Elders Count Nevada

2021 Report

Aging and Disability Services

January 2021

Center for Healthy Aging

Acknowledgements and Contributors

The 2021 Elders Count report was made possible through the collaboration of the Center for Healthy Aging, Office of Statewide Initiatives at the University of Nevada, Reno School of Medicine, the State of Nevada Aging and Disability Services Division and the Department of Health and Human Services – Office of Data Analytics. A special thanks and appreciation to the following contributors and project partners (in alphabetical order):

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Director's Office

Helping people. It's who we are and what we do.

Richard Whitley, MS
Director

January 21, 2021

Dear Nevadans:

As the Director of the Department of Health and Human Services it is with great pleasure that I write a letter of support for the Elders Count Nevada 2021. Developing a report that is focused on the health and social support indicators of Nevada's elder population, provides law makers and policy decision makers critical information to take positive action within our communities to better serve the elderly population in Nevada.

Elders Count Nevada continues to support the Departments mission to collect data on key health factors impacting our programs and the individuals they serve. Today's elders make up a growing demographic within our state with a projected increase of 40% for those 65 and older and 25% for the age 85 and older. Policy makers need reliable and readily available information about the growth senior population and this report will provide that. Having the data to drive policy decisions is critical to making policy decision aimed at improving the lives of the elder population and making Nevada an age friendly state.

I commend this joint initiative between the Nevada Department of Health and Human Services Office of Data Analytics, the Aging and Disability Services Division, the University of Nevada, Reno, and the Center for Healthy Aging. Thank you all for working to improve the lives of Nevada's senior citizens.

Sincerely,

Richard Whitley, MS
Director

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CENTER FOR HEALTHY AGING

Dear Nevadans,

Nevada has been and will continue to experience an aging tsunami. Between 2011 and 2018 Nevada population increased by 11.42% with the 65 and older population increasing by 40% and the 85 and older population increasing by 25%. Nevada's growth rate for the age 85 and older population is double the national rate. In fact, Nevada's population is expected to continue to age at higher rates through 2030.

The 81st Session of the Nevada legislature will confront some of the most serious challenges in the history of our state, given the current pandemic and lack of resources. Health and human services are one of the most severely impacted areas. Elders have been impacted the hardest from COVID. Those who depend on public and private benefits will doubtless present decision-makers with difficult choices. This report provides comparative demographics and health indicators compiled from authoritative state and nationwide databases. Elders Count Nevada is a fact book with relevant information that will help policy makers, federal and state organizations, media, advocates, businesses, and service providers make decisions about how to serve our elders today and in the future.

Elders Count Nevada 2021, like the original published in 2007, provides authoritative data on the number and condition of our state's elder population, including some of the lowest public health indicators, demanding that we improve the awareness of the elder population's needs and the challenges they face. This year's report also contains some legislative policy recommendations that identifies needs and sets priorities.

Many organizations throughout Nevada have joined forces to support this valuable data project in order to recognize the needs of elders in our communities. The state's Adult and Disability Services Division has provided the leadership and direction to produce Elders Count Nevada every two years starting this year, 2021.

Please utilize this data book and develop recommendations that will add life to years for Nevada elders.

Sincerely,

Lawrence J. Weiss, Ph.D.
CEO

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Executive Summary

This report was compiled by the Nevada Aging and Disability Services Division, Department of Health and Human Services Office of Analytics, the Center for Healthy Aging, and the Office of Statewide Initiatives at the Nevada University Nevada, Reno School of Medicine.

The vision for Elders Count Nevada (2021) originated with Dr. Lawrence J. Weiss, CEO of Center for Healthy Aging, and former director of the Sanford Center Aging. Determined to keep his vision of giving a voice to Nevada's elders Mr. Weiss convened several meetings to discuss the need for this report, resulting in a collaborative effort led by the Nevada Aging and Disability Services Division (ADSD), to complete the Elders Count Nevada with a commitment to produce the report bi-annually.

The 2021 report utilized data from authoritative sources. The report contains information on key topics: population, economics, health status, health risks and behaviors, health care and infrastructure including a new subsection on workforce related to elder care. The data and information are presented for interpretation and use by the reader. Each section includes data highlights as well as descriptive analysis of the data charts. More advanced statistical analysis would be required for interpreting relationships among variables. This report is supplemented by an online Elders Count Dashboard with additional data elements for analysis.

The Elders Count workgroup made an effort to not duplicate existing specialized reports such as the Nevada Office of Food Security – Nutrition programs for Older Nevadans which focuses on nutrition and food insecurity of older adults in Nevada, or the Guinn Center for Policy Priorities, Helping Hand: An Assessment of the Personal Care Aide Workforce in Nevada.

- http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/GCFS/dta/Publications/Nutrition%20Programs%20for%20Older%20Nevadans(2).pdf
- https://guinncenter.org/publications/policy-reports/

The report contains a set of policy recommendations to improve healthy aging focused on chronic care interventions, caregiver support, mental health support, strengthening protections against elder abuse, housing, employment, transportation and increasing public awareness of healthy aging.

For the purposes of the report, the terms "elder", "senior" and "older adult" have been used interchangeably. In most cases, these terms refer to an individual 65 or older. Data has also been presented by age group categories, 50-64 year old, 65-74, 75-84 and age 85 and older.

Special thanks to the ADSD Planning, Advocacy and Community unit Chiefs, Jeff Duncan and Cheyenne Pasquale for your leadership and management of this project.

Policy Recommendations

The following policy recommendations, submitted by the UNR – Health Resource Research Center and the Nevada Commission on Aging, provide a snapshot of considerations for state agencies and local communities to consider. These recommendations are based on data within this report, as well as national efforts to improve Healthy Aging.

Improving Access to Evidence-Based Chronic Care Interventions

- Programs that target critical issues for the aging population in Nevada should be implemented in a stream-lined manner, making them available to seniors in rural and urban counties across the state. Services should be offered individually to promote self-care and patient engagement through care providers; through senior community centers and other community-based organizations; as well as online. Evidence-Based Program recommendations:
    - Multiple Chronic Conditions: Chronic Disease Self-Management Program, Diabetes Self-Management Program
    - Depression Management: Healthy IDEAS, PEARLS
    - Physical Activity: Enhance Fitness
    - Medication Therapy Management

Increasing Family Caregiver Support

- Provide mental and social support for caregivers through Evidence-Based-Practices and Model Programs selected by the Family Caregiver Alliance. These include programs such as the Caregiver Health Education Program, Coping with Caregiving REACH I, the Caregiving Assistance Network, El Portal, etcetera.
- Develop workplace reimbursement for family caregivers such as Paid Family Leave, Unemployment Insurance for Family Caregivers, and Paid Sick Days.
- Provide workplace caregiver support on the job, such as worker support and educational groups.
- Expand options that reimburse caregivers: VA benefits; Medicaid; Benefits Check Up; Nevada's Personal Care Services Program, caregiver tax credits.
- Promote and enhance Nevada 2-1-1 directory of services to assist seniors and their caregivers to access services and programs in Nevada including: medication management programs; respite care; adult daycare; kinship care; volunteer programs; transportation programs; community centers; senior recreational opportunities; volunteer opportunities; job opportunities; legal resources; etcetera.
- Expand support to caregivers and seniors to provide person-centered assistance in learning about and navigating long term service and support options through Nevada Care Connection.
- Assess caregiver needs and develop a statewide strategy on family caregiving.

Creating Innovative Mental Health Support

- Combatting the risk of social isolation, most notably seniors living in rural areas of Nevada, by targeting the seven specific risk factors: poverty; living alone;

divorced; separated or widowed; never married; disability; independent living difficulty.
- Focus on participatory services which have shown to have a more successful impact compared to providing services or trainings. PEARLS is a recommended evidence-based program which can be conducted in centers, at home, or online.
- Use technology to enhance communication and connectiveness.
- Continuing to fund and expand senior centers and community centers across the state.
- Expanding payor options for delivering mental health support services through a wider range of health professionals.
- Provide evidence-based suicide prevention programs.

Strengthening Protections Against Elder Abuse

- Enhance services to elder abuse victims.
- Support the Investigation and Prosecution of Elder Abuse Cases.
- Establish a research agenda to identify best practices for elder abuse prevention and intervention.
- Expand and continue cross-disciplinary training on Elder Abuse Awareness through ADSD and the Nevada Care Connection.
- Develop a Broad-Based Public Awareness Campaign to increase awareness and understanding of elder abuse in the community.

Housing

- Increase supply of accessible, affordable, adaptable housing, most notably in Northern Nevada and rural areas of the state.
- Programs such as SASH and CAPABLE programs that can be implemented at the local level through partnerships among healthcare and housing providers, nonprofits, and government entities.
- Consider housing initiatives that target divorced, separated, widowed, and disabled seniors living alone.

Employment

- Continue to foster the Senior Community Service Employment Program (SCSEP) to serve low-income individual 55 years and older with part-time community service opportunities.
- Develop innovative responses through community outreach to respond to job loss because of the COVID-19 pandemic.

Transportation

- Continue to engage community partners, and investing in efforts to expand public transportation, volunteer programs, voucher programs, coordinated services, ridesharing, etcetera.
- Developing a Mobility Management Program to guide community partnerships, build infrastructure, and remove the burden from the individual or caretaker of having to navigate the carious transportation options.

Empower Individuals to Develop an Action Plan for Successful Aging

- Provide educational insights for planning through the Aging Mastery Program developed by the National Council on Aging. Key focusses include key aspects of health, finances, relationships, personal growth, and community involvement, leading to improved health, stronger economic security, enhanced well-being, and increased societal participation. Recommend starting outreach efforts 10-years prior to Medicare eligibility.
- Oral health initiatives that include older adults, virtual dental homes within senior centers, integrated care models that encourage cross-professional oral health training are policy recommendations that should be explored to increase health services for older adults especially those within population groups known to experience health disparities.

Develop a Statewide Healthy Aging Campaign

- Increase public knowledge and awareness; community call-to-action; empower older adults and caregivers of their impact on the aging process.
    - Example: Aging Strong Public Awareness Campaign

Population

Nevada's population is spread across its 17 counties, encompassing 110,567 total square miles, making it the 7th largest state in the nation. Nevada has had the highest population growth rate in the nation for the past six decades, and the second highest growth rate for the decade 2010-2020. Census data continues to demonstrate Nevada's extremely high population growth rate. Nevada's population is expected to reach 3.5 million residents by 2032 (Nevada Demographer).

In three states, the age 65 and older population increased 57% or more between 2008 and 2018 (Alaska (69%), Nevada (57%), Colorado (57%) (A Profile of Older Americans: 2019) .

Highlights

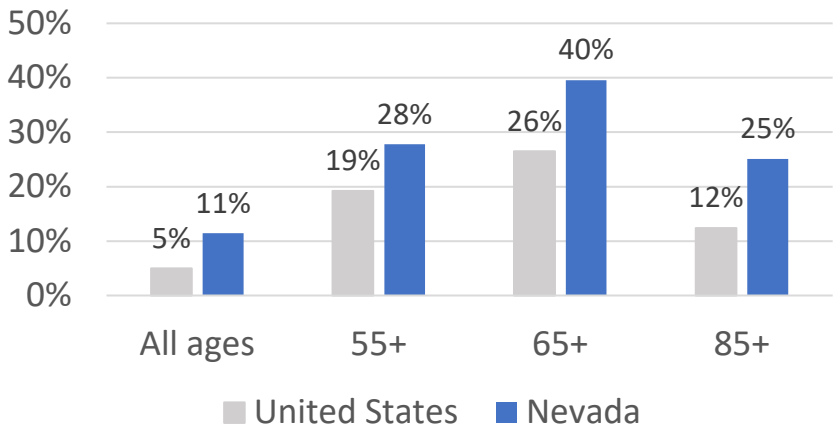
- Nevada continues to see higher growth rates in the population of older adults as compared to the rest of the U.S. (Fig. 1).
- These trends are expected to last into 2030. The continued growth of the age 55 to 64 continues to increase and will impact available resources (Fig. 2).
- The population by county shows the proportion of population aged 65 and older by county (Fig.3).
- While a higher number of older adults reside in urban areas, rural/frontier counties have a population that is older, with a higher per capita of older adults generally (Fig.4).
- Migration to Nevada by older adults continues to increase, particularly in Southern Nevada. The largest group migrating to rural communities is in the 55-64 range, indicating a larger percentage of older adults in those communities in the next 5-10 years. (Fig. 5).
- Over the next 25 years, the older adult population will continue to increase as evidenced by the swell of the population in their 30's (Fig. 6).
- The Nevada population has higher rates of individuals who are Hispanic or Asian as compared to national figures (Fig. 7).
- In southern Nevada, the rates of individuals who are limited English speaking is nearly double the national rate (Fig. 8).
- 14.3% of people 65 and older live alone in Nevada (Fig. 9).
- Nevada has a higher percentage of older adults who are divorced or separated than the national average (Fig. 10).
- On average, Nevada grandparents living with their own grandchildren follows national trends, although in southern Nevada this trend is higher than the national statistics (Fig. 11).
- In 2019, Republican voter registrations were higher for the older populations (Fig. 12).
- There is a higher prevalence of veterans in Southern areas of Nevada for both Male and Female veterans (Fig. 13).

Population Growth and Projections

Between 2011 and 2018 Nevada population increased by 11.42% (American Community Survey; Table:B01003) with the 65 and older population increasing by 40% and the 85 and older population increasing by 25%. In addition, the 55 and older population, which is aging into the Medicare eligible population, increased 28% (Fig.1).

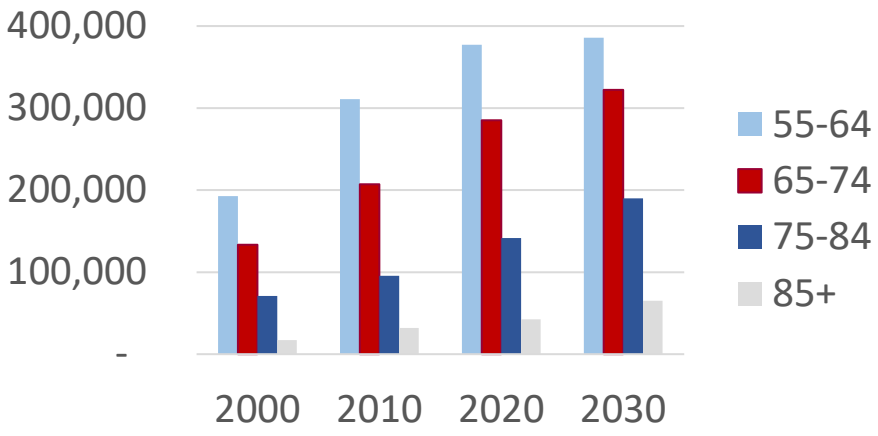
Nevada's growth rate for the age 85 and older population is double the national rate. In fact, Nevada's population is expected to continue to age at higher rates through 2030 (Fig. 2).

FIGURE 1: % GROWTH IN SENIOR POPULATION, 2011-2018



(Source: U.S. Census; American Community Survey 2011 1-Year Estimates, Table S0101; American Community Survey 2018 1-Year Estimates, Table S0101)

FIGURE 2: NV POPULATION GROWTH: YEAR BY AGE



(Source: Nevada State Demographer)

Population by County

Nevada's 14 most rural counties comprise approximately 87% of Nevada's land mass but only 10% of Nevada's total population, with an approximate average population of two (2) persons per square mile. This creates the anomaly that Nevada is one of the most geographically under-

populated states, with a population that is so concentrated as to make it also one of the most urbanized.

For the 65 and older population, the three Urban Counties (Carson City, Clark County, and Washoe County) comprise 87% of the Nevada's 65 and older population, while the other 14 counties comprise 13% (Fig. 3).

Over half of Nevada's counties (9 out of 17) have a 65 and older population over 19%, the remaining seven counties still have a high percentage of its population 65 and older ranging from 13% to 16%.

It should be noted, in some counties, the total population includes prison inmates so the percent of older adults in those counties may be understated, for example Pershing county has an inmate population of 1,685.

FIGURE 3: NV SENIOR POPULATION BY COUNTY, 2018

Geography	Age 65 and Older	
	Population	% of Total
Carson City	11,684	21%
Churchill County	4,067	16%
Clark County	297,833	13%
Douglas County	13,263	27%
Elko County	7,262	14%
Esmeralda County	265	27%
Eureka County	358	19%
Humboldt County	2,209	13%
Lander County	955	16%
Lincoln County	1,129	22%
Lyon County	11,121	20%
Mineral County	1,014	22%
Nye County	12,954	28%
Pershing County	1,034	16%
Storey County	1,231	30%
Washoe County	70,350	15%
White Pine County	2,019	19%
Nevada	438,748	14%
United States	52,346,789	16%

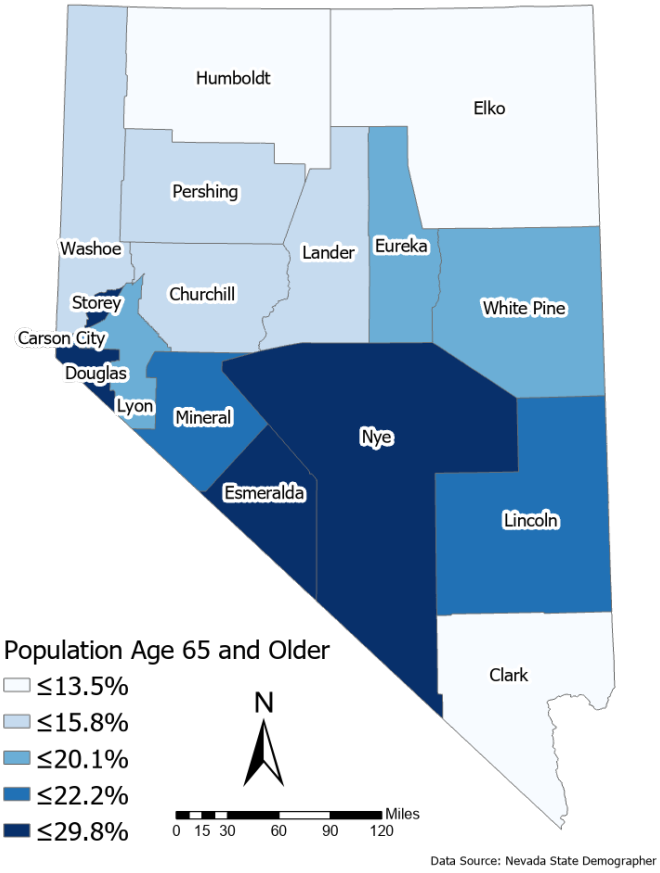
(Source: Nevada State Demographer; U.S. Census QuickFacts)

While a larger percent of older adults resides in urban areas, rural/frontier counties tend to have an older population, with a higher per capita of older adults (Fig. 4). This trend continues from the 2013 report.

Nevada rural areas can be several hours from its urban area, and sometimes the closest urban area may be in another state. For example, the city of Elko is 289 miles from Reno (4-hour drive) and 230 miles (3.25-hour drive) to Salt Lake City, Utah. An additional point is that Elko is still 109 miles from the Utah state line.

Rural areas historically lack access to critical services for older adults, most notably healthcare services, and transportation services. With populations continuing to age at rates higher than the national average, Nevada will have continued challenges in ensuring this population has access to these traditionally, highly utilized services by older adults.

FIGURE 4: NV % OF SENIOR POPULATION BY COUNTY, 2018

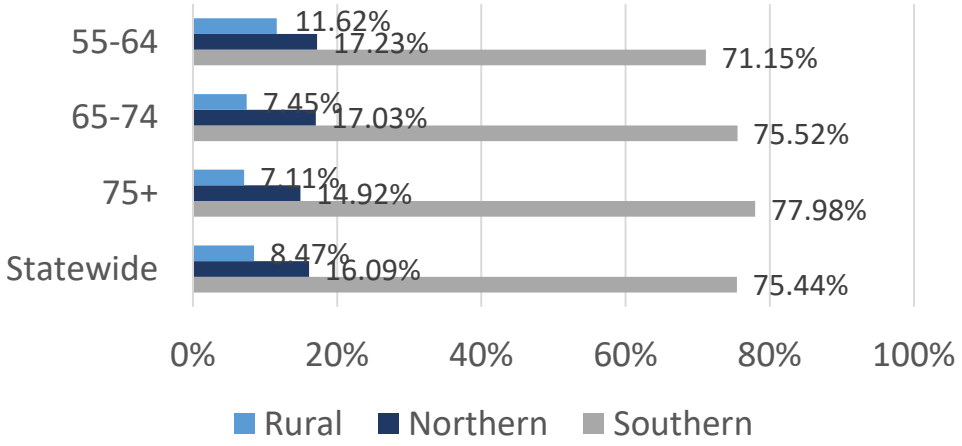


Migration

Migration to Nevada by older adults continues to increase, particularly in Southern Nevada (Fig. 5). This also continues to exacerbate Nevada's population imbalance, where currently 73% of Nevada's population resides in Clark County. The largest older adult group migrating to rural communities is in the 55-64 range, indicating a larger percentage of older adults in those communities in the next 5-10 years. For the past three years, migration into Nevada has

remained relatively consistent with approximately 140,000 new residents each year (American Community Survey, Table S0701).

FIGURE 5: NV MIGRATION BY AGE AND AREA

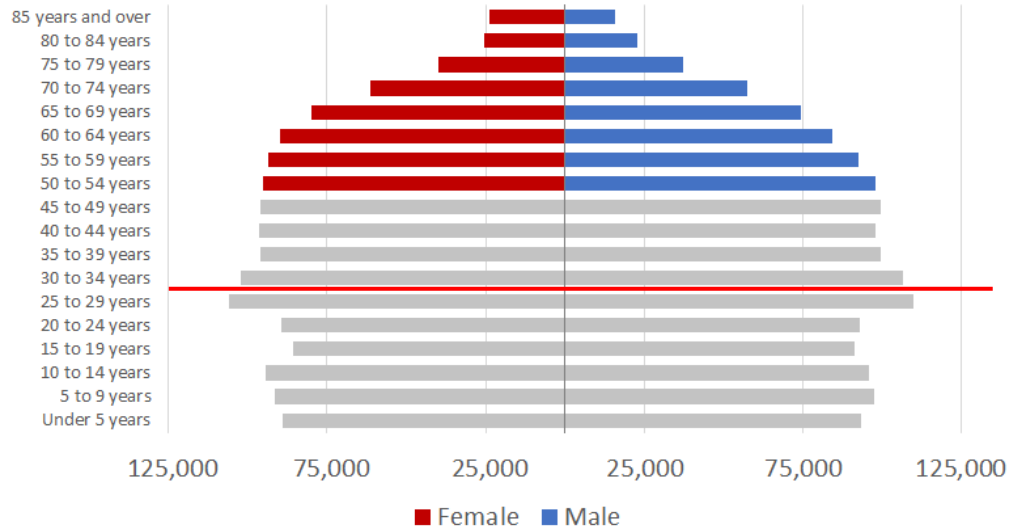


(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table S0701)

Gender and Age Distribution

Gender distribution follows life expectancy trends, where females tend to live longer than males. In the age groups under age 64, males and females each make up approximately half of the population, with a slightly higher female rate at the national level, reflecting national trends (American Community Survey, Table S0101). As age increases, the 64-84 population distribution of females increases. In Nevada, the difference between percent of males and females is slightly less than national difference, still reflecting national life expectancy trends.

FIGURE 6: NV AGE AND GENDER DISTRIBUTION, 2018



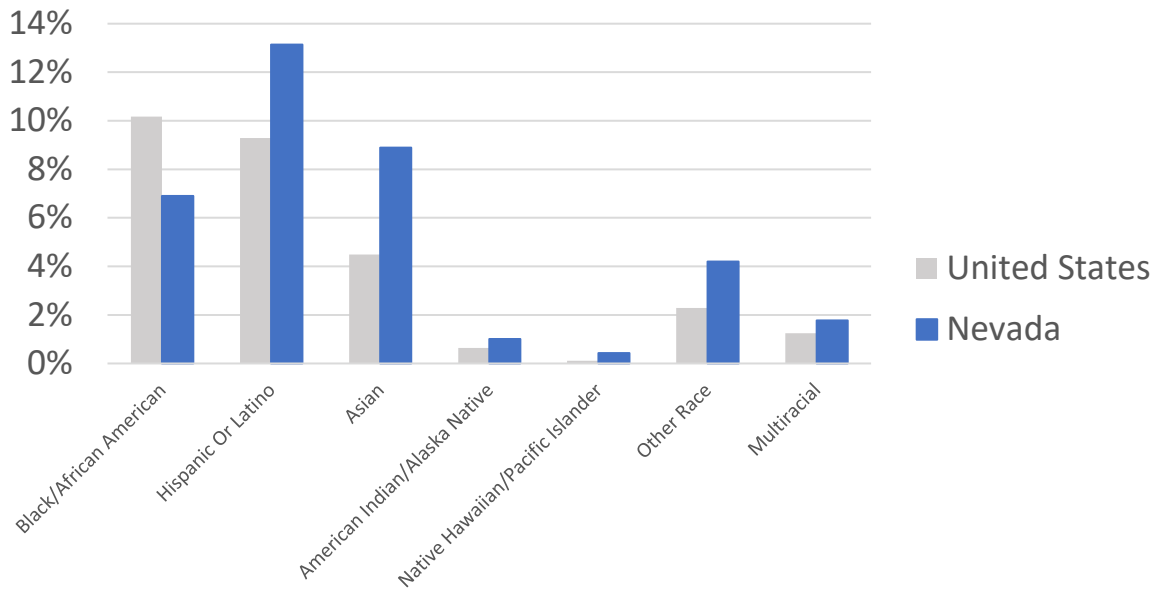
(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table S0101)

The above chart demonstrates age group distribution in 5-year cohorts, based on 5-year estimates within the American Community Survey (Fig. 6). Individuals in each age cohort will age into the next age cohort, with life expectancy aging trends. This gives a projection, all things being equal, for how to anticipate an aging population. While we are experiencing a swelling of the older adult population now, because of the baby boomer generation, there is predicted to be another swell based on the 25-34 age cohorts.

Race and Ethnicity

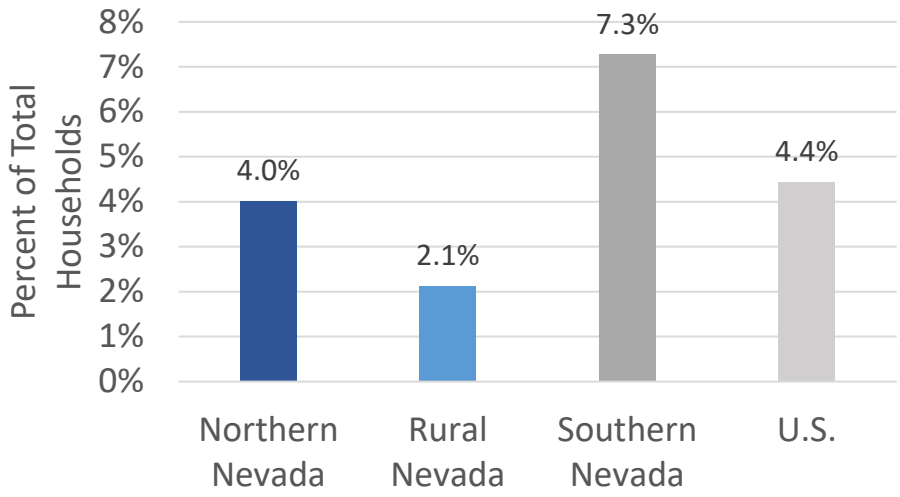
Overall Nevada's population is more diverse than nationally. Where only 68.5% of Nevada's population is White, the national average is 74.5% White. Nevada has a higher portion of minorities in all categories except for Black or African American. Populations such as Hispanics and Asians are significantly higher than the national average in Nevada (Fig. 7). Additionally, in southern Nevada, the rates of individuals who are limited English speaking is nearly double the national rate (Fig. 8). Limited English-speaking individuals will have a greater challenge in accessing information and services to meet their needs.

FIGURE 7: RACE AND ETHNICITY, AGE 55 AND OLDER



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B01001, B01001 A-I)

FIGURE 8: NV LIMITED ENGLISH SPOKEN AT HOME



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table S1602)

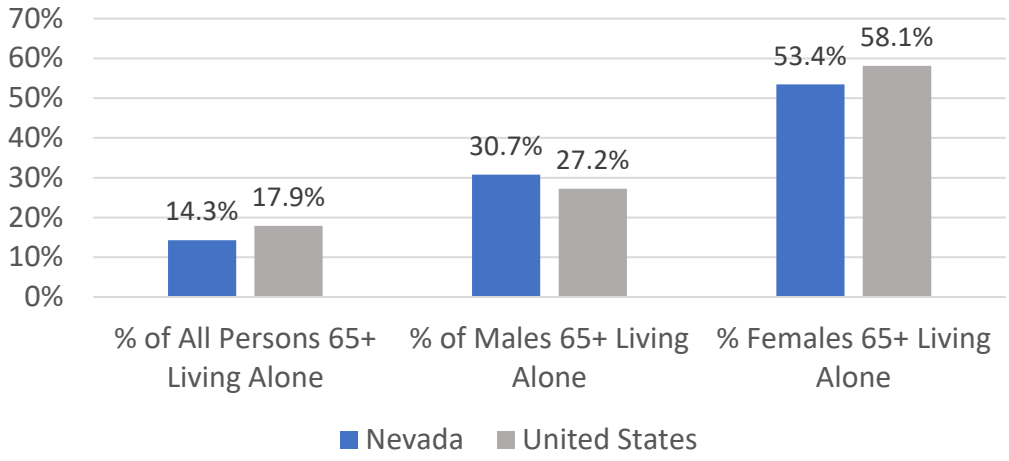
Education

Most adults, age 55 or older have limited higher education backgrounds, with rural areas being the lowest (American Community Survey, Table B15001). Northern seniors are more likely to have a bachelor's degree or higher than southern and rural counterparts.

Living Arrangements

In Nevada, 14.3% of the people who live alone are age 65 or older. Of that, 53.4% are females compared to 30.7% of males. There are slight differences from the national averages, with Nevada males trending higher and Nevada females trending lower (Fig. 9). These trends are going down from the 2013 estimates, where in Nevada the total percent of people living alone who is 65 and older was 24.6%.

FIGURE 9: LIVING ALONE, AGE 65 AND OLDER



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B09020)

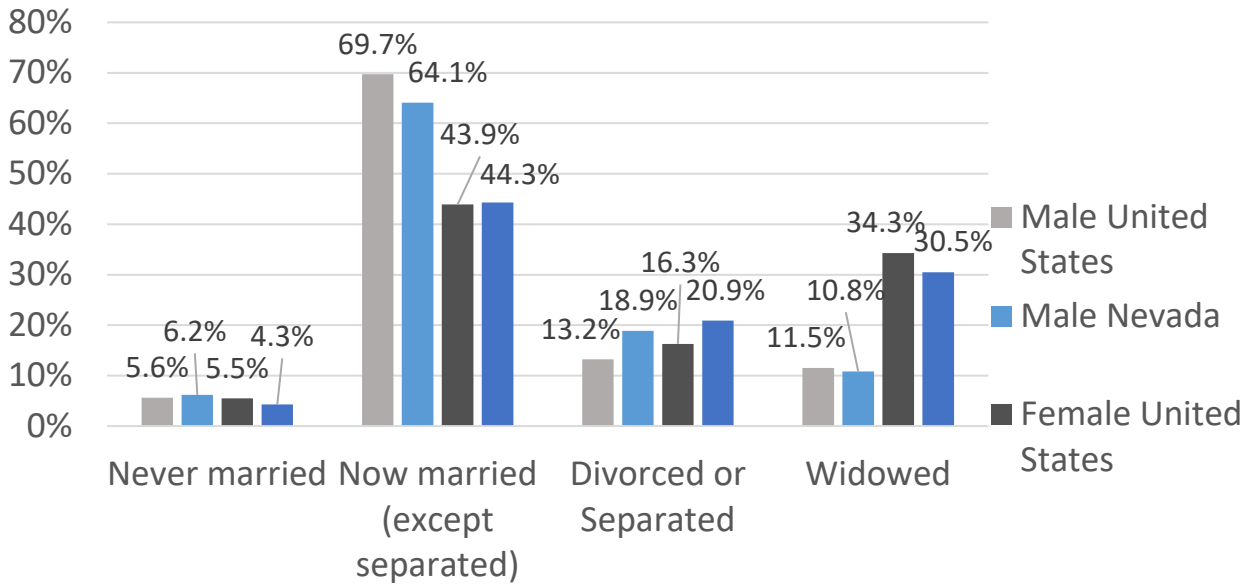
Marital Status and Grandparenting

For the most part, Nevada trends for adults aged 60 and older for *Nevada Married*, *Now Married*, *Divorced* and *Widows* follow national trends (Fig. 10). In Nevada, for males, *Now Married* is slightly less than the national average as is *Widowed*. For females, *Widowed* is slightly less than the national average.

An interesting note is Nevada has a higher divorced (or separated) rate than the national average. And both nationally, and in Nevada, females have a much higher prevalence of *Widowed* than their male counterparts. These rates also coincide with the number of individuals age 65 and older living alone, as noted above.

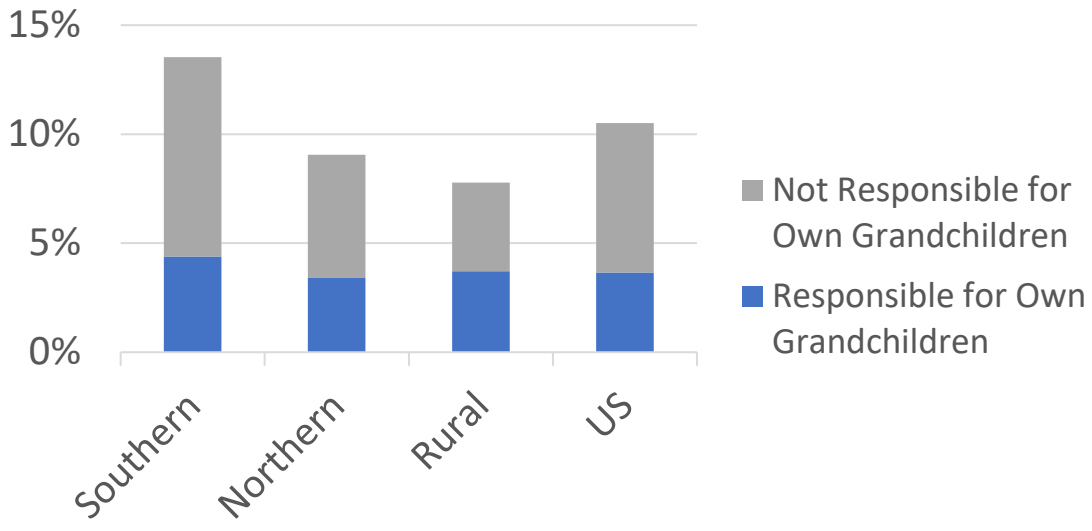
On average, Nevada grandparents living with their own grandchildren follows national trends, although in southern Nevada this trend is higher than the national statistics (Fig. 11). While most grandparents are not responsible for their own grandchildren, we know multigenerational households are trending upwards, creating greater need to address familial challenges and compound caregiving in Nevada.

FIGURE 10: MARITAL STATUS, AGE 60 AND OLDER: LOCATION BY SEX



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table S1201)

FIGURE 11: % GRANDPARENTS LIVING WITH THEIR OWN GRANDCHILDREN



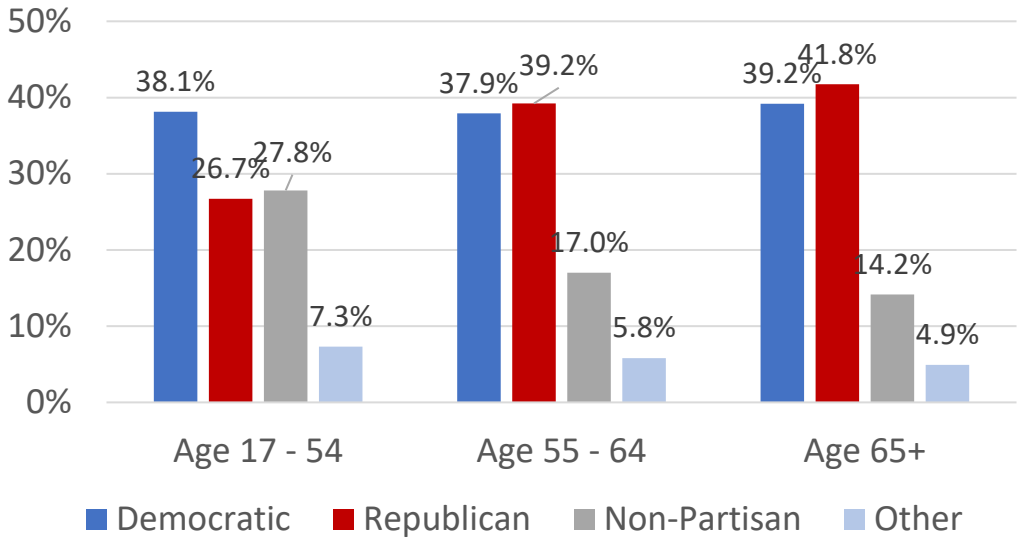
(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B10051)

Voter Registration

Voter registrations can vary depending on the political environment. In 2019, Republican voter registrations were higher for the older populations. In addition, the older populations more consistently registered for either Republican or Democrat than for Non-partisan or Other.

The younger generation, registered Non-partisan or Other 35% of the time whereas the older generation was between 19% for 65 and older and 23% for 55-64 (Fig. 12).

FIGURE 12: NV VOTER REGISTRATION, 2019



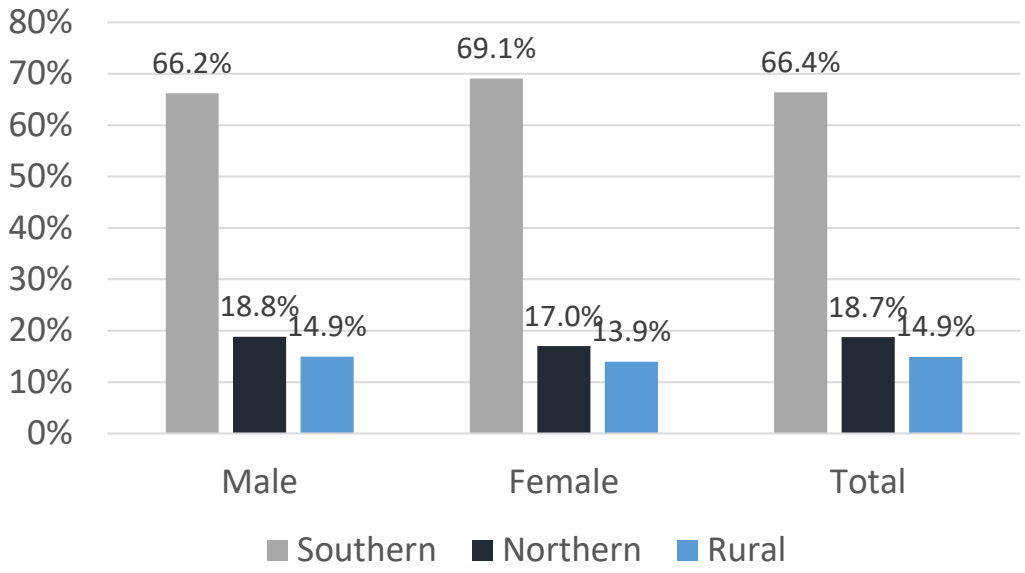
(Source: Nevada Secretary of State, Voter Registration Statistics)

Veterans

There is a higher prevalence of veterans in Southern areas of Nevada for both Male and Female veterans. However, when compared to the population dispersion (73% of Nevada's population resides in Clark County) there are less than expected despite both Nellis and Creech Air Force Bases (Fig. 13).

When looking at the age breakdown, the higher prevalence in Southern Nevada correlates with the younger cohorts (18-34; 35-54). Northern and Rural Nevada have a higher prevalence for those 65 and older, following general population trends noted earlier in this report.

FIGURE 13: NV VETERANS, SEX BY LOCATION



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B21001)

Strategies

This space is intentionally left blank to note strategies, policy considerations, or action steps.

Economics

Many Nevadans face economic challenges as they age. These challenges stem from fixed incomes, higher healthcare costs, and the rising rate of inflation. This section evaluates the impact of economic conditions on older Nevadans, highlighting poverty levels, income, and rising housing costs.

Highlights

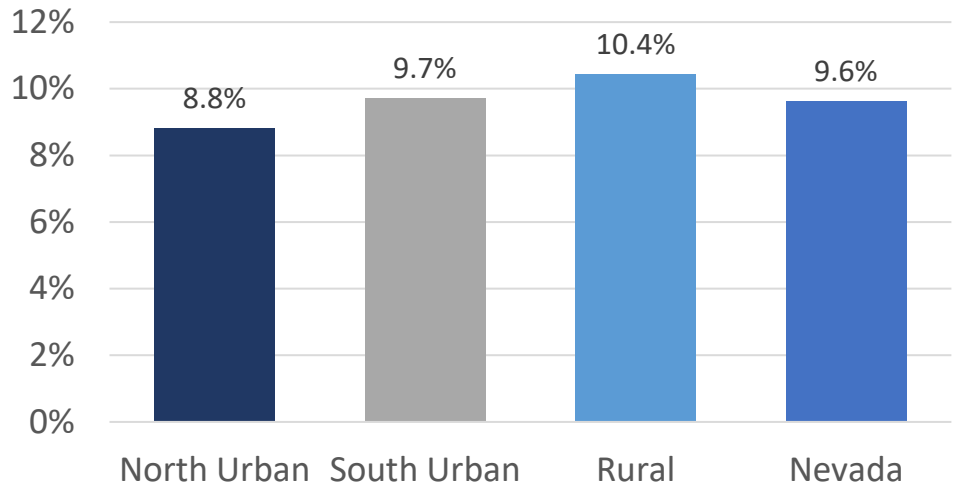
- The poverty rate among Nevadans aged 65+ is lower than for other age ranges but is likely to increase in the future as individuals living in poverty age (Fig. 14).
- Social Security Benefits are the primary source of income for many older adults, leading many to stay in the labor force as they age (Fig. 15 and 16).
- Housing and transportation are the largest categories of expenditures for individuals age 65+ (Fig. 18).
- Homelessness in a growing problem in northern Nevada as housing costs increase (Fig. 19)

Poverty

In 2018 approximately 12.8% of Nevadans were living in poverty (American Community Survey, Table B17017). These Nevadans face significant challenges in meeting their daily needs including food, housing, and medical care. The U.S. Census Bureau defines annual poverty thresholds based on age and household composition. For an individual aged 65 and over, the poverty threshold was $12,043 in 2018. Data from the U.S. Census Bureau's American Community Survey indicate 9.6% of Nevadans age 65 and over fell below this poverty threshold (Fig. 14). Nevada's rate was slightly higher than the national average of 9.3% of individuals age 65 plus (American Community Survey, Table S1701). Nevada's percentage is likely to increase in the future because 11.8% of the 45 to 64 age group currently falls under the poverty threshold; many of the financial challenges faced by this age group may continue into their later years. These financial stressors may increase the demand for public services such as healthcare and long-term services and supports.

Figure 14 provides an additional breakdown of individuals aged 65 plus that fall under the poverty threshold. The Rural region of Nevada has the highest share of older adults in poverty at 10.4%. The Southern Urban region is next at 9.7%. The Northern Urban region has the fewest individuals age 65 and above that fall under the poverty threshold (8.8%).

FIGURE 14: NV % OF HOUSEHOLD WITH HOUSEHOLD AGE 65 AND OLDER LIVING IN POVERTY

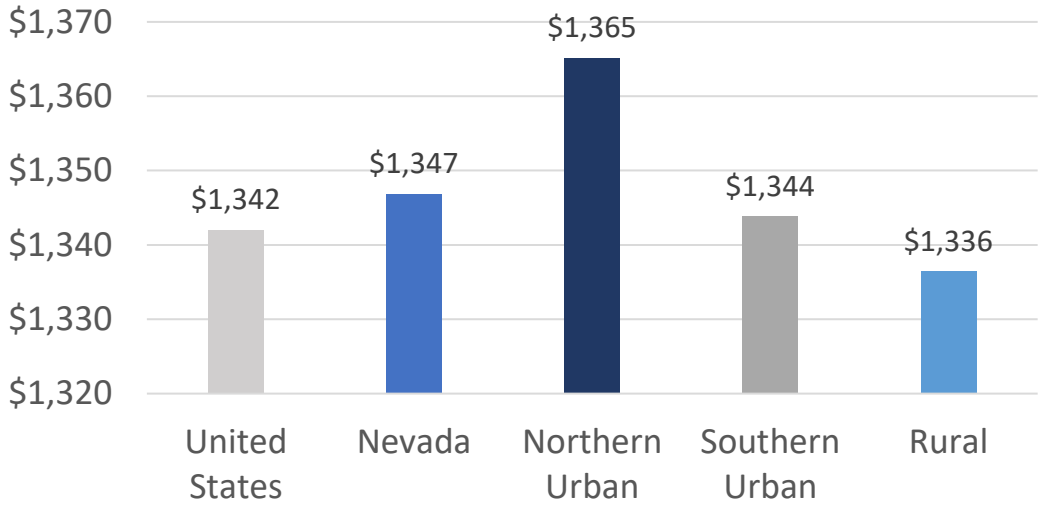


(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B17017)

Social Security Benefits

Social Security Benefits serve as a major source of income for older adults. For one in four seniors, Social Security provides at least 90 percent of their income (Center on Budget and Policy Priorities). The average Social Security payment for Nevadans is $1,347, approximately five dollars above the average for the United States (Fig. 15). Note that Nevada does not have a personal income tax and therefore Social Security Benefits are untaxed in the state, allowing retirees to retain more of their benefits.

FIGURE 15: AVERAGE SOCIAL SECURITY PAYMENT, AGE 65 AND OLDER BY REGION, 2019

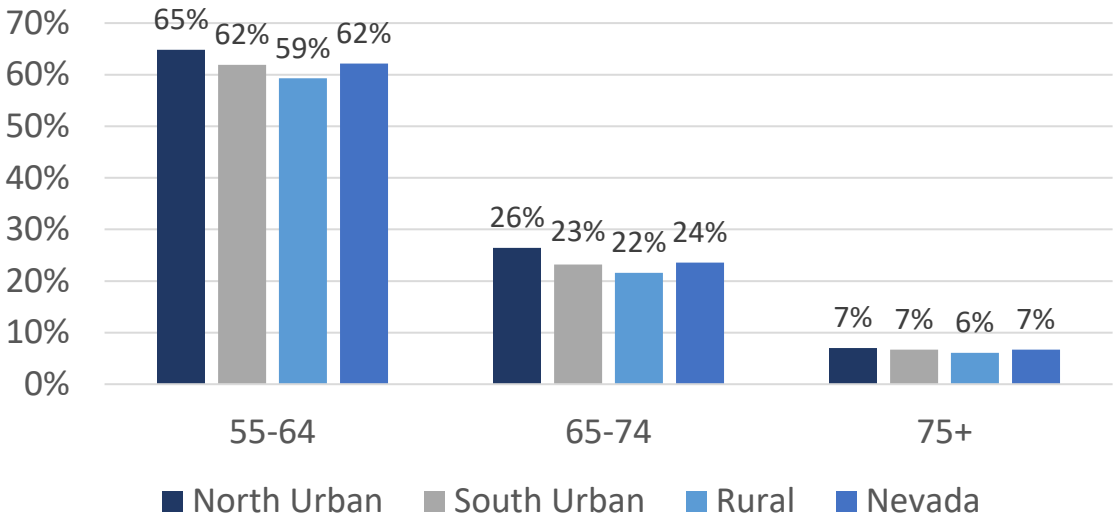


(Source: Social Security Administration - Old age, survivors, and disability insurance (OASDI) program)

Labor Force Participation

Nearly a quarter of Nevadans aged 65-74 years old and 7% over age 74 continue to participate in the labor force (Fig. 16). More than six out of ten people aged 65-85 who remain in the labor force indicate that they are working into retirement purely for financial reasons (Mercado). A separate study found that about 30% of individuals who plan to continue working beyond age 65 will do so to maintain their health benefits (Mercado). Others continue working for personal reasons such as still enjoying working and working to fill time or avoid loneliness (Provision Living).

FIGURE 16: NV LABOR FORCE PARTICIPATION BY AGE GROUP AND REGION, 2018

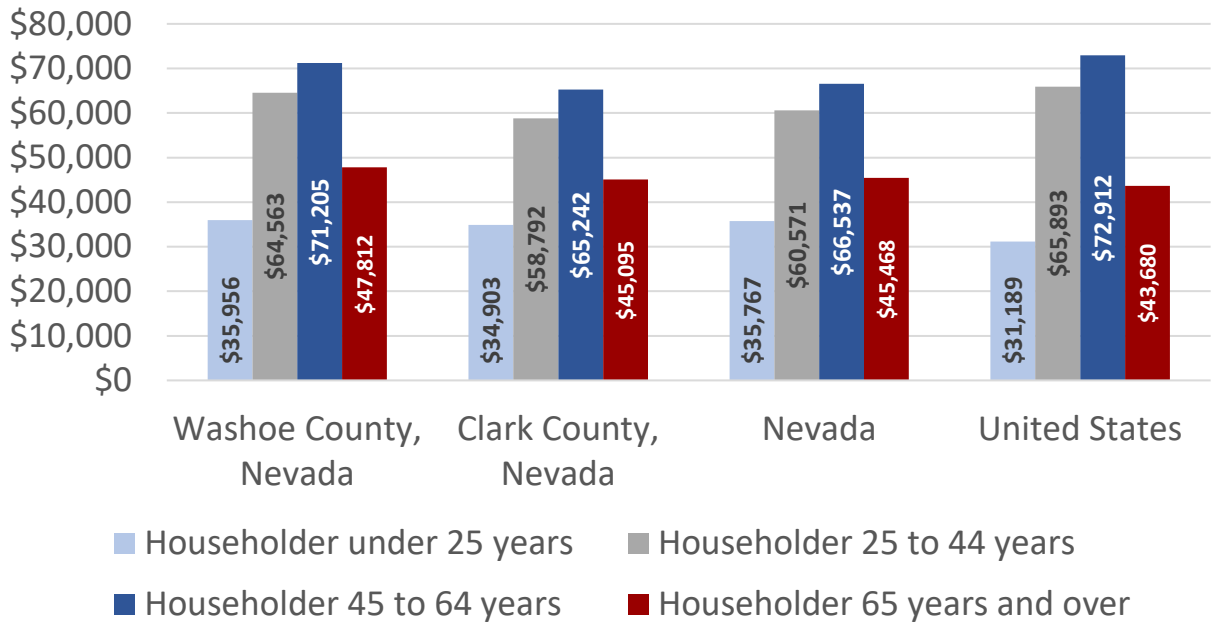


(Source: U.S. Census Bureau, American Community Survey, 2018 5-Year Estimates, Table B23001)

Household Income

Nevada's median household income varies significantly by the age of the householder. For householders age 65 years and over, the median household income in Nevada is $45,468 (Fig. 17). This figure is approximately 4% higher than the median for the United States as a whole. There are some regional differences in household income, with Washoe County incomes for this age range coming in approximately 6% higher than in Clark County.

FIGURE 17: MEDIAN HOUSEHOLD INCOME BY AGE OF HOUSEHOLDER



(Source: U.S. Census; American Community Survey 2018 5-Year Estimates, Table B19049)

Assets

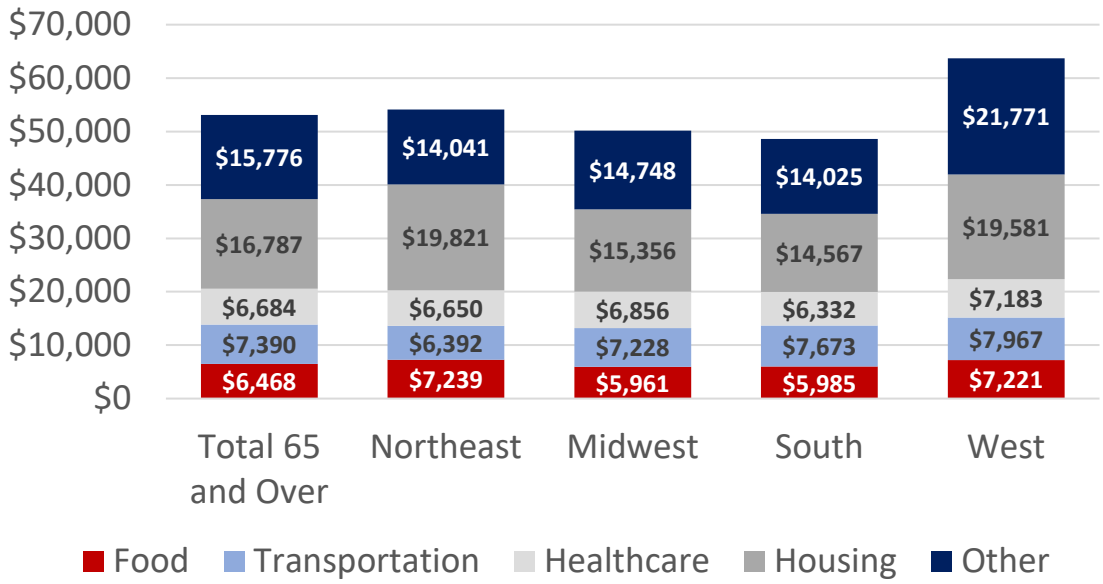
In addition to income assets are important for helping families get through hard times and changing circumstances. Net worth is defined as assets minus liabilities. Assets include things like retirement accounts, stock holdings, and real estate while examples of liabilities are unpaid loans and credit card debt. According to the Federal Reserve's Survey of Consumer Finances, median inflation adjusted net worth for families headed by a person aged 65-74 grew by 9% between 2010 and 2019, reaching approximately $266,000 in 2019 dollars. This growth in net worth provides financial stability for families and helps them get through unforeseen circumstances. For families headed by individuals age 75 and over, the median net worth remained stable at $255,000 during this time.

Expenditures

In the western region of the United States, housing is the largest component of household expenditures for individuals aged 65 and older, making up 34% of their spending – this aligns with the national average of 34% (Fig. 18). Transportation is next at 14%, followed by healthcare and food (both at 12%). Other expenditures combine to make up the remaining 27%. The largest

of these include personal insurance and pensions (7%), cash contributions (7%), entertainment (6%), and apparel and services (2%).

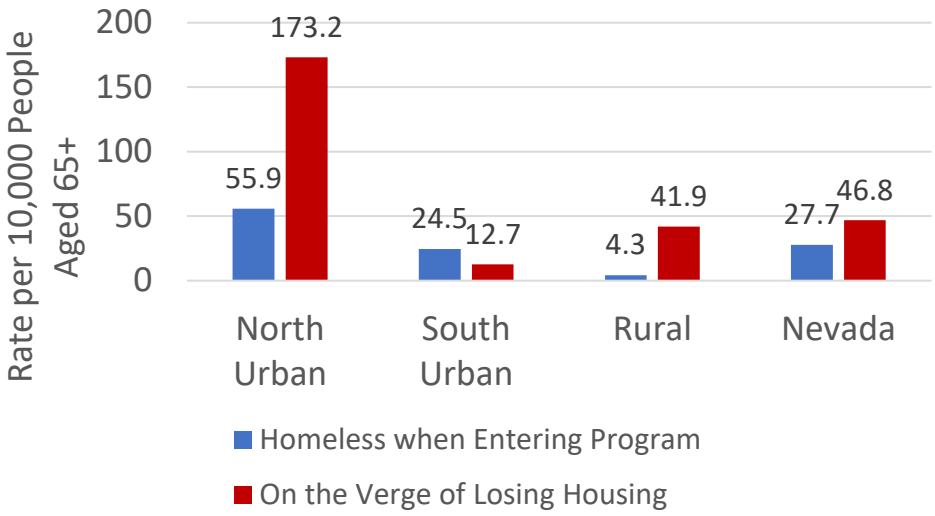
FIGURE 18: AVG ANNUAL EXPENDITURES WITH HOUSEHOLDERS AGE 65 AND OLDER, BY U.S. REGION



Housing and Homelessness

Rising rents, challenging economic conditions, and behavioral health or substance abuse issues contribute to the state's growing homelessness situation among older individuals. Throughout Nevada, the average rate of homelessness (when entering programs) is 27.7 people per 10,000 for individuals age 65 and older (Fig. 19). Additionally, an average 46.8 individuals age 65 and older per 10,000 are on the verge of homelessness. The rates of individuals on the verge of homelessness in northern urban Nevada is over three times that amount, at a rate of 173.2 individuals per 10,000. The growth of industry in northern urban Nevada, including the influx of population has raised housing rates in recent years. This impact has been felt especially by older adults living on fixed incomes.

FIGURE 19: NV PREVALENCE OF HOMELESSNESS OR RISK OF HOMELESSNESS FOR ADULTS 65 AND OLDER



(Source: Homeless Management Information System, 2019)

Strategies

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Health Status

The life expectancy of people in the United States increases by age. Based on the National Vital Statistics Reports (2017), by age 65 the average life expectancy for males is 83 and for females it is 85.6. By age 85, the life expectancy for males increases to 90.9 and for females is 92.

While increases in limitation to perform activities of daily living may be a "normal" part of the aging process, Nevada's health status in other areas compound these issues and are important to note for planning and policy reform, particularly given the percentage of older adults living alone in Nevada (page 16).

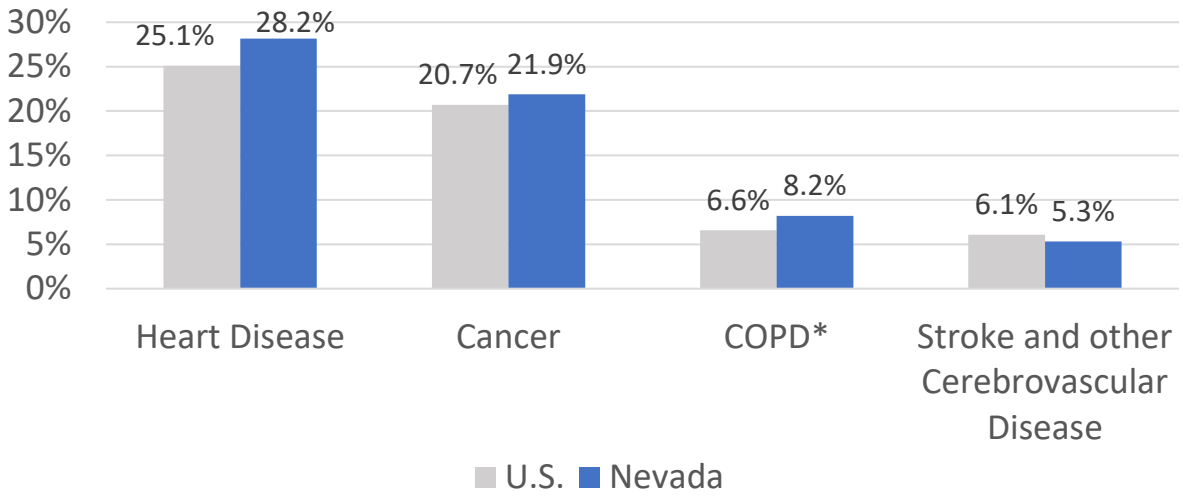
Highlights

- The percentage of deaths related to heart disease and cancer is slightly higher in Nevada than the U.S. averages (Fig. 20).
- In Nevada, 66.4% of older adults report having had any permanent tooth removed (Fig. 21).
- In 2018, Older adults having lost 6 or more teeth, 39.5% report the loss was due to tooth decay or gum disease (Fig. 22).
- Of individuals age 55 and older, the prevalence people accessing mental health services is highest for individuals that have less than a high school education, constituting 35% of the people who have experienced at least one mental health day per month (Fig. 23).
- In 2019, the rate of adults 65 and older accessing mental health treatment was 90% lower than the 55-64 age group (Fig. 24).
- People age 65 and older have fewer mental health treatments as compared to the younger age group (Fig. 25).
- In Nevada, the rate of suicide among older adults is significantly higher than the U.S. rate (Fig. 26).
- The percentage of veterans who report thoughts of suicide is surprisingly low (Fig. 27).

Mortality (Causes of Death)

According to the National Center for Health Statistics, heart disease has been the leading cause of death in the U.S. for decades, followed by cancer. This remains true in Nevada, with the percentage of deaths related to heart disease and cancer slightly higher in Nevada than the U.S. averages (Fig. 20). Other chronic conditions, including Chronic Obstructive Pulmonary Disease (COPD) and Strokes round out the leading causes of death for older adults in Nevada. The prevalence of chronic disease in Nevada highlights the danger of these conditions when left untreated. While there are low rates of disease among older adults, the mortality rate from them is nearly double the rates. Health Risks and Behaviors will be explored further in the next section.

FIGURE 20: LEADING CAUSES OF DEATH, AGE 65 AND OLDER, 2017



*Chronic Obstructive Pulmonary Disease

(Source: Centers for Disease Control and Prevention)

Disability

As people age their disability status increases with approximately 50% of the population in Nevada having a disability after age 75. Interestingly, females show a higher percentage of disability over males at the age of 75 and older, although the opposite is true for the age group 65-74 (American Community Survey, Table: B18101). Along these lines, the rates of hearing and vision difficulties nearly double in both females and males after age 75, as compared to the rates for the 65-74 age group (American Community Survey, Table: B18101). Increased disability, vision difficulty and hearing difficulty all increase the need for supports as people age.

Although the rates of disability increase as people age, it is interesting that overall, the age group of people 55 and older reports less limitation in the ability to work in higher income groups (BRFSS). Additionally, based on data from the American Community Survey 2018, the percentage of older adults with a disability is higher in rural Nevada than in urban areas of Nevada.

Oral Health

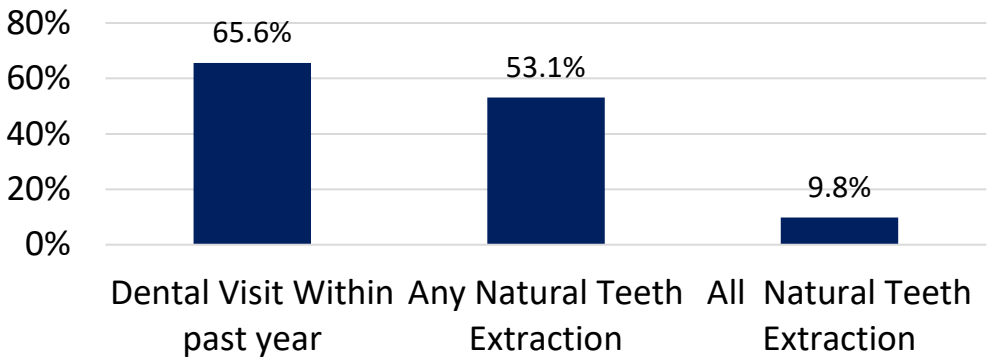
Poor oral health undermines overall health and well-being. Poor oral health, which includes experiencing dental decay, periodontal disease (infections of the bone surrounding teeth and

gums), and lesions in the head and neck have been linked to malnutrition, heart disease, diabetes, oral cancer, and aspiration pneumonia, a leading cause of hospital readmission in older adults (Terpenning). In a practical sense, poor oral health makes it difficult to speak or chew nutritious foods, can lead to infection, exacerbate chronic conditions, impact quality of life, and affect self-esteem. Optimal health cannot be achieved without maintaining good oral health.

In Nevada, the 2018 CDC Behavioral Risk Factor Surveillance System indicates that 66.4% of adults 65 years and older report having had any permanent tooth removed (Fig. 21). Moreover, the trend of tooth decay and loss in older adults in Nevada is moving in an unfavorable direction. In 2016, 33.4% of adults aged 65+ reported having lost six or more teeth due to tooth decay or gum disease and in 2018 this number grew to 39.5% (Fig. 22).

Lack of universal dental coverage, high out-of-pocket expenditures, lack of transportation, fear of the dental office, gaps in health literacy, and lack of understanding of the importance of oral health create barriers to care for older adults. Inadequate access to oral health care leads to a compromised oral health status and often results in exorbitant hospital emergency department visits. According to the Department of Health and Human Services, Office of Analytics, non-traumatic dental emergency department encounters for individuals 45 and older constitute 23% of cases and Medicaid is the predominant payer source of for these services.

FIGURE 21: NV ORAL HEALTH, AGE 55 AND OLDER, 2018



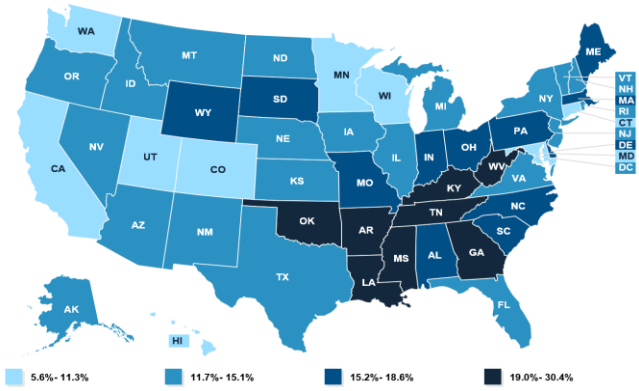
(Source: Behavioral Risk Factor Surveillance System)

Disparities in functional dentition (≥21 teeth) in U.S. adults has doubled in the past two decades.

FIGURE 22: EDENTULISM OR TOTAL TOOTH LOSS, 65 AND OLDER, 2016

Declining Edentulism (**18%**), but disparities remain among lower income adults (**34%**)

This disproportionately affects some adults based on ***where*** they live

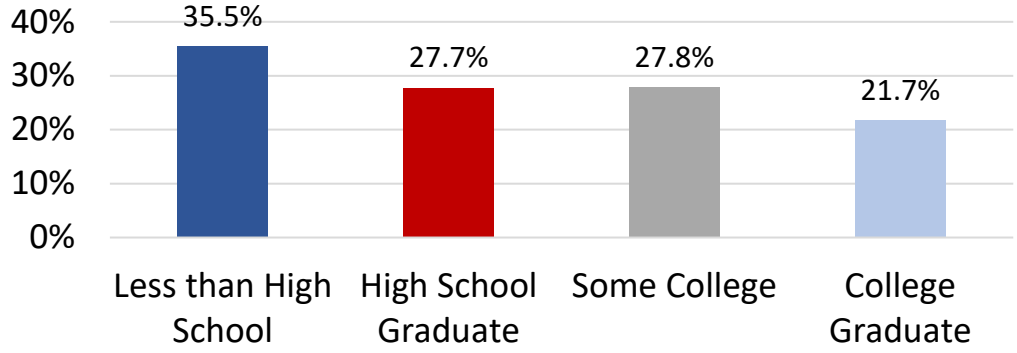


Source: Kaiser Family Foundation analysis of the Center for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2016 Survey Results. Accessed on April 10, 2019.

Mental Health

According to the 2020, America's Health Rankings Report, depression in adults in Nevada continues to increase. Approximately 11.9% of older adults, age 65 and older report depression. Overall, this is slightly less than the U.S. total of 14.7%, although the rate of increase is faster in Nevada than the U.S. Of individuals age 55 and older, the prevalence people accessing mental health services is highest for individuals that have less than a high school education, constituting 35% of the people who have experienced at least one mental health day per month (Fig. 23).

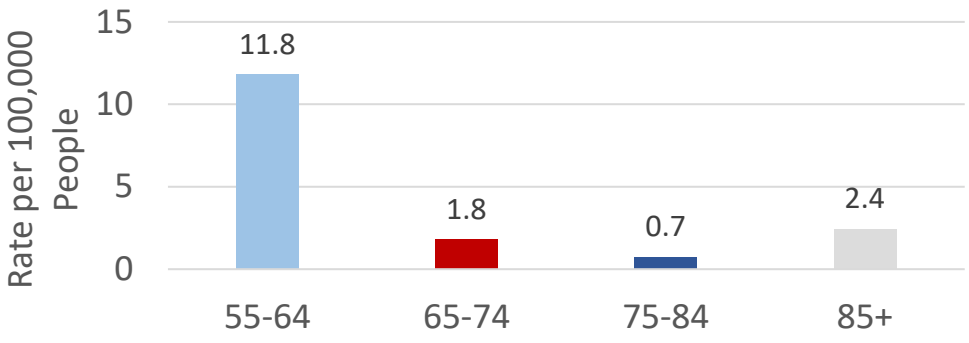
FIGURE 23: NV AT LEAST ONE MENTAL HEALTH DAY PER MONTH, AGE 55 +,2018



(Source: Behavioral Risk Factor Surveillance System)

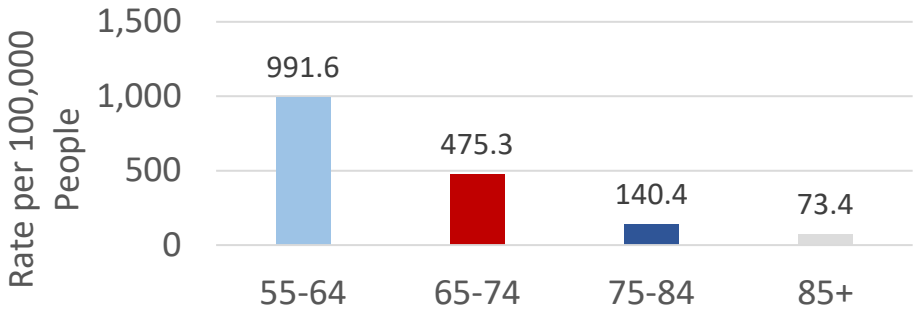
Nevada ranks 25th in the nation for risk of social isolation in adults age 65 and older. The America's Health Rankings Report uses the following risk factors to determine social isolation risk: disability, marital status (divorced, separated, or married), independent living difficulty, living alone, never married, and poverty. Isolation and loneliness lead to greater rates of depression (11.9% of older adults in Nevada), however factors such as transportation, income, and access to services limit people's ability to access mental health treatment. In 2019, the rate of adults 65 and older accessing mental health treatment was significantly lower than the 55-64 age group (Fig. 24). Additionally, people age 65 and older have fewer mental health treatments as compared to the younger age group (Fig. 25).

FIGURE 24: NV PEOPLE RECEIVING MENTAL HEALTH TREATMENT, 2019



(Source: Avatar, Nevada State Demographer)

FIGURE 25: NV MENTAL HEALTH TREATMENTS, 2019

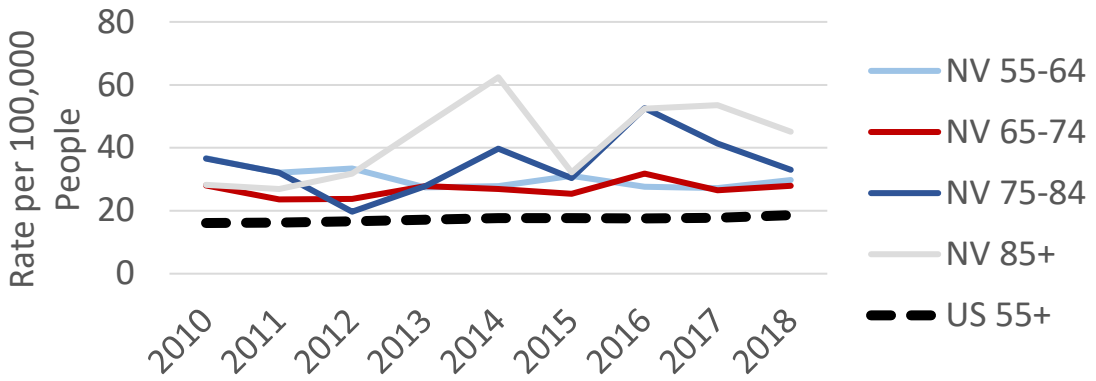


(Source: Avatar, Nevada State Demographer)

Suicide

Suicide is a continuing risk across all populations in the U.S., with an estimated attempt of suicide happening every 27 seconds. In Nevada, the rate of suicide among older adults is significantly higher than the U.S. rate (Fig. 26). Factors such as high risk of social isolation, economic concerns, and overall health status of older adults lead to high rates of suicide. According to the 2020 America's Health Ranking report, Nevada has the highest suicide rate among people age 65 and older.

FIGURE 26: SUICIDES BY AGE GROUP, 2010-2018

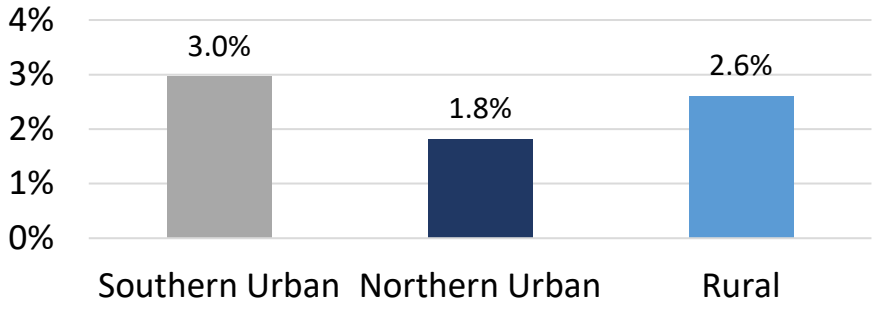


(Source: Nevada Electronic Death Registry System (EDRS), Nevada State Demographer; Centers for Disease Control and Prevention - WONDER Online Database)

Veterans

In Nevada the percentage of veterans who report thoughts of suicide is significantly low, although the rate of attempted suicide is high within this group (Fig. 27).

FIGURE 27: NV VETERANS, THOUGHT OF SUICIDE IN PAST YEAR, AGE 55 AND OLDER, 2018



(Source: Behavioral Risk Factor Surveillance System)

Strategies

This space is intentionally left blank to note strategies, policy considerations, or action steps.

Health Risks and Behaviors

The health of a population is dependent on many different factors; however, some factors can be better predictors of health and future healthcare needs. Risk factors include declines in physical health, substance use or abuse, and prevalence of chronic disease. As people age, they use more health care resources. Estimates are that 12% of people over the age of 65 are at risk for high health care costs because of various risk factors. Supporting people in managing risk and connecting with services early is key to facilitating better health outcomes as people age.

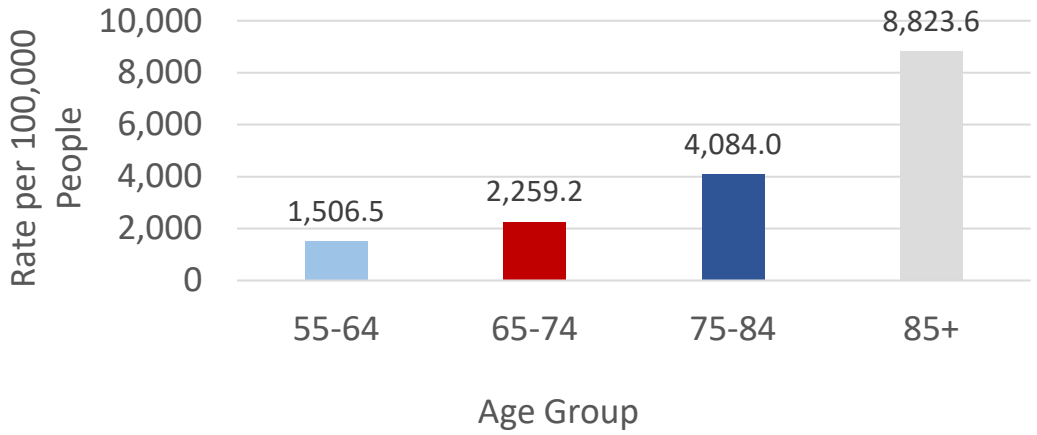
Highlights

- Falls increase with age and doubled from 4.084.0 per 100,000 population (4.1%) people aged 75 to 84 to 8,823.6 per 100,000 population (8.8%) for those aged 85+ (Fig. 28).
- Readmissions from falls – 90% are single visits 10% for all other readmission (Fig. 29).
- Mortality from falls in adults age 85 and older is 271.6 per 100,000 population (3.1% of falls) (Fig. 30).
- In Nevada, 66.1% of aging adults are overweight or obese (Fig. 31).
- People age 85 and older, make up the largest share of individuals in the “normal weight” range (Fig. 32).
- Nevada age 55 and older reporting heavy alcohol use has held relatively steady around approximately 6% over the last several years (Fig. 33).
- Alcohol related emergency department visits is highest for the age group 55 to 64 (Fig. 34).
- The rate of hospitalizations due to drug overdose is 58% higher for the age group 85 and older (Fig. 36).

Falls and Fall-Related Injuries

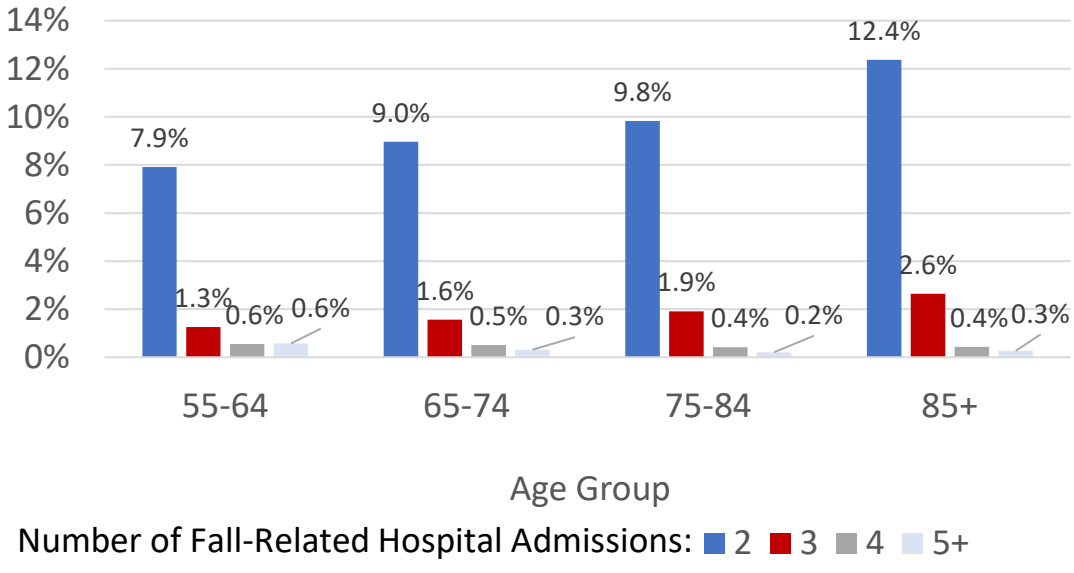
The incidence of falls significantly increases with age almost doubling every ten years. The rate of falls doubled from 4.084.0 per 100,000 population (4.1%) people aged 75 to 84 to 8,823.6 per 100,000 population (8.8%) for those aged 85 and older (Fig. 28). The Centers for Disease Control notes the percentage of falls by older adults is 25.5% nationally. In Nevada, that is roughly 111,690 people who experience a fall each year. Falls are particularly dangerous after an acute care hospital stay and contribute to increased 30-day hospital readmission rates, particularly in older populations (Fig. 29). For people age 85 and older, 15.7% of readmissions within 30 days are due to two or more falls. In 2018, an estimated 16,672 older adults went to a hospital or clinic associated with a hospital due to a fall.

FIGURE 28: NV RATE OF FALLS BY AGE GROUP, 2018



(Source: Nevada Center for Health Information Analysis (CHIA); Nevada State Demographer)

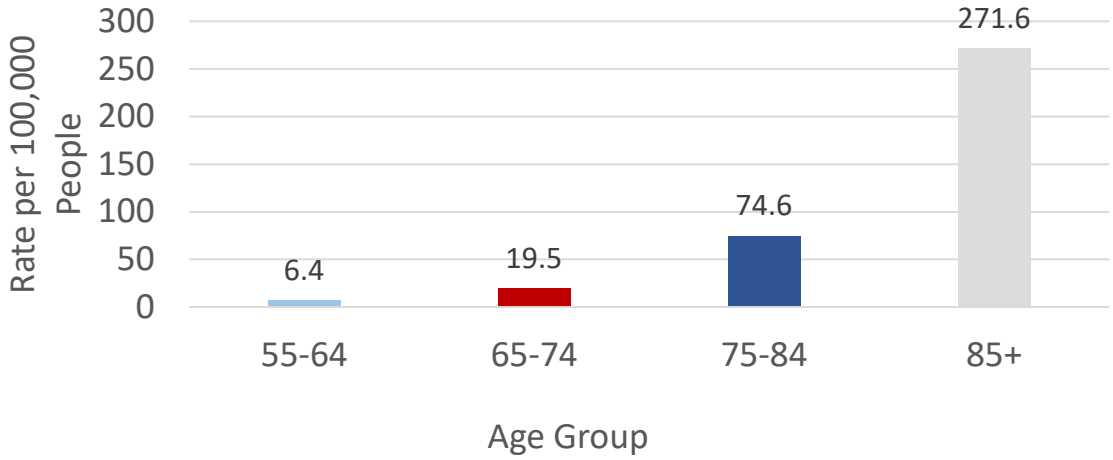
FIGURE 29: NV FALLS READMISSIONS WITHIN 30 DAYS BY AGE GROUP, 2018



(Source: Nevada Center for Health Information Analysis (CHIA))

Even more alarming is the rate at which the mortality rate increases with age. For people age 85 and older, the mortality rate is nearly 4 times that of people aged 75-84 increasing from a rate 74.6 per 100,000 population to 271.6 per 100,000 population (Fig. 30).

FIGURE 30: NV FALLS MORTALITY RATE BY AGE GROUP

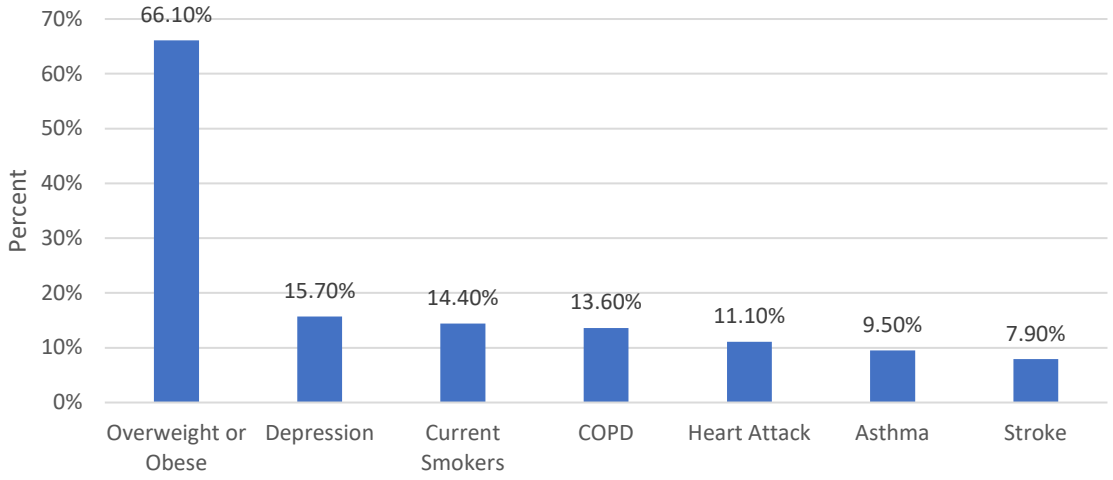


(Source: Nevada Electronic Death Registry System; Nevada State Demographer)

Chronic Diseases Overview

Chronic diseases, particularly those associated with heart disease, are a critical indicator of the health of a population given that heart disease continues to be the number one cause of death in the United States. In Nevada, 5 of 7 leading chronic conditions also correlate with heart disease. For people age 60 and older, two-thirds of individuals (66.1%) are overweight or obese (Fig. 31). Obesity is a growing problem, with the percentage of individuals age 60 and older who are obese increasing by 10% from 2015 to 2018 (BRFSS).

FIGURE 31: NV CHRONIC DISEASE PREVALENCE – AGE 60 AND OLDER, 2016-2018

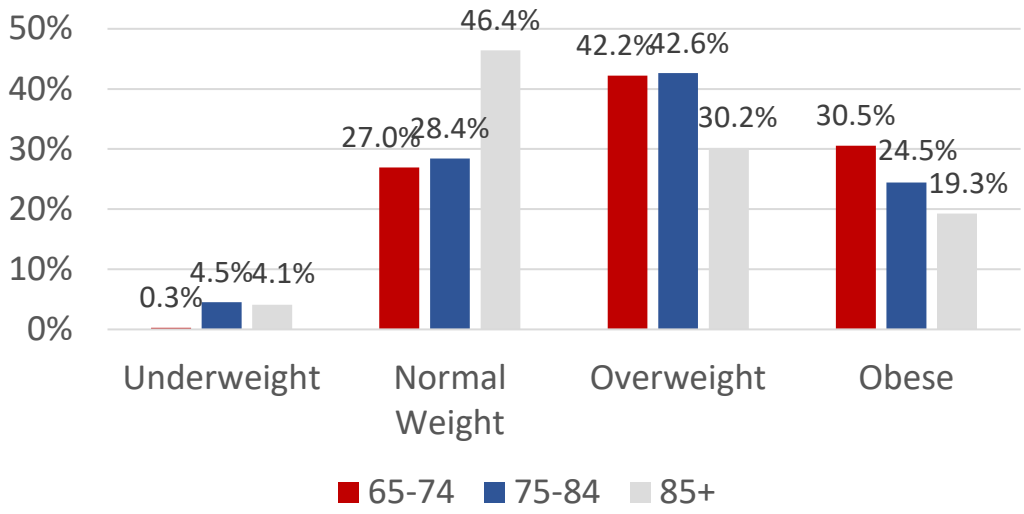


(Source: Behavioral Risk Factor Surveillance System)

Overweight and Obesity

Nearly 70% of people age 60 and older in Nevada are overweight or obese, yet only approximately 30% of people age 55 and older report participating in physical activity or exercise (BRFSS). Although being overweight is not necessarily unhealthy when aging, weight management is critical to preventing obesity. Being obese leads to higher rates of diabetes, heart disease and other medical issues. An interesting observation is that people age 85 and older, make up the largest share of individuals in the "normal weight" range, based on self-reported data (Fig. 32).

FIGURE 32: NV ADULTS AGE 65 AND OLDER BY WEIGHT CATEGORY, 2018



(Source: Behavioral Risk Factor Surveillance System)

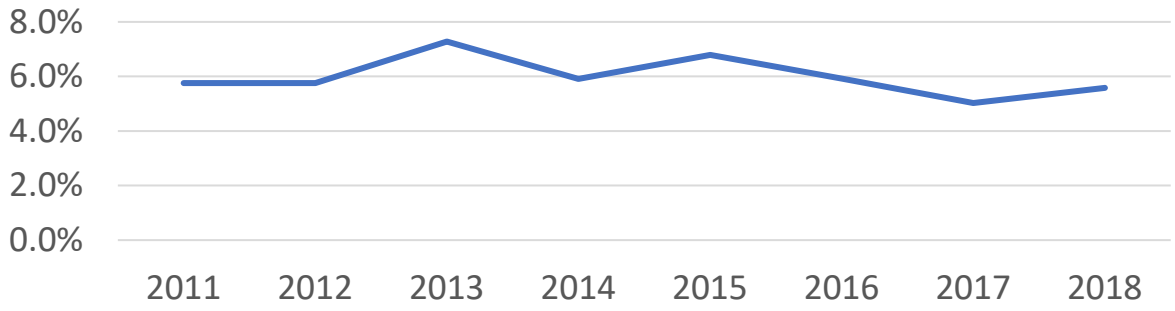
Tobacco Use

Tobacco use can increase the likelihood of disease, including cancer and heart disease. Overall, there has been a slight decline of people age 55 and over who smoke, from nearly 20% in 2011 to just 14.4% in 2018 (BRFSS). This is a dramatic decline from the 2013 Elders Count report, which reported 21.3% of adults used tobacco in 2010. The continued decline in tobacco use is a promising trend for the health of Nevadans.

Alcohol Use

Heavy alcohol use is defined by the BRFSS as more than two drinks per day for men or more than one drink per day for women. Nevadans age 55 and older reporting such heavy use has held relatively steady around approximately 6% over the last several years (Fig. 33).

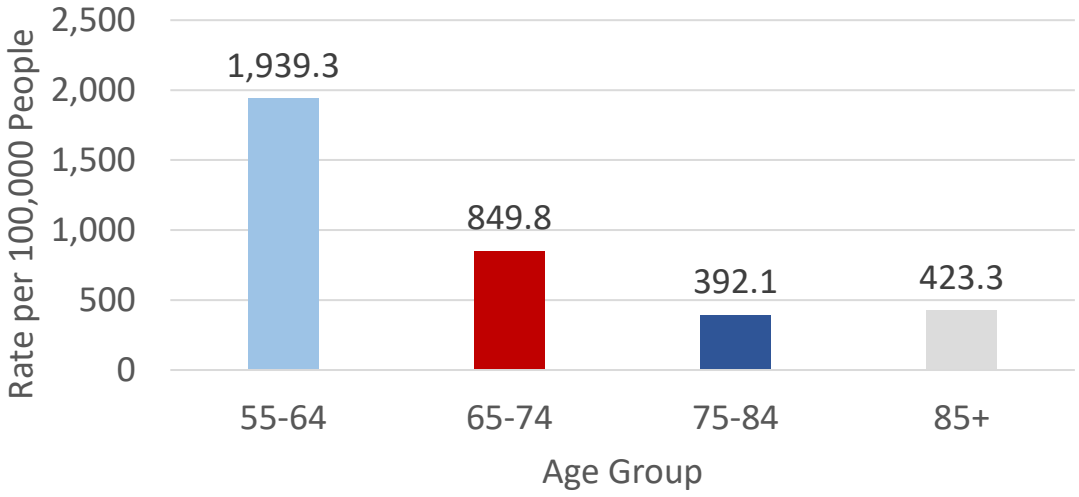
FIGURE 33: NV HEAVY ALCOHOL USE, AGE 55 AND OVER, 2011-2018



(Source: Behavioral Risk Factor Surveillance System)

Among people aged 55 and over, people aged 55 to 64 have notably higher rates of alcohol-related emergency hospitalizations (Fig. 34). These rates fall by around 80% for people aged 75 and over.

FIGURE 34: NV ALCOHOL-RELATED EMERGENCY DEPARTMENT VISITS, 2019

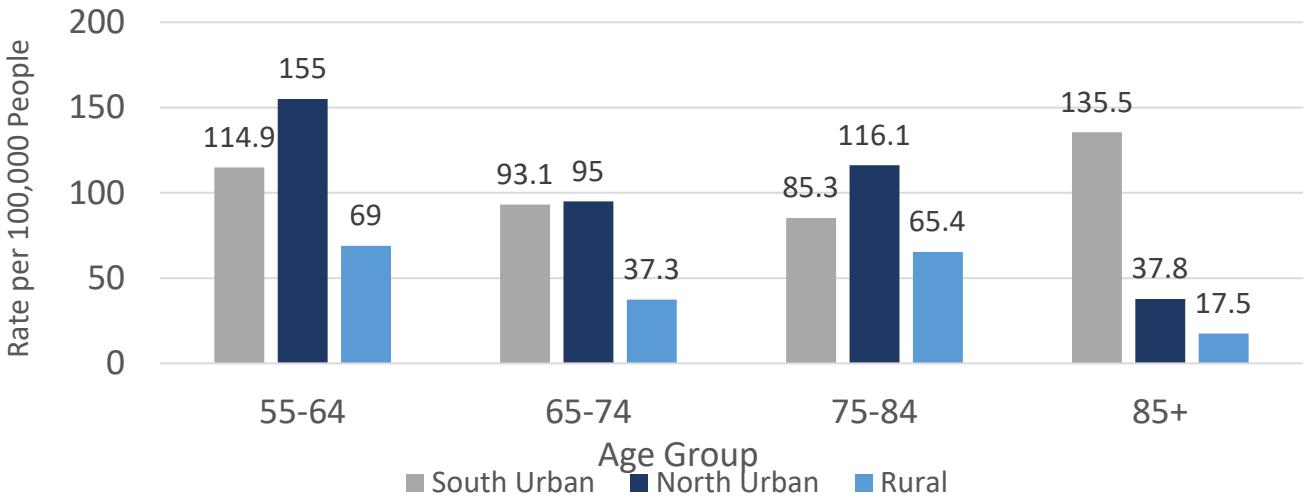


(Source: Nevada Center for Health Information Analysis (CHIA); Nevada State Demographer)

Drug Overdose

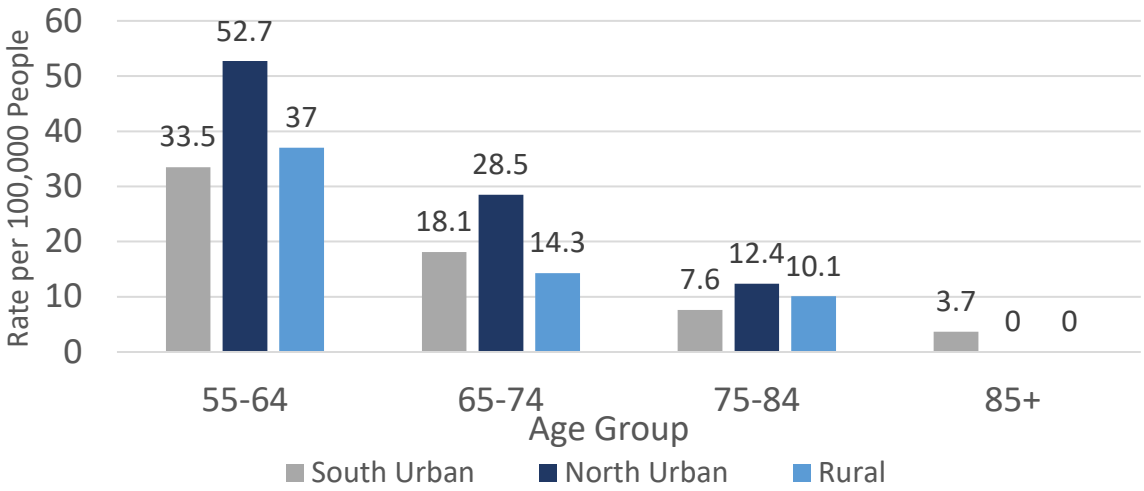
While overall the rates of drug overdose related to inpatient admissions in Nevada for people age 55 and older is relatively small, there is an alarming increase in the rate per 100,000 population in people age 85 and older as compared to the 75-84 age group (Fig. 35). The rate of hospitalizations is 58% higher for the older age group and correlates with the increased rate of falls of this age group as discussed earlier, although there are few deaths associated with drug overdose in older age groups (Fig. 36).

FIGURE 35: NV DRUG OVERDOSE RELATED INPATIENT ADMISSIONS, 2019



(Source: Nevada Center for Health Information Analysis (CHIA); Nevada State Demographer)

FIGURE 36: NV DRUG OVERDOSE RELATED DEATHS, 2019

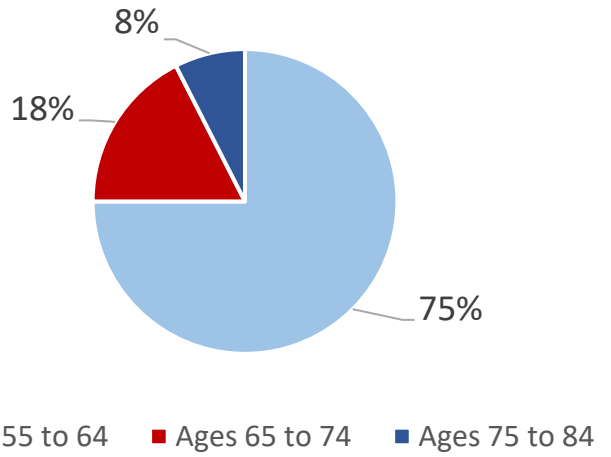


(Source: Nevada Electronic Death Registry System; Nevada State Demographer)

Gambling and Other Process Addictions

While gambling and gambling addictions are of particular concern among older adults, particularly those with fixed-incomes and/or low-incomes, people over the age of 65 are showing responsible gambling. The challenge is in the percentage of people age 55-64 who are diagnosed with gambling addiction, 75% of the population who is 55 and over and on Medicaid. These individuals are likely to have greater debt management issues, decreased resources to support healthy aging, and other risk factors discussed in this report.

FIGURE 37: NV AGE DISTRIBUTION OF GAMBLING ADDICTION DIAGNOSIS, MEDICAID, AGE 55+

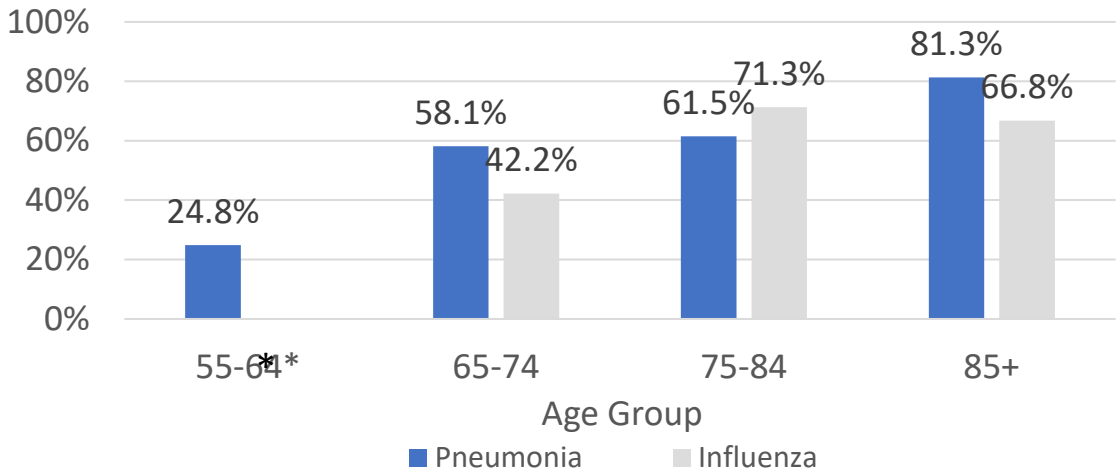


(Source: NV Medicaid Fee for Service Data Warehouse (DSS) and MCO DW Encounters Reports)

Influenza and Pneumonia Vaccinations

Adults age 55 and older in Nevada appear to be receiving regular immunizations to prevent pneumonia and influenza. From the 65-74 age group to the 75-84 age group, the number of people who receive a flu vaccine more than doubles.

FIGURE 38: NV INFLUENZA AND PNEUMONIA VACCINATIONS, AGE 55 AND OLDER, 2017



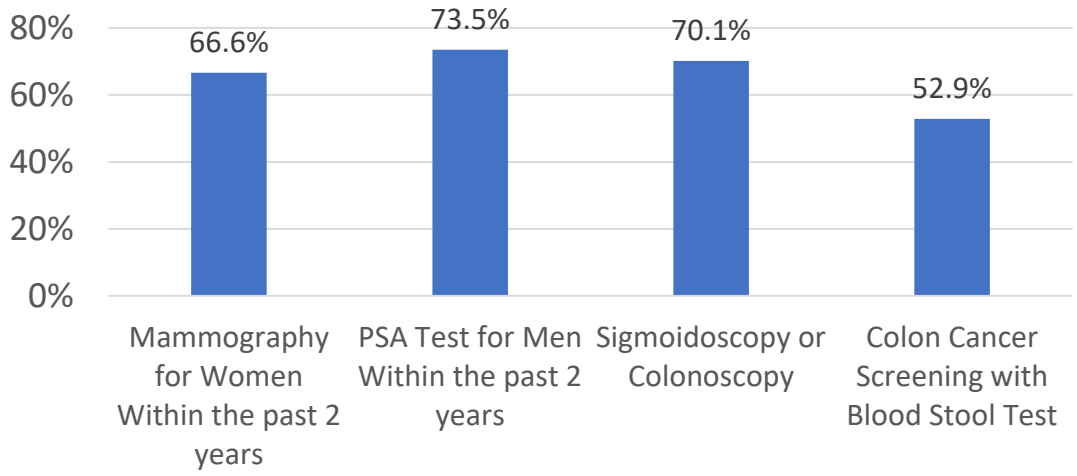
*No Influenza data available for this age bracket

(Source: Behavioral Risk Factor Surveillance System)

Cancer Screenings

Cancer is the second leading cause of death in the United States, although in Nevada the percentage of older adults who are doing their cancer screenings is high.

FIGURE 39: NV CANCER SCREENING, AGE 55 AND OLDER, 2018

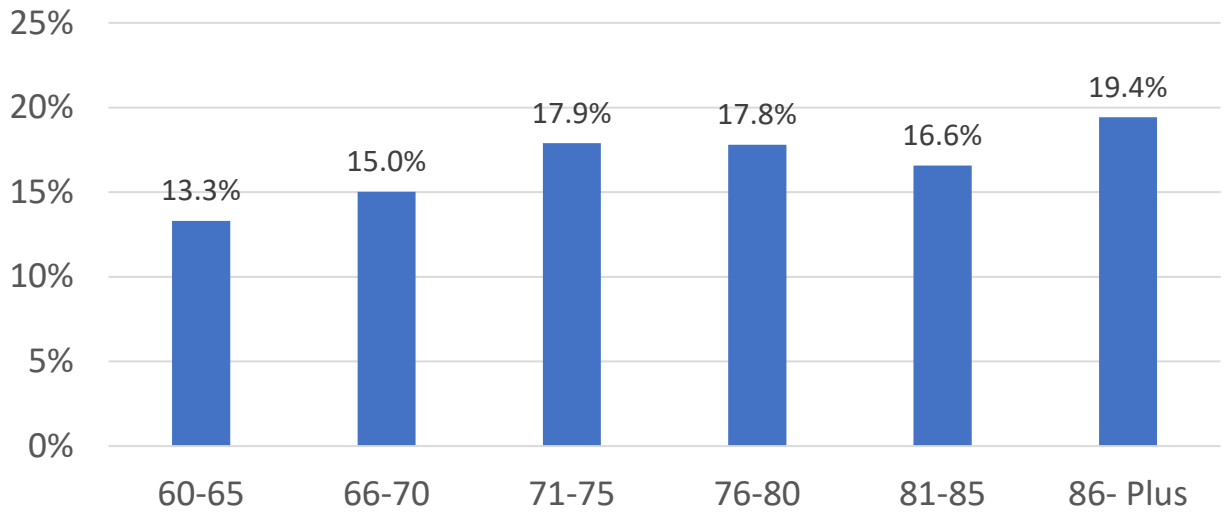


(Source: Behavioral Risk Factor Surveillance System)

Elder Abuse, Neglect, and Exploitation

Elder abuse, neglect, and exploitation is a growing problem in the United States. According to the Adult Maltreatment Report, 2019, nationally there was a 3% increase in the number of reports accepted for investigation between FFY2018 and FFY2019. Additionally, self-neglect is the number one allegation reported, comprising 51% of reports nationally. In Nevada, individuals age 86 and older are the highest group of victims, while nationally the largest age group is 75 – 84 (Fig.40). A victim is an individual who has received an investigation regarding a report of alleged maltreatment and one or more of the allegations is substantiated (NAMRS).

FIGURE 40: NV ELDER ABUSE – VICTIM AGE, AGE 60 AND OLDER, 2019

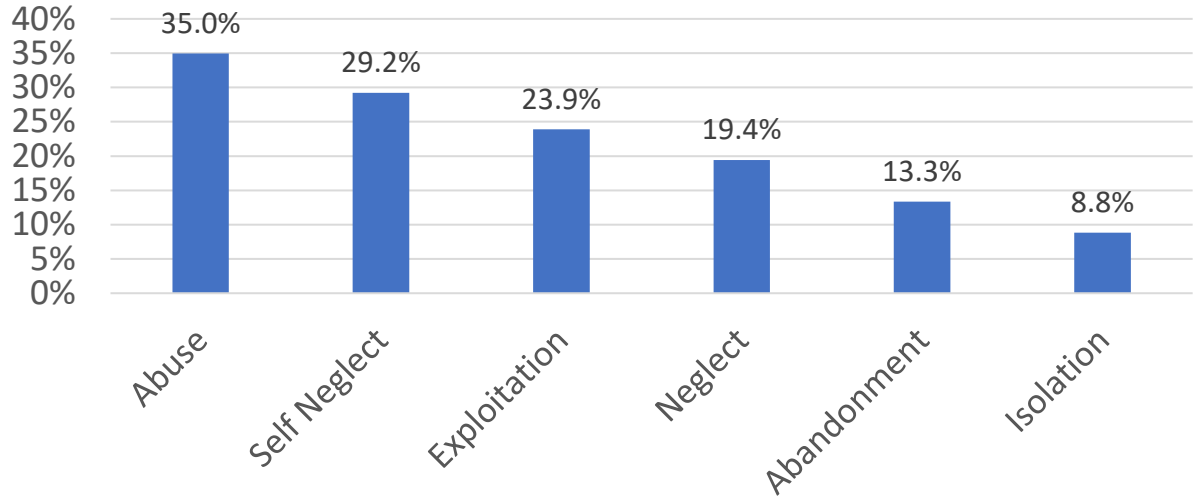


(Source: Nevada Adult Protective Services System)

There are 6 types of abuse investigated by the Nevada Adult Protective Services program. Abuse, which includes physical, sexual, or emotional, is the most substantiated type of abuse

(35%), followed closely by self-neglect at 29% (Fig. 41). Substantiated cases are those reports that have been investigated and one or more allegations have been proven.

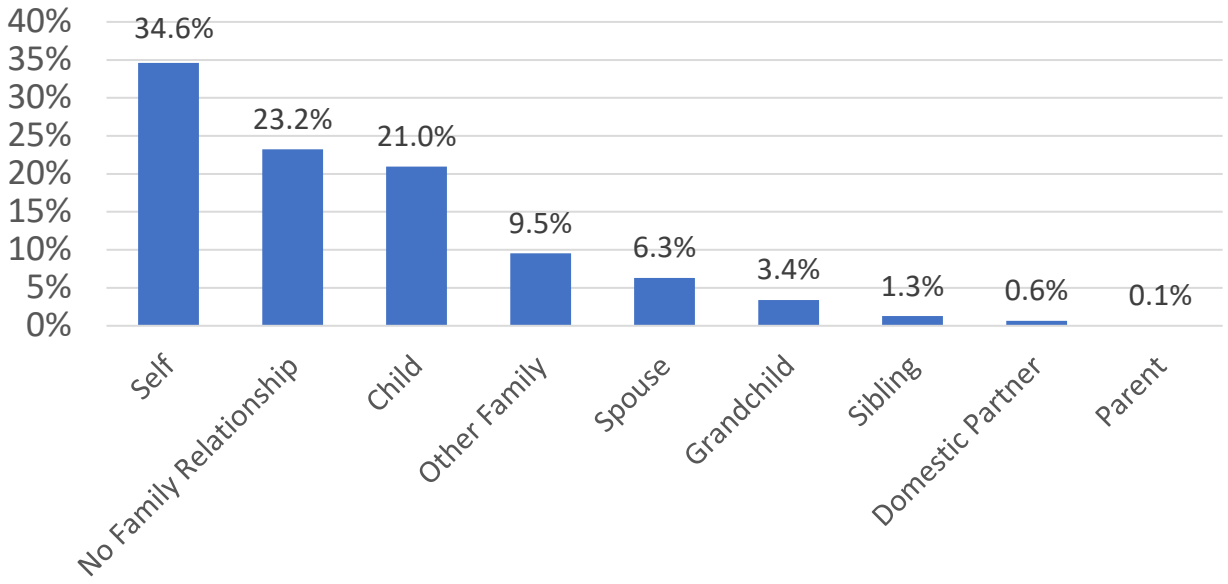
FIGURE 41: NV ELDER ABUSE – SUBSTANTIATED CASES, 2019



(Source: Nevada Adult Protective Services System)

In every investigation, there is a suspect (or perpetrator) of the allegations. With one in three victims being substantiated cases of self-neglect, the suspect in those cases is "self". Across the remaining types of maltreatment, children and individuals with no familial relationship to the older adult make up the largest percentage of suspects (Fig. 42). While the percentage of suspects who are the children (21%) of the older adult compares to national statistics, in Nevada the percentage of suspects who have no familial relationship to the older adult (23.2%) is lower than the national percentage of 33.1%.

FIGURE 42: NV ELDER ABUSE – SUSPECTS, 2019



(Source: Nevada Adult Protective Services System)

Strategies

This space is intentionally left blank to note strategies, policy considerations, or action steps.

Health Care

Since 2010, the United States healthcare system has been undergoing reform beginning with the passage of the Affordable Care Act and subsequent efforts to further reform healthcare. With the implementation of the Affordable Care Act and Nevada's Health Insurance Exchange, many more Nevadans now have access to healthcare, although approximately 14% remain uninsured (Guinn). Additionally, as part of healthcare reform efforts many changes have been made to Medicare coverage which includes increased coverage for preventive services, elimination of the coverage gap in the prescription drug program (aka "the donut hole") and incentives to hospitals to reduce 30-day readmission rates (NCOA).

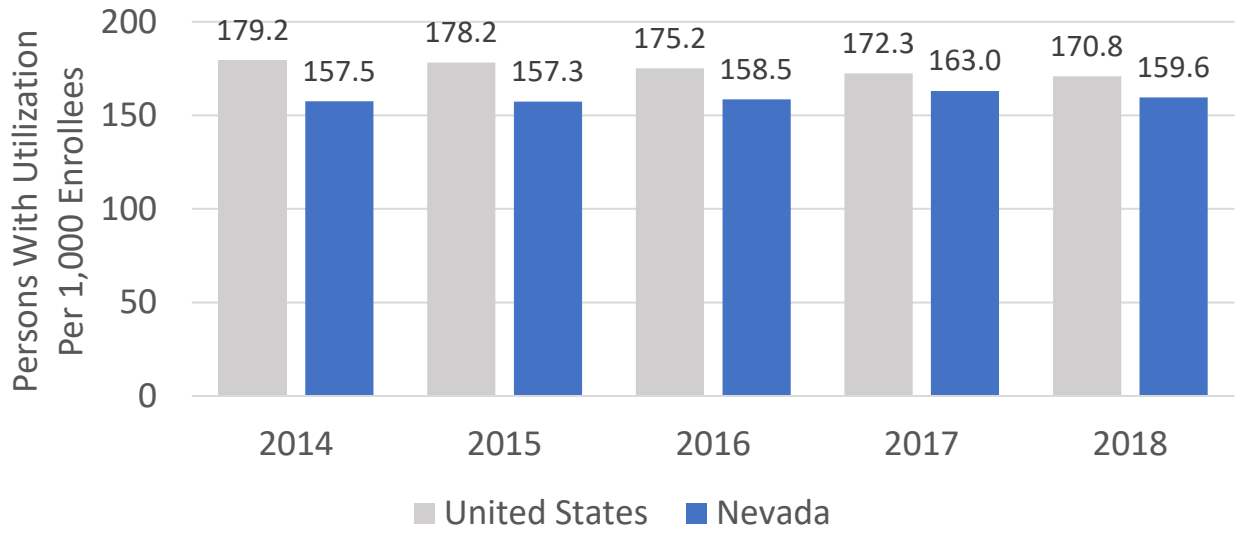
Highlights

- Inpatient hospital utilization is lower in Nevada than the U.S. for Medicare beneficiaries (Fig. 43).
- Medicare outpatient hospital utilization rates in Nevada have stayed relatively stable between 2014 and 2018, with only a slight increase in 2018 (Fig. 44).
- Since 2010 the percentage of older adults who are delayed or did not get medical care due to cost has been on a downward trend (Fig. 45).
- Nationally, the largest age group enrolled in Medicare is the 65-74 group, comprising 48% of the Medicare enrollees in 2017 (Fig. 46).
- Nationally, Medicaid enrollees age 65 and over is approximately 7% of the total (Fig. 47).
- For people who have Medicare Part D coverage, the average cost is $0.65 per unit, a savings of $0.46 over private pay costs (Fig. 48).
- Nevada's hospital expenditures (the largest of healthcare expenditures) is slightly less than the US (Fig. 49).
- In-home services are nearly half the average cost per year than a skilled nursing facility (Fig. 50).
- The rate of nursing home residents in Nevada is approximately half of that of the U.S. (Fig. 51).
- NV residents in the 85-94 age group are the largest portion of the nursing home census, making up 33.8% in 2014 (Fig. 52).
- Nevada has a significantly higher number of health deficiencies within nursing homes than the U.S. (Fig. 53).

Medical Services Use & Health Insurance Coverage

Data from the Centers for Medicare and Medicaid Services (CMS) shows Nevada's inpatient hospital utilization is lower in Nevada than the U.S. for Medicare beneficiaries. Interestingly, between 2014 and 2018, the rate of utilization in Nevada stayed relatively the same, while nationally it dropped during this same period (Fig. 43). Since the implementation of healthcare reform efforts, Nevada's inpatient hospital utilization rate has gone down. In 2010, data from the Centers for Disease Control, National Center for Health Statistics showed Nevada's inpatient hospital admission rate was 283.5 per 1,000 beneficiaries.

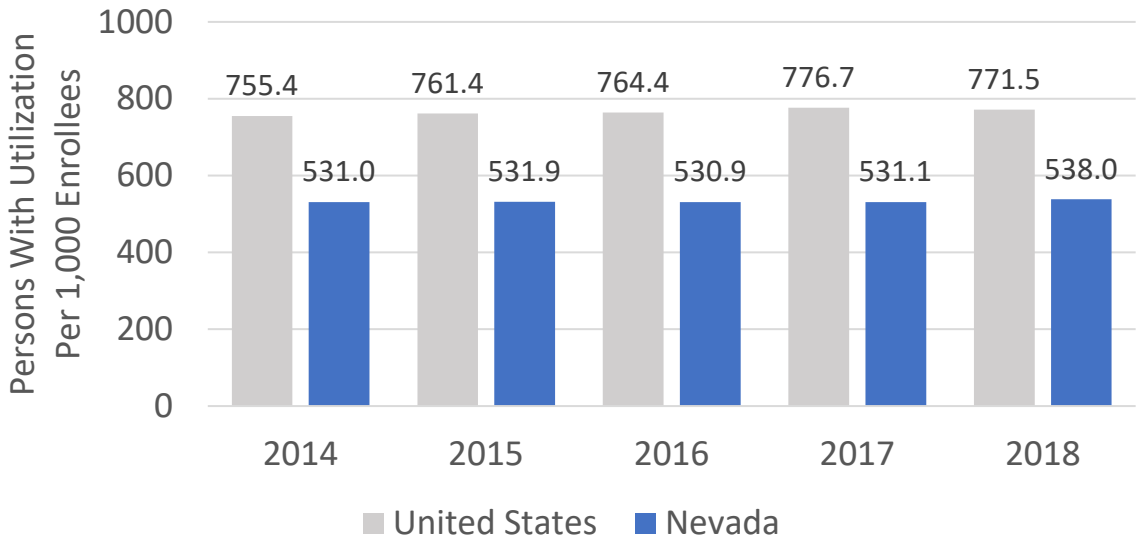
FIGURE 43: MEDICARE INPATIENT UTILIZATIONS, 2014-2018



(Source: Centers for Medicare & Medicaid Services)

Similarly, Medicare outpatient hospital utilization rates in Nevada have stayed relatively stable between 2014 and 2018, with only a slight increase in 2018. However, nationally, outpatient hospital utilization has seen a steady increase each year during the same time (Fig. 44). Overall, Nevada's outpatient utilizations are significantly lower than national rates.

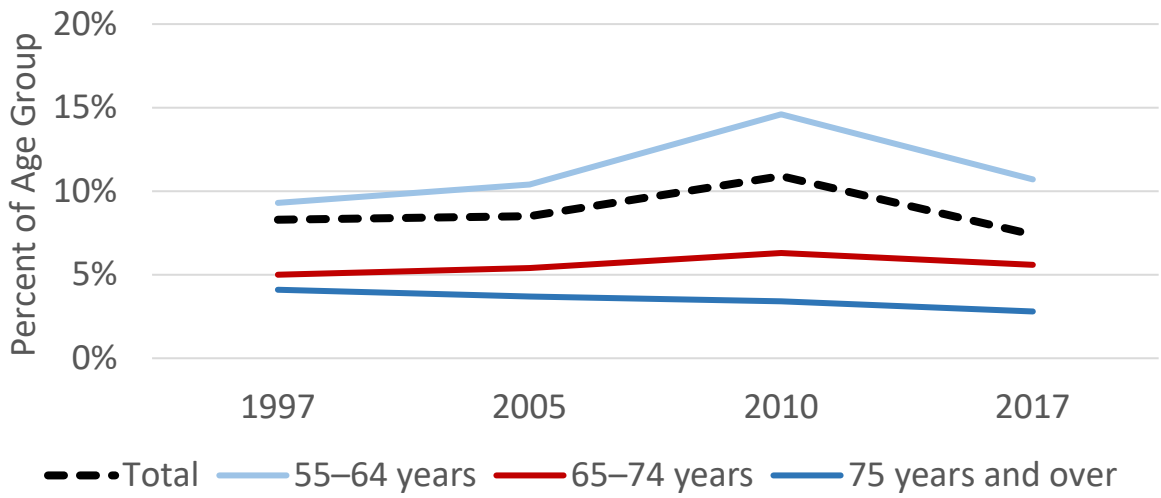
FIGURE 44:MEDICARE OUTPATIENT UTILIZATIONS, 2014-2018



(Source: Centers for Medicare & Medicaid Services)

According to CDC data, since 2010 the percentage of older adults who are delayed or did not get medical care due to cost has been on a downward trend (Fig. 45). It peaked in 2010 but has been steadily declining since the passage of the Affordable Care Act. This is particularly noticeable in the age group of 55-64.This group accessing healthcare earlier (as opposed to delaying care until Medicare age is reached) theoretically should improve health status and outcomes in later life, although further exploration of data for this age group is needed. This downward trend also coincides with a turn in the economy. As Nevada, and the nation looks towards the future and considers the impact of COVID-19, not only on health status, but on the economy, we may see these trends reverse.

FIGURE 45: US DELAY OR NONRECEIPT OF MEDICAL CARE DUE TO COST



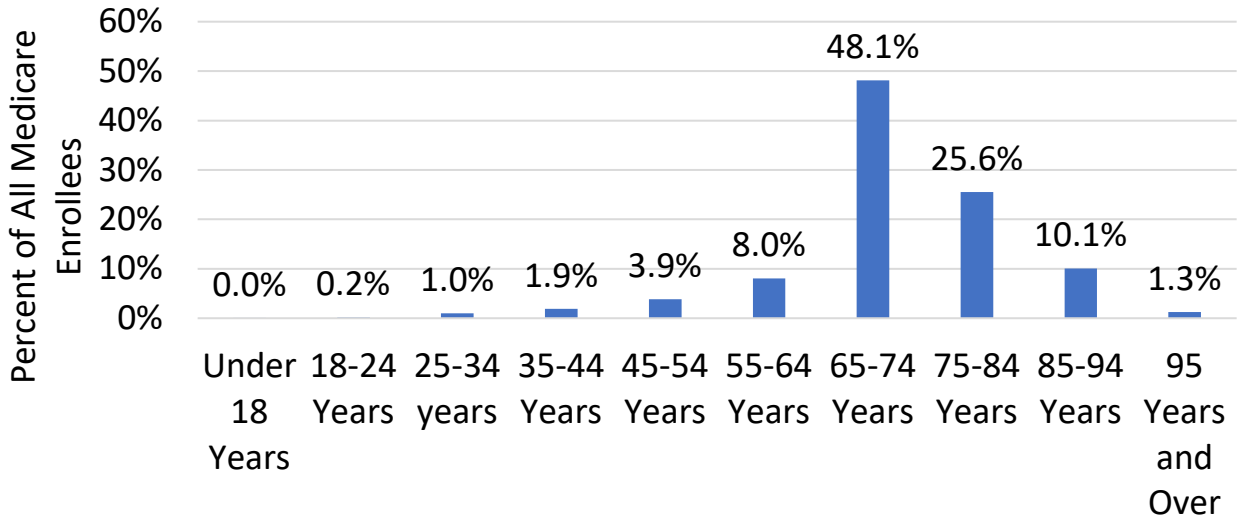
(Source: Centers for Disease Control and Prevention, National Center for Health Statistics)

Medicare and Medicaid Enrollment

Nationally, the largest age group enrolled in Medicare is the 65-74 group, comprising 48% of the Medicare enrollees. (Fig. 46) According to the Administration for Community Living (ACL), there are 472,585 Medicare eligible individuals in Nevada, and constitute approximately 15% of Nevada's population. Within Nevada, rural counties have a higher percentage per capita of Medicare beneficiaries. Mineral, Nye, and Douglas counties' Medicare eligible population is over 30% of their total population.

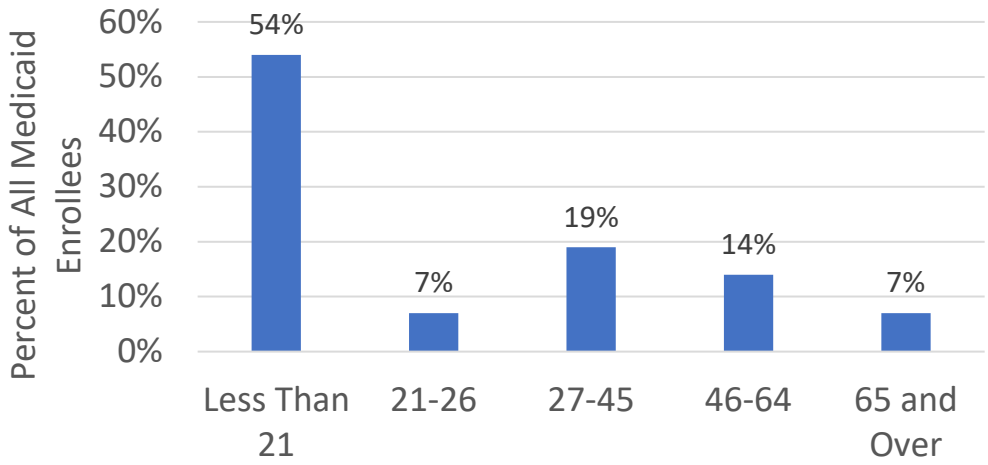
Conversely, Medicaid enrollment is much lower for older adults, age 65 and older. Nationally, this age group is approximately 7% of Medicaid enrollees (Fig. 47). While this is a relatively small percentage, the Medicaid-Medicare dual eligible population is the most expensive population in our healthcare system and is largely made up of the age group 65 and older. In CY2013, the dual-eligible population made up 20% of enrollees in Medicare but accounted for 34% of spending (Mapac). For Medicaid, the dual-eligible population constitutes 15% of enrollees, but comprises 32% of spending (Mapac).

FIGURE 46: U.S. AGE DISTRIBUTION OF MEDICARE ENROLLEES, 2017



(Source: Centers for Medicare & Medicaid Services)

FIGURE 47: U.S. AGE DISTRIBUTION OF MEDICAID AND CHIP ENROLLEES, 2017



(Source: Medicaid.gov)

Caregivers

Unpaid family caregivers are woven into the fabric of long-term services and supports system, providing countless hours of care and support for older adults across the United States. Based on data from Nevada's Lifespan Respite Care Program, approximately 15% of caregivers report having a health limitation or concern of their own. Only 39% of caregivers in the sample are spouses or significant others, the largest share being children and in compound caregiving roles (carrying for children and parents). Most caregivers (83%) reported having the care recipient living in their home, meaning their caregiving role potentially extend to 24 hours a day/7 day a week.

Caregivers provide a variety of services and supports including medication management, transportation, medical appointment support, in-home services and much more. While 56% of caregivers seek outside support to strengthen their ability to maintain care at home, these caregivers also show far greater need for some freedom and the ability to maintain the social, emotional, and professional associations they value.

While most respite services focus on a single, annual voucher studies show regular respite breaks are needed to maintain caregiver health and reduce the stress of caregiver burden. In a pilot program, Nevada offered monthly respite for one year. While caregivers request an average of 14.7 hours of relief from care each week, the actual average hours used per week falls to just 4.4 hours per week as caregivers struggle to fit respite support into their lives.

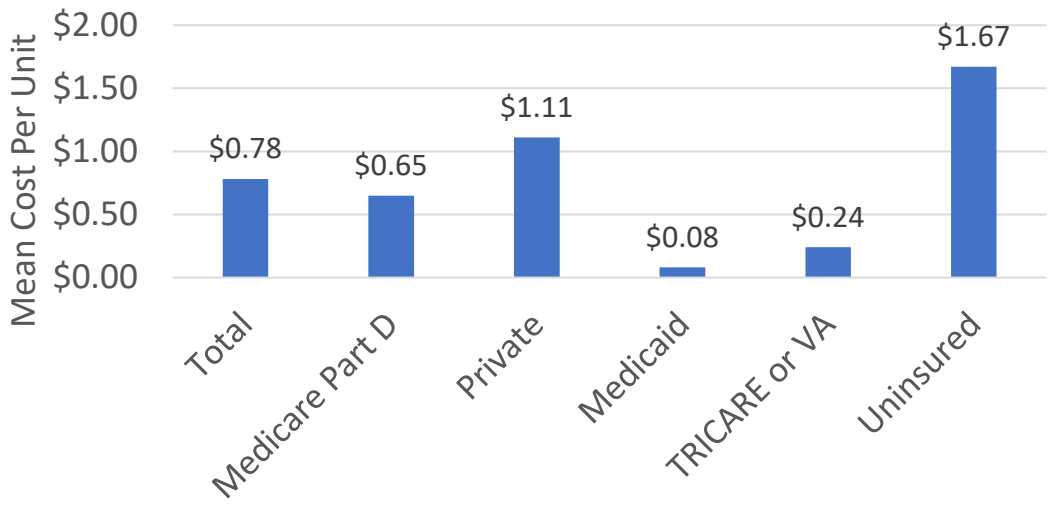
Prescription Drugs

Medicare prescription drug coverage (Part D) is available to all Medicare beneficiaries. Although it is an optional benefit penalties may be applied if a Medicare beneficiary does not enroll into a prescription drug plan when first eligible. Part D plans are only available through private insurance companies that contract with Medicare. Beneficiaries can choose a stand-alone prescription drug plan (PDP) that works with Original Medicare or a Medicare Advantage Prescription Drug Plan (MA-PD) offered as a set of benefits included with a Medicare Advantage

(MA) Plan. In 2020, there were 28 stand-alone PDPs available in Nevada and 100 MA plans offering Part D coverage (CMS PDP landscape and MA Plan landscape).

Since 2012, the number of enrollees in Medicare Part D plans has steadily increased. According to CMS Data (2019), there were 179,045 individuals enrolled in a PDP and 180,424 individuals enrolled in a MA-PD in Nevada. Prescription drug coverage that is sufficient and affordable is critical to older adults in Nevada. According to data from the U.S. Department of Health and Human Services, out of pocket costs for outpatient prescriptions average $0.78 per unit. For people who have Medicare Part D coverage, the average cost is $0.65, a savings of $0.46 per unit over private pay costs (Fig. 48).

FIGURE 48: U.S. OUT OF POCKET COSTS FOR OUTPATIENT PRESCRIPTION DRUGS, 2016

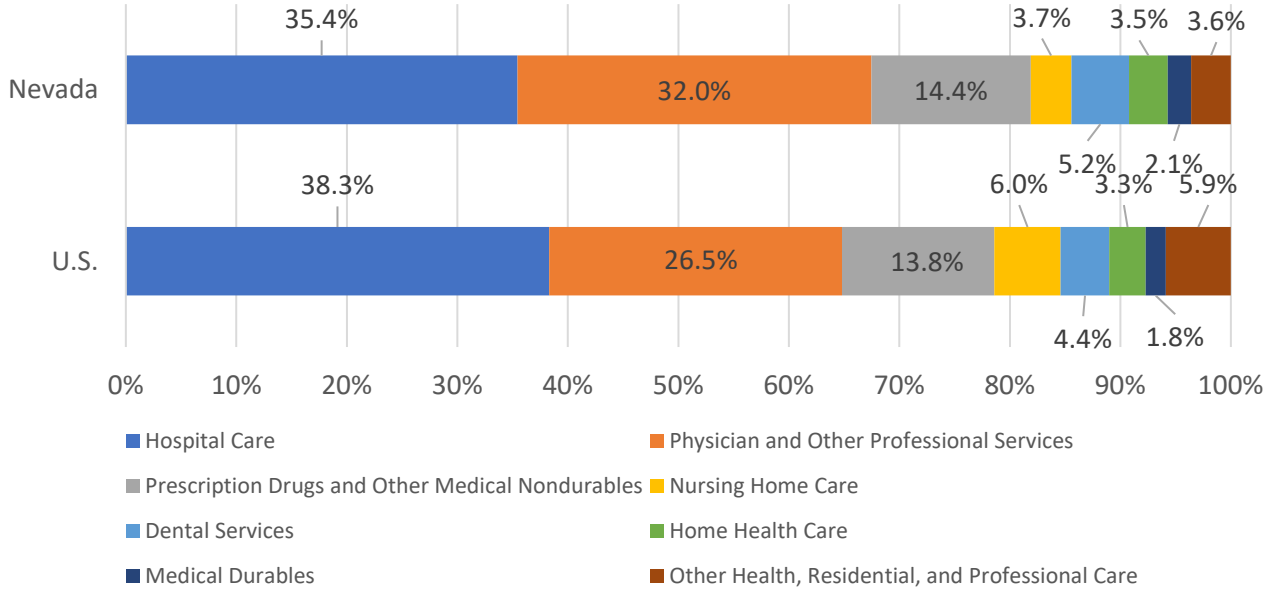


(Source: U.S. Department of Health & Human Services, Medical Expenditure Panel Survey)

Expenditures

Hospital care constitutes the largest health care expenditures in both Nevada and across the United States, with Nevada's hospital expenditures being slightly less than the U.S.(Fig.49). In terms of physician services, Nevada's expenditures in this category are significantly higher than the U.S. expenditures, despite Nevada outpatient utilizations being much lower than the U.S.

FIGURE 49: HEALTHCARE EXPENDITURES BY TYPE, 2014

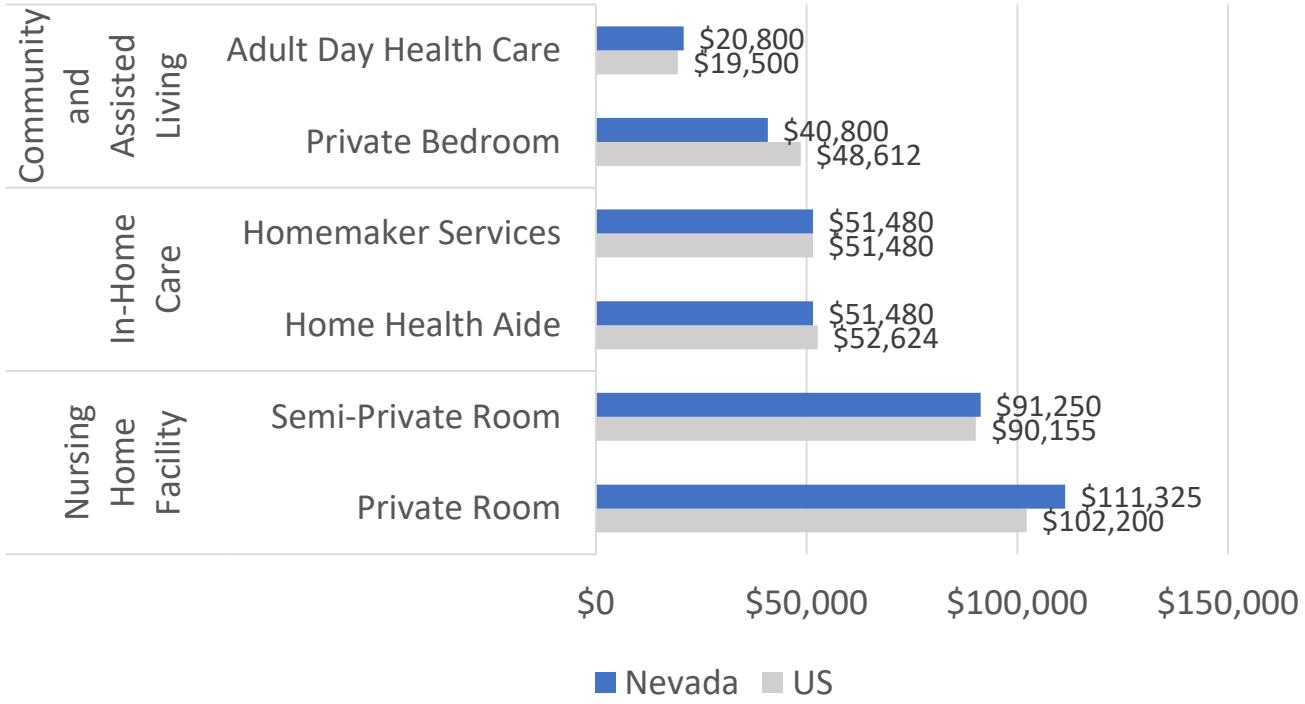


(Source: Kaiser Family Foundation)

Long-Term Care Facilities

Since 2012, Nevada Medicaid has been working to rebalance spending on home and community-based care over institutional care. The value of community-based services in both terms of expenditures and quality of life is undeniable, although long-term care facilities are still a critical part of the healthcare infrastructure for many older adults. In-home services are nearly half the average cost per year than a skilled nursing facility (Fig. 50).

FIGURE 50: MEDIAN ANNUAL COSTS OF CARE, 2019

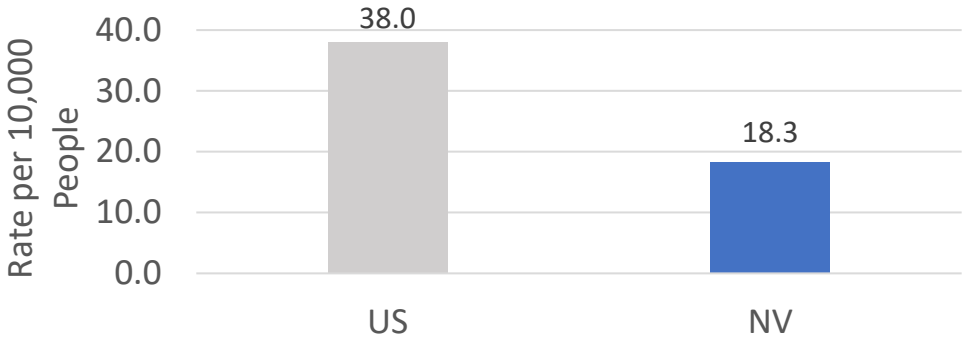


(Source: Genworth Cost of Care Report)

On a national level including in Nevada, states have been working to transform the long-term services and supports (LTSS) system to rebalance spending on community-based services by supporting care transition programs and streamlining access to services. These efforts began with the passage of the Olmstead Decision in 1999 and have continued to grow over the last 20 years.

Alongside these efforts are efforts to reform long-term care facilities, supporting residents' rights, increasing person-centered choice within facilities, and increasing safety standards. Today, Nevada has nearly 7,000 long-term care facility beds. The rate of nursing home residents in Nevada is approximately half of that of the U.S. (Fig. 51).

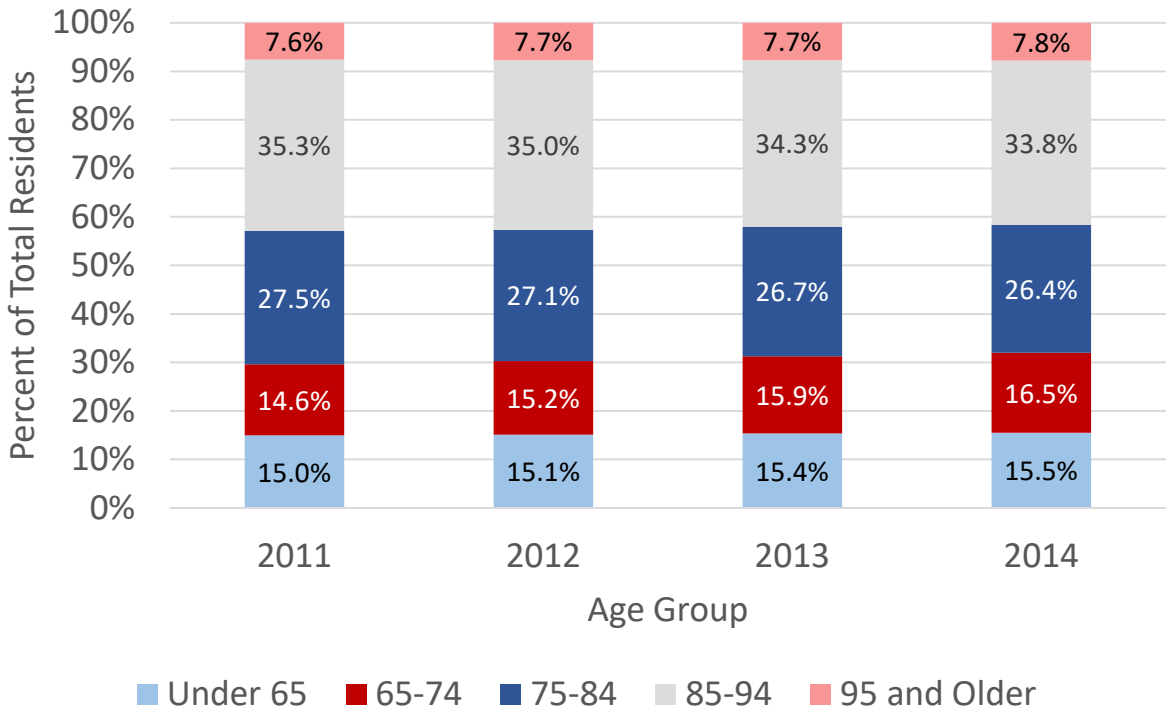
FIGURE 51: NV RATE OF NURSING HOME RESIDENTS, 2019



(Source: Kaiser Family Foundation, U.S. Census)

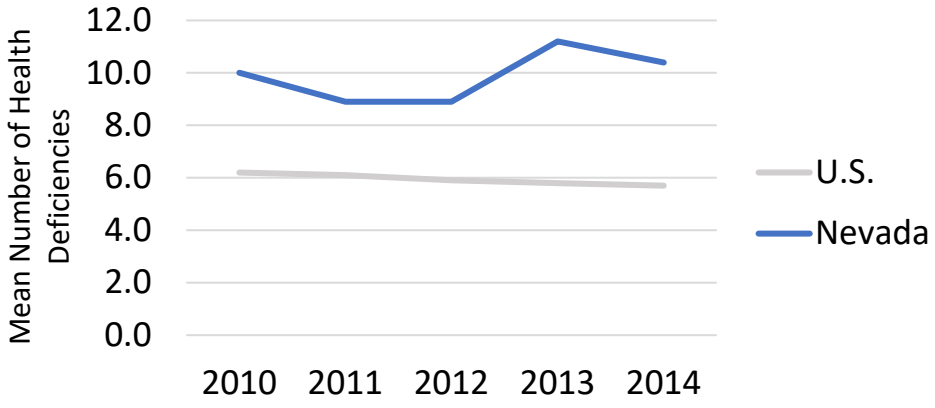
Within nursing facilities in Nevada residents in the 85-94 age group are the largest portion of the census, making up 33.8% in 2014 (Fig. 52). This population is also likely to be the highest level of care and have the greatest safety concerns due to frailty. Consequently, Nevada has a significantly higher number of health deficiencies within nursing homes than the US.(Fig. 53).

FIGURE 52: NV % NURSING HOME RESIDENTS BY AGE, 2011-2014



(Source: CMS: Nursing Home Data Compendium 2015)

FIGURE 53: AVERAGE NUMBER OF NURSING HOME DEFICIENCIES, 2014



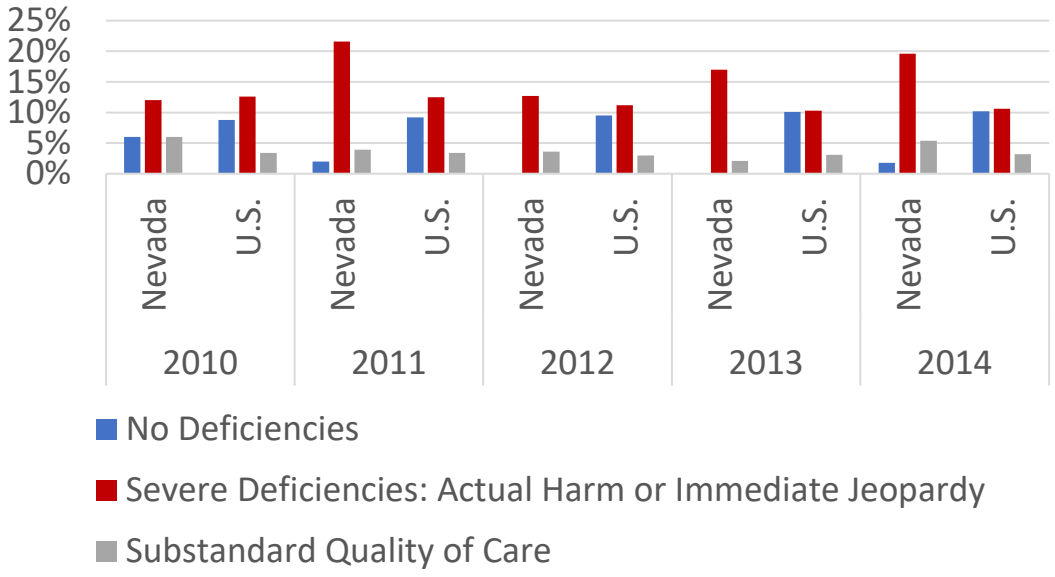
(Source: CMS: Nursing Home Data Compendium 2015)

CMS surveys nursing homes each calendar year and the data is reported as part of the Nursing Home Data Compendium. The three definitions used include:

- No deficiencies – no deficiencies were cited during the calendar year.
- Severe deficiencies – citations for actual harm to a resident or an immediate threat to the health or life of one or more residents.
- Substandard quality of care – these are citations that may not result in actual harm or immediate threat but are severe in nature.

Nursing homes in Nevada have outpaced the U.S. in severe deficiencies and substandard quality of care since 2011(Fig. 54). This table demonstrates the need for extensive review of nursing home regulations to improve care for residents which have been amplified by the COVID-19 pandemic.

FIGURE 54: NURSING HOME DEFICIENCIES IN DETAIL, 2014



(Source: CMS: Nursing Home Data Compendium 2015)

Strategies

This space is intentionally left blank to note strategies, policy considerations, or action steps.

Infrastructure

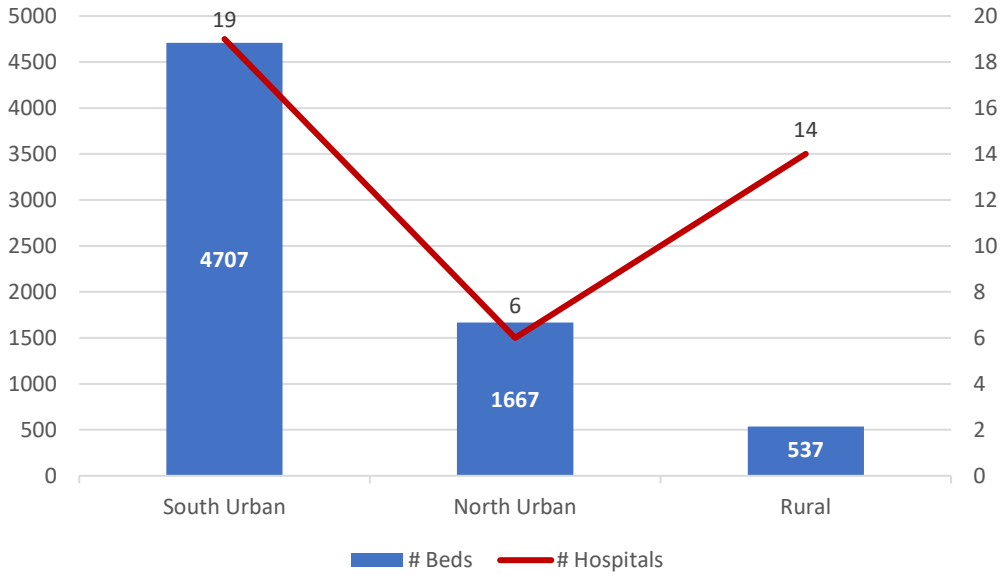
Infrastructure is the framework to support society. In supporting older adults, infrastructure is multi-faceted: healthcare, social services, community, transportation, and more. To support our population growth, healthcare, and community-based living, all of these systems must work in concert with each other.

Healthcare Infrastructure

Nevada's healthcare infrastructure in both rural and urban areas is a critical need for older adults. Rural Nevadan's are often forced to travel large distances (both in state and out of state) for healthcare resources and needs, depending on where they live.

Major hospital systems are in more densely packed urban areas. Due to the vast size and rural nature of Nevada, many residents are forced to go out of state to the nearest hospital system for care. While the number of licensed hospitals is roughly the same between Nevada regions, the number of beds is significantly lower in rural areas (Fig. 55).

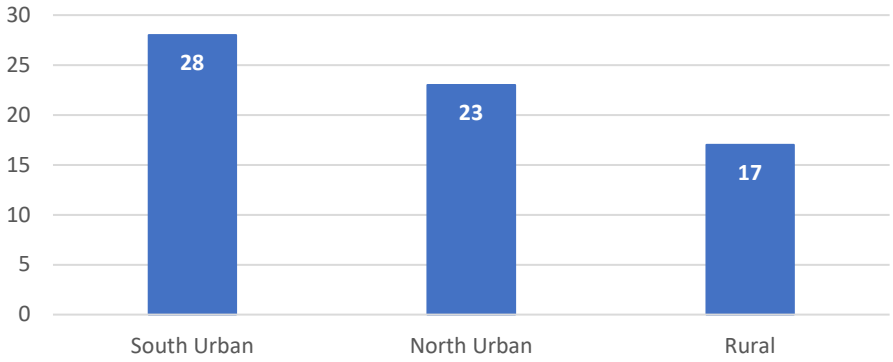
FIGURE 55: NV HOSPITALS AND TOTAL BEDS, 2020



(Source: Division of Public and Behavioral Health, Licensees)

In addition, Nevada has 68 Federally Qualified Healthcare Centers (FQHC). A FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to all persons of all ages, regardless of their ability to pay or health insurance status.

FIGURE 56: NV FEDERALLY QUALIFIED HEALTHCARE CENTERS



Veterans' Health Administration

The Veteran's Health Administration (VHA) provides an infrastructure of support to Nevada's veterans. There are two main VA Medical Hospitals in Nevada, located in Las Vegas and Reno. For northeastern Nevada, veterans must travel to Salt Lake City to access the full range of services available through a VA Medical Hospital. To increase access to primary care, the VA Healthcare System is enhanced through community-based outpatient clinics(Fig. 57).

FIGURE 57: VETERANS HEALTH ADMINISTRATION FACILITIES

Facility Type
VA Medical Hospital
Reno
Las Vegas
Community-Based Outpatient Clinic
Elko
Fallon
Gardnerville
Reno
Henderson

Due to the shortage of VA healthcare resources nationwide, the VA has also launched the Veterans Choice program that allows veterans to access healthcare through non-VA clinics in rural areas.

Workforce

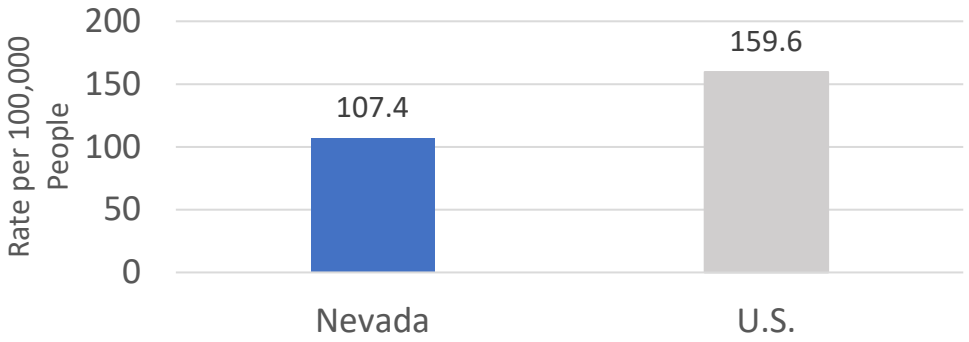
As people age they use more health care resources. The aging process means that 70% of the population just turning 60 and older are probably healthier and use their existing primary care physicians. As the population ages, these physicians probably utilize continuing education units to be more aware of aging issues or refer their clients to specialists. Nevada is experiencing a shortage of primary care physicians, as compared to the U.S. (Fig. 58).

Nevada has 438,000 people over the age of 65, of which 12% are at risk for high health care costs. This means 55,000 Nevadans are high risk for more acute medical attention for which

there are fewer available specialists resulting in higher costs using emergency services from the health care system.

Long term services staff which delivers most of the health care (e.g., home health care and aging/disabled services), require professional attention. The workforce is estimated to be at 60% of needed staffing to match the national staffing levels.

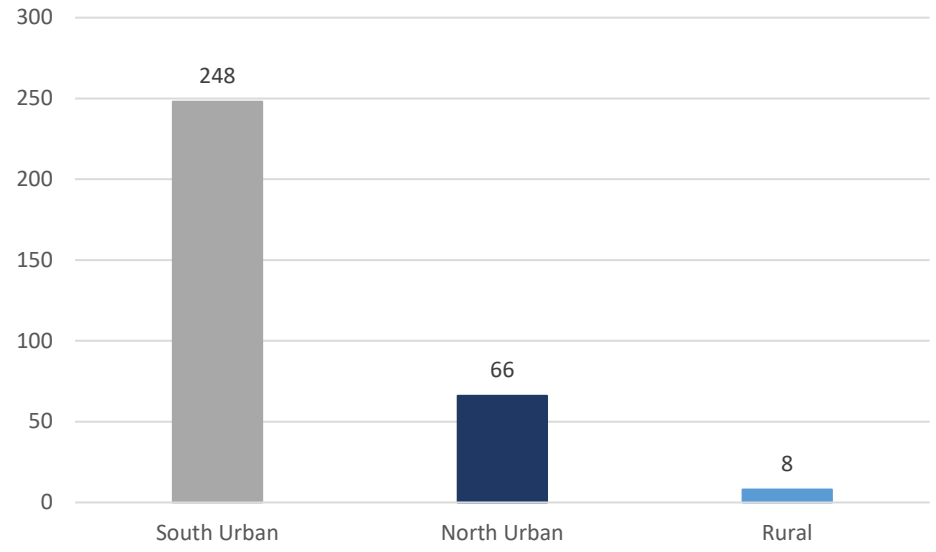
FIGURE 58: ACTIVE PRIMARY CARE PHYSICIANS, 2019



(Source: America's Health Rankings)

Nevada has a very low number of physicians who are licensed as gerontologists. According to the Department of Employment, Training and Rehabilitation, there are 60 statewide, with the bulk of these (46) based in Clark county. Nevada's Nurse Practitioner workforce, focusing on the older adult population is filling this gap, although with only 322 statewide there is still a significant shortage of medical care personnel in the state (Fig. 59).

FIGURE 59: NV NURSE PRACTITIONERS, BY REGION



(Source: NV Department of Employment, Training and Rehabilitation)

Physician shortages are not the only workforce shortages impacting the quality of care and support for older adults in Nevada. In the 80th session of the Nevada Legislature, Assembly Bill

122 was passed for the Department of Health and Human Services to conduct a feasibility study related to establishing assisted living facilities in rural areas that also provide certain other services. The results of this study highlighted workforce shortages across the state. The following is an excerpt from the full report.

> *Calculations in the report use data from 2015 and 2019 (from the same data source) for both the number of workers and the percent change over five years as the data were available for both Nevada and the U.S. (Quarterly Census of Employment and Wages, Bureau of Labor Statistics, 2020). We also report the numbers of workers per 100 older adults for Nevada and the U.S. These ratios compare the availability of LTSS workers in Nevada and in the U.S.*
>
> *Table 3.3 shows the change in employment for the four LTSS industries in Nevada. Total LTSS employment increased from 29,024 to 34,400 over the five years, an increase of 5,376 workers or 18.5%. Employment increased in seven of the nine sectors. After dividing the 2015 number of employees by the number of older adults in Nevada in 2015 (397,622 from Table 3.2) and multiplying by 100, we obtain the number of employees per 100 older adults in Nevada in 2015. We use a comparable procedure to compute the number of employees per 100 adults in Nevada in 2019, after changing the number of older adults in Nevada to 484,328 for 2019. Total LTSS industry employment dropped from 7.30 workers per 100 older adults in 2015 to 7.10 workers per 100 older adults in 2019. This was a 3% drop in the number of workers per 100 older adults.*

Table 3.3: Employment in Health Care Industries Supporting the Aged in Nevada – 2015 to 2019

Major Sector Industry	2015	2019	Difference		2015 per 100k	2019 per 100k	Difference	
			Number	Percent			Number	Percent
Home Health Care	4,765	5,766	1,001	21.0	1,198	1,191	-8	-0.7
Services for the Elderly and Disabled	9,869	12,294	2,425	24.6	2,482	2.538	56	2.3
Community Care/Assisted Living	3,626	4,323	697	19.2	912	893	-19	-2.1
Continuing Care Retirement *	1,111	1,403	292	26.3	279	290	10	3.7
Assisted Living Facilities *	2,515	2,920	405	24.6	633	603	-30	-4.7
Nursing Care Facilities	6,281	7,324	1,043	16.6	1,580	1,512	-67	-4.3
Residential Mental Health Facilities	3,926	4,260	334	8.5	987	880	-108	-10.9
Other Facilities	659	433	-226	-34.3	N/A	N/A	N/A	N/A
Nursing and Residential Care	14,390	16,340	1,950	13.6	3,619	3,374	-245	-6.8
Total Employment	29,024	34,400	5,376	18.5	7,299	7,103	-197	-2.7

Source QCEW from Bureau of Labor Statistics (bls.gov)
Note: * lines are subset of Community/Assisted Living and not added into total employment

> *Comparison of the 2015 and 2019 rates per 100 older adults by industry indicates steady growth for two industries: Services for Older Adults and People*

*with Disabilities (56 or 2.3%) and Continuing Care Retirement (10 or 3.7%). The workforce grew by 18.5%, and the population grew by 21.8%. The difference between these two growth rates mean fewer people were available to work in these industries per 100 older adults living in Nevada. To achieve the 2015 ratio of workers to 100 older adults with the 2019 number of older adults, employment would have to increase by 968 individuals. (Calculated via 0.2 * 484,328 / 100, where 484,328 was the number of older adults in 2019 and 0.2 was the change in the ratio of workers per 100 adults.)*

The study also highlighted additional occupational categories serving older adults.

Data requested from Nevada DETR gives a picture of the occupational workforce for the Services for Older Adults and People with Disabilities (see Table 3.13). These services include adult day (AD) programs, senior centers, and other businesses. This is the largest workforce serving the senior adults. With the combining of PCAs into HH aides, 84.3% of this workforce are HH aides and 6.5% of the workers are in occupations with numbers too small to count (categorized as undetermined staff, e.g. rehabilitation counselors, healthcare social workers, and LPNs). Nationally, the distribution is 73.9% home health and PCAs. The business support staff percentage (13.1%) is very similar to the national percentage (12.1%).

Table 3.13: Services for Older Adults and People with Disabilities in Nevada - 2018

Occupation Group	Occupation Tile	Employed	Percent of Occupation	Percent of Employment
Health care support	Home Health Aides	9,790	100.0	84.3
Health care practitioner	Registered nurses	50	45.5	0.5
	Psychiatric technicians	60	54.5	0.6
Sub-total		110	100.0	1.0
Social and human service	Social & human assistants	90		0.8
Management		110		1.0
Office admin and support		440		4.0
Food preparation		90		0.8
Unidentified staff		750		6.9
Total Employment		11,620		100.0

Source: Nevada Department of Employment, Training, and Rehabilitation, 2019 data. Retrieved 2020.

Community Non-Profit Services

Community non-profit services provide the safety-net of support for older adults in Nevada and throughout the United States, often providing critical services not available through other sectors. Nevada ranks at the bottom (last) in terms of the non-profit share to total employment, with limited non-profit coverage across the state. Nevada has 1,318 registered non-profit organizations, providing social services, with most in urban areas (Fig. 60).

FIGURE 60: NV NONPROFITS BY COUNTY, 2020

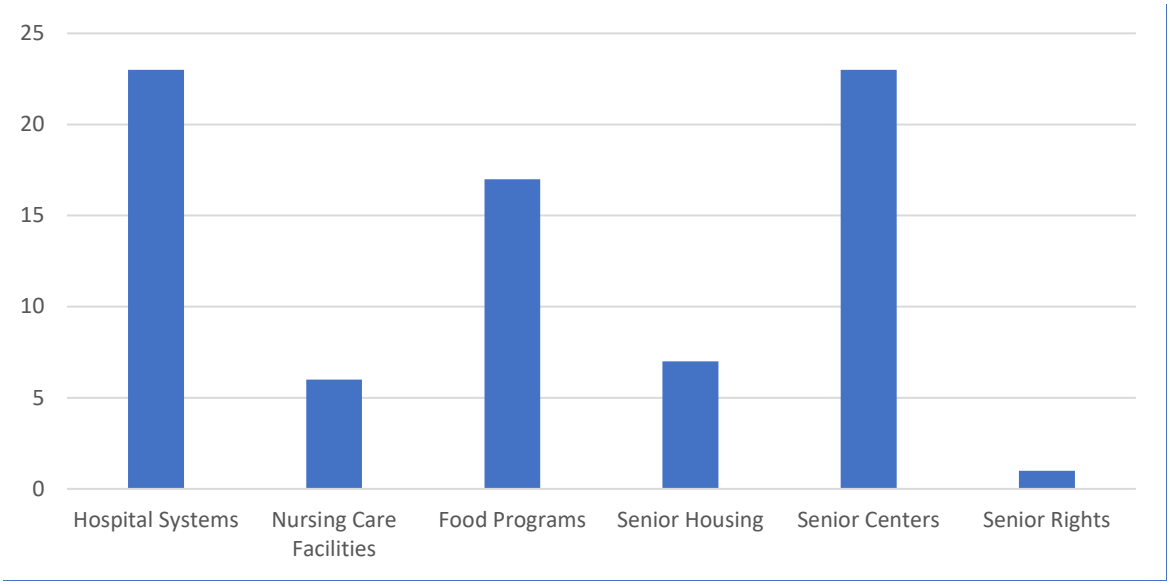
Region/County	Community Organizations – Religious and Civic – 2018	
	Number	Number per 100,000 Population
Rural and Frontier		
Churchill County	22	84.9
Douglas County	38	76.3
Elko County	26	46.9
Esmeralda County	0	0
Eureka County	0	0
Humboldt County	14	81.9
Lander County	6	98.7
Lincoln County	5	95.4
Lyon County	27	46.8
Mineral County	0	0
Nye County	26	53.1
Pershing County	5	71.6
Storey County	0	0
White Pine County	4	37.1
Region Subtotal	173	58.5
Urban		
Carson City	53	39
Clark County	764	32.8
Washoe County	328	68.5
Region Subtotal	1145	40
Nevada	1,318	42.8
Note: There are no reported community organizations in Esmeralda, Eureka, Mineral and Storey counties.		

(Source: United States Census Bureau (2020g)

Looking at non-profit organizational categories that would likely focus on serving older adults, this report considered the following categories: hospital systems, nursing care facilities, food programs, congregate meals, home delivered meals, senior housing and retirement communities, senior centers, and senior rights. Nevada has 77 registered non-profits that fall within these categories (Fig. 61). These categories are defined by the main mission of the registered non-profit organization. Other categories, such as social services would increase these numbers however, they may not have a senior focus.

Many seniors rely on community non-profits for their daily nutritional needs, in 2016 16,622 individuals, approximately 4% of Nevada's older population, were served through home delivered meal programs and the two largest food banks reported serving over 41,000 older Nevadans in 2016.

FIGURE 61: NV REGISTERED NON-PROFITS BY CATEGORY



Transportation

While the 21st century has seen an increase in the digital footprint and changed the way people interact with one another and access services, transportation systems are still a fabric of our infrastructure. As people age and capacity to drive independently decreases, transportation systems are foundational to keeping older adults connected with services that maintain their health and well-being. Transportation is consistently identified as highest rated service for need and missing, or not available as needed.

Nevada's access to transportation infrastructure includes public transportation services (RTC; buses); paid services (Taxicab,Uber,Lyft); connected transportation services (hospitals transports; senior centers, volunteer based); and private (self, friend, neighbor, family).

As expected, transportation services are often more prevalent in urban areas based on population. 5 of Nevada 17 counties have no public transportation services, meaning limited options for the 3,800+ Nevadans 65 years and older in these counties (Fig. 62).

FIGURE 62: TRANSIT RIDERSHIP - URBAN AREAS, 2019

County	Urban Transit System	Rural Transit Service	No Public Transit Service
Carson City	x		
Churchill County		x	
Clark County		x	
Douglas County		x	
Elko County		x	
Esmeralda County			x
Eureka County			x
Humboldt County		x	
Lander County			x
Lincoln County		x	
Lyon County		x	
Mineral County			x
Nye County		x	
Pershing County		x	
Storey County			x
Washoe County	x	x	
White Pine County		x	

(Source: Nevada Department of Transportation - Public Transportation Providers)

Urban transit systems are complex interconnected systems that include buses and paratransit services. Interwoven with these systems are paid services such as taxicabs and ride-share services. Urban transportation systems historically have more ridership than other service options. They are also more affordable than paid services.

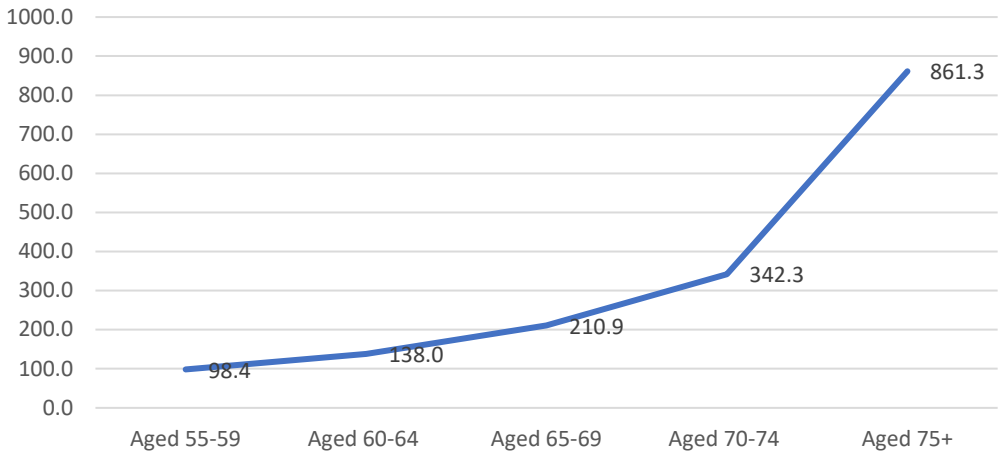
Rural transit services are typically county based. These services are often limited in connectivity, focusing on connections to food and healthcare resources in the community. Some rural transit services provide connection to urban areas, but this is limited to specific days and times, which still presents challenges for citizens to connect with healthcare and other critical services.

For counties without any public service, as well as the urban and rural counties with public service other transportation systems may exist. These include connected services such as those provided by senior centers, other non-profit organizations, and family/friends. ADSD community service grants for transportation direct services for older adults provided $1,530,903 in funding statewide in state fiscal year 2019. This funding served 17,455 clients and a total of 192,069 rides. The average cost per ride was $7.97. While these community-based services are often limited to shopping, healthcare, and senior center access, they are a lifeline for many older adults, especially in rural areas.

COVID-19 Pandemic

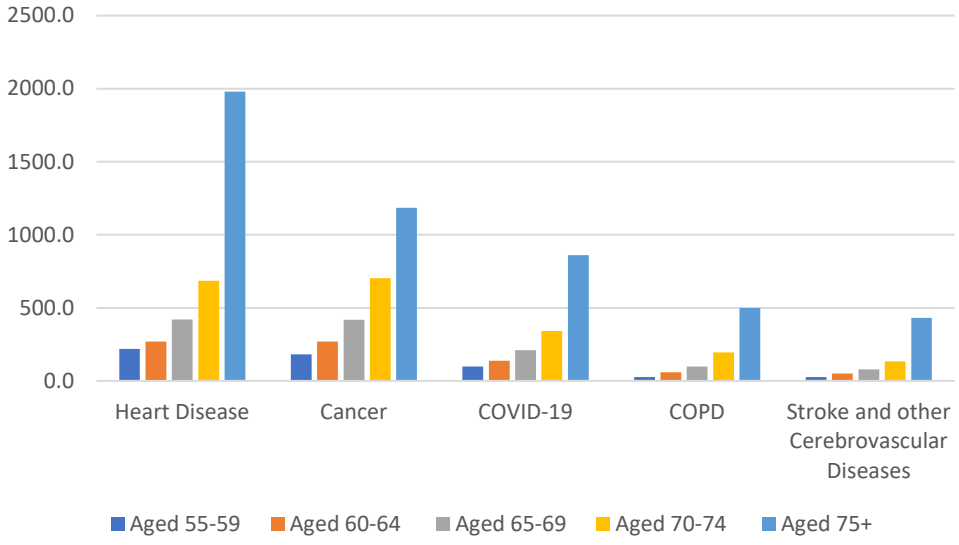
The COVID-19 pandemic will have a long-lasting effect on Nevada and the world. Older adults have disproportionately been affected by this pandemic due to the health, social, and economic impacts that have been realized. Older adults not only face higher rates of infection and mortality of the virus itself, with rates of death more than tripling between the Age 70-74 group and the Age 75+ group(Fig. 63). The COVID-19 disease was also the 3rd leading cause of death for people age 55 and older in 2020 (Fig. 64).

FIGURE 63: NV COVID-19 DEATH RATES, AGE 55+, 2020



(Data Source: Electronic Death Registry System, State Demographer)

FIGURE 64: NV LEADING CAUSE OF DEATH, AGE 55+, 2020



(Data Source: Electronic Death Registry System, State Demographer)

Older adults are also at an increased risk of long-lasting health impacts because of social isolation. While the aging services network historically served low-income and high-risk older

adults, offering a wide range of support and education services; doing so with a workforce already stretched then, the pandemic created an increased demand on services that we do not yet have a way to measure.

Consider the case example of “Joe”, an 83-year-old Las Vegas resident who lives alone. Prior to the pandemic he was active in his community, going to dance classes three times a week, visiting the dog park daily, dining out with friends and family a couple of times a week and walking daily. Today, he often refuses to get out of bed. His son and daughter in-law have become caregivers, bringing him food, ensuring he prepares and eats meals and attempts to get him to walk daily. His cognitive decline has accelerated, and his overall health is significantly impacted. They are beginning to look at support options for him, a man who lived independently and without significant health concerns just 9 months ago.

The COVID-19 pandemic also has several implications for the economic status of older adults, particularly in Nevada. With a larger percentage of older adults remaining in the workforce and the economic impact to Nevada’s primary industry of tourism, older adults may be disproportionally impacted. Programs such as the Senior Community Service Employment Program and strengthening partnerships through the Workforce Investment Opportunity Board will be critical to supporting economic status of older adults in Nevada.

Data Limitations, Challenges, and Cautions

All reports have inherent limitations that could influence the reliability and validity of the information presented. While citing all data limitations is not possible, key limitations, challenges and cautions are included in this section.

Data cited in this report are from nationally recognized, reliable sources. The data also are secondary, which means that we did not develop the surveys, collect the information, or analyze the data. As such, we cannot account for the data collection processes, the possibility of response bias, problems due to small sample size, conflicting data, or error. In addition, the dates of available data varied from 2010-2019 across (and even within) sources. Differences in years of data collection complicated efforts to make comparisons. Therefore, we reported some of the information by year without comparison. Finally, even with efforts to cross-validate information over multiple sources, it is still a possibility that results were misinterpreted.

Other challenges related to the lack of national- and state-level data specific to the senior population. This was particularly apparent when researching information about illicit substance use and gambling among older Nevadans, researching data on older Nevada veterans, and getting adequate sample sizes in surveys completed by underrepresented populations. National sources such as the Substance Abuse and Mental Health Services Administration (SAMSHA), National Survey on Drug Use and Health (NSDUH) surveys report use and dependence data only through age 59. This makes it difficult to capture a good picture of substance use issues among the nation's older adults. With gambling prevalence, we found a lack of reliable data regarding issues relating specifically to Nevada's older adults.

It was challenging to find information specifically about older veterans in Nevada because this population has not been on the radar of researchers. Finally, BRFSS samples sizes from underrepresented groups such as Blacks, Asians, etc., were too small to ensure reliability. We chose not to use these data, even though this left gaps in the available information. As a result, interpretations of the existing data must be made with caution.

It is important to consider that participant bias may have skewed survey results, demographics and prevalence rates. A respondent may inflate measures related to education and income while understating other measures such as weight and number of alcoholic drinks consumed. Although retrospective accounts are understandably inaccurate and unreliable, trend data is not as sensitive to respondent bias because individuals are less likely to report with systematic bias over time. In addition, if some respondents choose not to answer specific questions, nonresponse bias may occur.

In addition to respondent bias, data collection is susceptible to an array of errors, such as misinterpretations of responses by interviewers, data entry errors and missed questions. Errors can occur during data analysis, such as computer coding, scanning, and processing.

Resources such as time for research and development, as well as funding for design and printing limited the scope of this project. In the future, as more data are collected about the older adult population, baselines and/or benchmarks could be established to measure and evaluate Nevada's performance in meeting the needs of its older adults.

Specific Data Source Information

The secondary data contained in this report was collected from a variety of federal, state and private resources. These were chiefly the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Henry J. Kaiser Family Foundation, Centers for Medicare and Medicaid Services (CMS), Nevada State Demographer and the Nevada State Health Division.

CDC Behavior Risk Factor Surveillance System (BRFSS)

Due to sampling and weighting procedures, the CDC recommends that caution be taken when interpreting prevalence rates if the unweighted sample size for the denominator is less than 50. Sample sizes of less than 50 were considered potentially unreliable and were used with caution in this report. The result was that responses for certain underrepresented groups were often not captured at all. Thus, caution is encouraged in the interpretation of data.

The Nevada State Health Division is federally funded to collect annual BRFSS data via random phone surveys of Nevada residents and to analyze the results. Although BRFSS data were collected across the state of Nevada, the percentage of older adults within each county ranged from 11.0% of Elko County to 30.5% of Mineral County. Older adults constituted less than a quarter of the population in 12 of 17 counties. In addition, the percentage of older adult participants was small; therefore, the responses received from older adults may not be reflected adequately in this report.

CDC National Center for Injury Prevention and Control

This organization, which obtains much of its data from the National Center for Health Statistics, recommends caution with sample sizes of less than 20. Most health data on Nevada older adults were not analyzed for prevalence and trends across races or older age groups because sample sizes were too small.

U.S. Census Bureau

The Census Bureau collects data through the mail, over the phone, and in person for its decennial census. The American Community Survey (ACS), an ongoing nationwide survey designed to provide communities with a fresh look at how they are changing, is based on a sample of the community. The survey is administered every year to a small percentage of the population. Where possible, five-year ACS aggregate data were used as this provided the most comprehensive data. However, in cases where information was unavailable through this method, the one-year ACS data sets were used. These data sets may not adequately reflect the smaller populations living in the rural/frontier regions of the state.

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