Haubner, Fredericksburg, Virginia, attributes his longevity to exercise. Until 2004, he rode his bike everyday.

At the 2009 World Masters Games in Sydney, Australia, 28,000 senior athletes, up to age 101, competed in a variety of sports. The gold medal in the backstroke went to a 90 year old and a 100 year old took the gold in the shot put.

Facts about Alzheimer's Disease:

- *Every 71 seconds, someone develops Alzheimer's.*
- *Alzheimer's is the sixth-leading cause of death in the United States.*
- *Nationally, 10 million Boomers will develop Alzheimer's disease in their lifetime.*

A recent assessment of Virginia's long-term care system revealed that over half of Virginia's nursing facility residents have depression and 46 percent have dementia.

Maintaining Mental & Cognitive Health

Mental health is as important as physical health when striving to live and age optimally. Contrary to popular belief, "normal aging" does not predicate a decline in either cognitive function or emotional disposition. Typically, cognitive changes that occur naturally simply translate to a slower pace of learning and the need for new information to be repeated. While the majority of us will encounter only these normal changes, one in eight people over 65 will develop dementia.

Dementia

Dementia develops when the parts of the brain involved with learning, memory, decision-making, and language are affected by infection or disease. The most common cause of dementia is Alzheimer's disease but there are as many as 50 other known causes. Today over 130,000 Virginians have been diagnosed with Alzheimer's disease, a number that is expected to double by 2030. Beyond its debilitating nature, this neurological disorder often robs individuals of their dignity and eventually crumbles the foundation for meaningful communication. In addition to the heartache it imposes on families, it demands their round-the-clock care and financial support. Nearly 250,000 family caregivers in Virginia provide over two million hours of unpaid care every year for their loved ones with Alzheimer's disease. Although this translates to approximately 75 percent of the individual's care, still the family's out-of-pocket expenses average nearly $19,000 a year. The alternative is cost-prohibitive to most families – nursing home care averaging about $65,000 annually or assisted living facilities averaging $36,000. Given that most individuals with Alzheimer's disease live 8 - 20 years beyond diagnosis, the lifetime financial burden on a family can be crushing.

Although research has not found a way to prevent Alzheimer's disease and other dementias, there are alarming trends which identify high risk factors. Data from a large-scale longitudinal study indicate that persons with a history of either high blood pressure or high cholesterol levels are twice as likely to get Alzheimer's disease. Those with both risk factors are four times as likely to become demented. Recent research suggests that regular physical exercise, reduced hypertension, a daily diet filled with fruits and vegetables, and social engagement may each help to improve overall cognitive health and collectively may help to delay or even prevent cognitive decline.

Depression

Surveys indicate that depression is often thought to be a "normal" part of aging, an attitude shared even by many seniors. While emotional expressions of sadness, grief, and temporary "blue" moods are typical responses to isolated circumstances, persistent depression that interferes significantly with daily function is not normal at any age. Estimates of major depression in older people living in the community range from less than 1 percent to approximately 5 percent but

rises to 11.5 percent in older hospital patients and to 13.5 percent for those who require long-term care. Studies indicate that health professionals often mistakenly think that persistent depression is an acceptable response to other serious illnesses or to social and financial hardships that often accompany aging – a false premise that contributes to low rates of diagnosis and treatment in older adults. According to the National Institute of Mental Health, depression, one of the most common conditions associated with suicide in older adults, is widely underrecognized and therefore under-treated. Studies show that up to 75 percent of older adults who die by suicide visited a physician within a month of their death. Furthermore, most elder suicide victims either live with relatives or are in regular contact with family or friends, underscoring again that their depression is largely overlooked or dismissed as a normal aspect of aging. One major obstacle faced by mental health professionals and caregivers is that older adults do not typically seek treatment for mental health problems.

Studies indicate a sociological bias by many that view youth suicide as a greater tragedy than late-life suicide. While they comprise only 12 percent of the U.S. population, adults over 65 account for 18 percent of suicide deaths.

Substance Abuse

Other contributing factors to depression in later life are prescription drug misuse and alcohol abuse. Ultimately, the potential for unintentional or intentional death by the use of alcohol, prescription drugs, over-the-counter drugs, or a combination of these substances is significant. Physiological changes which occur with aging can increase the risk for drug interactions and toxicity and can alter the absorption rate of otherwise harmless prescription drugs. Declining vision, hearing loss and memory impairment can cause confusion about directions and increase risk of misuse. Impaired judgment or lack of financial resources can lead to drug-sharing and hoarding. These factors coupled with multiple physicians treating one individual without care coordination can create the "perfect storm" for unintentional prescription drug misuse and even addiction. The psychological effects of alcohol are also more deleterious in the elderly than in younger adults, especially when mixed with medications.

According to statistics from AARP the average American over the age of 75 has more than 11 drugs prescribed yearly.

Detection and Management

The majority of seniors thrive in spite of minor physical and cognitive changes as well as losses of family and friends that frequently are associated with later life. However, nearly 20 percent of older adults suffer from mental disorders that are not part of "normal" aging. Depression, anxiety, and dementia are often debilitating and can be life threatening. Increased awareness and education and improved communications between family and friends can provide greater opportunities for detection and treatment. Regular physical activity can help to balance mood swings, reduce stress and increase energy levels. Attention to medication dosages and interactions with foods and over-the-counter drugs can completely reverse unintentional drug reactions. Together, these simple life changes may mean the difference between "existing" and "living" for an older adult challenged by non-disease-related decline in cognitive and/or emotional health.

"We have demonstrated that old age is not a defeat but a victory, not a punishment but a privilege….we all have a responsibility to remain active in retirement, to keep ourselves well informed, to cooperate with responsible public and private agencies concerned with programs and activities that will make our nation strong morally, spiritually and materially for the benefit of all Americans."

— Ethel Percy Andrus
Founder of AARP

Engagement

Optimal Aging encompasses every aspect of our lives including how we engage in work and play. "Engagement" is a recent catch word that refers to active participation in paid and unpaid activities, aligning our work with our interests, developing meaningful relationships, continuing to learn, and enjoying personally rewarding experiences. Civic, community and social engagement provide opportunities for us to contribute our skills and knowledge in a wide range of settings. These activities have a bi-directional benefit, providing a positive impact in the community and in our lives as well.

For years gerontologists have studied the positive affects of engagement – social, religious, educational, and intergenerational. Most recently they have added "civic" and "community" to the list, with an emphasis on social action and political involvement. Regardless of the type of engagement, evidence shows that the resulting connectivity through families, friends, volunteer groups, encore careers, and lifelong learning, may not cure chronic disease but has been proven to reduce their debilitating effects, prolong good health and expand overall quality of life.

Re-careering

Not only are older adults living longer but we are also retiring earlier than previous generations, creating an average retirement span of nearly 20 years. The "golden years" however, are taking new shape. An evolving trend especially with boomers and young seniors is "re-careering" or developing an "encore career." Not just a job change, re-careering demonstrates a personal choice to follow a completely different vocational path, often from corporate to non-profit or public service. Although encore career jobs tend to pay less with fewer benefits, they generally offer more flexible work arrangements, less stressful working conditions, and fewer managerial responsibilities –attractive qualities that support later lifestyles. Research shows that the number of people either in or considering encore careers is growing, with estimates as high as one half of older adults engaged in "bridge" jobs before retiring completely. According to AARP, staying productive and the need for additional income are the two most common reasons retirees continue to work.

Volunteerism

When additional money is not a requisite, older adults make enormous volunteer contributions through civic engagement, producing positive impacts for ourselves as well as the communities we serve. Just like re-careering, volunteering is a growing retirement endeavor, which has increased by nearly 65 percent over the past couple of decades. In fact, of all ages, older adults are the most likely to serve over 100 hours per year, equating to millions of dollars worth of unpaid talents invested in Virginia annually.

Unlike episodic volunteering, which is much more prevalent in boomers

and young adults, older adults tend to give substantial hours through single organizations or causes and over long periods of time, with nearly 60 percent contributing through educational programs and/or faith-based communities. Further, spiritual engagement often provides meaning and purpose and gives individuals with similar beliefs unique opportunities to develop support networks that assist with daily activities that might otherwise be sought through social service programs.

Life-Long Learning

Lifelong learning also ranks high as a positive influence in maintaining health and overall quality of life. While previous generations of older adults have considered education to be primarily a youth-oriented phenomenon, many of today's seniors view education as a continuous process over the life course. Elderhostel programs, community colleges and universities, and public libraries are among the most popular providers of continuing education — improving cognitive, emotional, physical, and social health, while also developing the talent pool of individuals better prepared to contribute back to the community.

Social Networking

Social networking is still a fairly new and controversial form of electronic communication. Critics agree that although there are potential dangers, when used with caution, it can be an excellent way of reducing isolation and bridging geographical and generational gaps. A recent study by the Pew Internet & American Life Project offers a closer look at the ages and usage of social networking. Not surprising the study shows that young people are much more likely to use online social networks than adults. Specifically, Pew found that only 30 percent of adults ages 35-44, 19 percent of adults ages 45-54, 10 percent of adults ages 55-64, and 7 percent of adults ages 65+ had a profile on a social networking site. However, additional data suggests that older adults are quickly catching up with the social networking phenomenon. In fact, according to Facebook, the fastest growing demographic of users is women aged 55 and older.

Intergenerational Activities

According to a new ACE/MetLife report, older adults prefer intergenerational learning to age-segregated education, recognizing that both older and younger students can learn from one another. This is also underscored by a recent survey showing mentoring and tutoring as the most popular activities among older volunteers. Furthermore, the benefits are bi-directional – studies show that students tutored by older adults make significantly greater gains on achievement tests. Aside from the educational benefits, intergenerational programs also demonstrate universal benefits such as helping to dispel generational stereotypes and encouraging tolerance and understanding of cultural and generational differences. Studies also show that strong intergenerational grandparent/grandchild relationships, either through kinship or foster programs, prompt older adults to become more altruistic, philanthropic and service-oriented.

A survey by AARP reports that 80 percent of boomers say they plan to work at least part-time during their retirement.

According to Generations United, successful intergenerational programs are based on reciprocity, are sustained and intentional, and involve education and preparation for all ages. Young and old are viewed as assets and not problems to be solved.

The number of women living in poverty over the age of 65 is twice that of men.

It has been estimated that a 65-year-old couple retiring in 2009 can expect to pay about $240,000 out-of-pocket for health care over the rest of their lives.

Financial Security

According to a recent State Profile conducted by the US Administration on Aging, Virginia's older adult population appears to be financially better off compared to most neighboring states with a higher average annual income from earnings, Social Security and retirement pension than the national average. Still, nearly 15 percent of Virginia's roughly 900,000 adults 65 and older have incomes near or below the poverty level, climbing to 20 percent in urban areas and 30 percent in rural Virginia, with minorities and women being even higher. Unfortunately, these estimates probably do not reflect the actual level of poverty of older Virginians as they are based on a 30+ year-old federal formula for calculating poverty levels that does not take into consideration today's household costs, including the cost of medical care – a significant expenditure for older adults.

Additionally, older adults in the population known as LGBTI (lesbian, gay, bisexual, transgender, intersex) face even greater risks related to poverty. When a partner is not legally recognized as a spouse, Social Security, Medicaid, and pension benefits are not accessible. Tax laws also do not recognize same-sex partners, precluding the surviving partner from receiving thousands of dollars a year. End-of-life decisions can be especially challenging from a legal standpoint, and with fewer children, often family caregiving options are also limited. Together these challenges lead to an even greater need for services to address late life poverty, isolation and depression within the LGBTI community.

Health Care Expenses

Last year, approximately 13 percent of all expenditures in households headed by people 65 and over were healthcare-related, including health insurance, medical services, prescription drugs, and medical supplies – compared to 7 percent for people age 55-64. Although Medicare covers nearly all adults 65 and older, premiums, deductibles, co-pays, and holes in the benefit package can result in substantial out-of-pocket expenses. Additionally, older adults must pay for services not covered by Medicare, such as dental, routine vision and hearing exams and most long-term care services. For low-income older adults, high out-of-pocket health care costs can easily deplete their savings, forcing them to turn to family and friends for financial help, forgo necessary care, or choose between their health, rent or even groceries.

Delayed Retirement

A generation ago, many retirees could count on guaranteed monthly pensions, Social Security and Medicare for financial and health security. Instead of traditional pensions, many people approaching retirement today have 401(k) plans that have been battered by the stock market. Declining home equity, rising health care costs, uncertain long-term care needs, low private saving rates, and hollow retirement plans now cloud the retirement outlook for many. Today, the top two sources of aggregate income for adults age 65 and over are Social Security – 37 percent and work earnings – 28 percent.

The financial landscape, however changing, does offer some strategic solutions. For instance, working a little longer can be a win-win – raising an individual's annual retirement income and boosting the government tax revenue. On average, working an additional year increases annual retirement income 9 percent and 5 extra years can boost it by 56 percent. Likewise, a one-year universal delayed retirement would raise approximately $180 billion in additional tax revenue in 2045 and a delay of 5 years would exceed $1 trillion. Additionally, as the massive numbers of boomers move into retirement age, Virginia's workforce will need to sustain older workers longer in order to remain competitive. Older workers choosing to delay retirement will soften the blow and help to fill the imposing workforce void.

Cost of Long-Term Care

Planning to work longer assumes we will stay healthy. But what happens if we don't? Seventy percent of people over 65 in need of long-term care must pay for some or all of that care through personal resources. Long-term care is expensive. In Virginia, the average daily nursing home rate for a semi-private room is $180 per day or $65,700 per year; for an assisted living facility it is about $36,000 annually; and even modest care such as 3 visits a week from a home health aide can equate to nearly $20,000 per year.

Consumer surveys have shown that many individuals don't realize that health insurance, Medicare and/or disability coverage do not pay for most long-term care services. Planning ahead can reduce emotional and financial stress on each of us and our families and can ensure more flexibility and greater independence in making choices if care is needed.

Optimal Aging

It stands to reason that the longer we preserve our mental, physical, and social functioning, through exercise, nutrition, engagement and healthy life-style management, the longer we can contribute to our families and communities. Much of this is in our control; however there are outside factors that can significantly influence how we age – our gene pool, poverty, access to health care, trauma, and our environment all impact our aging process even when we make the best choices possible. Optimal Aging does not discount these factors; it simply prompts us to make the most of our current abilities, regardless of where we are on the continuum. In fact, Optimal Aging stresses that this goal is valid at any and all ages. Despite chronic conditions and related disabilities, we can continue to grow and learn, serve as valuable resources and purposeful contributors to a society that needs us and benefits greatly from our participation.

Often, the only barrier between the decision to live our best life and actually achieving Optimal Aging is a lack of knowledge. Fortunately, there is a tremendous amount of good information available on all topics but it can be challenging to know where to begin. The Commonwealth can play a vital role in helping Virginians plan for and manage their later years by ensuring that relevant, accurate and helpful information is readily accessible — for the benefit of all.

Online information and the "Own Your Own Future" Kit can help Virginians plan to reduce financial risks related to long-term care costs in later life. www.vda.virginia.gov/oyf

Virginia Easy Access www.easyaccess.virginia.gov and SeniorNavigator.org provide valuable information about health, aging, and long-term services and supports for older adults, individuals with disabilities, families and caregivers.

Recommendation:

Develop mechanisms to educate Virginians about the differences among public programs and private financing options for long-term services and support Virginia's Long-Term Care Partnership, an alliance between the private insurance industry and state government to plan for future long-term care needs.

Recommendation:

Maximize the use of all existing resources such as Virginia Easy Access and SeniorNavigator to raise awareness, educate, and empower Virginians with information to age optimally.

Recommendation:

Plan for needs and abilities specific to special populations when developing programs and services that support older adults "aging in place" and in outreach efforts to educate them about available support.

Recommendation:

Identify and replicate creative partnership models that enable successful federally-funded programs with age-specific eligibility requirements, such as friendship cafes and congregate meals, to be expanded to also serve individuals under the age of 60 with lifelong disabilities.

Tom Arrington, of Lodi, Virginia, died November 4, 2009, at age 73. He was believed to be the oldest man in history with Down Syndrome.

Special Populations

In addition to the wide variability of resources and needs among older Virginians, there are some special populations whose unique situations call for particular consideration and targeted supports.

Aging Adults with Lifelong Disabilities

Virginia, as the rest of the nation, is witnessing an unprecedented aging of its citizens with lifelong developmental disabilities. This term applies to a broad spectrum of conditions including intellectual disabilities, cerebral palsy, autism, blindness, deafness, neurological and orthopedic impairments, spinal cord, head and brain injuries, and multiple other lifelong disabilities that occur before age 22. The largest subgroup is persons with intellectual disabilities (formerly called mental retardation).

The survival to later life of large numbers of individuals with developmental disabilities is a relatively recent phenomenon that has caught both aging and developmental disabilities systems off guard. Today, at least 1 in every 100 adults age 60 or older is living with a lifelong disability, totaling more than 10,000 in the Commonwealth – a number expected to triple in the next decade.

The overwhelming majority of today's older adults with lifelong disabilities have lived in the community either in the care of their parents or in regular contact with them. These parents became effective caregivers and advocates for their children. In fact, continuous caregiving by parents and families has been a major contributor to their endurance. At the same time, those who are older with lifelong disabilities tend to be survivors, relatively capable, higher-functioning adults. When considering aging with lifelong disabilities today, both the aging adult and the caregiving family must be addressed, in other words, a "two-generation" geriatric context. Outreach, training, and services to this group should consider the interwoven relationship of both generations.

The definition of lifelong disabilities is shifting to one that is multi-dimensional, recognizing functional skills, individualized supports, personal well-being, and personal competence, all of which may be improved through environmental modification, skills acquisition, and use of prosthetics. There is little established protocol, cross-training between providers, or public policy regarding the needs, capacities or challenges of older adults with lifelong disabilities. Additionally, there is evidence that those who are currently older (age 50 or above), are qualitatively different from their younger counterparts – residing in family or small-group residential settings and requiring more assistance with self-care and self-advocacy.

Beyond the shared needs of all aging individuals such as dignity, respect, and supportive services to help maintain autonomy or assisted autonomy, older adults with lifelong disabilities also have special needs that have not been adequately addressed through current service system structures. These

include: opportunities for peer socialization and involvement in community services; access to day program services which provide skill development and interventions designed to sustain an individual's current skill level; family living and small group situations with appropriate accommodations to changing individual needs; exercise; nutritional counseling and other health-promoting physical activities; leisure time and recreational activities appropriate to disability and aging impairment levels.

Grandparents and Older Relatives Raising Children

Today's grandparents are very involved in their grandchildren's lives – communicating and visiting with them regularly – many even providing child care and support to working parents. In Virginia, however, 6.2 percent of all children or 107,602 are actually being raised in a home where the grandparent is the head of household, often without a parent present at all. In these homes, grandparents and other older relatives have become the primary provider or "kinship caregiver" for children whose parents can no longer care for them due to illness, death, economic hardship, divorce, substance abuse, domestic violence, incarceration, or other family crises.

The immediate challenge is the sudden financial burden felt when one or more children are in need of care with no advance planning. Grandparents raising grandchildren must establish legal custody in order to enroll grandchildren in school, access medical records and apply for benefits. The process of gaining legal custody or guardianship can be expensive, emotionally draining and confusing. These grandparents are 60 percent more likely to live in poverty than grandparents who are not responsible for children. The cost of caring for children can be overwhelming for those on a fixed income. Many grandparents make significant employment changes such as delaying retirement or quitting work sooner than planned in order to care for children.

The longer term and ongoing challenges may also include cultural and language barriers, confusion about roles, and lack of awareness about youth-related issues. Often the grandchildren are victims of an emotional loss, abuse, violence, exposure to harmful substances, sex offenses, emotional and/or physical trauma, or unhealthy prenatal conditions – any of which can negatively impact their development and behavioral patterns. As a result, they may struggle with grief, anger, loss, and may display increased aggression, cruelty, or self-destructive or criminal behaviors.

Grandparents and other older relatives often lack information about the range of support services, benefits and policies that can guide them through their caregiving role. In response to the growing numbers of kinship care families, state legislators, public and private agencies and grassroots coalitions in Virginia and across the nation are working to expand services and supports inside and outside the child welfare network.

Recommendation:

Support recommendations of the Virginia Tech Institute for Public Policy Research, intended to strengthen outreach and educate kinship care families on their rights and responsibilities and available benefits and services and encourage community agencies to organize kinship care support groups and respite programs.

Grandparents raising children, it is not a new scenario. Martha and George Washington raised two of their grandchildren, Eleanor Parke Custis (Nelly) and George Washington Parke Custis (called "Wash" or "Tub") at Mount Vernon.

According to AARP, 59,464 grandparents report they are raising their grandchildren in Virginia – 40 percent are African American; 3 percent are Hispanic/Latino; 3 percent are Asian; and 52 percent are White.

During the next 25 years, the older Latino population will grow four-fold, from two million today to eight million in 2030. The older Asian population will grow from one million to four million.

Some years ago the Arlington County Area Agency on Aging learned that literal translations of program materials do not always work – information translated from English to Spanish described "Meals on Wheels" as "Food on Tires."

Aging Immigrants

Like the rest of America, Virginia's population is becoming increasingly diverse. Until 1970, one in every 100 Virginians was born outside of the US. In 2006, one in every 10 Virginians was foreign born with the majority from Asian and Latin American countries. Nationally, 11 percent of recently arrived immigrants are people over the age of 65 and the number of foreign-born older adults is expected to reach 16 million by the year 2050. Many are parents of newly naturalized American citizens who have sponsored them to live in the United States with children and grandchildren. Older immigrants tend to live at a lower level of the economic scale than their American counterparts – generally unprepared to work outside the home; they have little opportunity to earn income independently. Entering the country with few possessions, they are often completely financially dependent on children and grandchildren once they arrive.

Grounded in the culture of national origin and often speaking only their mother tongue, many older immigrants struggle to adjust to a family life that reflects contemporary American culture and practices. Their adult children have often already assimilated and are raising their children as assimilated youth, many of whom do not even know their grandparent's native language. According to the 2003 JLARC Report, *The Acclimation of Virginia's Foreign-Born Population*, "Among service providers and immigrants alike, the most commonly cited challenge foreign-born residents face in becoming fully acclimated is a limited command of the English language." Updated data suggests that over a quarter of foreign-born households are linguistically isolated where all adults have some limitations communicating in English. Older immigrants wishing to learn English may be able to attend adult education classes but these are generally not free, do not provide transportation and are not designed for the older learner. As a result, older immigrants are often vulnerable and isolated, even though they are living with family.

Moving from their family home to an unfamiliar environment is stressful for many older adults, even when language and culture remain the same. Considering the adjustments demanded of older immigrants, it is easy to imagine how such a move can lead to depression and cognitive decline. Adjustment difficulties can be compounded when the immigrant is fleeing a war torn country.

Older Prisoners

The past decades have seen a dramatic increase in the number of incarcerated older prisoners due to mandatory minimum sentencing, generally longer sentences, and tighter parole policies. The Virginia Department of Corrections (DOC) reports that in FY07, 7.8 percent of new commitments, 12.2 percent of the confined population, and 9.8 percent of those being released were age 50 or older. In just the past 17 years, the number of inmates aged 50 and older has increased by 600

percent – an increase greater than four-fold the increase for the entire general inmate population.

Older inmates tend to have multiple health problems at a younger age than their non-incarcerated counterparts. A lack of consistent health care, poor personal health decisions, chronic illnesses due to tobacco, drug, and alcohol use and abuse, and the stress of living in prison all result in a population that often appears much older than their chronological age. In fact, DOC categorizes inmates age 50 and older as "old" due to their deteriorating health conditions and need for special assistance. In FY 2007, these older prisoners averaged $3,350 in health care costs in comparison to $790 for prisoners under age 50, with off-site medical costs for older prisoners totaling $14.7 million.

Older prisoners also have different physical and mental health requirements than younger inmates including problems with mobility, medical conditions, hearing, vision, and diet, which create special needs in providing for their housing and care. For example, older prisoners are often unable to climb up to the second and third levels of bunk beds so they must be housed in special wings or separate facilities. They have special security needs because they may be easily victimized by younger inmates. They also have special programming and treatment needs.

Many older prisoners will be with DOC for a long time. More than 84 percent of prisoners aged 65 and older have a primary violent or sexual offense which makes it difficult to obtain parole or early release. Ironically, nearly 80 percent of prisoners aged 65 and older are first-time offenders, nearly half of whom will not be eligible for release until age 75 or older. However, when it is time for release, additional challenges arise. Families are often unavailable or unwilling to accept released individuals back into the community and private long-term care facilities are also often unwilling to accept discharged prisoners no longer able to live on their own. In addition, public programs and funding are not available due to their offender status, leaving older ex-prisoners without any options for life's most basic necessities.

Recommendation:

Support Piedmont Geriatric Hospital in its efforts to provide long-term care to inmates transitioning from prison to the community and assist in development of a program to do so by 2012.

Recommendation:

Request that the Governor's Mental Health/Criminal Justice Consortium include representation from the Virginia Department for the Aging and other aging-related stakeholder groups such as the Alzheimer's Association.

In Virginia, new commitments age 50+ have increased nearly six-fold and released inmates age 50+ have increased more than five-fold over the past 12 years.

AGING IN PLACE — COMMUNITY

While each of us bears personal responsibility to maintain our physical and mental health, remain active and engaged in our communities and prepare for our financial future to the best of our ability – the communities we live in and the services available to us can also have a tremendous impact on our health and well being as we age. As noted earlier in this document, there are transformational changes underway in aging services – we are moving from a cultural mindset of individuals spending the final years of life in an institution to supporting individuals at home with the necessary level of care to thrive and contribute as active members of our community. This transformation from facility-based care to "Aging in Place" is being driven by both individual preferences and awareness that the former level of long-term institutional care will not be sustainable as the number of seniors increase.

On a personal level, surveys often document that the overwhelming majority of us prefer to stay in our own home as we grow older - maintaining connections to our communities and friends, enjoying the comfort and security of familiar surroundings, streets, and stores, and retaining medical professionals who know our history. In addition, while some of us will need the assistance of publicly funded programs, most individuals will pay for some or all of the cost of supportive services out-of-pocket. Personally, it is less expensive for an individual to remain in their home than to move to a facility, often because much of the assistance needed is provided by family caregivers. In fact, according to a MetLife study, family caregivers provide approximately 80 percent of all long-term care services in the United States.

With narrower lanes, safer intersection designs, curb ex-tensions and median crosswalks, bike lanes, wider sidewalks and street trees, "Complete Streets" work for all users: walkers, bikers, drivers, and transit users. One such example is "Places 29" a joint transportation and land use plan in Albemarle County and Charlottesville designed to reduce congestion and improve safety along US 29.

Beyond the personal level, policy makers have long acknowledged that the Medicaid/Medicare system cannot support institutional care for the number of older adults that will be reaching later stages of life over the next 25 years. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive nearly 25 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. A recent national study *Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs* found that the average total public expenditure for a recipient of Home and Community-Based Services through a Medicaid waiver (who must meet the eligibility criteria for institutionalization) was about $44,000 less per year than for a person receiving institutional services.

Finally, because so many older residents continue to contribute to their communities in so many ways, helping seniors age in place can benefit the larger community as well. In fact, some forward-thinking localities strive to attract retirees to their area and market their aging-friendly services to help attract new businesses.

Unfortunately, the design of most of our communities in the past several decades have not prepared us to Age in Place. The majority of our society is aging in the suburbs, often isolated from grocery stores, pharmacies and medical and other services that are not within walking distance and where there is little or no access to public transportation. In short, the very neighborhoods that were wonderful places to grow up are now proving to be terrible for growing old.

It is imperative that local leaders and community planners consider the needs of the rapidly aging population in planning for the future. Unfortunately, this is not yet the norm. A 2006 report led by the National Association of Area Agencies on Aging (n4a) found that only 46 percent of American communities had begun planning to address the needs of the explosive aging population. Similarly, a 2009 survey conducted by the Older Dominion Partnership on behalf of the Virginia Association of Counties and the Virginia Municipal League, found that 49 percent of local officials reported being unaware of data showing the aging of their community and only 38 percent were aware of any local or regional planning related to the age wave. Fortunately, there are models and resources available to help communities not just survive the impending demographic shift but actually seize the opportunity to design or redesign their communities for the betterment of all their residents. Of particular note is the national movement to create aging-friendly or "livable" communities for all ages.

Livable Communities

AARP defines a livable community as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life." While all communities have their own unique characteristics, there are also some universal ways to enhance livability for older residents. These include: sufficient affordable housing and homes and communities with universal design features to help people remain in their communities; street signage and traffic patterns designed with older drivers in mind; walking paths and transit systems that help those unable to drive remain mobile; sufficient and meaningful opportunities for lifelong learning and engagement in social and civic activities throughout the life span; and access to necessary services from shopping to medical care.

The Older Dominion Partnership

Another valuable resource unique to Virginia is the Older Dominion Partnership (ODP). Designed as a coalition of businesses, non-profits, philanthropic foundations, academia, and government, the ODP has taken a unique approach to "age wave planning." Predicated on the belief that the most effective planning comes from "the bottom up" – from the people who make up a community – ODP is engaging residents, businesses and organizations that have a vested interest in their community's future and best understand its idiosyncrasies, unique needs and vision. Coined as a "coalition of the willing," The members of the Older Dominion Partnership have developed working teams to address the topics of Community Readiness, Business Readiness, and Civic Engagement. To date, the ODP has conducted research to: document the level of awareness and priority given aging issues by individuals, businesses and local leaders; helped to create statewide and local conferences on age-wave planning; and developed a comprehensive research database to assist localities in resource development and transition planning. In 2010, this non profit entity will conduct the first statewide survey of older Virginians since 1979 and make the data available by locality.

Virginia Localities

Fortunately, a few Virginia localities are counted among the ranks of an ever increasing number of big cities, small towns and rural areas nationwide that are working now to redesign their communities to better meet the needs of the future. Two examples are:

The Thomas Jefferson Planning District (Charlottesville and surrounding area) is benefiting from collaborative efforts of 85 organizations and over 500 individuals that together created *The 2020 Plan*: *Aging in Community* – a comprehensive plan to make their community a great

A report by the EPA suggests that activities designed to increase endurance, strength, flexibility, balance, and the principles of injury prevention can also be built into community design and development to encourage walking, biking, and active use of parks, so that people of all ages get exercise in the course of daily life.

Recommendation:

Provide communities, through a partnership with the Older Dominion Partnership, the data, tools and assistance necessary to develop and implement comprehensive local or regional plans to address the array of demands and opportunities presented by the aging of Virginia's population.

Recommendation:

Explore the feasibility of developing and/or adopting a program and statewide standard for certifying communities in Virginia as "Aging-Friendly" or "Livable" communities.

A recent study of low-income seniors found traditional neighborhoods with 'eyes on the street' (porches, stoops, windows, and buildings along sidewalks just above street level) showed improved physical functioning for older residents over a three-year period; they also showed more social support and reduced psychological distress. Norfolk has discovered significant decreases in crime in neighborhoods and public housing by incorporating "eyes on the street" – not only are they safer environments for everyone to use, they also encourage community connectedness.

place to age. Work groups of community members addressed the issue areas of citizen participation, cultural and recreational opportunities, health, infrastructure and land use and developed goals and strategies for each to guide decision-makers preparing to meet the needs and expectations of seniors in the coming decades. The 2020 Plan won the prestigious "Livable Communities for All Ages Award," a national competition sponsored by the U.S. Department of Health and Human Services, Administration on Aging. The plan was recognized for its comprehensive, age-inclusive approach to prepare for the dramatic increase in the area's senior citizen population by the year 2025.

Fairfax County Board of Supervisors recognized the need to look into the future and see how their community would need to change as their traditional population of working adults and young families was rapidly growing older. The Board formed a Committee on Aging to examine the interdependent issues of housing, community planning, care giving, health, mental health, transportation, technology, and diversity. The *50+ Action Plan* was created to set forth an agenda for the future, with every county department playing a role in the planned initiatives.

Certainly, there are other Virginia communities that are also planning and taking aggressive steps to prepare for the future – but not enough. In some regions of the country, communities are being spurred to action as they compete to be designated as a "livable," "aging-friendly," or "elder-friendly" community. Applicant communities are evaluated on a list of criteria that usually includes access to health care, housing options, transportation and mobility, community services, and opportunities for volunteerism and civic engagement. Successful communities then use the earned designation as an economic development tool in attracting more affluent retirees and new businesses to their area.

Safety and Security

Safety is core to quality of life, regardless of age. However, some of us become more vulnerable in later years due to physical, cognitive, mobility, or financial challenges. As individuals we can protect ourselves by locking doors, guarding personal identification information and staying connected with friends and family. As a community, we have a responsibility to protect those most vulnerable in both daily life and in the event of a disaster.

Abuse, Neglect and Exploitation

Driven in part by the rapid increase in the aging population and likely exacerbated by the severe economic recession, the incidence of adult abuse, neglect and exploitation is on the rise. This includes physical and emotional abuse, isolation and abandonment, and financial abuse such as theft, fraud and scams. Often scared, embarrassed or

confused about where to turn, many older adults do not report elder abuse, thereby making it difficult to accurately measure the incidence rate. Even so, looking solely at the number of cases that have been reported to the Virginia Department of Social Services, Adult Protective Services (APS), the Commonwealth has experienced a nearly 50 percent increase in reports of abuse, neglect and exploitation over the past decade and 31 percent in the last five years alone. As a result, 70 of the 120 local departments of social services report waiting lists with a current total of 457 requests for APS services which cannot be met. At the same time, the number of APS workers and the resources for preventive and protective services are declining as staff turnover and hiring freezes combine to widen the gap.

More than two-thirds of those committing elder abuse are members of the victims' families and the older adult is often physically and/or financially dependent on the abuser. Many victims are also challenged by mobility issues or chronic illness. Together, these factors complicate the situation and place a greater burden on law enforcement agencies. Although programs have been developed, there are limited resources for specialized training which is critical for local law enforcement agencies to properly respond to elder abuse.

Prevention is a key component to reversing the increase of elder abuse. Funding for local law enforcement agencies to provide crime prevention programs comes primarily from federal grants. Yet, according to the Virginia Department of Criminal Justice Services (DCJS) 2008 report, *"The Status of Crime Prevention,"* of the $8.6 million of federal grants awarded over the past 12 years, only 9 percent ($763,410) focused on older Virginians. When funding declines, crime prevention/community policing units are often cut. Utilizing partnerships to reduce costs and collaborate on new training approaches is the most effective strategy to address a growing need with shrinking resources.

Legal Support

In 2006, a three-year grant from the Administration on Aging called Project 2025 prompted the development of statewide legal assistance planning, targeted toward current and future older adults in Virginia. This initiative recognized that as we reach our later years, we often face specific legal concerns such as wills, power of attorney, advanced directives, involuntary discharge from a care facility, and more. Given the current demand on essential state resources and the finite legal assistance delivery mechanisms in place for those 60 years and older, Project 2025 offers information to guide advocates and service providers for clients needing advocacy, information & referral, legal advice, and/or legal representation. Tangible outcome measures to date include: a firmly established Elder Law Task Force and Elder Law Listserv; pilot programs targeted to increase pro bono participation by private attorneys in Virginia; strategic and statewide planning to improve the current legal services delivery system; website development and on-line tools

The National Elder Abuse Incidence Study estimates that for every reported incident of elder abuse or neglect, five others go unreported.

Recommendation:

Strengthen Adult Protective Services through interagency coordination and communication and provide additional funding for local Departments of Social Services to meet current needs and eliminate waiting lists.

Recommendation:

Standardize and incorporate an elder abuse prevention and detection curriculum into the basic academies for first responders, and state and local law enforcement.

Recommendation:

Expand Triad partnerships and other community coalitions between public agencies and private-sector organizations to broaden training and education about senior safety, crime and fraud prevention, and domestic violence.

Recommendation:

Continue statewide leadership and coordination of available legal resources for older adults by building upon the success and broad stakeholder support of the Project 2025 initiative.

Recommendation:

Ensure that older adults with disabilities are adequately represented in statewide and community-level disaster preparedness planning and testing, especially in the areas of accessibility of shelters and transportation.

Recommendation:

Leverage Virginia's No Wrong Door system to create a statewide emergency response registry for older adults, based on consent, to identify physical, cognitive, or sensory disabilities that may influence preparedness, response, and/or recovery plans.

to assist service providers in locating legal assistance for their clients, and other strategies designed to increase efficiency and protect the rights and independence of older adults.

Emergency Preparedness

The events and impacts of 911 and Hurricane Katrina have prompted governments and health and human service providers to reexamine our readiness in the face of disaster. In the aftermath of failed rescue procedures, a new focus has been placed on older adults and individuals with physical, sensory and cognitive disabilities, who may be exceptionally vulnerable. As recent disasters illuminated, even persons living in long-term care facilities that have disaster plans are not necessarily exempt from harm during evacuation and recovery efforts. After these large-scale tragedies, it became evident that emergency responders had inadequate knowledge about the special needs of older adults or individuals with disabilities and no system for identifying or locating them.

Additional planning is required for those of us who may move more slowly or may not have the flexibility to move through small spaces. Consideration should also be given to medicines and assistive devices such as hearing aids and walkers. Even with something as simple as a prolonged power outage during a summer storm, the risk of heat stroke for an older adult rises significantly along with the temperature. Additionally, power may be needed for critical medical and life support equipment.

Under the overall coordination of the Governor's Office of Commonwealth Preparedness and led by core preparedness agencies such as the Department of Emergency Management, the Department of Health, and the Department of Transportation, all state agencies share a common goal to strengthen the culture of preparedness. Seven regional work groups called Regional Preparedness Advisory Committees (RPAC) meet quarterly to collaborate on local planning efforts. The RPACs benefit from broad-based representation including public safety, higher education, emergency management, chambers of commerce, private business and industry, hospitals, and area agencies on aging, all working together to provide resources and expertise.

The Virginia Department of Social Services has oversight responsibility for the State Managed Shelter Program. This program is designed to keep family units intact by co-locating persons with special medical needs and older adults and individuals with disabilities within the general population shelters. Future plans include expanding shelter capacities to house pets and service animals in close proximity to their owners. Several best practices and tools have emerged in recent years to help prepare us for "sheltering in place." The Red Cross Guide was developed by older adults for older adults, offering practical information needed to prepare for a variety of disasters and the Department of Health offers a *Disaster Supply Kit Checklist* identifying important items to help prepare for an emergency.

Living Environments

The sentiment "There's no place like home" does not diminish as we age. Staying in our own home enables us to maintain our connections to community and friends and retain health care professionals who know our medical history. It also provides the comfort and security of familiar surroundings, streets and stores. Fortunately, most older adults live in adequate, affordable housing. However, a considerable percentage face significant housing-related concerns like accessibility and/or affordability, that make it challenging to remain in the environment we know as "home."

Home Ownership and Rental

Eighty percent of older Virginians own the homes in which they live and most of us would prefer to stay in them as long as possible. Unfortunately, it is not always easy or practical. As we age, we often experience declining mobility, reduced flexibility and fixed incomes. At the same time, our homes are aging as well and may require increased attention. Although these factors can affect us differently depending on household incomes and wealth, together, they can make it increasingly difficult to remain in our homes without assistance.

Lack of affordable and accessible housing is a universal issue across all age groups but for seniors on a fixed income who may also be facing declining mobility; it is a complex and growing problem. Even when a mortgage is completely paid, the costs associated with home ownership, such as property taxes and home repairs, can be a significant financial burden. When living on a fixed income, a simple repair for a leaky roof can go unattended and eventually create substandard housing conditions and threaten our ability to remain safe in our home. A recent U.S. Department of Housing and Urban Development (HUD) report indicates that nationally, more than one million households with an older resident with a disability have unmet structural housing needs such as a front-door ramp or handrails in the bathroom. Additionally, more than 7.4 million pay more than they can afford for their housing, the majority of whom are on fixed incomes and receive no housing assistance. In fact, 1.4 million very low-income older adults actually pay more than 50 percent of their incomes for housing.

These national trends are reflected in Virginia as well. The Virginia Department of Housing and Community Development recently reported that HUD's Comprehensive Housing Affordability Strategy data based on the 2000 Census indicated 194,894 Virginia households (121,740 renters and 73,154 homeowners) with household incomes at or below 30 percent of area median income were living in substandard conditions – defined not only as paying 30 percent or more of their incomes on housing, but also lacking complete indoor plumbing, a complete kitchen, and/or overcrowded. Almost half of these homeowners were age 62 or older. These statistics are not surprising given the trend noted since 1990 of a growing gap between incomes and housing costs for very low-income households and especially households headed by those on fixed incomes.

Recommendation:

Enhance Virginia's ability to monitor and report the impact of the current recession on low-income older home owners, including their ability to age in place, utilize home-equity conversion options, and take advantage of programs that provide accessibility modifications.

Home ownership accounts for about 79 percent of median wealth among people age 65 and older.

Beacon Hill Village was established eight years ago in Boston by a group of neighbors who decided to initiate a membership program whereby older adults could remain in their own homes, yet be connected to a broad network of supportive social, personal and health services. Also referred to as "virtual villages" this growing trend is developing across the country and has taken root in both Southwest and Northern Virginia.

Despite their many benefits, garage apartments and extra housing units are usually prohibited by local zoning. Some localities are beginning to change that. Rural Fluvanna and Louisa Counties now offer programs to help provide modular units or kits that can be quickly erected when a fully accessible home is needed.

Some assistance is provided to older low income homeowners through such programs as Virginia's Emergency Home Repair, Indoor Plumbing and Weatherization programs and through local property tax exemptions and assistance for utilities such as the Fuel Assistance Program. However, demand for these services far exceeds program resources. Older Virginians who rent their homes experience similar affordability and accessibility problems, yet have access to even fewer resources.

Home equity loans and reverse mortgages are thought to be an option for some older homeowners who wish to use the equity in their homes for repairs and accessibility modifications and to meet their basic living expenses. However, the recent housing "bust" has significantly reduced housing values and thus much of this home equity may no longer be available as collateral for these loans. This current circumstance should be monitored in order to determine if it becomes a longer term trend.

Alternative Housing Models

New alternatives to single family housing have recently provided additional options for older adults. "Co-housing" is a collaborative setting designed to overcome the alienation that some older adults experience in modern subdivisions lacking in a sense of community. This option balances the traditional advantages of home ownership with the benefits of shared common facilities and ongoing connections with neighbors. Virginia has seven Co-housing Communities from Northern Virginia to Southwest Virginia. Another alternative is called Elder Cottage Housing or "ECHO," usually a small studio or one-bedroom apartment constructed separately or as an attached structure on the same property as the family's home. While these and other options provide new and innovative solutions to support older adults without the expense of private care or the loss of independence, local zoning issues can create barriers for families who want or need to take advantage of these new and innovative housing options.

Special Needs

The dynamics of fixed incomes, high costs and limited supply of affordable housing options are compounded by the increasing aging population requiring a range of supportive and health care services. Currently, people with "special needs" – older adults, adults with disabilities and the homeless – make up a large share of households needing both housing assistance and a variety of supportive services to allow them to live independently. These services may be needed on a transitional or permanent basis, and when the ability to pay for such services is limited, as is often the case, multiple subsidies are needed. The provision of supportive housing requires ongoing availability of housing and service subsidies as well as coordination between housing and service providers. Not only are subsidy streams inadequate, but given the separate and distinct funding streams, virtually all levels of government are challenged to successfully coordinate housing and support services.

The most disturbing situation is, of course, when there is no place to call

home at all. Historically, people age 65 and older generally did not end up on the streets or in homeless shelters because of Social Security and Medicare. Although the aging homeless are relatively invisible, it is estimated that 20 percent of the U.S. homeless population are age 50 and over. As boomers age and waiting lists for affordable housing climb to unprecedented proportions, older adults in far greater numbers may end up homeless and their unique needs related to mobility and chronic disease will significantly impact our communities' homeless management systems.

Financing of Affordable Housing

The Virginia Housing Development Authority (VHDA) is a self-supporting state finance agency created in 1972 by the Virginia General Assembly to provide mortgage loans to the state's low– and moderate–income residents. In this capacity, VHDA is authorized to sell taxable and tax-exempt bonds in order to finance affordable housing in Virginia. In addition, VHDA also administers the federal Low Income Housing Tax Credits Program and federal rent subsidy programs. Because Federal restrictions limit the use of tax-exempt bonds to finance first-time homebuyers and affordable rental housing, VHDA focuses primarily on financing affordable senior apartments. VHDA is promoting the following activities to increase housing options for older Virginians and Virginians with disabilities.

- Preserving the existing affordable housing stock by recapitalizing older senior assisted rental developments to allow for rehabilitation and modernization, and retain federal rent subsidy assistance.

- Selling rental housing bonds and allocating federal tax credits to encourage the creation of new affordable rental housing for older persons and persons with disabilities.

- Promoting the incorporation of "Universal Design" and "visitability" features into new housing in order to accommodate the changing physical needs of seniors as they age-in-place.

These and other efforts by VHDA have yielded successful results, financing 87 senior housing developments resulting in more than 7,000 affordable apartment units over the past decade. However, many more facilities are in need of modernization and/or retrofitting and refinancing in order to accommodate supportive services to aging residents, assure quality of life, accessibility and marketability.

Universal Design and Visitability

What can be done to turn the tide? A number of states are now mandating economical accessibility design features. Georgia, Minnesota and Texas have mandated design requirements for single-family homes built with state subsidies. Vermont went further to require certain elements in both subsidized and most unsubsidized single-family construction. Features

Recommendation:

Support the development of a Virginia Housing Trust Fund, using a dedicated stream of state revenue, to address the rising cost of housing.

Recommendation:

Integrate the concept of Universal Design into the Virginia Uniform Statewide Building

The EPA reports, "Developers and community planners are learning that providing a wider range of housing choices within one community is not only good for older adults but also provides community character, helps to make it more attractive and interesting, and holds value over time."

Prince William Area Agency on Aging partnered with local developers to build a Universally Designed home to promote the benefits and increase awareness about design concepts possible for a livable environment.

Recommendation:

Improve coordinated financing to create a rental assistance program that would provide additional subsidies for extremely poor older adults with disabilities who cannot otherwise afford housing.

Medicaid spend down occurs when medical expenses, both acute and long-term care, cause an individual to spend their financial assets down to Medicaid eligibility. Spend down happens relatively quickly in the nursing home with between one-quarter and 36 percent of residents going through their assets down during the first three months of a nursing home stay, and one-half to three-quarters within the first year.

such as a no-step entrance to the home, widened doors and hallways on the first floor, accessible climate controls and electrical outlets encompass the concept of "Universal Design" or "Visitability." With a cost of about $200 per single-family home, visitability design removes barriers for any and all members of our community – our parents, children, friends, those in a wheelchair, pushing a baby carriage, pulling wheeled luggage – anyone moving into and out of our homes – all of us.

Smart homes, also called high-performance and automated homes, were once only for the privileged few. New technology has made them more affordable and appealing. Beyond their obvious accessibility-friendly features, experts say that smart homes are eco-friendly, secure, more comfortable, have higher resale value, and are better equipped to integrate future technology than their standard counterparts.

In Virginia, VHDA is taking an incentive approach to Universal Design and visitability providing training to architects and builders, and offering competitive scoring points in the Qualified Allocation Plan for federal Low Income Housing Tax Credits. In addition, the Virginia Board for People with Disabilities and VHDA have initiated an "EasyLiving Home" program that enables homebuilders to cost-effectively advertise visitability design features through state-wide certifications of building plans and use of the "EasyLiving Home" logo in marketing. This is similar to the Energy Star program for energy efficiency, although the certification process does not include governmental involvement.

Facility-based Long-term Care

Long-term care is a continuum which provides various levels of living options when we want more support than we are comfortable receiving at home or when living at home is no longer possible due to the intensity and level of support required. Although the current trend is moving away from institutional-based long-term care toward home-based supportive services, there will always be a necessity for the continuum of facility-based long-term care to address needs related to rehabilitation and severe chronic health conditions; especially in the absence of informal caregiving support for an individual. Facility-based long-term care may be provided through unique institutional settings or through a Continuing Care Retirement Community, which provides a stepped approach to Independent Living, Assisted Living, and Nursing Home Care, based on our evolving needs.

Continuing Care Retirement Communities

Continuing Care Retirement Communities offer service and housing packages providing flexible accommodations designed to meet health and housing needs as they change over time. Residents entering a Continuing Care Retirement Community sign a lifetime contract that provides for housing, services and nursing care, usually all in one location, enabling older adults to remain in one constant community regardless of needs. Independent living choices include single-family homes, apartments or condominiums. If we begin to need help with activities of daily living (e.g., bathing, dressing, eating, etc.), we may be transferred to an assisted living or nursing home on the same site.

Assisted Living and Adult Foster Care

Assisted Living Facilities (ALFs) are licensed by the Virginia Department of Social Services to provide supervision or assistance with activities of daily living (ADLs); coordination of services by outside health care providers; and monitoring of resident activities to ensure health, safety, and well-being. Assistance may include the administration or supervision of medication or personal care services provided by a trained staff person. With group dining areas and common areas for social and recreational activities, assisted living facilities are an option for individuals for whom independent living is no longer comfortable or a viable alternative but who do not need the 24-hour medical care provided by a nursing home. Currently in Virginia there are 31,500 licensed assisted living beds.

Adult Foster Care (AFC) provides an alternative to an Assisted Living Facility when a smaller, home-like atmosphere is preferred. AFC is a community-based contractual arrangement between DSS and local families, providing room, board, supervision, personal care, and other special services for three or fewer older adults or persons with a disability. An AFC must be authorized and monitored by the local department of social services with a minimum level of care equal to the residential assisted living requirements. Currently there are 53 approved AFC providers in Virginia housing 60 individuals.

Auxiliary Grant

The Auxiliary Grant (AG) Program, administered by DSS, provides a supplement to income for qualifying residents of assisted living or adult foster care. This assistance, designed to ensure that recipients are able to maintain a standard of living that meets a basic level of need, is funded with 80 percent state and 20 percent local dollars. The maximum rate is determined by the Virginia General Assembly and is adjusted periodically. Individuals receiving an auxiliary grant also receive a personal allowance for such things as clothing, medical co-payments, toiletries, over-the-counter medications, prescriptions not covered by Medicaid, dental care, eyeglasses, and personal transportation. Currently the personal needs allowance is $81 per month. There were 2,724 older adults receiving grants in FY 2008 and 2,634 in FY 2009; more than 700 were 85 years or older and 27 of whom were over 100 years of age. The decline in AG recipients over the past year mirrors a continuing multiple-year downward trend that is attributed to the refusal of may assisted living facilities to accept AG residents because of the low state reimbursement rate that fails to cover the cost of providing required care.

For FY 2009, Piedmont and Central regions each made up 23 percent of the total Auxiliary Grant cases. Eastern, Western and Northern regions made up smaller percentages at 22 percent, 18 percent, and 14 percent respectively. These percentages were unchanged from FY 2008.

Nursing Homes

When Assisted Living and Foster Care are no longer an option, a Nursing Home provides constant care for adults with significant dependencies related to activities of daily living, often due to an accident, surgery, or chronic illness. A "Skilled Nursing Facility" is certified to participate in, and be reimbursed by Medicare; a "Nursing Facility" is certified to participate in, and be reimbursed by Medicaid. Both are required to have licensed nurses on duty 24 hours a day. In Virginia, together these facilities house more than 31,000 beds and are licensed by the Virginia Department of Health. These facilities

Recommendation:

Support the goals and recommendations of the Virginia Pressure Ulcer Resource Team (VPURT) to promote prevention strategies through outreach and training.

Recommendation:

Support the expansion of the Virginia Culture Change Coalition in its efforts to strengthen workforce stability, resident choice, resident and staff satisfaction and empowerment, and patient-centered care.

must comply with state regulations and with federal regulations if they are certified for Medicare and Medicaid. Some nursing homes are also specialized by the type of need or condition that residents have including dementia, ventilator-dependent or rehabilitative care.

One measure of quality of care in nursing homes is the incidence of pressure ulcers, commonly known as bed sores. A national study estimates that as many as 24 percent of all long-term-care residents may develop pressure ulcers, approximately 70 percent of which will occur in individuals over the age of 70. In 2006, responding to a report that listed Virginia as having one of the highest rates of pressure ulcers in the country; a statewide healthcare coalition was formed. The Virginia Pressure Ulcer Resource Team (VPURT) issued a "Call for Action" to improve quality of care related to skin integrity and identified critical prevention and treatment measures. With a focus on education, policy and practices, the coalition has developed a website, facilitated conferences and created reporting requirements to reduce or even eliminate this painful and chronic issue related to long-term care.

Culture Change

"Culture Change" is the term used to describe the organizational shift in long-term care facilities from institutional models of care to 'person-centered' or 'person-directed' care – from task-oriented care to an approach that recognizes the dignity, choice and autonomy of the individual and builds a culture of caring. Culture change philosophies and practices engage staff at all levels to assist residents to reach an optimal level of health and well-being – resulting in better quality of care and decreased health care-related expenses.

A unique stakeholder group of public and private providers, consumers, and advocates formed the Virginia Culture Change Coalition several years ago, committed to supporting the implementation of culture change principles and practices across the long-term care continuum. With the voluntary sponsorship of multiple partner agencies and the use of Geriatric Education Training funds generated by the Virginia Center on Aging, the Coalition has facilitated several statewide conferences to: inform providers, consumers, regulators and advocates about culture change; promote best practices; and increase communication and understanding among providers and regulators to eliminate misconceptions concerning regulatory obstacles.

Coalition members and other stakeholders have also actively collaborated with the Department of Medical Assistance Services to develop the statewide quality improvement program, "Virginia Gold," which recently awarded five grants to nursing homes to utilize culture change principles in initiatives to improve workforce stability. The work of the Coalition also dovetails well with a number of other important initiatives to improve care in licensed facilities, including the Caregivers' Coalition, and the Assisted Living Work Group on the state level, and the "Advancing Excellence in America's Nursing Homes" initiative on the national level. Its positive and collaborative work holds great promise for improvement in the quality of long-term care, not only in facilities, but also in community-based care as recognized by the Joint Commission on Health Care staff in examination of the Coalition's work.

Transportation

Transportation and mobility are essential to the community infrastructure, helping people access goods, services, and social networks critical to the support of daily activities and quality of life. Yet many of us will outlive our ability to safely operate an automobile. Compounded by the fact that most of our population lives in suburban or rural environments that were never designed to connect to transit lines; we can begin to grasp this critical dilemma.

When we are no longer able to drive, we may lose our ability to access jobs, shopping, recreational activities, medical services, and social and spiritual interactions. In essence, the risk of being isolated from everything that is fundamental to our independence and well being escalates. Once we can no longer drive, our mobility becomes limited by a dependence on public transportation, human service transportation, private transportation, or family and friends.

Trends in Ridership

In Virginia, 57 public transit operators provide critical links for older adults to their communities. With the age wave, it is no surprise that the Commonwealth is experiencing a dramatic increase in transit ridership. In fact, between FY 2002 and FY 2007, ridership grew by 19 percent, for a total of over 31 million trips. This compares to a national growth trend of only four percent during the same period. Current research is being conducted for the Department of Rail and Public Transportation (DRPT) to determine current and future demand for transportation for older adults, people with disabilities, and people living below poverty. Initial research shows that by the year 2035, at a minimum, the demand for transportation for older adults will be over 14 million trips annually, and for the total population in Virginia, could be as high as 56.5 million trips per year.

Special Routes and Services

In addition, the need for special routes and accessible services is also growing. It doesn't help for the bus to stop at the next corner if we can't get to the corner. Between the escalating number of riders and enhanced service requirements, public transit simply cannot meet the needs. Enter Virginia's human service transportation system, comprised of community non-profits, faith-based organizations, and quasi-local government agencies that offer transportation in addition to primary service responsibilities. Curb-to-curb and door-to-door services are now offered by most providers. In addition, many Area Agencies on Aging (AAAs) and Community Service Boards have enhanced services to provide door-*through*-door as well. Specifically designed to meet the mobility needs of people who cannot drive or who do not own an automobile, these services fill critical mobility gaps for Virginia residents who live outside public transit service areas, need to access services outside public transit service hours, or need more personal or specialized services to travel. Examples of such services include:

Men and women who reach their 70s outlive their ability to drive on average by six and ten years, respectively.

In 2004, Virginia became the first GrandDriver state in the country. Managed by the Virginia Department for the Aging, GrandDriver facilitates local CarFit events in each region of Virginia, where technicians assist older drivers through a 12-point safety check including:

- *adjusting head rests*
- *checking line of sight above the steering wheel*
- *testing range of motion and adjusting mirrors to avoid blind spots*
- *honking horns*
- *examining lights.*

Older drivers can also access information and take a quiz to measure driving skills on the GrandDriver website at www.granddriver.net

Recommendation:

Strengthen the role of the Interagency Coordinated Transportation Council by empowering members to develop policy and report annually on the progress of human services transportation and best practices, encouraging training for local and regional planners and providers to improve coordination and provision of services.

Local government initiatives, such as RADAR in Roanoke, a nonprofit corporation, and JAUNT, a public corporation owned by five local governments in the Charlottesville area, were established expressly to provide transportation services to persons served by local public and private social service agencies or state and federal government programs.

The Fairfax County's Seniors-on-the-Go! taxi voucher program offers transportation options, especially for same day or unscheduled transportation needs.

- Some Area Agencies on Aging have developed comprehensive transportation systems to include vans, buses, and trolleys – filling a void for older adults and other populations, especially in rural Virginia.. Four County Transit, operated by Appalachian Agency for Senior Citizens, Lake Area Bus, run by Lake Country Area Agency on Aging, District Three Public Transit, managed by District Three Senior Services, and Bay Transit, operated by Bay Aging, together cover the transportation needs in 26 localities and 10 additional subsidiary areas.

- Mountain Empire Older Citizens, an Area Agency on Aging in rural Southwestern Virginia, has received significant recognition for their regional transit system including the "United We Ride National Leadership Award" from the U.S. Department of Transportation. Success stems from: a commitment to assessing the larger needs within the community; coordination with a wide range of local human service organizations and other stakeholders; and resourcefulness in identifying a large and diverse array of funding sources for sustainability.

- Med-Ride offers non-emergency transportation to help uninsured and medically-indigent patients obtain necessary health care and prescriptions. Dispatched by New River Valley Senior Services to any of seven transportation providers, rides are provided to physicians and dental offices, free clinics, hospital outpatient centers, health departments and local pharmacies. The program serves five rural jurisdictions spread over1400 square miles in Southwest Virginia.

Planning and Coordination

The FY 2011 grant application cycle for the Federal Transit Administration offers new funding in a variety of areas to support older adults and individuals with disabilities including seed money for Senior Transportation start-ups. Recent funding as well as new opportunities require a process that ties the grant application more directly with local stakeholder review to encourage coordinated planning efforts. As a result, in 2008, 21 regions developed a Coordinated Human Service Mobility (CHSM) Plan. The plans are designed by a locally designated body of stakeholders that also serves in an advisory capacity to support the regional vision and shape future strategies and service priorities. CHSM Plans can be accessed at www.drpt.virginia.gov/studies/default.aspx

A variety of state agencies fund transportation services. To help facilitate the coordination of these programs, in 2003 DRPT established *the Interagency Coordinated Transportation Council* to promote multiple agency cooperation at the state level. Created to enable state agencies to actively work together to identify and recommend policy changes, the Council works to eliminate duplication and improve transportation coordination of services to key populations.

Home and Community-Based Services

Home and Community-Based Services (HCBS) are the collective supports provided in our home or in our community, designed to enable us to "age in place." HCBS fill the gap between what we need in order to remain in our own home and what we or our informal care network of neighbors, friends and family can provide. A broad spectrum of support, these services offer necessary assistance for older adults and our families when physical or mental impairments reduce our ability to perform the activities of everyday life such as eating, toileting, bathing, dressing, cooking, shopping, paying bills, or managing our medications. Many of the HCBS programs are considered "direct service delivery" such as transportation, in-home medical assistance, personal care, and home-delivered meals. Others, equally as valuable yet less familiar, such as benefits counseling, service coordination, and transition planning, streamline access to direct services and help us to better utilize our own resources, ultimately delaying or even preventing "spend-down" to Medicaid and unnecessary institutionalization. Additionally, HCBS offer invaluable support to family caregivers including respite care and adult day care, enabling caregivers to also attend to their own health, employment and other personal responsibilities.

Older adults comprise 11 percent of people receiving Medicaid services, but drive nearly one-quarter of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services.

Virginia's Aging Network

While many state, local, public and private organizations offer programs and services for older adults, it is the local Area Agencies on Aging, with the guidance of the Virginia Department for the Aging, that serve as the community focal point for information and referral and many of the HCBS utilized by Virginia's seniors.

VDA is the Commonwealth's designated state unit on aging as required by the Older Americans Act and the federal Administration on Aging. The Department is responsible for planning, coordinating, funding, and evaluating programs for older Virginians made possible through funding from both the Older Americans Act and from the Virginia General Assembly. VDA oversees fiscal management, serves in an advisory capacity, and monitors implementation of quality standards for a full range of nutrition, transportation, health, education, and socialization and recreation services, contracted through Virginia's 25 AAAs. The Department also administers statewide programs and contracts with AAAs and approximately 20 other community-based organizations to implement: the Community Service Employment Program – providing employment services to low income older adults; the Virginia Insurance Counseling and Assistance Program (VICAP) – offering benefits counseling to Medicare beneficiaries; the Local Public Guardianship and Conservator Program – protecting more than 600 indigent and incapacitated adults; Virginia GrandDriver – a resource for senior drivers and their caregivers; and the Office of the State Long-Term Care Ombudsman through a contract with the Virginia Association of Area Agencies on Aging. The Department provides staff support for three advisory boards whose members are appointed by the Governor and the General Assembly: the Commonwealth Council on Aging; the Alzheimer's Disease and Related Disorders Commission; and the Virginia Public Guardianship and Conservator Advisory Board.

AGENCY	FEDERAL	STATE
VDA	$32,397,012	$17,530,064
DMAS	$525,696,179	$429,845,570
DSS - for adults of all ages including seniors	$9,127,626	$22,961,986
	$567,220,817	$470,337,620

While federal dollars have reflected a modest increase in recent years, Virginia's general fund allocation to support Older Americans Act programs has plateaued, resulting in a 2010 funding level of $7.62 per Virginian over age 60. Although this per capita funding has fluctuated over the last decade, it is now $0.32 less per person than the average of the previous10 years.

Area Agencies on Aging

Virginia's network of 25 local AAAs, established under the Older Americans Act, are designated by VDA with the sanction of local governments to plan, coordinate, and administer aging services at the community level. Some AAAs are private nonprofits, others are a part of local government, and still others are jointly sponsored by counties and cities within their Planning District. AAAs serve specific geographical areas which generally correspond with the boundaries of one of Virginia's Planning Districts. (See Appendix E for map of AAAs).

For the past 40 years, millions of the Commonwealth's older citizens have benefited from the services provided by Virginia's AAAs. Funded through federal, state and local government allocations, private grants, fees and contributions, AAAs provide in-home and community-based services designed to assist older adults with the basic activities of daily living that enable us to age in place. Other AAA services promote healthy lifestyles, prevent chronic diseases, and strive to improve the quality of life for older adults and our families. Most of the services funded through the Older Americans Act are targeted to adults 60 and older with the greatest social and economic need. Although these federally-funded programs are provided at no cost, AAAs also offer services on a sliding-fee scale to those who can afford to pay for all or a portion of the cost.

With an ultimate goal of preserving dignity and autonomy and delaying or even preventing institutional care, the AAAs provide a common set of Older Americans Act programs including: home-delivered and meals at congregate sites; transportation; legal assistance; elder abuse prevention; in-home and family caregiver support services; and information and referral to community resources. Each AAA has considerable flexibility to also develop and provide additional services, often reflecting local needs. The Older Americans Act, the Virginia General Assembly and VDA encourage AAAs to work with their localities to create a range of programs that are responsive to the unique needs of their older residents – programs like care coordination, employment assistance, senior volunteer programs, tax counseling, and support for grandparents raising their grandchildren. Some AAAs manage senior centers, providing opportunities for recreation, education, and socialization, or operate adult day care centers with daily supervision and activities for older adults who can no longer safely remain alone at home. A few AAAs also administer senior housing programs, run PACE centers, provide personal care services, offer home modification, serve as local weatherization programs, or offer other helpful programs to local seniors and their families.

The Older Americans Act and other federal programs bring almost $32.4 million in federal dollars to Virginia and the Virginia General Assembly provides an additional $17.5 million. Most of these funds are administered and distributed by VDA using a formula developed by the Commonwealth in cooperation with the AAAs. Considering inflation, the rapid increase in the aging population and the additional cuts re-

quired in this fiscal year due to the recession, the gap in services, already significant, will continue to intensify and could reach dangerous proportions if the network is not infused with additional funding. For example, in just the past year, 1.7 million home-delivered meals were not served; 100,476 hours of adult day care could not be offered; 869,100 hours of personal care and in-home assistance were not available; 180,276 trips to the doctor could not be made; and 8,868 homes could not be made more safe and accessible for eligible seniors because there was simply no money.

Many AAAs also offer counseling at no charge to Medicare beneficiaries through the Virginia Insurance Counseling and Assistance Program (VICAP). Answering questions, resolving billing issues and providing assistance choosing a Medicare supplemental insurance policy, a Medicare Part D prescription drug plan and/or long-term care insurance, through VICAP, AAAs help individuals make the best choices to fit their circumstances and help the Medicare system and seniors save time and money.

Department of Social Services

HCBS are also offered to eligible adults of any age (including seniors) through local departments of social services. Although funding is limited, financial assistance is available to support companion care, adult day services, chore, and homemaker services for low income adults with a disability. In addition, DSS administers other programs for adults such as: adult protective services, the Auxiliary Grant for assisted living and adult foster care, and the Caregivers grant program. In FY 2009, combined state and federal support for these services was $32 million, although $23 million of this represents state support for the auxiliary grant. Funding for the 2009 Caregivers Grant program was eliminated due to budget reductions.

Medicaid Waivers

The most significant funding for HCBS comes through the State Medicaid program – the largest payer of long-term care services in the Commonwealth. The Department of Medical Assistance Services administers the Medicaid program and has created alternatives to nursing facility home care provided through several "waivers" to the Medicaid program. These waivers allow Medicaid to pay for home and community-based services rather than more costly and restrictive institutional settings. Virginia has embarked on a path to balance the state's Medicaid system by providing enhanced funding to HCBS waiver programs and in 2008, 43 percent of Medicaid long-term expenditures (including HCBS and institutional care) were for home and community-based care – up from 30 percent in 2001. In paying for waiver services, Medicaid is effective in augmenting (not supplanting) the majority of the care being delivered by the informal network of family and friends. While Medicaid "rebalancing" is underway on both the national and state levels, waitlists currently exist for some of the Commonwealth's Medicaid HCBS waivers. Funding for additional Medicaid waiver slots and/or community programs serving older adults at risk for nursing facility placement could expedite progress in helping more older and disabled Virginians remain at home.

Recommendation:

Increase the capacity and flexibility of funding of Virginia's Area Agencies on Aging to better serve the rapidly growing population of older adults.

Recommendation:

Expand the capacity of the Virginia Insurance Counseling and Assistance Program (VICAP) to assist Medicare beneficiaries in understanding and accessing their benefits and managing their costs.

About 9,000 Virginians apply for Medicare each month.

Individuals receiving services through Virginia's Medicaid waivers may choose to self-direct much of their care by hiring their own aides. Approximately 7,000 individuals are currently using consumer-directed services, accounting for the employment of over 16,000 attendants, the majority of whom are in the Elderly or Disabled with Consumer Direction (EDCD) waiver program. Of those employing consumer directed care in this waiver, 64 percent are older Virginians.

Recommendation:

Provide necessary funding to the Ombudsman Program to fulfill its mandated responsibility to address concerns of older adults and their families regarding the quality of home and community-based long-term care.

"High quality effective care in any long-term care setting includes a well-trained and adequate workforce, appropriate housing placement, and high quality supportive services. These efforts will require cross-agency collaboration and public/private sector collaboration to ensure proven best-practice models are identified and replicated wherever possible."

— Governor's Health Reform Commission Report

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive community-based health care plan that assists those 55 and over to remain in their homes and communities. Administered by DMAS, Virginia is at the forefront in national development of PACE which features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE services are provided by interdisciplinary teams in an adult day care setting in a PACE center. The PACE center attendance is meant to promote socialization, alleviate caregiver concerns and help ensure health and functioning. The six Virginia PACE programs offer and manage all medical, social and rehabilitative services 24 hours a day, 7 days a week, to preserve or restore independence, enabling participants to remain in their homes and communities and maintain their quality of life. PACE programs are continuing to expand in other areas, with a new site earmarked to open in Portsmouth in June 2010.

Virginia's Long-Term Care Ombudsman

In addition to the federal and state regulatory bodies, Virginia has the Office of the State Long-Term Care Ombudsman, which provides complaint resolution services to individuals (and their families) who reside in a nursing home; identifies problems and concerns related to long-term care services; and recommends changes in the long-term care system which can be universally beneficial. The Long-Term Care Ombudsman Program (LTCOP) also educates consumers about their rights regarding long-term care services, teaches self-advocacy, and operates a statewide toll-free telephone number (1-800-552-3402) to assist individuals requesting information or filing a complaint.

With the growth in the aging population and the shift toward community-based care, there will be an increased need to significantly expand the work of the LTCOP in advocating for those of us receiving long-term care in the community and to identify, investigate and resolve complaints and concerns. In order to do this, there must be a significant increase in resources to effect a fulfillment of what has largely to date been an unfunded mandate as referenced by the Joint Commission on Health Care, Healthy Living/Health Services Subcommittee 2009 report.

The LTCOP serves a distinct and unduplicated purpose in identifying systemic problems that place one or more older adults at risk and is uniquely poised to follow elders across care venues – an increasingly important function as Virginia moves from institutional care to more HCBS.

Systems Change to Support Community Living

Beyond rebalancing Medicaid and embracing emerging delivery models such as PACE, Virginia is actively engaged in a multi-year, cross-agency effort to affect a global "systems change" related to long-term care. With the assistance of federal, state, public and private funding, championed by legislators and administered through the leadership of the Office of the Secretary of Health and Human Resources, systems change puts individuals at the core of the delivery system ("person-centered") and sup-

ports our ability to make choices regardless of where we are on the continuum of care. A great example of this approach can be seen in the self direction philosophy that has been integrated into several of Virginia's Medicaid waiver programs, encouraging individuals to employ and schedule attendants and develop care plans with the assistance of a service facilitator.

Virginia's strategy to facilitate real change and modernize the Commonwealth's long-term care delivery and payment system is leveraging the support of several federal grants to move toward a system-wide "Person-Centered Community Living" approach. These federal initiatives underway in Virginia include: Systems Transformation, Money Follows the Person, Aging and Disability Resource Centers, and Community Living Programs.

Systems Transformation Grant

The Systems Transformation Grant, a five-year initiative awarded in 2006, laid the foundation for Virginia's strategy to streamline access to needed long-term supports that are integrated, individualized and simple to use. It is driven by the philosophy that services and supports should meet individuals wherever we are on the continuum of care, engage us in the process, offer more affordable solutions, and delay or even help us to avoid unnecessary institutional care. This encompasses delivering services at home or in a home-like environment, with us in the center, empowered by information and support to make our own choices, meet our own individual needs, and direct our own support network. Simply put, it translates into each individual not only fully understanding available options but also enabling us to decide who will provide the services we need and how they will be provided.

The Systems Transformation Grant also prompted Virginia to explore common threads between agencies that have historically provided services with a focus on a unique population. Recognizing that approximately 40 percent of older adults have a disability, 28 percent of persons with a disability are also over the age of 65, and a growing population of older adults are caring for adult children with a disability; this grant challenged Virginia to rethink service delivery and develop strategies to streamline access for older adults and for adults of all ages with physical, cognitive, intellectual, or sensory disabilities. It also prompted Virginia to develop a "self-directed" online tool for this broader audience, to be available on the web portal, *Virginia Easy Access*. Through the Systems Transformation Grant, the Commonwealth has committed to making publicly-funded long-term services and supports for older adults and adults with disabilities, self-directed and person-centered.

Money Follows the Person Grant

In May 2007, Virginia received an award from the Centers for Medicare and Medicaid Services, for the Money Follows the Person (MFP) Rebalancing Demonstration Project established by the federal Deficit Reduction Act of 2005. Funding to make this initiative possible comes from

Recommendation:

Aggressively adopt and support federal and national initiatives to transform Virginia's system of long-term care through coordinated efforts to streamline access to information and services, encourage self-direction of care, increase consumer choice and person-centered practices, employ evidence-based programs, and enhance technology to achieve comprehensive systems change.

About 21.9 percent of all households in 2007 had one or more persons age 65 years and older and 39.4 percent of persons age 65 years and older had a disability.

Recommendation:

Encourage and support Virginia's Area Agencies on Aging in fully adopting the federal model of Aging and Disability Resource Centers, offering a person-centered, individualized and flexible approach to home and community-based services, including the option of consumer direction, to older adults, adults with disabilities and veterans of all ages.

Recommendation:

Expand the No Wrong Door initiative to all regions of the Commonwealth, enhance the technology and develop best practices to support maximum utilization by public and private providers in the efficient delivery of services to older adults, adults with disabilities and their caregivers.

Recommendation:

Strengthen service coordination between Area Agencies on Aging and Centers for Independent Living to better serve the growing population of older adults who also have disabilities.

both federal and state sources. This project provides individuals of all ages and all disabilities that live in institutions in Virginia options for community living that have not been offered before. No age or disability is excluded from participation. MFP is available to persons who reside in a nursing facility, intermediate care facility for persons with mental retardation, or long-stay hospitals and have for the last six consecutive months and continue to require long term care benefits from Medicaid upon discharge. It is anticipated that more than 1,000 eligible individuals will choose to transition out of institutions and return to the community with HCBS provided through Medicaid waivers during the 4-year demonstration period.

No Wrong Door/Aging and Disability Resource Centers (ADRC)

The Virginia Department for the Aging recently received a second ADRC grant to further develop and expand this federal initiative designed to help seniors and adults with disabilities find information and streamlined access to long term services and supports. Augmented by a state general fund appropriation and currently known as No Wrong Door (NWD), this initiative is creating a *virtual* "One-Stop System" so consumers and their families do not have to contact multiple providers – retelling their stories and filling out forms – in their search for the services they need. The NWD initiative promotes local coordination and planning through Community Advisory Councils, harnesses technology to increase the efficiency of providers and stretch resources, and empowers consumers with information and choice through *Virginia* Easy Access.

Prompted by Systems Transformation, Virginia's NWD serves both seniors and adults with disabilities and is designed to eliminate walls between service populations and address long-term care by individual need. As the applicant to the federal ADRC grants, VDA has served as the statewide lead but the evolving model relies heavily on a multi-agency (public and private) cooperative approach. At the local level, the General Assembly has designated the AAA as the lead for implementing ADRC/NWD in their respective localities but they do so in collaboration with Centers for Independent Living (CILs), Community Service Boards, local DSS, health departments, and other public and private providers. This shift is also driving AAAs to broaden their service delivery to include adults under the age of 60 with a disability and is underscoring the importance of strengthening interagency coordination across populations.

NWD provides the technology and protocols for public and private providers to share client information (with consent and in a protected environment) to enable better coordination of services, access to updated client information, streamlined eligibility determination for public programs, electronic referrals among agencies, and improved tracking of services. Ultimately, NWD will not only reduce frustration, confusion and long waits for consumers but will also eliminate duplication and increase accuracy by the broad network of service provides. Currently, about half of the 25 AAAs are utilizing the NWD technology and developing ADRC models in their communities. Pilot agencies for the other human service systems are implementing the technology and private providers are joining the network to reap the benefits of electronically coordinating client services.

Virginia Easy Access

Finally, NWD puts information and tools directly in the hands of consumers through the web portal – *Virginia* Easy Access. Created by a public/private partnership with the Commonwealth of Virginia, SeniorNavigator, and 2-1-1 Virginia, Easy Access is designed to offer seniors and adults with disabilities valuable information and links to public services. Because Easy Access is integrated with the SeniorNavigator database providing direct access to over 21,000 programs and services, an individual or their family can easily search for the local support they need. 211 Virginia provides 24-hour online support to answer questions for visitors to the portal and together, this partnership creates an effective "self-help" tool for anyone seeking information about long-term care supports in Virginia.

Although additional funding and effort will be required to achieve its full potential, NWD is Virginia's best chance to better serve the ever increasing numbers of individuals needing home and community-based services.

Nursing Home Diversion/Community Living Program Grants

VDA has also received two federal grants to help 11 AAAs pilot the transformation of their service delivery. Originally known as Nursing Home Diversion and now entitled Community Living Programs (CLP), these pioneering agencies are providing "options counseling" to individuals at high risk of nursing home placement and Medicaid eligibility and assisting them in designing an individualized service plan and monthly budget to meet their needs in the community. Participants are again encouraged to direct their own care when feasible by choosing providers and hiring aides.

This grant funding, just recently awarded to Virginia for the second time, also expands the target audience to include veterans, another population that shares significant service overlaps with older adults and adults with disabilities. Additionally, CLP is creating a cadre of professionals trained in options counseling and self-directed services; designing fiscal practices for the flexible use of existing federal, state and local funds; and measuring the success in diverting targeted individuals from nursing home placement.

Collectively, these grants not only are providing funding but they also are helping to build an infrastructure to support both systems change and Aging in Place. By investing in innovative technology, inclusive policies, and creative partnerships, Virginia is leveraging its strengths and expanding its capacity in order to meet the growing need for long-term supports. The greatest challenge, especially in a deprived economy, is to continue to support systems change at a sustainable level to reap the long-term benefits of healthy Virginians aging within a healthy statewide long-term support system.

People with moderate dementia have been able to defer institutionalization by nearly a year when their family members received caregiver support services, including counseling, information, and ongoing support. At current rates for nursing home residential care, a one-month delay in nursing home admissions, collectively for all individuals in the United State with Alzheimer's Disease and Dementia translates to an annual savings of $1.12 billion.

Recommendation:

Implement the workforce development recommendations of the Governor's Health Reform Commission to build the workforce of direct support and health care professionals and to improve preventative care and wellness programs for adults, especially high risk populations.

Recommendation:

Continue and expand General Fund appropriations for the Geriatric Education and Training initiative, Virginia's only state-funded program to develop skills and build capacities of the gerontological/geriatric work force, across disciplines from pre-professional to professional.

Recommendation:

Develop a comprehensive strategy to raise awareness about the positive aspects of careers related to eldercare and recruit direct care workers such as paid caregivers, CNAs, and personal and home health aides.

Recommendation:

Recruit retiring and retired military health care personnel to volunteer or enter a second career in geriatrics, gerontology, or direct care for older adults and also to address barriers such as liability.

Health Care

Older adults make up only 12 percent of the current population, however we account for: 26 percent of doctor appointments; 35 percent of hospital stays; and 47 percent of outpatient visits. While optimal aging is partially influenced by our ability to maintain our own good health, there are outside factors that can assist or oppose our efforts. For instance, how can I keep track of my blood pressure when the closest doctor is two hours away? How do I ensure nutritional health when I don't understand what foods are best to eat? How do I know if the symptoms I am experiencing are due to disease or the interaction of my 15 medications? Developing a professional and direct service workforce trained in aging issues, promoting prevention, utilizing innovative service delivery practices and non-traditional partnerships, supporting family caregivers, and addressing challenges specific to individuals with dementia and behavioral health issues are paramount in helping us all to age optimally regardless of physical, cognitive, financial, educational, or geographic limitations. Maintaining optimal physical and cognitive health is partially driven by individual choice, partially by genetics, and partially by the decisions we make on a statewide and community level to ensure access to information and services that promote healthy aging across the continuum.

Professional and Direct Service Workforce

With Virginia's older adult population nearly doubling by 2030, it is predicted that many of us will also have at least one chronic illness and a significant number will have five or more chronic conditions. In view of the heated debate over health care reform, it is important to recognize, regardless of the plan that is adopted, success hinges on two critical points: 1) an adequate workforce of medical and non-medical support staff and 2) accessible health care – even in rural and other areas of greatest need. Although these are issues that will affect other populations, they are exacerbated in the field of aging because of the increasing gap between the number of us reaching older age and the number of professional and direct care workers trained in geriatrics or gerontology. According to the Institute of Medicine, less than 1 percent of nurses, pharmacists and physician assistants specialize in geriatrics and fewer than 4 percent of social workers are gerontological specialists.

A 2007 report by the Virginia Health Reform Commission and a 2008 national report, "Retooling for an Aging America: Building the Health Care Workforce" agree on basic strategies: to monitor the progress of the health care workforce for older adults; to increase scholarship and loan repayment programs and the number of graduate medical education slots; and to award grants to medical schools with innovative practices to change the medical education model. Considering it takes 12 years to train a geriatrician and 3 additional years to qualify to teach at a medical center, it is nearly too late to train enough geriatricians to care for the aging wave. Additionally, simply increasing medical school class size will not be enough since trends indicate that graduates of American medical schools do not preference primary care, the main

curriculum that produces geriatric candidates. In summary, virtually every single area of health care and human service workforce critical to the coordinated delivery of services to older adults has a shortfall in critical mass and time is running out.

Beyond the fact that there simply aren't enough health care professionals, there is also a considerable issue created by high turnover of qualified personal care service workers, due to the absence of health benefits, low wages, and inadequate training. An instable health and personal care workforce has multiple blatant impacts but, specific to aging, there is a dramatic hidden effect as well. Quality care depends in large part on continuity of care. With turnover rates in home care nearly 40 percent, continuity of care is severely jeopardized. According to the Journal of the American Board of Family Practice, nine out of ten seniors say they would change physicians only if they were given no other choice. It seems though that this is not only their preference but also a healthy decision. Maintaining a long-term relationship with a primary care physician and with support service providers is associated with better health outcomes for patients at a lower cost. It also increases the likelihood patients will take their medications as directed and keep their medical appointments.

Caregiving Network

With increased numbers of aging adults and decreased numbers of professionals, thank goodness for family caregivers! Without a doubt, the single most valuable support to the health and well-being of Virginia's older adults is the network of informal care provided by family and friends. The recent State Profile estimates that Virginia caregivers provide nearly $10 billion in services. As the numbers of professional healthcare workers decrease relative to the numbers needing their services, the burden of care will likely increase for informal caregivers. Unfortunately, the trend of shrinking family size – 76,000,000 Boomers compared to 62,000,000 in Generation X – suggests that the availability of family caregivers will also decrease, placing an even greater burden on the informal care network.

One common myth is that support provided by caregivers is "free." Although it is true that there are no costs incurred by the recipient, by Medicare, or by supplemental health insurers – there are expenses, albeit often hidden, for individual caregivers and their employers. AARP and the National Alliance for Caregiving estimate that the cost of caregiving to the average worker is over $650,000 across their lifespan in lost wages, lost pension, and negative impact on Social Security. It also estimates that employers bear the burden of over $1,100 annually in lost productivity for each caregiver employed. That adds up quickly considering approximately 60 percent of caregivers are employed. Additionally, regardless of whether a caregiver is employed or not, local caregivers spend an average of $5,500 annually in out-of-pocket expenses and long-distance caregivers approximately $9,000, according to the National Alliance for Caregiving. Beyond the financial burden, caregivers experience a toll on their health as well. Research shows that caregivers

Recommendation:

Build capacity of Virginia's healthcare workforce to address the severe lack of professionals trained in geriatrics by:

- *Developing a statewide recruitment strategy for primary care professionals, the major source of geriatric fellowship applicants.*
- *Initiating a program of loan forgiveness for geriatric medicine and geriatric psychiatry fellows, both of which are critical to the needs of older adults.*
- *Supporting one Geriatrics faculty position at each of Virginia's four (five in 2010) medical schools to foster the mentoring of and serve as role models for medical students and teaching support for subspecialties commonly used by older adults, such as Urology, Orthopedics, Dermatology, Surgery, Ophthalmology, and Otolaryngology.*
- *Incorporating geriatric education into the licensure requirements of all health care professionals and including demonstration of competence in the review process.*
- *Requiring medical residents in primary care and nursing students to deliver care to older patients at the setting in which the patients live, to include assisted living, nursing homes and patients' homes.*

Recommendation:

Restore funding to maintain the Virginia Caregivers Grant and the Respite Care Grant and develop new public and private funding for services to assist caregivers in all regions of the Commonwealth.

Recommendation:

Develop a standardized training program for family caregivers through the Area Agencies on Aging and/or the community college system, available through on-line resources, community sites with in-home consultation, and the hospital discharge process.

A study conducted by the National Alliance for Caregiving found that:

- *nearly 35 percent of caregivers surveyed dipped into their savings*
- *nearly one-third cut back on maintaining their home.*
- *nearly one-quarter spent less on their health or dental care*
- *approximately 37 percent quit jobs or scaled back their work hours.*

have higher rates of depression, anxiety, sleep problems, elevated blood pressure and compromised immunity, and 63 percent have a higher mortality rate than non-caregivers of the same age. Despite the personal toll, approximately 700,000 Virginians continue to care for their loved ones providing an estimated 793 million caregiving hours each year. If Virginia is to manage the growing needs of our aging population, clearly success hinges on providing better support to our unpaid but critical network of caregivers.

Cognitive, Behavioral, and Mental Health

While many tangible steps can be taken to assist older adults with physical and sensory disabilities to Age in Place, it is far more challenging to address the needs of individuals with dementia and other cognitive disorders and behavioral health issues. Nationally, mental illnesses, substance use and cognitive disorders pose a serious and increasing risk to the health and well-being of many older adults; resulting in increased disability and impairment, compromised quality of life, reduced independence and community-based functioning, increased caregiver stress, increased mortality and increased risk of suicide. Some older adults experience acute psychiatric problems that go undetected or untreated often leading to deterioration that results in more expensive treatment.

The incidence of Alzheimer's Disease alone, will double between 2000 and 2030, from 2.6 to 4.3 percent of the Commonwealth's population. However, Virginia does not presently have a clear policy on what role, if any, state agencies should have in providing services to persons with Alzheimer's and other forms of dementia, particularly if they have behavioral problems. The lack of community-based options for older adults appears to increase the reliance on institutional services yet most long-term care facilities lack expertise both in caring for older adults with mental illness as well as managing dementia-related behavioral problems.

Advocates have long been concerned that no state agency is responsible for providing services to individuals with dementia. In response to a 2006 JLARC study, the Department of Behavioral Health and Developmental Services (DBHDS) developed State Board Policy 1008 86-3 "CSB/BHA and State hospitals shall provide services to the greatest extent possible to older adults with Alzheimer's Disease or related conditions when they exhibit behaviors or other diagnoses that meet the state hospital's or CSB/BHA admission criteria, including significant behavior problems as determined by qualified state hospital or CSB staff." The JLARC report adds, however that it is nearly impossible to find a private hospital willing to serve older adults with mental illness or dementia-related behavioral problems because many nursing homes refuse to readmit residents after a period of psychiatric treatment. Private hospitals fear they will be "stuck" with a patient they cannot discharge. In fact, it is reported that older clients often remain long after inpatient treatment is necessary, for lack of another place to go.

There are two primary categories of older adults that are accessing the mental health system: those longstanding consumers of the public

DBHDS system and those with late onset problems that combine mental health, substance abuse and various forms of dementia. Similar to the national picture, Virginias' older adults with mental health problems are a diverse population.

According to the 2010-2016 DBHDS Comprehensive State Plan, waiting lists for adults 60 and older present a snapshot of need vs. capacity: 328 needing mental health services; 230 waiting for intellectual disability services; and 40 requiring substance abuse services. However the waiting lists don't paint a complete picture. According to *Mental Health: A Report of the Surgeon General*, nearly 20 percent or an estimated 349,520 Virginians 55 or older, experience mental disorders that are not part of "normal" aging, and yet last year only 11,160 were served by public community-based mental health services. As more seniors Age in Place, demands for home and community-based mental health services will increase. The DBHDS Master Plan for Geriatric Services outlines a continuum of specialized services to meet the complex needs of older adults: educated primary care providers equipped to manage and treat minor psychiatric conditions in older adults; short-term respite care that includes psychiatric treatment; assisted living and nursing facilities with integrated psychiatric treatment options; payment systems where the money follows the person; and enhanced availability of program models such as PACE, covering psychiatric care in the individual's residence. Across the Commonwealth several regional efforts have resulted in model programs. These include:

- In Northern Virginia, the community services boards have established, the Regional Older Adult Facilities Mental Health Support Team, RAFT, which enables adults 65 and older to be discharged from two state facilities to less-restrictive community-based settings.

- In Eastern Virginia, the Hampton Newport News CSB has a Geriatric Psychiatric Continuum Model for older adults, which focuses on addressing the needs and preferences of both the patient and the family, employs evidence-based best practices, and provides comprehensive and integrated services and supports.

- The Region Ten CSB, serving the Charlottesville area, has convened an Interagency Mental Health Support Team for Aging to improve communication and cooperation among community agencies involved in providing and monitoring appropriate care and treatment for aging residents. Considered to be a best practice model for the provision of community services by the federal Substance Abuse and Mental Health Services Administration this team coordinates multi-agency responses for older assisted living facility residents with histories of severe, enduring, and complex mental and often physical health conditions.

- The Southside Geropsychiatric Services, a collaborative project involving Chesapeake, Norfolk, Portsmouth, Western Tidewater and Virginia Beach CSBs, offers free training and consultations to facility and family

The National Institutes of Health report a unique profile that differentiates people who maintain cognitive function from people who show age-related decline:

- *people who exercise at least once a week are 30 percent more likely to maintain cognitive function;*
- *those with at least a high school education are nearly three times as likely to stay sharp;*
- *older adults with a ninth grade literacy level or higher are nearly five times as likely to maintain cognitive function;*
- *non-smokers are nearly twice as likely to stay sharp; and*
- *people working, volunteering and living with another person are nearly 25 percent more likely to maintain cognitive function in later life.*

Recommendation:

Develop a full continuum of collaborative care for older adults who have mental health needs, intellectual disabilities, and/or substance use disorders by expanding current state and community-based programs focused on reversing the escalation of issues which can lead to expensive and preventable institutionalization.

Recommendation:

Develop a comprehensive suicide prevention plan for older adults addressing public awareness, prevention education, early identification, intervention, treatment, and support for survivors.

Recommendation:

Continue funding through the Department of Criminal Justice Services to provide Alzheimer's-related training to first responders including law enforcement officers, emergency medical services, and fires services.

According to The Journal of Family Practice, despite a clear need, substance abuse prevention services for older adults are an infrequent component of public health programs.

caregivers providing care for seniors with dementia or other mental health issues that put them at risk of psychiatric hospitalization.

- The Geriatric Mental Health Planning Partnership, with members from the Governor's Office, Secretary's Office, DMAS, Adult Protective Services, VDSS Licensing, VDA, Department of Corrections, and private consultants, works collaboratively through a common vision to improve care and access in cost effective means by developing a continuum of care for older adults – the "right care, at the right time, at the right place."

Substance Abuse

Prescription drug abuse and addiction in older adults is a complex issue. Researchers are only beginning to realize the pervasiveness of substance abuse disorders among older adults. Until recently, prescription drug abuse – which is now estimated to affect as many as 17 percent of older adults – was not discussed by either addiction experts or in gerontological literature, partly because symptoms have been mistaken with those of dementia, depression. In addition to the suffering that substance abuse inflicts upon older adults and their families, there is also a large societal cost. Nationally, Medicare expenditures for substance abuse and related mental health problems amount to over $7 billion annually. Although these numbers seem high, experts say they may actually be underreported given the complexity of prescription drug abuse in older adults. Looking ahead, there is speculation that there could likely be an even greater impact of alcohol and substance abuse, considering the rapidly growing population of older adults who grew up during an era of increased illicit drug and alcohol use.

Studies suggest that if older adults and family caregivers had a better understanding of the dangers posed by prescription drugs, much abuse and addiction could be avoided. Experts recommend a combined approach – education about medication regimens, potential side effects and interaction between medications, over-the-counter drugs, herbal home remedies, and food and enhanced communication between providers, older adults and caregivers. To that end, the following recent efforts have been initiated in Virginia to raise awareness and prompt communication and education:

- Virginia ABC formed the Alcohol and Aging Awareness Group in 2007 to educate older adults, family caregivers and service providers about the issues related to alcohol misuse and possible interactions between alcohol and medications. A website will host web-based trainings and future outreach will focus on services and treatment statewide, with plans to offer training to primary care physicians.

- Grant funds from prescription drug settlements are assisting SeniorNavigator to combat prescription drug abuse and addiction among Virginia's seniors through outreach, education and improved communications. In cooperation with the National Council on Aging and CVS pharmacies, SeniorNavigator Centers host pharmaceutical screenings and evaluations to explore potential unintentional drug interactions.

New Approaches to Providing Care

Changing the way that care is organized and delivered is an important component to maximizing each individual's highest level of ability and improving future geriatric health care. One trend that shows the pendulum swinging back is the recurrence of "house calls." The aging population, Medicare reimbursement rates for home visits, off-site diagnostic technology, and health monitoring at home, have led to the resurgence of house calls over the past ten years. However, since 2005, due to declining rates, they have become less practical. Still, the ripple-effect benefits are substantial. Studies show that frail elderly adults are less likely to leave home for routine checkups and more likely to seek treatment only once problems have become exacerbated, resulting in more visits to the emergency room and hospitalizations. According to the Centers for Medicare and Medicaid Services, the average hospital stay for a Medicare beneficiary age 65 and over is nearly six days, at a cost of about $3,500 per day; an ER visit from a 9-1-1 call costs about $2,000; and an urgent house call, $100 - $200. Studies suggest that giving these patients better care earlier can reduce costs down the road.

Technology is also an important vehicle to maximize professional resources, save money and care for older adults in their home environments. New technology solutions now enable safe and sustainable models to connect people to a network of care, empower individuals to take charge of their own health, enable families to maintain real time awareness of their family member's well-being, and provide consistent daily supportive and health care services in ways never before possible.

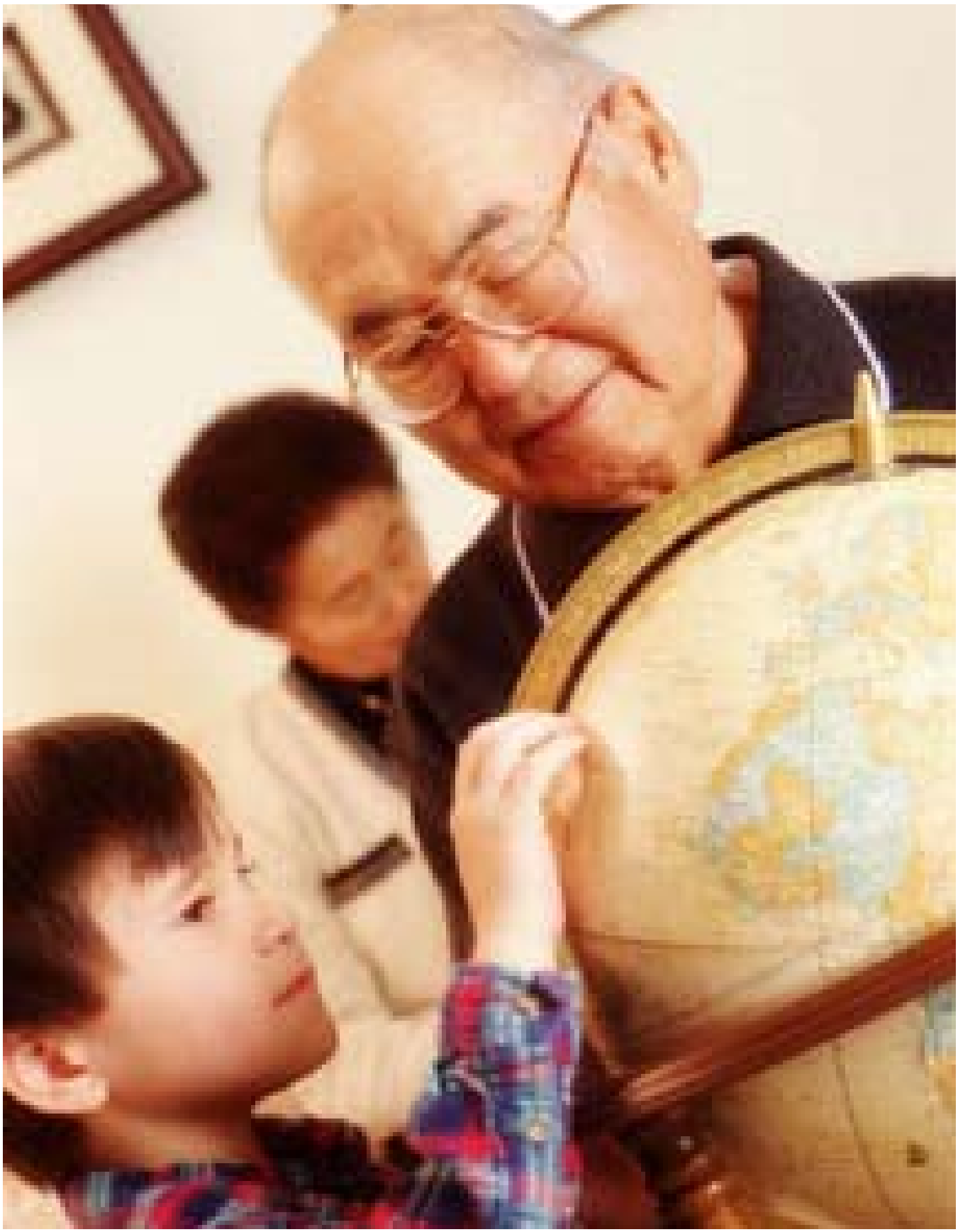
Prevention

While great strides are being made in managing chronic disease, the very best scenario for us is to not get sick in the first place – prevention could be one of the strongest influencing factors in reducing the need for acute and long-term care. Targeting older adults in health promotion campaigns can help dispel myths and begin to breathe hope into those of us who may think it is too late for healthy choices to make any difference. In an effort to decrease morbidity, however, targeting only older adults would be a mistake. The sooner we understand how our choices of today are impacting tomorrow, the better chance of extending good health into old age. Boomers are ready, reports AARP, with 87 percent of 60 year olds saying they want to take better care of their physical health. Health literacy decline is also a major concern and should be strongly considered in the development of health promotion campaigns, with 39 percent, age 75 and over below basic health literacy levels, compared to 23 percent, 65 to 74 and 13 percent, 50 to 64. Beyond health promotion, communities can also take an active role in prevention by ensuring that sidewalks are smooth, cross walks are safe, handrails are plentiful, flu vaccine sites are accessible, parks and green space invite exercise, and community gardens and farmers' markets are within walking distance to low-income and senior housing. Prevention may just be the key to Aging in Place, but it will take an individual and community commitment to make it happen.

Dr. Peter Boling, Professor of Geriatric Medicine at VCU Medical Center, originated the VCU House Calls program in 1984 and now champions a proposed "Independence At Home" to promote this type of medical care through National Health Reform.

Seventy-five percent of older adults say they are willing to receive telemedicine to diagnose or monitor health conditions remotely in their home.

Among older Americans, the average level of health literacy – the extent to which people can obtain, process and understand basic health information and services – was lower than that of any other age group, and it continued to decrease with age.



OLDER ADULTS AS RESOURCES

The National Academy on an Aging Society writes, "On January 1, 2006, the first baby boomers turned 60 years of age. They are the leading edge of the largest, healthiest, and best-educated population of American adults ever. With many boomers on the verge of retirement, looking for ways to maintain meaningful work throughout later years, and the ongoing need to address important social problems and strengthen community life, a tremendous opportunity presents itself to contemporary society: To more fully engage older adults as a civic resource for addressing community needs through both paid and unpaid work."

"There is a personnel tornado on the horizon: In more than half the states, one in five employees will be retiring over the next five years."

— Governing Magazine

A clear majority of Virginia's state agencies (72 percent) confirmed that the loss of older employees will have a significant impact on agency operations. On a positive note, 83 percent report conducting specific succession planning strategies in 2008.

According to a survey of business leaders in Virginia conducted by the Older Dominion Partnership – 65 percent say the aging workforce is a serious issue for the economy and 41 percent say it is a major challenge for their organization as well.

Diminishing Workforce

Historically, the labor market has provided few choices to older workers: full-time work, full retirement, or low paying part-time work. But, just as virtually every other aspect of our society is being affected by the aging boom, so too is Virginia's workforce. The labor demographic profile is beginning to undergo a substantial shift as large numbers of older workers are being joined by relatively few new entrants to the labor market.

Although currently, only about 3 percent of people over 65 are working either part or full time, research suggests that more boomers will work beyond their retirement age to ensure financial security and/or to retain the sense of well-being that they associate with meaningful employment. However, as our seasoned workforce retires from career positions at unmatched rates, public and private employers will encounter a critical loss of experience and knowledge. These trends are expected to create gaps in skilled workers and managerial occupations in particular, because boomers are more likely to currently occupy such professional and managerial positions than previous retiree generations.

According to the 2007 State Workforce Planning Report by the Virginia Department of Human Resources Management, the average age of classified state employees is 45.8 years old. However, nearly10 percent of the Commonwealth's workforce is age 60 years or older. The Virginia Retirement System reports that if the current retirement rate continues over the next 10 years, 38,400 state employees will be eligible to retire with an unreduced benefit, not including employees of Virginia's public colleges and universities that may be enrolled in other retirement plans.

Virginia's workforce and businesses are also experiencing an impact due to the increased number of employees caring for a dependent older relative. Typically, employed caregivers' productivity will decrease unless policies and programs that reinforce caregiving practices are put in place. In the years ahead, there will be far fewer adult children to care for their aging parents, theoretically resulting in steeper employer costs due to a greater burden on each individual caregiver. In fact it is estimated that the cost per employee could be as high as $2,441 annually – double that of today's estimates. Policies such as flextime, telecommuting and job-sharing, as well as support programs such as respite care and adult daycare services will reinforce employed caregivers' ability to be productive at work. This change has already begun. Approximately 33 percent of large employers currently have an eldercare program to help employees with caregiving responsibilities. Such policies help maintain productivity, manage caregiving stress, and mitigate the number of employees who leave the workforce altogether. Employer and public policies that support caregiving employees will also help contain health care and long-term care costs for taxpayers, individuals and businesses alike.

New Ways to View Retirement

In order to bridge the skilled labor gap and preserve the tremendous resource of knowledge on the verge of retirement, employers need to offer creative and flexible solutions. As more workers reach retirement age, employers are offering options such as "phased retirement" – job sharing, reduced work schedules, or rehiring retired workers on a part-time or temporary basis. To combat "experience drain" and maximize the "experience dividend," employers will need to better support a healthy work-life balance for older adults who want to retire. Options like flex-time and telecommuting may make it easier to retain workers. Recruiting retirees through a company "corporate reserve" or third-party databases of retirees is another way to retain specific knowledge and skills for short-term or part-time assignments.

With the Social Security "test" eliminated for those 65 and older, no longer is there a ceiling for earnings that reduce SS payments. Permitting seniors to work if they need or wish to, without loss of pension or SS monies, will go a long way in helping to close the gap between those retiring and new labor entering the market. The good news is that a recent poll of workers over the age of 45 showed they want to work into their "retirement years." However, most indicated they would prefer part-time options and are looking for better ways to balance their work and personal life. Other experience retention innovations include: cross-training, mentoring, coaching, shadowing and comprehensive exit interviews to foster the transfer of knowledge; and cross-company collaborations to bolster a thinning of in-house expertise.

Volunteerism

The potential contributions of today's older adults as well as aging boomers stretch far beyond their productivity as paid employees. Most older adults and boomers express a desire to remain politically and socially active in our communities. The volume of volunteer hours and the value of community benefits will depend largely on physical and cognitive health, financial capacity, family supports, and the communities' ability to provide meaningful opportunities for engagement. If, in fact, volunteer energy can be funneled into service areas to supplement professional care of older adults, communities may be able to provide unique opportunities to boomers and older adults for meaningful engagement while also addressing shortfalls in aging services.

According to a recent report commissioned by AARP entitled "More to Give," rewards and incentives can influence behavior and policymakers wisely use them to encourage activities that benefit the public. Just as donations to charity are tax-deductible in order to encourage philanthropy, volunteering can be rewarded in order to foster a commitment to service. Currently, a wide range of incentives are offered to encourage people to serve, including full-time and part-time stipends to cover living costs, educational awards, travel reimbursement, and even Presidential recognition.

Recommendation:

Support the goals of the 2010-13 Virginia State Service Plan for Volunteerism and National Service to fully engage older adults in volunteerism and other best practices that draw upon the knowledge and skills of older Virginians.

According to a recent AARP report, 70 percent of regular volunteers, said they use the internet at least a few times a week – a trend that is likely to increase with each generation. This represents a significant opportunity for the expansion of web-based information on volunteer opportunities for Virginians.

A MetLife /Civic Ventures New Face of Work Survey found that half of Americans age 50-70 said they were interested in work that would improve the quality of life in their communities, with one fifth 50-59 identifying this as a top priority.

According to a recent study on older Americans, on an average day, most adults 65 and older spent at least half of their leisure time watching television.

Research indicates that physical activity keeps both our bodies and brains in shape, and that mental exercise helps keep our brains younger.

Fifty percent of the students graduating from VCU with a Masters in Gerontology (the only school offering this degree in Virginia) are "re-careering."

Life-Long Learning

Virginia can also maximize the potential of its older citizens through recognition and support of the lifelong learning movement. Virginia's institutions of higher education can help prepare older adults for encore careers and act as catalysts to further lifelong learning. Additionally higher education institutions can provide conceptual guidance, curriculum assistance and provide a rich pool of instructor resources to creative partnerships like the Lifelong Learning Institute in Chesterfield County which harnesses the expertise of health care providers, government specialists, State Department representatives, linguists, financial planners, and more.

Virginia has more than seven life-long learning centers including ones facilitated by the following colleges and universities: Christopher Newport University, George Mason University, Old Dominion University, University of Richmond, University of Virginia, Virginia Commonwealth University, the College of William and Mary. Additionally, the Virginia Center on Aging at Virginia Commonwealth University (VCU) has provided Elderhostel programs, now known as Exploritas, for more than 30 years. Their mission is to empower adults to explore the world's places, peoples, cultures and ideas, and in so doing, to discover more about themselves. A fellowship of learning and the joy of discovery are the hallmarks of the Exploritas experience.

Livable communities that encourage Aging in Place, harness professional experience and intellectual capital, foster community engagement, embrace cultural diversity, provide accessible opportunities, and embrace innovative solutions will be well-positioned to reap profound benefits from this rapidly growing pool of diverse and valuable human resources.

CONCLUSION

Humankind is experiencing a movement of such speed, proportion and impact that it is unprecedented in history. Call it the triumph of longevity; we have extended life in the past century from an average lifespan of 40 years to now, 78 years. To put the gravity of this movement into context, our recent growth in life expectancy exceeds that of the previous 50 centuries combined. This represents a truly extraordinary accomplishment, for sure, but at the same time presents equally extraordinary challenges – to public services and programs, to the private sector and non-profits, and to individuals of all ages. …Above all else, the goal is to ensure that we celebrate our new longer-life experience with dignity."

— *Transforming the Aging Experience*
Eskaton, Senior Residences and Services

Recommendation:

Eliminate duplication of effort and encourage efficiencies by consolidating multiple legislatively mandated planning and reporting requirements specific to aging into one comprehensive Plan for Aging Services.

Given that the overwhelming majority of older persons repeatedly say they want to remain in their homes and communities as they age, it is imperative that local leaders consider the needs of this growing population in planning for the future. Unfortunately, this is not yet the norm.

— The Maturing of America

Planning for the Aging Wave

The population of the Commonwealth of Virginia is aging and aging fast. In just two decades, one in five Virginians will be over age 65 and a larger proportion of our population will be "senior citizens" than Florida claims today. This demographic imperative will bring challenges, opportunities and change to all aspects of life in our communities. Businesses will face an aging workforce and aging consumers; more and better community services for older residents will be in high demand; the health care system could be strained beyond capacity; senior friendly housing and public transportation systems will need to expand; educational institutions will see more aging students wanting to learn; tourism, recreation and the arts will need to appeal to a grayer audience, and; an army of better educated volunteers eager to give back to the community could be a windfall for community programs. Failure to prepare now will not only adversely affect today's seniors and the aging boomers, but younger generations as well if our future economy and service infrastructure is ill equipped to support an older population.

In response to this reality, the Virginia General Assembly mandated this four-year planning process for aging services. Previously, in 2006 the legislature required all state agencies to prepare annual reports on the impact of an aging population on their ability to deliver services and required VDA to summarize these reports for the Governor and General Assembly. Again, in 2009, the legislature adopted budget language requiring the Secretary of Health and Human Resources to develop a comprehensive "blueprint" that spans to the year 2025, builds on the Four-Year Plan for Aging Services and other aging initiatives and encompasses "broad-based issues of active, daily life in our communities." It is clear that the intent of the Virginia legislature is that the Commonwealth be ready.

Given today's climate of shrinking budgets and downsized organizations, we must be efficient in our use of resources and yet comprehensive in our approach to addressing aging issues. Multiple planning efforts and reporting requirements should be well coordinated and consolidated whenever practical – leading to a clear and shared vision of how we need to proceed.

The Way Forward

The future is a shared responsibility. Wherever we are on the continuum, whatever our individual circumstances and challenges may be; as individuals we must take steps to maintain our physical and mental health to the greatest extent possible, to remain engaged in the civic and social life of our communities, and to work and plan to the best of our ability to secure our financial future. As a society we must help individuals Age in Place and continue to be valuable resources to their families and communities by providing helpful information, designing livable communities and ensuring that targeted and well designed services are accessible when needed.

Despite declining state revenue and necessary budget reductions, the Commonwealth is making significant progress in modernizing, coordinating and improving our system of long-term services. By embracing national trends such as Culture Change, rebalancing the Medicaid system to support more home and community-based services, implementing new models of care like PACE, and aggressively maximizing federal grants – Virginia is setting a clear direction. Together, these progressive initiatives are aimed at transforming our system of aging services by: coordinating programs that serve different populations with similar needs, empowering us with information, helping us remain in our homes and communities, creating a person centered system more responsive to the needs and wishes of the individual, increasing choices, and placing the consumer more in control. In other words, creating a system of services we would want for our grandparents, our parents, and for ourselves.

However, there are still troubling gaps in services and an ever-increasing population of older Virginians. Funding must not only be restored for aging services as the economy recovers but new and expanded services developed to meet the growing demand. Perhaps of most importance, state and local leaders need to put preparing for an aging Virginia near the top of their agenda and develop and implement plans now to meet the needs and seize the opportunities that are just on the horizon.

This first Four-Year Plan for Aging Services is a small but important step to designing the path to achieve these goals. §2.2-703.1 of the Code of Virginia calls for an annual update on the status of aging services and VDA and the planning team consider this report the first step in an ongoing process. Public input must be solicited, more relevant data collected, some issues explored further, desired outcomes defined, recommendations prioritized and made actionable, benchmarks for measuring progress established, and a process for evaluating effectiveness designed and implemented. There is obviously much to do and little time to prepare. The future is almost here.

Virginia's citizens and leaders can take great pride in the recognition the Commonwealth has received such as The "Best Managed State," the "Best State for Business" and as a great place to raise children. The time has come to ensure that Virginia is also known as a great place to grow old.

Recommendation:

Continue leadership by the Virginia Department for the Aging of a broad coalition to further refine and update Virginia's Four-Year Plan for Aging Services to identify specific outcomes, performance measures, priorities, strategies, costs, and potential funding mechanisms to achieve success.

"The current recession will not slow down the age wave; it is a demographic reality that cannot be denied. And, it will hit Virginia in the years ahead. While it will take years to fully engulf us, we need to plan for it now. The strength of our local economies and our quality of life will depend on it. We need to prepare now to make sure that impact is positive. Making Virginia a great place for older adults will make it a great place for people of all ages."

— The Older Dominion Partnership

Appendix A

§ 2.2-703.1. Powers and duties of Department relating to four-year plan; report.

A. The Department shall develop and maintain a four-year plan for aging services in the Commonwealth. Such a plan shall also serve as the State Plan for Aging Services as required by the federal Administration on Aging. In developing the plan, the Department shall consult various state and local agencies, including, but not limited to, Virginia's Area Agencies on Aging, the Commonwealth's Health and Human Resources agencies, the Virginia Department of Transportation, the Virginia Department of Housing and Community Development, the Virginia Housing Development Authority, and the Virginia Department of Corrections, as well as the Commonwealth Council on Aging, the Virginia Alzheimer's Disease and Related Disorders Commission, and the Virginia Public Guardianship and Conservator Program Advisory Board. The Department shall also consult with businesses, nonprofit organizations, and stakeholders as the Department deems appropriate.

B. The four-year plan shall include a description of Virginia's aging population, its impact on the Commonwealth, and issues related to providing services to this population at both the state and local levels. The plan shall include factors for the Department to consider in determining when additional funding may be required for certain programs or services. The following shall be included in the plan:

1. Information on changes in the aging population, with particular attention to the growing diversity of this population including low-income, minority, and non-English speaking older individuals;

2. Unmet needs and waiting list data for aging-related services as reported by Virginia's Area Agencies on Aging and those state agencies that may maintain and provide this information;

3. The results of periodic needs surveys and customer satisfaction surveys targeted to older Virginians that may be conducted by the Department, the Area Agencies on Aging, or any other state or local agency;

4. An analysis by those state agencies listed in subsection A of how the aging of the population impacts their agency and how the agency is responding. This analysis shall be provided to the Department every four years on a schedule and in a format determined by the Department;

5. The impact of changes in federal and state funding for aging services; and

6. Any other factors the Department deems appropriate.

C. In carrying out the above duties, the Commissioner shall submit the plan to the Governor and the General Assembly by November 30 of 2009 and every four years thereafter.

D. The Commissioner shall also submit an annual report by November 30 of each year to the Governor and the General Assembly on the status of aging services in the Commonwealth.

Appendix B
Aging Four-Year Plan Work Group

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Alzheimer's Association
Carter Harrison

Commonwealth Council on Aging
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Council on Virginia's Future
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Piedmont Geriatric Hospital
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State Long-Term Care Ombudsman
Joani Latimer

Virginia Association of Area Agencies on Aging
Courtney Tierney, Prince William Area Agency on Aging and

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Virginia Department of Planning & Budget
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Virginia Department of Social Services
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Virginia Department of Veterans Services
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Virginia Geriatric Education Center & Virginia Alzheimer's Disease and Related Disorders Commission
Dr. Ayn Welleford

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Bruce DeSimone

Virginia Public Guardian and Conservator Board
Cynthia Smith

Virginia Department for the Aging
Linda Nablo, Commissioner
Katie Roeper, Assistant Commissioner
Bill Peterson, Policy Analyst
Tim Catherman, Director of Support Services
Kathy Miller, Director of Long-Term Care

Appendix C

Recommendations Included in the Four-Year Plan for Aging Services

Develop mechanisms to educate Virginians about the differences among public programs and private financing options for long-term services and support Virginia's Long-Term Care Partnership, an alliance between the private insurance industry and state government to plan for future long-term care needs.

Maximize the use of all existing resources such as Virginia Easy Access and SeniorNavigator to raise awareness, educate, and empower Virginians with information to age optimally.

Plan for needs and abilities specific to special populations when developing programs and services that support older adults "aging in place" and in outreach efforts to educate them about available support.

Identify and replicate creative partnership models that enable successful federally-funded programs with age-specific eligibility requirements, such as friendship cafes and congregate meals, to be expanded to also serve individuals under the age of 60 with lifelong disabilities.

Support recommendations of the Virginia Tech Institute for Public Policy Research, intended to strengthen outreach and educate kinship care families on their rights and responsibilities and available benefits and services and encourage community agencies to organize kinship care support groups and respite programs.

Support Piedmont Geriatric Hospital in its efforts to provide long term care to inmates transitioning from prison to the community and assist in development of a program to do so by 2012.

Request that the Governor's Mental Health/Criminal Justice Consortium include representation from the Virginia Department for the Aging and other aging-related stakeholder groups such as the Alzheimer's Association.

Provide communities, through a partnership with the Older Dominion Partnership, the data, tools and assistance necessary to develop and implement comprehensive local or regional plans to address the array of demands and opportunities presented by the aging of Virginia's population.

Explore the feasibility of developing and/or adopting a program and statewide standard for certifying Virginia communities as "Aging-Friendly" or "Livable" communities.

Strengthen Adult Protective Services through interagency coordination and communication and provide additional funding for local Departments of Social Services to meet current needs and eliminate waiting lists.

Standardize and incorporate an elder abuse prevention and detection curriculum into the basic academies for first responders, and state and local law enforcement.

Expand Triad partnerships and other community coalitions between public agencies and private-sector organizations to broaden training and education about senior safety, crime and fraud prevention, and domestic violence.

Continue statewide leadership and coordination of available legal resources for older adults by building upon the success and broad stakeholder support of the Project 2025 initiative.

Ensure that older adults with disabilities are adequately represented in statewide and community-level disaster preparedness planning and testing, especially in the areas of accessibility of shelters and transportation.

Leverage Virginia's No Wrong Door system to create a statewide emergency response registry for older adults, based on consent, to identify physical, cognitive, or sensory disabilities that may influence preparedness, response, and/or recovery plans.

Enhance Virginia's ability to monitor and report the impact of the current recession on low-income older home owners, including their ability to age in place, utilize home-equity conversion options, and take advantage of programs that provide accessibility modifications.

Support the development of a Virginia Housing Trust Fund, using a dedicated stream of state revenue, to address the rising cost of housing.

Integrate the concept of Universal Design into the Virginia Uniform Statewide Building Code.

Improve coordinated financing to create a rental assistance program that would provide additional subsidies for extremely poor older adults with disabilities who cannot otherwise afford housing.

Support the goals and recommendations of the Virginia Pressure Ulcer Resource Team (VPURT) to promote prevention strategies through outreach and training.

Support the expansion of the Virginia Culture Change Coalition in its efforts to strengthen workforce stability, resident choice, resident and staff satisfaction and empowerment, and patient-centered care.

Strengthen the role of the Interagency Coordinated Transportation Council by empowering members to develop policy and report annually on the progress of human services transportation and best practices, encouraging training for local and regional planners and providers to improve coordination and provision of services.

Increase the capacity and flexibility of funding of Virginia's Area Agencies on Aging to better serve the rapidly growing population of older adults.

Expand the capacity of the Virginia Insurance Counseling and Assistance Program (VICAP) to assist Medicare beneficiaries in understanding and accessing their benefits and managing their costs.

Provide necessary funding to the Ombudsman Program to fulfill its mandated responsibility to address concerns of older adults and their families regarding the quality of home and community-based long-term care.

Aggressively adopt and support federal and national initiatives to transform Virginia's system of long-term care through coordinated efforts to streamline access to information and services, encourage self-direction of care, increase consumer choice and person-centered practices, employ evidence-based programs, and enhance technology to achieve comprehensive systems change.

Encourage and support Virginia's Area Agencies on Aging in fully adopting the federal model of Aging and Disability Resource Centers, offering a person-centered, individualized and flexible approach to home and community based services, including the option of consumer direction, to older adults, adults with disabilities and veterans of all ages.

Expand the No Wrong Door initiative to all regions of the Commonwealth, enhance the technology and develop best practices to support maximum utilization by public and private providers in the efficient delivery of services to older adults, adults with disabilities and their caregivers.

Strengthen service coordination between Area Agencies on Aging and Centers for Independent Living to better serve the growing population of older adults who also have disabilities.

Implement the workforce development recommendations of the Governor's Health Reform Commission to build the workforce of direct support and health care professionals and to improve preventative care and wellness programs for adults, especially high risk populations.

Continue and expand General Fund appropriations for the Geriatric Education and Training initiative, Virginia's only state-funded program to develop skills and build capacities of the gerontological/ geriatric work force, across disciplines from pre-professional to professional.

Develop a comprehensive strategy to raise awareness about the positive aspects of careers related to eldercare and recruit direct care workers such as paid caregivers, CNAs, and personal and home health aides.

Recruit retiring and retired military health care personnel to volunteer or enter a second career in geriatrics, gerontology, or direct care for older adults and also to address barriers such as liability.

Build capacity of Virginia's healthcare workforce to address the severe lack of professionals trained in geriatrics by:

- *Developing a statewide recruitment strategy for primary care professionals, the major source of geriatric fellowship applicants.*

- *Initiating a program of loan forgiveness for geriatric medicine and geriatric psychiatry fellows, both of which are critical to the needs of older adults.*

- *Supporting one Geriatrics faculty position at each of Virginia's four (five in 2010) medical schools to foster the mentoring of and serve as role models for medical students and teaching support for subspecialties commonly used by older adults, such as Urology, Orthopedics, Dermatology, Surgery, Ophthalmology, and Otolaryngology.*

- *Incorporating geriatric education into the licensure requirements of all health care professionals and including demonstration of competence in the review process.*

- *Requiring medical residents in primary care and nursing students to deliver care to older patients at the setting in which the patients live, to include assisted living, nursing homes and patients' homes.*

Restore funding to maintain the Virginia Caregivers Grant and the Respite Care Grant and develop new public and private funding for services to assist caregivers in all regions of the Commonwealth.

Develop a standardized training program for family caregivers through the Area Agencies on Aging and/or the community college system, available through on-line resources, community sites with in-home consultation, and the hospital discharge process.

Develop a full continuum of collaborative care for older adults who have mental health needs, intellectual disabilities, and/or substance use disorders by expanding current state and community-based programs focused on reversing the escalation of issues which can lead to expensive and preventable institutionalization.

Develop a comprehensive suicide prevention plan for older adults addressing public awareness, prevention education, early identification, intervention, treatment, and support for survivors.

Continue funding through the Department of Criminal Justice Services to provide Alzheimer's-related training to first responders including law enforcement officers, emergency medical services, and fires services.

Support the goals of the 2010-13 Virginia State Service Plan for Volunteerism and National Service to fully engage older adults in volunteerism and other best practices that draw upon the knowledge and skills of older Virginians.

Eliminate duplication of effort and encourage efficiencies by consolidating multiple legislatively mandated planning and reporting requirements specific to aging into one comprehensive Plan for Aging Services.

Continue leadership by the Virginia Department for the Aging of a broad coalition to further refine and update Virginia's Four-Year Plan for Aging Services to identify specific outcomes, performance measures, priorities, strategies, costs, and potential funding mechanisms to achieve success.

Appendix D
Network of Public Agency-Supported Aging and Long-term Services

Virginia Department for the Aging (VDA) VDA, through local Area Agencies on Aging (AAAs), provides a variety of services to older Virginians. Services include nutritional programs through home delivered and congregate meals, transportation, information and referral, legal assistance, elder abuse prevention, and in-home and caregiver services. In addition, through AAAs and other contractors, VDA oversees programs for care coordination, employment assistance, counseling and assistance to Medicare beneficiaries, GrandDriver, and the public guardianship and conservator program.

Virginia Department of Behavioral Health and Developmental Services (DBHDS) DBHDS provides services to people with intellectual and developmental disabilities as well as persons with mental illness and those suffering from substance abuse. Services are provided in one of 16 state operated facilities or through local contracts with Community Services Boards (CSBs). There are 40 such CSBs across the state that provide treatment, medication monitoring, crisis stabilization, and many other services.

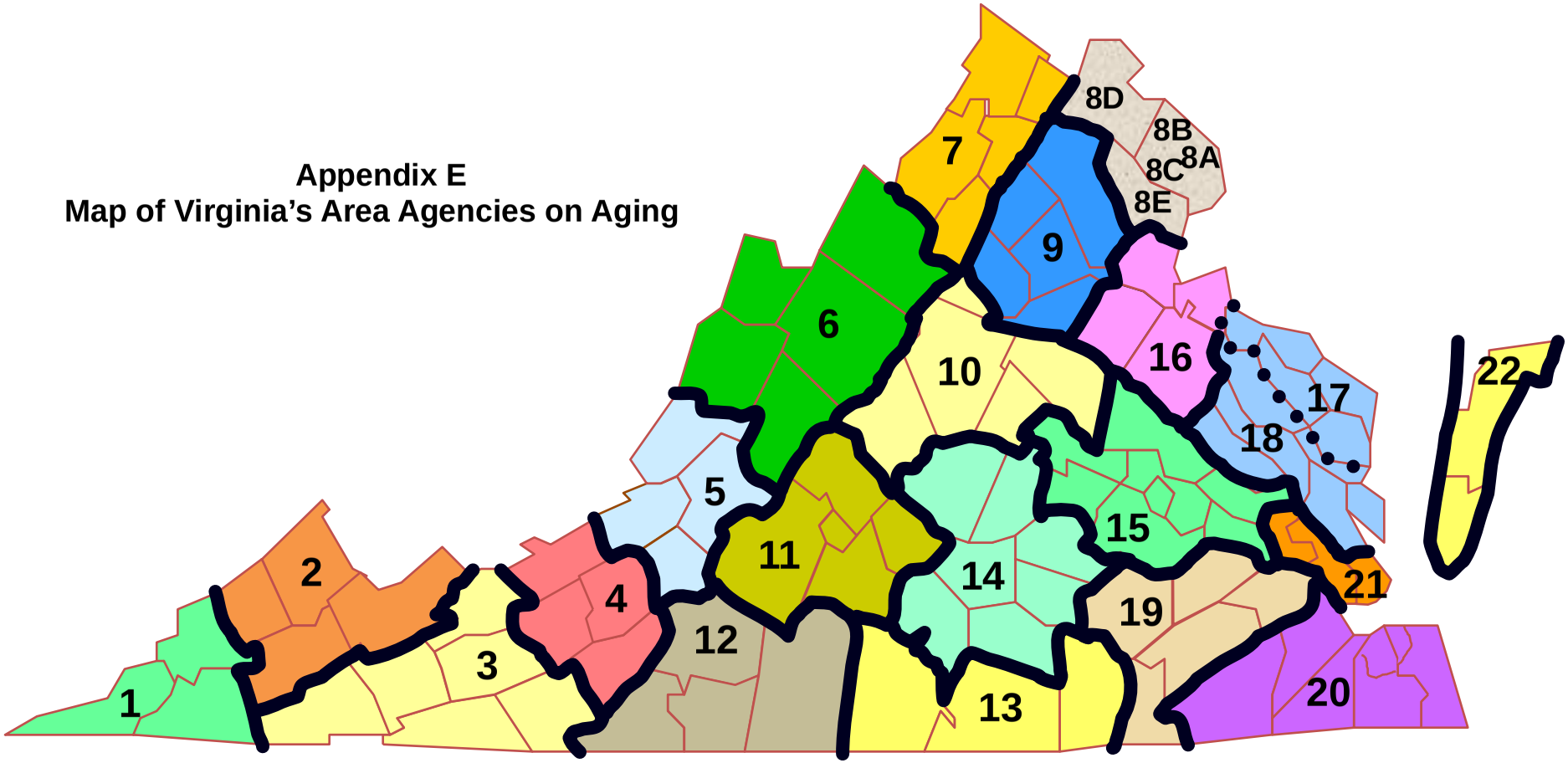
Virginia Department of Health (VDH) VDH provides a wide array of public health services to the community such as immunization, water quality and emergency preparedness. In addition, the VDH Office of Licensure and Certification inspects all Medicaid and Medicare-certified nursing facilities in the Commonwealth as well as home health agencies and hospice services.

Virginia Department of Medical Assistance Services (DMAS) DMAS administers the state's Medicaid program that covers both institutional and home and community-based long-term care for eligible individuals. Medicaid is the primary public payer for long-term care services in Virginia and covers care in a nursing facility, intermediate care facilities for persons with mental retardation (ICFs/MR) and care provided in long-stay hospitals. Medicaid may also pay for community-based services in lieu of institutional care through the use of 1915(c) home and community-based care service (HCBS) waivers. Virginia currently operates seven HCBS waivers: the HIV/AIDS, Elderly or Disabled with Consumer-Direction (EDCD), Individual and Family Developmental Disabilities Support Waiver (DD), Mental Retardation (MR), Technology Assisted (Tech), Day Support (DS), and Alzheimer's. In addition, DMAS oversees the Program for All-Inclusive Care for the Elderly (PACE)

Virginia Department of Rehabilitative Services (DRS) DRS provides many services to people with disabilities and some seniors who use long-term care services. DRS operates a personal assistance services (PAS) program that provides non-medical support with activities of daily living to consumers. In addition to the PAS program, DRS provides vocational rehabilitation services, assistive technology and equipment, and processes disability determination claims for the Social Security program.

Virginia Department of Social Services (VDSS) VDSS, through contracts with local Departments of Social Services, completes Medicaid eligibility screenings, provides services such as companion care, chore and homemaker services for low income adults of any age with a disability; provides adult protective services; administers caregiver grants and the auxiliary grant program to provide supplemental cash assistance for long-term care services in assisted living facilities. VDSS, through its central office, also licenses all assisted living facilities in Virginia.

Appendix E
Map of Virginia's Area Agencies on Aging



1 *Mountain Empire Older Citizens*
2 *Appalachian Agency for Senior Citizens*
3 *District Three Senior Services*
4 *New River Valley Agency on Aging*
5 *LOA Area Agency on Aging*
6 *Valley Program for Aging Services*
7 *Shenandoah Area Agency on Aging*
8A *Alexandria Office of Aging and Adult Services*
8B *Arlington Agency on Aging*
8C *Fairfax Area Agency on Aging*
8D *Loudoun County Area Agency on Aging*
8E *Prince William Area Agency on Aging*
9 *Rappahannock-Rapidan Community Services Board and Area Agency on Aging*
10 *Jefferson Area Board for Aging*
11 *Central Virginia Area Agency on Aging*
12 *Southern Area Agency on Aging*
13 *Lake Country Area Agency on Aging*
14 *Piedmont Senior Resources Area Agency on Aging*
15 *Senior Connections, The Capital Area Agency on Aging*
16 *Rappahannock Area Agency on Aging*
17/18 *Bay Aging*
19 *Crater District Area Agency on Aging*
20 *Senior Services of Southeastern Virginia*
21 *Peninsula Agency on Aging*
22 *Eastern Shore Area Agency on Aging - Community Action Agency*

Appendix F
Aging Four-Year Plan Resources

AARP Public Policy Book, 2009
www.aarp.org

A Blueprint for Action: Developing a Livable Community for All Ages (2007)
National Association of Area Agencies on Aging (n4a)
http://www.n4a.org/

Adults and Social Network Websites: Pew Internet Project Data Memo (2009)
Pew Internet & American Life Project, January 2009
http://www.pewinternet.org/Reports/2009/Adults-and-Social-Network-Websites.aspx?r=1

A Guide for Long-Term Care Services in Virginia (2009)
Virginia Department of Medical Assistance Services
www.dmas.virginia.gov/downloads/pdfs/ltc-guide_srvcs.pdf

Access to and Availability of Geriatricians: Report of the Joint Commission on Health Care to the Governor and the General Assembly
Report Document # 75, 2007
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD752007/$file/RD75.pdf

Acclimation of Virginia's Foreign-Born Population: Report of the Joint Legislative Audit and Review Commission to the Governor and the General Assembly
House Document # 9, 2004
http://jlarc.state.va.us/reports/Rpt300.pdf

Advancing Aging Policy as the 21st Century Begins (2000)
Haworth Press
www.haworthpress.com

Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population (2001)
Joint Center for Housing Studies of Harvard University
www.jchs.harvard.edu/publications/seniors/lawler_w01-13.pdf

Aging with Grace: What the Nun Study Teaches Us About Living Longer, Healthier, and More Meaningful Lives
Author: David Snowdon, PhD, Bantam Books, 2001
http://ije.oxfordjournals.org/cgi/content/full/31/4/879

Alzheimer's Disease Facts and Figures (2009)
Alzheimer's Association
www.alz.org

Alzheimer's Disease: Public Safety and Emergency Response (2009)
Department of Criminal Justice Services
www.dcjs.virignia.gov

AlzPossible Website
Virginia Alzheimer's Disease and Related Disorders Commission
www.alzPossible.net

American Community Survey (2009)
U.S. Census Bureau
http://www.census.gov/acs/www/

Anticipating the Future – Fairfax 50+ Action Plan (2007)
Fairfax County Board of Supervisors, Fairfax, Virginia
http://www.fairfaxcounty.gov/olderadults/plan.htm

Social Networking: Are You Tweeting Yet?
National Association of State Unites on Aging (NASUA), November 2009
http://www.nasua.org/

Beacon Hill Village – Welcome to Beacon Hill Village
Boston, MA
www.beaconhillvillage.org

Beyond 50.05 – A Report to the Nation on Livable Communities: Creating Environments for Successful Aging (undated)
AARP
www.aarp.org

Blueprint for the Integration of Acute and Long-Term Care Services (2006)
Virginia Department of Medical Assistance Services
www.dmas.virginia.gov

Boomer Consumer: Ten New Rules for Marketing to America's Largest, Wealthiest and Most Influential Group (2007)
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