Institute of Gerontology
Center for Urban Studies
Center for Healthcare Effectiveness Research

FACING THE FUTURE:
2002 CITY OF DETROIT
NEEDS ASSESSMENT OF OLDER ADULTS

An Excerpt

For the City of Detroit
Department of Senior Citizens

Research funded by The City of Detroit, Department of Senior Citizens. The findings and conclusions of this report do not necessarily reflect the views of the Detroit Department of Senior Citizens or the City of Detroit.

ACKNOWLEDGEMENTS

Research Team Collaborating Structures

Institute of Gerontology (IOG)

The Institute of Gerontology was established 35 years ago and represents one of the most enduring state-level and university-level commitments to the study of aging in the United States. The mission of the IOG is to discover, synthesize, and disseminate data and information which will (1) increase knowledge about aging and related processes, (2) improve the practice of gerontology and geriatrics, and (3) influence the development and implementation of public policy. The IOG is a dynamic coalition of researchers and educators from multiple disciplines who believe that this mission can best be accomplished by facilitating interdisciplinary collaboration and participating in the culturally diverse urban environment in which we live.

Center for Healthcare Effectiveness Research (CHER)

The Center for Healthcare Effectiveness Research (CHER) is a joint initiative of the Wayne State University School of Medicine (SOM) and the Detroit Medical Center (DMC). The mission of the CHER, as set out by its planning task force, includes several objectives that can most succinctly be described with a biochemical metaphor: CHER is to serve as a catalyst for change in the DMC-SOM. The CHER provides a link across multiple disciplines that facilitates the medical center's constructive response to a changing U.S. health care delivery system.

Center for Urban Studies

The Center for Urban Studies (CUS) provides Wayne State University with a central organization whose focus is to investigate contemporary urban issues. Its major functions include: 1) facilitating and conducting research; 2) acting as a resource and technical assistance center; and 3) initiating and developing demonstration models in urban settings. CUS encourages faculty participation from those academic disciplines pertinent to urban issues. Hence, CUS is unique to traditional academic structures in that it provides an interdisciplinary approach where appropriate. Included among the specialized programs that comprise CUS is Survey Research, with survey design, data collection, data processing, data analysis and other support capabilities. The CUS Survey Research unit conducts quantitative studies by mail, on the telephone, and in person. Additionally, staff is experienced in qualitative methods of data collection, particularly focus group interviews. The unit is equipped with a state-of-the-art Computer Assisted Telephone Interviewing (CATI) facility.

Team Qualifications and Experience

Elizabeth Chapleski, M.S.W., Ph.D., Principal Investigator of the study and Associate Professor of research at the Institute of Gerontology, has extensive experience in survey research and needs assessments both statewide and in local Michigan communities, including the Detroit Area Study. She has been the Principal Investigator on needs assessments of older citizens conducted for the Michigan Office of Services to the Aging (1987, 1989) and the Michigan Department of Public Health (1990). She offers valuable knowledge and experience in the field of gerontology as well as her survey research experience. Dr. Chapleski is the primary author of this report.

R. Michael Massanari, M.D.,M.S., Medical Director of the CHER and Professor of Medicine in the School of Medicine, serves as co-Principal Investigator of the study. He directed the analysis of the health outcomes assessment instrument, provided oversight on the health analysis and the chapter on health issues. The Health Chapter is authored by Drs. Massanari and Barth-Jones.

Linda Herskovitz, M.A., Director of Survey Research at the Center for Urban Studies, serves as co-Principal Investigator of the study. She has extensive experience with survey research methods, based on her education, her teaching and her position in the CUS, where she manages and fields numerous studies each year. Dr. Chapleski and Ms. Herskovitz have eight years' experience teaching the graduate Research Seminar in Survey Methodology which is cross-listed in four disciplines--sociology, political science, anthropology, and urban & labor management.

Other Research Team Members

Daniel Barth-Jones, Ph.D., epidemiologist, CHER – Director /Coordinator for data analyses.
Leslie Mahlmeister, M.B.A., administrative director, CHER.
LaShawn Wordlaw Stinson, M.A., Graduate Research Assistant, IOG – Publicity and Senior Center Coordination
Rochelle Zaranek, M.A., Graduate Research Assistant, IOG - Senior Center Interviews and Conceptualization of Casino Issues
Lynnette Essenmacher – Research Assistant, CHER – Data Management and Analysis

Consultant for In-Person Sample

Steven Heeringa, Ph.D., Director of Research and Sampling, Institute for Social Research, University of Michigan, Ann Arbor.

CUS Team Members

Senithia Brown-Marino- CATI/Field Coordinator
John Jakary – CATI Programming and Management
Kurt Metzger – MIMIC – Census Analysis Support
Doug Townes – MIMIC – Census Analysis and Mapping

Thanks to all the interviewers who worked diligently to locate the respondents and conduct a lengthy (45-60 minute) interview.

Last and most importantly we thank all the 1,410 residents and 50 senior center participants age 60 and older who gave willingly of their time and provided invaluable information for planners and advocates to better understand the needs and preferences of older persons in the City of Detroit.

City of Detroit Senior Citizens Department

The Senior Citizens Department of the City of Detroit Mission Statement:

> *To serve as an advocate, planning, research, monitoring, and coordinating department, and to provide direct and indirect service in order to ensure that the senior citizens population attain and/or maintain life long dignity and independence.*

The SCD is located at 65 Cadillac Square, Suite 300 and offers two very important programs/services for seniors:

- Senior Aides Program: Assists residents age 55 and older in finding jobs that offer on-the-job training and job search techniques, such as computer training, customer service, telephone etiquette and basic office procedures. Contact 313/224-4803.

- Information and Assistance Service: Offers personalized service to seniors who need assistance with housing, prescriptions, etc. Programs and services are tailored to meet the needs of individuals. Contact 313/224-5444.

The Department, and Director Sandra Tene Ramsey report to the City Council and to Mayor Kwame M. Kilpatrick.

EXECUTIVE SUMMARY

The issues significant to Detroit's older adults communicate both challenges and opportunities. The increased longevity of older adults both state-wide and in the city of Detroit behooves us to examine the perceptions and challenges that accompany this longevity. The community should tap the rich resource of our older citizens and create an environment in which people can age in dignity and independence preferably in their own homes.

City planners and officials recognized the need to profile the community in a participative and inclusive manner. While secondary data sources, such as the decennial Census, offer much information from which need may be inferred, they often fail to ask important questions about health, mental health, and service use or to assess attitudes and preferences which may uncover future behaviors. Few cities of this size have undertaken such an extensive assessment of their senior citizens.

The domains of interest to the city were health, housing and transportation. Other foci included issues related to quality of life, environment and neighborhood, and service utilization behavior, as well as casino attitudes and behaviors and social support issues.

Therefore a comprehensive needs assessment focusing on older persons, their needs, their competencies and their diversity was begun in April 2001. It is a cross sectional study of 1410 persons aged 60 or older residing in the City of Detroit; 1310 were interviewed using the Random Digit Dial telephone method and 100 were contacted in their homes and interviewed face to face. This summary can only highlight the important trends and patterns observed throughout the report and the reader is urged to review the entire document to fully understand the vulnerability as well as the strengths of this population.
The following key points provide an overview of the findings.

1. ***Demographic data*** from this sample of older adults show that they are more likely than comparative national samples to have limited education, low incomes, live alone, and be unemployed. Forty-one % did not graduate high school, although younger respondents have more education than older respondents; 70% considered themselves retired, while 16.5% work either full or part-time, 2.7% are disabled and 10.7% report being unemployed. Over 55% report incomes less than $20,000 per year. Seventy percent of the respondents are female, and thirty percent male; 42% live alone. Those of African American or mixed race (with African American) represent 83.8% of the study, with 13.5% white. Seventy-two percent own the homes in which they live, and more than half have lived at their same addresses for over 25 years. On average these seniors have lived in Detroit for over 54 years.

2. Detroit's older population is declining as a proportion of the total. U.S. Census figures in 2000 reported 128,400 persons age 60 and older, 13.5% of the total population in Detroit. In 1990 the 60 and older population totaled 167,219, 16.4% of the total. The reasons for this decline are not a subject of this report, but some questions did seek to learn about ***future plans for moving and locations of likely moves***. Furthermore, about a third (34%) of the respondents are considering moving to another location, and half of those (50.3%) prefer to move somewhere else in Detroit. They mentioned senior housing, continuing care retirement communities and assisted living as places they would consider. If they cannot find the type of housing they need in the city, it is likely they will look elsewhere to meet their needs. Most important to housing planners are the amenities preferred. The most highly ranked preference is for a 'safer neighborhood', followed by 'lower housing costs' and 'no stairs to climb'. People also prefer to be 'close to family' and some (especially those over 75) would like services, meals and transportation included. Unimportant is whether they live with other seniors. Generally, people prefer to age in place in an environment that allows independence, comfort and health.

3. Although the majority express they are either somewhat or very satisfied with their current ***housing***, sixty-five percent reported one or more problems with their housing. The top four problems are excessive noise, inadequate cooling, lack of fire extinguishers, and insects/rodents.

   Similarly, people reported satisfaction with their ***neighborhood*** in general, yet they reported considerable neighborhood problems. The top four problems are streets/sidewalks need repair, lack of shopping, crime, and dark streets. There was a strong correlation between housing and neighborhood satisfaction and the number of housing and neighborhood problems. Only 28% feel very safe in their neighborhood at night, while fifty-seven feel very safe during the day. Clearly there is some lack of congruence between specific objective issues and reported satisfaction.

4. ***Transportation*** analysis showed only 63% of the respondents have both a vehicle and a drivers' license to provide them total autonomy in transportation. Seventeen percent have neither, and the remainder have one but not the other in their households. Those 37% have to rely on others or public transportation to get places they need to go and further study reveals they are not always able to do so. While the total sample shows 17% with no personal transportation, for those who live alone, are female, over 75, not married and are considered among the most vulnerable (low social support, poor health and in poverty combined), this percentage is much greater. Thus, the majority has adequate transportation but for those with health difficulties, financial problems, or who depend on friends/relatives to take them places, transportation is often a very serious problem. A number of problems and barriers to public transportation were uncovered (see Transportation Section).

5. ***Use of formal services, awareness and need*** were analyzed for seventeen generic services. Most used was Health Screening (20.7%, followed by free transportation services (16.6%) and senior centers (16.5%), Home Health Care (14.5) and Home Repair (12.1%). All other services were used by less than 10% of the respondents, with the least used service Adult Day Care (1.8%). On the other hand, when 'need' was assessed a higher percentage expressed having needed such a service in the past year. For example, home repair was needed by 35.6% and used by 12.2%, thus a total of 47.8% had need of home repair services. A large percentage reported having needed financial services and utility assistance. Thus, the barriers to use should be examined carefully. Over all the proportion reporting having needed services is 66% greater than the proportion reporting having used services. Information and Referral was needed by 17.3% but used by only 7.5%; this is a critical link to other services.

6. ***Social support*** can influence a person's emotional and economic well being through living arrangements, marital status and availability of potential caregivers. Questions were asked to assess both size and distance from social network members and perceived levels of social support. Marital status is influenced by both age and gender, with males and those under 75 more likely to be married. Only 15% of the females over 75 are married. Forty-two percent live alone, with white males the most likely (48.4%) to do so, and African American males the least likely (38.1%). Thirty-eight percent of African American females live with others (no spouse). Two social support measures were derived to assess two aspects of social support: *social support network* (denoting size and proximity, and *perceived social support* (denoting perception of available support if help was needed in an emergency, for a short period of time, or for a long period of time, and satisfaction with this support). Females, both over and under 75 years of age are more likely to report strong social support networks than are males. Most of the elders (62%) reported high perceived social support, indicating most feel assured of assistance if the need were to arise.

7. ***Activities and interests*** were assessed to discover how older adults prefer to spend their time. The most enjoyed activities are of a passive nature that could conceivably be done in solitude—71.2% enjoy listening to music a lot, 66.4% reading and 65.6% watching TV. The ten other activities formed an 'active' activity scale. The younger (under 75), those with more than a high school education, those above 150% of poverty, those in the top health and mental health quartiles, who are African American and female, were significantly more likely to report enjoyment of active activities. Other contributions Detroit elders are making are related to the 28% who actively belong to community or neighborhood groups, and the 30% who do volunteer work. Twenty-seven % have used a computer within the past year and of those who did not, 56% would like the opportunity to do so.

8. ***Casinos*** are another source of social activity for about 44% of the seniors. Of those, only a small percentage appears to be at risk of gambling problems. More than half of the respondents, or 66.7%, reported that they either rarely or never visit casinos. Those who do go to the casinos include a small percentage of respondents who visit a few times a year (15.7%), 5.7% monthly; 5.7% visit a few times a month; and only 5.6% visit the casinos once a week. Only a few showed indications of problem gambling (less than 10%). Most felt that casinos have been good for Detroit and that they are safe.

9. ***Health Status*** **–** Both physical and mental health status is comparable to norms for seniors in the US. There is a positive relationship between income and physical and mental health status scales. To state the observation in the converse, the most economically disadvantaged respondents were more likely to have low physical and mental health scores. The burden of illness is measured by chronic conditions, mobility limitations and depression; 89% of respondents have at least one chronic illness. While 39% report three or more chronic illnesses; the most prevalent conditions reported are hypertension (64%), arthritis (60%), heart disease (27%), and diabetes mellitus (23%). When compared with national norms, hypertension and diabetes are more prevalent than expected based on national data. Additionally, 35% of respondents report "serious limitations" in mobility and 11.55% of respondents feel depressed "a good bit of the time" to "all of the time."

   The burden of illness creates considerable ***demand for health services*** with 94% of respondents reporting they visit a physician at least once per year. On average, seniors visit a physician 7.7 times per year. Frequency of physician visits is associated with physical health status, mental health status, and number of chronic diseases reported. Additionally, 85% of respondents take one or more prescription drugs and 73% take two or more prescription drugs.

   Seniors report ***barriers to obtaining appropriate health care*** including access to local pharmacies; 51% of respondents reported concerns about paying for prescription drugs. Ability to obtain adequate transportation was a barrier to physician visits. Respondents with inadequate transportation saw a physician less frequently than those with adequate transportation. Among respondents who reported concerns with transportation, only 16% had utilized "free" transportation services provided in the community. Thirty-six percent of respondents with inadequate transportation had never heard of the free transportation service.

   Considering those with health issue needs, access to assistance and utilization of services for some is difficult. Forty-five percent of respondents experienced at least one serious health event defined as an ER visit, hospitalization, admission to nursing home, or more than 4 bed-

days during the past year. Depending on the type of event 4-19% lacked access to someone who could assist them during the event and recovery. Among respondents who reported serious limitations of mobility, only 23% have utilized home health services for assistance.

10. ***Quality of life*** is a multidimensional concept that includes all of the elements assessed in this study—demographic characteristics, physical and mental well-being, purposeful activity, personal autonomy, housing/neighborhood environment, and social support, plus spirituality (which is not in this study). Self efficacy or the ability to believe that one can handle whatever life brings, is a key feature of quality of life or successful aging. This concept is tapped by agreement with the statement "Being a senior is the best time of life." Fifty-nine % agreed with this statement and 6% were neutral. Those 65 and older are even more likely to agree with this statement and are comparatively more positive than a national sample of the same age. Strongly associated with this optimism is good health, high perceived social support, being under 75, scoring high on 'active' activity enjoyment and being African American.

11. ***Comparisons across the ten geographic areas*** reveal differences depending on where one lives in the city. These comparisons show some areas to be in greater need than others. Demographic, housing, neighborhood, health indicators and safety issues are compared in Chapter IV. For those interested in examining specific geographic areas, it is recommended that the tables be studied carefully.

In conclusion, this report reveals great heterogeneity both within and between race, gender and age groups. It shows areas of need among older Detroit residents, depending on their life circumstances and conditions. We have shown that need for services outstrips use. Further analysis of the service delivery side of the equation is warranted. There is no 'uniform experience' of aging. Most importantly, this report also reveals many strengths of older Detroit residents and a resiliency of spirit.

In order to implement and coordinate plans for health, transportation, improved housing, neighborhoods, and services to older Detroiters, mechanisms for cooperative efforts must be utilized. Many sources, representing sectors of healthcare, aging services, transportation, and housing, are devoted either entirely or in part to serving older adults. Clearly to meet the needs addressed in this study requires much more than any one source or agency, whether government, nonprofit or private, can offer. It will require collaboration, cooperation and a commitment to enhancing the lives of our city elders.