THE SENIOR Solution

Detroit Area Agency on Aging

COMMUNITY NEEDS ASSESSMENT REPORT

2025

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Table of Contents

Executive Summary

This report presents the findings of the 2025 Community Needs Assessment conducted for the Detroit Area Agency on Aging Region 1-A (DAAA 1-A) by the Wayne State University Center for Social Work Research (CSWR). The survey aimed to identify the key needs, challenges, and priorities of older adults within DAAA's service area, which includes Detroit, Grosse Pointe, Grosse Pointe Park, Grosse Pointe Shores, Grosse Pointe Woods, Grosse Pointe Farms, Hamtramck, Harper Woods, and Highland Park. This report will analyze the survey results, highlighting critical areas for potential development and offering recommendations for addressing the community's most pressing needs. This work should offer direction for DAAA as they plan for future programming.

Description of the Sample

This report contains original data from four sources. First, we collected a multimode Community Needs Assessment Survey targeted adults aged 60 and older in the DAAA service area, with a stratified random sample drawn from voter registration lists and a supplemental list of non-registered voters. A total of 7,574 addresses were mailed surveys, and 1,017 individuals responded, exceeding the required sample size of 853 for sufficient statistical power. Respondents completed the survey either by mail (n=642) or online (n=375). This total also included phone interviews of homebound seniors who had received DAAA services (n=30). Second, we also collected email surveys about caregiving from individuals who had attended a workshop or training on caregiving (n=44). Third, a stakeholder survey was distributed to organizations collaborating with DAAA (n=64). Finally, CSWR worked with DAAA to conduct focus groups with seven organizations that serve multiple populations to understand the needs of older adults who belong to different communities that DAAA seeks to serve.

Key Highlights

Community Survey Highlights

The 1017 respondents included adults over 60 in Detroit, Hamtramck, Highland Park, Harper Woods, Grosse Pointe Park, Grosse Pointe, Grosse Pointe Farms, Grosse Pointe Woods, and Grosse Pointe Shores.

Demographics:

- Respondents were well-educated, with 14.5% with a 4-year college degree and 17.9% with a graduate or professional degree, though 7% did not complete high school.
- The average age of respondents is 72.2 years with 68% female and 31% male.

- The sample is 70% Black/African American, 22% White/Caucasian, and 2% or less identifying as Hispanic or Latino, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Middle Eastern or North African, and other racial and ethnic identities.
- Many respondents belonged to unique communities – 52% identified as a person with a disability, 25% identified as a caregiver, and 15% were veterans.

Community & Housing:

- Respondents are generally dissatisfied with their community, with 53% rating their community as "Fair" or "Poor".
- Most respondents, 79%, were satisfied with their current housing.
- However, respondents expressed concerns about aging in place: need for home repairs (46%), financial reasons (42%), crime and safety (31%). In open ended responses, respondents expressed need for affordable, safe housing (n=20).

Transportation:

- Many still drive themselves (41%), while 19% rely on others for transportation.
- In open ended responses, older adults expressed need for more transportation services (n=19).

Social Support & Participation:

- A significant majority, 71% support a senior millage to fund services for older adults.
- Most have frequent interactions interact with friends, family, or neighbors daily (61%).
- Top needed but unused services: home repair (23%), technology training (17%). In open ended responses, respondents also expressed need for assistance with home repairs and maintenance is a pressing need among respondents (n=53).
- In open ended responses, financial help and navigation of financial programs are also essential for many respondents (n=24). Need for social activities and educational opportunities, including technology training and financial literacy programs (n=16).

Communication & Information:

- Access to information is a key factor in predicting service utilization. In open ended responses, older adults expressed need for improved informational outreach (n=7).

Health:

- Respondents are healthy, with 34% rating their health as "Good" and 29% as "Very Good".
- Caregivers, care recipients, and individuals with disabilities reported higher rates of mental health challenges.
- Reliance on others for transportation is a barrier to physical, mental, and social/emotional health.
- In open ended responses, respondents express a need for healthcare and wellness support, including medical, dental, and mental health services (n=22).

These findings highlight the need for targeted interventions to address the concerns and needs of older adults in the community, particularly in areas such as housing, transportation, social support, and healthcare:

- **Good housing and good communities** go together to promote health and well-being. DAAA should engage with the Detroit Home Repair Task Force, City of Detroit Green Task Force, flood mitigation, and air quality initiatives.
- **Exercise and getting out** for social and recreational activities are critical. DAAA should build upon the success of Strides for Seniors and encourage events that involve bike rides, as well as walking.
- **Millage support** is strong amongst constituents. However, outreach to those disengaged with DAAA (e.g., suburban adult age populations) may have diminishing returns.
- **Support transportation options**. Policymakers and practitioners should prioritize supporting transportation options, including public transportation, ride-sharing services, and alternative modes of transportation like biking.
- **Get the word out.** Service utilization, health, community satisfaction and housing satisfaction are driven by information more so than by need alone. In other words, no matter how much people need services, they still need to get the information needed to use services. DAAA should build upon technology training and partnerships with non-profits, health organizations, senior centers, and libraries to get the word out about these services.

Serving All Americans: Focus Group Highlights

We conducted seven focus groups with a total of 60 participants to ensure that we heard from older adults and persons with disabilities who have particular needs.

Visibility & Outreach: Enhanced marketing and outreach strategies are needed to improve access to existing programs and services offered by DAAA.

- Constituents suggest using simplified language and multiple languages in marketing materials to clarify eligibility criteria and application processes.
- Targeted outreach to isolated groups, such as homebound and disabled individuals, is necessary to link them to services.
- A centralized resource guide or mobile application in multiple languages could help consolidate resources and services.

Health & Safety Initiatives: Constituents emphasized the need for **greater efforts to support the health, safety, and independence of older adults**.

- Regular check-in calls or home visits can help reduce isolation and address safety concerns among older adults.
- Increasing access to emergency response devices and promoting awareness of patient advocacy and disability rights resources can enhance safety and independence.

Training & Education: Older adults were interested in **learning new skills** to increase their independence and social connectedness.

- Technology literacy classes basic cell phone and computer skills to online privacy, security, and scam awareness.
- Financial workshops can help older adults increase their independence, and social connectedness.
- Training opportunities for caregivers, senior living staff, and healthcare professionals on best practices for working with older adults are also needed and should emphasize **empathetic enrichment and person-centered approaches**.

Areas for Advocacy: DAAA should continue to advocate for programs and policies that support older adults, particularly those from underserved backgrounds, such as LGBTQ+ individuals.

Cultural Considerations: Findings suggest that immigrant and other older adults experience **greater isolation** due to cultural differences and limited opportunities for connection.

- Promoting community-based cultural events and hiring bilingual or multilingual staff can help support immigrant older adults and reduce isolation due to cultural differences.
- Additional data collection may be necessary to determine needs specific to target populations, such as Hispanic/Latino and Native American older adults.

Caregiver Survey Highlights

The data from the caregiver survey (n=44) show some key lessons.

- Caregivers experience a range of problems, including emotional burden, social strain, and life stress (n=5), financial strain and employment difficulties (n=4), and transportation issues (n=3).
- Caregivers who are **paid** are more confident and have fewer unmet needs. However, a high number of people are providing **unpaid** care. Approximately 74% of the caregiver respondents are unpaid and 80% of the community respondents have unpaid caregivers. Comments note the financial and emotional strain of caregiving.
- Caregivers living with children under 18, parents, or other adult relatives/friends are more **confident.** Caregivers living with adult children are **less confident** and have more **unmet needs**.
- Caregivers expressed the need for help **finding information**. Caregivers have used services related to food and wellness with success (n=4), but some have faced challenges in accessing services due to eligibility issues (n=7) or lack of awareness (n=6).
- The primary health concern reported by caregivers is dementia (n=20), often accompanied by multiple physical health issues such as diabetes and chronic pain (n=12) and mental health concerns like schizophrenia (n=6).

Key recommendations include the following:

- There is a potential need for specialized training for **dementia care**, and adding resources related to dementia to the DAAA website may be useful. Caregiver care management classes support the **self-rated health** of caregivers.
- **Caregiver support** should be tailored based on the **household composition** as some are giving care to children, adult children and older adults.

- **In addition to in kind services, caregivers need cash to compensate them for their time and expenses to stay healthy.**
- Some caregivers suggest that the **timing and duration of DAAA services could be improved**. Caregivers express a need for more social and community activities, as well as more accessible and reliable transportation to these activities (n=4).

Stakeholder Survey Highlights

A third, separate survey was developed for use with stakeholders – those agencies and providers who work with DAAA in the older adult space. The stakeholders represented here have specific knowledge of the older adult population, their needs, and concerns.

- Of the 64 stakeholders responded to the survey, 32% were human service organizations and 27% were contractors or vendors.
- The majority, 60%, have had a long relationship with DAAA (10 years or more), with 42% reporting weekly interactions.
- The **DAAA has a positive reputation as a trusted resource** (mean score: 4/5). The **DAAA's service offerings have a positive perception** among stakeholders (mean score: 7/10), but less so among health organizations and those in the eastern suburbs.
- Stakeholders appear to be more concerned about the impact of COVID than the community survey respondents.

Key actions from the stakeholder survey suggest the following:

- Improve marketing by connecting with the community through **non-technological promotion** (newspapers, bus ads, posters in prominent locations, billboards, mailed materials) (n=16).
- Prioritize services like transportation (n=10) and **home services** such as home health care, home repair, food delivery, and services for homebound people (n=11).
- Collaborate with partners at neighborhood (e.g., block clubs, senior centers, local nursing homes and assisted living facilities) (n=7), organizational (e.g., professional organizations, colleges and universities, local businesses, healthcare providers) (n=3), and government levels (n=3).
- Increase technological literacy (n=6) and assist community members in aging in place (n=3).
- DAAA should consider targeted outreach to stakeholders in eastern suburbs.

- DAAA should expand involvement and collaboration with **health sector stakeholders** on key issues like **emergency preparedness, and health access initiatives**.

Key Overall Recommendations

Within and across the multiple methods used in this community needs assessment, there are pieces of actionable information that may assist DAAA in shaping the future of their work with older adults.

Advocacy and Systems Issues:

- Expand **geriatric care management personnel** to help older adults navigate systems.
- Respondents ask that DAAA advocate for **LGBTQ+ older adults**.
- By working with other service partners, Increase **supportive services for caregivers**, such as respite care and care planning support, payment for caregiving, wellness, and transportation.

Training Needs:

- Provide **financial planning and financial wellness** workshops for older adults.
- Offer **technology literacy classes** that include online privacy, security, and scam awareness.
- Train caregivers, senior living staff, and healthcare professionals on best practices for supporting older adults, especially around **dementia**.

Marketing and Outreach:

- Create flyers with **simplified language** and printed materials in **multiple languages**.
- Host **professionally translated information sessions** and collaborate with agencies serving special populations to reach all Americans.
- Increase outreach to individuals nearing older adulthood and **promote exercise and wellness to those ages 60-70** that may prevent increased care as they age.

Additional Recommendations:

- Increase accessibility of devices like **Life Alert Emergency Response**.
- Promote awareness of **patient advocacy and disability rights resources**.
- Provide better customer service to older adults, including newer Americans, by promoting **cultural events and hiring bilingual and multilingual staff**.

- Review resources devoted to **dementia care** given the high rate of dementia among those needing care.

For more details, see the full report.

Methods

The 2025 Community Needs Assessment conducted by the Wayne State University Center for Social Work Research (WSU CSWR) in partnership with DAAA employed a mixed methods approach to gather comprehensive data from older adults, caregivers, stakeholders, and underserved populations across nine communities. The study utilized surveys, focus groups, and interviews to ensure that diverse perspectives were represented. In each case, we worked closely with DAAA to select samples and used contact lists they provided. The WSU Institutional Review Board determined the study did not constitute human participant research (IRB #2024-217).

Community Needs Assessment Survey Methods

Participants and Sampling

Eligible participants were adults aged 60 and older residing in the DAAA service area. While the target population was older adults, responses from individuals under 60 or outside the service area were not excluded, as they may have been caregivers or recent relocators. A stratified random sample was drawn from two sources:

- A voter registration list of individuals aged 60+ (N=200,813) provided by the WSU Institute of Gerontology.
- A supplemental random sample of 4,500 non-registered voters aged 60+ purchased from Data Axle.

These lists were combined and stratified by community, with oversampling in smaller communities to ensure representation. A total of 7,574 addresses were included in the final mailing list.

Using G*Power, to detect a small effect size of 0.015 with alpha 0.05 and a power of 0.95 for a regression with 15 predictors, we only needed a sample size of 853.

- Overall, 1,017 individuals responded to the survey at varying levels of completion – more than enough to have sufficient statistical power for a variety of tests.
- A total of 642 respondents completed the community survey by mail and 375 respondents completed the community survey online. Of the online survey respondents, 112 accessed the community survey via the QR code and 335 accessed the community survey through a URL link (even if they did not finish the survey). The community survey was successful in reaching a fairly large audience, as the response rate reached nearly 15%.

Data Collection

Surveys were distributed both online and by mail. A pre-notification postcard with a QR code was sent the week of February 10, 2025. Paper surveys were mailed the week of February 24, followed by a reminder postcard the week of March 10. The online survey remained open from February 10 to March 31, 2025, and mailed responses were accepted through April 7. Vulnerable populations were reached through DAAA's email lists, social media, and phone interviews for homebound individuals. The survey was hosted on Qualtrics and took approximately 15–20 minutes to complete. Respondents could enter a raffle for one of 200 $25 Meijer gift cards.

The community assessment was also administered to homebound constituents via phone interviews. A convenience sample of 30 homebound seniors who had received DAAA services participated in phone interviews between March 10–20, 2025. Interviewers read the full community survey aloud, with minor modifications for clarity. Participants received a $25 Meijer gift card for their time.

Analysis

Paper surveys were scanned using a specialized data scanning program, as well as hand entered by the WSU team. Scanned surveys and hand-entered surveys were checked by WSU for accuracy. Each data file was cleaned and merged into one complete data file. Unanswered questions were coded as missing, but incomplete responses were left in the data set to retain as much data as possible.

Open-ended responses were separated from the data set and coded by the WSU team using thematic analysis. Through this approach, common themes emerged from the data and responses were sorted into each theme. Data analysis included frequencies, descriptive statistics, ANOVA, cross tables, correlations, and some regression tables. Other variables in the survey were screened using correlations, variance inflation factors, and Bayesian model averaging to provide diagnostics for selection of final models.

Measures and Covariates: Surveys to assess perceptions and needs from community members, with specific outreach to those who were homebound and receive services, were revised jointly with DAAA. The CSWR selected validated scales where possible and developed items to reflect the ideas DAAA sought to assess. Dependent variables included community satisfaction, housing satisfaction, ease of information, self-rated health, self-rated emotional/mental health, older adult problems, factors to prevent living in home, number of activities changed post-COVID, number of services used. We utilized closed- and open-ended questions to capture both qualitative and quantitative insights in three

domains: community and housing, social support and participation, communication, and information. The survey also collected respondent demographics. The race/ethnicity options included White or Caucasian, Black or African American, Hispanic or Latino, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Middle Eastern or North African and Other with a text box for specification (this was standardized on all survey instruments). Participants could select all race/ethnicities that apply.

Data Diagnostics: The Qualtrics platform has a built-in bot and duplication detection feature, but it flagged only a few responses. We evaluated the missing values using the Little test[1] and concluded that the missing values were missing completely at random. This means that results are robust to imputation, a method to replace missing values, and listwise deletion. For regression analyses, first we dropped responses that had more than 30% of their responses missing. Typically, these were respondents that only completed the questions about housing and community. Because Qualtrics assigns "check all that apply" items that were left blank as "missing", these were heuristically recoded to zero score if the survey was completed. The rest of the missing responses were imputed using a random forest algorithm (quick_impute, a wrapper for ranger from the pewmethods package in R). This algorithm fills in missing values in a way that preserves the means and standard deviations. Estimates of raw and imputed data were compared to ensure that imputation did not bias results. In general, imputation slightly increased the effect size, but did not change the direction of the effect. We created post-stratification weights to ensure that the response rates were representative of the Census American Community Survey 2019-2023 older adult population 60+ by community within the DAAA Service Area[2]. These weights were applied to bivariate and multivariate responses. Differences between weighted and unweighted results are indicated in the appendix.

Focus Group Methods

Design and Participants

Focus groups were co-developed by WSU CSWR and DAAA to explore needs related to health, housing, food, and transportation. A brief demographic survey collected participants' year of birth and race/ethnicity. Seven focus groups were conducted with 60 participants from the following target populations: Arabic Americans, Asian Americans,

[1] Little, Roderick J. A. 1988. "A Test of Missing Completely at Random for Multivariate Data with Missing Values." *Journal of the American Statistical Association* 83 (404): 1198–1202. doi:10.1080/01621459.1988.10478722.

[2] *Weight* = (ACS Population 60+$_{Community}$ / Total ACS Population 60+ in DAAA) / (Number Responses $_{Community}$ / Total Number Responses).

Hispanic/Latino Americans, Native Americans, Homeless individuals, LGBTQ+ individuals, and Veterans.

Recruitment and Data Collection

DAAA identified community partners to recruit participants. Focus groups were held in person (except for the Veterans group, which was conducted via Zoom) between February and April 2025. Interpretation was provided by service organization staff for Arabic and Asian American groups. Sessions were recorded, transcribed, and analyzed using thematic analysis. Participants received a $25 Meijer gift card.

Table 1. *Focus group participants by site and population (n=60)*

Population	Site	Date	n
Arabic	ACCESS	April 8	10
Asian	Association of Chinese Americans	March 5	9
Hispanic/Latino	Bridging Communities	March 10	8
Native	North American Indian Association of Detroit	February 26	13
Homeless	Cass Community Social Services	February 24	13*
Veterans	Detroit Area Agency on Aging	April 2	3
LGBTQ+	MiGen and Hannan Center	April 9	4

*Of the 13 homeless participants, 8 were currently unhoused.

Caregiver Survey Methods

Participants and Sampling

The caregiver survey targeted individuals who had attended caregiving workshops or training. No exclusions were made based on current caregiving status. A convenience sample of 44 respondents completed the survey between February 18 and March 28, 2025 at varying levels of completion. In some cases, questions were not applicable to respondents.

Survey Content and Data Collection

The survey, co-developed by WSU CSWR and DAAA, included items on caregiver type, frequency, duration, self-efficacy, unmet needs, services used, and health. DAAA and WSU CSWR reviewed the survey to discuss each item and adjust as needed. DAAA provided a list of email addresses for survey distribution containing 373 unique names. The survey was available to access through personalized links, anonymous links, and QR codes found on flyers that were distributed to DAAA and other service agencies. DAAA shared the survey with their Board and Advisory Council and asked that it be shared to increase response rate. Reminder emails were distributed on March 10, 2025, and March 14, 2025, and DAAA also shared a reminder to the list. In total, emails were sent three times. Respondents were

incentivized with an optional raffle of 20 $25 Amazon e-gift cards. The WSU IRB determined that this study was not regulated as human participant research.

Analysis

Data was cleaned and incomplete responses were retained. Descriptive statistics, correlations, and regression analyses were conducted. Open-ended responses were analyzed thematically. Due to the small sample size, inferential statistics were limited. Dependent variables included average self-rated health, average self-rated emotional/mental health, average caregiver self-efficacy, total unmet caregiver needs, and total caregiver problems. Other variables in the survey were screened using correlations, variance inflation factors, and Bayesian model averaging to provide diagnostics for selection of final models.

Stakeholder Survey Methods

Participants and Sampling

The stakeholder survey was distributed to 339 individuals from organizations collaborating with DAAA, including WSU social work practicum sites and agencies serving older adults and people with disabilities. No organizations were excluded. A total of 64 valid responses were received between February 19 and March 18, 2025.

Survey Content and Distribution

The survey assessed agency services, service areas, relationships with DAAA, perceptions of DAAA's role and reputation, and COVID-19 impacts. DAAA and WSU CSWR reviewed the survey to discuss each item and adjust as needed. It was distributed via email with personalized links, QR codes, and flyers. Reminder emails were sent on February 24, March 6, and March 14. In total, the survey was distributed three times. Respondents were incentivized with an optional raffle of 10 $25 Amazon e-gift cards. The WSU IRB determined that this study was not subject to regulation.

Analysis

Three questionable responses were removed. Missing data were handled consistently with the community survey. Frequencies and descriptive statistics were reported. Variables were screened using correlations, variance inflation factors, and Bayesian model averaging. Dependent variables were the relationship with DAAA (duration, frequency, type of interaction, strength), perceived role of DAAA, and DAAA's reputation. Independent variables in the survey were screened using correlations, variance inflation factors, and Bayesian model averaging to come up with final models. Open-ended responses were thematically coded.

Community Needs Assessment Survey

Introduction

The primary data source for the needs assessment was a large-scale survey of community members. For DAAA, the community includes residents of Detroit, Grosse Pointe, Grosse Pointe Park, Grosse Pointe Shores, Grosse Pointe Woods, Grosse Pointe Farms, Hamtramck, Harper Woods, and Highland Park. The survey itself was created over several weeks with close consultation and final approval for wording of all items by DAAA staff and leadership.

Broad areas of concern relate to the Social Determinants of Health (SDoH)[3] including community and housing, transportation, social support & participation, communication & information technology, and health. In particular, DAAA was interested in assessing caregiving (i.e., receiving care from professionals or loved ones; or providing care for others), problems (e.g., food insecurity, environmental quality, finances), and service utilization. The topics were chosen, in part, based on previous needs assessments and an eye toward contributing toward a new 5-year plan.

Method

The community needs assessment was distributed via paper survey by mail or online. From February 10 through April 7, 2025, the survey received responses from 1,017 constituents at varying levels of completion. Of the total number of respondents, 642 completed the community survey by mail while 375 completed the survey online.

Results

Below is a summary of key data points, followed by analysis highlighting significant relationships among them. Data tables displaying survey results are in **Appendix A**.

The sample for the community survey included 1,017 respondents. People were free to skip an item, and some items allowed for multiple responses, creating varying response totals (n=valid sample size) throughout the survey. The mailed postcard or paper mailing was the most common way people heard about the survey at 73%, followed by an email or social media post (22%).

[3] World Health Organization. (2024, January 7). *Social determinants of health*. World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

Demographics

Respondents were asked to provide their year of birth and a mean age of 72.2 was computed. The sample included 68% female, 31% male respondents, and 1% other gender (non-binary, genderfluid, prefer not to disclose, and unspecified other). Black/African American was the most common race reported (70%), followed by 22% White/Caucasian. Two percent (2%) or less each was reported for Hispanic or Latino, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Middle Eastern or North African, and other racial and ethnic identities.

72 average age of respondent

68% female

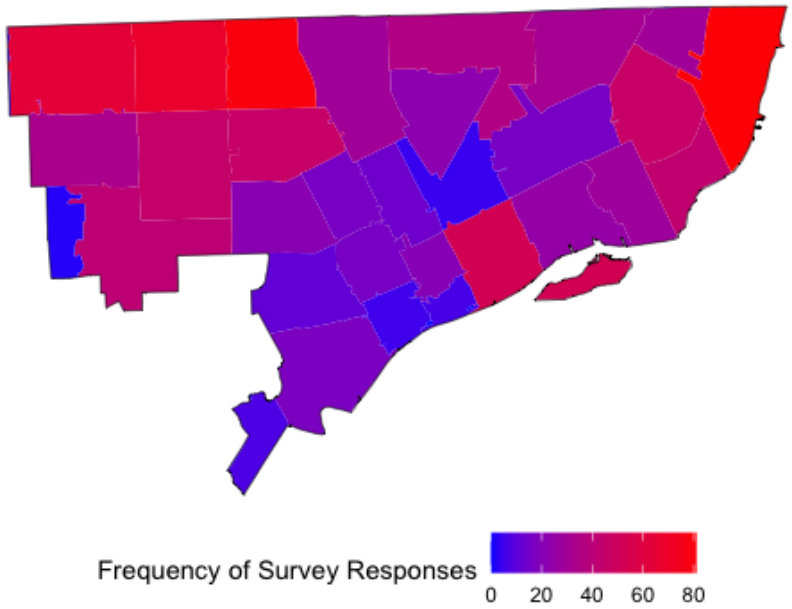
70% Black or African American

Many respondents belonged to unique communities – 52% identified as a person with a disability, 25% identified as a caregiver, and 15% were veterans, as shown in **Figure 1**. When asked if a disability or chronic illness prevents them from taking part in activities, 61% said "No", while 30% said "Yes".

Figure 1: *Respondents self-identifying with unique communities*

All zip codes of the service area were reached. The heat map in **Figure 2** displays the concentration of responses.

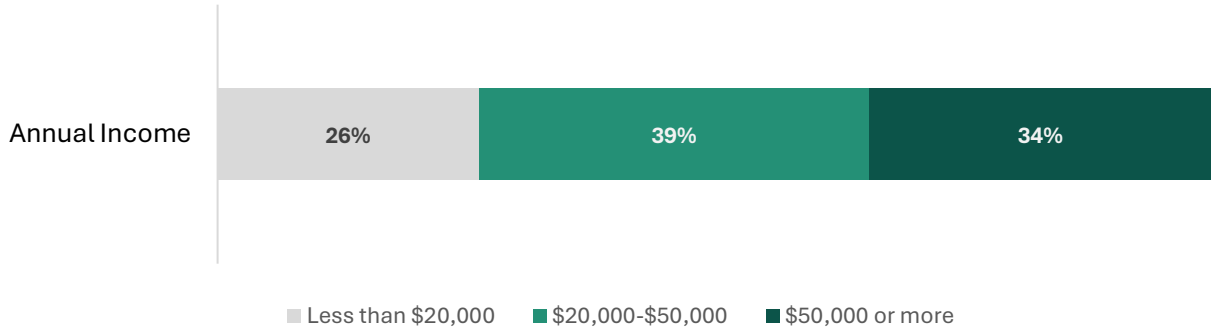
Figure 2: *Distribution of Zip Code Responses (n=992 with 955 inside service area and 41 outside the service area)*



As for relationship status, 29% of respondents were married, 21% were never married, and 48% were divorced, separated, or widowed. A total of 386 respondents (34%) noted that they lived with others. Mainly, this was another adult or relative (44%), but 32% lived with an adult child over 18, and 13% had children under 18 in their home.

This sample of respondents was well educated, with 19% holding a graduate or professional degree and 38% having completed a 2- or 4-year degree or some postgraduate study. A large portion of the sample (43%) were retired, while 24% were employed in full-time, part-time, or self-employed positions. The income level of the respondents included 27% who had less than $20,000 a year, 39% with $20,000 - $50,000 a year, and 34% with $50,000 or greater in income, as shown in **Figure 3**.

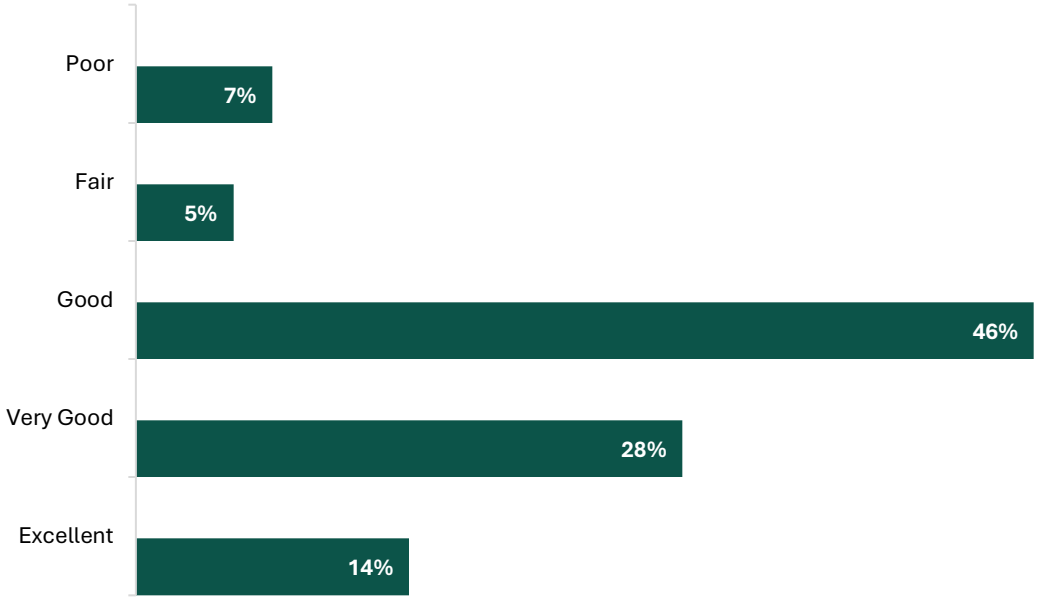
Figure 3: *Distribution of annual income*



Community & Housing

The first set of questions asked about perceptions of the community and housing. When asked to rate their community as a place for people to live as they age, respondents were split with 46% rated it as “Good”, followed by 28% “Very Good”, and 14% “Excellent”. All responses are displayed in **Figure 4**.

Figure 4: *Aging-friendly community ratings*



Most respondents were tied to their community; 73% own their own home. **People who reported higher community satisfaction tended to be White, had private health insurance, higher incomes, and a college education**. For example, 44% of residents in Grosse Pointe Shores, Woods, or Farms rated their community as "Excellent". Alternatively, **people who reported lower community satisfaction included care recipients, those living with non-spousal adult relatives, and Medicaid recipients**, with only 16% of care recipients and 12% of non-care recipients rating their community as "Excellent".

Below are factors that appear to predict community satisfaction.

- The largest positive association is between housing satisfaction and community satisfaction ($\beta = 0.47$, $p < 0.001$). Constituents who had higher housing satisfaction were more likely to have higher community satisfaction as well.

- Crime and safety concerns are negatively associated with community satisfaction ($\beta = -0.37$, $p < 0.001$). Constituents who had more concerns about crime and safety were less likely to have high community satisfaction.
- Community satisfaction is also positively associated with social/recreational activities, ease of finding information, and self-rated health. Constituents who were more satisfied with their community were more likely to be engaged in social/recreational activities, more likely to have an easier time finding information, and more likely to have higher self-rated health. This highlights the importance of providing **satisfactory housing in safe neighborhoods** to older adults.

Most respondents were satisfied with their current housing, as 79% reported being "Satisfied" or "Very Satisfied".

- People who reported higher housing satisfaction tended to be homeowners, caregivers for older adults, White/Caucasian, have higher education levels, and higher incomes, with 57.3% of those with incomes over $75,000 reporting being "Very Satisfied".
- On the other hand, people with disabilities, households with children under 18, and Medicaid users reported lower housing satisfaction, with only 22% of Medicaid users and 23% of people with disabilities being "Very Satisfied".
- The largest driver for housing satisfaction is the respondent's Community Rating ($\beta = 0.33$, $p < 0.001$), where those who had a more positive community rating were also more likely to be satisfied with their housing.
- However, the need for home repairs was negatively associated with housing satisfaction ($\beta = -0.32$, $p < 0.001$) as were environmental concerns such as air quality and floods ($\beta = -0.17$, $p < 0.001$). Those who had higher home repair needs and environmental concerns were less likely to have high housing satisfaction. Participation in social or recreational activities, ease of finding information, and household income are also positively associated with housing satisfaction.

Aging in place is an important concept, but there are many reasons that may prevent this, including education and economic vulnerability[4].

- The concerns that prevent respondents from living in their home included a **need for home repairs** (62%), followed by financial reasons (40%) and crime and safety (41%), as shown in **Figure 5**.

[4] Smith, R. J., Baik, S., Lehning, A. J., Mattocks, N., Cheon, J. H., & Kim, K. (2022). Residential segregation, social cohesion, and aging in place: Health and mental health inequities. *The Gerontologist*, *62*(9), 1289–1298. https://doi.org/10.1093/geront/gnac076

- In terms of bivariate relationships, respondents who were currently or previously homeless, as well as those with higher incomes and older age groups, reported fewer housing concerns, with those 85 and older reporting about half a problem less than those under 65. In contrast, the disability community, those who were divorced, separated, widowed, or never married, and those caregiving for someone with dementia reported significantly more housing issues.

Figure 5: *Top 3 concerns that prevent respondents from living in their home*

Transportation

Most older adults were still driving themselves (41%), while others relied on someone else to drive them (19%). Respondents were also asked if they would vote in support of a millage that would devote a small portion of property taxes to funding services for older residents, such as senior centers, Meals on Wheels, transportation, and other programs.

- A total of 71% said they would vote in support of a senior millage, while only 4% said they would not.
- Those least likely to support the millage were suburban constituents, White/Caucasian, those with annual incomes over $75,000, those with graduate degrees, people without disabilities, and male.
- Those who get information from DAAA, a doctor, health care professional, or department of health are more likely to support millage to fund services for older adults and people with disabilities than those who do not get information from these sources.

Social Support & Participation

Most respondents reported interacting with friends, family or neighbors daily (61%), while 5% interact less than monthly or almost never. That interaction could be by phone or in person. Results indicate that a **change in post-COVID activities is associated with increased rating in housing problems, and reporting problems getting to go places**. On the other hand, being White/Caucasian is associated with fewer changes in post-COVID activities.

As a service provider and coordinator, DAAA was interested in assessing the need for a range of services.

- Many indicated they **did not need** Longterm Care Ombudsman (76%), Meals on Wheels (74%), or Adult Day Services and respite care (73%).
- Home repair was the **most needed but unused** service (23%), followed by technology training (17%).
- The services **most used** were assistance with accessing health and support services (20%), and both home care and home repair services (16% each).
- The top three services that older adults **had not heard of** were MI Choice Waiver Program (52%), Intergenerational programming (50%), and Evidence-based programs (42%).

Higher service use was reported among caregivers for older adults or individuals with dementia, those living with parents or children, individuals with health coverage such as Medicare, Medicaid, or employer-sponsored insurance, and members of racial or ethnic minority groups, including Black, Hispanic, and Native Hawaiian/Pacific Islander populations. Older respondents and female respondents also reported higher service use, with older respondents using more services overall and female respondents using more services than male respondents.

- **Access to information** was a key factor in predicting average service utilization among older adults, specifically:
    - Constituents who **received information from DAAA** were more likely to utilize services, ($\beta = 0.25$, $p < 0.001$)
    - Constituents who received information from a **local senior center or community wellness center** were second-most likely to utilize services, ($\beta = 0.11$, $p < 0.001$)
    - Receiving information from local nonprofit organizations and the public library was also related to service utilization, but not as strongly.
- Most striking is that service utilization was not highly related with need or membership in any community. This may suggest that having **access to information and the source of information are important** to older adults' utilization of services, rather than need for services alone.

Respondents were asked to rate a list of problems on a scale of 1) "Not a Problem", 2) "Serious but Can Manage", and 3) "Very Serious". Overall, none of the issues were perceived as major concerns. **Figure 6** displays the top responses received for each problem category.

Figure 6: *Top responses to problem area categories*

"Not a Problem"	"Serious but Manageable"	"Very Serious"
➢ Substance use (96%) ➢ Physical or financial abuse or neglect (92%) ➢ Getting help taking medication (92%)	➢ Home/apartment upkeep (25%) ➢ Job/income security (paying bills) (24%) ➢ Stress/mental health/loneliness (20%)	➢ Home/apartment upkeep (11%) ➢ Environmental concerns such as air quality and floods (9%)

People who reported more problems, such as **food security, medication, and environmental quality issues**, tended to be from the disability community, unhoused, non-married, and from some racial or ethnic minority groups, including Black and Native Hawaiian/Pacific Islanders. The **homeless/unhoused community** reported the most problems.

- Those who reported fewer problems tended to be White, have higher education levels, such as graduate or professional degrees, and annual incomes above $30,000. Having private insurance was also associated with having fewer problems.
- Various factors contribute to **older adult problems** (e.g., food security, basement flooding), including financial concerns, reliance on special transportation services, changes in daily routines post-COVID, and being a member of the disability community.
- Those who reported fewer problems were also more satisfied with their housing, had higher incomes, reported better self-rated mental health, and found it easier to find information about services.

Communication & Information

The older adults who responded to this survey had internet access (90%) and were comfortable with operating smartphones, tablets, or computers (76%). This may influence their ability to access information they need. Most respondents (62%) said they can find information on programs or services "Most" or "All of the Time".

- **Internet/media** was the primary source for locating information (23%), followed by doctors/healthcare providers (19%), faith-based organizations (13%), and DAAA (12%).

- Those who reported having **more difficulties finding information** they needed tended to be individuals with disabilities, care recipients, and those with lower incomes and lower educational attainment. Among people with disabilities, 14% reported that they "Rarely" or "Never" find the information they need.
- In contrast, those who reported better access to information and services tended to be higher-income individuals and college-educated groups.

Multivariate regression analysis showed that those who had an **easier time finding information** were also more likely to:

1. Have participated in technology training ($\beta = 0.14$, $p < 0.001$).
2. Have higher community satisfaction.
3. Be receiving MI Choice Waiver services.
4. Be engaged in social or recreational activities.
5. Use home repair services.

Conversely, those who **needed home repairs** ($\beta = -0.24$, $p < 0.001$) were more likely to:

1. Have a harder time finding information.
2. Report more problems keeping up their home/apartment.
3. Report more problems paying bills.

Combined, these results suggest that **difficulty accessing information** and **needing home repairs** can be barriers for older adults. Having an easier time finding information can **decrease barriers** for older adults, such as the need for home repairs.

Health

When it comes to health, this group compared themselves favorably to other people their age. While 34% rated their health as "Good", 29% described it as "Very Good", and 11% as "Excellent". Only 4% described their health as "Poor".

- People who reported **higher self-rated health** tended to be homeowners, have employer insurance, and be married, with 31% of homeowners and 32% of those with employer insurance rating their health as "Very Good".
- In contrast, those who reported **lower self-rated health** tended to be care recipients, have disabilities, have lower education levels, and have lower incomes, with 11% of care recipients, 11% of people with disabilities, and 12% of those without high school diplomas rating their health as "Poor".

- The biggest **driver of self-rated health** was riding a bike ($\beta = 0.67$, $p < 0.001$), followed by being able to drive oneself to errands and ease of finding information. Additional positive associations included community satisfaction, housing satisfaction, and participation in social or recreational activities.
- Those who reported relying on others for transportation ($\beta = -0.22$, $p = 0.003$) had the largest negative association with self-rated health, followed by stress/mental health concerns and loneliness. This model explains 34% of the variance in self-rated health, meaning that over one-third of the changes in self-rated health can be explained by the relationship between higher transportation reliance and lower self-rated health, stress and mental health concerns, and loneliness. This suggests that **reliance on others for transportation** is a **barrier for older adults** and may **affect their physical, mental, and social/emotional health**.

Next, respondents were asked to rate their emotional/mental health. The largest percentage of respondents (35%) said their emotional/mental health was “Very Good”, followed by 29% who reported it as “Good”, and 18% as “Excellent”.

- Caregivers, care recipients, and individuals with disabilities reported **higher rates of mental health challenges**, with approximately 30% of caregivers and care recipients and 37% of people with disabilities rating their mental health as only "Fair" or "Poor" when accounting for bivariate relationships.
- **Positive indicators of mental health**, such as higher rates of "Very Good" or "Excellent" mental health, were associated with higher education levels, such as graduate degree holders, and higher incomes, with 67% of graduate degree holders and 72.6% of those with incomes over $75,000 reporting better mental health.
- The biggest **driver of self-rated mental health** was comfort operating devices such as smartphones ($\beta = 0.23$, $p = 0.001$), followed by housing satisfaction, ease of finding information, and recreational activities.
- The biggest roadblock to mental health was stress/mental health challenges ($\beta = -0.60$, $p < 0.001$) and loneliness, followed by relying on others for transportation.

Respondents’ relatively good overall health may be linked to **frequent physical activity.**

- One-third (33%) reported engaging in physical activity several times a week, while 24% reported doing so every day.
- Only 7% said they never engage in physical activity, while 8% reported doing so less than once a month.

To maintain physical health, 95% have **visited a doctor in person** over the last year while 39% have **used telehealth** in the last year.

- Most respondents have Medicare insurance coverage (42%), followed by 23% with insurance from a current or former employer.
- Additionally, 13% are covered by Medicaid and 12% purchase insurance directly.

In this sample, **259 people reported providing care for another person**, with some caring for more than one person.

- While 46% care for an older adult, another 20% care for someone with dementia, and 18% care for a person under 18.
- Only 18% of respondents say someone is caring for them in their home. That caregiver was described primarily (41%) as an adult relative, and 32% as a paid caregiver.

Summary of open-ended questions (online survey only):

The final question asked respondents for additional comments about programs or services. A total of 238 people provided some type of response, of which 179 were codable. Non-codable responses included responses such as *"N/A"* and *"Thank you for this survey"*.

Home Repairs and Maintenance

The largest theme found across responses was a need for assistance with home repairs and maintenance (n=53). Respondents needing assistance in this category wrote about larger-scale projects, such as roof repairs, plumbing work, and basement flooding. Respondents also expressed the need for assistance with regular, smaller-scale upkeep as well, such as mowing the lawn, shoveling snow, and taking out the trash. There was also concern for the affordability of home repair and maintenance services for older adults.

> ***"I desperately need roof and plumbing and electrical work, SSI [is] less than a thousand dollars a month."***

Financial Help

Many respondents (n=24) **require assistance financially**, as well as with navigating financial programs and institutions (such as navigating money-saving utility programs or government assistance programs).

Health and Wellness

Many respondents (n=22) expressed a need for **healthcare and wellness support**. Regarding healthcare, the need for medical, dental, and mental health clinics was expressed. Regarding wellness support, there was expressed need for exercise opportunities and affordable high-quality food.

Housing, Safety, and Quality of Life

Some respondents (n=20) **require assistance with affordable, safe housing**. Another concern was neighborhood safety, such as loose dogs or criminal activity. One concern raised by some was the need for single-level housing to accommodate aging in place. Another concern raised by some was the lack of affordable housing and housing for low- and middle-income Detroiters.

Transportation

Some respondents (n=19) expressed a **need for transportation.** Reliable, affordable, and accessible transportation was expressed as a need, as well as more information on how to access transportation options. Some respondents (n=5) wrote about difficulties finding a caregiver for hire or respite for caregivers. Others (n=5) wrote specifically about the need for dementia-specific support.

> ***"Reliable door to door transportation is a great need. I would be willing to pay. The expense would be cheaper than the expense of owning a car."***

Social Activities and Education

Some respondents (n=16) expressed **interest in social activities and educational opportunities.** Some social activities mentioned were lunches, field trips/day trips, bingo, and movies for older adults. Some educational opportunities mentioned were technology training, financial literacy training, and language classes.

Service Provision

Some respondents (n=7) suggested more **informational outreach** to older adults, especially for homebound older adults. They were not aware of available services or knew of others who were not aware. Some respondents (n=5) expressed discontent with current service provision. The major issue that these respondents have faced is a **lack of follow-through from various service agencies and assistance programs.** They also expressed frustration with being turned away from services due to a lack of funding or availability. A few respondents (n=4) noted that the area of service provision has an impact on their utilization of services. For example, they may not be familiar with an area where a service is offered, or they cannot travel to the location where a service is offered.

Community Survey Summary

The respondents included adults over 60 in Detroit, Hamtramck, Highland Park, Harper Woods, Grosse Pointe Park, Grosse Pointe, Grosse Pointe Farms, Grosse Pointe Woods, and Grosse Pointe Shores. Respondents were well-educated, with 14.5% with a 4-year college degree and 17.9% with a graduate or professional degree, though 7% did not complete high school.

The respondents varied in how they perceived their community, housing, and living conditions. While household income was associated with housing satisfaction and self-reported problems, it was one of the smallest drivers of these. As found in national studies, service access is challenging in neighborhoods where low-income older adults are concentrated[5]. Likewise, economic vulnerability can further restrict transportation access to valued activities, consistent with national data[6]. A total of 25% of respondents identified as caregivers – the same as national rates that show about 25% of the U.S. adult population identify as caregivers[7].

The community survey suggests the importance of the following actions:

- **Exercise and getting out** for social and recreational activities are critical for older adults. DAAA should build upon the success of Strides for Seniors and encourage events that involve bike rides, as well as walking.
- **Good housing and good communities** go together to promote health and well-being. DAAA should engage with the Detroit Home Repair Task Force, City of Detroit Green Task Force, flood mitigation, and air quality initiatives.
- **Support transportation options**. The findings suggest that transportation is a significant concern for older adults, particularly those who rely on others for transportation. Policymakers and practitioners should prioritize supporting transportation options, including public transportation, ride-sharing services, and alternative modes of transportation like biking.
- **Get the word out.** Service utilization is driven by information, not by need. Thus, no matter how much people need services, they still need to get the information needed to use services. Community and housing satisfaction also relied on information. It is critical for health. DAAA should build upon technology training and partnerships with non-profits, health organizations, senior centers, and libraries.
- **Millage support** is prevalent amongst constituents. However, outreach to those disengaged with DAAA (e.g., suburban adult age populations) may have diminishing returns.

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[5] Lehning, A. J., Mattocks, N., Smith, R. J., Kim, K., & Cheon, J. H. (2021). Neighborhood age composition and self-rated health: Findings from a nationally representative study. *Journal of Gerontological Social Work*, *64*(3), 257–273. https://doi.org/10.1080/01634372.2020.1866731

[6] Lehning, A., Kim, K., Smith, R., & Choi, M. (2018). Does economic vulnerability moderate the association between transportation mode and social activity restrictions in later life? *Ageing & Society*, *38*(10), 2041–2060. https://doi.org/10.1017/S0144686X17000411

[7] *Caregiving: Poll reveals who's providing care and who they're …* institute for population research. (2024, August 6). https://psc.isr.umich.edu/news/caregiving-poll-reveals-whos-providing-care-and-who-theyre-caring-for

Homebound Subset of the Community Survey

Introduction

Interviews were conducted over the telephone with homebound seniors. The purpose of the survey was to determine the use and awareness of services, as well as to articulate the needs of homebound older adults. Homebound constituents are a critical population to engage, as they are heavy service users with less access to traditional services.

Method

A convenience sample of thirty older adults was pulled from a list of homebound constituents who had received services from DAAA. Thirty interviews were completed between March 10 and March 20, 2025, through telephone calls. Respondents were asked to respond to the questions from the 2025 Community Needs Assessment Survey, with slight modifications made to improve communication between the interviewee and respondent.

Results

Thirty respondents participated in the homebound interview. All respondent numbers are out of 30 unless otherwise specified. All tables are displayed in **Appendix B**.

Demographics

Most respondents (87%, n=26) identified as female while 13% (n=4) identified as male. About half (55%, n=16 out of 29) of respondents were widowed, while 17% (n=5 out of 29) were married, 17% (n=5 out of 29) were never married, and 10% (n=3 out of 29) were divorced. Most respondents (93%, n=28) were Black/African American, and 7% (n=2) were white/Caucasian. Respondents' ages ranged from 68-99 years old, with a mean of 84 years old.

84 average age of respondent

87% female

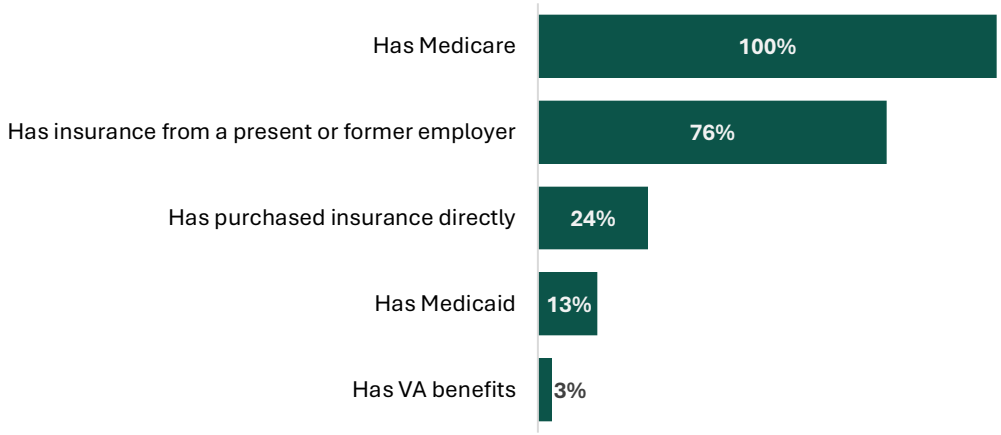
93% Black or African American

The household income of respondents ranged from $10,000 to over $75,000, with the median grouped income between $20,000 - $29,999. Nearly half of respondents (48%, n=14 out of 29) held a college or graduate degree, while 30% (n=10 out of 29) had a high school diploma or GED. An additional 10% (n=3 out of 29) reported some post-secondary education or training and 7% (n=2 out of 29) did not have a high school diploma. All respondents (100%; n=29) lived within Detroit in the DAAA service area.

Most respondents (83%, n=25) were retired and not looking for work. One respondent (3%) identified as unable to work due to disability, another respondent reported being self-employed (3%), and 3 respondents reported they were retired and looking for work (10%).

All respondents (100%, n=29 out of 29) reported having Medicare. Additionally, 76% (n=22 out of 29) had insurance from a present or former employer, 24% (n=7 out of 29) purchased insurance directly, 13% (n=4 out of 29) had Medicaid, and 3% (n=1 out of 29) reported receiving VA benefits, as shown in **Figure 7**.

Figure 7. *Insured status of homebound interview respondents (N=29, multiple responses per person)*



Community and Housing

While 77% (n=10 out of 13 respondents) lived with an adult child, 39% (n=5 out of 13 respondents) lived with an adult relative or a friend. Additionally, one person (8%) lived with a child or children who were under 18, and one person (8%) lived with a child or children who were away at college. Most respondents (87%, n=26) owned their own home, and 90% (n=27) were satisfied or very satisfied with their housing.

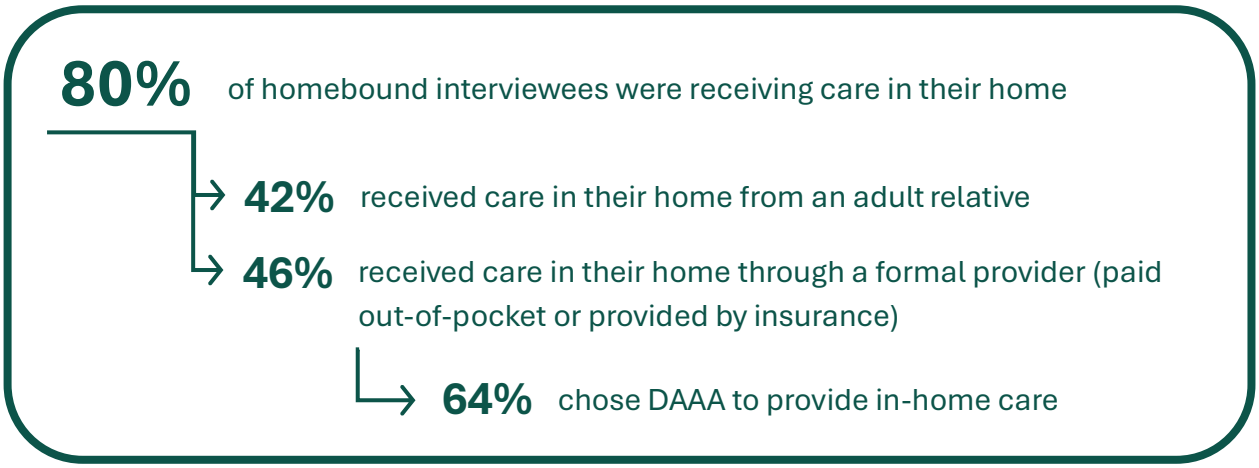
Many (93%, n=28) rated their community as a "fair" or better place to live while aging, which is significantly higher than other respondents ($p<0.001$). However, 85% (n=17 out of 20) people indicated that **accessibility issues are the main factor that would prevent them from continuing to live in their home**, followed by the need for home repairs (45%, n=9) and

crime and safety issues (35%, n=7). Additionally, nearly half of respondents (47%, n=14) had Internet access in their home.

Figure 8. *Top 3 concerns that prevent respondents from living in their home*

Most respondents (80%, n=24) were currently receiving care in their home, predominantly by an adult relative (42%, n=10) or through paid/insurance-provided care (46%, n=11). Of those eleven receiving paid care or insurance-provided care, **seven (64%) received in-home care from DAAA**.

Figure 9: *Subgroups of in-home care*



Transportation

Most constituents (97%, n=29) reported that they had others who drove them to places for shopping, doctors' appointments, and running errands, though 27% (n=8) reported using special transportation services. A few respondents reported driving themselves to places (10%, n=3), some reported taking a taxi or rideshare (10%, n=3), and some reported walking (7%, n=2).

Social Support and Participation

Homebound survey respondents were also asked if they would vote in support of a senior millage. Ninety-three percent (93%; n=28) indicated they would vote "yes" whereas two respondents (7%) were unsure how they would vote. This is significantly higher than other respondents, ($F = 2.247$, $p = 0.008$).

Compared to before the COVID-19 pandemic, changes were mostly made to respondents spending time inside their homes (77%, n=10), visiting restaurants and other eating/drinking establishments (69%, n=9), and going to the grocery store (69%, n=9), as shown in **Figure 10**. Homebound respondents have -0.849 fewer post-COVID changes than other respondents to the survey (p=0.045). It should be noted that it is not possible to discern if these changes were due to the virus or the respondents' disability.

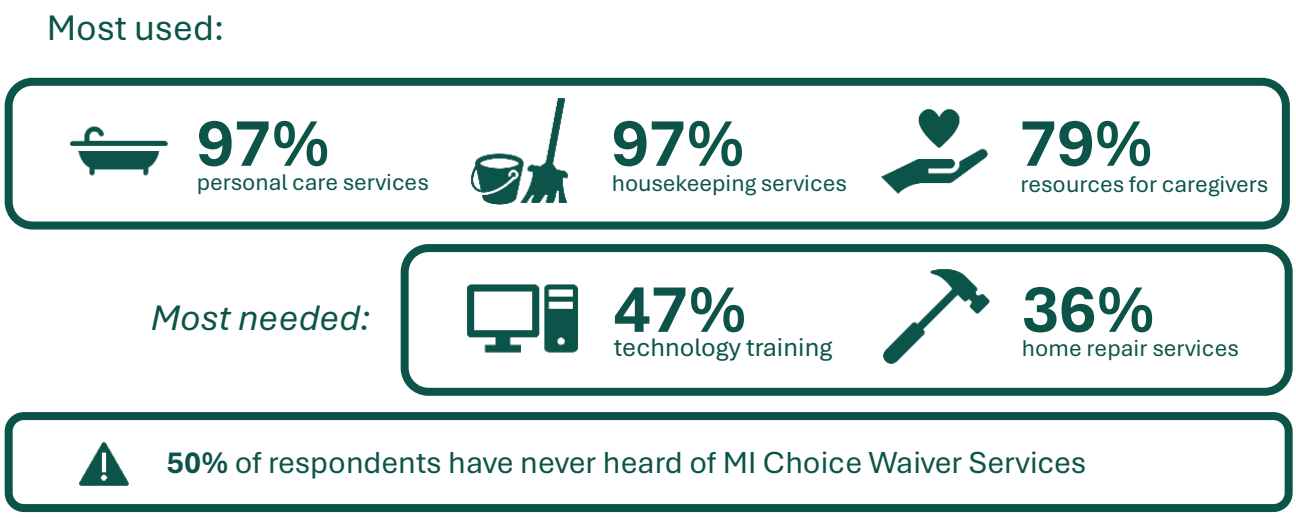
In open-ended responses, some explained further that they have begun gradually returning to public spaces, and others explained that the COVID-19 pandemic made them more aware of being in large crowds.

Figure 10. *Top 3 lifestyle changes during the COVID-19 pandemic*

Homebound interviewees were asked if they had heard of, needed, or used a variety of services (**Figure 11**). On average, they use services more than other respondents (β=0.658; p<0.001).

- The services **most used** by respondents were personal care and housekeeping (97%, n=28 out of 29) and resources for caregivers (79%, n=23 out of 29).
- Technology training (47%, n=14) and home repair services (36%, n=10) were **needed but not used**.
- The **most unknown service** was MI Choice Waiver Services (50%, n=15).
- Many indicated they **did not need** LGBTQ+ services (97%, 27 out of 29) and intergenerational programming (77%, 23 out of 30).

Figure 11. *Most used and most needed services by homebound interviewees*



Respondents were asked to rate a list of problems on a scale of 1) "Not a Problem", 2) "Serious but Manageable", and 3) "Very Serious".

- **Not a Problem:** For most respondents, issues such as substance use (100%, n=30), physical or financial abuse or neglect (97%, n=29), food insecurity (93%, n=28), getting help with Medicare or Medicaid (93%, n=28), and assistance with taking medications (90%, n=27) were not reported as problems.
- **Serious but Manageable:** Stress/mental health/wellness (33%, n=10), home upkeep (36%, 10 out of 29), and getting to places they need to go (20%, n=6) were identified as serious yet manageable.
- **Very Serious:** Some (28%, n=8 out of 29) felt that managing their home was a very serious problem that was not being managed.

Communication and Information

Over half of respondents (57%, n=17) indicated that they were able to find information on programs and services "most" or "all of the time", with the remaining respondents (43%, n=13) "sometimes" able to find the information they needed. This is statistically significant compared to other respondents ($F = 3.221$, $p < 0.01$).

Most used DAAA (97%, n=28 out of 29), their doctor or other health professionals and agencies (79%, n=23 out of 29), and media (62%, n=18 out of 29) to find information on services for older adults.

Health

When asked to compare their health to most people their age, most respondents (43%, n=13) rated their health as just "Fair". In contrast, 73%, (n=21) rated their **emotional and mental health** as "Good" or better. This is statistically significant compared to others ($F = 3.776$, $p < 0.01$).

- Physical activity was common, with 43% (n=13) exercising several times a week or more.
- Almost all (97%, n=29) had seen a medical provider in person in the past year, while 40% (n=12) had engaged with a medical provider via telehealth in the past year.
- Most respondents (83%, n=25) interacted at least weekly or more with their friends and family. However, 57% (n=17) engaged with recreational activities monthly or less than monthly, with some respondents (30%, n=9) never engaging in recreational activities.

Additional Programming

Respondents were asked if they had ideas about programs and services for older adults in their community. A total of seventeen (57%) respondents provided feedback. Responses fell into the following main themes: home-related medical services (41%, n=7), transportation (24%, n=4), social caregiving and engagement (18%, n=3), and home management services (24%, n=4).

Home-Related Medical Services

Three respondents shared that an increase in available in-home care hours for homebound older adults is needed.

One person suggested that a medical alert system for older adults who live alone would be helpful. Another person specified that there is a need for mental health services specifically.

Two respondents shared concerns about care they have received from DAAA, expressing difficulties with low assistant skill level, consistency, and reliability (no shows and no calls).

Transportation

The main concerns shared by respondents regarding transportation were access to affordable transportation, needing more information about transportation services (such as being unsure who to call) and suggesting an increase in the provision of transportation services.

Social Caregiving & Engagement

One respondent suggested a program encouraging neighbors to look in on each other or help older adults in their neighborhood.

Another suggested that reassurance calls would be helpful, and that DAAA could promote this service more. A third respondent suggested field trips in town as a way of meeting older adults' social needs.

Home Management Services

Three respondents expressed that in-home chore services would be helpful, such as snow removal, lawn care, repairs and taking out the trash.

One person added that home management services should consider seniors' needs and protect them from being taken advantage of.

Homebound Summary

In summary, responses from the homebound interviews show some key lessons:

- The homebound are significantly more satisfied with their communities than others. Most homebound constituents reported getting their service information from DAAA, indicating that DAAA is successful in engaging this subgroup of older adults. They report statistically significant higher ease in obtaining information.

- Homebound constituents report **significantly lower self-rated health**, use significantly more services, and are significantly more likely to support a senior millage.
- Accessibility issues emerged as the primary factor that would prevent homebound individuals from living in their homes.
- Homebound older adults need home repair and housekeeping assistance, in addition to technology training.
- This subgroup experiences reduced engagement in social and recreational activities. Suggestions to address social isolation include accessible, community-based activities and caller programs that engage older adults via phone on a frequent basis.
- Few reported use of special transportation services. Homebound individuals would benefit from **linkage to transportation services** or advocacy on their behalf to increase access to such services.

Focus Groups: Serving All Americans

Introduction

Focus groups were conducted with seven target populations to understand the needs of older adults who belong to specific, diverse communities that DAAA seeks to serve. Participants were engaged in open-ended conversations to gain insight into the needs and challenges of older adults from various backgrounds.

Method

WSU CSWR and DAAA co-developed focus group questions to assess the needs of older adults, covering topics such as health, housing, food, and transportation. The focus groups were facilitated by a consultant and WSU staff. Demographics were collected and participants received a gift card for their time.

Results

Demographics

Most respondents (37%, n=21) identified as Black or African American. The ages of the participants ranged from 57 to 86, with an average age of 71. Most (44%, n=24) were in their 60s. Three participants (5%) did not report race/ethnicity and six (10%) did not report their year of birth.

The tables below display self-reported race/ethnicity and age range of all focus group participants. Demographics of participants by focus group site may be found in **Appendix C**.

Table 2. *Race/ethnicity of focus group participants*

Race/Ethnicity (N=57)	n	%
Black or African American	**21**	**37%**
Middle Eastern or North African	10	17%
Asian	9	16%
American Indian or Alaskan Native	6	10%
Hispanic or Latino	5	9%
White or Caucasian	5	9%
Native Hawaiian or other Pacific Islander	0	0%
Other, please specify: *"American"* (n=1) *"ADOS (American Descendant of Slavery)"* (n=1)	2	3%

Table 3. *Age of participants*

Age (N=54)	n	%
< 60 years old	2	4%
60-69 years old	**24**	**44%**
70-79 years old	19	35%
≥ 80 years old	9	17%

Service Needs

Familiarity with DAAA: Many were unfamiliar with DAAA and expressed the need for DAAA to increase visibility in the community.

- Some did not understand the role of DAAA or confused DAAA with other entities such as DHHS or PACE.
- A participant who was familiar with DAAA described the organization as ***"the world's best kept secret"***.

However, those unfamiliar with DAAA were interested in learning more. Participants were given DAAA flyers to familiarize them with the organization. Some raised questions or concerns about the flyer, noting that the language used to advertise services could be clearer and more descriptive.

- To increase DAAA recognition and visibility, participants suggested community outreach events, such as information sessions, to meet with seniors face to face.
- Older adults also suggested that DAAA promote services through flyers in the community and advertisements on television and radio.

Priority Areas: Older adults highlighted several key areas for DAAA to prioritize in its strategic plan. Four central themes emerged as priority areas – basic needs and income, safe, affordable housing, accessible transportation, and service usage.

Basic Needs & Income

Older adults shared experiences of financial and food insecurity in addition to unemployment. Some reported waiting for months to receive unemployment or SNAP benefits.

Constituents were interested in senior employment programs, as they often feel overlooked in the workforce due to their age. Those who participate in meal programs such as Meals on Wheels were unsatisfied with offerings and desired nutritious, tasty, and affordable food options. Constituents emphasized that the **quality of food** was important, highlighting the desire for food that is visually appealing and pleasant in taste.

Safe, Affordable Housing

Older adults reported needing assistance with home upkeep, including chores, repairs, and modifications, citing tasks such as changing lightbulbs and installing handrails.

Many found existing housing options inadequate and identified a need for more affordable senior housing in the Metro Detroit area. Some also expressed concerns about living in buildings with frequently broken elevators, emphasizing the importance of first-floor housing for the aging population.

Accessible Transportation

Participants described many transportation options as cost-prohibitive and inaccessible, particularly for individuals with physical disabilities.

Public transportation and senior transit services were seen as unreliable and inadequate. Individuals with disabilities found that transportation services fail to provide sufficient support and expressed a need for transit services that ensure riders get into their homes safely. The absence of sheltered bus stops was also identified as a deterrent to using public transportation.

Service Use

Older adults reported difficulties with accessing services and resources, highlighting a need for more support in this area.

Participants indicated needing assistance with accessing respite care, in-home caregivers, and medical equipment, and reported challenges in obtaining handicapped parking permits and establishing conservatorships or powers of attorney. Many also commonly experienced challenges with determining service eligibility and believed eligibility information is often unclear when applying for support services.

Social Connectedness

Sources of Connection: Places of worship (churches or mosques), senior programs, and senior living communities were identified as main sources of social connection.

- Senior living communities appear to foster social connectedness as activities, events, and resources are regularly shared with residents.
- Constituents' interactions with one another indicated that **senior programs** and **service organizations** greatly influence social connection. Some constituents formed friendships through their involvement in senior programming.

Findings indicate that ACCESS plays a vital role in the social connectedness of Arabic older adults, much like the Association of Chinese Americans does for Chinese older adults.

- Both groups experience a strong sense of community at their respective service organizations, as both organizations reflect the **culture and language** of constituents.

Barriers to Connection: Transportation, mobility limitations, and social dynamics were identified as key barriers to social connectedness.

- Lack of transportation and use of mobility aids or medical equipment restricts participation in social activities. Constituents with disabilities found **public spaces** and **transportation** to be inaccessible.
- **Immigrant older adults** reported distinct barriers to social connection. Many felt isolated due to language barriers and discrimination. Constituents also noted a shortage of organizations that offer services in Arabic and Chinese.

Constituents noted that aging men tend to be more isolated than women, especially in the case of men from different cultures. Women reported being more socially active than their husbands and often need to encourage them to participate in events.

- It was suggested that **more outreach and support** be directed toward connecting single aging men with services.

Some reported changes in social connection due to COVID-19.

- Older adults shared that the **risk of exposure** is a factor they must carefully consider when attending crowded places.
- Increased use of **virtual technology** since the pandemic has reduced opportunities for in-person connection. For example, constituents noted a decline in attendance at in-person church services, as many now watch church services online.

Some constituents spoke about feeling a lack of care from younger neighbors toward creating personal connections or building and maintaining their community. Some

constituents reported experiencing apathy from neighbors that reinforced hesitancy to participate, organize, and advocate for community-based events. **Multigenerational local programming that is accessible to all ages could be a way of breaking down barriers between generations and fostering community care.**

Health

Mental Health: **Social connectedness** and **engaging in hobbies** were identified as primary contributors to positive mental health of older adults.

- Constituents cited activities that help them stay mentally healthy such as gardening, playing pool, watching television, and spending time with friends, family, or neighbors.

Many recognized the adverse effects that social isolation can have on mental wellbeing.

- Constituents felt that older adults may experience isolation and depression because of **unfavorable attitudes** toward aging.
- Some constituents reported **feeling "trapped"** or unfulfilled due to a sedentary lifestyle and dwindling social connectivity.
- Some older adults shared the importance of **resiliency while aging**. For example, one participant with a visual impairment shared that although his condition could be limiting, he remains socially active, recognizing that connection is essential to his mental well-being.

Physical Health: Older adults struggled to identify what helps them remain physically healthy. When asked, *"What helps keep you physically healthy?"*, many constituents responded by highlighting the **barriers** to maintaining physical health.

- Constituents who identified strategies for health maintenance mentioned activities such as walking, yoga, and swimming.
- Some found that running errands or participating in senior activities provides light physical activity.
- Prepping and freezing meals in advance was also identified as a strategy to maintain health and nutrition.

A **resilient mindset** also appears to support physical health, as some constituents reported staying active despite physical limitations.

- For example, one participant shared that although he can no longer take part in previous hobbies like bowling, he has started gardening, which is better suited to his physical abilities.

Barriers to Mental & Physical Health: Older adults said **transportation** was a barrier to participating in activities that would improve their mental and physical health.

- Limited transportation makes it difficult for older adults to attend doctor appointments or attend exercise classes.
- Some identified inadequate healthcare as a barrier to health maintenance as well. For example, a participant who is quadriplegic was unable to undergo a medical procedure because the hospital did not have equipment to provide accommodation.

Stress was also identified as a primary barrier to health.

- Those experiencing food and financial insecurity were unable to identify ways they stay mentally healthy, as their stress felt unmanageable. Many participants were very insightful about the interconnected nature of mental health and external factors creating a negative feedback cycle, **highlighting the importance of holistic wellness support**.
- Constituents were also concerned about budget cuts to programs such as Medicare or Meals on Wheels.
- Older adults from immigrant communities reported feeling isolated and fearful due to current events which negatively impacted their health.

Target Population Highlights

Focus groups highlighted the unique experiences of older adults from diverse backgrounds. Findings also indicate a need for more in-depth assessment of certain populations to better understand their specific needs and challenges.

Arabic Americans

There was significant interest in a food assistance program that caters to the **cultural dietary needs** of Arabic Americans. Constituents emphasized the importance of food being not only halal, but also of **high quality** and **respectful** of their cultural traditions. For example, they expressed preference for basmati rice over other varieties. It was suggested that Arabic older adults be actively involved in the food selection process to ensure that items align with Arabic and Muslim culture.

Asian Americans

Chinese American constituents reflected on Detroit's former Chinatown and shared feeling **disconnected** from their culture. Though constituents reported that Madison Heights offers goods, services, and food respective to Chinese culture, older adults miss the **sense of community** that Chinatown once offered. Increased access to cultural events may strengthen community bonds and sense of belonging among Chinese older adults.

Hispanic/Latino

Findings unique to the Hispanic/Latino population were limited. Although constituents were given the option to select multiple racial and ethnic categories, only three out of five participants in the focus group conducted at Bridging Communities self-reported as Hispanic or Latino. Demographic data suggests the target population was **not properly engaged**, though it is important to consider that external factors may influence how constituents self-reported race and ethnicity.

Aside from self-reported demographics, the focus group did not yield findings specific to the Hispanic/Latino community. The results aligned with overarching findings from all focus groups, indicating the need for more intentional engagement to better understand the specific needs of Hispanic/Latino older adults.

Native Americans

Needs and challenges specific to the Native American population were not identified. Native American older adults shared feedback that aligned with the general needs and challenges expressed by other focus group participants, contributing to limited findings distinct to this population. **Further engagement** with the Native American community is recommended to develop a deeper understanding of the unique needs of this population.

Homeless/Unhoused

Unhoused older adults described **internal and interpersonal barriers** to social connection. Constituents found that a lack of trust – in others and from others – impacts their ability to form and maintain relationships. They noted that **lack of compassion from others** contributes to feelings of isolation. These insights suggest that the mental, emotional, and physical toll of homelessness may influence the ability to build healthy social connections. Despite these challenges, unhoused older adults found that social interaction supports their mental well-being and expressed interest in building stronger social connections.

Veterans

Veteran older adults expressed frustration with the **limited support offered by the Department of Veterans Affairs**, particularly relating to transportation and disability accommodations. The eligibility criteria for transportation services through the VA are restrictive, and veterans found other transportation services insufficient. Two veterans with disabilities expressed that VA healthcare providers did not adequately accommodate their needs. Veterans also reported experiencing discrimination within the healthcare and benefit system based on combat status and source of illnesses or injuries.

LGBTQ+

LGBTQ+ older adults presented with a **strong sense of belonging and social connectedness** due to having *"been in this community for a while"*. They felt supported by organizations that focus on LGBTQ+ services, such as Affirmations and HIV clinics. However, constituents expressed concerns about the generational gap within the LGBTQ+ community and noted that many LGBTQ+ friendly spaces once frequented by older adults have since closed.

Focus Group Summary

Visibility & Outreach: **Enhanced marketing and outreach strategies** may improve access to existing programs and services. Many constituents expressed interest in receiving assistance that is offered by DAAA, such as caregiver support information and employment programs.

Constituents also noted that many organizations were unclear in their advertising of services, making it difficult to understand the application process and eligibility requirements. Suggestions to **increase DAAA's visibility and service access** include:

- Flyers with simplified language that detail eligibility criteria such as age and income
- Printed materials available in Arabic, Chinese, Spanish and other languages prevalent within DAAA's service area.
- Host information sessions with senior groups, distribute flyers at churches, doctors' offices, and clinics, and advertise through television and radio.
- Targeted outreach to more isolated groups (e.g., homebound, disabled, single or widowed, unhoused, immigrants) and linkage to services.
- Outreach efforts targeting individuals approaching older adulthood to raise awareness of available resources once eligible.

- Consolidate resources and services into a centralized format, such as a printed resource guide or mobile application, available in multiple languages.

Health & Safety Initiatives: Constituents emphasized the need for **greater efforts to support the health, safety, and independence of older adults.** They highlighted that those living in the community with limited social connections face **increased risks** of isolation, poor mental health, and physical safety concerns. Suggestions to promote the health and safety of older adults include:

- Regular check-in calls or home visits to reduce isolation and address safety concerns.
    - Having a **consistent relationship** with a specific check-in caller, like the VA's buddy system program, increases the **impact** of the calls and fulfillment of **social connection**.
- Increase access to **emergency response devices**, such as Life Alert, which constituents identified as valuable tools for enhancing safety.
- Promote awareness of **patient advocacy and disability rights resources** to help reduce disability-related barriers, such as inaccessible transportation, housing and healthcare services.
- **Increase visibility of resources** for solo agers/elder orphans to increase confidence in program and morale.
- Implement a **digital community board** via WhatsApp or a similar service to announce opportunities and issues that could affect constituents.
    - Some older adults stressed the utility of having a platform that was **quick and easy to access**.

Training & Education: Older adults were interested in **learning new skills** to increase their independence and social connectedness. Many also suggested training opportunities for those who work closely with the older adult population. Suggestions include:

- Technology literacy classes that cover topics ranging from basic cell phone and computer skills to online privacy, security, and scam awareness.
    - Improved technology skills can also make it easier for older adults to access resources online.
    - Many constituents were eager to use technology, but they **lacked the confidence** to independently perform tasks without in-person support.
- Financial workshops that teach skills such as budgeting and how to pay bills.
- Classes or presentations clarifying the membership and roles of social programming organizations
    - Many constituents wanted to understand the individual roles of various organizations to **set expectations** and **clarify the process to rectify issues**.

    - While some constituents were pleased to have access to support staff for assistance, many still wanted this knowledge to increase confidence through **transparency**.
- Training opportunities for caregivers, senior living staff and healthcare professionals on best practices for working with older adults.
    - Training opportunities should emphasize **empathetic enrichment** and **person-centered approaches**.

Areas for Advocacy: Many were concerned about policy decisions that may impact funding of services and subsequently impact quality of life. DAAA should **continue its advocacy** for programs and policies that support older adults, particularly those from underserved backgrounds.

- LGBTQ+ older adults said that DAAA can best support them by **advocating for LGBTQ+ rights**, with one participant stating, *"Our rights are under attack"*.
- DAAA may also engage in **local transportation advocacy**, as older adults emphasized the need for affordable, reliable and disability accessible transportation.

Cultural Considerations: Findings suggest that immigrant older adults experience **greater isolation** due to cultural differences and limited opportunities for connection.

- DAAA can support this population by **promoting community-based cultural events** and **hiring bilingual or multilingual staff**.

It is important to note that the identified target populations are broad categories that encompass many cultures and experiences. For example, highlighting the perspectives of one subgroup, such as Chinese Americans, does not fully represent the experiences and viewpoints of all Asian Americans.

Additional data collection may be necessary to determine needs specific to target populations such as Hispanic/Latino and Native American older adults. It is also recommended that trained language interpreters be involved in future focus groups with non-English speaking participants. Professional interpreters are trained to provide verbatim translations and avoid inserting personal opinions or summaries. Staff who volunteered to assist with interpretation were vital to data collection, but indirect translation posed a potential loss of data.

Caregiver Survey

Introduction

Through their Caregiver Support Program, DAAA provides education, training, and support such as respite services to caregivers in the Detroit area. As an important stakeholder group, the needs assessment sought to gather a full range of impressions from those who are caregivers. The survey included questions about caregiver type, frequency, and duration, in addition to self-efficacy, service needs, and health.

Method

The caregiver survey was distributed to individuals who had attended a workshop or training on caregiving. From February 18 through March 28, 2025, the survey received participation from 44 respondents at varying levels of completion.

Results

Descriptive Information

The first set of items in **Table 4 – 7** below provides descriptive information about the sample.

- Those who cared for a single older adult who is a family member or relative have been providing care for 1 to 5 years.
- Half of those who provided a response noted that the person they are providing care for has dementia.
- The number of hours devoted to caregiving varied, but 35% of caregivers provide 40 hours a week of care, while 40% provide less than 20 hours a week of care.

Two thirds of the sample said they care for one person, while the rest identified as compound caregivers[8] with 24% caring for two people, 7% for three people, and 2% for four people. This predominately occurs in the home of the person receiving care (50%), or the caregiver's home (35%).

- Caregivers reported providing a wide range of activities with similar counts given to providing companionship (n=37), managing household tasks (n=37), managing health care (n=34), and providing transportation (n=32).

[8] Wang, F., Marsack-Topolewski ,Christina N., DiZazzo-Miller, Rosanne, & Samuel, P. S. (2022). Health of aging families: Comparing compound and noncompound caregivers. *Journal of Gerontological Social Work*, *65*(3), 290–304. https://doi.org/10.1080/01634372.2021.1963024

Table 4. *Care-recipients*

Are you providing care to any of the following? (N=44)	n	%
Older adult	**39**	**87%**
Person with dementia	22	50%
Adult child (i.e. with a disability)	8	18%
Grandchild under 18 years old	4	9%

Table 5. *Number of care-recipients*

How many people are you caring for currently? (N=44)	n	%
1 person	**28**	**64%**
2 people	10	23%
3 people	3	7%
0 people	2	5%
4 people	1	2%

Table 6. *Length of time caregiving*

How long have you been providing care? (N=44)	n	%
1-5 years	**28**	**64%**
6-9 years	5	11%
Less than 1 year	4	9%
I am not a caregiver	4	9%
10+ years	3	7%

Table 7. *Relationship to caregiver*

Do you provide care for… (N=43, multiple responses per person)	n	%
A family member/relative	**42**	**93%**
A neighbor/friend	2	4%
Not a relative or friend	1	2%

Multivariate Results

Caregivers see the two biggest challenges to providing care as having a **lack of support** at home for caring for a loved one and the **emotional stress** of being a caregiver and working.

- The support services reported as most needed were respite care (28%, n=23) and help getting access to services (22%, n=18).

Table 8. *Support services needed by caregivers*

Which of the following support services do you most need, that you are currently not getting? (N=38, multiple responses per person)	n	%
Respite care (i.e. short- or long-term breaks for people who provide care)	**23**	**28%**
Help in getting access to services	18	22%
Individual counseling to help cope with giving care	17	21%
Support groups	15	18%
Caregiver doesn't need any of these services	6	7%
Classes about giving care, such as giving medications	4	5%

Self-Rated Health. Self-rated health and emotional mental health were measured on a five-point scale with 1 = poor health and 5 = excellent health.

Caregiver survey respondents (n=44) who reported taking **caregiver care management classes** had on average a 0.34 increase in self-rated health (p = 0.007) and a 0.26-point increase in self-rated emotional/mental health (p=0.002) when holding other variables constant.

- This means that when taking all other factors into account, taking caregiver management classes was still significantly related to an increase in self-rated health and an increase in self-rated emotional/mental health.
- Those who reported "other challenges" had -1.06 points lower self-rated emotional/mental health (p=0.043) and those who reported getting information about services from "other" sources also reported a -0.99 lower average in self-rated emotional/mental health (p=0.001).
- Those who provided care show **higher self-rated emotional/mental health** for providing **transportation** (beta = 0.59, p=0.021) or providing **companionship** (beta = 0.69, p=0.037).

Mean Caregiver Self Efficacy. Caregiver Self-Efficacy is the confidence in being able to provide care for someone. **Higher self-efficacy,** or feeling more confident in being able to provide care to someone, was related to:

1. Living with children, parents, or other adults.
2. Being a professional caregiver.
3. Caring for someone in assisted living or long-term care.

Lower self-efficacy, or feeling less confident in being able to provide care to someone, was related to:

1. Expressing challenges with a "Lack of support system/assistance at home with caring for loved one," (on average -1.61 lower average self-efficacy scores, p=0.003).
2. Living with adult children or who had children away at college.

This suggests that **caregivers' support system** and **location of care** affect their feelings of **self-efficacy**.

Unmet Caregiver Needs. Professional caregivers paid in a fee for service model had fewer unmet needs. Those who reported living with **adult children** had more unmet needs, as do those who reported that it is **too time-consuming handling both job and caregiving responsibilities.** Only three respondents reported caring for someone under 18. Their needs included homework help, latchkey and babysitting, and legal issues like guardianship.

Caregiver Problems. Caregivers were asked about the problems they face (e.g., food insecurity, help with Medicare/Medicaid, income). The caregivers who reported being unable to keep up with job demands or standards of performance at work also reported 4-8 more problems with caregiving (p=0.048). Likewise, caregivers who took or are aware of **diabetes management classes** also reported 1.5 more problems with caregiving (p=0.020).

Caregiver health. This sample of caregivers was relatively healthy. Sixty-three percent (63%) rated their health as good to excellent compared to others their age. Sixty-two percent (62%) reported exercising once a week or more, and 91% reported that they had not seen a doctor in the past year. All had insurance, with 61% having insurance from an employer.

Figure 12: *Caregiver health*

Below are additional noteworthy findings:

- Caregivers were asked about support for a senior millage. An overwhelming majority (84%) said they **would support a millage.**

- Additionally, 82% expected to **continue providing care** for someone in the next two years.
- In terms of information, 55% are **generally able to find what they need**, but 46% do **need help**. This group noted they rely on DAAA and other agencies for finding information.
- Most (97%) had internet and 94% were confident using technology, indicating sharing information via social media and websites is a good approach.

Figure 13: *Respondents self-identifying with unique communities*

Summary of open-ended questions

Forty-three (43) caregivers offered responses to the open-ended questions in the survey. Below is an outline of the main themes that emerged from their responses to each question.

Main Health Concerns

Caregivers reported on the health issues faced by the people they care for. Overall, **the most prevalent concern was dementia** (n=20). Many people experience multiple physical health issues, such as diabetes and chronic pain, alongside dementia (n=12). Mental health concerns such as schizophrenia were also reported (n=6).

Service Usage

Services around food and wellness have been used with success by some respondents (n=4). Some caregivers enjoyed social support services offered to them by DAAA, but they suggested that the **offered times can be difficult** when working full time or the sessions could be longer to accommodate more sharing (n=3). However, some caregivers reported themselves or their family member(s) weren't eligible for the services, or that accessing the services was an additional burden on them (n=7). Some caregivers also said

> ***"I needed transportation services for a loved one for medical appointments.***
>
> ***It is difficult to arrange because there are so many restrictions. You have to qualify by your income and some companies do not pick up in certain areas. It was very frustrating."***

that they did not know how to access the services or were unaware of services (n=6).

Problems Facing Caregivers

Caregivers also reported on the serious problems they experience as a caregiver. Some caregivers reported feeling **emotional burden, social strain, and life stress** (n=5). Financial strain and employment difficulties were also faced by some caregivers (n=4). Transportation issues were also noted as a concern by some (n=3).

> ***"At the time, it was difficult to balance my needs and responsibilities with those of the person I assisted.***
>
> ***His family lived in another state and could not assist."***

Access to Information

Caregivers were asked where they find information about services for older adults. Most caregivers did not respond to this question, but some indicated that they received information from organizations, such as AARP and the Alzheimer's Association (n=3).

Activities and Transportation

Finally, some caregivers expressed the need for **more social and community activities**, as well as more accessible and reliable transportation to activities (n=4).

Caregiver Summary

In summary, the data from the caregiver survey show some key lessons:

- Caregivers who are **paid** are more confident and have fewer unmet needs.
- However, a high number of people are providing **unpaid** care. Seventy-four percent (74%) of the caregiver respondents are unpaid and 80% of the community respondents have unpaid caregivers. Comments note the financial and emotional strain of caregiving.
- Caregiver care management classes support the **self-rated health** of caregivers. Prior research has documented awareness for these courses among older adults[9].
- Caregivers living with children under 18, parents, or other adult relatives/friends are more **confident.**
- Caregivers living with adult children are **less confident** and have more **unmet needs.**
- Caregivers need help **finding information**, as have older adults generally[10].

[9] Hopp, F. P., Thomas, Shirley A., Keys, Fay, & and Ward, M. (2025). Predictors of Service Awareness: Results from a Community Survey in an Urban Area. *Journal of Gerontological Social Work*, *68*(3), 321–336. https://doi.org/10.1080/01634372.2024.2445026

[10] Ibid (2025).

- There is a potential need for specialized training for **dementia care**, and adding resources related to dementia to the DAAA website may be useful. This is also consistent with the literature on caregiving[11].

[11] Gonella, S., Mitchell, G., Bavelaar, L., Conti, A., Vanalli, M., Basso, I., & Cornally, N. (2022). Interventions to support family caregivers of people with advanced dementia at the end of life in nursing homes: A mixed-methods systematic review. *Palliative Medicine*, *36*(2), 268–291. https://doi.org/10.1177/02692163211066733

Stakeholder Survey

Introduction

A third, separate survey was developed for use with stakeholders – those agencies and providers who work with DAAA in the older adult space. Gathering outside perspectives is important for gauging outreach needs. The stakeholders represented here have specific knowledge of the older adult population, their needs, and concerns. In addition, they can speak directly to DAAA's reputation and resources in the community.

Method

The survey was distributed to a DAAA-provided email list of 339 organizations that collaborate with DAAA, as well as those who work with older adults and people with disabilities in the State of Michigan and beyond. Sixty-four (64) valid responses to the survey were received between February 19, 2025, and March 18, 2025.

Results

Organizational Characteristics

The first item asked stakeholders about their roles or affiliations with DAAA, yielding 63 respondents, as shown in **Table 9**.

Table 9. *Stakeholder association with DAAA*

My association with DAAA Region is… (N=63, multiple responses per person)	n	%
Human Service Organization	**20**	**32%**
Contractor	9	14%
Direct Service Purchase Vendor	8	13%
Advocacy Role	7	11%
Healthcare System	6	10%
Government/Policymaker	5	8%
Media/Internet	1	2%
Faith-Based Partner	0	0%
Other, please specify:	15	24%

This data highlights the diverse set of stakeholder positions within DAAA, with human service organizations (32%, n=20) and contractors and vendors (27%, n=17) making up the largest portion of the respondents.

The stakeholders were asked about their service area. **Table 10** indicates that most stakeholder respondents primarily serve the DAAA area and Detroit suburbs, with a smaller portion extending their services to other areas within Michigan or beyond.

Table 10. *Stakeholder service area*

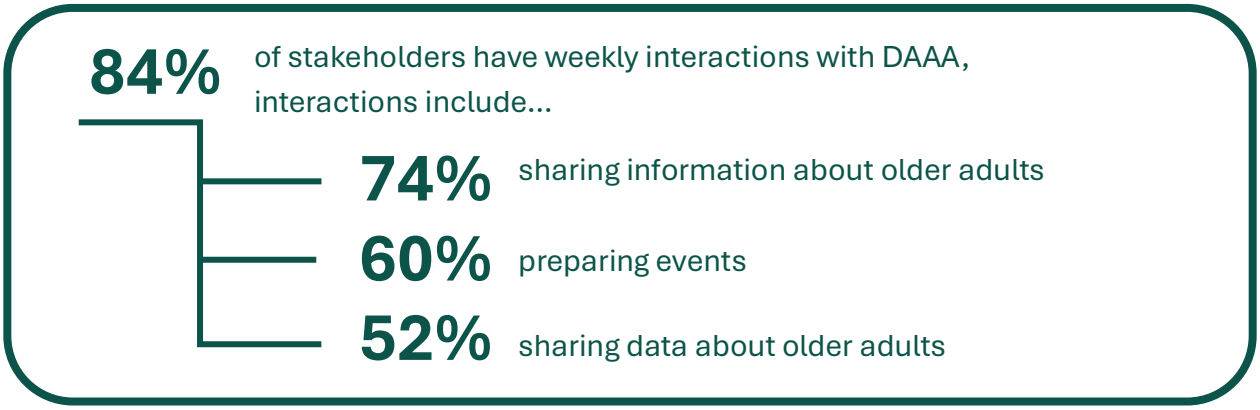
My agency/position services people in… (N=63, multiple responses per person)	n	%
DAAA area	**50**	**79%**
City of Detroit	**29**	**75%**
Highland Park	17	44%
Hamtramck	15	39%
City of Grosse Pointe	5	13%
Grosse Pointe Park	4	10%
Grosse Pointe Shores	4	10%
Grosse Pointe Farms	3	8%
Grosse Pointe Woods	3	8%
All of the above	15	39%
Other Detroit suburban area	23	37%
State of Michigan	18	29%
Michigan and other states	7	11%
Other, please specify: *"Family and friends"* *"Labor and Education"* *"None"*	3	5%

Relationship with DAAA

Respondents have had a long relationship with DAAA, with 60% saying 10 years or more.

- Many (42%) reported having weekly interactions with DAAA, showing how integrated the connections are.
- The nature of the interactions includes sharing information about older adults (74%), preparing events (60%), and sharing data about older adults (52%).

Figure 14: *Stakeholder interactions*

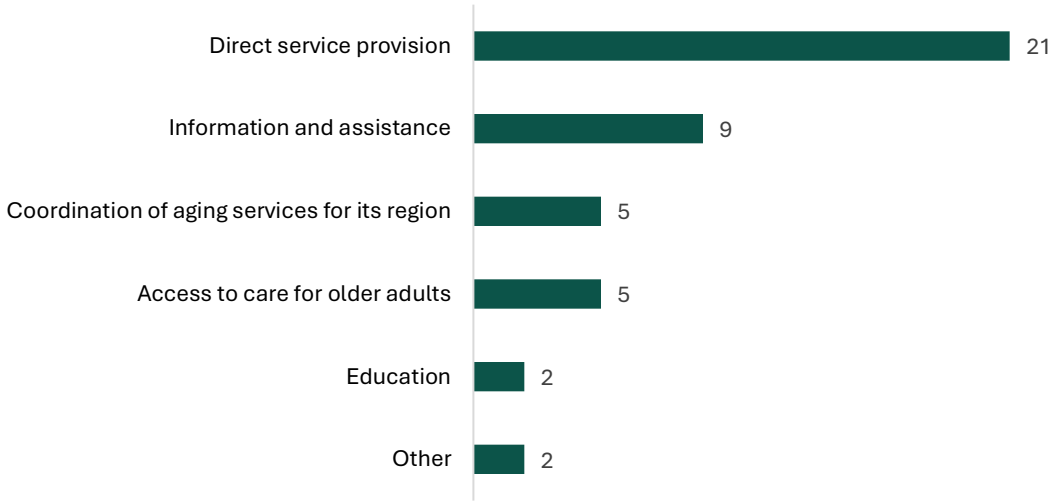


There were fewer reported opportunities to coordinate responses and respond to public health emergencies. This type of coordinated effort may be increasingly important as funding shifts and resources are scarcer. Additionally, stakeholders who know the older adult landscape would overwhelmingly support an older adult millage (84%).

In a multivariate regression, for every one-point increase in the strength of the working relationship, stakeholders rated the quality of the service offerings 1.34 points higher, suggesting that a **stronger working relationship** is related to **more positive perceptions of service quality**.

- Stakeholders coordinating public responses about older adult events rated service offerings 1.32 points lower than others, suggesting that the stakeholders who are involved in this way have **less positive perceptions of service offerings**.
- Public health emergency preparedness stakeholders rated DAAA's services 0.91 points higher ($p = 0.037$), which may suggest **more positive perceptions of service offerings** for this group of stakeholders.

Figure 15. *Top priority chosen by respondents for DAAA's role in its service area (n=44)*



"Other" responses included "Legal assistance" (n=1); no further info given (n=1)

In multivariate regression, two stakeholder groups rated their relationship with DAAA significantly lower than others[12] — healthcare systems (β = -0.65, p = 0.022) and public health emergency preparedness stakeholders (β = -0.49, p = 0.026).

Conversely, stakeholders who rated DAAA's service offerings highly and those operating at a statewide level tended to report **stronger relationships**.

- The strongest positive association came from stakeholders who coordinate public responses about older adult events (β = 0.98, p = 0.001), indicating **they rated the relationship nearly one point higher than others**, controlling for all other variables.

In multivariate regression, several notable patterns emerged about DAAA's perceived role in the community:

- Public health emergency preparedness stakeholders rated DAAA's role in **education** (e.g., cybersecurity, Medicare, fraud) 1.54 points higher than others, controlling for other factors (p = 0.016), suggesting they perceive DAAA's role in education more strongly than other stakeholders.
- Healthcare systems rated DAAA's role in "access to care for older adults" 1.78 points lower than other stakeholders (p = 0.042), suggesting they perceive DAAA's role in healthcare less strongly than other stakeholders.

[12] This item— "Please rate the overall strength of the working relationship your agency has with DAAA"—had 20 missing responses out of 64. Despite this, imputation did not appear to bias the results.

    - For each one-point increase in interaction frequency with DAAA, there was a 0.36-point decrease in rating this role area (p = 0.042), suggesting that having more frequent interactions with DAAA is related to lower ratings in perceiving DAAA's role in healthcare.
- Agencies serving Grosse Pointe rated "Other, please specify" 2.3 points higher than others (p = 0.041), suggesting unique or localized perceptions of DAAA's role.

Impact of COVID

The COVID pandemic has brought changes in behavior for most people.

- For stakeholders, the biggest changes were in staff levels and number of clients, with 43% saying that it has changed very much.
- Policies/procedures and services were moderately changed, while location of services was not changed at all for many (31%).

Stakeholders were also asked about their perceptions of how older adults have adjusted to the pandemic. Overall, their assessments were somewhat negative. The largest percentage was in the lowest category for five out of eight items.

- Older adults are perceived as falling behind on socialization needs, transportation needs, and volunteering in the community.

Table 11. *Perceived impact of COVID-19*

How well do you think older adults have adjusted after the height of the COVID-19 pandemic with respect to...	Very well	Moderately well	Slightly well	Not very well
Physical health (N=39)	0 (0%)	13 (33%)	12 (31%)	**14 (36%)**
Mental/emotional health (N=39)	0 (0%)	8 (21%)	14 (36%)	**17 (44%)**
Socialization needs (N=40)	1 (3%)	6 (15%)	13 (33%)	**20 (50%)**
Transportation needs (N=38)	1 (3%)	10 (26%)	9 (24%)	**18 (47%)**
Civic engagement (N=39)	3 (8%)	10 (26%)	**16 (41%)**	10 (26%)
Volunteering in community (N=39)	2 (5%)	3 (8%)	16 (41%)	**18 (46%)**
Attending cultural events or entertainment (N=39)	1 (3%)	10 (26%)	**17 (44%)**	11 (28%)
Attending religious/spiritual services (N=39)	4 (10%)	10 (26%)	**19 (49%)**	6 (15%)

Perception of DAAA

As shown in **Table 12**, 64% (n=27) have some familiarity with DAAA. The service offerings have a positive perception with a mean score of just over 7 on a 10-point scale.

Table 12. *Community perception of DAAA*

How familiar do you think the public is with DAAA? (N=42)	n	%
Very unfamiliar	3	7%
Somewhat unfamiliar	12	29%
Somewhat familiar	**24**	**57%**
Very familiar	3	7%

Additionally, DAAA has a very positive **reputation as a trusted resource** with a 4 out of 5 mean score. These scores point out that, while mainly positive, DAAA should continue to work to improve familiarity and sustain its reputation in the community.

On a scale from 1-10
How would you rate DAAA's service offerings in the community? (N=42)

SD = ±1.579, Mode = 7 (n=12)

On a scale from 1-5
How would you rate the reputation of DAAA as a trusted resource in the community? (N=38)

SD = ±.837, Mode = 5 (n=14)

A one-level increase in interaction frequency was associated with a 0.13-point increase in perceived public familiarity with DAAA ($p < 0.001$), indicating that interacting more with DAAA was related to perceiving the public as more familiar with DAAA. Additionally, a one-level increase in the perception that older adults are re-engaging civically post-COVID was linked to a 0.27-point increase in perceived public familiarity, controlling for other variables. This suggests that those who were more likely to perceive that older adults are re-engaging more post-COVID were also more likely to perceive that the public is familiar with DAAA.

For every one-point increase in perceived quality of service offerings, there was a 0.20-point increase in DAAA's reputation. This suggests that as perceptions of quality increase, so do perceptions of DAAA's reputation.

- Agencies serving Grosse Pointe rated DAAA's public reputation 0.89 points lower than other respondents.
- The consistent link between **high service quality ratings** and **reputation** reinforces the importance of **service perception** in building stakeholder trust.

Summary of Regression Results

Some items in the stakeholder survey had a high rate of missing values. However, analyses using both imputed and raw data yielded similar results, suggesting minimal bias due to missingness.

Summary of open-ended questions

Thirty-eight (38) stakeholders offered responses to the open-ended questions in the survey. Below is an outline of the main themes that emerged from their responses to each question.

Feedback for DAAA

Stakeholders were asked how DAAA can best make training, education, and support services available. Some stakeholders recommended that DAAA **connect out in the community** (i.e. community centers, neighborhood block organizations, city recreation centers); (n=7). Stakeholders also recommended **advertising and outreach**, especially through more traditional methods (i.e. newspapers, radio, fliers in locations where seniors frequent); (n=6). Other suggestions included offering both **virtual and in-person methods** of engagement (n=4) and improving transportation accessibility (n=4).

> ***"Participate at more vendor events. Go where the seniors go. Be where the seniors are.***
>
> ***Information should be available at clinics and hospitals. Social workers should be referring [clients to] DAAA."***

To increase visibility for DAAA, most stakeholders (n=16) suggested **non-technological promotion** (newspapers, bus ads, posters in prominent locations, billboards, mailed materials), local partnerships and presence (more involvement at local events, having partners in healthcare and social work who can refer clients to DAAA), and technological promotion (increase social media presence, newsclips on local TV stations, online meet & greets).

When asked about their vision for DAAA, some stakeholders (n=7) expressed increased visibility and usage of services, expansion of services to more people, more resources to do the work, and increased collaboration with community partners and organizations.

Some stakeholders provided feedback on DAAA branding. Many (n=7) said that they would prefer the DAAA name to be kept as-is. Some of those who did have suggestions for a name change (n = 3) focused on **positivity**, such as incorporating words like "Age Well," "Thrive," "Maturing," or "Gracefully." Others (n=3) suggested the integration of "Disabilities," "Veterans," and "Caregivers" into the name.

Changes in Needs due to COVID-19

When asked how needs have changed because of the COVID-19 pandemic. Most responses (n=20) fell into four main categories.

1. Services are more in demand, and some services have become harder to find or have reduced in availability.
2. Stakeholders noted an increase in social isolation.
3. Similarly, stakeholders noted an increase in overall wariness since the start of the COVID-19 pandemic. Older adults are not leaving the house as much, and they desire more control over who is coming into their homes (i.e. no strangers, not one unvaccinated, no fill-in staff).
4. Stakeholders also expressed overall difficulties with increased reliance on technology. There is a disparity in technological literacy between those who have learned to use new technology and those who have not.

> ***"Many services have diminished due to COVID and the isolation is has caused for direct services which are now mostly remote...***
>
> ***leaving a lot of older adults at a disadvantage due to their digital literacy skills and economic disadvantages."***

Transportation

Stakeholders were asked how DAAA can work with partner agencies to make transportation services more readily available and dependable.

- Expanding on the question, some (n=5) highlighted the importance of collaborations and commitments with partners to enhance transportation accessibility, reliability, and affordability.
- Suggestions included public transit systems, private rideshare companies, local government, small business paratransit vendors.
- Some (n=6) also highlighted that more communication and transparency about available transportation options would improve transportation accessibility.

Key Collaboration Partners

Stakeholders offered thoughts on key partners that DAAA should collaborate with. Three main levels of partners were identified.

1. Neighborhood level partners (n=7) such as block clubs, senior centers, local nursing homes and assisted living facilities.
2. Organizational level partners (n=3) such as professional organizations, colleges and universities, local businesses, healthcare providers.
3. Government level partners (n=3) such as the City of Detroit government.

Services and Strategic Plan

When it came to the prioritization of services, many stakeholders (n=10) highlighted **transportation** as a top priority. Many (n=11) also highlighted home services as a top priority, such as home health care, home repair, food delivery, and services for homebound people.

Multiple stakeholders (n=6) suggested the integration of **technology** into services and increasing technological literacy for community members as key trends on the horizon that DAAA should consider in its strategic plan. Others (n=3) also identified helping community members **age in place** as a key trend, as well as assisting with the requirements necessary for this (such as grants for home accessibility modifications).

Finally, stakeholders also expressed that **different cohorts** of older adults may have **different service needs**.

- Some stakeholders (n=4) suggested that younger seniors may face income challenges and may still be working, so they may be unable to utilize services. They may also need unique social support, such as family assistance or post-retirement community building.
- Stakeholders (n=6) also suggested that older seniors may need more home repairs, in-home support and caregiving, and transportation.

Stakeholder Summary

Most stakeholders who responded have a long-standing relationship with DAAA and see them as a positive organization providing direct service to older adults. The also have a positive endorsement of DAAA on communication about events for older adults. They are human service organizations that primarily serve the DAAA area, though a small number serve across multiple areas.

Two key challenges in collaboration emerged in that few health care systems report working with DAAA. These systems ranked DAAA's proposed role in "access to care for older adults"

lower than other stakeholders. Also, both health care systems and public health emergency preparedness stakeholders rate their relationship with DAAA lower than other types of organizations. That said, public health emergency preparedness stakeholders ranked DAAA's proposed role in education higher (e.g., cybersecurity, Medicare, fraud).

The most notable information may be stakeholders' perspectives on the changes brought about by the pandemic.

- Unlike older adults, who rate themselves fairly well, stakeholders seem to have **more concerns** about how older adults have fared since the pandemic.
- Studies show that **social isolation** after the pandemic remains an important issue for older adults. [13] Stakeholders seem to echo these concerns in their responses.

Key actions from the stakeholder survey suggest the following:

- Improve marketing by connecting with the community through non-technological promotion (newspapers, bus ads, posters in prominent locations, billboards, mailed materials) (n=16).
- Prioritize services like transportation (n=10) and home services such as home health care, home repair, food delivery, and services for homebound people (n=11).
- Collaborate with partners at neighborhood (e.g., block clubs, senior centers, local nursing homes and assisted living facilities) (n=7), organizational (e.g., professional organizations, colleges and universities, local businesses, healthcare providers) (n=3), and government levels (n=3).
- Increase technological literacy (n=6) and assist community members in aging in place (n=3).
- DAAA should consider targeted outreach to stakeholders in eastern suburbs.
- DAAA should expand involvement and collaboration with health sector stakeholders on key issues like emergency preparedness, and health access initiatives.

[13] *How did the pandemic affect older adults' mental health?* Anxiety, Depression, and Sleep: The Pandemic's Toll on Older Adult Mental Health. (2024, April 26). https://www.ncoa.org/article/anxiety-depression-and-sleep-the-pandemics-toll-on-older-adult-mental-health/

Overall Observations

Within and across the multiple methods used in this community needs assessment, there are pieces of actionable information that may assist DAAA in shaping the future of their work with older adults. We found themes across the methods around training, marketing and outreach, advocacy and systems issues, and more. Some are things that DAAA is already doing, but because many were mentioned in comments or focus groups, the compiled data below may help in viewing feedback in one central location.

Advocacy and systems issues

- Older adults, through focus groups and the community needs survey, noted that **navigating systems is challenging**. There is some trouble with finding resources, determining eligibility, etc. One model that may be effective is to expand geriatric care management personnel.
- Many were concerned about **policy decisions** that may impact quality of life. For example, LGBTQ+ older adults said that DAAA can best support them by advocating for LGBTQ+ rights, with one participant stating, *"Our rights are under attack"*. DAAA may also engage in local transportation advocacy, as older adults emphasized the need for affordable, reliable, and disability accessible transportation.
- The **Caregiver Resource Collaborative** needs assessment has shown that Michigan's Area Agencies of Aging have been planning to increase supportive services for caregivers (e.g., respite care, care planning support, training)[14]. Areas for expanded efforts by DAAA include:
    - Increasing respite support, collaboration with wellness centers for exercise, massage, and similar services.
    - Greater collaboration with other service partners around planning and access. Cities, senior centers, health providers and private agencies could work together to offer a wider range of services and may be able to address broader issues, such as transportation, that are not feasible to coordinate alone.

Training Needs:

- Provide guidance on **financial planning** and **finance discussions** among families.
- **Financial wellness workshops** for older adults that teach skills such as budgeting and how to pay bills.

[14] Ilardo, J. L., King ,Sherri, & Zell, A. M. (2023). Balancing caregiver resources provided by Michigan's Area Agencies on Aging. *Journal of Gerontological Social Work, 66(4)*, 530–547. https://doi.org/10.1080/01634372.2022.2128132

- **Technology literacy classes** that go beyond basic cell phone and computer skills to include online privacy, security and scam awareness, and accessing resources online.
- Training for caregivers, senior living staff, and healthcare professionals on **best practices for supporting older adults** – DAAA already does caregiver trainings but could expand the scope, especially around dementia.

Marketing and Outreach:

- **Flyers** with simplified language that detail eligibility criteria such as age and income.
- **Printed materials** in Arabic, Chinese, Spanish and other languages within DAAA's service area.
- Host **translated** information sessions to increase service access for non-English speaking older adults.
- **Increasing collaboration** with agencies serving special populations like those participating in focus groups.
- Host **information sessions** with senior groups, distribute flyers at churches, doctors' offices, and clinics, and advertise through television and radio.
- **Outreach** to individuals who are nearing older adulthood to increase knowledge of resources available once eligible.
- **Promotion of exercise and wellness** to those ages 60 to 70 to stave off physical and mental ailments that may lead to an increased need for care.

Additional Findings:

- Devices such as **Life Alert Emergency Response** were identified as valuable tools that should be more accessible to older adults.
- Increase **awareness of patient advocacy and disability rights resources** (sharing pamphlets, including in presentations, etc.) to reduce disability-related barriers.
- Cultural Considerations: Findings revealed that immigrant older adults experience isolation due to cultural differences and limited opportunities for connection. DAAA can support this population by **promoting cultural events and hiring bilingual and multilingual staff.**
- There was a high rate of dementia among those needing care and comments related to dementia, so a **review of resources devoted to dementia care** is warranted.

Appendices

- Appendix A: Community Needs Assessment Survey Data Tables
- Appendix B: Homebound Interview Data Tables
- Appendix C: Focus Group Data Tables
- Appendix D: Caregiver Survey Data Tables
- Appendix E: Stakeholder Survey Data Tables
- Appendix F: Community Needs Assessment Tool
- Appendix G: Homebound Interview Protocol
- Appendix H: Focus Group Protocol
- Appendix I: Caregiver Survey Tool
- Appendix J: Stakeholder Survey Tool