Multnomah County

Aging Disability and Veteran Services and the Joint Office of Homeless Services

FY 2023 Budget Note

as requested by Commissioner Jayapal

March 2023

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> The authors would like to thank all the people and teams that provided their valuable time, expertise, and insights in the creation of this report.

1. Approved Request

Recent research shows that older adults with experiences of homelessness are twice as likely to have cognitive impairments and 2.5 to 10 times more likely to have difficulty with self-care. The *Multnomah County 2019 Point in Time* report shows that the population of older adults (age 55 and older) experiencing homelessness increased 15% over a two-year period. Once placed in housing these households likely need additional support in their homes to address challenges caused by physical and mental impairments to remain successful.

Because homelessness disproportionately impacts households of color, this population of older adults are at higher risk of negative housing outcomes such as returns to homelessness from permanent housing. This budget note requests that the Department of County Human Services and the Aging, Disability, and Veterans Services Division, with assistance from the Joint Office of Homeless Services, produce a report for the Board of County Commissioners that addresses the following areas:

A. Identify the services needed for older adult households, as well as the number of older adult households that could potentially be served.
B. Identify common risk factors that older adult tenants face that increases rates of eviction due to unmet in-home care needs.
C. Recommend potential programs to address the issues identified.
D. Offer options for implementation of resources and approaches for piloting the models.

2. Description of Division/Departments

2.1. Joint Office of Homeless Services (JOHS)

The Joint Office of Homeless Services is a partnership between Multnomah County and the City of Portland to provide housing, shelter, health care, employment assistance, and case management to people experiencing homelessness.

2.2. Aging, Disability, and Veterans Services Division (ADVSD)

The Aging, Disability and Veterans Services Division (ADVSD) is the federally designated Area Agency on Aging for Multnomah County. ADVSD represents the diverse needs of 181,000 older adults, people with disabilities, and veterans. ADVSD maintains a coordinated service system that supports individuals to achieve independence, health, safety, and quality of life. ADVSD services include 24/7 community resource

information; social and nutrition services; eligibility for Medicaid health and long-term support services; access to Veterans benefits; protective and guardianship services; and adult care home licensing. ADVSD administers 27 programs that include over 48,000 participants receiving Medicaid long-term services and supports and over 7,500 participants receiving community social supports.

3. Updates and Terminology

3.1. Point-In-Time Report (PIT)

The questions on this report were informed by the *Point-in-Time* (PIT) report of 2019. During the production of this report, the new PIT report for 2022 was published by the Joint Office of Homeless Services. As such, the current report will primarily utilize the information provided by the PIT report of 2022.

3.2. Area Plan, Aging Disability and Veterans Services Division

As an additional source of information, the *Multnomah County, Aging, Disability, and Veterans Services Division (ADVSD) 2021-25 Area Plan* and its one-year update will inform the material presented in this report as applicable.

3.3. Older Adult

An older adult is defined by the National Institute on Aging as a person 65 and older (NIH, 2022). Similarly, in Oregon, a person's age to qualify for Medicare is 65 and older, although age exceptions exist depending on other considerations such as disability status (SHIBA, 2022). We acknowledge that there are age variations for the classification of an older adult, one of such examples is that the Older Americans Act (OAA) provides services for individuals aged 60 years and older (OAA 2022). For the purposes of this report, multiple age brackets might be analyzed or referenced depending on the services being reported. A notation on such age brackets will be included for reference.

3.4. Aging in Place

The U.S. Centers for Disease Control and Prevention defines aging in place as: *the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level* (CDC, 2022).

4. Background

The world population is aging at an increased rate. The World Health Organization (WHO) estimates that *by 2030, 1 in 6 people in the world will be aged 60 years or over* (WHO, 2022). The report *An Aging World: 2015* by the U.S. Department of Commerce estimated that in 2015, the population aged 65 and older constituted approximately 7% of the total world population. It was further estimated that in 2015, this population group would exceed 21% of the total population in 94 countries, including 28% or more in 39 of those countries. Based on available data, adults 65 and older are expected to grow from an estimated 14-21% of the total U.S. population in 2015 to an estimated 21-28% in 2050 (Wan He, et al., 2015). More recently, the 2020 U.S. population aged 65 and over was reported at 55.6 million, including 30.8 million women and 24.8 million men (OAA, 2021). Of this population group, about 27% (15.2 million) older adults lived alone in 2021. This included 33% of women and 21% of men. The proportion of individuals living alone increases with advanced age, e.g., 43% of women 75+ lived alone in contrast to 33% for women 65+ (Figure.1).

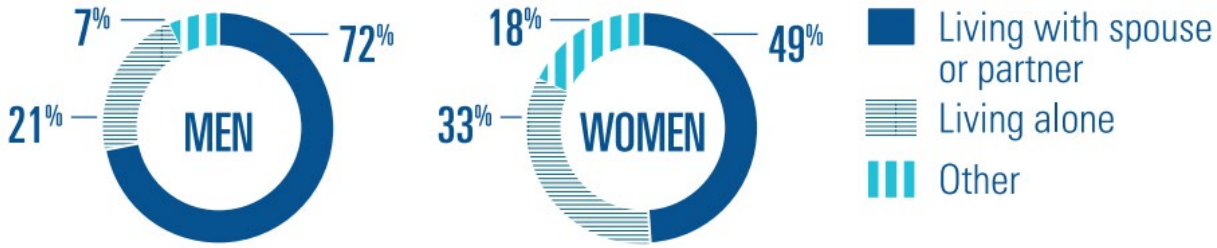


Figure 1. Living Arrangements of U.S. persons aged 65 and older, 2021. Sources: 2021 Profile of Older Americans; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement 1967 to present.

In 2020, the State of Oregon reported 789,527 persons aged 65+ (18.6% of the population). Out of these individuals, 7.3% were below the federal poverty level (U.S. Census Bureau, 2020).

Multnomah County is the most populous county in Oregon with a July 1, 2022, population estimate of 810,242 people. From this estimate the City of Portland accounts for 647,697 individuals, and the City of Gresham for 114,833. Other cities such as Lake Oswego, Fairview, Maywood Park, Troutdale, and Wood Village, as well as unincorporated areas, account for the remaining population difference. Individually, none of these other jurisdictions currently exceed 50,000 individuals (PSU, 2022). Table 1 shows the Multnomah County population characteristics as analyzed for the work of the ADVSD 2021-2025 Area Plan, both as a whole and divided by service area district.

Table 1. Population characteristics by ADVSD service area. All estimates are for the 60+ population unless otherwise noted. Source: PSU Population Research Center.

	County	East District	Mid District	N/NE District	SE District	West District
Total	151,827	33,281	31,823	32,193	22,790	33,701
Below 185% FPL	33,890	6,404	9,590	6,566	5,260	6,069
People of Color	31,185	5,436	9,640	7,728	3,948	4,433
People 18-59 with disability	48,767	11,219	12,180	10,791	7,729	6,848
Persons 60+ with disability	47,865	10,263	12,679	9,598	6,620	8,706
People speaking primary languages other than English	6,373	1,074	2,948	626	1,001	724
African	973	1,074	268	314	1	236
American Indian or Alaska Native	2,419	506	587	428	506	392
Asian	10,615	1,570	4,163	1,719	1,942	1,221
Black or African American	7,683	776	1,633	4,041	437	796
Native Hawaiian or Pacific Islander	732	210	180	169	132	41
Latino, Latinx or Hispanic	4,978	1,102	1,535	1,034	565	743
Middle Eastern	966	313	202	86	54	311
Slavic	5,011	910	1,685	511	838	1,067
White	132,026	27,500	25,918	26,656	20,128	31,824

As the population born between 1946 and 1964 (the baby boomer generation) continues to live longer the strain placed on services provided to the aging population has the capacity to cause housing instability. It is expected that this increase in the population will put further demands on a housing market that seldom considers additional factors in the needs of older adults to allow them to age in place, particularly those with fixed or lower incomes, disabilities that are cognitive or mobility-related, and/or low social connectedness.

The *ADVSD 2021-2025 Area Plan Needs Assessment Survey* showed that housing was a significant area of need for older adults in Multnomah County. The survey showed that housing, income, healthcare, and food were ranked as the top four needs among all respondents (see Figure 2). This aligns with the convergent and salient themes identified in a study by Dys, S., et al., (2021) in which participants in a 2013 survey named financial insecurity, age discrimination, employment and health, and interpersonal relationships as the main subjects influencing their perceived risk of future homelessness. Similarly, in a recent Age+ report (2022), the three primary factors cited as contributing to housing stability challenges for older adults were cost, location, and suitability.

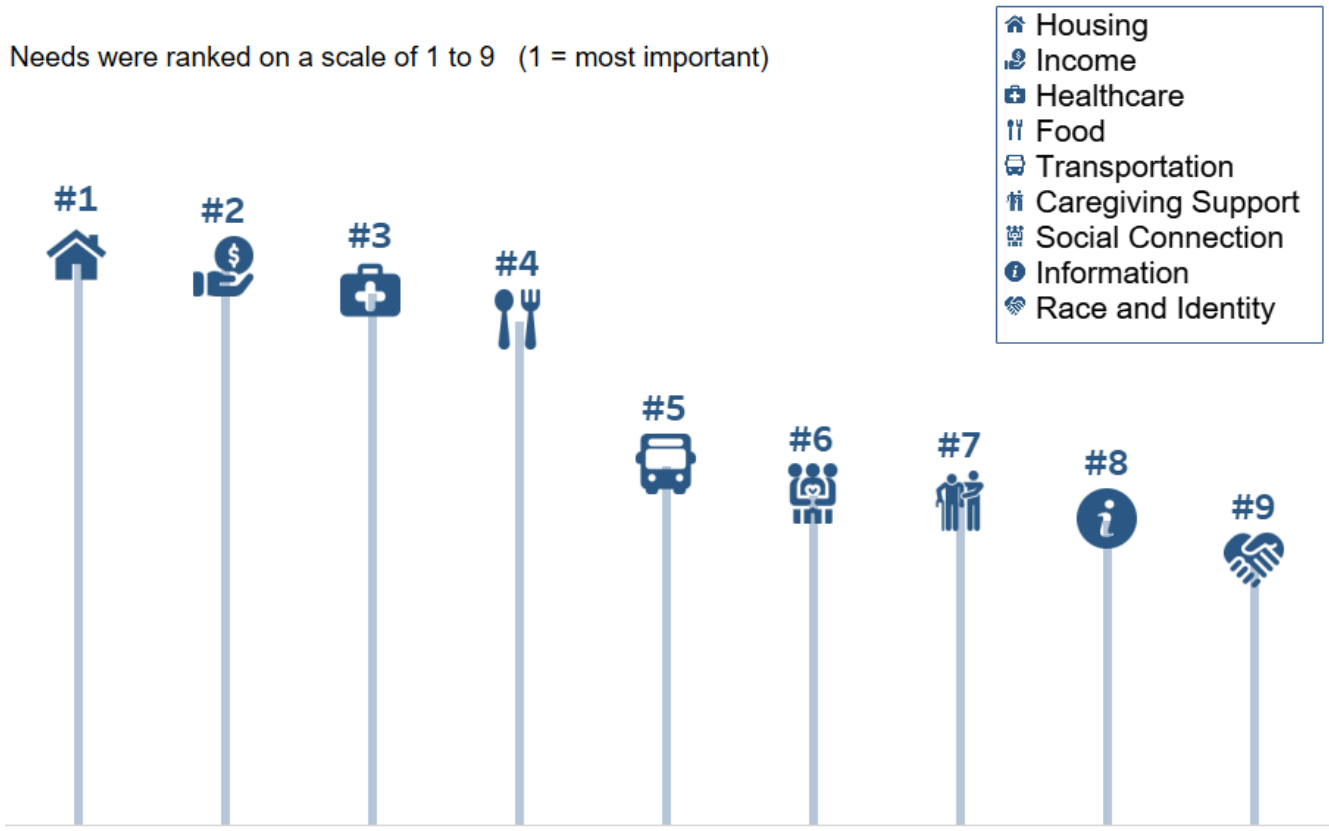


Figure 2. 2021-2025 Area Plan needs assessment. Source: ADVSD 2021-2025 Area Plan.

While the option to age in place might be the goal of a large part of the population, the median age of single homeless adults in the U.S. went from 37 in 1990 (Hahn et al., 2006) to approximately 50 in 2010 (USICH, 2010; Culhane et al., 2013). However, those born between 1954 and 1964 are at increased risk for homelessness in comparison to other age cohorts (Brown, et al., 2013, Culhane, et al., 2013).

In the world of aging services, there is a strong emphasis on *Aging in Place*. Aging in place is defined as having choice and determination as to where you live as you grow older. Essential to that, apart from sufficient income and affordable housing costs, is having access to health care, transportation and, if needed, services to support activities of daily living. This becomes a nearly impossible proposition for someone who is living in unstable housing situations, such as, in a motel, in a shelter, or living outside.

Housing is a foundational protective factor for all people. Housing as a protective factor interlaces with health, access to education and employment opportunities, and mitigates exposure to certain types of violence (Tong et al., 2021). It is widely accepted that there is a relationship between housing and health (Stone, 2018). For example, populations experiencing homelessness, housing instability, or living in temporary or diverse housing environments (e.g., living in a motel or shelter) also experience *accelerated aging* (Cohen, 1999; Gelberg, et al., 1990). Accelerated aging manifests in the

occurrence of geriatric conditions traditionally associated with housed adults 20 years their senior (Brown et al., 2016). Adults aged 50 to their early 60s that are experiencing homelessness exhibit geriatric conditions found in housed older adults aged 65-70 (Pleis et al., 2010). These conditions include memory loss, falls, difficulty performing activities of daily living, and urinary incontinence (Gelberg et al., 1990).

The term activities of daily living (ADLs) first appeared in a 1950 paper by Sidney Katz assessing self-maintenance. These activities are then separated into basic ADLs and instrumental ADLs as described in Edemekong, et al., 2022.

Basic Activities of Daily Living (ADLs)

- Ambulating,
- Feeding,
- Dressing,
- Personal hygiene,
- Continence, and
- Toileting.

Instrumental Activities of Daily Living (IADLs)

- Transportation and shopping,
- Managing finances,
- Shopping and meal preparation,
- House cleaning and home maintenance,
- Managing communication with others, and
- Managing medications.

The decline in the ability of the older population to independently perform either level of ADLs can be derived from different causes such as the natural process of aging; neurological, circulatory, musculoskeletal, or sensory conditions; side effects of medications; social isolation; or the person's home environment (Farias., et al., 2013; Chu et al., 2020, Edemekong, et al., 2022). Sands, et al., reported that acute illness and the resulting acute hospitalization is associated with the loss of ADL functions. In a study by Civinsky, et al., where patients were evaluated prior to and after hospitalization it was concluded that several older people are discharged with a diminished ADL function compared to their initial baseline function (Edemekong, et al., 2022).

Housing costs are among the largest expenses for households, especially for older adults and people with disabilities living on fixed or low incomes. We can reasonably conclude that additional expenses, especially due to health, would have a significant impact on the stability of this population's housing and ability to continue to live

independently. A current measure used to identify the level of income that a family or an individual adult would need to cover the cost of the basic necessities such as housing, childcare, food, health care, transportation, miscellaneous items, as well as the cost of taxes, is the self-sufficiency standard for Oregon (Kucklick & Manzer, 2021).

In 2019, the *Poverty in Multnomah County Report* identified that 34% of Multnomah County households fell under the self-sufficiency standard calculated for 2017, which indicated that an adult would need an annual income of $25,360 ($12.01 hourly.) to meet basic needs (Pearce, 2017). For 2021, it was estimated the same adult would need $31,521 annually or $14.92 hourly to meet basic needs. This estimate represents an increase, between 2017 and 2021, of $6,161 in the annual income needed for an adult to meet the self-sufficiency standard (Kucklick & Manzer, 2021). The report on the *State of Aging in Portland* from 2021 found that older adults living in rental apartments are burdened with rent being approximately 35% or more of their income (DeLa Torre, et al., 2021).

When discussing the impact that income has on a person's ability to age in place and have stable housing, it is important to highlight pay and racial disparities between the populations belonging to different racial and ethnic groups. In addition to race and ethnicity, another factor associated with disparity in pay rate and earning potential is gender. Fontenot et al., (2018) reported that in 2017 across the U.S. women working full-time and year-round earned 20% less than men with similar working parameters. That is, for every dollar a man earns, a woman earns $0.80 (AAUW, 2018). In Oregon specifically, the American Association of University Women (AAUW) reported (2020) that in 2019 Oregon men made an average of $55,654 annually compared to $44,634 for women, which resulted in a $11,020 difference in annual pay—a 20% earning gap.

As we consider the gender pay gap, we need to consider the effects of the systemic racism still present in hiring and promotion practices. Although there is a sense of increased awareness of racism and its impacts in the U.S., Quillian, et al., (2017) performed a meta-analysis of racial discrimination in hiring practices in the U.S. specifically as experienced by African Americans and Latinos from 1989 to 2015. This analysis concluded that there was not a significant change in the respective levels of discrimination over that timeframe. It is also reported that even as overt or explicit prejudice seems to have declined over time, implicit bias and stereotype measures show little change over the recent decades (Devine P., Elliot, A, 1995; Dovidio J. & Gaertner S., 2010). This also brings us to the conclusion that rather than racial bias having disappeared from certain scenarios vital to one's livelihood, it has morphed into being more subtle, covert, and contingent (Dovidio J. & Gaertner S., 2010; Bonilla-Silva E, 2006).

Understanding the impact that these disparities have long-term, not only on the ability of a person to earn during their working years, save for retirement, and procure a long-term home, but also after retiring, on their ability to afford rent or maintain their home in their preferred location constitutes a more extensive body of work than what this report aims to achieve as part of the present request. As such, we would like to acknowledge that earning capacity and its long-lasting impacts over the life of a person are diverse and multilayered. Additionally, many of the challenges faced by different races might be inherent to that specific group, for example certain conditions might be more predominant in one race versus another, and their earning potential play a role in the successful resolution of such conditions. In figure 3 we observe the race distribution in Portland aged 65+, bringing forward some of the diversity observed, and at the same time, the knowledge that different communities have shared and individual challenges.

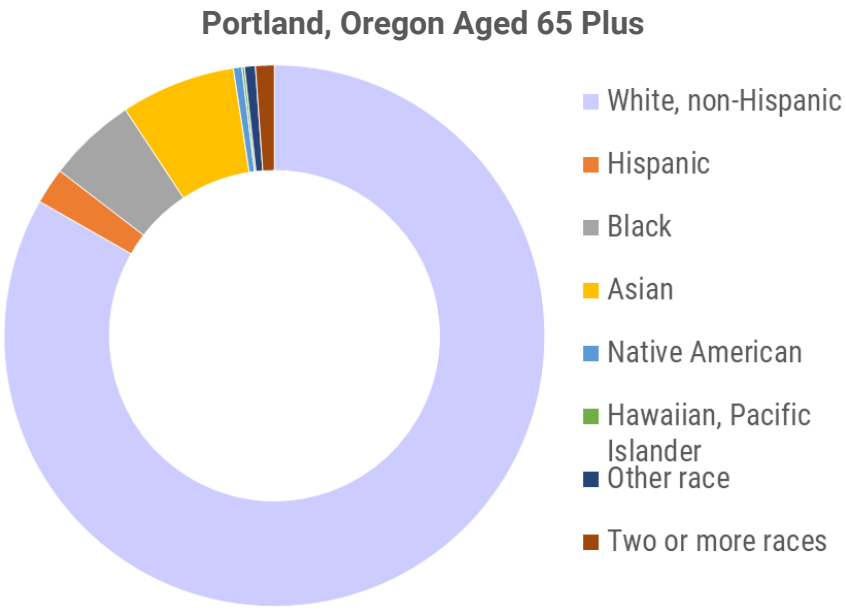


Figure 3. Race distribution of people 65 and older in Portland, Oregon as reported in the American Community Survey, 2013-2017. As this chart shows, non-White groups in the 65+ bracket, both individually and collectively, represent a minority of the population. (DeLa Torre, et al., 2021)

Multnomah County

In Multnomah County, homelessness among people 55 and older is on the rise. According to the *2013 Multnomah County Point in Time report*, 13% of the homeless population were between age 55-69 and 1% were over the age of 70. According to the *2022 Point in Time report*, those percentages increased to 22.5% and 2.4% respectively. It is important to note that nearly half of the people over 70 said they were unsheltered; this reinforces the urgency of ensuring that we have housing and shelter programs that effectively serves this considerably older and vulnerable population.

Similarly, the percentage of homeless individuals living with a disability jumped from 53% to 65% between those same years.

There is also a growing racial disparity in the homeless population. The percentage of unhoused people who are people of color increased between 2019 and 2022 (36.1% to 38.5%), while the percentage of people who are both unhoused and who identified as non-Hispanic White decreased (59.0% to 52.8%).

5. Discussion and Business Questions

5.1. Identify the services needed for older adult households, as well as the number of older adult households that could potentially be served

Multnomah County's Aging Disability and Veterans Services is classified as a Type B Transfer Area Agency on Aging (AAA) (DHS, 2023). Type B Transfer AAAs administer the OAA, OPI and Medicaid, financial services, SNAP, adult protective services and regulatory programs for older adults and people with disabilities. As such, most of the work is administering services to those qualified according to APD (Aging & People with Disabilities), including the restrictions for funding and quantity of clients. The difference between the number of clients served and the eligible population is considered in this report as a possible gap for the number of older adult and/or disabled households that could be served. We understand that the full count of this population might not need our services. However, we will use this as an approximation.

ADVSD does not currently have a research project to identify the specific number of people or households that could be served. However, this report will present information from different bodies of work and available data to represent this population as well as possible. This will be completed by showing different sources of information about the population of Multnomah County, community feedback from a needs assessment completed for the ADVSD Area Plan; the waitlist for Community Services (CS) program; Aging and Disability Resource Center (ADRC) calls with the top 25 identified needs by callers; and finally a report on the population served through Oregon Project Independence (OPI), Long Term Services and Supports, and Community Services provider partners.

If a more in-depth analysis of the possible service population is desired, we would like to raise the need of funding to establish a project with a duration of approximately three to four years with dedicated support staff and a minimum of one researcher.

5.1.1. Studies and Research on Population

In this section we discuss the population growth trends among older adults using 5-year population estimates from the American Community Survey (ACS). Both 5-year and 1-year estimates are provided in Table 3. ADVSD considers its serviceable population to include adults age 65+, adults 18+ with disabilities, and veterans. Multnomah County's total population was estimated to be 788,459 in 2017, of which 96,693 were aged 65 and older, 95,990 were aged 18 years and older with a disability, and 39,407 were veterans. In 2021, the total population was estimated to have increased to 810,011, of which 155,170 people were 60+ and 109,753 were 65+. A more recent study by Portland State University (2022) estimated the total population for 2022 to be 810,242, roughly in line with the ACS 5-year estimate for 2021.

This data suggests that the population that is most likely to benefit from ADVSD's services is growing. Although population trends and forecasts vary, the number and percentage of older adults living in the Portland metro region are expected to increase at greater rates than the rest of Oregon and the U.S over the next two decades.

Utilizing data from the American Community Survey, our 5-year estimate for poverty in Multnomah County for people age 60+, 65+, and 60-64 years are represented below in table 2. We estimate 12.7% of the county's total population is living below 100% of the federal poverty level (FPL). Among those aged 60+,11.2% (over 17,095 people) are below 100% FPL. For the 65+ population this percentage decreases to 10.1% below 100% FPL. Although more study is needed to determine the reason for this decrease, traditionally this is the age when social security and other benefits become available for the 65+ population which might have a positive, if small, impact on their income.

Table 2. 5-year estimates for poverty status in Multnomah County

5-year estimates for Multnomah County **Poverty status in the past 12 months – based on federal poverty level (FPL)**	Total	60+	65+	60-64**
*Population for whom poverty status is determined	795,930	152,636	107,553	45,083
Percent below 100% FPL	12.7%	11.2%	10.1%	13.8%
Percent between 100–149% FPL	7.6%	7.4%	8.0%	6.0%
Percent at or above 150% FPL	79.7%	81.5%	81.8%	80.8%

**Calculations derived from finding the difference between 65+ and 60+ estimates. Estimates have higher margins of error due to multiple calculations using available rounded numbers and percentages.

Table 3 shows the estimated serviceable population age 65+, adults with disabilities 18+, and veterans for the year 2021.

Service population estimates for adult aged 65 plus		
Source: 2021 American Community Survey Data	**1-year estimates**	**5-year estimates**
Total population	803,377	810,011
People age 65+	115,226	109,753
*People with disabilities 18+	102,864	93,564
Veterans	35,007	35,054
Total Duplicated count of serviceable population in Multnomah County for ADVSD	**253,097**	**238,371**
*People with disabilities 65+	38,942	35,921
**Veterans 65+ without disabilities	9,534	10,363
**Veterans <65 with disabilities	3,558	3,871
Total unduplicated count of serviceable population in Multnomah County for ADVSD	**201,063**	**188,216**

* Results may reflect a slight undercount because the denominator includes only people with disabilities among the total *civilian noninstitutionalized population* instead of the total population of Multnomah County.
** Results reflect a slight undercount because the denominator includes only the *civilian population 18 years and over for whom poverty status is determined*.

5.1.2. Multnomah County Needs Assessment Area Plan 2021 - 2025

ADVSD developed and built an online survey tool to learn from older adults and people with disabilities about their lives, experiences, needs, and priorities related to services. For the purposes of the survey, an older adult is defined as a person 50+ or an elder as defined by their community. The survey also sought participation from people with disabilities 18-59 years of age. The survey was offered in 17 languages. The analysis included 1,392 responses. The full methodology for this project can be found on ADVSD's Area Plan webpage located at: https://www.multco.us/ads/2021-2025-advsd-area-plan.

Below are some examples of needs identified in the community from the survey.

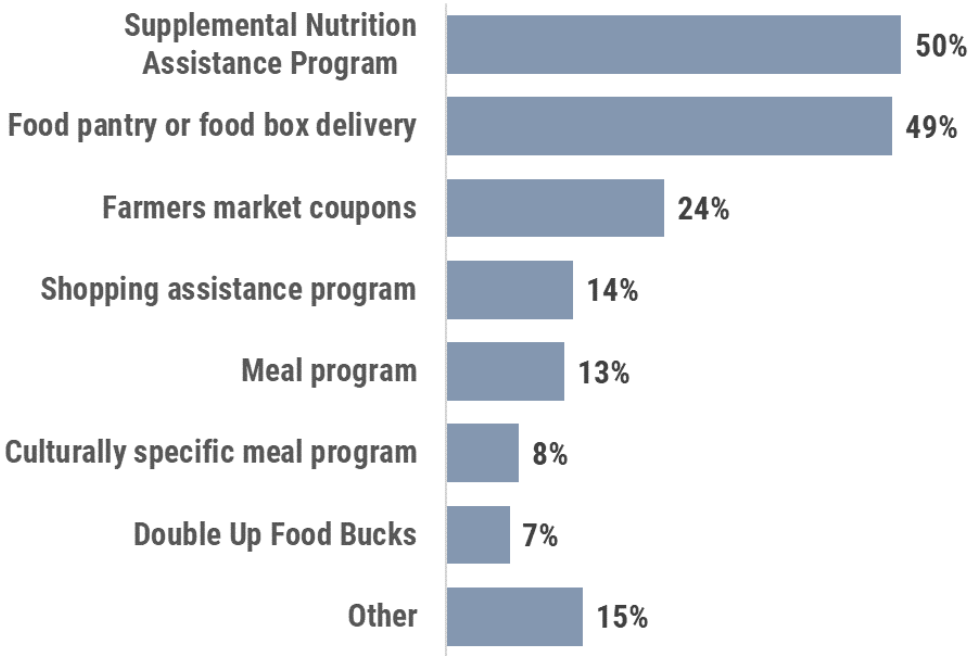
A. What we learned from community members through the needs ranking exercise:
   - Income, housing, food, and healthcare were resoundingly ranked among the top four needs among all respondents to the survey.
   - Transportation remains a high need among the overall population of respondents.

B. Other important needs not included in the ranking activity identified by community members:
   - Improved safety and sense of security.
   - Employment opportunities and support.
   - Greater access to public spaces, especially parks and other green spaces.
   - More technology training and ways to access information for those who do not use technology.

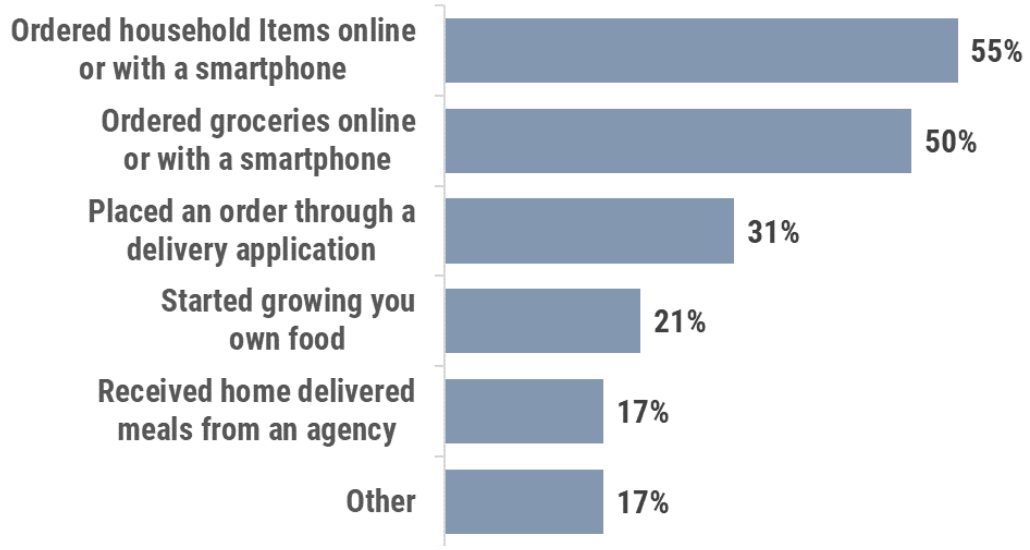
Additional information from the survey related to food, income, housing, social connectedness, and caregiving are brought forward for consideration. We hope this information will offer a better understanding of community member needs.

FOOD

We asked people which food assistance programs they used over the past year (2020): (Percent out of 804 responses. Respondents could select multiple answers.)



We asked if community members have done any of the following for the first time since the COVID-19 pandemic started in March 2020: (Percent out of 950 responses. Respondents could select multiple options.)

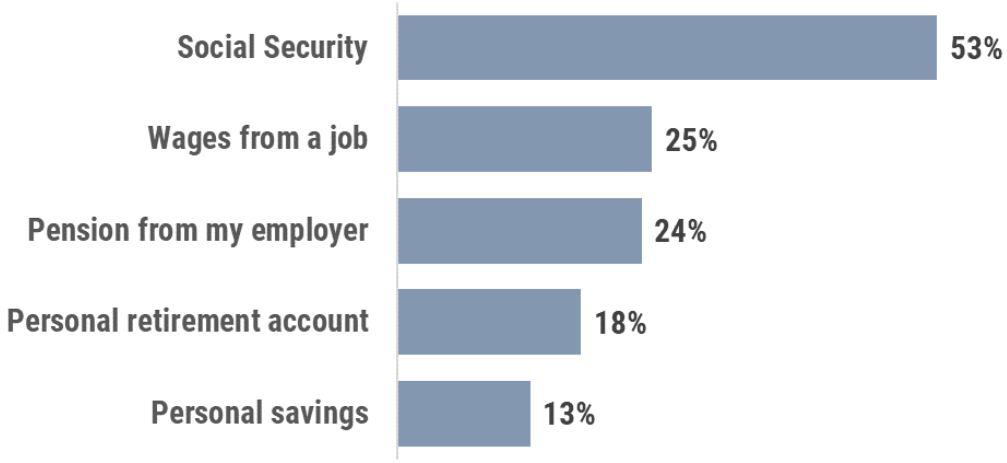


INCOME

We asked community members to share their monthly income: (% out of 1,170 responses)

Income	Federal Poverty Level 2020	Percent of respondents in income range*
$530 and less	50% or under	8%
$531 - $1,063	51 - 100%	24%
$1,064 - $1,966	101 - 185%	24%
$1,967 - $2,127	186 - 200%	11%
$2,128+	201%+	34%

Top 5 sources of income: (Percent out of 1,185 responses)



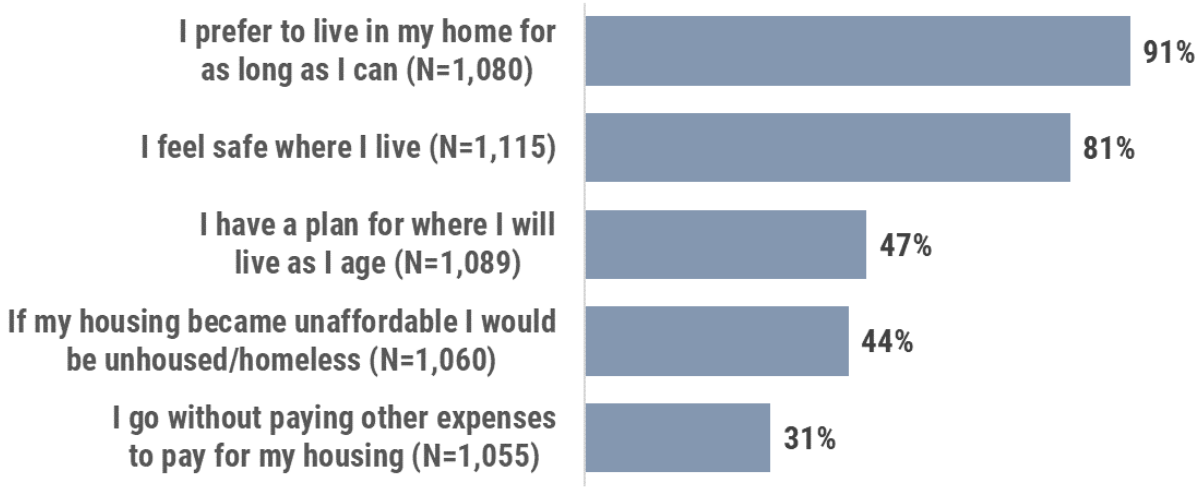
Other sources of income mentioned include income from self-employment and informal jobs, unemployment benefits, VA benefits, SSI, SNAP, and rental income.

What we learned from comments shared by community members about their income or retirement needs:

- Income, savings, and social safety net programs are insufficient and are not keeping up with the increasing cost of living.
- Many subsist on fixed incomes, social services, and rely on part-time or *gig* work to supplement their income and afford their basic needs.
- People must make difficult choices prioritizing which of their basic needs to meet.
- Many existing challenges have been aggravated by the impacts of the COVID-19 pandemic.

HOUSING

We asked people to share their level of agreement with the following statements about their housing. (Percent out of "N" responses which indicated *strongly agree* or *agree* to each statement.)



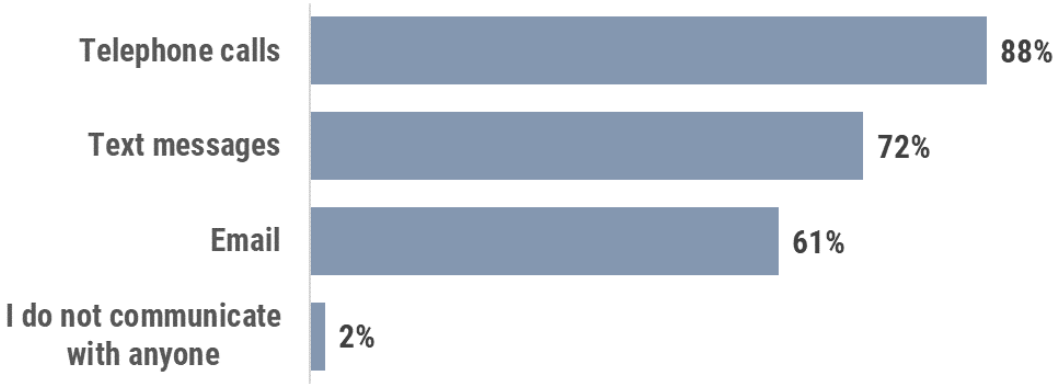
Additional feedback on community housing situations and needs:

- Many older adults are housing insecure and would not know what to do if their cost of living increased or housing situation changed.
  - The main source of instability is increased rent or property taxes causing unaffordable housing.
  - The assistance older adults receive is vital to maintain their housing security but affordability is still an issue.
- The cost of housing is a primary concern for many older adults.
  - A large portion of income goes towards housing.

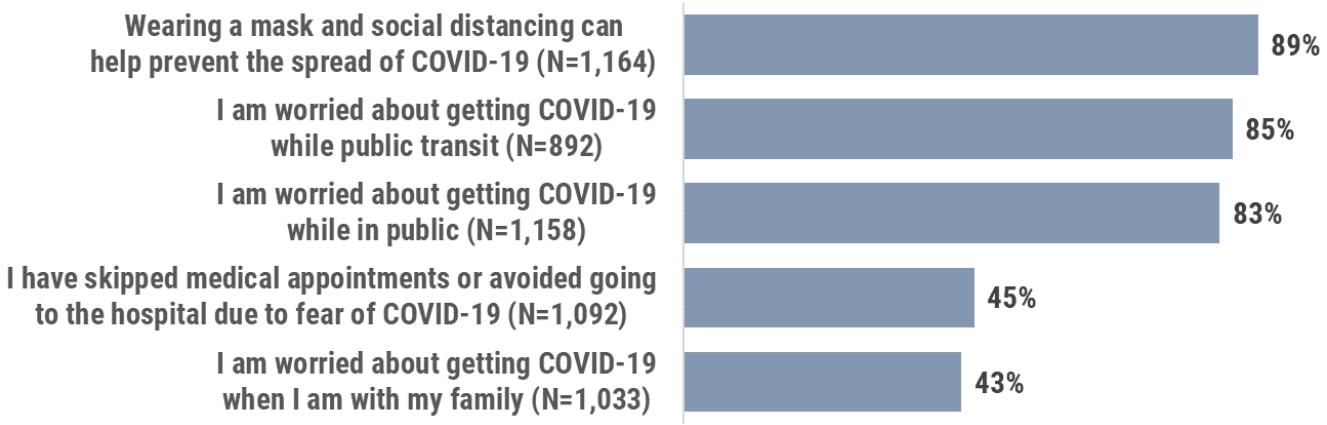
  - Older adults on fixed incomes struggle with increasing housing costs.
  - Homeowners are concerned about the affordability of increased property taxes while renters are concerned about the affordability of increased rents.
- Housing conditions are not suitable for older adults.
- Receiving assistance with cost or space to live.
- Concerns about safety.

Social Connectedness

We asked people to share the ways they prefer communicating with friends, family, or neighbors. (% out of 1,174 responses. Respondents could select multiple options.)

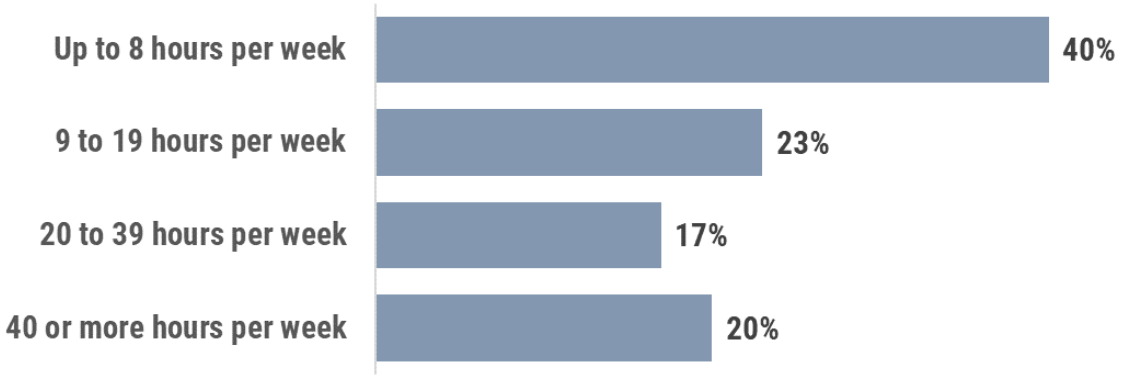


We asked people to share their level of agreement with the following statements about COVID-19. (Percent out of "N" responses which indicated "*strongly agree*" or "*agree*" to each statement)



CAREGIVING

We asked people to share the number of hours they provide care in an average week. (Percent out of 354 responses)

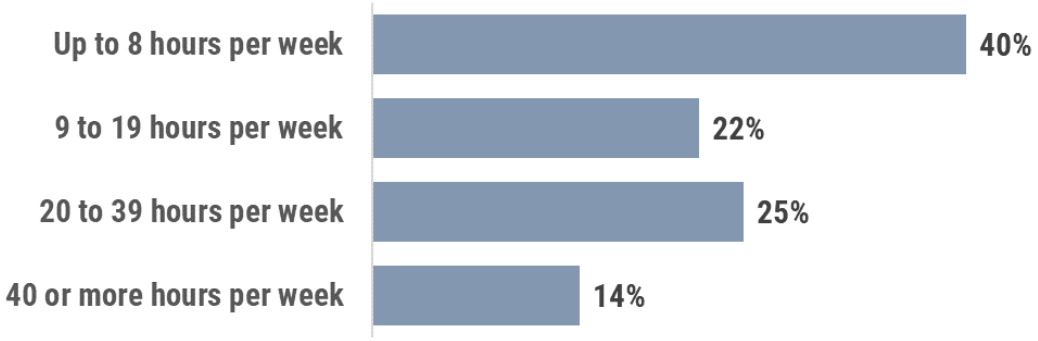


What we learned from the community about Caregiving:

- Caregivers primarily cared for a partner, spouse or significant other (25%), a parent or parent-in-law (22%), a child (20%), or a family friend or chosen family member (14%). (Percent out of 374 responses)
- Time spent caregiving since the start of the COVID-19 pandemic increased for 44% of caregivers, stayed the same for 40% of caregivers, and decreased for 15% of caregivers, resulting in a net increase in hours spent caregiving for 29% of caregivers. (Percent out of 364 responses)

CARE RECEIVING

We asked people to share the number of hours they received care in an average week. (Percent out of 232 responses)



What we learned from the community about receiving care:

- 51% of those receiving assistance or care did so from a paid caregiver. (Percent out of 258 responses)
- Recipients received most of their care from a professional caregiver or nurse (25%); a partner, spouse or significant other (19%); a child (18%); or a family friend or chosen family member (14%). (Percent out of 261 responses)
- Care needed since the COVID-19 pandemic increased for 29% of care recipients, stayed the same for 61% of care recipients, and decreased for 9% of care recipients resulting in a net increase in care needed for 20% of care recipients. (Percent out of 238 responses)

Positive feedback from community members about the care they received:

- Caregivers provide the help needed with tasks of daily living, especially help allowing some to continue living independently at home.
- Caregivers provide needed human attention and connection.
- Caregivers approach their work as a vocation and provide high quality, caring service.
- Receiving care from trusted family members and friends is appreciated.

Feedback about what should be changed about the care community members received:

- Increase the number of hours and help provided by caregivers.
- More care and support, especially in the areas of daily needs and home improvements.
- More reliable and consistent caregivers and service.
- Better communication and coordination being caregivers and other service systems.
- Improve caregiver selection and training.
- Increase compensation and support for caregivers.

5.1.3. JOHS homeless prevention information for fiscal years 2020 – 2022

The JOHS tracks the total people enrolled in homelessness prevention programs (Figure 4A) and the number of people newly enrolled in prevention programs (Figure 4B). The clear trend is that both counts of people grew significantly between fiscal year 2020 (FY20) and fiscal year 2022 (FY22). From this information we can observe that the total count of people enrolled in homeless prevention programs grew by approximately 3.5 times (28,240 people) from FY20 to FY21, and an additional 8,820 people from FY21 to

FY22. A similar growth trend can be seen in the information reported for people newly enrolled in homelessness prevention programs (Figure 4B).

This information can also be analyzed in terms of age group breakdown (Figure 5). For example, we observe that from FY20 to FY22 the share of the population under 18 decreased each year, and by around 3 percentage points overall. At the same time, we observe consistent increases in the population shares for the 18-24, 25-44, and 45-54 age groups. Meanwhile, the population shares for the 55-69 and 70+ age groups each decreased from FY20 to FY21, and then grew from FY21 to FY22. We offer the consideration that the COVID-19 pandemic may have affected these populations differently than those of lower age brackets. For example, the multiple support programs and moratoriums on evictions established by the government during this time may have had different and unintended impacts for different age groups.

Additionally, we observe the changes on the population enrollment through their reported race and ethnicity, while overall, we see an increase of over 2% in the BIPOC population between FY20 and FY21, we also see a decrease of approximately 1% between the following FY21 and FY22 (Figure 6). This trend seems to repeat in some categories such as non-Hispanic white, and African, Asian or Asian American, Hispanic or Latinx. While other categories such as Black, African American seem to continue in an upward trend through FY20-FY22. What is also interesting from a research perspective is that the Native American, American Indian, Alaska Native or Native, Middle Eastern and Slavic show a consistent decrease from FY20 to FY22. The reason for this decrease is not known. We would need additional funding to determine if there are other external factors offering support to these communities, such as tribal and/or government support, non-profit work, etc.

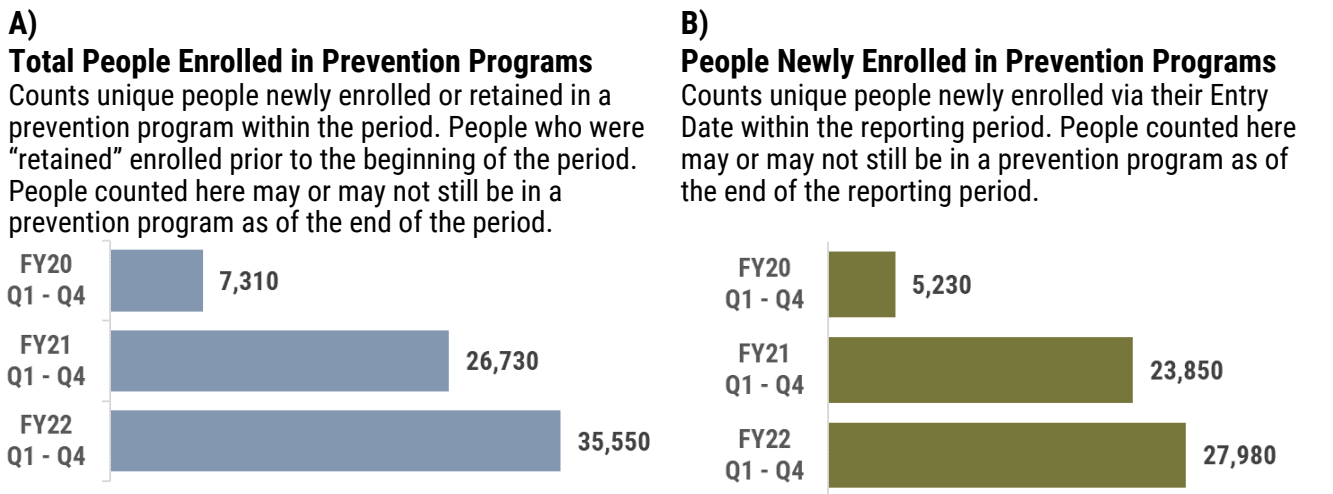


Figure 4. A) The total count of people enrolled in prevention programs experienced a marked increase from FY20 to FY22. B) The count of people newly enrolled in prevention programs at JOHS also increased significantly from FY20 to FY22.

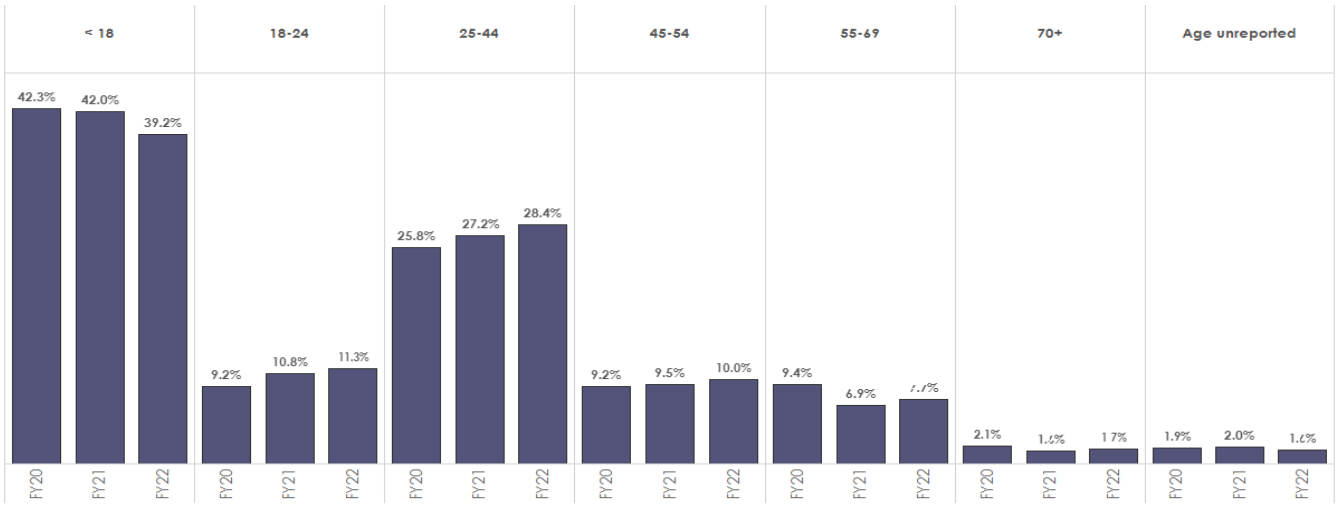


Figure 5. Shows the breakdown by age group for FY20 to FY22 in homelessness prevention programs.

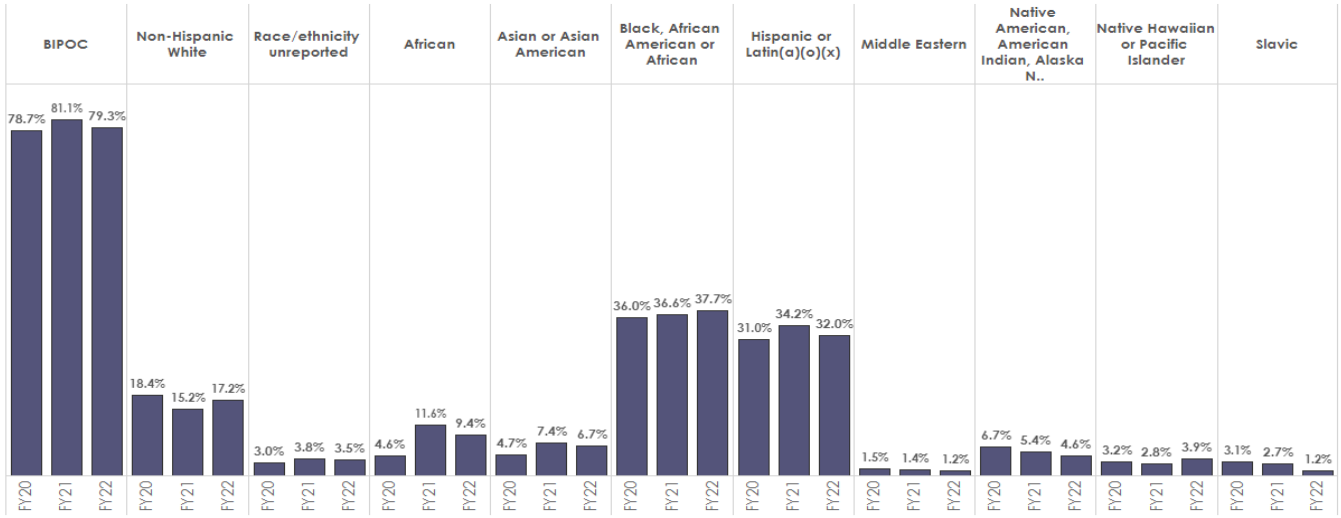


Figure 6. Shows the breakdown by race and ethnicity for FY20 to FY22 in homelessness prevention programs.

Current FY23, quarter 1 reporting shows the total people enrolled and people newly enrolled in homeless prevention programs to be below quarter 1 from FY22 (Figures 7A, 7C). It is also evident that in the comparison of Q1 for FY20-FY23 the current FY23 Q1 count is falling in between the FY21 and FY22 Q1s (Figures 7B, 7D). While this is only one quarter of reporting, it would be interesting to see if this trend continues throughout the remainder quarters or if they increase to surpass FY22 in the final count.

The distribution by age group for FY23 Q1 also shows over 70% to be under 45 years of age, with the remainder being 9.8% in the age bracket 45-54, and 7.6% in 55-69 age with a 2% for 70+ (Figure 8). From these distributions we see that 79.9% of people identified as BIPOC, with the highest ethnicities reported being Hispanic or Latinx, Black, African American, non-Hispanic white, and followed by African, Asian or Asian

American, Native Hawaiian or Pacific Islander, Native American, American Indian, Indian, Alaska Native, Slavic and Middle Eastern (Figure 9).

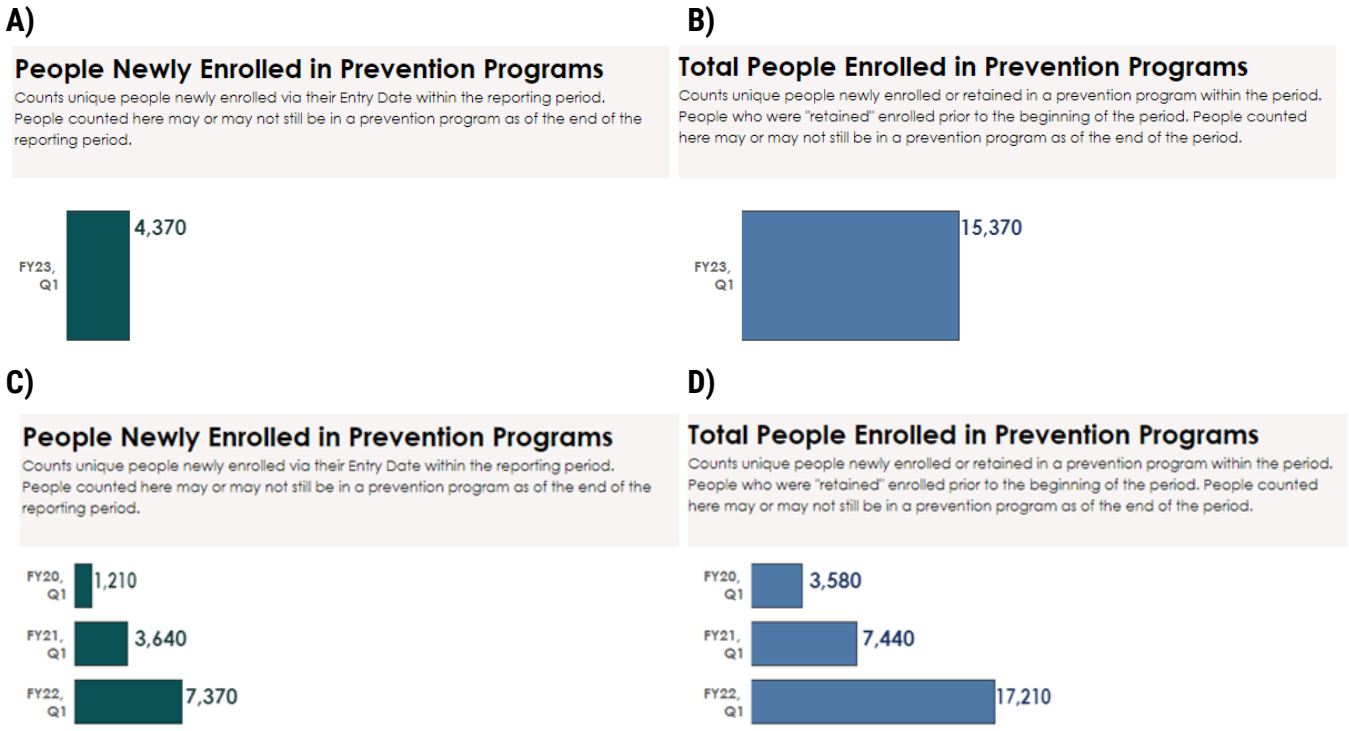


Figure 7. Shows the Q1 reporting for FY23 of A) Newly Enrolled, and B) Total People enrolled. C) FY20-FY23 for newly enrolled people in homelessness prevention programs and D) Total people enrolled in homelessness prevention programs.

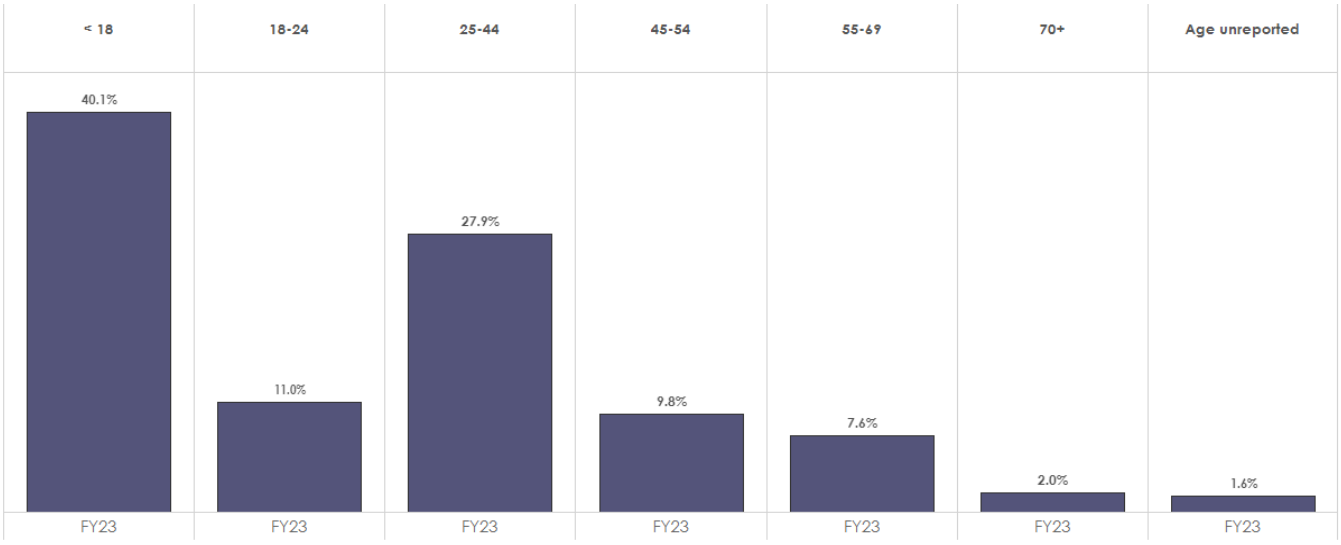


Figure 8. Shows the Q1 reporting for FY23 for total enrolled people in homelessness prevention programs by age bracket.

Demographic by race ethnicity

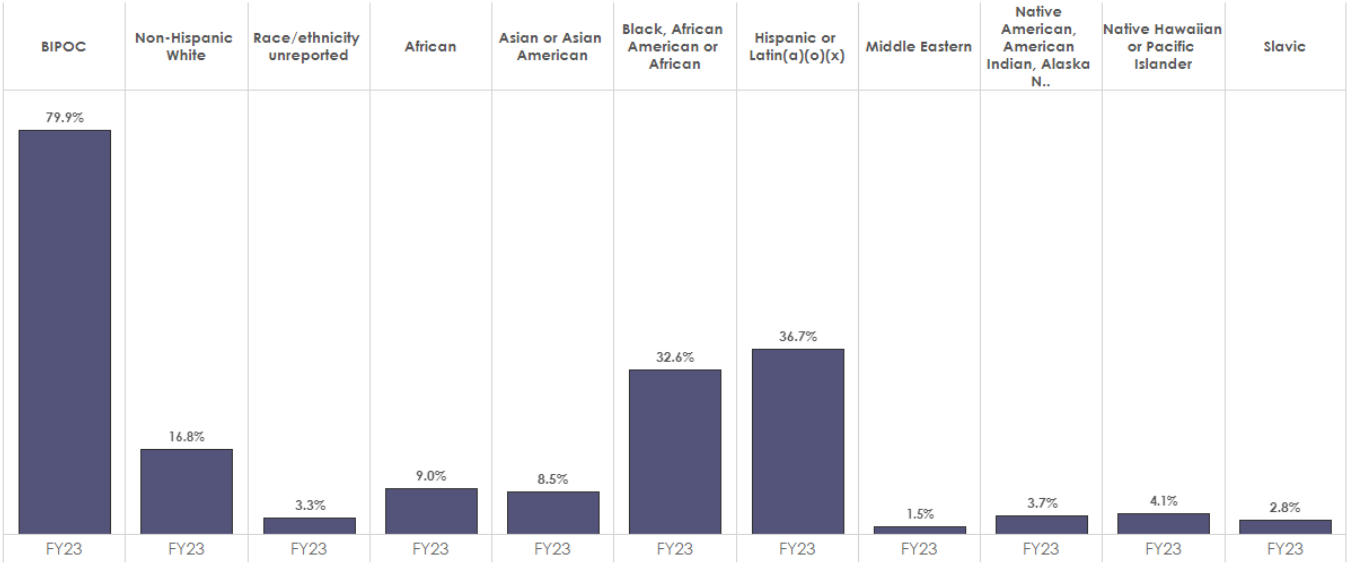


Figure 9. Shows the Q1 reporting for FY23 for total enrolled people in homelessness prevention programs by race and ethnicity.

5.1.4. ADRC (Aging and Disability Resource Connection)

The ADRC is considered as a single point of entry, in Oregon this is part of the *No Wrong Door* system. This resource is available 24/7 through phone and email. They are able to help the Multnomah county population with referrals to enrolling in government programs, searching for resources, investigating possible abuse, finding guardianship services, locating adult care homes, connecting with culturally-specific services and support for unpaid family caregivers.

This section presents the partial information for FY22 (7/1/22 – 2/28/22) that is available. Please note that due to the implementation by the State of *REALD* (Race, Ethnicity, Language, and Disability) in *GetCare* interrupted the data mart jobs.

Table 4 shows the counts of consumers that contacted the ADRC with specific needs, as shown in the *Need Category* section. This table excludes the referrals back to the ADRC to avoid double-counting of the same person. From this table it is possible to observe that the contacts of consumers under 60 years, doubles as the age bracket increases to 60-74 to then decrease again at the 75+ age. We can also observe that the number of referrals multiplies as some consumers might get multiple referrals per contact.

In this table we can also see that the consumers in the 60-74 age bracket contacted the ADRC in the following general categories more often: health and wellness; crisis support, legal services and safety; food; Medicare; Medicaid and other insurance; and community support and recreation. Similarly, for those 75+, the top calls were health and wellness; food; crisis support; legal services and safety; community support and recreation; Medicare, Medicaid and other insurance.

Equally important are the remainder of the callers that identified financial assistance, family caregivers and in-home services, transportation, veterans, disability services and supports, and employment and education as the reason for calling.

Table 4: ADRC providers included in this report: 211info, Asian Health and Service Center, El Programa Hispano, Friendly House Inc., Hollywood Senior Center (dba, Community for Positive Aging), Immigrant and Refugee Community Organization (IRCO), Impact Northwest, Multnomah County Aging, Disability, and Veterans Services, Urban League of Portland, YWCA of Greater Portland
Report Excludes: Referrals back to ADRC and referrals where no Need Category was specified

	# Consumers				# Contacts				# Referrals			
Need category (general) Totals exclude referrals back to ADRC	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**
Health and Wellness	631*	1,551	1,145	285	750**	3,273	2,625	285	887***	3,902	3,040	330
Crisis Support, Legal Services and Safety	626	1,035	560	180	824	1,338	735	181	1,046	1,592	894	204
Food	480	1,028	633	93	562	3,276	2,884	93	648	3,465	3,125	109
Medicare, Medicaid and Other Insurance	302	1,193	433	274	386	1,648	556	274	445	2,007	651	296
Community Support and Recreation	453	893	541	219	535	1,418	858	219	573	1,510	945	257
Financial Assistance	352	734	237	112	491	1,031	338	115	706	1,273	390	164
Housing	328	599	253	127	383	719	282	127	866	1,408	491	225
Family Caregivers and In-Home Services	281	409	386	162	330	487	475	162	457	623	653	225
Transportation	60	200	198	22	64	248	240	22	75	311	290	37
Veterans	11	46	40	8	12	52	42	8	19	71	48	11
Disability Services and Supports	41	35	18	10	43	35	19	10	58	43	28	10
Employment and Education	26	27	11	11	26	30	13	11	46	42	22	17
Total	**2,518**	**4,909**	**2,696**	**1,309**	**3,737**	**10,272**	**6,475**	**1,315**	**5,826**	**16,247**	**10,577**	**1,885**

How to read this table:

*631 unique consumers ages 0-59 contacted the ADRC helpline one or more times during the report range and indicated that they needed health and wellness services.

**The ADRC handled 750 contacts (calls or emails) in the report range where a consumer aged 0-59 needed health and wellness services.

***During the report range, the ADRC provided 887 referrals for health and wellness services to consumers aged 0-59.

Note: Totals will not equal the sum of all subtotals because consumers can have multiple need categories per contact and multiple referrals per need category. there can also be more than one consumer per contact.

Note: Consumer age is based on age as of the report range end date (2/28/2022).

To get a better understanding on these needs, we present the data by the top 25 taxonomy terms by consumer count (Table 5), with specific needs that fall within the general categories presented in table 4.

For the 60-74 age bracket we see that the Medicare information/counseling is the category with the most consumers (874), followed by case/care management (785), specialized information and referral (528). The next categories are the Supplemental Nutrition Assistance Program (SNAP), and congregate meals (nutrition sites) with 498 each, followed by communicable disease control, immunizations, vaccine information.

It is important to also note that in the 75+ age the congregate meals/nutrition sites have the greatest number of consumers (485), followed by case/care management (430), communicable disease control, immunizations, vaccine information (405), specialized information and referral (318), and Long-Term Care Options counseling (315).

When analyzing these tables through the lens of needs for continued independent living we highlight sections pertaining to these needs as: crisis support; legal services and safety; food, community support and recreation; financial assistance, housing, family caregivers and in-home services; transportation, and disability services and supports.

However, table 4 might not show the full extent of relevance since the general classification may be too broad. In the specific 25 taxonomy of table 5 it is more clear to see the services related to independent living, such as: SNAP, congregate meals/nutrition sites, Long-Term Care Options counseling, utility service payment assistance, personal care, legal counseling, rent payment assistance, low income/subsidized private rental housing, senior ride programs, housing search assistance, caregiver training, family caregiver subsidies, and low cost home rental listings.

Table 5. Shows the calls to the ADRC by the 25 taxonomy terms by specific consumer count.

	# Consumers				# Contacts				# Referrals			
Top 25 taxonomy terms by consumer count (specific) Totals exclude referrals back to ADRC	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**	**Age <60**	**Age 60-74**	**Age 75+**	**Age unknown**
Case/Care Management	534	785	430	103	637	1,142	655	103	641	1,146	656	111
Medicare Information/Counseling	128	874	269	108	180	1,215	348	108	204	1,355	375	127
Specialized Information and Referral	293	528	318	131	342	908	552	131	349	916	557	134
Food Stamps/SNAP	444	498	119	71	517	580	140	71	557	628	152	79
Medicaid Applications	294	396	221	221	337	443	232	221	352	452	234	224
Congregate Meals/Nutrition Sites	2	498	485	1	2	2,642	2,644	1	2	2,642	2,644	1
Communicable Disease Control, Immunizations, Vaccine Information	6	423	405	20	6	1,572	1,433	20	6	1,973	1,735	20
Adult Protective Intervention/Investigation & Elder/Dependent Adult Abuse Reporting	211	318	217	53	326	392	266	54	458	527	352	56
Long Term Care Options Counseling	37	255	315	17	40	316	421	17	44	318	423	17
Utility Service Payment Assistance	94	289	106	11	143	428	183	14	183	467	192	15
Medicare Savings Programs	62	301	115	20	71	329	127	20	82	368	125	21
Personal Care	67	191	213	21	77	221	251	21	145	264	346	44
Legal Counseling	12	174	122	32	12	286	185	32	13	312	206	32
Rent Payment Assistance	107	148	25	11	152	211	33	11	223	294	48	20
Low Income/Subsidized Private Rental Housing	101	145	31	12	112	157	33	12	325	410	110	47
Senior Ride Programs	26	115	119	9	30	125	124	9	30	151	138	16
Housing Search Assistance	75	144	27	15	81	156	29	15	102	185	34	25
Caregiver Training	87	49	28	84	92	49	30	84	101	49	30	85
Family Caregiver Subsidies	66	78	92	7	83	99	102	7	85	106	103	7
Senior Centers	17	76	90	13	22	108	129	13	22	114	130	14
Medicare Part D Low Income Subsidy (Extra Help) Applications	27	106	53	3	27	111	55	3	23	81	35	3
Extreme Heat Cooling Centers	0	79	81	2	0	84	94	2	0	83	94	2
Social Security Retirement Benefits	4	115	21	12	4	124	22	12	4	131	23	14
Welfare Rights Assistance	54	79	8	9	59	89	8	9	59	91	8	10
Social Security Disability Insurance	80	48	3	18	82	50	3	18	87	52	3	20
Low-Cost Home Rental Listings	39	74	20	12	40	77	20	12	50	96	21	12

5.1.5. Information on Community Services waitlist

This section shows the number of people choosing to be included in Oregon Project Independence (OPI) and the OPI Expansion that is administered by ADVSD through its Community Services program for FY22 (Table 6A) and Current 2023 (Table 6 B). For this report, we consider this waitlist as a need in the population.

Table 6A, shows the number of people divided by age brackets for FY22. In this data, we observe that the population under 60 constitutes about 26% of the total registered people, with the remainder of 74% being 60+ in age. We can also observe that the current count in table 6B for the same age brackets that the population under 60 remained the same, as well as the 60+ total population. However, we also observe a fluctuation and shift between 60-74 and 75+ if we compare the same brackets to FY22.

Table 6. Shows the OPI and OPI Expansion waitlist as captured by the community services program at ADVSD. A) Shows the OPI+OPI Expansion count for FY22, and B) Shows the OPI+OPI Expansion client count for the current 2023 period.

A)

OPI+OPI Expansion (FY22)	
Age bracket	**Client count**
Unknown	1
Under Age 60	100
Age 60-74	139
Age 75+	142
Total	**382**

B)

OPI+OPI Expansion (Current)	
Age bracket	**Client count**
Unknown	1
Under Age 60	100
Age 60-74	132
Age 75+	149
Total	**382**

An additional consideration is that this waitlist might transfer to our community partners for enrollment.

5.1.6. Population Served

ADVSD serves the needs of the population through multiple programs at different stages of their life. The services and data currently available on counts show that 9,234 people received in-home services through the FY22 period through Long Term Services and Supports (LTSS). Additionally, Community Services provided OPI to 695 clients, with most clients in the age brackets of 60-74 and 75+. For personal care and shopping 808 clients received services with those 60+ years old the majority at 714 served.

This trend can be seen in all services. Transportation had 777 clients (704 were 60+); culturally specific case management had 823 clients (803 were 60+); Meals on Wheels People had 4,441 clients (4,241 were 60+); and culturally specific nutrition services had 1,744 clients (1,712 were 60+). These numbers reflect that the majority of clients served

by ADVSD are in the older adult classification. However, this observation does not negate that clients might have other qualifying circumstances, for example being a veteran, or having a disability.

5.1.6.1. Long Term Services and Support (LTSS)

This section presents the number of consumers receiving LTSS services by the different age brackets, with a total served of 11,273, of which 2,227 were under the age of 60, with 4,358 on the 60-74 age bracket and 4,687 at the age of 75+ (Table 7).

Table 7. Shows the number of clients serviced through LTSS with 3 different age brackets.

# LTSS service consumers in FY22	11,273
Age Under 60	2,227
Age 60-74	4,358
Age 75+	4,687
Age Unknown	1

Please note that LTSS services clients that qualify under the different State and Federal guidelines. This count in no way reflects the total of the population that might need similar services. From anecdotal information we are aware that our teams experience a constant growth in the number of clients wanting support to determine eligibility and enrollment across all ADVSD branches throughout the County.

LTSS provides home delivered meals for qualifying clients. Table 8 shows the number of clients that received home delivered means in the fiscal year FY22 with the majority of clients in the age brackets 60+. This service might also help the qualifying clients to maintain some independence in living.

Table 8. Show the number of consumers/clients that received home delivered meals in the fiscal year FY22. Data was only available for calendar year 2022

# of LTSS service consumers who received home delivered meals in 2022	680
Age Under 60	173
Age 60-74	371
Age 75+	134
Age Unknown	2

5.1.6.2. Community Services (CS) report of services provided.

This section reports on the work completed by the CS program which includes administration of Oregon Project Independence (OPI) services. All reports show the information in a table format and in figure or graph form to help with the processing of information by the reader. Additionally, included here is a list of acronyms for community partners for reference: AHSC–Asian Health & Services Center; EPHC–El Programa Hispano Católico; FH SAGE–Friendly House–Sage Metro Portland; IRCO (EE)–Immigrant and Refugee Community Outreach; NARA–Native American Rehabilitation Association; NAYA–Native American Youth and Family Center; UL–Urban League of Portland.

Table 9. Shows the number of distinct clients by age bracket served by the OPI program in the period corresponding to fiscal year 2022 (June 30, 2022, to July 1, 2023). The current age indicates the point in time age of the population served when this information was query, in this case, February 2023.

FY 2022 OPI distinct **client count** by age & age on service date

Age Range	Current Age	Age On Service Date
Under 60	55	69
60-74	265	291
75+	375	335
Total	695	695

FY 2022 OPI distinct **client count** by age and age on service date

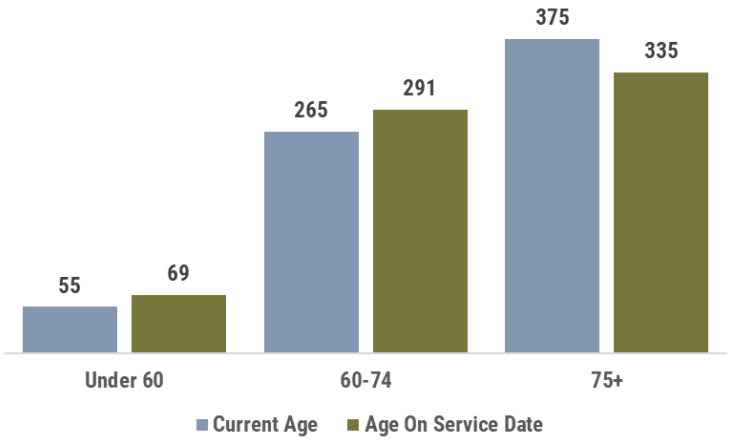


Figure 10 Illustrates the information presented in Table 9. above. In this graph we can appreciate the changes in the distribution of services by age bracket and the difference in the population between February 2023 (represented as *Current Age*), and the age brackets in fiscal year 2022 (represented as *Age on Service Date*).

Table 10. Shows the information on services provided by Community Services with three different age brackets (60, 60-74, and 75+ years of age), for the period between June 30, 2021 to July 1, 2022 (Fiscal year 2022). A) Shows the distinct client count by age on service date. This means the number of unique clients without counting repeating services to the same person. B) Shows the number of services by client age bracket, unit types are marked by service line. In this report all the units are hours of the service line.

A)

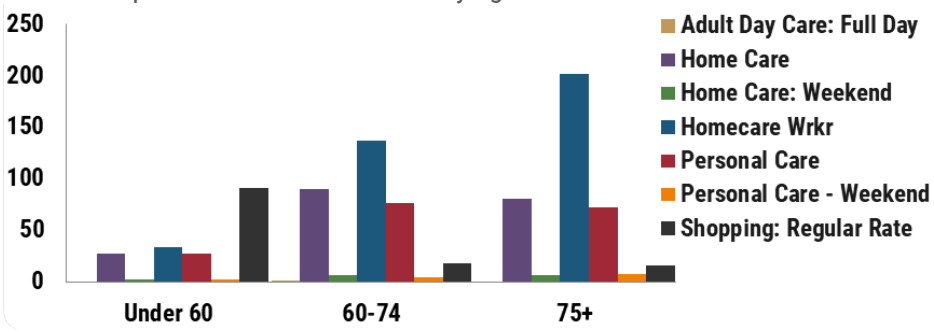
FY 2022 OPI distinct **client count** by age on service date				
Personal Care Service Code Description	**Under 60**	**60-74**	**75+**	**Total**
Adult Day Care: Full Day	0	1	0	1
Home Care	27	90	80	197
Home Care: Weekend	2	6	6	14
Homecare Worker	33	137	201	371
Personal Care	27	76	72	175
Personal Care: Weekend	2	4	7	13
Shopping: Regular Rate	3	18	16	37

B)

FY 2022 OPI **unit count** by age on service date				
Personal Care Service Code Description	**Under 60**	**60-74**	**75+**	**Total**
Adult Day Care: Full Day (Hr)	0	34	0	34
Home Care (Hr)	2,726	6,387	5,384	14,498
Home Care: Weekend (Hr)	9	254	25	287
Homecare Worker (Hr)	4,116	14,828	21,808	40,753
Personal Care (Hr)	837	2,498	2,445	5,780
Personal Care: Weekend (Hr)	3	80	20	103
Shopping: Regular Rate	129	320	530	979

A)

FY 2022 OPI personal care **client count** by age on service date



B)

FY 2022 OPI personal care **unit count** by age on service date

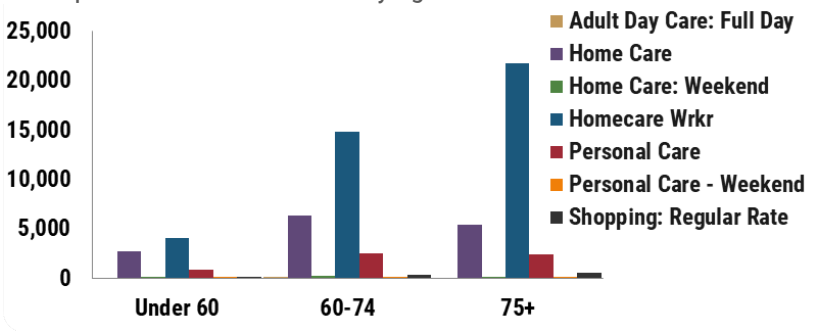


Figure 11. Shows the graphic representation of Table 10 above. A) Shows the distinct client count by age on service date. In this graph all units are clients. B) Shows the number of services by client age bracket. In this graph all the units are hours of the service line.

Table 11. Shows the information of services provided by ADVSD through the transportation program. A) Shows the unique client count by age on the service date. B) Shows the services received by clients by age bracket. Units of each service are specified on individual lines of service description in brackets at the end of the service types.

A)

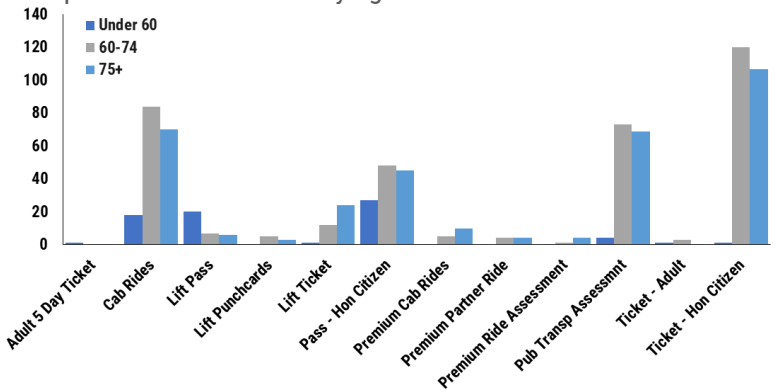
FY 2022 **client count** by age on service date				
Transportation Service Code Description	**Under 60**	**60-74**	**75+**	**Total Clients**
Adult 5 Day Ticket (Ticket)	1	0	0	1
Cab Rides (Ride)	18	84	70	172
Lift Pass (Pass)	20	7	6	33
Lift Punch cards (Ticket)	0	5	3	8
Lift Ticket (Ticket)	1	12	24	37
Pass – Honored Citizen (Pass)	27	48	45	120
Premium Cab Rides (Ride)	0	5	10	15
Premium Partner Ride (Ride)	0	4	4	8
Premium Ride Assessment (Activity)	0	1	4	5
Public Transportation Assessment (Activity)	4	73	69	146
Ticket – Adult (Ticket)	1	3	0	4
Ticket – Hon Citizen (Ticket)	1	120	107	228

B)

FY 2022 **unit count** by age on service date				
Transportation Service Code Description	**Under 60**	**60-74**	**75+**	**Total Units**
Adult 5 Day Ticket	6.1	0	0	6.1
Cab Rides	56	378	399	833
Lift Pass	228	79	46	353
Lift Punch cards	0	36	28	64
Lift Ticket	9	140	228	377
Pass – Honored Citizen	243	519	426	1188
Premium Cab Rides	0	129	365	494
Premium Partner Ride	0	20	13	33
Premium Ride Assessment	0	1	4	5
Public Transportation Assessment	4	77	78	159
Ticket – Adult	22	16.5	0	38.5
Ticket – Honored Citizen	2	853.7	849	1704.7

A)

FY 2022 transportation **client count** by age on service date



B)

FY 2022 transportation **unit count** by age on service date

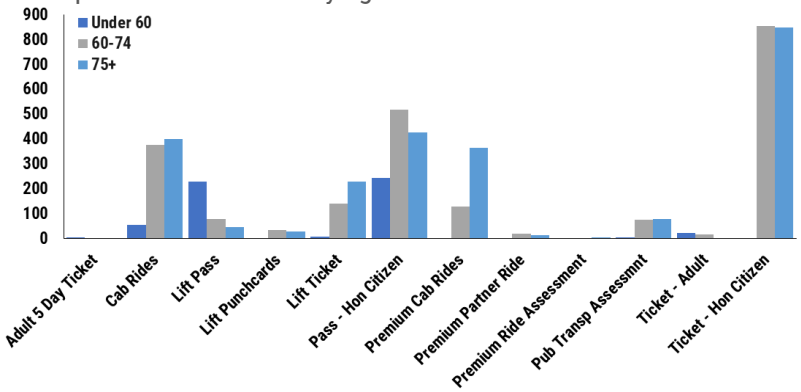


Figure 12. Shows the graphic representation of Table 11 above. A) Shows the unique client count by age on the service date, as a number of clients by age bracket color-coded B) Shows the services received by clients by age bracket color-coded to match graph A, with the horizontal axis showing the type of service received.

Table 12. Shows the culturally specific case management delivered through the program. A) Shows the unique counts of clients serviced by the program. B) Shows the culturally specific services provided by each of the partner providers, the units for these services are calculated as hours of service for all of the programs.

A)

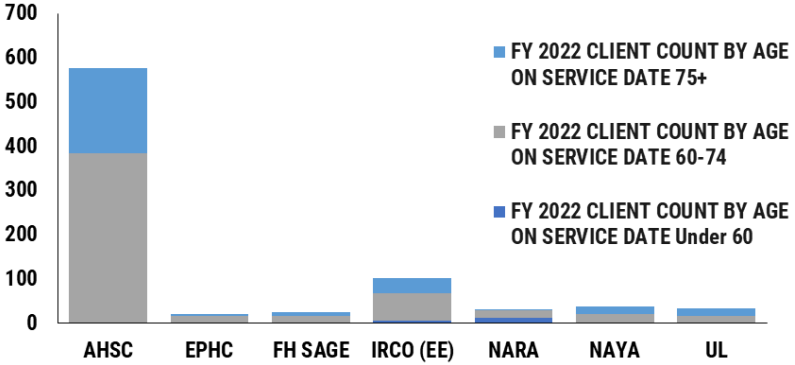
FY 2022 **client count** by age on service date				
OAA-CM Service Provider	**Under 60**	**60-74**	**75+**	**Total**
AHSC	1	383	193	577
EPHC	0	16	4	20
FH SAGE	0	16	9	25
IRCO (EE)	5	62	35	102
NARA	12	16	2	30
NAYA	1	19	17	37
UL	1	14	17	32

B)

FY 2022 **unit count** by age on service date				
OAA-CM Service Provider	**Under 60**	**60-74**	**75+**	**Total**
AHSC	0.8	1,179.8	517.5	1,698.0
EPHC	0.0	378.0	318.8	696.8
FH SAGE	0.0	101.5	31.0	132.5
IRCO (EE)	38.3	532.3	260.8	831.3
NARA	26.3	33.3	4.8	64.3
NAYA	1.0	284.8	221.8	507.5
UL	8.0	130.5	192.8	331.3

A)

FY 2022 OAA case management **client count** by age on service date



B)

FY 2022 OAA case management **unit count** by age on service date

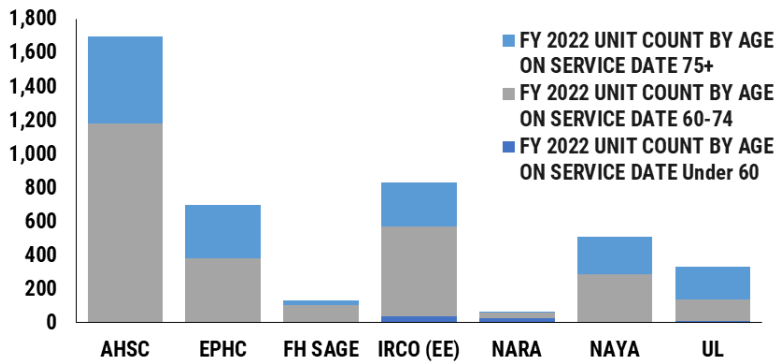


Figure 13. Shows the graphic representation of Table 12 above. A) Shows the unique counts of clients serviced by the program through the different partner providers and color-coded for each age bracket. B) Shows the culturally specific services provided by each of the partner providers, the units for these services are calculated as hours of service for all the programs. Color-coded by corresponding age bracket.

Table 13. Shows the meals provided through the Meals on Wheels People (MOWP) partnership under the MOWP #1223 only. Additionally, there is a count for home delivered meals under the OPI program funding. A) Shows the unique count of clients by age bracket. B) Shows the number of meals provided to clients in each age bracket. Units are calculated as meals provided, with nutrition education being a session.

A)

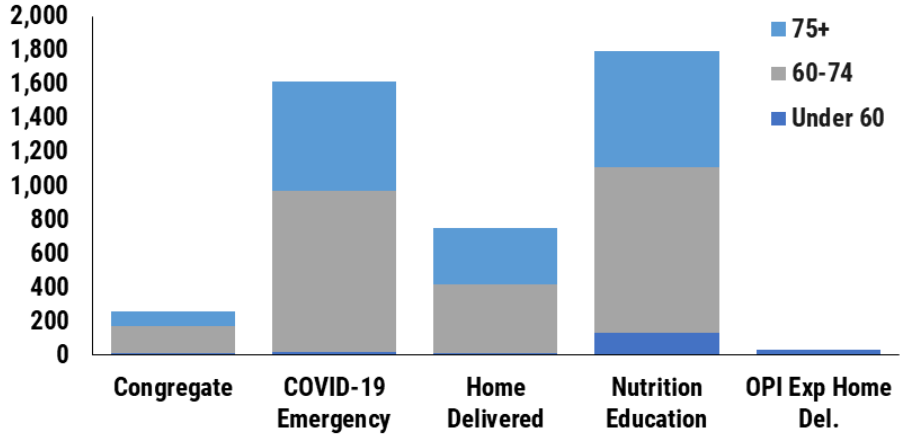
FY 2022 **client count** by age on service date (MOWP #1223 only.)					
Nutrition Services Service Provider	**Service Code Desc.**	**Under 60**	**60-74**	**75+**	**Total Clients**
Meals On Wheels	Congregate Meals	11	157	89	257
Meals On Wheels	COVID-19 Emergency Meals	16	955	645	1,616
Meals On Wheels	Home Delivered Meals	12	404	332	748
Meals On Wheels	Nutrition Education	132	979	680	1,791
Meals On Wheels	OPI Exp Home Delivered Meals	29	0	0	29

B)

FY 2022 **unit count** by age on service date (MOWP #1223 only.)					
Nutrition Services Service Provider	**Service Code Desc.**	**Under 60**	**60-74**	**75+**	**Total Service Units**
Meals On Wheels	Congregate Meals	250	2,209	1,025	3,484
Meals On Wheels	COVID-19 Emergency Meals	2,462	168,212	94,066	264,740
Meals On Wheels	Home Delivered Meals	1,955	98,857	82,627	183,439
Meals On Wheels	Nutrition Education (Session)	158	1,106	820	2,084
Meals On Wheels	OPI Exp Home Delivered Meals	10,165	20	0	10,185

A)

FY 2022 **client count** by age



B)

FY 2022 **unit count** by age

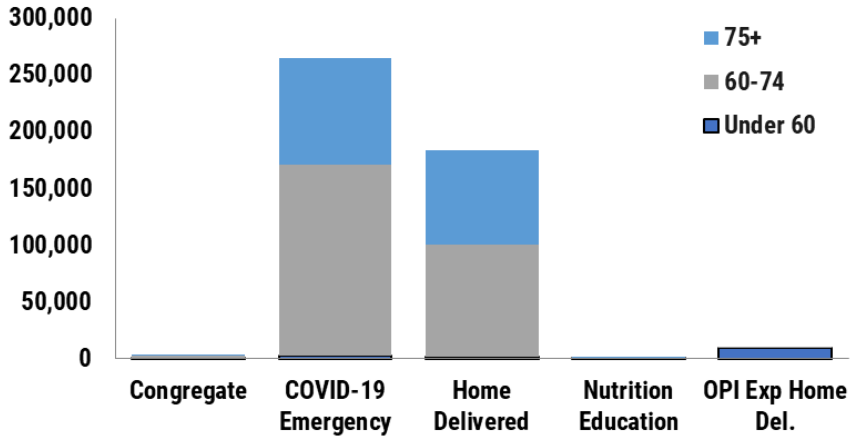


Figure 14. Shows the graphic representation of Table 13 above. A) Shows the unique count of clients by age bracket color-coded. B) Shows the number of meals provided to clients in each age bracket. All units are calculated as meals provided.

Table 14. Shows the culturally specific nutrition services provided by ADVSD partners. A) Shows the unique client count by age bracket. B) Shows the number of services provided by service provider partners, with the units for all of the line items as meals.

A)

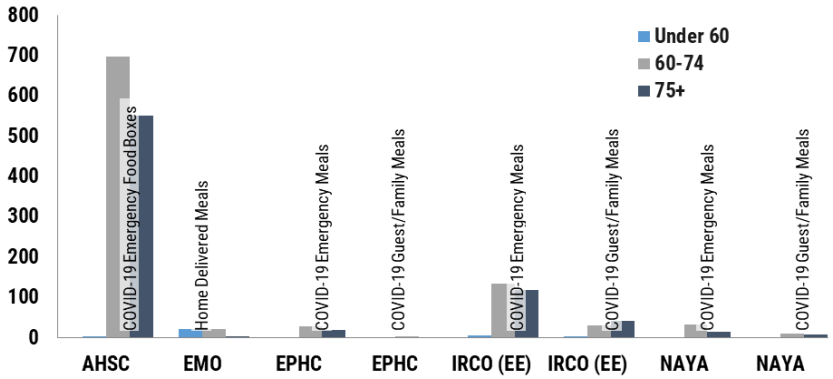
FY 2022 **client count** by age on service date					
Nutrition Service Provider	**Service Code Desc.**	**Under 60**	**60-74**	**75+**	**Total Clients**
AHSC	COVID-19 Emergency Food Boxes	2	698	552	1,252
EMO	Home Delivered Meals	22	22	1	45
EPHC	COVID-19 Emergency Meals	0	28	19	47
EPHC	COVID-19 Guest/Family Meals	0	2	0	2
IRCO (EE)	COVID-19 Emergency Meals	6	135	118	259
IRCO (EE)	COVID-19 Guest/Family Meals	2	31	42	75
NAYA	COVID-19 Emergency Meals	0	32	14	46
NAYA	COVID-19 Guest/Family Meals	0	11	7	18

B)

FY 2022 **unit count** by age on service date					
Nutrition Service Provider	**Service Code Desc.**	**Under 60**	**60-74**	**75+**	**Total Service Units**
AHSC	COVID-19 Emergency Food Boxes	9	6,936	5,708	12,653
EMO	Home Delivered Meals	4,835	5,763	91	10,689
EPHC	COVID-19 Emergency Meals	0	4,970	3,454	8,424
EPHC	COVID-19 Guest/Family Meals	0	58	0	58
IRCO (EE)	COVID-19 Emergency Meals	702	18,168	15,060	33,930
IRCO (EE)	COVID-19 Guest/Family Meals	220	3,312	4,828	8,360
NAYA	COVID-19 Emergency Meals	0	7,330	3,088	10,418
NAYA	COVID-19 Guest/Family Meals	0	2,654	1,213	3,867

A)

FY 2022 nutrition services **client count** by age



B)

FY 2022 nutrition services **unit count** by age

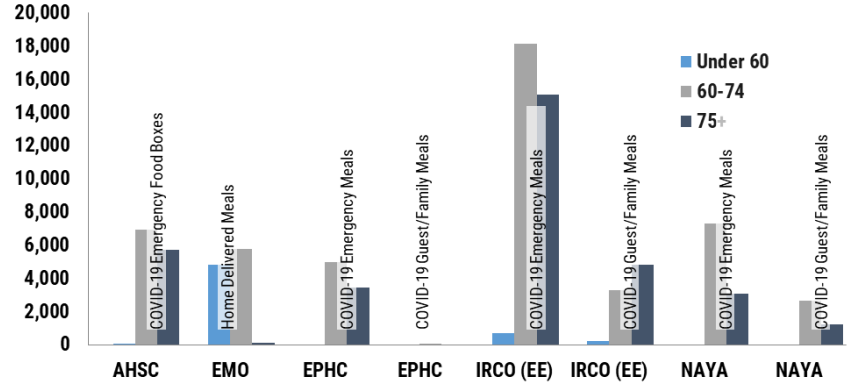


Figure 15, Shows the graphic representation of Table 14 above. A) Shows the unique client count by age bracket. B) Shows the number of services provided by service provider partners, with the units for all the line items as meals.

5.2. Identification of common risk factors that older adult tenants may be at risk of eviction due to unmet in-home care needs.

One of the conclusions reached is that older adults at risk of eviction or housing instability tend to have a combination of social and health related items that converge.

The common theme or comment received at our programs and community partners from participants is that "*...once things get off track, it's hard to get back on track…*"

Building on the information provided in the Background (Section 4) of this report regarding risk factors for older adults, we would like to also present work that ADVSD implements to mitigate these impacts. The following programs offer support to participants:

1) Safety Net Program:
   a) Unmet home care needs. (Safety Net offers support to pay unpaid utility and medical bills).

      This basic need can put older adults at risk of eviction. Living on a modest or fixed income might not allow for incidentals or unplanned bills, including additional medical expenses. This can start the downward spiral of late fees, utility shut off notices, etc. making it challenging to recover from and get back on track on the established budget.

   b) Hoarding Tendencies. (Safety Net helps with cleaning and organizing participants' belongings. The Older Adult Behavioral Health Initiative (OABHI) program has educational sessions to mitigate hoarding tendencies.)

      Older adults might have accumulated household items, for example, mail, donations, family gifts piling up. These collections: may suggest hoarding behaviors and result in an eviction notice.

      In extreme situations when a hoarding disorder is present the older adult might not want people coming into their home. Mental and/or behavioral health may factor in when considering the reason why an older adult does not want support to maintain their housing.

2) Care Transitions. (Case managers connect with participants after hospital discharge to assist them with discharge orders and follow up to help prevent hospital readmittances)

Older adults experience multiple chronic conditions at a higher rate than the general population and have a higher risk of hospitalization. Chronic condition care

management can be challenging and can result in one's inability to properly maintain their household tasks.

3) GetCare, ADRC (Aging and Disability Resource Connection)

The programs GetCare and the ADRC have information specific to homeless callers, people seeking shelter, low-income housing and other reporting capabilities tied to older adults and people with disabilities. Note: Housing is one of the ADRC top calls (See section 5.1.4). Additionally, the ADRC offers referrals to partner agencies for services, such as Home Forward, NW Pilot Project, etc.

Sometimes callers contact the ADRC about services that do not exist, demonstrating that there is a need that might be unmet. If this is information that would be needed, a new project and funding would be needed to be set in place to track this type of calls, and operational changes might be needed to collect this information specifically.

4) Mobile Team (Long Term Services and Supports)

Through joint funding from the Joint Office of Homeless Services, ADVSD Long Term Services and Supports has created an intake mobile team who will meet people in the community. This team focuses on the aged and disabled houseless population residing in shelters or connected with a community resource to try and evaluate them for long term care benefits and services. Due to challenges with communications, scarcity of phones and technology, the Houseless Mobile Team (HMIT) does a majority of the evaluation in the community.

5) Housing Navigator (Long Term Services and Supports)

Housing navigators offer consultation to case managers and direct consumer assistance. They assist with locating and sharing resources, conducting tenant screenings and housing assessments to identify barriers to successful housing. They help with applications, moving details, education and training. They also advocate and help consumers overcome issues with landlords as needed.

5.3. Recommendations of potential programs to address the issues identified.

GAP AREAS:

Currently there is no governmental program that provides housekeeping exclusively, and in the experience of our teams, this is more often than not all that an older adult needs to maintain housing independence.

Combining a service such as housekeeping with other programs such as MOWP (Meals on Wheels People) and OAA (Older Americans Act) case management or Long Term Care Options counseling, can mean the difference between health and safety, and risk of health decline, and/or eviction.

Older adults often use all of their independence on completing tasks such as dressing, prepping meals, arranging transportation, and therefore might not meet service priority levels (SPL) criteria. However, these tasks may result in older adults struggling to complete or having no energy/time for other tasks that could help them be more connected to their community.

An individual might be independent in all activities of daily living (ADLs) and not qualify for in-home help, but at the same time never be able to mop a floor, clean a tub or clean behind a toilet. They may be independent, but not remember to pay rent or pay bills. This group of older adults has been found to be vulnerable to scams. Additional support for medication management, grocery shopping, meal prep, and housekeeping are beneficial to these adults who otherwise are considered too independent to be eligible for on-going services.

The team also considered the elimination of the eviction moratorium and the additional funding that was available during the COVID-19 pandemic to help people maintain housing. This could be part of the reason the *Point in Time* report shows an increase in reported homelessness.

EXISTING PROGRAMS:

Also see section 5.2.

- Safety Net program
- Older Adult Behavioral Health Initiative (OABHI)
- Oregon Money Management Program (OMMP – representative payee services)
- Home delivered meals, MOWP, nutrition program
- Care Transitions
- Oregon Project Independence (OPI, OPIM, FCAP)

- Veteran Directed Care
- Case management
- ADRC

PROPOSALS:

1) Creation and funding for a program that provides free housekeeping services for anyone age 60 and older—perhaps under a certain income threshold. Additional considerations, for those experiencing chronic homelessness, are above a certain age range and experiencing health conditions that increase risk of eviction or housing insecurity as they might not be able to maintain their housekeeping level acceptable to continue to rent.

We estimate , a once a month visit for support for 4-hours, could help stabilize and support those in the older adult community who might also be struggling with isolation.

2) Expansion or creation of a program to help older adults while caring for their pets. For example, walking, bathing, and feeding a pet that might be their primary company. Current homecare worker programs do not allow for pet care.

3) 24-hour care is no longer available. Reinstating or creating a program that can offer support overnight.

PROPOSALS - HOUSING RELATED:

4) Partner with housing organizations/buildings with onsite case management to provide immediate assistance to individuals in need. This replaces referrals to outside organizations and waiting on eligibility determinations. The support to the individual would be immediate to those at risk of eviction.

5) Housing organizations/buildings that set up automatic rent payments when people move in to prevent non-payment.

6) In home mental and behavioral health support.

7) Volunteer programs supporting older adults in their home to address money management, housekeeping, yard work, etc.

8) Housing organizations/building management committed to working with tenants to help solve issues and remain housed.

PROPOSALS - FINANCIAL:

9) Increase capacity for OMMP to serve as representative payee to enhance case management and other in-home supports. There is also a need for more informal assistance with bill paying and money management, especially for individuals without natural supports or the financial means to hire professionals in this area.

Lack of support with IADLs such as money management/assistance with paying bills, i.e., for care or other in-home supports, rent or mortgage payments, property taxes. Lack of support in this area can also increase the risk for financial exploitation and possible eviction due to others who are not on the lease moving in with the person.

5.4. Options for implementation of resources and approaches for piloting the models

Note: This question focuses on pilot models that could help recruit and maintain staffing especially for home care workers (HCW).

Financial compensation is recognized as a barrier to recruitment in many areas of caregiving and healthcare. However, organizations administering Medicaid and Medicare funding have a prescriptive salary range that is dictated by the contract established with the funding agency. Additionally, this career path might be seen by some as not having growth opportunities or being a dead-end job.

PROPOSALS TO HELP RECRUIT, INCENTIVIZE, AND RETAIN STAFF INCLUDE:

- Skills training programs
- Continuing education opportunities provided by the hiring agency to help with skill development and preparation for potential new growth opportunities within the agency/company.
- Fostering an inclusive and diverse work culture.
- Offering mental and behavioral health support, and group support to workers. Since they work with older adults and might often be the main or only point of contact they have outside of their home. Some workers might also need grief counseling if the person they are supporting passes away.

Some additional ideas and considerations can be found on the article by Melody Benefits at: https://melodybenefits.com/incentives-home-healthcare-providers/.

Additional Projects:

The Multnomah Idea Lab also piloted a project called *A Place for You* where the viability and scalability of using ADU units (Accessory Dwelling Unit) as an alternative to mass shelter options for enrolled clients was tested. This project provided a home for five years to families that qualified in a Multnomah County resident's property. In addition to building the ADU, the County also provided support through the Mobile Housing Team (MHT) for a safe and successful tenancy. Although this project is not specific to HCW, it is included here as one of the possible benefits identified included increased social connections for both the ADU residents and the homeowners. This program is now housed at the JOHS in Multnomah County.

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