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Advocacy Work for Low-Income Older Adults

Analysis of services for low-income older adults in Oregon

By
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An Honors Thesis Submitted in Partial Fulfillment of the
Requirements for Graduation from the
Western Oregon University Honors Program

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Abstract

Older adults with low socioeconomic status who age in their communities can be invisible. These people have unique needs and while there are systems in place to provide services, there is always room for improvement. Programs are available to older Oregonians who are financially vulnerable to address their basic needs. This work investigates the current challenges to addressing these basic needs and areas where advocacy work could be applied for this population.

Financially vulnerable older adults, especially those at or below the federal poverty line, face issues of food insecurity, problems finding adequate but affordable housing, the costs and accessibility of caregivers and medical care, and more. These realities have repercussions on health and quality of life for lower income older adults. These factors, additionally correlate in different ways with higher likelihood of negative health outcomes and greater likelihood of disability and death. Interviews with five professionals working to provide governmental assistance to this population reveal both what is being done and areas of improvement for these services.

Introduction

"Aging happens, life happens, poverty happens." As stated by one research participant in this study, these realities affect older adults every day. The intersection of advanced age, and low socio-economic status create an especially vulnerable population. This group often relies on government services to meet their basic needs. This research seeks to understand the network of these services and how they are able or unable to effectively serve low-income older adults.

In speaking to professionals working in the field, I sought to understand more about older adults who have limited economic resources and how financial insecurity is addressed from program providers serving this population. My research questions were:

- What are the critical needs of vulnerable older adults with low socioeconomic status aging in their communities?
- How are the needs of older Oregonians who are financially vulnerable being addressed (or not) through community and state programs?

Literature Review

Without work and with some of the additional expenses that come with age, financially vulnerable older adults can find themselves unable to meet the costs of basic necessities. Older adults whose needs are not met are reflected in health, disability status, and mortality. There are programs that can meet these needs, but problems exist in these services. This literature review will first highlight the retirement context for older adults in the United States and then focus on older adults who have limited financial resources.

Retirement Expectations and Realities

In the United States, older adults are expected to financially support themselves with assistance from government programs like Social Security and Medicare and the savings they accrue across adulthood. For some older adults, this model works and they have the financial resources to live comfortably. For others, as outlined below, these resources are inadequate.

Though some older adults choose to continue to work and earn income, retirement is both a cultural expectation and sometimes a necessity. Piggot and Woodland (2016) addressed some of the reasons older adults retire and detailed how they are financially able to transition out of the workforce. Health, perhaps contrary to popular belief, is not a primary reason why most older adults retire, although for some, health does play a role in the timing and necessity to retire early (Piggot & Woodland, 2016). Continuing to work does bring in income; however, when an individual reaches retirement age, it is possible to bring in

money from other sources. This option is encouraged both by the availability of those resources and by the disadvantages of continued work making other incentives like Social Security more appealing.

Traditionally, the ideal model that financially supports older adults after retirement has been known as the three-legged stool of retirement. The first leg of the stool is Social Security, sometimes called a public pension. Full Social Security benefits are available at age 67 (previously 65 but this has been scaled back due to increasing longevity). More benefits are available if collection is put off and less if it is taken early, with the earliest possible access to funds beginning at 62 years of age. For a median worker, Social Security replaces about 40% of previous earnings making it a significant percentage of the stool for the average worker (Piggot & Woodland, 2016).

The second leg is private pensions, usually tied to employment. There are two main types of employee pensions: Defined Benefit and Defined Contribution. Defined Benefit plans were more common but are offered less often now. A Defined Benefit pension works much the same as Social Security. Individuals pay into it and are able to start collecting early for less money or wait until normal retirement age for full benefits based on years of work. A Defined Contribution plan is familiar to most people in the US as a 401K plan which amounts to subsidized savings (Piggot & Woodland, 2016).

The last leg of the stool refers to what is saved personally outside of an employee retirement plan. This is the facet that is most variable and requires

personal discretion. Even for older adults with savings, this can be an uncertain source. Today, savings may not be worth what it was due to inflation. Mortality and lifespan are impossible to know meaning that a person can either outlive their savings or live too frugally unnecessarily. Morbidity, illness, and disability can produce unforeseen expenses. Investment is always a gamble that comes with a certain amount of risk (Piggot & Woodland, 2016).

This model is no longer a viable reality, and realistically it may never have been for some people. Marginalized sectors of the population are especially at risk for having less money than they need to retire. People of color have been more likely to rely more heavily on Social Security due to unequal employment and to work lower paying jobs due to unequal access to education and discrimination in the workforce (Stanford & Usita 2002). These kinds of jobs are less likely to offer a pension and with less income, less money can be put toward savings and investment. Cultural differences in understanding of retirement can mean that some populations may not be planning to retire and therefore refrain from saving for it. In the United States, however, retirement is the cultural norm, and the workforce may push older workers to retire. This can also be fueled by racial discrimination and poor health outcomes in populations of color, which also can lead to the necessity of retirement due to disability (Stanford & Usita, 2002). In the report to the United States Secretary of Labor on Gaps in Retirement Savings Based on Race, Ethnicity and Gender, it was stated that “Among prime working-age households ages 32-61, only 32 percent of Hispanic and 44 percent of Black

households had retirement account savings in 2019, as compared with 65 percent of White households." and that "Even among households with retirement account savings, the median account balance was modest: $38,000 for Hispanic households, $40,000 for Black households, and $83,000 for White households, respectively" (Butash et al., 2021, p. 24).

Similarly, adults born in other countries often face these experiences with retirement and more. Immigrants are likely to face the same job inequality, which may be exacerbated by language barriers, citizenship status, and lack of skills navigating the political workforce (Stanford & Usita 2002). They also may have less family or community support network ties to fall back on or receive assistance from in old age. More dire straits may arise in retirement because they may not be able to meet the requirements to receive Social Security benefits (Stanford & Usita 2002). In 2019, it was found that immigrants who were eligible for Social Security were less likely to retire and claim benefits earlier as opposed to native born citizens. This is possibly because immigrants may be less prepared for retirement or that they have more to gain from additional years working in terms of benefits allotted (Lopez & Slavov, 2019).

Women also are at risk of being less prepared for retirement than men, especially women of older generations. Women who did not work, entered the workforce later, or worked more sporadically often due to caregiving and parenting will be less economically prepared for retirement (Stanford & Usita 2002) . Discrimination in the workplace means that women are also likely to make

less money than men. Women also may be less financially literate and therefore have less of their income come from investments (Stanford & Usita 2002). Women face longevity risks, living longer than their male counterparts, and they may encounter financial hardship due to inflation, loss of a spouse, and healthcare costs (Butash et al., 2021). Caregiving, additionally, has a significant financial impact on retirement. Family caregivers, usually women, leave the labor force or work only part time to care for parents, spouses, and children. They typically on average spend nine years outside the workforce, losing income, reducing the years they have worked, and reducing opportunities for career advancement (Butash et al., 2021).

One stance would be that these individuals have failed to work the system, to plan, save and invest. What is more accurate is that the system in many ways has failed them. Due to a variety of factors, some of which were addressed here such as inequalities due to race and gender, many older adults' needs are not met by Social Security, especially without supplemental income.

Social Security functions on a quid pro quo merit system. The more income made during the working years, the more money is pulled as tax for Social Security, which an individual receives in benefits later (Margolis, 1990). This system penalizes the poor as it is the one leg of the stool that an individual can rely on if they are unable to save money. The government promises that by taking money during a person’s working years, they will receive it later when needed. This social contract is fulfilled but it is fulfilled “fairly” instead of equitably or

even equally. How much money you put into the system dictates how much you will get out of it. Therefore, those whose other legs of the stool will be generating income for them in retirement will also have the biggest payout while older adults who rely most on Social Security will receive the smallest sum.

Older Americans rely heavily on Social Security. It provides the majority of income for most older adults with about half of this population receiving 50% of their income from Social Security and about 25% receiving 90% of their income from this program *Policy basics: Top ten facts about social security* 2022). The average Social Security retirement benefit is $1,614 a month (*Policy basics: Top ten facts about social security* 2022). Older adults experience great diversity of outcomes with 5.4% relying on a defined benefit plan and Social Security, 15.1% had defined contribution and Social Security, 6.8% had all three, and 7.6% received retirement benefits but not Social Security. Approximately 14.9% of older adults had no income from any of those three sources. Social Security is an important part of the income puzzle for most older Americans but for almost half of the population it is the only source of income (Bond & Porell, 2020).

In Oregon, older adults represent 24% of the Oregon population with 1,043,811 individuals accounted for in the 2019 census. In 2019, 8.5% of older adults in Oregon over 60 were below the poverty line. An additional 8.1% was between 100-150% of the poverty line. We can see poverty or financial risk through other measures as well. For instance, 54.0% paid rent that was over 30% of their income, 6.4% received SSI, 2.6% received public cash assistance, and

12.5% received SNAP benefits. Only 54.4% have income from retirement and 46.5% have earnings (U.S. Census Bureau, 2019)

Oregon is on par with the national estimates for these figures, sometimes coming in slightly below. The national poverty levels come in at 9.7% of older adults over 60 were below 100% of the poverty line and another 7.9% between 100-150% of the poverty line (U.S. Census Bureau,2019) Many researchers and program providers additionally have pointed out that the poverty line is an inaccurate analysis in many ways. Other measurements determine that millions of older adults who fall above the federal poverty line still struggle to meet their monthly expenses (*Get the Facts on Economic Security for Seniors*, 2021).

These statistics do not include the economic impact of the COVID-19 pandemic which greatly affected older adults. Although no data currently is available on how low-income older adults were impacted by the pandemic, it has been theorized that poor older adults may be more at risk due to the facts that they have less access to technology and may be less able to navigate telehealth or take advantage of the CARES Act due to inability to access these services (Lee, 2020). The economic impact of COVID-19 on the finances of older adults will have been significant. The stimulus check was not sufficient to cover the cost of living. Older workers, a significant portion of them employed in high-risk areas, will have experienced unemployment and income loss due to loss of hours (Li & Mutchler, 2020).

Older adults face cost related barriers in meeting housing, food, medical needs, and support to stay in their own home. Meeting these basic needs costs money. Older adults who do not have enough money to live on, as outlined above, may be unable to satisfy these needs.

Food insecurity, a lack of availability of sufficient nutritious food, has an obvious link to health. In older adults, food insecurity has been correlated with physical functioning limitations-- the ability to carry out Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) which are tasks we all perform in our everyday lives to care for ourselves (Jackson et al., 2019). In addition, it has been found that low-income older adults with multiple chronic conditions are more at risk to be food insecure and that food insecurity in this group is associated with cost-related medication non-adherence which in turn increases risk for poorer health outcomes (Caouette, 2020; Jih et al., 2018). Issues for low-income older adults are often interconnected as illustrated by choices between medication and food, or the inability to afford either.

Health has been addressed by every variable stemming from financial insecurity so far but there are issues unique to it as well. Medicare and Medicaid are health insurance programs that help older adults, but they do not cover everything. Although some prescription drugs are covered by Medicare part D, it has been found that in a representative sample, 6.8% of older adults were still skipping doses, taking less than prescribed, or not filling prescriptions because they could not afford it (Chung et al., 2019). Medicaid waiver services can assist

finding and paying for services to cover care, such as assistance with ADLs and IADLs when help from family or community falls short. However, when it is not feasible in an area lacking in available services; Medicaid is not required to offer the waiver and that creates barriers for many community-dwelling older adults especially in rural areas. For example, Weaver, & Roberto (2019) found increased mortality among participants who were not able to receive the service (). The effects of low socioeconomic status on healthcare are broad and variable but deserves addressing.

Behavioral health and receiving appropriate behavioral healthcare are largely overlooked when considering the health needs of older adults. Behavioral health, including mental health, substance abuse, and other complexities are an underrepresented concern often overshadowed by physical health and the stigma of addressing these issues with older adults. DeGarmo, (2022) highlighted concerns for this population to include increased isolation and loneliness, high rates of depression in long term care facilities, and chronic pain or physical disability as risk for substance abuse. Older men, specifically, have the highest rate of suicide as compared to other age groups (DeGarmo, 2022). Medicare covers annual screenings for depression and substance use, as well as outpatient therapy, and counseling. As compared with eleven high income countries, older adults in the US were most likely, at 32%, to be diagnosed with a mental health condition. Among older adults with mental health needs, individuals from the

United States were most likely to report facing economic hardship (27%) and report cost related difficulties accessing care (26%) (Gunja et al., 2022).

Transportation is a need perhaps less crucial than others examined here. However, it is a factor that influences the ability to meet other needs. An older adult's choice in transportation and use of it is dependent on physical health, the perception of safety, the availability of transportation, and proximity to destinations (Loukaitou-Sideris, & Wachs, 2018). Transportation options vary based on geographic location and rural vs urban settings. In urban locations, public transportation is more widely available; however, it is not commonly used by older adults, even as driving decreases with age. Challenges of using public transit were identified as "inconvenient schedules, requiring a place to sit while waiting for the bus, lack of adequate bus shelters, mobility challenges getting to the stop or to one's destination, and overall time of travel" (*Older adults and people with Disabilities – RHIHUB Transportation Toolkit* 2019 p. 12). In rural areas, older adults who do not drive or have access to a vehicle have fewer options and may live farther from destinations or connections who could drive them (*Older adults and people with Disabilities – RHIHUB Transportation Toolkit* ,2019).

Aging in place is desirable for many older adults. This option, however, presents challenges, many of which are essential for daily living. Older adults identify the following as barriers to aging in place: mobility and safety moving around the home, bathroom safety, maintenance and physical improvements to the house, personal health, safety, and access to community services (Brim et al.,

2021). Cost is a barrier to several of these concerns; accessibility modifications, hiring home health aides, and simply the cost of housing either as rent or mortgage. Isolation is a concern, especially in rural areas, for older adults aging in place (Molinsky, 2017).

Houseless older adults have the highest needs. They serve as a case study for the overlap of basic needs, how one unmet need influences another. Chau and Gass (2018) highlighted outcomes when older adults are unable to secure housing. The HUD identifies Geriatric Homelessness (GH) as homeless people over 50 years of age, citing that homeless individuals experience health and mental health impacts that would be expected in someone 15 to 20 years older (Chau & Gass, 2018). In 2017, the general homeless population was on the decline, yet Chau and Gass (2018) established that GH was on the rise, doubling to 31% in 2014. The loss of work and the lack of affordable housing are the leading causes of homelessness. For the GH population, bankruptcy, especially due to medical costs is an equal factor, especially as a decline in health can lead to a loss of employment (Chau & Gass, 2018). Mental health, neurocognitive disorders, and depression also influence the GH population. Infectious disease, cardiovascular disease, dermatological conditions, and diabetes are all present for the GH population and are addressed as a consequence of homelessness or at the very least exacerbated by it (Chau & Gass, 2018).

As outlined by Chau & Gass (2018), financially viable options available to older adults include shelters, transitional housing, Section 8 housing, single-room

occupancy hotels, and skilled nursing facilities (the only long-term care covered by Medicaid). Barriers to accessing these options include mental health issues, substance abuse problems, sex offender status, and ability to complete ADL and IADLs. On top of these issues, pride and personal preference play into why some older adults choose or have to stay on the streets. Individuals who are unable to complete their ADLs and IADLs are a strain on shelters and may be unable to live in transitional housing, Section 8, and SROs due to their inability to care for themselves. Individuals with dementia are especially a challenge for this system. SNFs are equipped to handle these challenges but there are many reasons people do not stay in these facilities. First, they may not require that level of care after they have recuperated from an illness or injury. Second, one does have to qualify for Medicare and Medicaid which could be a problem for a younger age group with the health problems of an older one, or if someone does not qualify for other reasons like work status. Lastly, many people just do not want to live in SNFs as they are institutions that minimize freedom. Ultimately, the invention of the medical institution is not the solution to the geriatric homeless crisis (Chau & Gass, 2018).

Access to safe and adequate housing also intersects with food insecurity and medical access. Homeless older adults need to purchase food that does not require preparation or storage which may be less available or more expensive. Transportation and mobility are major barriers especially for this population. Being able to make it to a food pantry, soup kitchen, or affordable grocery store

and be able to wait in a line to access services are all concerns (Chau & Gass, 2018). Additionally, the homeless population does care about their health, but experience barriers to care similar to those faced by other low-income adults. Of note is the struggle to obtain, keep, and take prescription drugs (Chau & Gass, 2018). The use of mobile health outreach clinics and the partnership of pharmacists have been strategies to serve this population that have helped (Chau & Gass, 2018).

There are existing programs that address these issues both on the state and federal levels (e.g., Social Security, Supplemental Security Income (SSI), the Supplemental Nutrition Assistance Program (SNAP)). The department of Housing and Urban Development (HUD) has a variety of programs dedicated to affordable housing, and Medicare and Medicaid are some of the most well-known government programs for older adults (*Medicare.gov* (n.d.); *Hud.gov (n.d)*). The landscape is not bleak. There are services out there to be accessed but not all problems are solved merely by the existence of these agencies.

Although there are services accessible to older adults to meet some of these basic needs, there are barriers that prevent them from doing so. Several studies have addressed the reasons some older adults do not participate in government assistance programs for which they are eligible (Maltz, 2022; Zielinskie, 2017). In one study on the use of SNAP among older adults in rural Colorado, it was found that some participants were unaware that they qualified, others faced physical barriers such as limited access to technology or transportation to complete

applications, and the complexity of the application process. Stigma was also a major barrier to accessing SNAP (Maltz, 2022).

Research in Pennsylvania identified many of the same barriers preventing older adults from accessing programs. Older adults were unaware they were eligible for programs, did not know how to access them, had troubles navigating applications online, or had no transportation to apply in person. Older adults also feared the stigma of receiving government assistance (Zielinskie, 2017).

The stigma of accessing government benefit programs prevents a portion of eligible individuals from applying. As defined by the National Council on Aging "Stigma is best understood as a negative reputation that creates real costs—emotional, social, physical, time, and financial—or the perception that costs will be incurred."(*Ending Stigma Around Receiving Benefits* 2016, p?). Stigma comes in two forms, internal and external. Internal stigma is displayed as shame or embarrassment while external stigma manifests both as the negative perceptions of others and challenges inherent in the system (*Ending Stigma Around Receiving Benefits* 2016).

For older adults of color, additional barriers complicate accessing services even further. Immigrants for example face both restrictions and barriers that prevent them from applying. In 1996, federal welfare law created two categories of immigrants, qualified and non-qualified (Broder et al., 2022). Qualified immigrants include lawful permanent residents, refugees, and a select few others face restrictions receiving benefits such as a five year wait period before receiving

TANF, Medicaid, and CHIP. Non-qualified immigrants, including undocumented individuals and many people lawfully present in the US, cannot enroll in federal public benefit programs. Qualified immigrants still face many barriers that discourage the use of safety net programs. Complexity and confusion around eligibility are exacerbated by additional eligibility criteria. Fears about immigration and status for themselves and any family looking to join them in the US present real concerns for this population (Broder et al., 2022).

Method

Focusing on learning more about the needs of older Oregonians with limited financial resources, I developed and submitted an application and interview protocol to the Western Oregon University Institutional Review Board. Once approval was received, participants were identified from the professional networks of the primary researcher and her advisor. Potential study participants were contacted by email with an explanation of the study and recommendations for others who may provide important information and be willing to be interviewed. Additional participants were identified by recommendations made by the first selection of participants using a snowball sampling strategy. Five individuals agreed to participate in the study. Once their informed consent had been obtained, video conferences were scheduled individually with the participants. Participants met with the primary researcher over Zoom or Microsoft Teams. Generally, interviews lasted approximately an hour. All interviews were audio recorded and transcribed verbatim.

Participants in the study were professionals working with or on the behalf of older adults. Participants were employed by Oregon Department of Human Services Aging and Older Adults, an Area Agency on Aging, and a senior center. They were asked a series of questions about their organizations, the programs that are in place to serve older adults, the accessibility of services to clients, and the advocacy work they believed needed to further meet these needs (see Appendix I for protocol).

Interview transcripts were generated from interview recordings. Once the transcripts were made, recordings were destroyed. Data analysis began with open coding strategies (Berg & Lune, 2012). Broad codes were identified that included the needs of the population, social context of low-income older adults, barriers to accessing services, accessibility strategies, limitations to programs and services available, and opportunities for advocacy work. Next, axial coding was completed resulting in 25 subcodes. All interviews were coded using qualitative software (MAXqda) that aided in the organization of the data. From there, emergent themes were identified.

Results

The participants of this study provided insight into areas of services for older adults who have limited resources. Interviews with service providers revealed 5 overarching themes: a) the needs of low-income older adults; b) the social context of low-income older adults; c) barriers to accessing services; d) accessibility strategies; e) limitations to programs and services available; and f) opportunities for advocacy work. These themes helped to illuminate the landscape of services available to low-income older adults and provided a window into how they are working to meet the basic needs of this population.

Needs of Low-Income Older Adults

Service providers clearly articulated the basic needs that are critical for older adults to live, and live well. As one service provider highlighted, “I am a firm believer in Maslow’s hierarchy of needs…I believe that unfortunately people, when they are unhoused or unfed and their basic needs aren't met, none of the other stuff happens.” Service providers focused on the importance of meeting basic needs including housing, food, behavioral health, transportation, and supports for aging in place.

Housing

The exorbitant price of housing creates a significant problem for low-income adults. This is reflected in concern for homeless and housing insecure populations. One service provider working in a state agency shared, “I think that

not only our clients, but you know something that the whole state and probably nation is experienced with is homelessness…And trying to find affordable housing for our consumers sometimes is difficult." The issues of homelessness and affordable housing intersect with long term care. She went further to explain the precarious nature of life for older adults on limited incomes when she added,

> An individual trying to live on $880 a month Social Security… is going to always be on the verge of losing housing. And what that does is out of pure survival pushes them to seek living in a facility because really there is no other choice but to push into a Medicaid situation where their housing is provided and their care and there's a loss of independence with that."

Service providers consistently expressed the interconnectedness of different areas of need. For instance, one service provider explained that, "The housing crisis in our region is a real concern. I'm not going to be able to keep people safe, fed, and independent, and healthy in their communities if they don't have a place to live." Clearly, housing and the housing crisis were a top concern amongst service providers interviewed.

Food Insecurity

Food insecurity is understood to be a constant for vulnerable populations. Enough, nutritious food is crucial for health and wellbeing. Among the service providers, the importance of continuous access to food was identified as one of the foundational basic needs, often identified as a top need following housing. One service provider shared the top three needs of older adults with limited resources

when she explained, “I feel like…if people don't have safe housing and food and behavioral health supports and all those basic needs, the rest of it's never going to fall in place.”

Behavioral Health

Support needed for individuals with behavioral healthcare needs, such as mental illnesses and substance abuse disorders, was highlighted as an area of need. As one service provider underscored, “If you're a person with a mental illness and then you age into the aging system, getting you access to benefits is almost impossible because of the fact that you're served by a mental health department not the APD office.” Because behavioral health was understood as both a healthcare and housing issue, one service provider described the challenges of finding appropriate housing for mentally ill adults and older adults:

> I know that we are seeing a lot of older adults that are coming in younger with behaviors. And those individuals don't always fit into a community, a standard community-based care and so I really would love to see us look more into different types of housing for individuals that may be a little bit younger with behaviors.

It was clear from the service providers’ detailed responses that behavioral health needs intersected and influenced the ways that other needs were experienced for this specific population.

Transportation

Transportation was a major theme, mentioned across almost every interview as an area of need, which included public transportation and personal vehicles. One service provider underscored the cost of maintaining a vehicle at the same time an older adult experienced mobility issues emerging with aging. She stated that “most older adults with a variety of needs, can't afford a car payment or maintenance on a car or the fuel that goes with it.” She added that transportation also became more critical with the aging process. She explained that “At the exact same time [that] they're losing their physical mobility, …public transportation is not always ideal for them.” This was also seen as a medical issue by participants. For instance, one service provider shared, “I think transportation is always something that comes up as being challenging for people to get both to medical transportation and what they call an NEMT or Non-Emergency Medical Transportation.” This was especially problematic in rural areas, as one service provider shared, “I think in our rural community transportation is huge.” Transportation as identified by service providers, was both a need in and of itself as well as a compounding factor in the inability to meet other basic needs.

Supports For Aging in Place

Support for aging in place, especially the expansion of services beyond caregiving, was identified as an area of need by service providers. From their perspectives, in-home support programs were not enough to meet the needs of low-income older adults. As one service provider explained, “Most in-home health

care programs include a little family, a little case management, and then maybe a home health agency. They [low-income participants] rely on one component which would be government-aided in-home health care and that's really hard to navigate." Aging in place presents an opportunity for loneliness and isolation which there is no support to counteract. For instance, one service provider commented, "I think people want more companionship and stuff than they have. We base for Medicaid the number of hours on what somebody's activities of daily living, you know physical needs are, but I wish we could attend more to their emotional needs." In-home services were often mentioned in the context of maintaining independence.

The needs of older adults in poverty, as identified by these service providers, are representative of the issues they have observed and worked to meet from their various program and organizational efforts. Housing, food, behavioral health, transportation, and aging in place support were seen as basic needs where services currently available were not meeting. Additionally, needs were not isolated in that older adults with limited financial resources often experienced an intersection of these basic needs with aging that influenced well-being.

Social Context of Low-Income Older Adults

Understanding the social context in which an older adult is able or unable to meet their needs was underscored by service providers. As one service provider explained, "We ask them are you able to meet your needs? …because a low-

income person said to me ‘I do a lot with twelve hundred dollars a month and I love my life and I don't feel like I am suffering’.” Basic needs were viewed as interconnected, and all older adults will have unique experiences based on their life course. Their networks of support also influenced the experience of the older adult. Service providers generally stressed that the context of an older adult’s life and situation was important to understanding their basic needs and use of services.

The identified needs of housing, food, behavioral health, transportation, in-home support, and others were often contextualized by participants in a holistic view of the individual. Offering individualized care based on the needs of the individual was seen as important but often hard to achieve as voiced by one service provider:

> It would be really cool if case managers didn't have to have such huge caseloads and they could really look at all of the different aspects of a person's life and help them come up with services that would sort of wrap around, you know, and provide what they needed. That seems to me to be something that's really important.

Across interviews, understanding a more complete view of a person to be able to provide accurate and helpful assistance was frequently voiced.

Providers understood that an individual is the expert on their needs and circumstances. One provider advocated for listening to clients:

> As an organization we need to be asking what individuals need and how best we can support them so that they can utilize our services…I think with

> the pandemic we are really learning that community approach on, how to create that wraparound service for our older adults and how to really include everyone.

It was expressed by multiple service providers that individuals were most knowledgeable about their own needs and that the context of their support network affects what those needs are.

Recognizing both the needs of the older adult in the context of a support network and the needs of the people who make up that network also emerged in interviews. As one service provider shared:

> The conversation is what does your mom want? What do you want for your mother? What are her strengths? What are her weaknesses? What's important to you?...trying to figure out what's going on with this person or their family and what kind of care needs, and needs do they have.

This can lead to an awareness of generational poverty, where the support network members may also struggle with basic needs. One service provider reflected,

> I'm finally seeing, where I've heard of generational poverty, I didn't know it, and, but now I've seen it now. I'm seeing the mom and the child both are seniors and they're both in poverty. And they're raising their grandchildren and now all three of them are in poverty.

It may also be that the older adult has no, or little support as explained by another provider:

> Those individuals that are low-income tend in our group, tend to have fewer family connections or what we call assets in their life where they have a variety of people to draw on. And I don't know if there's a true correlation between low-income and that, but we find that that's the double whammy. Now they have no financial resources, and they have no family support.

The context of the support network was seen as essential to understanding the needs of an older adult.

Barriers to Accessing Services

For older adults with limited financial resources, knowing how to access critical resources for well-being is important. Several barriers that prevented people from accessing appropriate services emerged in interviews. These came from both internalized preconceptions by older adults and problems inherent in the systems provided to them.

One of the major barriers to access was the stigma older adults ascribed to receiving government assistance. Service providers shared that the first step for older adults was to acknowledge a need for help. One service provider explained, “People also want to maintain independence… It's really hard for a person to get to a point where they …feel like they need help and they're willing to ask for it.” The stigma of government assistance was prominent across all interviews. Another service provider shared, “I think there's a lot of stigma related to us being a state

agency . . .a lot of fear." One community provider was aware of this stigma and purposefully worked around it to provide services. She explained:

> We follow the thought process that most people are intimidated or scared to ask for help and that by asking for help there, it is pretty damaging to people's self-esteem and rather than … having to identify we bring them into the fold of how we operate and say you're a part of this and because you're a part of this this is free.

The same provider further explained, "We try to remove any barrier of bureaucracy… it's not coming to a resource office completing paperwork." She positioned the service model of her agency in contrast to those with more rigid application processes. Receiving assistance, especially from a government agency was stigmatized, a fact which discouraged people from using these resources.

Ageism is a similar barrier to access. According to service providers, older adults did not seek help because they do not want to be labeled as 'old.' One service provider described how ageism is internalized when she highlighted:

> There's also this sort of general perception of 'oh, if you need help' what does society think of you, you know? We are quite an ageist society without realizing it and people [who] are in Western culture are devalued when they…need assistance versus when they're 'contributing'.

Another service provider commented on internalized discrimination when she stated, "Seniors themselves perpetuate that bad behavior they put limitations on one another …the stigma would be if I go there or if you go there, you must be

old.” Being old held a negative connotation for these older adults and created more barriers to accessing appropriate resources.

Using a contextual and intersectional approach, service providers highlighted how older adults of color particularly faced significant barriers to access. As one service provider noted, “I don't think we have a lot of barriers to your standard White female, standard retired White male, but I think we have a long list of barriers for any culture, any diversity.” This was an area most agencies were actively working to improve. As one service provider shared, “I feel like in the past one to two years, we have, like a lot of agencies, really started focusing in this area.” Language accessibility was seen as a facilitator for access to services among most agencies. For many agencies, language access has occurred. One service provider noted, “We do have case managers that you know speak different languages...so Oregonians will feel more comfortable when they are, let's say, completing an interview or an application. And that materials are sent to them in their native language.” Despite improved language accessibility, all service providers saw areas of improvement to achieve service equity.

Another barrier to access was the complexity of the systems including applications, eligibility, and self-advocacy. As one service provider shared, “I think there is a perception, and it's true, that the system is complex and difficult to maneuver. And I think there are people who are hesitant to engage with the system for that reason.” Navigating the system was put on the person applying for benefits, making the process more difficult. As explained by a service provider,

“The system is complicated and so I think consumers have a hard time maneuvering and have to sometimes do extra work to get services that they're eligible for.” Not understanding how to apply or how the system works emerged as barriers to accessing services.

The complexities of technology also emerged as a barrier to receiving needed resources. “Well, I think when it comes to older adults, the online application can be really difficult, right? We have a lot of older adults that might not have access to a computer and if they do have access to a computer, kind of navigating that system and being able to apply can be difficult.” This was often posed as a barrier that they were able to offer solutions as one service provider noted: “We try to do everything face-to-face and one-on-one whenever possible because we still serve a population that is still struggling with the technology of today.” This barrier was not seen as insurmountable as others.

Service providers named stigma, ageism as internalized barriers that prevent older adults from accessing services. Older adults of color faced unique barriers. The complexity of the system presented a barrier for some older adults. Technology literacy presented another. These barriers stemmed from different issues but all prevented people from seeking assistance.

Accessibility Strategies

Service providers described the facilitators that helped older adults with limited economic resources access services with ease. This was an area of active

work for different programs trying to improve the accessibility of their programs. There was often a path from an identified barrier to an implemented strategy to promote ease of access. These issues were dynamic and as needs were met or changed, service accessibility was influenced.

One answer to the problems of stigma, ageism, and service inequity was community outreach and relationship building. As one service provider shared, “I think having discussions with the community as much as possible and really having that open door. Anybody is welcome to come in and ask questions. I hope helps with that stigma.” Being known as a supportive agency was important as explained by another service provider: “I think especially pre-COVID, we were really working at like when there's a Latino festival, getting out making sure that we have a table at those events, LGBTQ festivals for example, Pride Days, those kinds of things.” Outreach also took the form of making connections with community organizations, especially those that served minority groups.

The recently implemented ONE application system attempts to simplify application for benefits and condenses applications for a variety of government assistance programs into a single application. Before the implementation of this system, older adults would have to navigate different offices and applications to receive different benefits. Finding the correct point of access was an additional challenge. A service-provided shared some of the challenges and outlined that her agency had “tried to close that gap by having that ONE system where it's a one point application for all of the benefits that Oregon has, you know, like it will be

the Medicaid benefits, TANF, ERDC, all of the benefits that an Oregonian, you can apply for." Through the ONE system, individuals apply and receive assistance through multiple channels and at offices they were not previously able to access. They can call AAA, APD offices or the ONE Call Center to receive assistance. The implementation of the system overall has been well received although there has been an adjustment period.

An older program, Aging and Disability Resource Connection (ADRC), also aims to reduce complexity and offer alternatives for those facing technology barriers. The ADRC has both a call center and a website that connects older adults to the appropriate local resources dependent on their specific needs. One service provider shared:

> In our agency, we do really work like if someone calls us and we're not the agency that can provide service, really trying to make sure that we figure out the easiest way possible to get people connected with the services that they need…we're really working on trying to reduce barriers and make more warm handoffs and more warm transfers to other organizations.

It has not, however, been as widely used as some believe it should be. One service provider noted, "I don't think that they do [learn about services] …In our four-year strategic plan… the ADRC is one of the concepts that we need to work on doing some goals and objectives for and more outreach." The ADRC was highlighted as a tool to reduce barriers to access, especially for those older adults and family members not knowing where to begin the process.

Communication, collaboration, and referrals both between state systems and community partners were commonly identified together as an important tool and an area for? improvement. The ONE system and the ADRC are both systems that promote this goal. However, it was still apparent that there was room for growth in this area as one service provider stated:

> The coordination of agency to agency is very clunky. It is not smooth, and people get dropped through the cracks all the time. And then people become overwhelmed and then they don't get what they need. And every agency has slightly different… criteria, and slightly different processes and that's too much for a lot of people.

It was also seen that collaboration between different state departments could improve services. One service provider highlighted the need for collaboration when she stated, “For me [a goal is] breaking down the silos between behavioral health, developmental disabilities, and aging and people with disabilities programs because our systems don't talk to each other.” Another provider also referenced silos between departments saying: “I think also getting out of silos and looking at where we could work with say Self-Sufficiency or Child Welfare, what are some things that we could do in partnership?” There was significant focus on how communication, collaboration, and referrals could improve between agencies that would benefit from working together and the benefits that would be created for the populations served.

An additional access concern voiced by service providers focused on how the different services have different eligibility criteria. Some are available to all older adults, and others require older adults to meet financial and/or physical need to qualify. An idea that emerged was the benefits of services that support older adults that do not have financial eligibility criteria. One service provider remarked,

> I think part of the reason that the Older Americans Act has been reauthorized so many times and has stayed so popular in the 50-ish years that it's been around, . . . is because it's not a specifically low-income program. Although I would venture to guess that more people who have fixed or low incomes participate in some of the different programs.

Another shared that "We do not require that they identify as being low-income. It's age driven. So that's a service [Meals on Wheels] that's available. But we know because it is free, it is a great support to individuals that may have income limitations." It was understood that programs without eligibility requirements increased ease of access.

The idea was also raised by one service provider that the system of eligibility based on resources was not the most productive way to offer assistance. She explained:

> We try to neutralize the income piece here and focus at it from just an interest and stage of life instead and we find with that people are more generous with one another and also people feel like they're more part of

> things because they’re not being singled out by having to wear the badge of low-income.

The service provider also stated that:

> The majority of the senior population does not qualify for additional supports. And so if we can help people stay healthy and engaged, that big group then that 10% that really qualify for the additional supports can get our attention. And … we really try to make sure they get connected to the right resources. I always say there's 10% to qualify for supports, there's 10% that can write a check out right, and then rest in the middle are kind of marching along on their own.

This addresses the needs for support systems that are not based on eligibility criteria.

There is an evolving relationship between the identified barriers to access and the steps that are being taken to promote accessibility. For some barriers like technology, service providers identified simple solutions like providing multiple points of access on the phone or face-to-face meetings. For other barriers, the path forward was more complicated. Clearly, agencies are implementing strategies to improve accessibility. As expressed by service providers, however, there is still work to be done.

Limitations of Programs and Services Available

Several ideas emerged that explained the limitations for programs currently available and therefore serve as areas that could improve the system as a whole. Program needs included additional funding, increased workforce, reduced burden on systems, and scope of services offered.

Funding influenced different settings differently but the primary issue on funding was being able to allocate money as the agency saw fit as opposed to an external governing body. One service provider remarked:

> Oregon's system where the legislature makes a decision about how many positions a program gets, is crazy! ... We should be able to take the budget and be able to be agile and put staffing and funding where it's needed. And that can change throughout a biennium.

Otherwise almost all service providers had things they would do if allocated more money. One service provider underscored that "Senior services are underfunded. I think that the barrier to me providing services is that there's just never enough money." Finding enough funding and controlling how funds were spent limited what programs could achieve.

Workforce emerged as a concern at a similar level to funding. At the state level, it was an issue tied to funding. One service provider noted, "There's funding in terms of what we can provide to partners, and there's funding in terms of what we can use for hiring…and it really dictates what our priorities are too and how much we have to prioritize." At the AAA, it was the primary concern as voiced by

one service-provider: “Right now, the biggest one’s workforce [barrier to providing services] . . . Six years ago, it was money, now it's workforce so it's really changed because now I have all the money in the world but I can't hire case managers.” A similar issue was declining volunteerism as outlined by a service provider: “We've had our heydays where it just was natural and everybody volunteered and it didn't matter what they were doing, they just wanted to help. Well, that's not the case anymore. The volunteer looks totally different.” These services require staff to carry out their missions.

Overburdened systems combined with lack of funding, a lack of workforce, and programs stretched too thin. According to service providers, systems could provide better services were this not the case. As one service provider explained, “Everyone is spread so thin, case managers are carrying well over 100 people on their caseloads, and you can't possibly know 100 people. And they're intimate details of what they truly need. With that many people, it's not physically possible.” Service providers wanted to address more of the barriers to access as this participant explained, “We are in human services, across the nation, always under resourced for the programs and services that we want and are required to provide. So, it's always how do you work efficiently, how do you do more with less?” It was expressed that in some ways, systems were operating well above their capacity.

The scope of what different agencies could change was another limitation. As one service provider described, “In our department, I don't have any power to

fix Medicaid or Medicare so I can only help in the scope of work that I can do and that's to help people cope with that or prepare for it or avoid it." Especially when it came to the housing issue, service providers were passionate about that work but ultimately were unable to address the problem. As one service provider pointed out, "I think that's the biggest thing [housing]. Unfortunately, my agency is not an agency that can fix that problem. So, we're trying to figure out what that looks like for us as far as future development of our programs." Different agencies had different programs and things that they felt were beyond the scope of their mission.

The limitations of these programs-- funding, workforce, capacity, and scope were professional issues that service providers had only so much power to change. These issues defined how much agencies were able to do.

Opportunities for Advocacy Work

When asked to speak on what changes they would like to see in the future and what advocacy they thought was needed, service providers had a broad range of answers. They often touched on things that had been mentioned earlier in the interview such as basic needs that they saw unmet or professional issues that limited the work they did. Beyond that, service providers commented on policy, culture change, and prevention.

Specific answers on what legislation the service providers would like to see varied but repeated ideas were having less restrictions on programs, increased

training requirements, and improvements to programs. Less restrictions or requirements for programs was a repeated aim for new policy. As one service provider noted, “I would like to see legislation that makes it probably less restrictive for individuals to qualify for benefits. And I think that's something that we're always working with on the Centers of Medicare and Medicaid.” Increased training across the board for people working with older adults especially in direct care work arose multiple times among service provider interviews. One participant noted, “I think in terms of legislation I would love to see us require better training for people in long-term care facilities.” Additionally, improvements to programs especially Medicare and Medicaid were mentioned during interviews. One service provider explained this when she stated:

> Poor Medicare folks you know, once you're on Medicare, you have no behavioral health support benefit. There's not a lot of great benefits as far as dental care or eye care and there's no transportation. And so, they need to start figuring out how to fix that.

Service providers had a range of things they would like to see from policy.

Service providers also explained areas of advocacy work that do not go through legislative channels but instead would stem from cultural change. Service providers wanted to see the creation of dementia-friendly and age-friendly communities as described by one service provider: “To be a community for people of all ages and abilities would lend itself naturally to addressing low-incomes, if you really do create a community that's age-friendly.” Combating ageism through

cultural change as one participant mentioned, "Ageism is a real thing…Making sure that they [older adults and people with disabilities] still stay engaged and active in the communities I think is one of the best ways to reduce that stigma." These areas of change were stated with equal importance as legislative priorities.

Preventing poverty in this population was also seen as an area of advocacy. Prevention especially through planning and education were seen as achievable steps for older adults with financial needs. For instance, one service provider shared:

> If you address and plan while you're still working, you can change the course of your financial means as you move forward. Also, we try to educate on having a plan…So education is a number one, making sure people have all the facts and that they're making these decisions in a place where they have as many choices as possible which means earlier than later.

Education as a tool for poverty prevention was seen as a need for people of all ages. Addressing issues with people before they age into this situation was seen as an opportunity to prevent poverty in older adulthood. Financial literacy was one example of this kind of education:

> We're trying to build an elder justice team. So, working on the ideas of scam prevention, fraud prevention, a lot of focus right now on economic well-being and that's not just for older adults and people with

disabilities...Because if you don't fix the financial crisis from the ground up on all levels of community, I don't think you can actually impact change.

Prevention, planning, and education were all tools that these service providers used in their work to affect change.

Advocacy work across all five interviews was seen as a necessity. Areas of focus highlighted policy, culture change, and education as ways to make change. Service providers had different ideas and priorities but across the board, service providers saw ways to make improvements in the lives of low-income older adults.

Discussion

The basic needs identified by service providers were supported by the literature as instrumental to wellbeing (Jackson et al., 2019). Housing, food, behavioral health, transportation, and supports for aging in place are interconnected needs, crucial to wellbeing. As seen in Chau and Gass (2018), homeless individuals and those most financially vulnerable suffer on multiple fronts because of the interconnected nature of basic needs. Homelessness was a primary concern, within the overarching theme of housing and as an issue within its own rights, for good reason. The homeless population often struggles to meet their basic needs but their houseless status acts as a barrier. They may be in need of healthcare and behavioral healthcare, food insecure, and unable to access transportation but experience barriers to meeting those needs (Chau & Gass, 2018). The same basic needs as other vulnerable populations.

Generally, transportation is connected to most issues. Being able to access services is a barrier in its own right. Otherwise, the connection is simply that all of these basic needs cost money. It is well documented that there is often a choice between basic needs such as food or medication or the inability to afford either (Caouette, 2020; Jih et al., 2018).

While there are assistance programs, those offered to all older adults and safety net programs, to meet these needs there are barriers to accessing them. Barriers identified by service providers consistently aligned with barriers identified to specific programs in various studies (Maltz, 2022; Zielinskie, 2017).

Stigma was identified by service providers as both as the stigma of receiving government assistance and the stigma of being old. The primary definition of stigma is well researched as a barrier to access (*Ending Stigma Around Receiving Benefits* 2016); however, ageism as a similar stigma-based barrier has been observed but not well documented. Service providers positioned outreach and education as ways to disrupt this stigma.

Older adults of color are more likely to be low income or financially vulnerable (Butash et al., 2021). These populations face barriers to accessing services. Providers spoke to the existence of these barriers but rarely specified beyond that. It can be seen in the literature that immigrant status and language accessibility are key issues within this group (Broder et al., 2022). Information distribution in multiple languages, multilingual service providers, and translation services were strategies used by agencies interviewed. Outreach, especially partnerships with community organizations serving minority groups, was seen as key to building relationships, establishing trust, and getting information to minority communities.

Physical barriers such as transportation and technology are almost cliche at this point with jokes about old people who can’t drive or use computers, but they are real issues. Transportation, either lack of access or inability to use it can stop an older adult from going to an office to receive assistance. Technological literacy presents the same issues if applications and information are online (Maltz, 2022; Zielinskie, 2017). Service providers were meeting these challenges by providing

multiple points of access; either in person, online or on the phone, instead of any one of those options which may prove a barrier to an older adult. To distribute information and connect people to services the Aging and Disability Resource Connection (ADRC) offers ways to access services online, in person, or over the phone.

Complexity of the system, and not knowing what they may be eligible for, how to apply, or having difficulty navigating resources they are eligible for, are common barriers. Both Maltz (2022) and Zielinskie (2017) underscore how this was a barrier to accessing services. The ADRC as a database or hotline to connect people to resources aims to combat the initial phases of this problem. Another tool, the new Oregon ONE application system simplifies the application process. Whereas before older adults would have to connect to different offices, navigate different departments, and complete different applications, the ONE System allows anyone applying for benefits to complete one application for multiple programs (OHP, SNAP, TANF, TA-DVS refugee assistance, and EDRC). The ONE system allows offices across the state to serve as application sites for demographics they did not serve previously, allowing applications to be completed in person at these offices. A hotline and online application are also available.

These systems are steps toward enabling smooth communication, collaboration, and referral between programs and departments. However, there is still much room for improvement. Service providers highlighted the need for smoother transitions from program to program. Service providers emphasized the

need for collaboration between different departments of the governments highlighting silos that if brought down could provide more wholistic care for an older adult (i.e. behavioral health silos) and better support for a network and poverty prevention (i.e. child welfare). This would break down some of the barrier due to complexity.

One difference between programs was if there was an eligibility criteria participants needed to meet or if the program was available to anyone. Eliminating applications and eligibility criteria reduces stigma and complexity.

Limitations, Implications and Conclusion

This study was limited by the number of participants and the variety of their workplaces. By interviewing only five participants, the results were narrowed. By interviewing more participants, themes could have been more well established and additional themes identified. Most service providers worked for government agencies working for or on the behalf of older adults. Expanding the reach of this study to include other sectors with opinions on these issues such as legislators, nonprofits, or other sectors of government work would have provided a broader understanding of these issues. Lastly, talking with older adults experiencing these issues would centralize their voices and perspective on the issues that affect them so critically.

This research is important for the purposes of understanding the critical needs that poor older adults have and examines how the systems in place in Oregon are able or unable to meet their needs. This research shows clear needs for which there are services available. Service providers described barriers to accessing services and solutions that were being actively implemented. This study highlights the importance of making those improvements. Ultimately this work outlines what service providers already know. It highlights the important work being done in this area and shows the areas of growth.

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Appendix

Advocacy Work for Financially Vulnerable Older Adults
Protocol for Professionals

Interviewer: Maya Herb **Date: _____**

Project Title: Advocacy Work for Financially Vulnerable Older Adults
Principal Investigator: Maya Herb, Student, Western Oregon University
Advisor: Dr. Margaret Manoogian, Gerontology: Aging and Older Adulthood, Western Oregon University

Interviewee: _____
Employer: _____
Job title: _____

I want to thank you for agreeing to be interviewed. I am interested in hearing about your professional experience serving low-income older adults. I want to remind you that this interview is voluntary. You do not have to answer every question and at any time, you may stop this interview. I will now begin the recording. [Start Recording]

Part A: Organization Outline

1. Tell me about organization? (Probe: types of services/programs, geographical location served, client demographics—age and diversity) Tell me about what your position is? What do you do? How long have you served in this position?
3. How does your agency address the basic needs of low-income older adults?
4. How does your agency fit into the broader network of services?

Part B: Service Analysis

<u>Client Access</u>

5. How does an older adult qualify to receive your services?
6. What do you do to promote ease of access?

a. What is preventing people from accessing your services?
b. How do people learn about your services?

7. What do you do to combat stigma?
a. What kinds of stigma are the most damaging to your work?
8. How does your agency serve minority groups?
a. Evaluate how well your agency serves these populations

Service

9. What are the biggest needs of your clients?
a. How well do you think your agency is doing in meeting client needs?
10. What do you see as the barriers to providing services?
11. What are the most pressing needs and professional issues for your organization?
12. What are areas of growth for your agency?
13. How would you evaluate the network of services (of which your organization is involved?) that serve low-income older adults?

Advocacy

14. Overall, what would you suggest as to ways to best address the needs of older adults in poverty?
a. Probe programs, collaborative efforts, policy, new visions, finances
15. How does policy impact your work and what legislation would you like to see in the future?
16. Tell me about how funding influences your work?
17. What opportunities do you see for advocacy on the behalf of low income older adults?
18. Is there anything else you would like to add or that you think I should know?
19. Do you have any questions for me?