AGING PREPAREDNESS IN AMERICA

Results and Recommendations from CommonHealth ACTION's 2010 Survey

AUTHORS:
Myra G. Schneider, PhD, MSW
Natalie S. Burke
Kathleen A. Maloy, JD, PhD

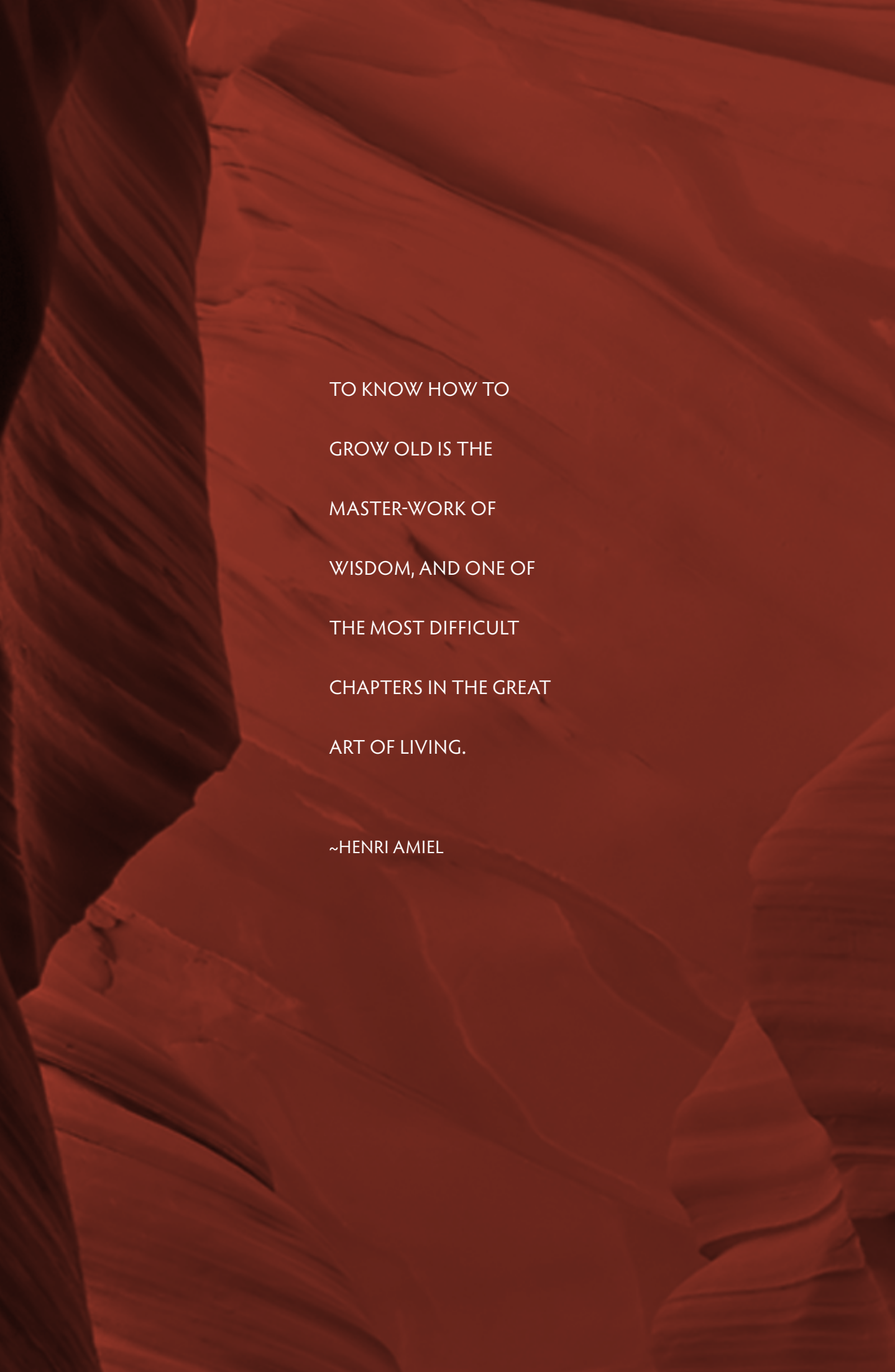
EDITORS:
Joan M.D. Burke, EdD
Vincent N. Lafronza, EdD
Nehanda A.M. Lindsey, MS, MIB

ACKNOWLEDGEMENTS:
We would like to thank our partner in the design and dissemination of the 2010 survey, BETAH Associates, Inc. (www.betah.com), as well as our colleagues around the country who reviewed, piloted, and disseminated the survey and those who contributed important ideas to this work.

AGING PREPAREDNESS IN AMERICA

Results and Recommendations from CommonHealth ACTION's 2010 Survey

table of contents



TO KNOW HOW TO

GROW OLD IS THE

MASTER-WORK OF

WISDOM, AND ONE OF

THE MOST DIFFICULT

CHAPTERS IN THE GREAT

ART OF LIVING.

~HENRI AMIEL

EXECUTIVE SUMMARY

Recent gains in U.S. life expectancy rates mean that Americans are living longer lives than ever before. Data from the Centers for Disease Control and Prevention (CDC) show that life expectancy rose to a record 78.2 years in 2009, up from 78.0 years in 2008. In a few short years, by 2050, over 88.5 million Americans will be over the age of 65, certainly more than double our current population. With a widening gap between upper and lower income levels due to decreases in individual and familial wealth, how prepared are American communities for this historic demographic shift?

CommonHealth ACTION's public health work repeatedly reveals emerging challenges related to the rapidly expanding aging population. As these challenges go unaddressed, we increasingly focus our public health efforts on addressing the social and economic determinants of risk associated with an older and less economically viable population. Moreover, apart from news stories, advancements in research, and celebrity-assisted initiatives on Alzheimer's disease and dementia, we note the absence of a comprehensive, national dialogue focused on systemic preparation for large numbers of seniors with limited economic means, expanding health needs, and living alone, often significant distances away from their families. The number one priority of older Americans is a growing desire to age in place. The issues of greatest concern include increasing rates of poverty and homelessness among the elderly; the deterioration of family structures and supports; an increasingly fragile Medicare system; and eroding social and public policy supports for aging issues and populations. In fact, as a nation, we are relatively silent about the many needs of this growing population and those that must care for our older counterparts.

As these challenges go unaddressed, we are teetering on the precipice of social, economic, and public health calamity.

To catalyze, inspire, and inform a comprehensive, national dialogue, in 2005 CommonHealth ACTION conducted a survey that explored what Americans were thinking - and perhaps doing - to prepare for aging. With a sample size of 404 Internet users, the data were compelling, with 20% reporting being unprepared to meet their personal needs as they age, and another 60% reporting they were only somewhat prepared. In 2010, CommonHealth ACTION launched an expanded survey with support from BETAH Associates, Inc. We intend for the 2010 data presented herein to serve as the basis for public policy debate and increased national and local action; the development of innovative technologies to support the aging population; increased advocacy efforts; increased individual, public, and private sector preparedness for the growing needs of the elderly; and increased public awareness regarding the need for aging preparedness.

ABOUT THE RESEARCH TEAM

Natalie S. Burke

President and Co-Founder, CommonHealth ACTION

As President and Co-Founder of CommonHealth ACTION, Ms. Burke provides vision and leadership for CHA's initiatives, oversees components of day-to-day operations, works collaboratively with funders, and develops external relationships that build organizational sustainability and capacity. In her programmatic work, she provides technical assistance to local governments, philanthropy, and community-based organizations to address determinants of health, build community capacity, promote technological innovation in public health, increase equity, and improve the public's health. Ms. Burke was a 2010 Lead the Way Fellowship recipient, awarded by New York University's Wagner School of Policy. In 2004, the University of North Carolina's Schools of Public Health and Business selected her as an Emerging Leader in Public Health Fellow.

Joan M. Detry Burke, EdD

Senior Consultant

Dr. Burke provides technical expertise to CommonHealth ACTION in the areas of aging, adult education, and qualitative research that includes survey design, data analysis, and focus groups. In addition to her work with CHA, Dr. Burke has taught numerous courses in the areas of business and human resources at the University of Phoenix. A former Project Director and Research Associate at the Center for Aging and Diversity, Institute on Aging at the University of North Carolina, Dr. Burke holds a doctorate in Adult Education and a Certificate of Gerontology from the University of Georgia, as well as a masters degree from Johns Hopkins University.

Vincent N. Lafronza, EdD, MS

President and Co-Founder, CommonHealth ACTION

As President and Co-Founder of CommonHealth ACTION, Dr. Lafronza provides leadership and direction on all initiatives and develops collaborative efforts with CHA's numerous partners across the nation. A long-time public health professional, he also serves as President and CEO of CHA's newly formed Institute for Public Health Innovation (IPHi). Dr. Lafronza holds a Doctorate of Education, Master of Science, and Certificate of Gerontology from the University of Georgia. He also completed an Oak Ridge Institute for Science and Engineering Postgraduate Research Fellowship in Public Health.

Nehanda A.M. Lindsey, CMP, MIB, MS

Senior Program Manager, CommonHealth ACTION

Ms. Lindsey is a manager, technical writer/editor, and certified meeting professional. She currently oversees CDC and foundation-funded public health programs for CommonHealth ACTION. Ms. Lindsey is highly-skilled in program management, research and writing, evaluation, budget management, contract negotiation, event identity design, and communications and marketing. She has played an integral role in planning large conferences for CommonHealth ACTION, the Centers for Disease Control and Prevention, the National Association of County and City Health Officials, Health Resources Services Administration, and the U.S. Department of Education. She holds masters degrees in Information Design and Communication and International Business.

Kathleen A. Maloy, JD, PhD

Senior Consultant
Principal, Strategic Consulting for Equity in Health

Dr. Maloy has worked for 30 years to improve the lives of low-income and vulnerable populations by engaging in research, policy, and advocacy focused on health equity and social justice. Her expertise includes Medicaid, Medicare, healthcare financing reform, state health and mental health policy, the intersection of health and public health policy, and the social determinants of health. Dr. Maloy translates complex research and policy issues into language accessible to diverse audiences, and conducts evaluation and community-based participatory research designed to understand how to affect outcomes and implement systemic change. Her recent work has focused on how to achieve health equity by creating conditions conducive to health-producing communities. She holds a PhD in health policy and a JD from Boston College.

Myra G. Schneider, PhD, MSW

Research Associate, CommonHealth ACTION

Dr. Schneider is a seasoned Research Associate with extensive experience in public health and epidemiology. She has served in administrative and management capacities in inpatient and outpatient psychiatric settings as a social worker, and has also taught and mentored social work and public health students. In her work at CommonHealth ACTON, she focuses on qualitative and quantitative research including survey design and implementation, and data analysis and synthesis. Her research and publications have focused on population health outcomes, health disparities in minority and vulnerable populations, and issues related to aging and health in racial and ethnic populations. Dr. Schneider holds a PhD in public health and epidemiology, a Master of Social Work, and she completed a 2-year post-doctoral training program in the epidemiology of aging.

INTRODUCTION

The impending aging and retirement of the baby-boom generation (commonly defined as those born between 1946 and 1964) with its burgeoning numbers and increasing diversity, are drawing the attention of researchers, professionals, and policymakers.

Census data project that the older population will increase to 72 million people in 2030, representing nearly 20 percent of the total U.S. population,[i] meaning that nearly one in five U.S. residents at that time will be 65 or older. These data also suggest that the population 85 and over (the oldest-old) could grow from 5.7 million in 2008 to 19 million in 2050.[ii] The profile of America's older adults (aged 65 and over) will also become more diverse and reflect the demographic changes in the U.S. population as a whole.

Older adults almost universally say they want to **age in place**[1] and maintain their independence.[x,xi]

The substantial increase in the number of Americans aged 65 and older living longer raises serious concerns about the resources necessary to support them and creates new challenges for the current administration. Policy discussions on the implications of this demographic shift have focused on resource allocation, as the population of retirees will grow more quickly than the taxpaying workforce.[iii] Pensions and associated health insurance will decrease and financial pressures on Social Security and Medicare will increase. The rate of growth of Medicare Part B premiums has been greater than the increase in Social Security benefits in recent years due to increased medical spending. Social Security beneficiaries received no cost of living adjustment in 2010 (poised to see none again in 2011) and paid higher premiums for the second year in a row.[iv] Decreasing capacity to afford retirement has been emerging for several years, especially for women, and the current recession has exacerbated these concerns, bringing more people who are middle class into the mix.[v]

Families have become more mobile and often cannot take care of their elderly family members. Older people have few choices of assisted living situations that provide more options than just home or nursing home care. Among those who provide care (44 million persons are informal caregivers), the challenge

[1] According to AIPatHome, "Aging in place [i.e. 'age in place'] is the ability to live in one's own home - wherever that might be - for as long as confidently and comfortably possible (http://www.aipathome.com/about-us).

of geographic distance and the stress of caregiving often exact a heavy emotional, physical, and financial toll.[vi]

Women, who live significantly longer than men, are particularly vulnerable to having insufficient resources to meet their retirement needs. Throughout their lifetime, they earn less than men earn and often lose work time due to family responsibilities. They have smaller pensions that result from careers consisting of part-time work or they may have work histories at smaller salaries than their male counterparts.[vii] Older persons living alone are more likely to be poor (17.8%) than older persons living with families (5.6%),[viii] and today, half of all women over age 75 live alone. The combination of family caregiving responsibilities, as well as inequities in pay and opportunity, put many women at an economic disadvantage that deepens as they age. Older low-income women, women of color, rural, and other underserved women are particularly vulnerable to economic disadvantage.[ix]

Older adults almost universally say they want to **age in place**[1] and maintain their independence.[x,xi] Aging in place may prevent the depletion of financial resources and delay nursing home admission.[xii] However, the U.S. lacks a foundation of home and community-based support services that could enable older adults to remain in their own homes and communities. Population aging raises questions about how to target new investments in preventive health. Adequate development of telemedicine could to some degree offset the demands on hospitals and nursing homes. However, telemedicine may be beyond reach for some segments of the older population that lack access to technology and adequate broadband.[xiii] These trends will provide challenges and opportunities for agencies, organizations, communities, corporations, public officials, and public policymakers.

[1] According to AIPatHome, "Aging in place [i.e. 'age in place'] is the ability to live in one's own home - wherever that might be - for as long as confidently and comfortably possible (http://www.aipathome.com/about-us).

SURVEY DESIGN

CommonHealth ACTION (CHA) researchers designed the survey instrument to collect personal perspectives about self-rated aging preparedness, availability of aging resources, access to and use of technology, and perceptions regarding government preparedness for an aging population. Intended for adults over the age of 18, the survey also explored concerns Americans have about aging, expectations about who will provide for their needs in their later years, and how they expect to meet those needs. Outreach strategies to solicit responses used list-serves focused on aging issues and public health, individual contacts at agencies dealing with aging issues (e.g., CDC, EPA), social media platforms (e.g., Facebook, Twitter), information disseminated at the 2010 Conference on Aging in Chicago, and direct contact with civil rights, political, advocacy, and public health organizations that represent populations of color. The survey was available online from March 3 to May 18, 2010, at www.commonhealthaction.org. The number of respondents (1,022) to the 2010 survey is more than twice the number of respondents who participated in the 2005 CHA aging preparedness survey.

Containing 41 questions, the instrument gathered demographic characteristics of survey respondents,[2] information about respondents' reliance on social security, as well as the availability of aging resources in their communities.[3] The survey also queried respondents about whom they would rely on for care (e.g., spouse, family member, friend, paid professional) and where they planned to live after age 65 (e.g., their own home with help, home of family member, nursing home). In addition, the survey gathered information about respondents' preventive health maintenance (i.e., routine medical care, exercise, weight maintenance, eating choices), and about available community resources for maintaining their health. Finally, the survey asked respondents to rate their overall confidence in American systems being equipped for the increasing age of the population (e.g., safety net components such as Social Security and Medicare).

The survey embedded qualitative questions within quantitative ones. For example, it asked respondents to elaborate on their concerns as they aged as well as what they would look forward to with age. The survey also gathered input from respondents regarding chronic disease self-management, and asked them to provide examples of available programs in their communities that assist them to meet their health goals. Respondents were also asked to share their perspectives on (1) their confidence in the capacity

---

[2] Place of residence, age, gender, marital status, living situation, educational attainment, employment status, and income.

[3] For example: affordable assisted living facilities, affordable nursing home facilities, affordable health care, affordable housing, home utilities financial assistance, affordable hospice care, senior centers, affordable transportation, affordable meals on wheels, affordable legal aid, property tax relief, options for physical activity and exercise, social outlets.

of the federal government to support their needs as they age; (2) specific suggestions about actions the federal government should take to prepare better for larger numbers of older Americans; and (3) beyond the federal government, what entities should be involved in preparing for greater numbers of older Americans. Finally, the survey prompted respondents to share general comments about aging in America.

Five of the 41 questions addressed access to and use of technology. The first four questions required yes/no responses as well as optional explanations of a "no" answer. The questions asked:

(1) whether respondents had a broadband Internet connection in their homes or via cell phone;
(2) whether they anticipated using email, social networking tools, and computer technology to stay in contact with friends and family in their senior years (65+);
(3) whether they anticipated using the Internet and online tools to manage their health in their senior years (e.g., documenting blood pressure, blood sugar, or weight loss efforts); and
(4) whether they anticipated using the Internet to access information and services in their senior years.

The fifth question prompted respondents to identify specific barriers to Internet usage over the age of 65; open-ended responses were permitted.

SURVEY RESULTS

DEMOGRAPHICS

Survey respondents represented residents in nearly all 50 states with the exceptions of residents from Hawaii, Montana, New Hampshire, North Dakota, South Dakota, Utah, and Wyoming. The highest percentage of respondents resided in North Carolina (20%). Sixty-six percent of respondents identified as white, 20% as African American, and 7% as Hispanic/Latino. Seventy-nine percent of respondents were female, and 59%

Seventy-five percent of respondents reported their employment status as full-time, while 9% identified themselves as retired. Incomes ranged from zero to $150,000+, with the greatest number of respondents (27%) reporting income ranging from $50,000 to $74,999.

Table 1. Demographic characteristics of survey respondents

	N	%
Age		
18-29	72	7.3%
30-40	145	14.6%
41-64	635	64.0%
65-75	111	11.2%
76-90	27	2.7%
90+	2	0.2%
Gender		
Women	788	78.6%
Men	215	21.4%
Race		
White	660	65.8%
Black	197	19.6%
Hispanic	70	7.0%
Education		
Elementary school	2	0.2%
Some high school	2	0.2%
High school graduate	33	3.3%
Technical/trade school	26	2.6%
Some college	134	13.5%
College graduate	236	23.8%
Some graduate school	67	6.8%
Graduate degree	492	49.6%
Marital status		
Single (never married)	180	17.9%
Married	588	58.6%
Separated	8	0.8%
Divorced	141	14.1%
Domestic partnership	48	4.8%
Widowed	38	3.8%
Living situation		
Living alone	226	22.5%
Living with spouse	482	48.1%
Living with domestic partner	65	6.5%
Living with family	183	18.2%
Other	47	4.7%
Employment status		
Employed full-time	748	75.4%
Employed part-time	123	12.4%
Unemployed/seeking employment	18	1.8%
Unemployed/not seeking employment	16	1.6%
Retired	87	8.8%
Income		
$0 - $9,999	47	4.7%
$10,000 - $34,999	142	14.3%
$35,000 - $49,999	188	19.0%
$50,000 - $74,999	269	27.1%
$75,000 - $99,999	174	17.5%
$100,000 - $149,999	122	12.3%
$150,000+	50	5.0%

were married. Forty-eight percent lived with a spouse, while 23% lived alone. Twenty-four percent had a college degree, while 50% had a graduate degree. While the ages of respondents ranged from 18-90, 64% of respondents reported being between 41-64 years of age. Fourteen percent of respondents were 65 or older. Seventy-five percent of respondents reported their employment status as full-time while 9% identified themselves as retired. Incomes ranged from zero to $150,000+, with the greatest number of respondents (27%) reporting income ranging from $50,000 to $74,999.

Higher proportions of respondents with college (76%) and/or graduate (80%) degrees were employed full-time than those without those degrees, and they had higher incomes.

Table 1 displays the demographic characteristics of survey respondents. As a group, respondents have higher socioeconomic status (SES) than the general U.S. population. Equally notable, as shown in Table 2, blacks and whites have comparable socioeconomic characteristics; this result further highlights differences between the respondents and the general U.S. population, where whites as a group traditionally have higher levels of income and education than blacks.[xv]

Table 2 also shows gender differences among survey respondents in marital status, education, employment status, and income. A higher proportion of women than men were single, divorced, or widowed. Sixty-nine percent of men as compared to 57% of women reported being married; and 8% of men as compared with 16% of women were divorced. A higher proportion of women held bachelor's degrees (31%) than men (26%), while more men (68%) than women (61%) held graduate degrees. A higher percentage of men (21%) than women (13%) were retired, while men had higher incomes than women did at all income levels.

The respondents who reported educational attainment, full-time employment, and income levels varied by age range. The 41-64 age group had the highest educational attainment and most were employed full-time (81%). Income levels increased progressively with age, while the proportions of respondents with college degrees decreased with age. For example, 24% of people aged 41-64 held college degrees, while 15% of respondents aged 76-90 held college degrees. More respondents aged 30-40 held graduate degrees (58%) than in other age ranges.

Race and ethnicity also produced variations among respondents related to demographic characteristics. For example:

- There were fewer black male respondents (19%) than whites (22%), more married whites (69%) than blacks (49%), and more Hispanics in domestic partnerships than in the other two groups (9%).
- Fewer Hispanics lived alone (16%) than in the other two groups, an approximately equal percentage of blacks (24%) and Hispanics (23%) lived with family members, while lower percentages of whites reported living with family members (15%) than in the other two groups.
- Hispanic respondents were younger than the other two racial/ethnic groups: 37% of Hispanics were in the age group 18-40 as compared with 23% of blacks and 19% of whites. Smaller proportions of Hispanics (3%) were in the 65-75 age group than in the other two groups (blacks – 14%; whites – 12%).
- Twenty-three percent of blacks, 24% of whites, and 23% of Hispanics held college degrees. Fifty-two percent of blacks and of whites held graduate degrees, while 27% of Hispanics held graduate degrees.
- More whites (15%) were employed part-time than blacks (8%) or Hispanics (7%).
- The highest proportion of blacks (24%) and whites (28%) were in the middle-income range ($50,000-$74,999), while the highest proportion of Hispanics (31%) had lower incomes ($35,000-$49,999). Black and white respondents had comparable SES, while Hispanics had a slightly lower income and level of education.

Twenty-three percent of blacks, 24% of whites, and 23% of Hispanics held college degrees. Fifty-two percent of blacks and of whites held graduate degrees, while 27% of Hispanics held graduate degrees.

Table 2. Demographics by Gender and Ethnicity

Demographic Characteristics	Gender		Ethnicity		
	Male	Female	White	Black	Hispanic
Total	**21%**	**79%**	**66%**	**20%**	**7%**
Age					
18-29	6%	8%	7%	5%	11%
30-40	11%	16%	12%	18%	26%
41-64	62%	65%	66%	62%	59%
65-75	16%	10%	12%	14%	3%
76-90	5%	2%	3%	2%	1%
Education					
High school graduate	2%	5%	3%	4%	7%
Technical/trade school	3%	3%	2%	2%	9%
College graduate	26%	31%	24%	23%	23%
Graduate degree	68%	61%	52%	52%	27%
Marital status					
Single (never married)	16%	19%	14%	25%	28%
Married	69%	57%	64%	49%	54%
Divorced	8%	16%	13%	18%	9%
Domestic partnership	6%	5%	5%	3%	9%
Widowed	2%	4%	3%	5%	1%
Employment status					
Employed full-time	71%	77%	73%	77%	89%
Employed part-time	10%	13%	15%	8%	7%
Unemployed	2%	4%	3%	4%	3%
Retired	17%	7%	10%	11%	1%
Income					
$0 - $9,999	2%	6%	4%	4%	7%
$10,000 - $34,999	8%	16%	14%	13%	24%
$35,000 - $49,999	14%	21%	18%	20%	31%
$50,000 - $74,999	25%	28%	28%	24%	19%
$75,000 - $99,999	23%	16%	18%	19%	13%
$100,000 - $149,999	19%	10%	12%	16%	3%
$150,000+	9%	4%	6%	5%	3%

AGING AND RETIREMENT PREPAREDNESS

To obtain a sense of their concern about the future related to aging, respondents rated their level of worry (i.e., very worried, worried, somewhat worried, not worried at all) about potential aging/retirement issues. These issues included:

- assisted living/nursing home needs
- preparing meals
- cost of food
- being alone
- getting sick
- health care costs
- home maintenance/repairs
- finances
- not being useful to/valued by others
- prescription medication costs
- property tax increases
- providing care/caregiving for a spouse/partner
- reductions in Medicare coverage
- Social Security
- transportation needs

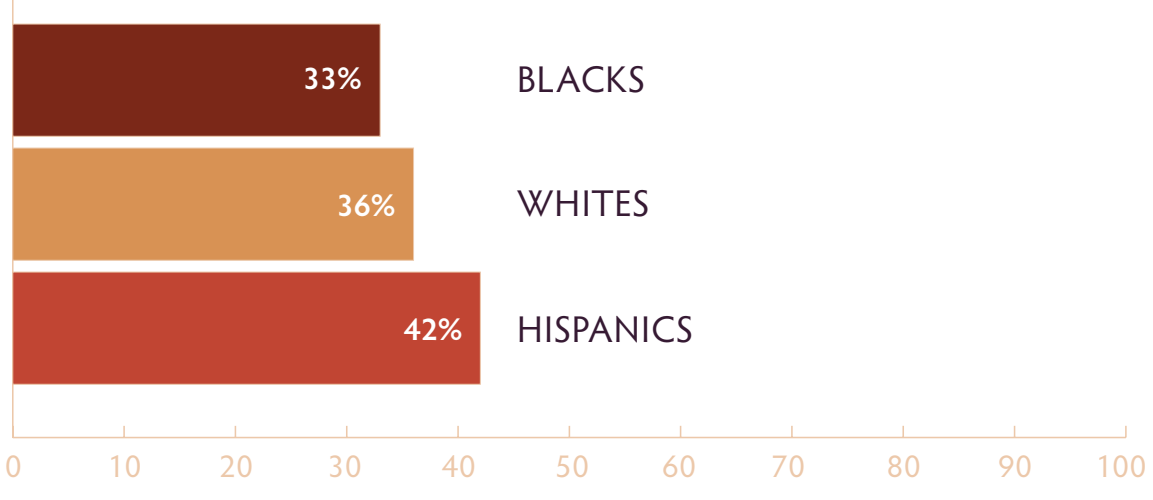
Thirty-seven percent of respondents reported being very worried about health care costs. Not surprisingly, this issue received the highest number of very worried ratings. Forty-seven percent of respondents reported being somewhat worried about assisted living/nursing homes needs, and this issue received the highest number of somewhat worried ratings. Given the frequent threats to cut Medicare and health care reform at the writing of this report, we anticipate concerns regarding health care and personal care to grow in CHA's 2011 survey.

Responses varied as well by age, gender, income, and race/ethnicity. For example:

- Forty-two percent and 38% of respondents in the middle age ranges (i.e., 30-40, 41-64 respectively) reported being very worried about health care costs, representing the highest percentage by age group reporting this rating.

- Younger respondents (aged 30-40) reported being very worried about receipt of Social Security (38%) and reduction in Medicare (26%), at greater percentages than for any other age group.
- Higher percentages of women than men were very worried about their health, health care costs, and finances in general. Nineteen percent of women compared to 8% of men were very worried about getting sick, and 24% of women compared to 17% of men were very worried about prescription medication costs. Forty percent of women compared to 18% of men were very worried about finances.
- Forty-eight percent of respondents with the lowest incomes compared to 26% with the highest incomes were very worried about health care costs, while 38% with the lowest incomes compared to 14% with the highest incomes were very worried about prescription medication costs. Forty percent with the lowest incomes compared to 15% with the highest incomes reported being very worried about reduction in Medicare; 44% compared to 19% in those same income categories were very worried about receipt of Social Security.
- Thirty-eight percent of blacks as compared with 22% of whites and 31% of Hispanics reported being not worried at all about assisted living/nursing home needs.
- Hispanics represented the group with the highest percentage (15%) reporting being very worried about food costs.
- Substantial percentages of all three groups reported being very worried about health care costs (i.e., 33% of blacks, 36% of whites, and 42% of Hispanics).

Substantial percentages of all three groups reported being very worried about health care costs.



Eight hundred and thirty-five respondents provided comments in response to the question, "What worries you most about getting older?" These were the greatest number of responses given to any of the qualitative items in the survey. Qualitative data showed that the majority of respondents worried about having sufficient retirement income and about access to affordable health care. Respondents also worried about the cost of health care and of assisted living facilities/nursing homes, and about the availability of affordable housing, transportation, and social programs. They also voiced concerns about their own failing health; their care and becoming a burden to their families; about being alone and loss of support; and about other losses that may accompany aging such as loss of health, failing physical and cognitive abilities, loss of mobility and ability to travel, and loss of control. A few addressed the issue of ageism, both in the workplace and in society as a whole.

Many of the concerns reflected in these qualitative data are indicative of current economic challenges and those anticipated by respondents in the future. Massive losses in housing equity and retirement investment mechanisms have left many seniors and soon-to-be seniors in precarious economic situations. At the same time, the "sandwich generation" (people caring for their parents while supporting their children) that has also lost equity and savings, is tapping into their remaining resources to compensate for the economic shortfalls of their parents. The danger in this is the erosion of generational wealth and the assumption of multi-generational debt experienced at the macro-level (the national debt) and the micro-level (familial debt that manifests in credit card debts, high student loan balances, and negative equity situations). Other qualitative data in this section speak to pervasive psychosocial challenges experienced during the aging process. While money and resources cannot resolve all psychosocial challenges that accompany aging, their absence often amplifies negative impacts and hinders effective planning and problem-solving on the part of families, communities, and governments.

Regarding retirement preparedness, the survey asked respondents whether they planned to rely primarily on their Social Security checks to survive and to what extent. This included five items that explored respondents' future retirement plans:

- whether they planned to retire;
- at what age;
- to what extent they would be prepared to provide for their personal needs in retirement (very

prepared, prepared, somewhat prepared, unprepared);
- how they thought they would pay for long term care; and
- whether they thought aging resources would be affordable in the future.

Of those receiving Social Security (14% of respondents), the highest proportion (36%) reported they relied on Social Security for one quarter of their income. More men (21%) received Social Security than women (12%) did, but more women (12%) than men (7%) reported they relied entirely on their Social Security checks to survive. A notably higher proportion of Hispanics (50%) reported they relied entirely on their Social Security checks to survive than blacks (4%) or whites (8%). Seventy-seven percent of respondents reported that they planned to retire. Results varied by gender, age, race/ethnicity, education, income, and marital status.

The highest proportion of respondents reported they planned to retire at aged 65-67 (35%).

- Men planned to retire at older ages than did women.
- A higher proportion of younger than older respondents planned to retire, e.g., aged 30-40 (84%) vs. aged 41-64 (76%).
- More whites (81%) than blacks (71%) or Hispanics (66%) reported they planned to retire.
- Similarly, more college graduates (80%) than high school graduates (61%) planned to retire as well.
- More respondents in the middle income range ($50,000-$74,000) (84%) than in other income categories planned to retire.

The highest proportion of respondents reported they planned to retire at age 65-67 (35%). These results varied by income and education. Respondents in higher income categories reported they would retire under age 65. No respondents with less than a high school education planned to work beyond age 70, while respondents with more education planned to work into their later years. Table 3 displays responses to these items by demographic characteristics.

These data indicate the need for open dialogue and public awareness regarding the resources, economic, and other assets required to support retirement. Perceptions and planning for retirement are out of alignment with our current economic reality. Even the assumed retirement age (65) has to be re-thought because realistically, many people will have to work more years to meet their individual needs, and others may not have the option to retire if they plan to remain financially viable. A later retirement age would require policy changes to retirement saving plans, pensions, and possibly Social Security.

Table 3. Do you plan to retire? At what age?

	Do you plan to retire?		At what age?				
Demographic characteristics	Yes	No	Under 65	Age 65-67	Age 68-70	Age 71-73	Age 74+
Total	**77%**	**23%**	**30%**	**35%**	**24%**	**8%**	**4%**
Age							
18-29	81%	19%	32%	28%	32%	6%	2%
30-40	84%	16%	26%	39%	26%	6%	4%
41-64	76%	24%	32%	36%	21%	7%	3%
65-75	64%	36%	0%	25%	41%	22%	13%
Gender							
Male	75%	25%	26%	33%	25%	8%	7%
Female	77%	23%	30%	36%	24%	7%	3%
Race							
White	81%	19%	29%	33%	25%	8%	4%
Black	71%	29%	32%	40%	19%	6%	3%
Hispanic	66%	34%	26%	42%	18%	8%	5%
Education							
High school graduate	61%	39%	33%	33%	27%	0%	7%
Technical/trade school	47%	53%	22%	33%	33%	11%	0%
College graduate	80%	20%	36%	39%	16%	5%	5%
Graduate degree	78%	22%	24%	32%	30%	10%	4%
Income							
$0 - $9,999	67%	33%	22%	44%	22%	6%	6%
$10,000 - $34,999	66%	34%	33%	36%	25%	3%	3%
$35,000 - $49,999	77%	23%	33%	37%	22%	4%	3%
$50,000 - $74,999	84%	16%	23%	38%	27%	9%	3%
$75,000 - $99,999	75%	25%	32%	34%	22%	6%	6%
$100,000 - $149,999	77%	23%	23%	32%	20%	18%	7%
$150,000+	76%	24%	55%	13%	26%	7%	0%
Marital status							
Single (never married)	78%	22%	25%	35%	26%	9%	5%
Married	77%	23%	35%	33%	23%	6%	3%
Divorced	71%	29%	16%	41%	21%	16%	5%
Domestic partnership	90%	10%	14%	46%	32%	5%	3%
Widowed	55%	45%	39%	31%	8%	0%	23%

As people age, while general spending decreases, declining health and increasing support needs require higher cash resources. Unfortunately, retirement is generally a time when incomes remain flat or often decrease in relation to inflation. Therefore, many seniors end up in situations where their financial and health needs have an inverse relationship to income. While many of these issues appear to be individual in nature, their impacts are felt at the communal and national levels. Therefore, we must use systemic approaches to educate, advocate, and prepare Americans to age.

When asked to rate the extent to which they were prepared to provide for their personal needs in retirement (i.e., very prepared, prepared, somewhat prepared, and unprepared), the highest proportion of respondents reported they would be somewhat prepared (47%); 7% reported they would be very prepared, while 16% would be unprepared. Retirement preparedness also varied by age, income, education, race/ethnicity, and gender. Twenty-eight percent of respondents aged 18-29 reported being unprepared, while 24% of those aged 30-40, and 15% of those aged 41-60 were also unprepared. Fifty percent of respondents aged 41-64 reported they felt somewhat prepared.

More men (38%) than women (26%) rated themselves as prepared. Higher proportions of Hispanics (31%) reported being unprepared than blacks (21%) or whites (12%). Fewer blacks (3%) than those in the other two groups (whites – 7%; Hispanics – 4%) were very prepared to provide for their personal needs in their retirement years. Findings showed that women and respondents with lower incomes anticipate being unprepared to provide for their personal needs in retirement. Table 4 shows responses to retirement preparedness by demographics.

How the respondents rated themselves as prepared for retirement.

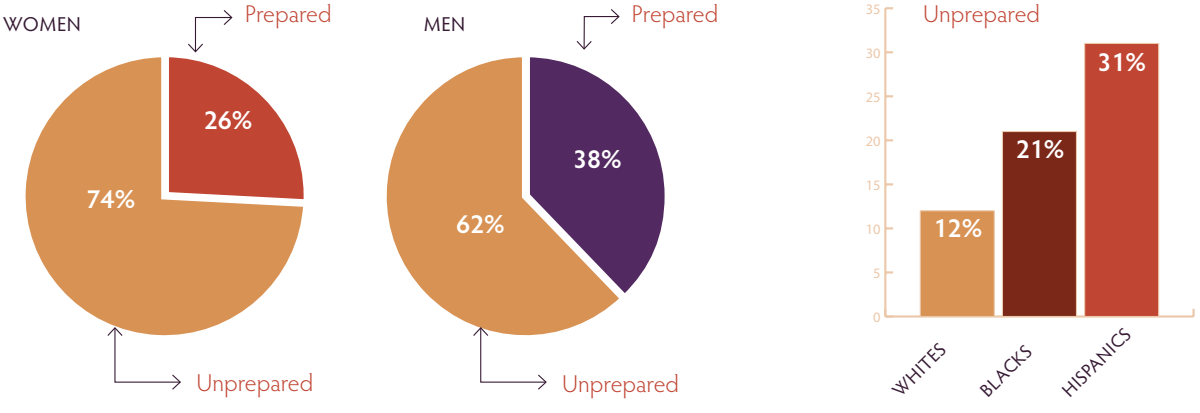


Table 4. Retirement Preparedness

Demographic characteristics	Very prepared	Prepared	Somewhat prepared	Unprepared	Unsure
Total	**7%**	**28%**	**47%**	**16%**	**2%**
Age					
18-29	11%	20%	40%	28%	2%
30-40	4%	20%	47%	24%	5%
41-64	6%	27%	50%	15%	2%
65-75	9%	47%	39%	8%	2%
76-90	15%	50%	31%	0%	4%
Gender					
Male	9%	38%	38%	17%	2%
Female	7%	26%	49%	16%	2%
Race					
White	7%	31%	48%	12%	2%
Black	3%	29%	47%	21%	2%
Hispanic	4%	13%	50%	31%	2%
Education					
High school graduate	3%	13%	50%	28%	6%
Technical/trade school	8%	4%	60%	28%	0%
College graduate	4%	28%	47%	17%	4%
Graduate degree	8%	33%	46%	13%	2%
Employment status					
Employed full-time	6%	25%	50%	18%	2%
Employed part-time	7%	30%	46%	14%	3%
Unemployed	10%	30%	37%	23%	0%
Retired	14%	58%	27%	4%	2%
Income					
$0 - $9,999	15%	10%	37%	34%	5%
$10,000 - $34,999	4%	19%	49%	25%	4%
$35,000 - $49,999	5%	26%	47%	21%	1%
$50,000 - $74,999	2%	30%	53%	15%	2%
$75,000 - $99,999	8%	36%	44%	9%	2%
$100,000 - $149,999	11%	33%	44%	10%	2%
$150,000+	26%	34%	36%	4%	0%
Marital status					
Single (never married)	6%	23%	46%	25%	1%
Married	7%	32%	46%	13%	2%
Divorced	5%	24%	49%	19%	3%
Domestic partnership	8%	17%	56%	17%	2%
Widowed	14%	36%	42%	8%	0%

AGING AND RETIREMENT RESOURCES

Older adults hope to age in place and maintain their independence, but are concerned about the lack of home and community-based support services. They also worry about their personal resources, i.e. who they can rely upon for care as they age and where they will live. The survey explored respondents' perceptions of available and affordable resources in their communities (e.g., affordable assisted living facilities, affordable nursing home facilities, affordable health care, affordable housing). Ratings ranged from excellent, very good, good, and fair to poor. Respondents rated all items as either fair or good.

In addition, participants indicated on whom they would rely to care for their needs after the age of 65. Seventy-seven percent reported that they expect to rely on themselves for care after the age of 65 while 44% expected their spouse to care for them, 35% expected that a child would care for them, and 26% expected to pay a professional for their care.

Responses varied by gender and by race/ethnicity:

- Higher percentages of men (52%) than women (42%) would rely on their spouse for care, while more women than men would rely on their children, siblings, or other family members, and would live with family members.
- A higher percentage of whites (12%) than blacks (5%) or Hispanics (2%) reported they would live in a nursing home.
- Similarly, a higher percentage of whites than blacks or Hispanics reported they would care for themselves or pay a professional to provide their care.
- Higher percentages of blacks (10%) and Hispanics (11%) than whites (4%) reported they would rely on a family member or friend for care and would live in their own homes or in the homes of family members.

Table 5 shows responses to the question regarding who respondents would rely on for care (percentages do not add up to 100% as respondents could make more than one selection), while Table 6 shows results for the item asking where they planned to live if they needed help caring for themselves.

Table 5. Who will you rely on to care for your needs after the age of 65?

Demographic characteristics	Care for myself	Spouse/ partner	Son/ daughter	Brother/ sister	Cousin/ relative	Friend(s)	Pay professional
Total	**77%**	**44%**	**35%**	**10%**	**4%**	**10%**	**26%**
Age							
18-29	59%	48%	29%	14%	3%	12%	17%
30-40	72%	51%	29%	10%	3%	9%	29%
41-64	80%	43%	35%	11%	5%	11%	26%
65-75	83%	43%	47%	6%	1%	6%	32%
76-90	52%	35%	35%	9%	4%	9%	22%
Gender							
Male	76%	52%	32%	7%	3%	10%	28%
Female	78%	42%	36%	11%	5%	10%	26%
Race							
White	79%	45%	32%	9%	2%	9%	28%
Black	75%	41%	42%	13%	7%	12%	24%
Hispanic	75%	43%	45%	13%	8%	18%	12%
Education							
High school graduate	60%	60%	47%	20%	3%	10%	7%
Technical/trade school	83%	46%	54%	13%	0%	13%	21%
College graduate	79%	41%	34%	13%	5%	10%	23%
Graduate degree	76%	46%	31%	7%	3%	11%	34%
Income							
$0 - $9,999	69%	47%	26%	11%	3%	8%	11%
$10,000 - $34,999	84%	42%	40%	12%	2%	9%	11%
$35,000 - $49,999	71%	43%	45%	11%	3%	11%	20%
$50,000 - $74,999	80%	40%	34%	10%	5%	9%	27%
$75,000 - $99,999	76%	50%	31%	11%	6%	14%	36%
$100,000 - $149,999	76%	42%	32%	7%	4%	9%	43%
$150,000+	82%	53%	24%	2%	2%	7%	31%
Marital status							
Single (never married)	76%	21%	13%	13%	3%	15%	18%
Married	76%	61%	42%	9%	4%	9%	29%
Divorced	89%	6%	37%	13%	7%	10%	24%
Domestic partnership	66%	68%	25%	11%	0%	16%	39%
Widowed	6%	6%	35%	3%	0%	3%	15%

Table 6. If you need help after the age of 65, where do you plan to live?

Demographic characteristics	My own home	Nursing home/ assisted living	With family members	No plans
Total	**59%**	**9%**	**6%**	**21%**
Age				
18-29	28%	16%	16%	39%
30-40	46%	8%	8%	34%
41-64	63%	8%	5%	19%
65-75	71%	9%	5%	12%
76-90	57%	17%	9%	9%
Gender				
Male	66%	12%	3%	18%
Female	57%	9%	7%	22%
Race				
White	57%	12%	4%	22%
Black	63%	5%	10%	20%
Hispanic	63%	2%	11%	23%
Education				
High school graduate	54%	7%	11%	25%
Technical/trade school	67%	13%	8%	8%
College graduate	59%	8%	8%	21%
Graduate degree	56%	11%	4%	24%
Income				
$0 - $9,999	39%	6%	14%	33%
$10,000 - $34,999	53%	8%	16%	20%
$35,000 - $49,999	66%	5%	8%	19%
$50,000 - $74,999	62%	9%	3%	23%
$75,000 - $99,999	61%	9%	4%	23%
$100,000 - $149,999	55%	15%	24%	22%
$150,000+	49%	18%	4%	13%
Marital status				
Single (never married)	48%	9%	10%	33%
Married	62%	10%	5%	18%
Divorced	61%	7%	10%	19%
Domestic partnership	58%	3%	5%	30%
Widowed	59%	13%	6%	16%

Sixty percent of respondents reported that they planned to live at home even if they will need help after age 65 while just 9% chose nursing home or assisted living. Additional comments by respondents amplified these findings. Respondents overwhelmingly stated that they hoped to age in place and regarded family and community support as fundamental to do so. As stated by one respondent, "I think more should be done to support older Americans to remain in their homes and communities during the aging process." "Put money into home health care programs and home modification programs so people can age in their own homes," suggested another respondent.

From the group of respondents who expected to rely upon family members for their care, one suggested, "We need to focus on keeping families together so that there is a sense of ownership for our aging family members." This group thought the government should provide resources to families with older members. "There should be tax incentives for young family members to care for elderly relatives," a respondent stated. Due to the mobility of contemporary families, "Programs to assist older Americans need to be nationally based because Americans are highly mobile," suggested another respondent.

A few respondents reported they had purchased long-term care policies to subsidize their care. Others planned to live in community-based homes with friends, in homes near their children, at home with health care (modified with accommodations), or in assisted or continuing care facilities. Respondents asserted that community resources to support senior members should be funded. "Adequately fund programs that support independent living and [e]nsure services regardless of income." "Senior centers are the visible statement of how communities value their older adults," was one respondent's opinion, while another remarked that, "Assisted living, senior centers, and health and wellness initiatives should be foremost in community development."

Most respondents reported adequate and affordable housing and transportation as crucial to aging in place. "We must provide seniors with safe, affordable housing and improve transportation systems in rural and suburban areas," according to one respondent. Another called for "a broader set of services to accommodate needs and services that reflect specificity of localities." "We as a nation are terribly behind in addressing our growing need for services, transportation, etc. that will be needed for the coming surge of aging Americans," remarked yet another respondent, commenting on the state of national systems in support of an aging population. One respondent called for "informal care systems and opportunities for seniors to contribute and feel valued, flexible policies that allow seniors to maintain independence, and development of major volunteer programs within rural areas."

AGING AND HEALTH MAINTENANCE

Social and community involvement

A large body of research provides evidence regarding the contributions of social connections and community involvement to advantageous health outcomes at all life stages.[xvi, xvii] Involvement in community groups and organizations may help people sustain interests developed earlier in life into older age and contribute to vital aging.

To assess the extent of social and community involvement, respondents were asked to select from a list of community organizations, groups, and associations of which they were a part, and they were allowed to select any of the options that applied. They were also asked whether they currently volunteer in their communities or plan to volunteer in the future. Fifty-eight percent of respondents reported being part of a religious or spiritual community and 58% reported being part of a neighborhood or town. Eighty-five percent of respondents volunteered or planned to volunteer in their communities. Forty percent of the respondents reported being involved in social clubs or organizations, 40% in professional associations, 38% in civic or charitable organizations, and 23% in college or university communities. Eight percent of respondents were not part of any community organizations.

Equal percentages of blacks and whites (94%) reported taking steps to prevent or manage chronic conditions as they age, while a lower proportion of Hispanics (83%) reported affirmatively.

Race/ethnicity, age, and income also produced varied responses to this question. A higher percentage of blacks (75%) than whites (55%) or Hispanics (53%) reported being part of a religious or spiritual community, while more whites (63%) considered themselves part of a neighborhood or town. Lower proportions of Hispanics than of the other groups reported being part of a community organization. Higher percentages of older than younger respondents reported being part of a religious or spiritual community, a social club, or a neighborhood or civic organization, while higher percentages of younger respondents than older were part of a professional organization or college or university organization. A higher proportion of respondents with the highest incomes reported being part of a neighborhood or town, while higher percentages of those with lower incomes reported being part of a religious or spiritual community.

Data in this section indicate that there are important differences in the way respondents characterize, perceive, and participate in "community." This should serve as guidance to local governments, philanthropy, and community-based organizations as they design programs and outreach efforts meant to engage seniors or aging communities of color.

Preventive health care

Appropriate preventive care, routine medical care, and maintaining a healthy lifestyle are important components of healthy aging. The survey asked respondents what steps they are taking now to prevent or manage chronic disease as they age and whether there were programs available in their communities to support their health needs. Ninety-three percent reported they were taking those steps, namely participating in regular exercise (65%), making healthy eating choices (81%), maintaining a healthy weight (57%), not smoking (85%), receiving routine medical and dental check-ups (89%), and promptly seeking help for medical problems (79%). Seventy-one percent of respondents reported there were programs in their communities to support their health needs.

As in other segments of the survey, responses about preventive health care varied by race/ethnicity, age, education, and income. Equal percentages of blacks and whites (94%) reported taking steps to prevent or manage chronic conditions as they age, while a lower proportion of Hispanics (83%) reported affirmatively. More, older respondents indicated that they engaged in preventive health care than younger ones. The highest percentages of those taking steps to prevent or manage chronic conditions (99%) were aged 65-75, and the lowest were in the aged group 18-29 (85%).

Qualitative data indicated that respondents were aware of the positive relationship between social connections and health, and of the potential contributions of stress reduction and spirituality to health maintenance. Community and interest groups included hobby groups, artistic groups, environmental conservation groups, and political organizations. A few people worried about the social isolation that could accompany aging, with the loss of older family members and friends. Others were concerned about the social isolation of caregivers, "We need to support caregivers and help address isolation and meaninglessness no matter what has induced it (i.e., poverty, emotional, mental, geographic factors)," was a comment from one of the respondents.

Some respondents indicated that they were positively engaged in health-related activities that might prevent or help manage chronic conditions as they aged. Examples included walking their dogs, working out using a Wii video game system, participating in sports, using a gym and/or personal trainer, and gardening. County health department facilities, employer-sponsored wellness programs, insurance company sponsored programs, senior center programs, church centers, and university recreational facilities were described as community resources that could support these activities. Respondents also indicated they were health conscious, obtained health screenings, received sufficient sleep, took vitamins/supplements, used sunscreen, obtained sufficient hydration, received flu shots, adhered to medication, and wore seatbelts. They also considered maintaining active brains to be a vital component of healthy aging, and suggested participation in projects and social activities.

INTERNET USE IN RETIREMENT

The survey measured the extent of access to the Internet and use of technology in the present and future. Ninety-four percent of respondents reported they had a broadband Internet connection in their home or on a cell phone. Ninety-three percent of respondents planned to use email, social networking tools, and computer technology to stay in contact with friends and family in their senior years. Sixty percent of respondents anticipated using online tools to manage their health in their senior years, and 93% anticipated using the Internet to access information and services as they aged.

Responses about access to technology varied by age, race/ethnicity, gender, education, and income (Table 8 displays these results). Ninety-six percent of blacks, 95% of whites, and 87% of Hispanics reported they had a broadband Internet connection. Slightly more men (97%) than women (94%) reported they had Internet access. Having Internet access decreased with older age. For example, 97% of those aged 18-29 had Internet access, while 81% of those aged 76-90 reported they had access. Access increased with more education – 81% of high school graduates had access, while 96% of those with a graduate degree reported access. Eighty-seven percent of those with incomes between $10,000 and $34,999 had Internet access while 97% of those with incomes between $50,000 and $74,999 reported having access.

Ninety-six percent of blacks, 95% of whites, and 87% of Hispanics reported they had a broadband Internet connection.

Responses to using email, social networking tools, and computer technology to stay in contact with friends and family in their senior years (65+) varied by race/ethnicity, age, and education. Fewer Hispanics (84%) reported they would use social networking tools than blacks (90%) or whites (95%). Lower proportions of respondents in the youngest group (18-29 years old: 86%) and the oldest group (76-90 years old: 85%) as compared with respondents in the mid age ranges (41-64 years old: 94%) reported they would use computer technology to stay in contact with family and friends. Affirmative responses increased with educational attainment (e.g., 75% of high school graduates as compared with 95% of college graduates). Exactly the same proportion of men and women reported they planned to use social networking tools (93%).

Using the Internet to access information and services in their senior years shows variation by race, marital status, education, and age as shown in Table 7. A higher proportion of whites (94%) than blacks (90%), or Hispanics (89%) reported they would use the Internet for this purpose. More married (95%) than single (89%)

people would similarly use the Internet. Fewer older than younger respondents would use it, particularly those age 76-90 (77%). Fewer high school graduates (75%) than college graduates (92%) reported they would use the Internet for this purpose, while almost equal proportions of men (92%) and women (93%) reported they would do so.

The survey asked respondents to indicate whether they anticipated barriers to Internet use at aged 65, allowing them to select any barrier that applied. Fifty-eight percent of respondents reported that nothing would prevent them from using the Internet. The most frequently chosen barrier was the cost of broadband, selected by 33% of respondents. The remaining barriers selected by this group of respondents were the cost of a computer (19%), a lack of trust in security of information on the Internet (13%), the lack of availability of broadband (11%), the lack of access to a computer (8%), not skilled at using a computer or new technology (5%), and not interested in computing (2%).

When asked whether they anticipated using the Internet and online tools to manage their health in their senior years, 60% of respondents replied in the affirmative. Table 8 shows that notable variations by race, gender, age, marital status, education, employment status, and income emerged in the results. Fewer whites (57%) than blacks (67%), or Hispanics (63%) reported they would use the Internet to manage their health, as did fewer women (60%) than men (65%), and fewer single (56%), including widowed (54%), than married respondents (61%). Affirmative reports about using the Internet to manage health decreased with age and higher educational levels.

The proportion of respondents aged 30-40 (63%) reporting they would use the Internet to manage their health was almost double the proportion of respondents aged 76-90 (35%). Sixty-three percent of respondents employed full-time reported they would use the Internet to manage their health in comparison to just 52% of those employed part-time, 53% of unemployed, and 54% of retirees. Affirmative reports about using the Internet to manage health increased with higher income, illustrated by the 67% of respondents with incomes greater than $75,000 who planned to use the Internet to manage their health.

Fewer whites (57%) than blacks (67%), or Hispanics (63%) reported they would use the Internet to manage their health...

Table 7. Current and Anticipated Use of Internet and Technology

Demographic characteristics	Broadband Internet connection in their homes or a cell phone		Plan to use email, social networking tools and computer technology		Anticipate using the Internet and online tools to manage their health		Anticipate using Internet to access information and services in their senior years	
	YES	NO	YES	NO	YES	NO	YES	NO
Age								
18-29	97%	3%	86%	14%	63%	37%	83%	17%
30-40	95%	5%	91%	9%	67%	33%	93%	7%
41-64	96%	4%	94%	6%	62%	38%	95%	5%
65-75	89%	11%	94%	6%	49%	51%	89%	11%
76-90	81%	19%	85%	15%	35%	65%	77%	23%
Gender								
Women	94%	6%	93%	7%	59%	41%	93%	7%
Men	97%	3%	93%	7%	64%	36%	92%	9%
Race								
White	95%	5%	95%	5%	57%	43%	94%	6%
Black	96%	4%	90%	10%	67%	33%	90%	10%
Hispanic	87%	13%	84%	16%	63%	37%	88%	12%
Education								
High school graduate	81%	19%	75%	25%	44%	56%	75%	25%
Technical/trade school	96%	4%	89%	11%	63%	39%	92%	8%
College graduate	95%	5%	95%	5%	63%	39%	92%	8%
Graduate degree	96%	4%	93%	7%	62%	38%	95%	5%
Income								
$0 - $9,999	93%	7%	88%	12%	42%	58%	78%	22%
$10,000 - $34,999	87%	13%	87%	13%	55%	45%	88%	12%
$35,000 - $49,999	92%	8%	91%	8%	59%	41%	91%	9%
$50,000 - $74,999	97%	3%	94%	6%	61%	39%	95%	5%
$75,000 - $99,999	96%	4%	96%	4%	67%	33%	98%	2%
$100,000 - $149,999	98%	2%	95%	5%	63%	37%	95%	5%
$150,000+	98%	2%	96%	4%	65%	35%	96%	4%
Employment status								
Employed full-time	94%	6%	93%	7%	63%	37%	94%	6%
Employed part-time	94%	6%	89%	11%	52%	48%	91%	9%
Unemployed	93%	7%	97%	3%	55%	45%	90%	10%
Retired	95%	5%	95%	5%	54%	46%	89%	11%

Table 8. Barriers to Internet access and use of technology

Demographic characteristics	Cost of broadband	Availability of broad-band	Cost of computer	Availability of computer	Not skilled at using computer for new technology
Total	**33%**	**11%**	**19%**	**8%**	**5%**
Age					
18-29	22%	5%	12%	7%	10%
30-40	33%	11%	17%	5%	<1%
41-64	36%	12%	20%	8%	5%
65-75	26%	11%	20%	9%	12%
76-90	8%	4%	13%	4%	13%
Gender					
Women	35%	11%	21%	9%	5%
Men	25%	10%	12%	4%	8%
Race					
White	30%	11%	17%	6%	6%
Black	36%	10%	19%	10%	5%
Hispanic	47%	13%	34%	11%	3%
Education					
High school graduate	55%	23%	42%	19%	7%
Technical/trade school	50%	25%	38%	8%	4%
College graduate	34%	8%	17%	8%	4%
Graduate degree	28%	11%	15%	6%	5%
Marital status					
Single (never married)	33%	12%	18%	10%	8%
Married	31%	11%	17%	7%	5%
Divorced	46%	14%	27%	11%	2%
Domestic partnership	20%	4%	15%	2%	7%
Widowed	39%	12%	27%	12%	3%
Employment status					
Employed full-time	36%	11%	20%	7%	5%
Employed part-time	28%	13%	14%	9%	9%
Unemployed	29%	11%	25%	18%	7%
Retired	16%	5%	11%	4%	8%
Income					
$0 - $9,999	32%	8%	29%	16%	5%
$10,000 - $34,999	49%	21%	33%	18%	5%
$35,000 - $49,999	39%	11%	22%	7%	6%
$50,000 - $74,999	31%	9%	15%	15%	5%
$75,000 - $99,999	32%	8%	16%	6%	5%
$100,000 - $149,999	23%	6%	11%	3%	5%
$150,000+	2%	4%	2%	0%	11%

Table 8. Barriers to Internet access and use of technology [continued]

Demographic characteristics	Not interested in computing	Don't trust security of information on the Internet	Nothing would prevent me from using the Internet
Total	**2%**	**13%**	**58%**
Age			
18-29	3%	22%	59%
30-40	2%	11%	61%
41-64	1%	11%	56%
65-75	3%	20%	61%
76-90	4%	13%	67%
Gender			
Women	1%	13%	55%
Men	3%	10%	69%
Race			
White	1%	12%	62%
Black	3%	14%	55%
Hispanic	3%	14%	38%
Education			
High school graduate	3%	26%	39%
Technical/trade school	0%	25%	42%
College graduate	1%	15%	57%
Graduate degree	2%	11%	63%
Marital status			
Single (never married)	3%	11%	55%
Married	2%	13%	61%
Divorced	0%	12%	47%
Domestic partnership	0%	7%	67%
Widowed	6%	15%	55%
Employment status			
Employed full-time	1%	12%	56%
Employed part-time	4%	16%	63%
Unemployed	0%	14%	54%
Retired	3%	15%	75%
Income			
$0 - $9,999	0%	18%	47%
$10,000 - $34,999	2%	18%	43%
$35,000 - $49,999	2%	16%	52%
$50,000 - $74,999	3%	9%	59%
$75,000 - $99,999	0%	10%	65%
$100,000 - $149,999	1%	10%	71%
$150,000+	0%	13%	73%

Table 8 displays respondents' reports regarding anticipated barriers to Internet and technology use by demographic characteristics, and reveals notable variations:

- Fifty-eight percent of all respondents anticipated no barrier to use after 65, with just 38% of Hispanics reporting no anticipated barrier compared with 55% of blacks, and 62% of whites.
- Seventy-five percent of retired respondents reported anticipating no barriers to Internet use.
- A larger proportion of the oldest respondents (aged 76-90, 67%) reported that nothing would prevent them than did younger respondents (aged 41-64, 56%).
- Forty-seven percent of Hispanics selected the cost of broadband as a deterrent to Internet use as compared to 36% of blacks and 30% of whites.
- More women (35%) than men (25%) reported cost of broadband as a barrier to use. More divorced people (46%) reported they would be deterred by this cost than those who were single (33%), or married (31%).
- Much smaller proportions of respondents of higher education and incomes reported cost of broadband as a barrier. For example, 55% of high school graduates as compared with 28% of those with graduate degrees considered cost a deterrent.
- Respondents in the youngest age group (aged 18-29) represented the smallest proportion (22%) reporting the cost of broadband a deterrent.
- More respondents who were employed full-time reported cost as a deterrent (36%) than those employed either part-time (28%) or unemployed (29%).
- Almost one-half of respondents (49%) with the least income reported anticipating that they would be deterred by cost of broadband.

Distrust of Internet security related to personal information storage seemed to be of greater concern to blacks (14%) and Hispanics (14%); respondents with less education such as high school graduates (26%); the youngest (aged 18-29, 22%) and older (aged 65-75, 20%) respondents; those employed part-time (16%); those who were retired (15%); and those respondents with the lowest incomes (18%).

Results showed that a substantially lower percentage of respondents reported they would use the Internet to manage their health in their senior years (60%), as compared with respondents who reported they would use the Internet for social networking (93%), or to access information and services (93%).

The qualitative data provided useful insights regarding respondents' high level of concern about the security of electronic information, especially medical records. Respondents reported they were especially concerned about privacy issues and the need for increased security of personal information on the Internet.

The concern that telemedicine might replace a personal, face-to-face relationship with health care providers seemed to underlie some of the apprehension revealed in these responses.

When asked to explain why they did not have a broadband connection at home, respondents reported a range of explanations including Internet connection available at work, residing in a rural/inaccessible area, receiving email by other means (e.g., dial-up service), difficulties in keeping their computers spam-free and malware-free, and concerns about using a poor Internet connection. With respect to reluctance about using e-mail and social networking tools, respondents most frequently mentioned concerns about privacy and the potential for identity theft. On the other hand, a few respondents reported being hopeful about having more time to keep up with computer technology as they aged, and mentioned the potentially positive role of technology in improving the management of aging in place.

Respondents frequently reported uncertainty as to what technology would be available when they reach age 65, and concerns about the need to keep up with technological innovations. Respondents who reported cost as a potential barrier to technology use as they age focused on the need to upgrade software and technology at frequent intervals. As stated by one respondent, "My health, food, medication, and basic needs would come way before having a computer in my home." Additionally, they perceived physical impairments that often accompany aging such as reduced visual acuity and arthritic conditions as potential barriers to future use of technology.

VIEWS ON GOVERNMENT'S ROLE IN AGING AND RETIREMENT PREPAREDNESS

The decreasing capacity of individuals to afford retirement, exacerbated by the current economy, has intensified concerns about the federal government's capacity to support its growing aging population, and about the allocation of increasingly scarce resources. Many have raised questions about the government's involvement in providing support and services for its aging residents. For example, should the federal government be responsible for services related to aging? For whom and how much? Is the government able to be responsible? If not the federal government, should state or local governments then assume responsibility?

The survey asked respondents to indicate how confident they were that the federal government could address the needs of older Americans[4] regarding a number of items.[5] Over half of respondents (54%) reported they were not confident at all that the federal government would support their needs as they aged. Over half of respondents were also not confident that the government would provide affordable nursing homes (53%), assisted living facilities (53%), or affordable home health care (51%). However, respondents thought the government was somewhat more prepared to provide adequate senior centers, and affordable meals on wheels.

Data showed that blacks were more confident in the government's capacity than were whites. Forty-six percent of blacks were somewhat confident, while 56% of whites and 60% of Hispanics were not confident at all.

Responses to the issue of government involvement varied by race/ethnicity, age, education, and income. Data showed that blacks were more confident in the government's capacity than were whites. Forty-six percent of blacks were somewhat confident, while 56% of whites and 60% of Hispanics were not confident at all. Blacks tended to rate the government as being somewhat prepared on more items than did whites or Hispanics. For example, 46% of blacks rated the government as somewhat prepared to provide affordable health care, while 34% of whites and 37% of Hispanics rated the government as somewhat prepared on the same item. Thirty-nine percent of blacks, 31% of whites, and 33% of Hispanics rated the government as

[4] **The ratings included:** *very confident, confident, somewhat confident, and not confident at all.*

[5] **These items included**: *affordable assisted living facilities, affordable nursing home facilities, affordable health care, affordable home health care, home utilities financial assistance, affordable hospice care, adequate senior centers, affordable transportation, affordable meals on wheels, affordable legal aid, property tax relief, affordable options for physical activity and exercise, and social outlets.*

somewhat prepared to provide affordable transportation. Significantly more men (57%) than women (16%) reported they thought the federal government would support their needs as they aged.

A higher percentage of respondents in the middle age groups (30-40 and 41-64) were not confident at all of the government's preparedness while higher percentages of those of other ages reported they were somewhat confident. A higher percentage of those in the middle age groups reported the government was not prepared at all to provide affordable health care, while a higher percentage of other ages reported the government was somewhat prepared. Respondents from all age groups except the youngest (18-29) regarded the government as not prepared at all to provide affordable transportation. A higher percentage of respondents with lower educational attainment and income were not confident at all about the government's capacity to support their needs as they aged than those with higher education and income.

The qualitative data provided useful insights. Seven hundred fourteen respondents commented when asked to explain their selections regarding the government's capacity to support an aging population. They provided a wide range of explanations for their opinions. This level of response is not surprising given the dire economic circumstances facing the country. Some thought it was not the government's responsibility at all to provide for their needs as they aged; rather it was each person's individual responsibility. Those who felt confident in the government's capacity explained that seniors would have increasing influence on legislation and federal programs due to their growing numbers, that entitlement programs would be maintained with the current administration, and that they were encouraged due to the recent passage of the health care reform bill. They thought that the baby boomers would push for better programs and services, illustrated by this statement from one respondent: "Baby boomers will change the face of aging."

On the other hand, some respondents questioned the government's capacity to meet their needs as they aged, precisely because of the growing size of the aging population and diminished capacity over time due to the numbers. Here are some of the comments:

- "I don't think they [the government] are prepared for the number that will need assistance."
- "There will be too many people and not enough resources."
- "The country has not solved how it will pay for Social Security for the country's largest growing demographic."
- "I'm confident the structures are in place, with broad political support, but I worry that they may become unsustainable."

Underlying these concerns was the perception that the current recession would undermine the government's ability to provide resources for an aging population. "The current state of the economy

makes me unsure and uneasy," one respondent explained. "I assume with national debt, economic downturn, and boomer population that there will be scarce money and resources," stated another. "One of our biggest problems is runaway cost and an economy that may never fully recover," a different respondent added. One respondent thought that the government misplaced its priorities, stating "Focusing on the elderly when there are so many children living in poverty is not appropriate."

Other respondents addressed the emerging conflict between the generations around shrinking resources. They doubted that the government would consider the needs of an aging population a priority. "Seniors are seen as disposable in our culture," expressed one respondent. "I hope this country will value older adults, as they continue to contribute in many ways to society after retirement," stated another. Another respondent remarked, "Our culture is focused on staying frozen in youth. The more we each come to terms with and celebrate aging, the more we recognize the gifts of every age. How do we communicate and support this message?" A different respondent commented, "Seniors have been our teachers, fathers, policemen, nurses, and grocery store employees. We should be preparing for them like they once prepared for us. We need to take care of them... and fast." One respondent addressed the particular challenges facing low income and rural seniors, "The federal government does not understand the plight of low-income seniors nor do they understand the lack of resources for seniors in small rural communities."

When asked what the federal government should do better to prepare for larger numbers of older Americans, providing adequate affordable health care was the most frequent response. Six hundred seventy-eight respondents submitted comments in response to the question. Older Americans need "affordable health plans, medication assistance, and more in home services," according to one respondent. "The biggest change/problem in the last 10 years has been that most companies no longer let retirees keep their health insurance," stated another. Respondents were also concerned about the provision of appropriate health care, i.e., care provided by physicians trained in geriatrics, as well as about the availability of an adequate number of physicians to meet the health care needs of an aging population.

For the respondents who commented about this, a majority did not think that the federal government alone could adequately prepare for the vast numbers of an aging population. They suggested that individual communities could help, as well as state and local governments, health care professionals, public health professionals, pharmaceutical companies, social service agencies, aging services, employers, the faith community, educational institutions, policymakers, and transportation and environmental specialists.

LIMITATIONS

This survey's findings should be interpreted with caution as respondents reported higher levels of income and education relative to the general U.S. population. Notwithstanding their higher SES and notable levels of concern about resources, a more representative group of respondents would likely report similar, if not higher levels of concern about retirement resources. In future surveys, CommonHealth ACTION plans to solicit responses from a population with broader ranges of education and income. While we used percentages to create comparability, it is important to note that the actual numbers of retired and oldest age respondents were quite small. Respondents aged 41-64 represented the largest number of survey participants, which is likely attributable to the outreach strategies for the survey. On the other hand, members of this age group are likely to express concerns and provide insights most relevant/informative on the subject of aging and retirement preparedness, given they are approaching the latter end of the aging continuum. The width of the age range meant we could not look at/parse the concerns for the above-50 and below-50 respondents. Consequently, we plan to create more narrow age ranges for future surveys. Despite these limitations, the survey responses created a sufficient sample size to examine responses by ethnicity and gender, even where SES differences by ethnicity and gender were not significantly pronounced.

CONCLUSIONS AND IMPLICATIONS

Preparing for America's aging population and subsequent/assumed retirement poses significant research, resource, and policy challenges. At a time of decreasing generational wealth, a shrinking middle class, and cuts to entitlement programs and other critical safety nets, the transformation of the U.S. into a significantly older populous is setting a tenuous stage for gaps in infrastructure, services, and supports. This potentially perfect storm has the propensity to cause great harm to individuals, families, and communities. The resources required to promote good health, functionality, and longevity of the aging population will undoubtedly inspire public debate in the foreseeable future.[xviii] Anticipated increases in health care costs, federal spending for entitlement programs, and the future viability of the Social Security and Medicare programs in the U.S. present daunting and historic challenges.

Respondents to this survey expressed pervasive uncertainty and apprehension about the government's ability to support an aging population, the future cost and availability of health care, and the availability of affordable housing and transportation as they age. They hoped to remain independent and to age in place, but were concerned about the resources that would be available to support their needs. They worried about the impact of our struggling economy on current and future resources. Anticipating their retirement years, women reported lower preparedness ratings than men to provide for their personal needs. Based on existing economic and social challenges, women and older members of historically disadvantaged groups will be particularly vulnerable to reductions in government resources. Advances in technology have

often meant decreased costs and improved capacity to support and serve vulnerable populations. Use of technology, especially with respect to the Internet, has significant potential to assist with aging preparedness. Access to the Internet will become increasingly important for aging and retired people to obtain information and manage various aspects of daily life. The aforementioned access will also be critical for family caregivers and senior advocates.

The survey results suggest several emerging issues associated with Internet access and the use of technology among older and aging adults. Our findings show significant differences in Internet access and use based on racial and ethnic groups, even among those people with higher SES. Respondents with lower education and incomes appear to be more likely to lack Internet access and they use technology less. Hispanics reported barriers to accessing technology at higher rates than did their counterparts. They also indicated lower SES, compared to whites and blacks. Forty-seven percent of Hispanics reported that the cost of broadband would be a barrier to Internet use over age 65, compared to 36% of blacks and 30% whites. Women are another potentially vulnerable group with regard to technology's role in aging. The survey data showed that the cost of broadband would deter more women (35%) than men (25%) from Internet use. Almost twice as many women (21%) as men (12%) considered computer cost to be a barrier to their use of technology.

Survey findings also indicate that advances in Internet security will be critical to whether and how Internet, mobile, and health information technologies become widely used tools. Companies must update technology to provide increased speed of connections and improved access across geographic regions and socioeconomic levels. Research and innovation in mobile technologies are particularly important to black and Hispanic populations' ability to use technology as a tool to support successful aging. According to the Pew Internet and American Life Project Mobile Access 2010 report, cell phone ownership among blacks (87%) and Hispanics (87%) is higher than that of their white counterparts (80%). This indicates significant opportunities to develop new, meaningful mobile applications targeted at these populations.

To support the aging population of the U.S. and maximize the benefits of technology and the Internet, private technology companies and those focused on health information technology should work in partnership with policymakers, local and state agencies, and community-based organizations to develop technologies that are accessible and relevant to older and diverse groups. Most notably, these findings

suggest that gender and ethnicity interacted with SES to influence respondents' views on access and use of Internet and technology. Companies, policymakers, and public officials must understand these differences and determine how improved technologies and policies can ensure equitable access and use; unconstrained by gender, ethnicity, and socioeconomic status.

The findings reported herein indicate that there are unique opportunities for community assessment and transformation to support healthy aging. Self-reported concerns from participants throughout the 46 states in this sample indicate a compelling pattern. Given the high educational and income level of respondents, we can logically conclude that a preponderance of baby boomers will simply not be prepared to support their needs in the current community structures and within the construct of existing public policies. Preparing for an older population - many with decreasing financial means - requires even greater social, technological, and policy innovations that must occur quickly to prevent significant harm to an increasingly vulnerable population.

How might we begin to stimulate innovation in community design and new models of shared support systems, beyond individual entitlement benefits? What policies are required to support the built environment and transportation systems to support the aging population? How should those entities and experts concerned with aging issues inform innovation in the technology sector? How might we leverage the emerging community health worker capacity as defined in the Affordable Care Act? How can we leverage existing capacity support in AmeriCorps and other programs designed to support community building? How should the country and its leaders engage in a results-focused national dialogue that ensures aging preparedness is part of the national public policy agenda? How might we increase collaboration among public health, planning, and other sectors to be well-prepared for this rapidly increasing demographic shift?

Respondents identified many stakeholders — state and local governments, social and religious organizations, community-minded business entities, and community-based groups — who must form productive alliances and provide effective leadership regarding how to create communities where seniors can remain vibrant and involved members, thereby promoting health and wellness for all community members. Through increased awareness on all levels of society, the seriousness of the challenges we face must rise to the top of our national priorities and meaningful action must take place.

RECOMMENDATIONS TO SUPPORT NATIONAL AND LOCAL AGING PREPAREDNESS

Unlike other industrialized countries, the U.S. has not invested significant public funds in comprehensive social and economic safety nets for seniors and retirees, nor have we collectively engaged in systems-level planning. While America engaged in massive efforts to build schools to accommodate the children of the baby boom in the 1950s and 1960s, we did little to plan for their senior years. As a result, we are now faced with critical questions regarding our collective responsibility to ensure that people can age with some basic level of physical and economic security, while doing so with dignity. As of May 2011, policies and activities on all levels of government have positioned us to be reactionary to the "graying" of our population.

The enactment of Social Security and Medicare in 1965 lifted millions of seniors out of poverty but faced severe opposition in Congress. We hazard to guess the plight of tens of millions of seniors if neither program existed today. While the moral argument to provide systemic support for seniors will be obvious to many readers of this report, the burgeoning economic argument should garner the attention of others. Our goal is to expand the scope and reach of future surveys, document society's perspectives and beliefs about aging, and ultimately, analyze the implications for public policy, with special emphasis on the role of technology and aging in place. Hopefully, thought leaders, policymakers, and community advocates will be inspired to discuss, debate, and begin comprehensive planning based on the data and analysis within this report.

As a nation, regardless of the extent of our preparedness, our families, communities, and public and private sectors will all experience America's "senior tsunami." The time to prepare commenced over 60 years ago. Let us strengthen the national dialogue and take action now.

1. **Federal government:** Convene a national commission, charged with assessing the nation's preparedness for the aging population and making recommendations for public policy to support community-based preparedness strategies. The commission's work would focus on government systems, state and local infrastructure, economics and financing, and public information and education. Leverage international research and evidence-based strategies and models to develop effective models for the U.S.
2. **Federal government:** Commission a report that develops effective measures of aging preparedness and quality of life for seniors. Annually, conduct and publish national and local assessments, measurements, and rankings to inform the public, policymakers, and advocacy organizations. Use the data to identify gaps and areas that require improvement, inform funding in the public and private sectors, and identify effective policies, models, and practices.
3. **National non-profits, community-based organizations, philanthropy, and academia:** Work collaboratively to develop and pilot local/community-based models of aging preparedness that support healthy aging. Such efforts should stimulate innovations testing and enhance the evidence base for policy and program supports necessary to accommodate an older population.
4. **Advocacy organizations:** Advocate for comprehensive federal and state resource allocation that advances aging in place, creates affordable housing, ensures access to age-appropriate, quality health care, and supports the development of, and access to, innovative technologies that promote healthy aging.
5. **Public and Private Sectors:** Implement a national campaign to promote individual and family planning for aging and positive perceptions and beliefs about the aging process and latter years of life.
6. **Corporations (Technology and Telecommunications):** Convene and actively engage diverse and newly identified stakeholders to inform innovation, accessibility, and adoption of technologies that support healthy aging, aging in place, independent senior living, social connectedness, access to quality health care, and remote monitoring. Invest in education, incentives, and workforce training that support professional specialization in the development of aging-related technologies.
7. **State governments:** Develop state policy agendas and comprehensive plans focused on funding local aging preparedness efforts and initiatives. Support local capacity development with health in all policies approaches to support effective development of age-friendly communities.
8. **Academia and national non-profits:** Conduct research to inform the development of effective public policy that supports healthy aging in America and improves the economic viability of the aging population.

AGING IS NOT

'LOST YOUTH'

BUT A NEW STAGE OF

OPPORTUNITY AND

STRENGTH.

~BETTY FRIEDAN

REFERENCES

i Federal Interagency Forum on Aging and Related Statistics (2010, July). Older Americans 2010: Key Indicators of Well-Being. Washington, DC: U.S. Government Printing Office.

ii U.S. Census Bureau. (2008, August 18). An Older and More Diverse Nation by Midcentury. Press Release. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb08-123.html.

iii Congressional Budget Office. (2004, March 18). The retirement prospects of the baby boomers. *Economic and Budget Issue Brief*, Retrieved from http://www.cbo.gov/doc.cfm?index=5195&type=0.

iv Coombes, A. (2010, October 24). Expenses rise even if social security doesn't. *The Wall Street Journal.* Retrieved from http://online.wsj.com/article/SB10001424052702303436904575570851965607316.html.

v Federal Interagency Forum on Aging-Related Statistics. (2009, December). Data Sources on the Impact of the 2008 Financial Crisis on the Economic Well-being of Older Americans. Retrieved from http://www.agingstats.gov/agingstatsdotnet/main_site/docs/DSOA_Aging_Brief.pdf.

vi U.S. Department of Health and Human Services, Administration on Aging. (2008). AoA Annual Report, 2008: Investing in Change: Enhancing the Health and Independence of Older Adults. Retrieved from http://www.aoa.gov/AoARoot/Program_Results/docs/2008/AOA_2008AnnualReport.pdf.

vii Ibid.

viii U.S. Department of Health and Human Services, Administration on Aging. (2008). Facts: Community Living Program. Retrieved from http://www.aoa.gov/aoaroot/Press_Room/Products_Materials/pdf/Community_Living_Programs.pdf.

ix U.S. Department of Health and Human Services. (2011). National Education and Resource Center on Women and Retirement Planning. Washington, DC.

x Egan, P. (2010, August 10). As older people grow in numbers, experts seek ways to handle the coming boom. *Washington Post*. Retrieved from http://www.washingtonpost.com/wp-dyn/content/article/2010/08/09/AR2010080904111.html.

xi National Center on Women and Aging; The Heller School for Social Policy and Management, Brandeis University. (n.d.) National program on women and aging. Retrieved from http://iasp.brandeis.edu/womenandaging/research.htm.

xii Federal Interagency Forum on Aging-Related Statistics. (2009, December). Data Sources on the Impact of the 2008 Financial Crisis on the Economic Well-being of Older Americans. Retrieved from http://www.agingstats.gov/agingstatsdotnet/main_site/docs/DSOA_Aging_Brief.pdf.

xiii Egan, P. (2010, August 10), As older people grow in numbers, experts seek ways to handle the coming boom. *Washington Post*. Retrieved from http://www.washingtonpost.com/wp-dyn/content/article/2010/08/09/AR2010080904111.html.

xiv CommonHealth ACTION. (2006). Growing in America 2005 survey highlights and PowerPoint presentation. Retrieved from http://www.commonhealthaction.org/2005AgingSurveyHighlightsandPresentation.pdf.

xv Shapiro, T. M., Meschede, T., & Sullivan, L. (2010, May). The racial wealth gap increases fourfold. Institute on Assets and Social Policy, the Heller School for Social Policy and Management, Brandeis University. Retrieved from http://iasp.brandeis.edu/pdfs/Racial-Wealth-Gap-Brief.pdf.

xvi Berkman, L. F. & Syme, S. L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 1(109)*, 186-204.

xvii Blazer, D. G. (1982). Social support and mortality in an elderly community population. *American Journal of Epidemiology, 115(5)*, 684-694.

xviii Satariano, W. (2006). *Epidemiology of aging: An ecological approach*. Sudbury, MA: Jones & Bartlett Publishers.

Design and Layout: Conceptual Geniuses, Inc., Silver Spring, MD (www.cgeniuses.com)

CommonHealth ACTION is a national, non-profit public health organization in Washington, D.C. We collaborate with national organizations and community-based partners to create conditions in which all people have equal opportunities to achieve optimal health.

To learn more about CommonHealth ACTION visit **www.commonhealthaction.org**

A COMMONHEALTH ACTION PUBLICATION

CommonHealth *ACTION*

1301 Connecticut Avenue, NW
Suite 200
Washington, DC 20036
p 202.407.7088
f 202.407.7089
healthyaging@commonhealthaction.org
www.commonhealthaction.org