United Way Alliance on Aging

A Collective Impact Initiative of the United Way of the Greater Lehigh Valley

United Way of the
Greater Lehigh Valley

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Lehigh Valley Seniors: Healthy at Home 2017 Update

A phone survey of Lehigh Valley residents, ages 55 and older, commissioned by the United Way of the Greater Lehigh Valley (UWGLV) and conducted by the Lehigh Valley Research Consortium (LVRC) and the Muhlenberg College Institute of Public Opinion (MCIPO). Report and analysis authored by Lanethea Mathews-Schultz, Professor of Political Science, Muhlenberg College, August 2017.

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Survey Overview

This report summarizes findings from a telephone-based survey of 1027 Lehigh Valley residents, adults ages 55 and older, living in Lehigh and Northampton counties in Pennsylvania. The survey was designed by the United Way Alliance on Aging, a Collective Impact Initiative of the United Way of the Greater Lehigh Valley (UWGLV) and administered by the Lehigh Valley Research Consortium (LVRC) in conjunction with the Muhlenberg College Institute of Public Opinion (MCIPO) in May-June 2017.

The following analysis provides a snapshot of the Lehigh Valley population of adults 55 years of age and older. It serves multiple purposes. First, it helps to identify existing levels of need among seniors for a range of services related to activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The survey estimates the number of seniors who currently receive supportive services to meet their self-care needs, as well as those who need but do not receive such services. Additionally, through a range of health behavior variables, the survey measures the extent to which aging adults in the Lehigh Valley may be at risk of needing supportive services in the future. Similar surveys were commissioned by the UWGLV in 2015 and 2014 with a particular focus on seniors ages 65 and older.[1] Taken together, these studies provide an important reference point for the UWGLV's community goal of increasing the numbers of seniors whose basic needs are met at home by 50% by 2022.

New this year, the survey sample has been expanded to adults ages 55 and older in an effort to focus on a range of measures of age-friendly communities. The survey speaks to perceptions of livability in the region along several dimensions, including housing, transportation, employment, and other variables related to living fully and independently at all ages. These new areas of focus emphasize the relationships between health and wellbeing, on one hand, and social, economic, and environmental dimensions of communities, on the other.

It is hoped that the outcomes of this project will assist the United Way of the Greater Lehigh Valley as it seeks to improve services in the community for seniors, and as it seeks to bolster preventative interventions designed to help older adults remain healthy at home to "age in

[1] Mathews-Schultz, 2015, *Lehigh Valley Seniors: Healthy at Home: 2015 Update*, a phone survey commissioned by the United Way Alliance on Aging Collective Impact Movement of the United Way of the Greater Lehigh Valley, conducted by the Muhlenberg College Institute of Public Opinion; and Mathews-Schultz, 2014, *Lehigh Valley Seniors Healthy at Home*, commissioned by the United Way of the Greater Lehigh Valley (UWGLV) conducted by the Lehigh Valley Research Consortium (LVRC), an affiliate of the Lehigh Valley Association of Independent Colleges (LVAIC), in conjunction with the Muhlenberg College Institute of Public Opinion. Both reports are available at: http://www.unitedwayglv.org/see-the-impact/healthy-aging/alliance-on-aging/publications.

place." It is also hoped that the information contained in this analysis will assist the Alliance on Aging, its member organizations, and other interested constituencies, in continuing to build strategies and services to meet the emergent needs of seniors in our community and further develop resources and commitments for an age-friendly Lehigh Valley.

About the LVRC

The Lehigh Valley Research Consortium (LVRC) is a collaboration among academic institutions in the Lehigh Valley region of Pennsylvania, which have joined together to enhance the teaching and scholarship opportunities at Lehigh Valley Association of Independent Colleges (LVAIC) institutions. Our aim is to use the LVRC as a point of departure for an examination of social, political, economic, health and environmental issues and solutions in a regional context. LVRC collaboration permits our smaller colleges and universities to join together and build upon our individuality while strengthening our ability to enhance learning opportunities for students, which would not be possible without this type of formal collaboration. The consortium opens up new research opportunities for faculty, experiential learning for students, and acts as an authoritative source of data for Lehigh Valley government officials, businesses, non-profits, and citizens. Faculty involved with the LVRC are actively involved in collecting new quantitative and qualitative data in those areas in which new information is required, connecting LVAIC institutions to the community, and disseminating a wide variety of information about the Lehigh Valley of regional, state, and even national significance. The LVRC is part of the Lehigh Valley Association of Independent Colleges, a 501(c)(3) organization, which includes Cedar Crest College, DeSales University, Lafayette College, Lehigh University, Moravian College, and Muhlenberg College.

About the Research Team

The Muhlenberg College Institute of Public Opinion is a public opinion research center that conducts scientific based survey research projects on public policy and political issues. As part of the college's mission of providing students with preparation for socially useful and self-fulfilling careers, the institute also undertakes projects in conjunction with community partners that examine contemporary issues relevant to the interests of the public and policy-makers. Dr. Christopher Borick, Professor of Political Science at Muhlenberg College, directs the Institute.

Dr. A. Lanethea Mathews-Schultz, Professor and Department Chair of Political Science at Muhlenberg College and researcher affiliated with the LVRC, analyzed the survey findings and authored this report. Please direct all questions and inquiries to her at: Department of Political Science, 2400 Chew St, Allentown PA 18104, 484-695-1390, mathews-schultz@muhlenberg.edu.

The views expressed in this report are those of the research team and do not reflect the views of the Polling Institute, Muhlenberg College, the LVRC, LVAIC, or the United Way of the Greater Lehigh Valley.

Executive Summary

Pennsylvania is getting older. Between 2011 and 2015, the population of seniors ages 65 and older in the state increased by 10%, compared to only a 0.5% increase in the general population. Seniors number approximately 2.2 million statewide, equal to about 17% of the total Pennsylvania population, making the state the 6th oldest in the nation. The median age in Pennsylvania in 2015 was 40.7 years—nationally, this number is 37.9 years.[2]

Population changes in Lehigh and Northampton counties generally follow statewide trends, with a few notable exceptions. Lehigh is among the fastest growing counties in the state and Northampton is not far behind.[3] Regional population increases are particularly interesting because recent estimates suggests that, in 2016, Pennsylvania experienced its first population decrease in more than 30 years. Population increases in the region may also prove counter-trends to statewide aging patterns. Between 2010 and 2015, Census data suggest that the median age in Lehigh County crept from 39.1 to 39.5. Annual population estimates released in 2017 point to a possible reversal of this trend with a reduction in the Lehigh County media age back to 39.1 in 2016 making it one of only 3 counties in the state to see a decrease in median age. [4]

According to the Census Bureau's American Community Survey, **there are approximately 192,963 individuals age 55 or older** in the Lehigh Valley region. The **number of seniors 65 years and older is approximately 106,100—the vast majority, about 101,000, are non-institutionalized individuals** (that is, not living in prisons, nursing homes, or psychiatric institutions). In 2010, seniors ages 65 and older constituted 15% of the combined Lehigh and Northampton population; in 2015, this figure was just over 16%. The corresponding increase among Valley residents ages 55 and older was even more significant, growing from 26.9% in 2010 to 29.4% in 2015. Statewide Census population estimates suggest that the 55 and older

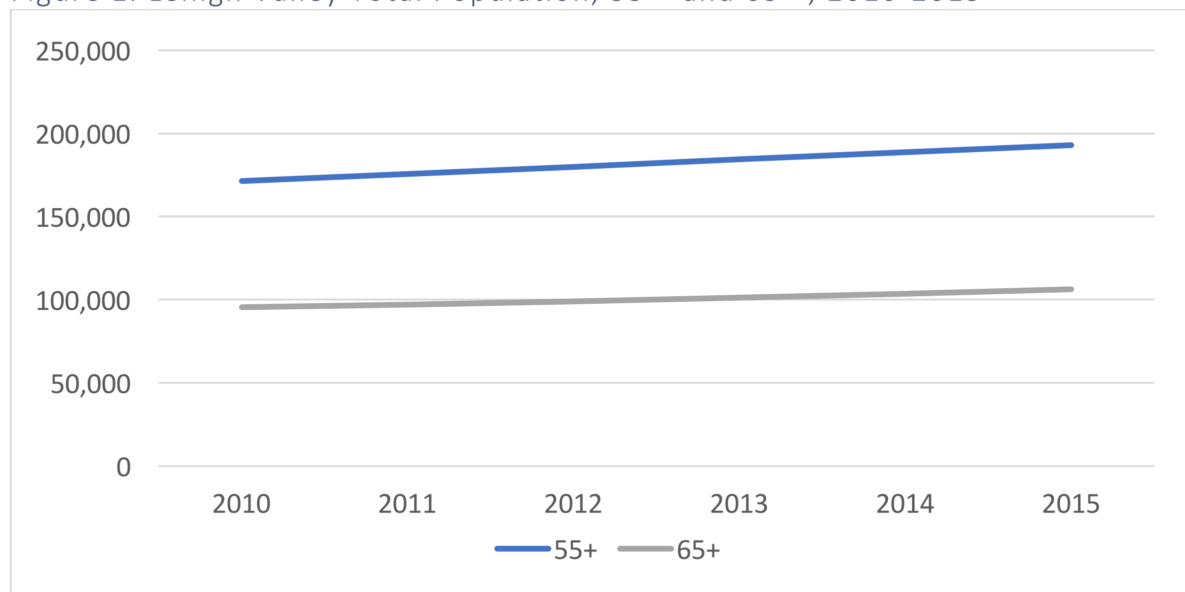
[2] These figures are drawn from the Pennsylvania Data Center's Research Brief, "Pennsylvania's Aging Population: 2011-2015," released in February 2017, which provides detail and analysis of the US Census Bureau's American Community Survey 1-year estimates.

[3] According to the Pennsylvania Data Center, 44 Pennsylvanian counties have experienced population decreases since 2010; growth in the state has been concentrated in the southeastern and southcentral parts of the state, including the Lehigh Valley, and neighboring counties of Berks and Montgomery. Monroe, Carbon, and Schuylkill counties have experienced population decreases. See Pennsylvania State Data Center, "2016 County Population Estimates," Research Brief, March 2017.

[4] See Tom Shortell, "The Lehigh Valley is growing grayer, more diverse," *Morning Call*, July 13, 2017.

cohort has seen the most dramatic increases of all age categories, growing by almost 13% across Pennsylvania since 2010.[5]

Figure 1. Lehigh Valley Total Population, 55 + and 65 +, 2010-2015



Source: American Community Survey, Five-Year Estimates, 2010-2015.

Demographic and population changes create both challenges and opportunities. As the aging population grows it is also diversifying. Compared to 2010, today's population of seniors ages 65 and older includes greater proportions of African Americans and Latinos; foreign born and bilingual individuals; individuals with a college education; and unmarried and never married individuals. While sizable numbers of respondents have lived in the Lehigh Valley for decades (more than one-half have lived at their current residence for more than twenty years), demographic changes in the region mean that more seniors have been living in the community for shorter periods of time. In the current survey, **more than one-quarter of respondents have lived in their current home for less than 10 years** (this compares to only 18% in the 2015 survey).

The United Way of the Greater Lehigh Valley (UWGLV) is committed to increasing the number of seniors in the region whose basic needs are met at home. This survey provides a snapshot of the Lehigh Valley regional population, similar to studies conducted in 2014 and 2015 (see **Table 1).** These studies do not permit for longitudinal analysis since the surveys were administered to different populations each time, but they do provide context for considering what we know to

[5] Penn State Data Center, "2016 State and County Detailed Population Estimates," *Research Brief*, June 22, 2017, https://pasdc.hbg.psu.edu/sdc/pasdc_files/researchbriefs/DetailedEstimates_2017.pdf

be true about the population from Census Bureau data and allow for deeper analysis of regional perceptions and needs.

The current survey confirms much of what was learned in 2014 and 2015. The Census Bureau estimates that more than 34% of seniors in Lehigh and Northampton counties have some kind of disability. This study finds similarly that **about 32% of regional residents, ages 65 and older, have trouble completing at least one activity of daily living or instrumental activity of daily living**. **Approximately 3% say that they receive no help**—from friends and family or from paid or subsidized services—in meeting at least one self-care need. Comparing these findings to ACA population estimates suggests that there are more than 32,000 Lehigh Valley seniors who have self-care needs and more than 3,000 who receive no help in meeting those needs.

Table 1. 2014, 2015, 2017 Lehigh Valley Seniors Healthy at Home Survey Findings[6]

	2014	2015	2017
ACS Estimate of Senior Population in Lehigh and Northampton Counties (65 years and older)	94,221	96,358	101,113
Survey Sample (adults 65 years and older)	803	830	685*
Survey estimate of percentage of seniors with at least one ADL/IADL	28%	27%	32%
Survey estimate of percentage of seniors reporting no help with at least one self-care need	5%	4%	3%

**Note*: The current 2017 survey sample included respondents ages 55 and older and included a total of 1027 respondents; 685 of these reported their age to be 65 or older in 2017. Sixty survey respondents declined to provide their year of birth. The 3% of respondents in 2017 who indicated an unmet ADL or IADL need equals only 23 respondents; it is not possible therefore to draw meaningful inferences from this data to the regional senior population and its need for and use of programmatic benefits for ADLs and IADLs.

[6] Each survey sample provides information about a different cross-section of the senior population. Therefore, the data do not offer a longitudinal comparison. The number of individuals who reported unmet self-care needs (that is, individuals who said they have difficulty and receive no help with a self-care need) is extremely small making it impossible to say whether or not these findings reveal actual differences or are simply a reflection of sample differences. Only 23 individuals ages 65 and older who completed the survey said that they had difficulty with but received no help completing at least one ADL or IADL.

Survey respondents report the greatest difficulties with the following instrumental activities of daily living: obtaining transportation for doctor's and social appointments, grocery shopping, cooking and preparing hot meals. Seniors report fewer problems with ADLs; the most common areas of difficulty among these activities are grooming, getting in and out of bed or a chair, and bathing independently.

Trouble with ADLs and IADLs is more common among women, Hispanics/Latinos and African Americans, low income residents (reporting annual incomes under $25,000), individuals living alone, and foreign-born (immigrant) residents. **Individuals with chronic health conditions**—diabetes or arthritis—**are also more likely to report trouble completing self-care tasks independently**. These two common health conditions are prominent among the regional senior population; 28% of respondents report that they have been diagnosed with diabetes and 52% say they have been told they have arthritis.

In much the same way that demographic variables are linked to independently living, **individuals who live alone, who report low family income, who are immigrants, or who report difficulties completing self-care tasks are significantly more likely to report feelings of social isolation and loneliness, or periods of depression and sadness**. Previous studies conducted by the UWGLV have found similarly that while the vast majority of older adults in the region do not report problems with depression or loneliness, these are significantly more common among particular subgroups of the aging population.

While much of what follows confirms previous studies conducted by the UWGLV, particularly when it comes to seniors' ADL and IADLs difficulties, what is new this year is a concerted focus on survey respondents' perceptions of the Lehigh Valley as an age-friendly, livable community. Encouraged by the World Health Organization (WHO) and American Association of Retired Persons' (AARP) emphasis on building and promoting age-friendly communities, the current survey includes several questions designed to measure livability in our region. Environmental factors, social context, and neighborhood characteristics are equally as critical to healthy aging as are individuals' health behaviors, chronic health conditions, and disability status.

Findings from the survey suggest that approximately **60% of adults ages 55 and older, rate their communities as an excellent or very good place to live as they age**. Reflecting the deep roots that many older adults have in the Lehigh Valley, **approximately 60% also say that it is very important to remain in their community as they age.** An even larger majority, **82%, agree or strongly agree that community events and activities in the region attract all generations by accommodating age-specific needs and preferences.** In fact, these feelings are strongest among older respondents and those who have lived in their current homes for longer periods of time.

Livable communities are safe, accessible and useable along many dimensions, including housing, transportation, work and voluntarism, civic life, environment, and health. This survey included questions related to food access, health and wellness services, access to community

information, and volunteering and job security for seniors, to begin thinking about the Lehigh Valley region as a livable community where individuals can age-in-place. When it comes to health and wellness and food access, survey respondents provide generally positive perceptions. The vast majority of respondents, **83%, are satisfied or very satisfied with health and wellness services in their community.** Similarly, **87%, say that they can easily purchase fresh and healthy food in their neighborhood.** This figure was somewhat lower among respondents who also say that they have difficulty obtaining transportation, pointing to the link between transportation, food access, and independent living—but, even among these individuals a clear majority say that they can easily purchase fresh and healthy food in their neighborhood.

Somewhat smaller majorities of respondents report that they have access to community information and communication in a number of ways, for example, clearly displayed information in large lettering, an automated and easy to understand information system, or access to computers and wifi in public places. The one notable exception in this regard is respondents' views on access to community information in a number of different languages. **A majority, 58%, say they do not have access to community information in different languages.**

Views on volunteering were extremely positive; **95% of respondents report that there is opportunity for volunteerism in the Lehigh Valley**. Views on job security for seniors, however, were less positive with **57% suggesting that there is not job security for seniors in the region**. Context seems to matter to these perceptions. Negative views about job security were strongest among respondents who have lived in their current residence for the greatest length of time.

There are a few notable differences among subgroups of the survey sample that are worth briefly emphasizing. **First, perceptions of respondents with ADL and IADL limitations highlight the links between social environment and disability.** In order to age-in-place, for example, many respondents anticipate that they will require home modifications. This is particularly the case among respondents who also report having ADL or IADL difficulties; in order to remain in their home as they age 54% of respondents with ADL/IADL difficulty will require bathroom modifications while 45% will require putting a bedroom, bathroom or kitchen on the first floor. Individuals with ADL/IADL difficulties were also less likely to say that they can access fresh and healthy food easily in their neighborhood.

Second, **perceptions of livability and whether or not the Lehigh Valley is an age-friendly community tend to vary with age, such that older individuals provide more positive views of their communities than do younger individuals**. These data point to potentially interesting future research questions about attitudes toward aging among younger adults. They may also point to gaps in younger adults' information and knowledge about services for seniors in their communities.

Third, and perhaps less surprisingly, income matters to one's experiences and evaluations of community. **Low-income respondents are less likely to rate their community as an excellent**

or very good place to age and less likely to report being satisfied with health and wellness services when compared to higher income respondents. Perhaps especially noteworthy in the context of the Lehigh Valley region, **individuals who are foreign born also communicate more negative perceptions about aging in their community.**

Finally, in part because the social determinants of health and wellbeing are linked to geography, so too are variables linked to livability and aging-in-place. While the survey sample is too small to draw firm conclusions, **respondents' views about their communities vary by place**, raising a host of questions about the ways in which inequality is distributed across the Lehigh Valley region. These differences do not break down neatly according to urban-rural-suburban communities, but there are some general trends. Respondents from the city of Allentown, for example, generally have more negative views about the age-friendliness of their community, report more difficulty accessing fresh and healthy food in their neighborhood, and are less satisfied with health and wellness services. Respondents from Slatington consistently provide more negative views than respondents from other townships or municipalities. Other communities, like South Whitehall, offer mixed views; here, respondents report high levels of satisfaction with their ability to purchase fresh and healthy food in their neighborhood, but mixed views on the age-friendliness of their community and they are the least likely to agree that they have access to community information in multiple language. Taken together, **Figures 5** (pg. 23), **11 (**pg.29), **14 (**pg. 32), and **Table 7** (pg. 35) offer many questions for future research and a starting place for identifying gaps in livability across the Lehigh Valley region.

Survey Method & Sample

The central goals of this survey are 1) to estimate need for services related to activities of daily living (ADLs) and instrumental activities of daily living (IADLs) among Lehigh Valley seniors; 2) to estimate the number of seniors who may be at risk of needing supportive services for ADLs and IADLs in the future; and 3) to explore residents' perceptions of the region as an age-friendly community in reference to a number of measures related to inclusive living. The **Appendix** contains all questions asked in the survey along with frequency responses.

The telephone survey was administered by the Muhlenberg College Institute of Public Opinion (MCIPO) to a random sample of non-institutionalized adults, ages 55 and older, who reside in Lehigh and Northampton counties using a random digit dialing sample procedure (five call back attempts were made for each number). In total, **1027 Lehigh Valley residents ages 55 and older completed the survey,** yielding a margin of error of +/- 3% at a 95% confidence interval. The margin of error for subgroups in the sample is larger due to the smaller sample size and, as a result, it is important not to overgeneralize results discussed in this report, especially when comparing subgroups from the sample.

Unless otherwise noted, the data are weighted by sex and race/ethnicity for the regional population ages 55 and older using the American Community Survey's 2011-2015 five-year estimates in the Lehigh Valley.[7] Percentages reported may not add up to 100% due to rounding.

A summary of the demographic makeup of the sample (after weighting by sex and race/ethnicity) is provided in **Table 2**; information about the geographic distribution and housing of survey respondents is summarized in **Table 3**.

Close to 30% of survey respondents are 55 to 64 years of age. Notably, about 7% of the sample identifies as Hispanic/Latino, 4% are Black/African American, and 5% report that they are foreign born. Approximately 14% of survey respondents report household incomes under $14,999 per year; an additional 16% report household incomes between $15,000 and $24,999 per year.[8]

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[7] At the time of survey data collection, the American Community Survey (ACS) five year estimates, 2012-2016 were not yet available.

[8] As a point of reference, the federal poverty level in 2017 for a family of one equaled $12,060; for a family of two, the threshold was $16,240. The US Census Bureau estimates that approximately 6.4% of seniors (ages 65 and older) in Lehigh County and 6% of seniors in Northampton County live below 100% of the federal poverty level. According to 2017 guidelines, 200% of the federal poverty level (the preferred measure for basic living expenses) equaled $24,120 for a family of one and $32,480 for a family of two.

Approximately 30% of survey respondents report that they live alone (by design, all respondents in this survey live in households, that is, noninstitutionalized settings). More than one-half of the survey sample reports living in their current household for more than 20 years; 23% have lived in their current home for more than 40 years.

Fifty-five percent of survey respondents live in Lehigh County, 45% in Northampton County. In line with the distribution of the population in the region, 19% of respondents live in Bethlehem, 17% in the city of Allentown, 5% in Easton, and 5% in Whitehall. Information about additional municipalities is included in **Table 3**.

Table 2. Demographic Summary of Survey Sample (N=1027)

Sex	Male	45% (465)
	Female	55% (562)
Age in 2017	55 to 64 years	29% (282)
	65 to 69 years	14% (134)
	70 to 74 years	16% (158)
	75 to 79 years	14% (134)
	80 to 84 years	13% (129)
	85 years and older	14% (131)
	Refused	6% (60)
Race/Ethnicity	White (non-Latino)	85% (883)
	Black/African-American	4% (36)
	Asian	2% (21)
	Hispanic/Latino	7% (75)
	Other	1% (13)
Household Income	Less than $14,999	14% (88)
	$15,000-$24,999	16% (98)
	$25,000-$39,999	20% (129)
	$40,000-$59,999	22% (137)
	$60,000-$99,999	17% (104)
	$100,000 and higher	12% (76)
	Refused	38% (394)
Foreign Born	Yes	5% (55)

Table 3. Geographic & Housing Summary of Survey Sample (N=1027)

County	Lehigh	55% (561)
	Northampton	45% (466)
Municipality	Allentown	17% (177)
	Bethlehem	19% (193)
	Easton	5% (49)
	Whitehall	5% (49)
	Lower Macungie	3% (33)
	Palmer	3% (33)
	Macungie	3% (31)
	Nazareth	3% (26)
	Forks	3% (25)
	Northampton	2% (24)
	Emmaus	2% (21)
	Coopersburg	2% (19)
	South Whitehall	2% (18)
	Salisbury	2% (16)
	Slatington	2% (15)
	Bangor	2% (15)
	Other (equal to 1% or fewer in each municipality/town)	28% (744)
Number living in household	Living alone	30% (310)
	Two	55% (563)
	Three or more	15% (154)

Table 3. Geographic & Housing Summary of Survey Sample (N=1027) continued

Time living at current residence	Fewer than 5 years	16% (157)
	6 to 10 years	11% (106)
	11 to 20 years	21% (207)
	21 to 30 years	17% (167)
	31 to 40 years	13% (132)
	41 to 50 years	13% (133)
	51 or more years	10% (98)

Narrative Summary of Findings

The Lehigh Valley as an Age-Friendly Community

According to World Health Organization (WHO) and the American Association of Retired Persons (AARP), age-friendly communities are livable communities, they promote health and sustain economic growth, and they work to help develop happy and healthy residents at every stage of human development. The AARP and WHO identify eight domains of livable communities. These include: 1) safe and accessible outdoor spaces and buildings; 2) affordable, dependable transportation; 3) affordable and accessible housing at all life stages; 4) opportunities for social participation to prevent social isolation and loneliness; 5) intergenerational community activities that are inclusive of people of all ages; 6) opportunities for work, volunteerism and engagement in civic life; 7) inclusive communication systems that provide multiple vehicles for accessing information (not only digital mechanisms); and 8) adequate access to affordable health services. Livable communities allow residents to age-in-place while promoting engagement in community, economic, and social life.

The United Way of the Greater Lehigh Valley has identified seven focus areas of interest in the region: health, housing, food, social respect and inclusion, communication and information, job and volunteer opportunities, and community navigation (transportation, outdoor spaces, walkability, etc.). The current survey includes several questions from the AARP's livability survey in an effort to begin taking stock of the Lehigh Valley as a livable region. The survey measures respondents' perceptions of key dimensions of livability which are useful in identifying gaps in needs and resources and can help to prioritize areas of focus.

Community Experience: Perceptions of Aging-In-Place

As seen in **Figure 2**, **a majority of survey respondents, about 60%, say that their community is an excellent or very good place for people to age**. An additional **28% say that their community is a good place to live as they age**. Only 12% of respondents rated their community as fair or poor on this question.[9] Interestingly, age is related to respondents' perceptions, such that **older**

[9] To provide additional context, these findings can be compared to those of a Muhlenberg College Institute of Public Opinion quality of life study conducted in 2015 which found that 92% of residents say that the Lehigh Valley is a good or excellent place to live. An additional study conducted by the LVRC in 2012, the *St. Luke's Community Health Study*, similarly found that 77% of seniors in the Lehigh Valley rated their community as a good place to grow old.

respondents are more likely to rate their community as an excellent place for people to age as shown in **Figure 3**.

Figure 2. Respondents' Perceptions of Aging in Place

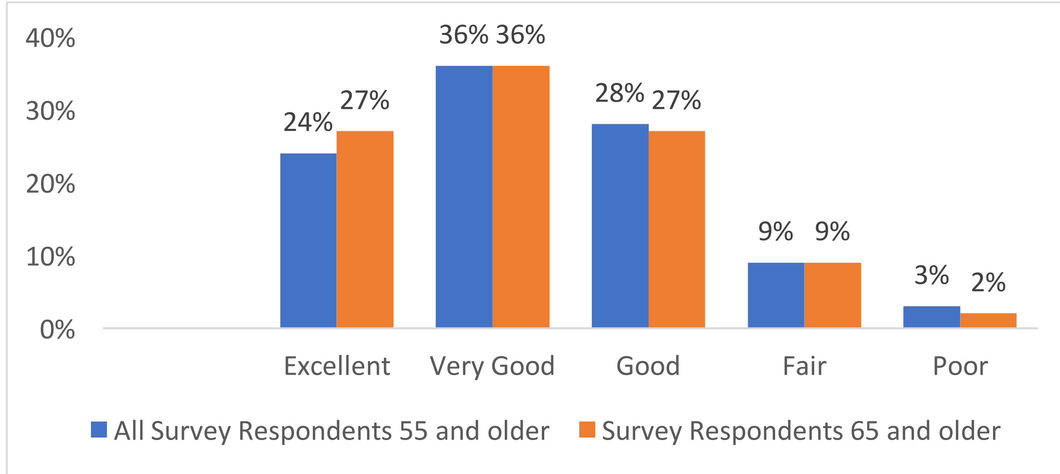
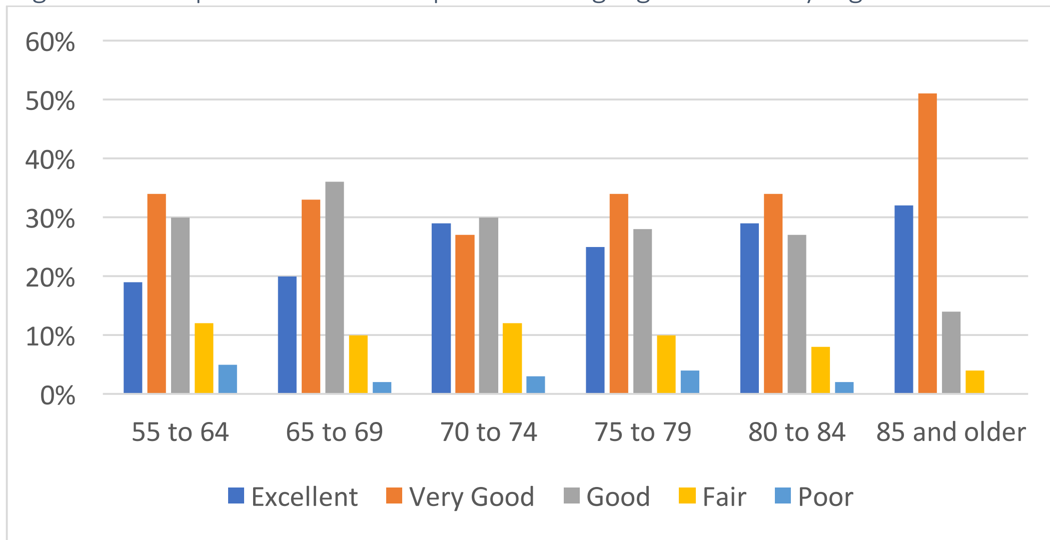


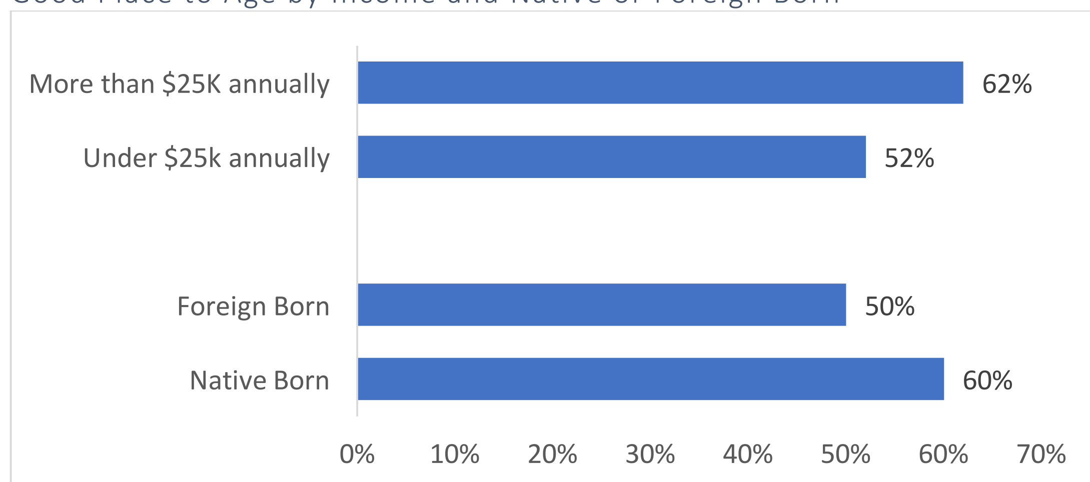
Figure 3. Respondents' Perceptions of Aging in Place by Age



Survey respondents who live alone and those who live with others are equally as likely to rate their communities as excellent or very good places to age. Similarly, respondents with ADL/IADL limitations are just as likely to evaluate their communities positively when compared to respondents without difficulty completing self-care tasks independently. These findings are encouraging, since research has suggested that living alone makes aging-in-place more difficult and is often associated with problems completing self-care tasks (these areas of concern are explored in more depth in the next section of this report).[10]

When it comes to positive evaluations of aging-in-place in the Lehigh Valley, there may be meaningful differences between low and high income individuals, however, as well as between those born in the US and those who are foreign born, as illustrated in **Figure 4**. Respondents who are native born and respondents who report higher annual family incomes are more likely to give positive evaluations of their communities than are respondents born outside or the US or those who are low income. The numbers of respondents in each of these categories is small—only 5% of the survey sample is foreign born, for example—but these findings nonetheless point to potential gaps in community livability for particular subpopulations.[11]

Figure 4. Percentage of Respondents Rating Their Community as an Excellent or Very Good Place to Age by Income and Native or Foreign Born

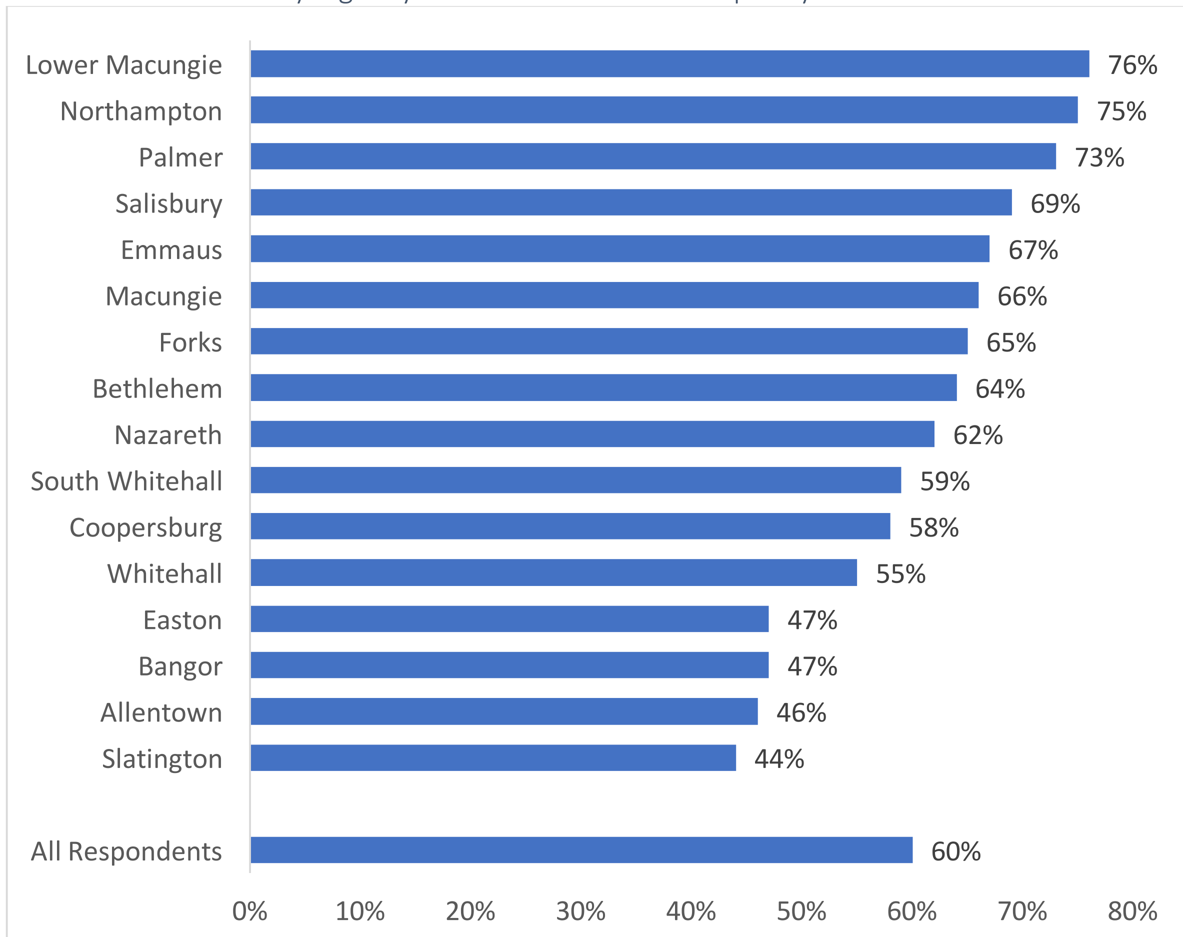


[10] For example, see National Institute on Aging, https://www.nia.nih.gov/health/aging-place-growing-old-home.

[11] One recent study suggests that low-income individuals may have a greater expectation of living in their current homes and communities as they age compared to higher income individuals (who have greater resources, perhaps, to re-locate). This raises particularly critical questions about building affordable communities that allow low income residents to age-in-place. See Amanda Lehning, Richard Smith, and Ruth Dunkle, “Do Age-Friendly Characteristics Influence the Expectation to Age in Place? A Comparison of Low-Income and Higher Income Detroit Elders,” *J Appl Gerontol* 34 (March): 158-180. In the current study, no significant differences were found between low and higher income respondents and the level of importance attached to remaining in community with age—approximately 90% of both low income and higher income individuals report that it is somewhat or very important for them to remain in their community as they age.

"Community" means different things to different people—it could refer to one's country, or one's county, township, or neighborhood. **Figure 5** provides a closer look at how respondents' positive evaluations of their community differ by township or municipality. There are clear differences, for example, between Slatington and Allentown on one hand, where the percentage of respondents rating their community as an excellent or very good place to age is well below the survey average (44% in Slatington and 46% in Allentown) and, on the other hand, locations such as Lower Macungie and Northampton where positive evaluations are quite high, reaching about 75%.

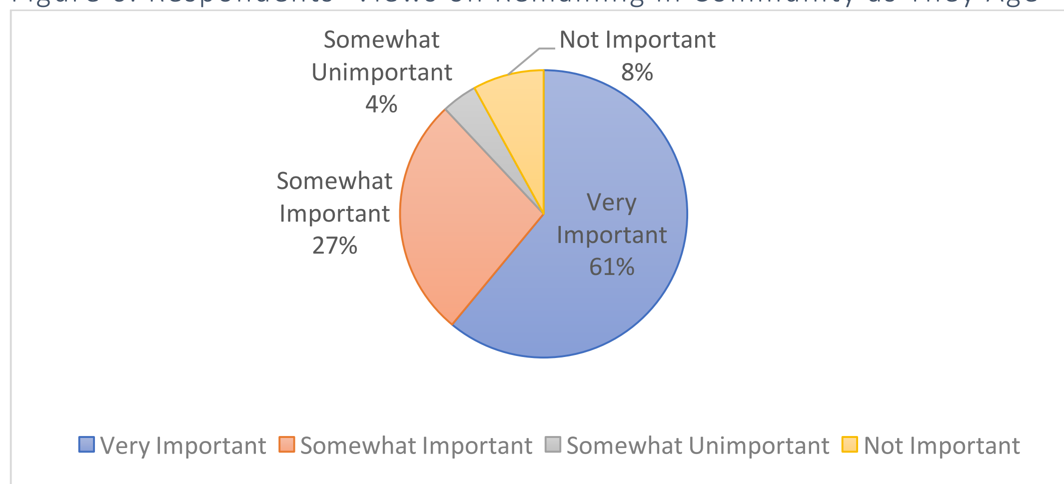
Figure 5. Percentage of Respondents Rating Community as Excellent or Very Good Place to Live as They Age by Hometown or Municipality



Note: This figure includes only the top sixteen home towns/municipalities identified by at least 2% of survey respondents. Please see **Table 3** for additional information about the geographic distribution of the survey sample. Due to small sample size, no claims can be made about the statistical significance of these findings. These findings may be substantively significant, however, pointing to interesting and important questions for future research.

Respondents were next asked about the importance of remaining in their community as they age. Findings are reported in **Figure 6, showing that more than 60% of respondents say it is very important to remain in their community as they age; an additional 27% say it is somewhat important**.

Figure 6. Respondents' Views on Remaining in Community as They Age



There is some association between the importance respondents attach to remaining in their community as they age and the length of time they have lived in their current residence, as seen in **Figure 7**.[12] These findings are consistent with similar studies, which have found that individuals with deep roots in community prefer to age in that community.[13]

At the same time that the vast majority of respondents report strong preference for remaining in their community as they age, many also say they anticipate needing home modifications in order to remain in their current home. As shown in **Figure 8**, most significantly, **43% of respondents anticipate needing bathroom modifications to remain in their current home as they age; 33% anticipate needing to put a bedroom, bathroom, or kitchen on the first floor**. **Figure 9** suggests that **30% of survey respondents anticipate three or more required modifications in order to remain in their home as they age**.

[12] These two questions are slightly different. The first asks respondents how important it is to them to remain in their *community* as they age; the second, asks respondents how long they have lived in their current *residence*. Aging-in-place for some may mean living in the home they've always lived in; for others, aging-in-place may mean living in a different (perhaps more accessible, affordable) home in their neighborhood. The current survey did not ask questions at this level of detail.

[13] The AARP maintains an archive of communities that have implemented the Livability Survey. See: http://www.aarp.org/livable-communities/archives/info-2014/livable-communities-survey-results.html. Several of these community studies report links between length of residence and the importance residents place on aging-in-place.

Figure 7. Respondents Who Say it is Very Important to Remain in Their Community as They Age by Length of Time at Current Residence

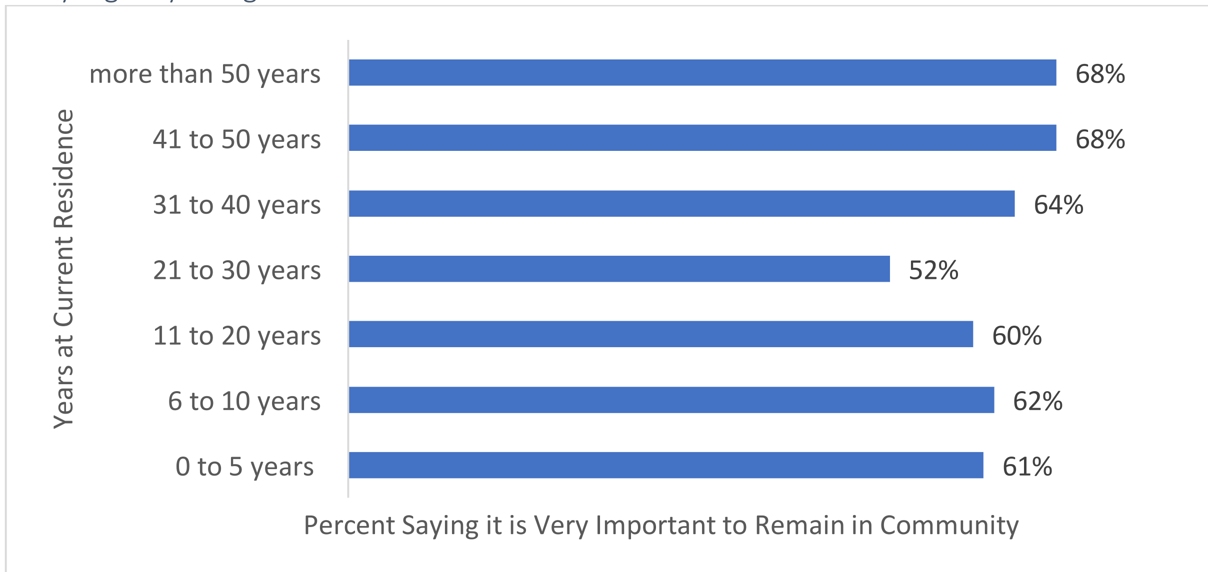


Figure 8. Respondents' Anticipated Home Modifications Required to Age-In-Place

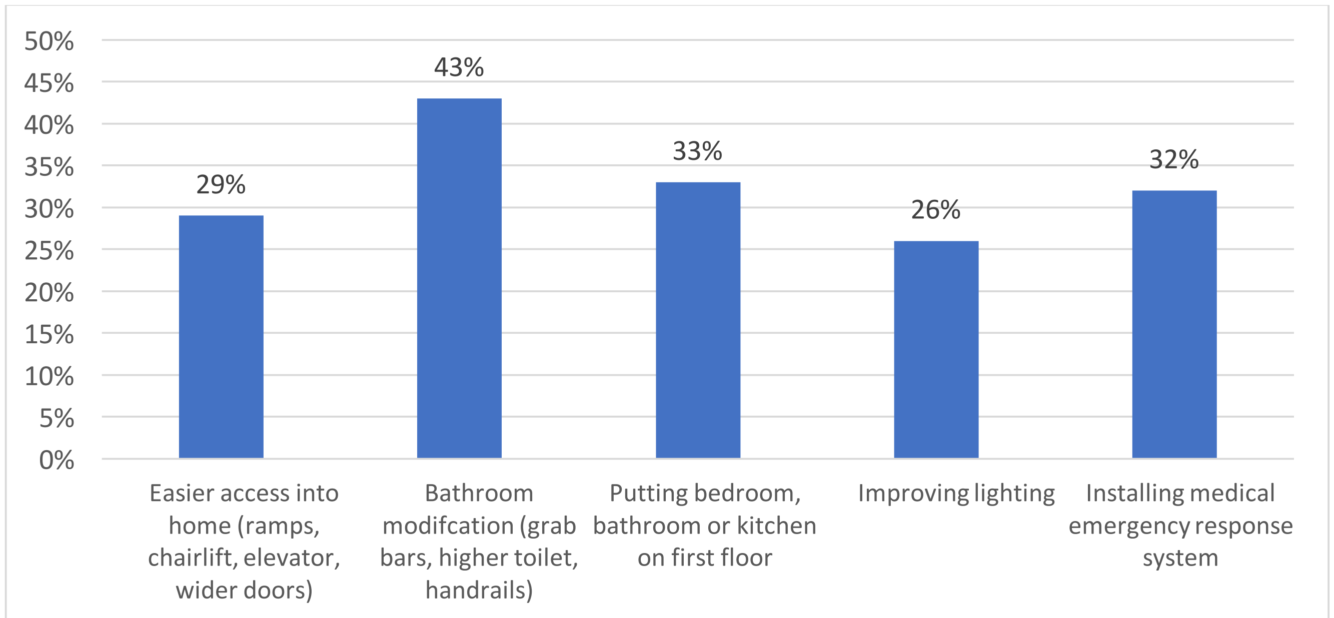
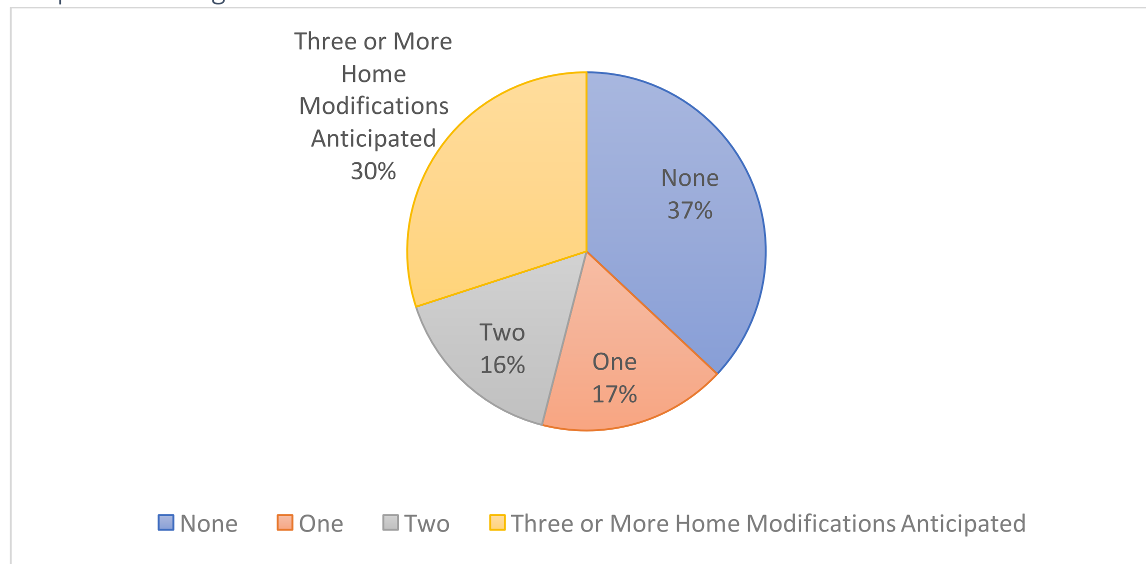


Figure 9. Percentage of Respondents Anticipating Multiple Home Modifications Required to Age-In-Place



Survey analysis suggests that individuals who have lived in their current home for longer periods of time, more than 40 years, are also more likely to say that they will need to make home modifications as they age. This makes sense, recognizing that these individuals are also more likely to be older residents.

As seen in **Table 4**, the need for home modifications is even greater among individuals who report difficulty completing at least one self-care task. **Among this group of respondents, the need for bathroom modifications jumps up to 54%. Similarly, 45% of respondents with at least one ADL/IADL difficulty anticipate that they will need to put a bedroom, bathroom, or kitchen on the first floor in order to continuing living in their home as they age**. Individuals with ADL/IADL difficulties may be most vulnerable when it comes to aging-in-place, requiring a greater degree of home modification to continue living independently in their current home.

Table 4. ADL/IADL Difficulty and Anticipated Home Modifications

	Easier access into home (ramp, elevator, chair lift)	Bathroom modification	Putting bedroom, bathroom or kitchen on first floor	Improving Lighting	Installing Emergency Response System
ADL/IADL Limitation	**33%**	**54%**	**45%**	**35%**	**39%**
No ADL/IADL Limitation	26%	40%	28%	22%	38%

Food Access

According to the County Health Rankings, in 2015, 13% of residents in Lehigh County and 11% of residents in Northampton County were food insecure. The UWGLV estimates that 1 in 10 people in the Lehigh Valley region, or approximately 63,000 people, are hungry. The American Association of Retired Persons has led research efforts in the state of Pennsylvania to identify food insecurity among seniors ages 65 and older, estimating that statewide, almost 15% of seniors are food insecure. Rates of food insecurity may be particularly high among seniors who live alone and seniors who are living in poverty.[14] Reducing the numbers of individuals in the region who are food insecure is a key goal of the UWGLV.

The survey included one question designed to measure respondents' perceptions about the ease with which they can access fresh and healthy food in their neighborhood. As reported in the **Appendix**, survey findings suggest that t**he vast majority of survey respondents, 87%, report that they can easily purchase fresh and healthy food in their neighborhood**. This figure remains high—at 80%—even among individuals who report at least one ADL/IADL limitation, as shown in **Figure 10**. Among all subgroups in the survey sample, respondents who also reported difficulty obtaining transportation were most likely to report trouble with food access in their neighborhood. **Twenty-three percent of respondents with problems obtaining transportation also say they are unable to purchase fresh and healthy food**.

Figure 11 lists the percentage of respondents who say they are able to purchase fresh and healthy food in their neighborhood by municipality/township of residence. While it is important to keep in mind that the number of respondents in some of these municipalities are few—for example, only 15 survey respondents are from Bangor, compared to 177 from Allentown—Figure 11 confirms what we know to be true and that is that food security is linked to geographic place.[15]

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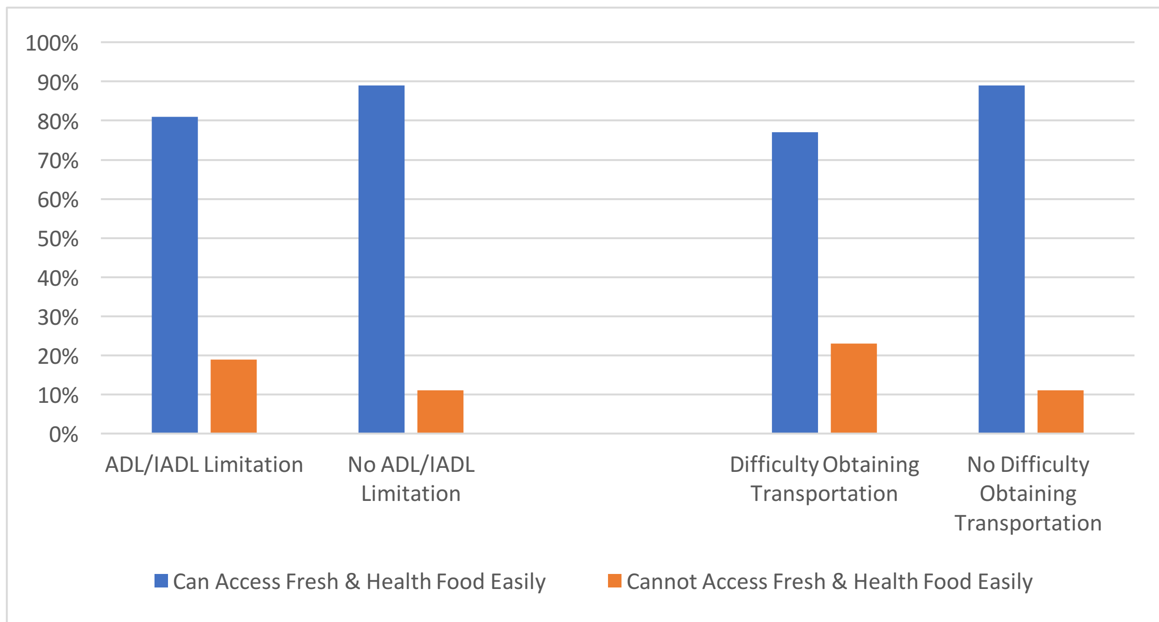
[14] The current survey did not reveal statistically significant relationships between living alone and being low income when it comes to respondents' views on being able to purchase fresh and healthy food. The 2012 *St. Luke's Community Health Study* collected some information about food security; findings suggest that, in 2012, younger adults were more likely than seniors ages 65 and older to report that they were unable to afford enough food and were unable afford healthy food or food that they'd like; younger adults were more likely than seniors to say that they had made sacrifices in bills in order to buy food. These findings are reported in the UWGLV's 2012 Status Report, "Helping Older Adults Stay as Independent as Possible."

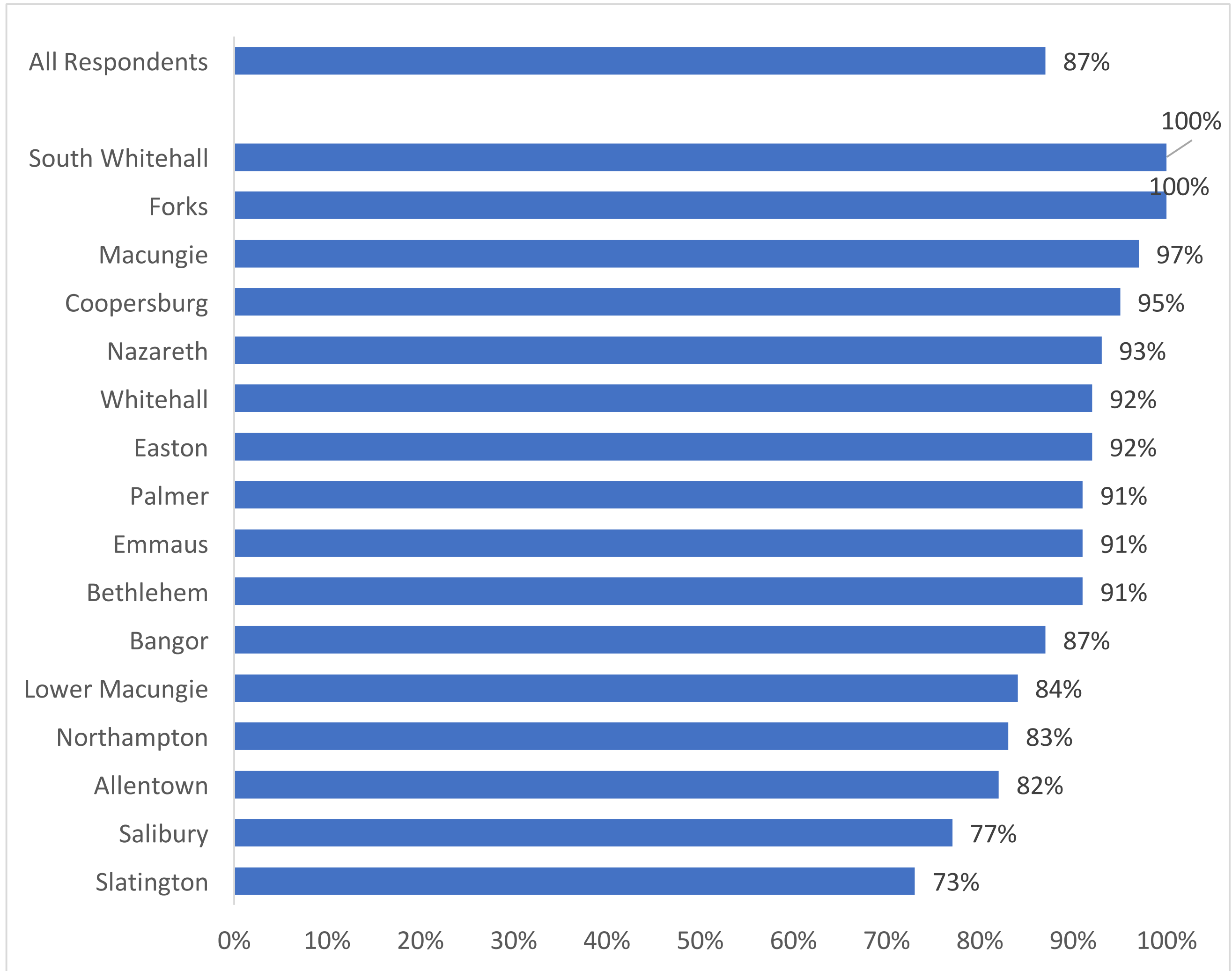
[15] Food security is also linked to poverty, although no significant differences on questions of food access were found between respondents of low income (families under $25,000 annually) and those of higher income.

Figure 10. Respondents' Who Can Easily Purchase Fresh & Healthy Foods by ADL/IADL Difficulties and Trouble Obtaining Transportation[16]



[16] The survey asked two questions about transportation. The first asked respondents if they have trouble obtaining transportation for vital appointments, such as doctors' appointments; the second asked about trouble obtaining transportation for social activities. In Figure 10, the second question is used to examine relationships between transportation and ease of purchasing fresh and healthy food in one's neighborhood. Both transportation questions revealed similar results, as reported in the Appendix.

Figure 11. Access to Fresh & Healthy Food by Respondents' Hometown/Municipality



Note: This figure includes only the top sixteen home towns/municipalities identified among at least 2% of survey respondents. Please see **Table 3** for additional information about the geographic distribution of the survey sample. Due to small sample size, no claims can be made about the statistical significance of these findings. These findings may be substantively significant, however, pointing to interesting and important questions for future research.

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Health & Wellness Services

Later sections of the report summarize survey respondents' answers to questions about several health indicators, including measures of respondents' abilities to complete self-care tasks independently, prevalence of chronic health conditions, and mental health and wellbeing. This section focuses on health and wellness as it relates to features of communities that allow individuals to age-in-place.

The survey asked respondents to indicate their level of satisfaction with available health and wellness services in their community including fitness activities, wellness programs and classes, and services that help seniors find personal care. All are key characteristics of livable communities. Considering all survey respondents, as reported in the **Appendix**, **83% say they are satisfied or very satisfied with health and wellness services.** Very few respondents, **only 5%, said that are dissatisfied or very dissatisfied with these services, although a notable 13% said they were unsure** (reflecting perhaps low knowledge about what services are available).

Responses by age group are illustrated in **Figure 12.** Age generally has a positive relationship with respondents' satisfaction; adults 75 years and older are most likely to report that they are satisfied or very satisfied with available health and wellness services. Respondents ages 55 to 64 are least likely to report being satisfied. Since the survey did not ask respondents about particular kinds of health and wellness services, it is difficult to interpret the kinds of services residents might desire (e.g., yoga, swimming, more emergency care centers); we do not know what services respondents have access to or use already, nor the kinds of services they'd like to have available. These findings are interesting and could point to several different explanations: for instance, individuals age 55 to 64 may be less aware of community health and wellness services in their communities such as those promoted by senior centers or agencies that focus on individuals ages 65 and older.

Figure 13 illustrates small, but potentially meaningful, differences in evaluations of available health and wellness services between respondents with and without ADL/IADL self-care difficulties, between respondents with low and higher incomes, and between respondents who are foreign born and those who are native born. Respondents who have at least one ADL/IADL limitation are more likely to say they are satisfied or very satisfied with health and wellness services in their communities—although this is a small and not statistically significant difference. Larger differences are seen when comparing low income to higher income respondents; even greater differences are evident when considering place of birth. While **83% of respondents who were born in the US say they are satisfied or very satisfied with available health and wellness services, only 73% of those who are foreign born say the same**.

Figure 12. Percentage of Respondents Reporting They are Very Satisfied or Satisfied with Health & Wellness Services in their Community by Age Group

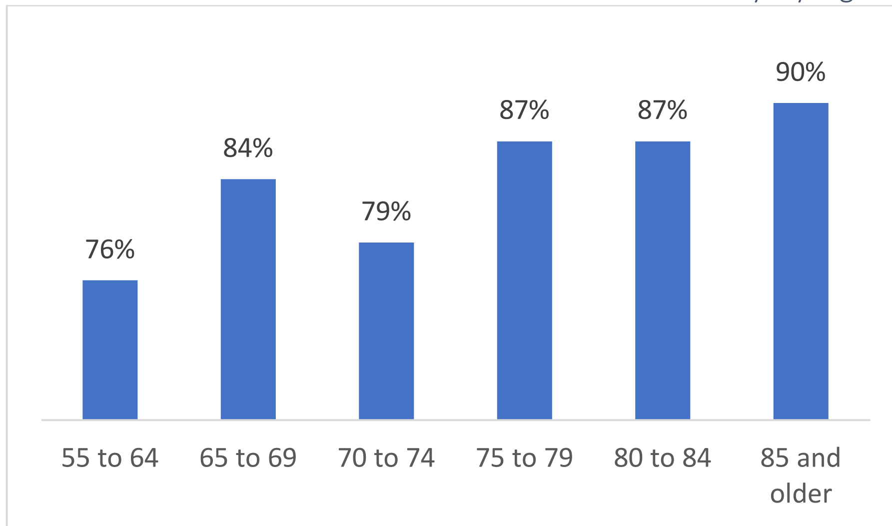


Figure 13. Percentage of Respondents Reporting they are Very Satisfied or Satisfied with Health & Wellness Services by ADL/IADL Limitation, Income, and Native vs. Foreign Born

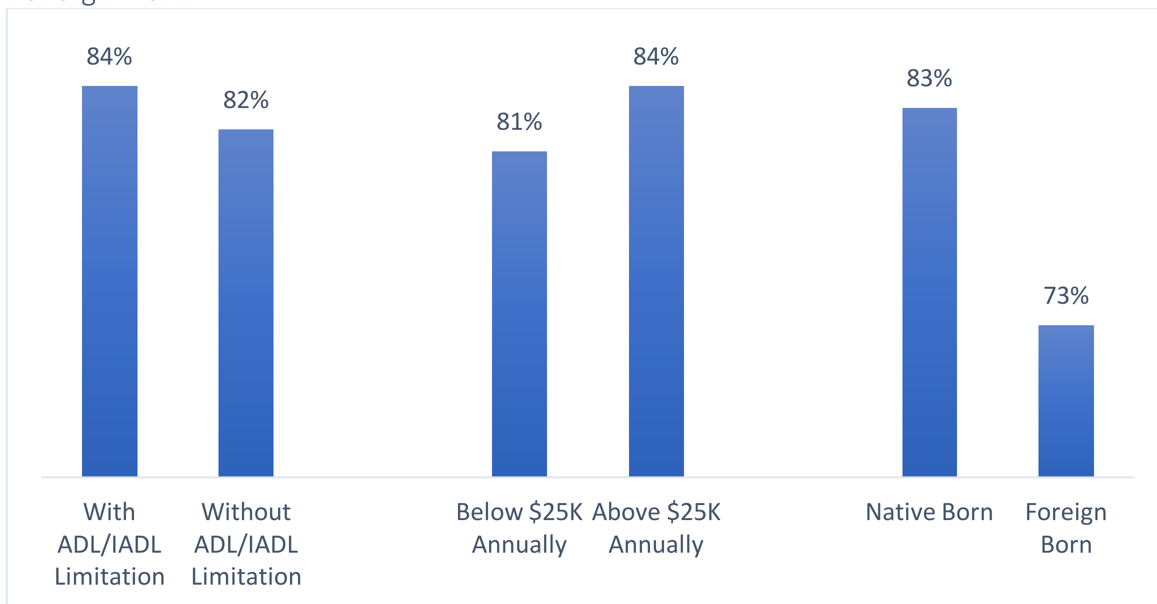
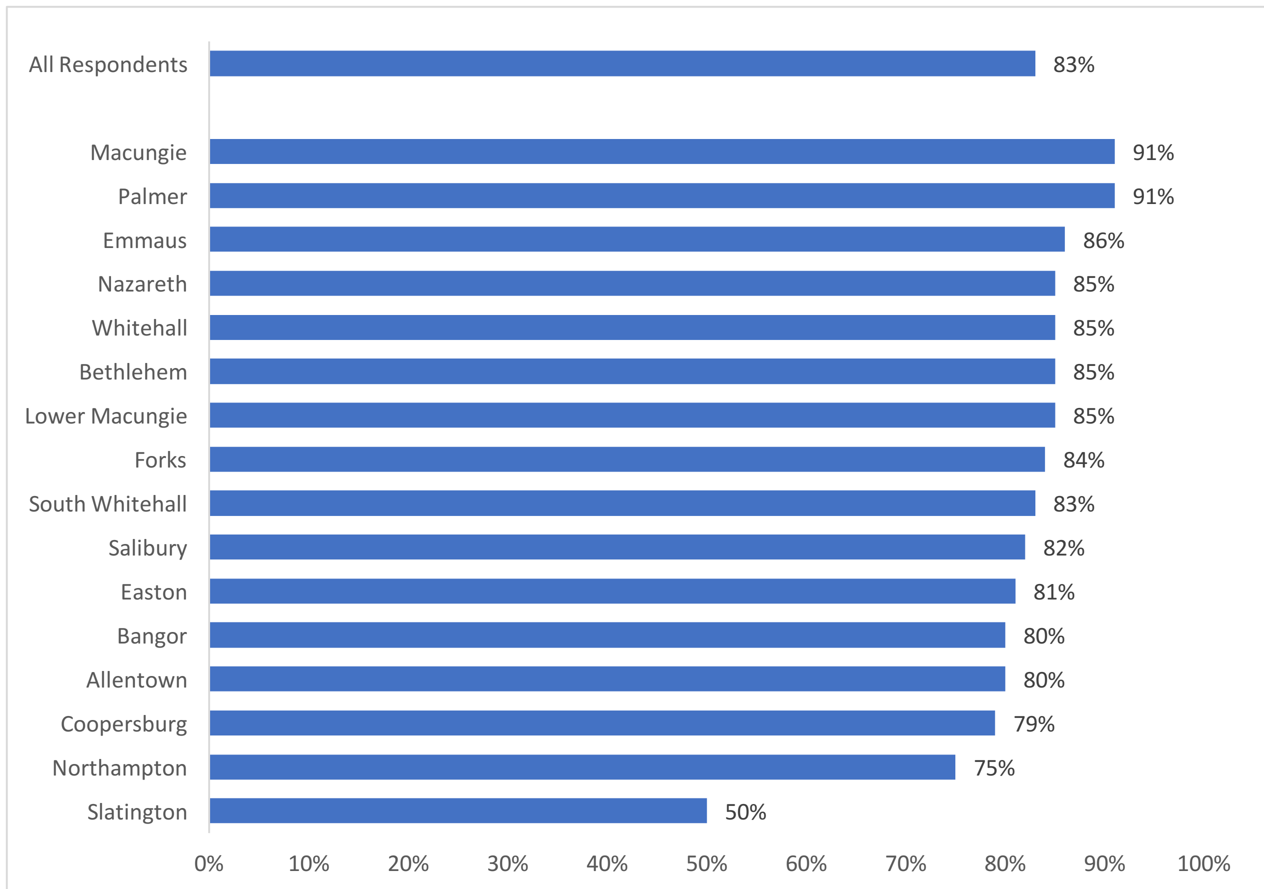


Figure 14 explores how respondents' satisfaction of community health and wellness services varies by geographic location. These data suggest potential gaps in health and wellness services in particular areas of the Lehigh Valley region. Only 50% of respondents from Slatington, for example, say that they are satisfied or very satisfied with available health and wellness services. Several locations fall below the survey average evaluation of 83% including Northampton, Coopersburg, Allentown, and Bangor.

Figure 14. Percentage of Respondents who are Satisfied or Very Satisfied with Available Health & Wellness Services by Hometown/Municipality



Note: This figure includes only the top sixteen home towns/municipalities identified by at least 2% of survey respondents. Please see **Table 3** for additional information about the geographic distribution of the survey sample. Due to small sample size, no claims can be made about the statistical significance of these findings. These findings may be substantively significant, however, pointing to interesting and important questions for future research.

Community Communication & Information

The World Health Organization and the American Association of Retired Persons include communication and information as key domains of age-friendly, livable communities. While emergent communication technologies offer many tools for providing information to an aging population, livable communities recognize that not all individuals in a community have access to these communication technologies, especially online and social media technologies.

Table 5 summarizes survey respondents' answers to several questions about the availability of community information in the Lehigh Valley. It is important to keep in mind that the questions ask respondents about access to community information—and access itself is shaped by many variables, including individual health and wellness, and social and environmental factors, such as transportation, education, and knowledge.

Majorities of respondents say that they have access to community information in one central source and that they have free access to computers and the internet in public places. Smaller majorities say that they have access to clearly displayed printed information in large lettering; automated, easy to understand information; and information delivered in person to those who may be unable to leave home. On this last measure, respondents who report they have trouble completing at least one ADL or IADL independently were more likely than respondents without ADL/IADL difficulties to agree that they have access to community information delivered in person—a positive finding, possibly suggesting those who do have trouble leaving home have higher levels of knowledge about available information services.

When it comes to having community information available in a number of different languages, however, the majority is reversed, with **58% reporting that they do not have this type of information.**

In an effort to gain more insight about this measure, **Table 6** summarizes respondents' views on access to information in multiple languages by two key measures included in the survey: whether respondents have ADL/IADL difficulties and whether respondents live alone or with others. In all cases, only a minority of respondents say that they have access to community information in multiple languages. Individuals with ADL/IADL limitations are somewhat more likely to say that they have access to information in multiple languages, reflecting perhaps increased knowledge gained through experience negotiating sources of support for self-care. Individuals living alone are less likely to say that they have access to information in multiple languages; this may be evidence of social isolation. No significant differences were found on this measure by income or age or by foreign-born status.

Table 5. Survey Respondents' Responses to: *"As a resident of the Lehigh Valley do you have…?"*

	YES	NO
Access to community information in one central source	**75%**	25%
Clearly displayed printed community information with large lettering	**61%**	39%
An automated community information source that is easy to understand	**66%**	34%
Free access to computers and the internet in public places	**79%**	22%
Community information delivered in person to people who may have difficulty or may not be able to leave their home	**57%**	43%
Community information that is available in a number of different languages	42%	**58**%

Table 6. Percentage of Respondents Agreeing that They Have Access to "Community information that is available in a number of different languages."

ADL/IADL Limitation	46%
No ADL/IADL Limitation	40%
Live Alone	37%
Live with Others	43%

Table 7 lists respondents' agreement on these measures of communication and information by the municipality or city of their residence, focusing attention on the ways in which access to community information (or perceptions of that access) depends on where respondents live. Well over 90% of respondents from Emmaus, for example, say that they have access to community information from one central source. This stands in stark contrast to respondents in Salisbury, where only 47% say that have access to centralized information. Respondents who live in the City of Allentown and those who live in Emmaus are more likely to say that they have access to information in multiple languages; in other locations, such as Macungie and Coopersburg, well under half of respondents agree. When it comes to free access to computers and wifi in public spaces, overall, agreement among respondents is high across all geographic areas. It is lowest among respondents from Slatington, where only 69% agre,e and highest among those in Palmer, where 91% of respondents agree.

Table 7. Percentage of Respondents Who Agree that they Have Access to Community Information by Hometown/Municipality

	Community information in one central source	Clearly displayed, large lettering	Automated information system	Free public access to computers and wifi	Information delivered in person	Information in different languages
All Survey Respondents	75%	61%	66%	79%	57%	42%
Allentown	77%	62%	67%	78%	63%	50%
Bangor	80%	60%	60%	80%	73%	47%
Bethlehem	75%	63%	66%	79%	54%	42%
Coopersburg	84%	78%	78%	84%	72%	32%
Easton	69%	61%	67%	71%	55%	47%
Emmaus	92%	71%	67%	77%	57%	55%
Forks	84%	73%	64%	77%	64%	52%
Lower Macungie	79%	56%	61%	76%	50%	55%
Macungie	88%	72%	65%	84%	68%	36%
Nazareth	85%	56%	67%	89%	62%	39%
Northampton	75%	67%	67%	75%	52%	42%
Palmer	74%	59%	74%	91%	67%	42%
Salisbury	47%	50%	63%	81%	63%	35%
Slatington	88%	53%	67%	69%	69%	40%
South Whitehall	67%	47%	41%	89%	53%	29%

Note: This figure includes only the top sixteen home towns/municipalities identified by at least 2% of survey respondents. Please see **Table 3** for additional information about the geographic distribution of the survey sample. Due to small sample size, no claims can be made about the statistical significance of these findings. These findings may be substantively significant, however, pointing to interesting and important questions for future research.

Social Participation, Voluntarism, Job Security

Livable, age-friendly communities provide opportunities for aging and older adults to continue to work for pay if they are interested in doing so, to fulfill volunteer opportunities in the community, and to continue participatory engagement in civic life. Age-friendly communities also promote inclusivity in community activities and events. With these goals in mind, the survey measured respondents' perceptions about community inclusion, voluntarism, and job security for seniors.

When it comes to community events and activities, survey respondents offer generally positive perceptions. As reported in the **Appendix**, **82% of respondents agree or strongly agree that community events and activities in the region "attract all generations by accommodating age-specific needs and preferences."**

As shown in **Figures 15-16**, positive perceptions are common among both individuals who live alone and those who live with others; in each category 82% strongly agree or agree that community events and activities are inclusive of all ages.

Figure 17 considers how age is related to respondents' perceptions about inclusive community events. Notably, individuals are more likely to agree or strongly agree that community events are inclusive of all generations by meeting age-specific needs and preferences as they age. The highest level of agreement was identified among individuals ages 80 to 84—87% agree that community events attract all generations.[17]

[17] While the survey does not provide enough information to explain these findings, one possibility is that respondents' views reflect attitudes about aging. If younger respondents, ages 55 to 64, have more negative views about community events and more negative views about their communities as a place to age (see above), this could reflect negative perceptions about aging, rather than objective features of communities. Further research might shed greater light on relationships between attitudes toward aging and individuals' perceptions of age friendly communities.

Figure 15. Respondents Who Live Alone: Agreement with the statement “Community events and activities in the Lehigh Valley attract all generations by accommodating age-specific needs and preferences.”

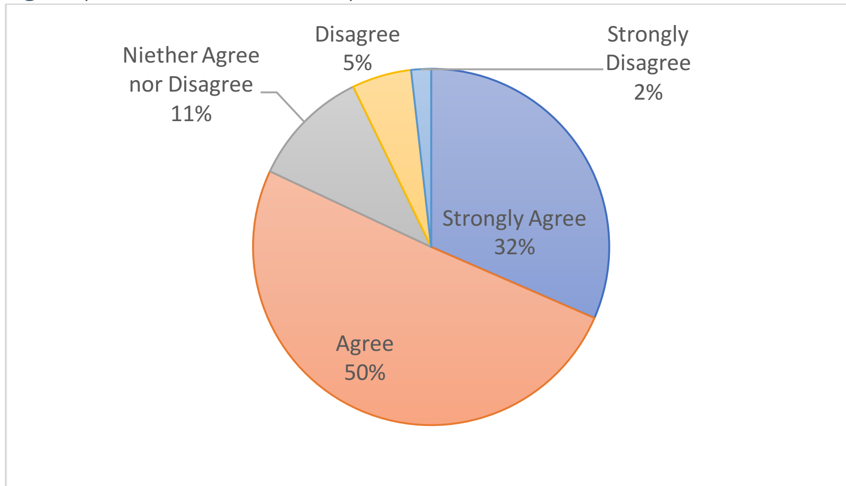


Figure 16. Respondents Who Live with Others: Agreement with the statement “Community events and activities in the Lehigh Valley attract all generations by accommodating age-specific needs and preferences.”

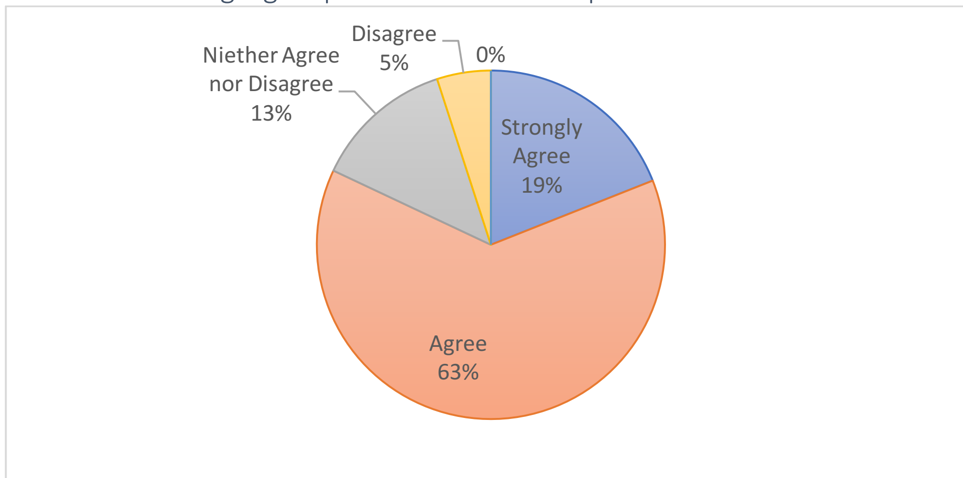
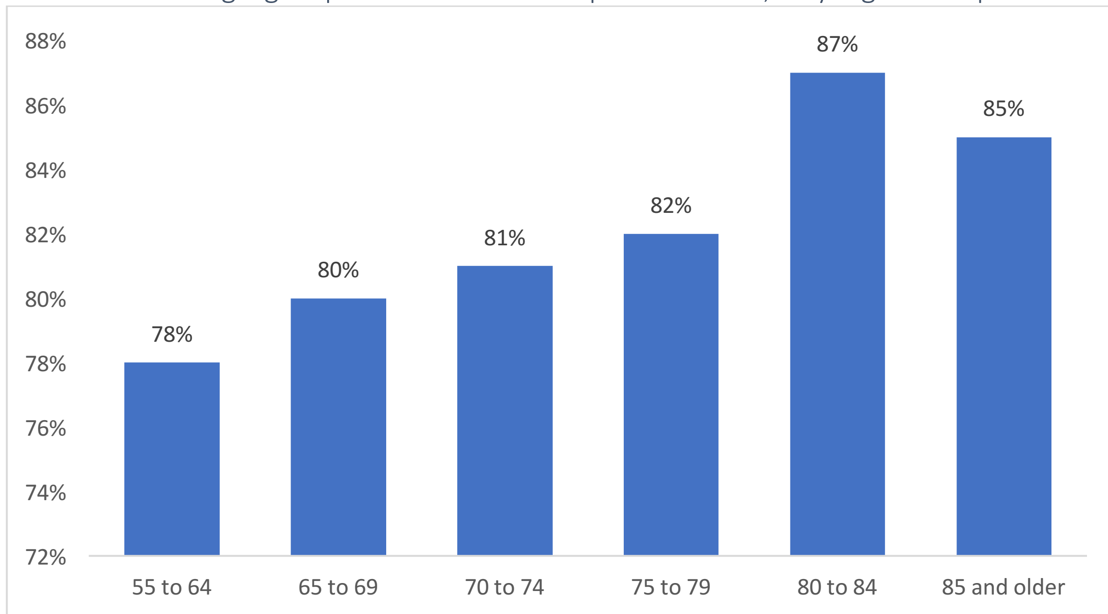


Figure 17. Percentage of Respondents Who Strongly Agree or Agree that "Community events and activities in the Lehigh Valley attract all generations by accommodating age-specific needs and preferences," by Age Group



A final group of questions asked respondents to share views and perceptions about volunteer opportunities and job security. As reported in the **Appendix**, **ninety-five percent of respondents said that they believe there "is opportunity for volunteerism in the Lehigh Valley." Only 25% of respondents, however, report being interested in volunteering themselves.**

When it comes to respondents' perceptions about job security, survey findings are less positive. As shown in **Figure 18**, only **43% of respondents agree that there is job security for seniors in the Lehigh Valley; 57% disagree**. Respondents' negative perceptions about job security increase in relation to the length of time they have lived in their current residence, as seen in **Figure 19**. This may reflect observations of shifting job opportunities over a lifetime of living in the Lehigh Valley; length of time at current residence may also serve in part as a proxy for age. Survey analysis did find that older respondents were more likely to have negative views about job security for seniors, but the differences were not statistically significant.

These findings might be considered in the context of research which suggests that older adults face many obstacles to employment and job security, including discrimination. The context of labor force participation among seniors is complex—some older adults may seek work out of necessity or need, others may simply desire to stay socially engaged. Regional studies have shown a somewhat varied job market in the Lehigh Valley over the past decade. According to the US Census Bureau, in 2015, approximately 15% of seniors, ages 65 and older were employed. This figure was 14% in 2010.

Figure 18. “Do you believe there is job security as a senior in the Lehigh Valley?”

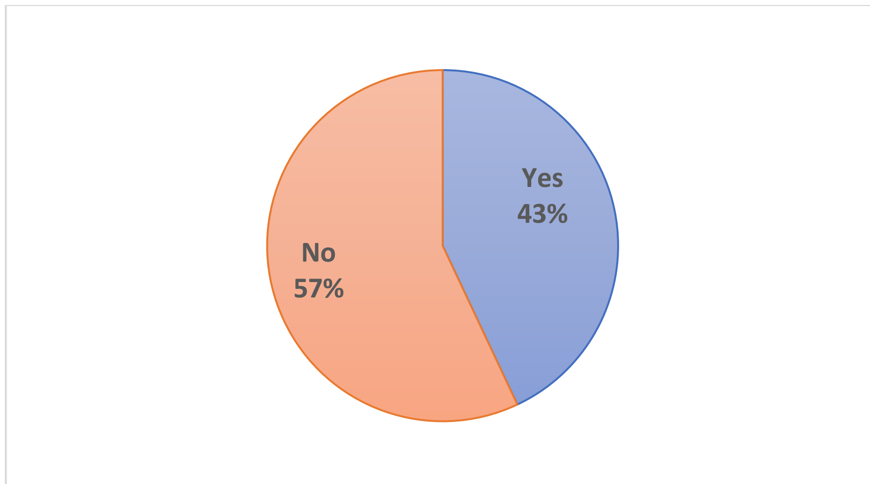
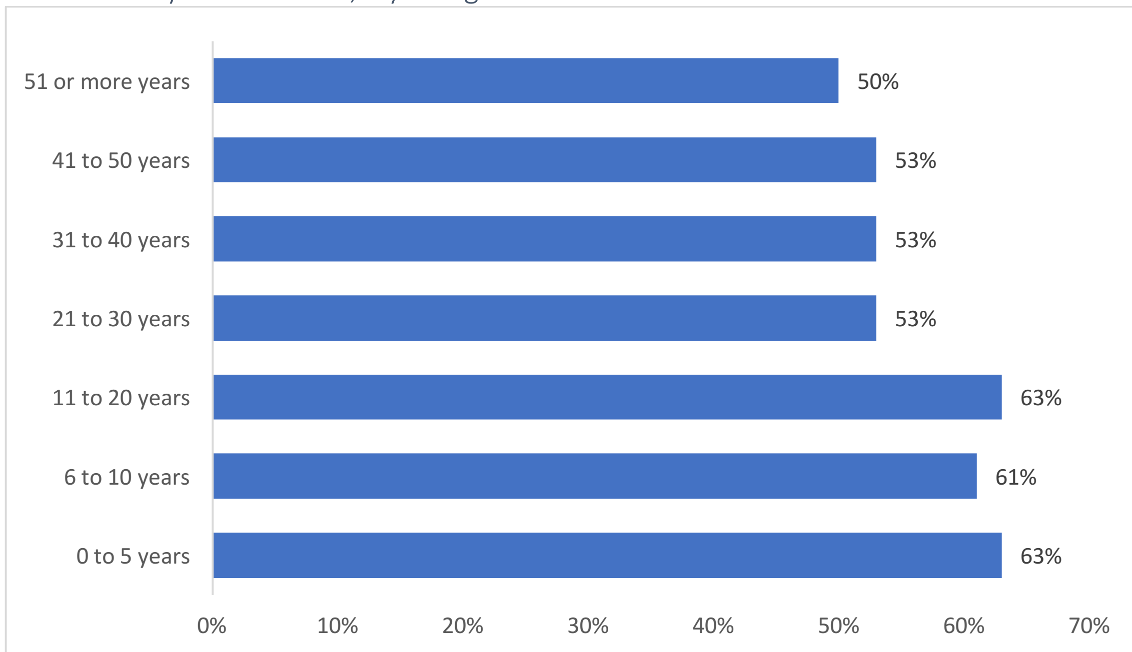


Figure 19. Percentage of Respondents **Disagreeing** that the Lehigh Valley Provides Job Security for Seniors, by Length of Time at Current Residence



Significant Health Needs of Lehigh Valley Seniors: ADLS & IADLS, Diabetes, Arthritis & Obesity

The Census Bureau's American Community Survey estimates that about 34.4% of the 101,113 non-institutionalized seniors, ages 65 and older, in the Lehigh Valley have some kind of disability.[18] By far, the most common disability is ambulatory difficulty, affecting almost 22% of seniors in the region, followed by independent living difficulty (15.3%) and hearing difficulty (13.5%).[19]

Table 8. Lehigh Valley Seniors (65+) and Disability, 2015

	Lehigh County	Northampton County	Lehigh Valley Combined	% of Total 65+ Population with this Disability
Hearing Difficulty	7,239	6,361	13,600	13.5%
Vison Difficulty	3,317	2,733	6,050	6.0%
Cognitive Difficulty	4,848	4,348	9,196	9.1%
Ambulatory Difficulty	11,160	10,808	21,968	21.7%
Self-Care Difficulty	3,675	3,795	7,470	7.4%
Independent Living Difficulty	7,347	8,109	15,456	15.3%

Source: American Community Survey, Five-Year Estimates, 2011-2015, Disability Characteristics among the civilian, non-institutionalized population.

These data provide context for considering the current survey, which asked respondents to indicate whether they are limited in a range of activities of daily living (ADLs)—bathing, toileting, dressing, getting in and out of bed, grooming, and eating—and several measures of instrumental activities of daily living (IADLs): taking medication, grocery shopping, preparing meals, obtaining transportation for vital appointments, obtaining transportation for social activities, handling home finances, and housekeeping. Both ADLs and IADLs are key tasks associated with one's ability to live at home independently and are often associated with estimating the help, assistance, and care that seniors may need as they age.

[18] Unfortunately, the Census Bureau does not report disability status for individuals in the age category 55 and older.
[19] The Census Bureau defines independent living difficulty to include, "difficulty doing errands alone such as visiting a doctor's office or shopping" due to a physical, mental, or emotional problem. Self-care difficulty in the Census refers to difficulty with activities such as "bathing or dressing."

A summary of findings is reported in **Table 9**. The results shown are similar to previous studies in that Lehigh Valley seniors, ages 65 and older, report greater difficulty with IADLs than with ADLs. Survey respondents report the greatest difficulty with obtaining transportation, grocery shopping, housekeeping, and cooking/preparing hot meals. Among ADLs, survey respondents report fewer difficulties; approximately 7.2% of respondents ages 65 and older say they have trouble grooming or doing their own hair independently, 3.5% report problems getting in and out of bed or a chair, and 3% say they have difficulty with bathing.

The survey asked respondents to specify whether they receive any help and support from family and friends, from subsidies and services, or from paid services for self-care needs. This information is reported in **Table 10** for the most commonly reported ADL and IADL difficulties among respondents 65 years of age and older. The numbers of respondents reporting difficulties with ADLs and IADLs is small and, therefore, it is important not to overdraw conclusions or to make inferences from this data to the actual Lehigh Valley senior population. The data do suggest, nonetheless, that few seniors report receiving no help at all for problems related to ADLs and IADLs. The majority in all cases also suggest that they receive help for these activities from family or friends rather than from a paid service or a program or subsidized benefit.

Table 9. Percentage of Respondents Reporting Problems with ADLs and IADLs

	All survey respondents (N=1027)	**Survey respondents ages 65 and older (N=685)**
ADLS (Activities of daily living)		
Bathing	2.9% (29)	3% (17)
Dressing	3.3% (34)	2.3% (16)
Toileting/Using the Bathroom	2.4% (24)	2.1% (14)
Getting in/out of bed/chair	3.3% (34)	3.5% (24)
Grooming	6.5% (66)	7.2% (60)
Feeding/Eating by yourself	2.1% (21)	2.1% (13)
IADLS (Instrumental activities of daily living)		
Taking own medication	2.9% (29)	2.8% (19)
Grocery Shopping	15.8% (163)	18.2% (124)
Cooking/Preparing hot meals	11.7% (121)	12.8% (86)
Obtaining Transportation for Doctor's/Vital Appointments	16.1% (166)	18.4% (127)
Obtaining Transportation for Leisure/Fun Activities	16.1% (166)	18.3% (124)
Handling Finances	8.1% (84)	9% (61)
Housekeeping	16% (165)	17.4% (119)

**Note*: Not all survey respondents were willing to provide their year of birth. Please refer to Table X above for further detail about the age groups in the sample. This table reports *all* survey respondents in the first column (that is, respondents of all ages and respondents who did not provide their age) and, in the second column, only the 685 respondents who indicated that they are 65 years of age or older.

Table 10. Sources of Support for Common ADL and IADL Problems, Respondents 65 years and older (N=685)

	% reporting a problem	**% receiving no help for this problem**	**% receiving help from family or friends for this problem**	**% receiving help from paid service for this problem**	**% receiving benefits/ subsidies/service for this problem**
ADLS (Activities of daily living)					
Bathing	3% (17)	ND (1)	1% (7)	ND (3)	0.9% (6)
Getting in/out of bed/chair	3.5% (24)	1.3% (9)	1.1% (7)	ND (2)	0.9% (6)
Grooming	7.2% (60)	ND (2)	2.3% (16)	3.5% (24)	1.1% (8)
IADLS (Instrumental activities of daily living)					
Grocery Shopping	18.2% (124)	ND (2)	15.9% (109)	1.1% (7)	0.9% (6)
Cooking/ Preparing hot meals	12.8% (86)	ND (1)	10.6% (72)	1.1% (7)	0.9% (6)
Obtaining Transportation for Doctor's/Vital Appointments	18.4% (127)	0.5% (5)	15.3% (105)	1.8% (13)	0.8% (5)
Obtaining Transportation for Leisure/Fun Activities	18.3% (124)	0.9% (6)	14.8% (101)	1.8% (12)	0.8% (5)
Housekeeping	17.4% (119)	ND (3)	11.5%(79)	5% (34)	0.5% (3)

Turning next to consider ADLs and IADLs in the aggregate, as shown in **Figures 20-21**, **30% of all survey respondents report difficulty with at least one activity of daily living or instrumental activity of daily living; among survey respondents 65 years and older, 32% report trouble with at least one ADL or IADL**. These numbers are close to Census estimates of seniors in the region who have some kind of disability as reported above (Table 8), and are comparable to findings from the 2014 and 2015 studies which suggested about 27% to 28% of seniors in Lehigh and Northampton counties have at least one self-care limitation. Many older adults report multiple self-care difficulties. Across all survey respondents, ages 55 and older, 22% report trouble with two or more of these activities. For senior respondents ages 65 and older, this figure is approximately 24%.

Figure 20. Respondents 55 and Older with at Least One ADL or IADL Limitation

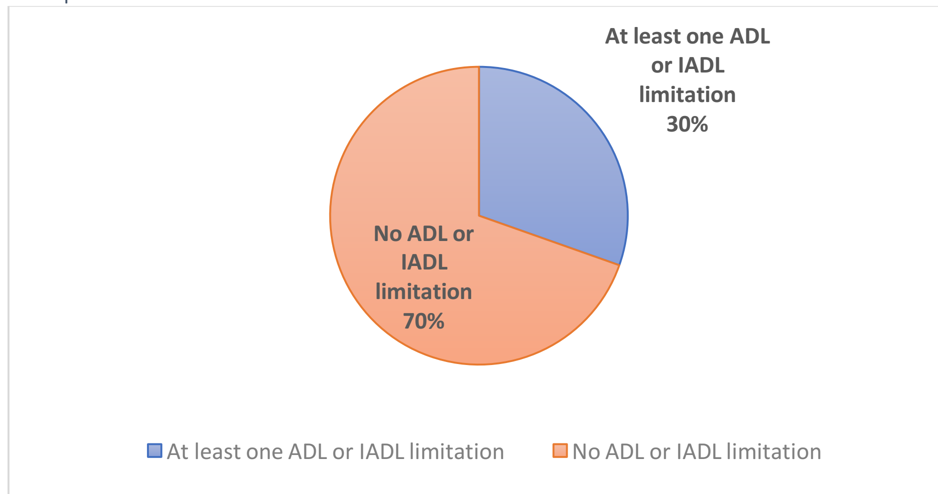


Figure 21. Respondents 65 years and Older with at Least One ADL or IADL Limitation

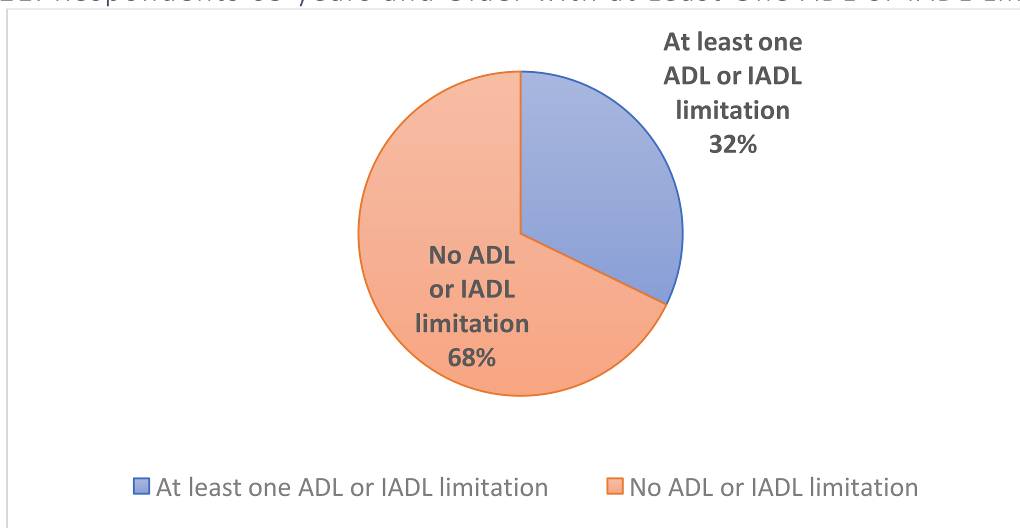


Table 11 provides a snapshot of relationships between ADL and IADL difficulties and key demographic variables, such as sex, income, race/ethnicity, respondents' immigrant status, and whether or not respondents live alone or with others. It is important to be cautious when drawing inferences from subsets of the survey sample to the Lehigh Valley population; the numbers of African Americans and Latinos who completed the survey, for example, is small, as is the case with the number of low income respondents and foreign born respondents. The patterns shown in Table 11 are nonetheless consistent with previous regional studies on the aging population and with national studies on aging.

Women are more likely to report problems with ADLs and IADLs than are men. In the full survey sample including all respondents, 31% of women and 29.7% of men said they have problems with at least one activity related to self-care.

Similar to previous studies, **survey respondents whose annual income is less than $25,000 and those who live alone are more likely to report problems with ADLs and IADLs** than are respondents who have greater income and who live with others.

Foreign born respondents are more likely to report self-care difficulties than are native born respondents. Thirty-seven percent of foreign born respondents report problems with ADLs/IADLs, compared to 30% of respondents who were born in the United States. The number of foreign born survey respondents is quite small and the survey did not ask respondents the age at which they immigrated to the United States; nonetheless, previous surveys in 2014 and 2015 similarly found that immigrants in the region had higher reported rates of ADL and IADL difficulties than native born seniors. In the context of population change in the Lehigh Valley, a region rich with recent and ongoing immigration, these findings are especially noteworthy. The relationships between immigration and health and disability over the life cycle are not well-understood. Some studies have found that aging immigrants have poorer health than native born individuals, particularly among women and among immigrants who were older at the time of migration.[20] Given demographic patterns in the Lehigh Valley region, the relationship between immigration and healthy aging-in-place is clearly deserving of further research.

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[20] See, for example, Jacqueline Angel, Cynthia Buckley, Art Sakamoto, "Duration or Disadvantage: Exploring Nativity, Ethnicity, and Health in Midlife," *The Journals of Gerontology: Series B*. 56 (5) September: S275-S284; Maria Monserud, "Age Trajectories of Physical Health Among Older Adults of Mexican Descent: Implications of Immigrant Status, Age at Immigration, and Gender," *Journal of Aging and Health*, July 2017; and Terry Yum and Julianne Vanderaa, "Health Disparities Among Immigration and Non-Immigrant Elders: The Association of Acculturation and Education," *Journal of Immigrant and Minority Health* 12 (October): 743-753.

Table 11. Percentage of Respondents Reporting At Least One ADL or IADL Difficulty

	All Respondents 55 and older	Respondents 65 and older
Men	29.7% (138)	28.4% (89)
Women	31% (175)	35.1% (130)
Foreign Born	37% (20)	40.5% (15)
Born in US	30.2% (294)	31.9% (207)
Below $25,000 K	48.4% (90)	48.4% (61)
Above $25,000 K	26.4% (118)	28.9% (88)
White	29.1% (257)	31.4% (190)
Black/African American	40% (14)	50% (16)
Hispanic/Latino	38.2% (29)	37.5% (15)
Live alone	38.6% (120)	38.5% (80)
Live with others	26.5% (249)	29.2% (131)

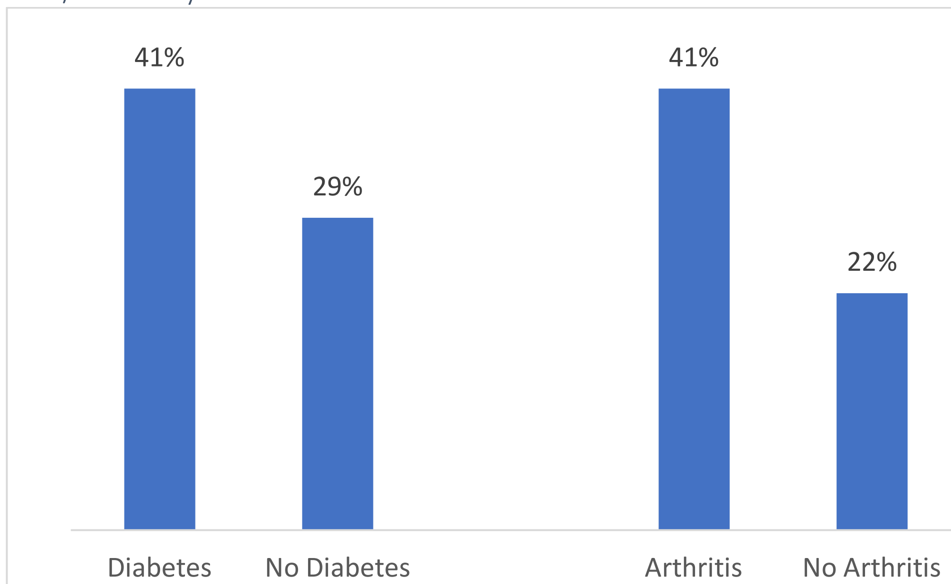
*Note: Many respondents refuse to provide information about their annual household income. Only 633 respondents answered both questions about ADLs and IADLs and income and, as a result, the numbers of respondents reporting ADL/IADL difficulty in the below $25,000 income group is very small (only 90 individuals). In 2015, a similar survey found that about 32% of respondents reporting household incomes under $25,000 annually reported trouble with at least one ADL or IADL.

Seniors' limitations performing activities of daily living and instrumental activities of daily living are related to chronic health conditions which may limit mobility and exacerbate functional limitations. Diabetes and arthritis are among the most common chronic health conditions effecting seniors nationwide. **Twenty-eight percent of survey respondents indicated that they have been told by a medical professional that they have diabetes; 52% say that they have been told by a medical professional that they have arthritis**.

The best comparative local data available is provided by the Pennsylvania Behavioral Risk Surveillance System (BRFSS), which suggests that in the Lehigh, Northampton and Carbon county region, about 29% of seniors 65 years of age and older have diabetes and 57% have arthritis.

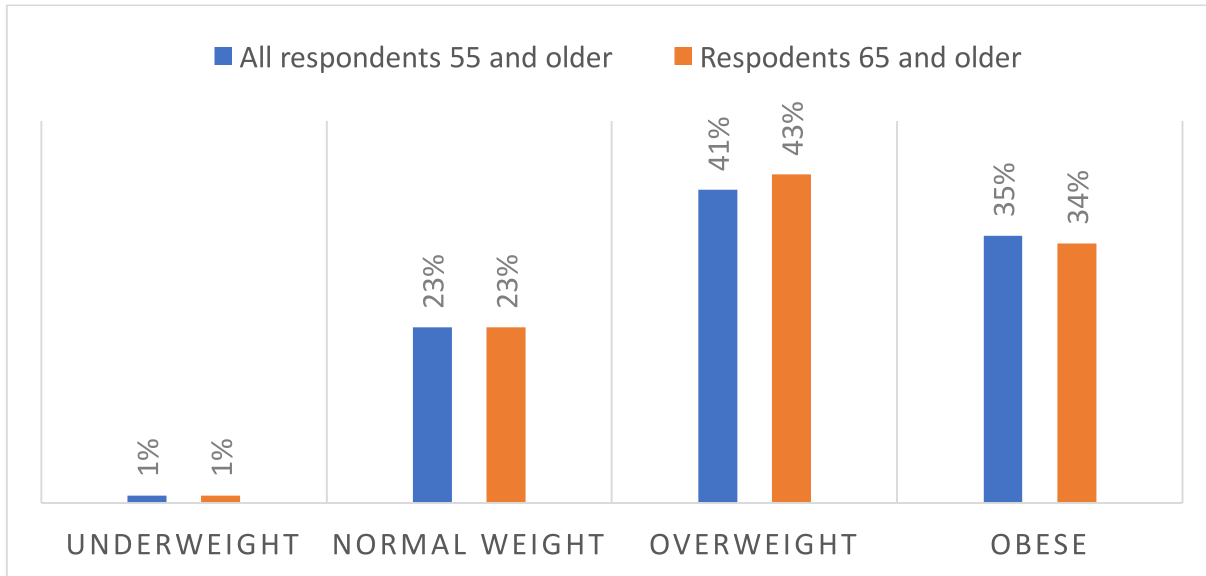
Figure 22 illustrates the relationships between these chronic health conditions and respondents' difficulties completing ADLs and IADLs. As shown, seniors with diabetes or with arthritis are significantly more likely to say that they have difficulty completing at least one ADL or IADL when compared to seniors who do not have these health conditions. These findings are consistent with nationwide studies, which have shown that both diabetes and arthritis are associated with physical disability and with individuals' ability to complete self-care tasks.

Figure 22. Senior Respondents (ages 65 and older) Who Report Difficult with ADL/IADLs by Diabetes and Arthritis



Obesity, itself a risk factor for diabetes and arthritis, may also be related to aging adults' ability to live independently. As shown in **Figure 23**, **41% of all survey respondents are overweight and another 35% are obese; among survey respondents ages 65 and older, 43% are overweight and 34% are obese**.[21]

Figure 23. Respondents BMI Status (Underweight, Normal Weight, Overweight, Obese)



The relationship between BMI status and survey respondents' abilities to complete self-care tasks is complex. National studies have found relationships between obesity and disability and between obesity and higher rates of ADL and IADL limitations. These patterns are generally evidence in the survey, as seen in **Figure 24**. It is important to recall that obesity status was derived from self-reported height and weight measurements and may in fact not represent respondents' true BMI. Of particular interest, among survey respondents, **being underweight is associated with problems with ADLs and IADLs**. This is consistent with past research that has suggested that being underweight (or frail) is a risk factor for ADL and IADL limitations.[22]

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[21]BMI was calculated using respondents' self-reported height and weight; an individual's weight in kilograms was divided by the square of height in meters (kg/m2). The CDC uses the following to classify BMI for all individuals over the age of 20: below 18.5 = underweight; 18.5-24.9 = normal weight; 25-29.9 = overweight; 30 and above = obese. Self-reported height and weight are not completely reliable and BMI is an imperfect measure of obesity particularly among seniors.

[22] For example, see Mary Elizabeth Brown, "The Relationship between Body Weight, Frailty, and the Disablement Process," J*. Gerontol B Pscyhol Sci Soc Sci* September (2012): 618-626.

Similarly, as shown in **Figure 25,** being underweight is associated with arthritis and diabetes—chronic health conditions that are clearly linked to individuals' limited abilities to perform self-care tasks. In the case of **Figure 24**, being overweight and obesity are also positively related to ADL/IADL difficulties.

Figure 24.BMI Status and Trouble with ADLs/IADLs

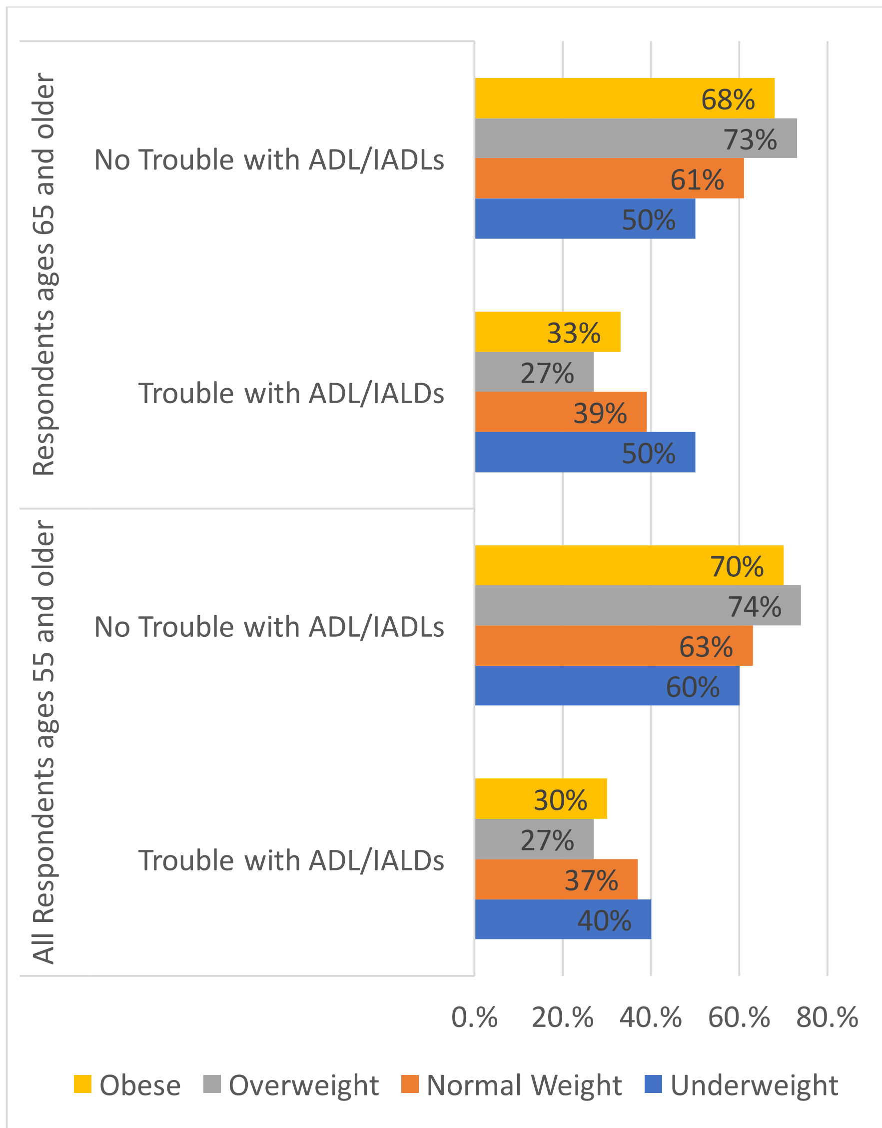
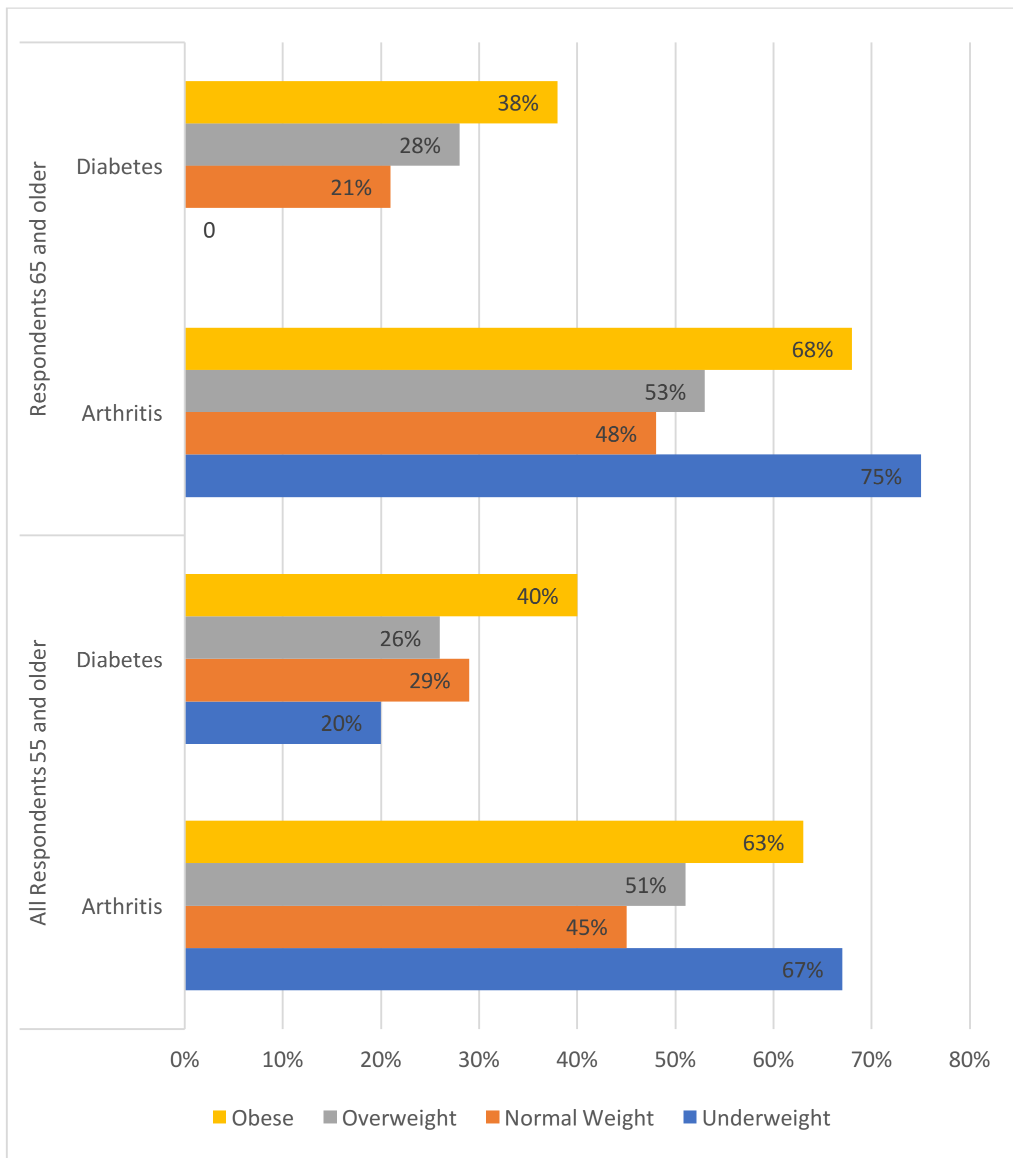


Figure 25. BMI Status and Diabetes and Arthritis



Mobility and Falls

Ambulatory difficulties are common among aging adults. As reported above, the US Census Bureau estimates that more than 11,000 Lehigh Valley seniors have an ambulatory difficulty. In the current survey, 3.3% of survey respondents report having difficulty getting in and out of bed or a chair without help. These figures are important considerations, since health and wellbeing are intricately linked to mobility and safe movement. Some estimates suggest that up to one-third of seniors ages 65 or older in the United States experience a fall every year, leading 2 million people to emergency rooms with fall-related injuries each year.

Among survey respondents ages 65 and older, **12% report experiencing a fall in the past year, 8% report two falls, and an additional 5% report three or more falls** in the same time period. Put differently, **one quarter (25%) of senior survey respondents have fallen at least once in the past year**. This figure is about 22% among survey respondents ages 55 and older. These findings are almost identical to studies of the regional senior population in 2015 and 2014.

Unsurprisingly, the likelihood that an older adult reports at least one fall in the past year increases with age, as shown in **Table 12**.

Table 12. At Least One Fall in the Past Year by Age Group

Ages 55 to 64	15.5%
Ages 65 to 69	21.6%
Ages 70 to 74	15.3%
Ages 80 to 84	27.1%
Ages 85 and older	28.9%

Falls are more common among seniors who use an assistive mobility device, such as a cane, walker or wheelchair; close **to 49% of seniors, ages 65 or older, who use an assistive mobility device also report at least one fall in the past year** (although it is not possible to determine whether assistive devices are markers of limited mobility or are conversely markers of mobility enhancements, or whether these devices prevented or contributed to fall prevalence). Older adults are also more likely to report at least one fall in the past year if they live alone, if they also report trouble with at least one ADL or IADL, or if they report having or being diagnosed with arthritis by a medical professional. These patterns are the same when the sample includes all residents ages 55 and older or when the sample is restricted to only respondents ages 65 and older.

Table 13. Percentage of Respondents Reporting At Least One Fall in the Past Year: Use of Assistive Device, ADL/IADL Difficulty, Living Alone, and Arthritis

	All Respondents Ages 55 and Older Reporting at Least One Fall in Past Year	**Respondents Ages 65 and Older Reporting at Least One Fall in Past Year**
Uses assistive device (e.g., cane, walker, wheelchair)	44%	48.6%
Does not use assistive device	15.4%	16.9%
At least one ADL/IADL difficulty	33.7%	40.6%
No ADL/IADL difficulty	16.9%	17.7%
Lives Alone	25.6%	28%
Lives with Others	20.3%	23.4%
Diagnosed with Arthritis	27.7%	30.8%
No Arthritis Diagnosis	15.5%	18.1%

Mental Health & Wellbeing

Recent studies published by the Institute on Aging have shown that depression increases after the age of 65. In fact, the proportion of people ages 85 and older with clinical depressive symptoms is higher than for any other age group. Depression can interrupt and be harmful to daily living and is related to chronic health conditions and behavioral risk factors, such as obesity. Research suggests that few adults ages 65 and older (perhaps only 10%) receive any kind of treatment for depression or other aspects of mental health and wellbeing.

Studies commissioned by the UWGLV have consistently found that a meaningful portion of the senior population in our region report markers of depression and social isolation. Mental health and measures of life satisfaction are increasingly recognized as central to health promotion, chronic disease prevention, morbidity and mortality, and risk of hospitalization.

In the current survey, **16% of survey respondents say that they have experienced two or more weeks of feeling blue, sad or depressed in the past year**. **Thirteen percent say that they always or sometimes feel lonely or isolated from others.** These data are similar to PA BRFSS findings, which show that in the combined areas of Lehigh, Northampton and Carbon counties, approximately 16% of seniors (ages 65 and older) have been told by a medical professional that they have a depressive disorder, such as depression. More than one-quarter of seniors in this region say that they have had at least one day of poor mental health in the past month.

While clearly not a majority of respondents, the survey findings are notable in a number of respects. Survey findings summarized in **Figure 26** offer a complicated view of the relationship between age and possible depression and feelings of isolation. This is consistent with previous regional studies of the senior population (showing in effect no clear discernable relationship between depression and loneliness and age) and stands in contrast to national studies, which have shown a clear relationship between aging and depressive symptoms.

Survey findings are more consistent with national studies in suggesting that **women are more likely to report feelings of depression or social isolation than are men**. In the current survey, including all respondents 55 and older, 20% of women say that they have experienced feeling blue, sad or depressed for at least two weeks during the previous year—this compares to 13% of men. Similarly, 15% of women say they always or sometimes feel isolated from others compared to 10% of men.

Perhaps most troubling, **respondents who live alone, who report low annual family income, or who report difficulty completing ADL or IADL self-care tasks are significantly more likely to report depressive episodes and feelings of isolation**. As shown, low income respondents are more than twice as likely to report two or more weeks of depression and always or sometimes

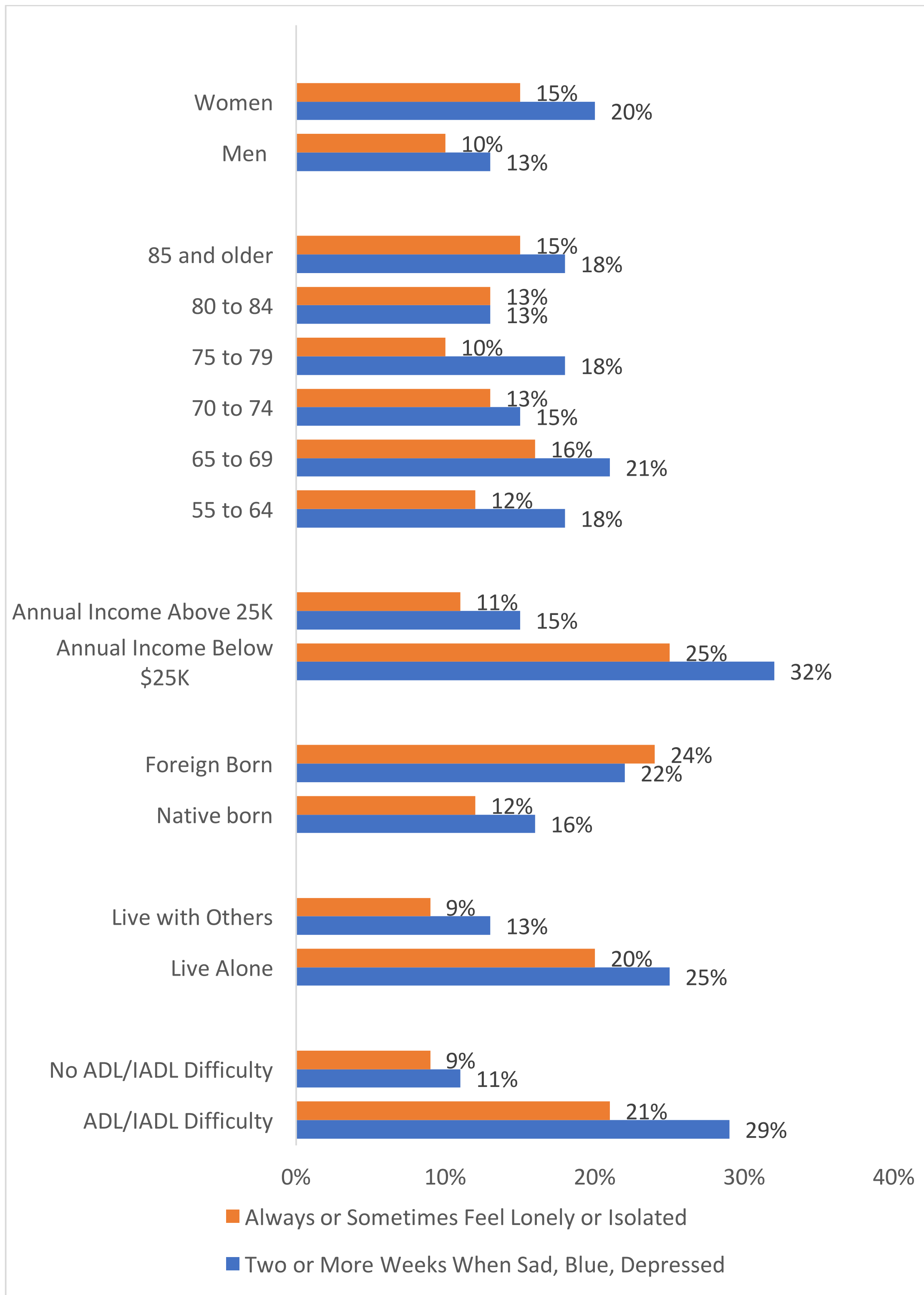
feeling isolated compared to higher income respondents. Close to one-third of all low-income respondents say they have suffered from two or more weeks of sadness or depression in the past year. This compares to only 13% of higher income respondents.

Similar patterns describe the difference among survey respondents who live with others versus those living alone. One quarter of respondents who live alone say they have experienced depression for two weeks during the previous year compared to 13% living with others.

Given the findings reported about the relationship between immigrant status and ADL/IADL trouble, it is worth emphasizing relationships between foreign born status and feelings of isolation and depression here. **Twenty-four percent of foreign born survey respondents say they always or sometimes feel lonely or isolated—this is double the percentage of native-born respondents**. Similarly, 22% of foreign born respondents say that they have had two or more weeks of sadness or depression in the past year, compared to 12% of respondents who were born in the US.

Finally, **ADL and IADL problems are clearly linked to respondents' feelings of depression and social isolation or loneliness**. In fact, respondents who report trouble completing at least one ADL or IADL task were almost three times as likely to report feeling depressed over the past year compared to respondents who do not report trouble with any ADLs or IADLs.

Figure 26. Depression and Social Isolation: Sex, Age, Income, Foreign vs. Native Born, Living Alone, and ADL/IADL Difficulty



Appendix: Survey Questions & Response Frequencies

Percentages may not add up to 100% due to rounding.

1. County (N=1027)			
	Lehigh		55%
	Northampton		45%
2. How would you rate your community as a place for people to live as they age? (N=1027)			
	Excellent		24%
	Very Good		**36%**
	Good		28%
	Fair		9%
	Poor		3%
3. How important is it for you to remain in your community as you age? (N=1027)			
	Very important		**61%**
	Somewhat important		27%
	Somewhat unimportant		4%
	Not important		8%
4. Can you easily purchase fresh and healthy food in your neighborhood? (N=1027)			
	Yes		**87%**
	No		13%
5. People sometimes make modifications to their home so they can stay there as they age. Do you think you will need to make the following types of modifications or improvements to your home to enable you to stay there as you age? (N=1027)			
Easier access into or within your home, such as a ramp, chairlift or elevator, or wider doors?	Yes 29%	No **69%**	Not Sure 5%
Bathroom modifications such as grab bars, handrails, a higher toilet or non-slip tiles?	Yes 43%	No **54%**	Not Sure 3%
Putting a bedroom, bathroom or kitchen on the first floor?	Yes 33%	No **64%**	Not Sure 2%
Improving lighting?	Yes 26%	No **64%**	Not Sure 2%

Installing a medical emergency response system that notifies others in case of emergency?	Yes 32%	No **62%**	Not Sure 7%

6. How satisfied are you with available health and wellness services in your community, for example, fitness activities, wellness programs and classes, services that help seniors find personal care? (N=1027)

Very Satisfied	**42%**
Satisfied	41%
Unsure	13%
Dissatisfied	3%
Very Dissatisfied	2%

7. As a resident of the Lehigh Valley, do you have: (N=1027)

Access to community information in one central source?	Yes **75%**	No 25%
Clearly displayed printed community information with large lettering?	Yes **61%**	No 39%
An automated community information source that is easy to understand like a toll-free telephone number?	Yes **66%**	No 34%
Free access to computers and the internet in public places such as the library, senior centers, or government buildings?	Yes **79%**	No 22%
Community information that is delivered in person to people who may have difficulty or may not be able to leave their home?	Yes **57%**	No 43%
Community information that is available in a number of different languages?	Yes 42%	No **58%**

8. Please indicate your agreement with the following statement. "Community events and activities in the Lehigh Valley attract all generations by accommodating age-specific needs and preferences." (N=1027)

Strongly Agree	21%
Agree	**61%**
Neither agree nor disagree	13%
Disagree	6%
Strongly Disagree	1%

9. Do you believe there is opportunity for volunteerism in the Lehigh Valley? (N=1027)		
	Yes	**95%**
	No	5%
Are you interested in volunteering?	Yes 25%	No **75%**
10. Do you believe there is job security as a senior in the Lehigh Valley? (N=1027)		
	Yes	43%
	No	**57%**
11. In the past year, how many times have you fallen? (N=1024)		
	None	**78%**
	Once	11%
	Twice	7%
	Three or more times	4%
12. Do you use an assistive device, like a cane, walker, or wheelchair? (N=1027)		
	Yes	23%
	No	**77%**
13. Has a doctor, nurse, or another health professional told you that you have: (N=1027)		
Diabetes	Yes 28%	No **72%**
Arthritis	Yes **52%**	No 47%
Another chronic condition	5% high blood pressure	
14. In the past year, have you had two or more weeks during which you felt sad, blue or depressed, or when you lost interest or pleasure in things you usually cared about or enjoyed? (N=1027)		
	Yes	16%
	No	**83%**
15. Overall, how often do you feel lonely or isolated from those around you? (N=1027)		
	Always	1%

	Sometimes	12%
	Rarely	28%
	Never	**59%**
16. Next, I'd like to ask you some questions about whether you have any problems completing activities of daily living and if you might benefit from help completing these activities. Please tell me whether you have a problem completing these activities and, if you do, whether you receive help from a family member, a caregiver, or someone else in these activities. (N=1027)		
BATHING	No, it is not a problem.	**97%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.2%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	2%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.4%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.7%
DRESSING	No, it is not a problem.	**97%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	2%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.3%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.6%
TOILETING/USING THE BATHROO*M*	No, it is not a problem.	**98%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.3%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	1.3%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.2%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.6%

GETTING IN/OUT OF BED/CHAIR	No, it is not a problem.	**97%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.8%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	2%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.3%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.6%
GROOMING	No, it is not a problem.	**94%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	2.4%
	Yes, it is a problem; I currently pay a service for help completing this activity	3%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.8%
FEEDING/EATING BY YOURSELF	No, it is not a problem.	**98%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.1%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	1.3%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.5%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.2%
TAKING OWN MEDICATION	No, it is not a problem.	97%
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	2%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.4%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.2%
GROCERY SHOPPING	No, it is not a problem.	**84%**

	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	14%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.8%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.9%
COOKING/PREPARING HOT MEALS	No, it is not a problem.	**88%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.3%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	10%
	Yes, it is a problem; I currently pay a service for help completing this activity	1%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	1%
OBTAINING TRANSPORTATION FOR DOCTOR's/VITAL APPINTMENTS	No, it is not a problem.	**84%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	13%
	Yes, it is a problem; I currently pay a service for help completing this activity	2%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	1%
OBTAINING TRANSPORTATION FOR LEISURE/FUN ACTIVITIES	No, it is not a problem.	**84%**
	Yes, it is a problem; I do not receive any help completing this activity.	1%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	13%
	Yes, it is a problem; I currently pay a service for help completing this activity	1%

	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	1%
HANDLING OWN FINANCES	No, it is not a problem.	**92%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	7%
	Yes, it is a problem; I currently pay a service for help completing this activity	0.2%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.2%
HOUSEKEEPING	No, it is not a problem.	**84%**
	Yes, it is a problem; I do not receive any help completing this activity.	0.4%
	Yes, it is a problem; I do receive help completing this activity from a family member or friend	11%
	Yes, it is a problem; I currently pay a service for help completing this activity	4%
	Yes, it is a problem; I receive benefits or subsidies to receive a service to help me complete this activity at no cost.	0.7%

17. Are you legally blind? (N=1027)		
	Yes	2%
	No	**98%**
18. What is your height?	*See BMI calculations in report*	
19. What is your weight?	*See BMI calculations in report*	
20. What year were you born?	*See age ranges in report*	
21. What is your home zipcode?	*See geographies in report*	

22. What is your home town/municipality?	*See geographies in report*	
23. Are you: (N=1027)	Male	45%
	Female	**55%**
24. How many people live in your household, including yourself? (N=1027)		
	One	30%
	Two	**55%**
	Three or more	15%
***25.* How long have you lived at your current address? (N=1000)**		
	Less than 5 years	16%
	6 to 10 years	11%
	11 to 20 years	21%
	21 to 30 years	17%
	31 to 40 years	13%
	41 to 50 years	13%
	51 or more years	10%
26. Were you born in the United States? (N=1027)		
	Yes	**95%**
	No	5%
27. Which of the following best describes you? (N=1027)		
	White	86%
	Black/African American	4%
	Asian	3%
	Hispanic	7%
	Other	1%
28. Which of the following best describes your household income? (N=1027)		

	Less than $14,999	14%
	$15,000-$24,999	16%
	$25,000-$39,999	20%
	$40,000-$59,999	**22%**
	$60,000-$99,999	17%
	$100,000 +	125