Women, Health and Aging:

Building a Statewide Movement

Papers Commissioned by

The California Endowment

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Executive Summary

California's aging population is rapidly increasing and is growing in diversity; between 2010 and 2030 the population over age 65 will nearly double.[1] By 2040, the majority of California's elderly population will be ethnic minorities, many of whom have limited English proficiency.[2, 3] Adding complexity is the rising numbers of California elders living in poverty, with seniors of color three times more likely to be poor than their white counterparts. Moreover, three out of four low-income seniors are women.

In an effort to consider effective strategies to address the growing needs of older persons in California, The California Endowment (TCE) commissioned three papers to provide an overview of the policy and program environments that affect access to care and economic assistance for low-income, immigrant, ethnic and racial minority, and female seniors in California—the state's vulnerable elder population.

Although different in focus, the three papers provide rich contexts for better understanding the demographic, cultural, financial, policy, and systemic issues that collectively impact access to care and economic security for this population. In addition, they propose related and overlapping strategies to address the challenges identified by the authors. They offer detailed examples of successful program models and suggest specific policy recommendations that, taken together, provide a roadmap for advocacy and for implementing policy and systemic change. Thus, they share a pragmatic outlook and optimism.

This anthology of papers follows earlier efforts by TCE since 2000 to engage a number of stakeholders, including grantees, community leaders, policymakers and academics, on the issue of healthy aging. The culmination of research and early discussions led to a focus on women due to higher poverty rates, longer life expectancy, and a greater dependence on California's safety net. More significant is the pivotal role that women play in the care of family members as caregivers and their unquestionable ability to be passionate agents of social change. A foundation-sponsored convening being held in May 2007 in Los Angeles, "Women, Health and Aging: Building a Statewide Movement," will examine the critical issues that have been surfaced by the papers and begin a dialogue on how to create the capacity to build a visible campaign on the challenges faced by vulnerable older women in accessing care.

THE PAPERS

Improving Care and Assistance Security for Vulnerable Older Women in California

The lead paper by Plumb and colleagues provides an overview of the program and policy environments that affect access to care and economic assistance for vulnerable older women in California. Discussion of the policy environment

focuses on some of the disparate factors that have obstructed improving access to services and economic security for vulnerable elders in the state, such as: the state budget crisis; the implementation of term limits; the immigration backlash; and inadequate coordination of advocacy activities. Following this discussion, the paper critically analyzes current economic security and health care programs including Medicare, Medicare Part D, and long-term care services.

The authors recognize that improving economic security and access to care services for elder Californians requires implementing multiple capacity-building strategies, as well as access-building strategies. The four recommended capacity-building strategies include:

- Training diverse cadres of older women as policy advocates;
- Training diverse groups of older women in research and evaluation skills;
- Establishing a statewide aging advocacy coalition; and
- Investing in strategic placement of older women's policy analysts.

The five recommended access-building strategies, which focus on ways to increase access to services for which elders are already eligible, include:

- Increasing enrollment of vulnerable older women in safety net programs;
- Increasing compliance with language access requirements in Medi-Cal managed care and long-term care;
- Supporting development and adoption of an economic self sufficiency standard;
- Filling the access gap for women age 45-64; and
- Replicating housing models that are affordable and culturally appropriate.

In addition, the paper highlights programs and coalitions that have successfully implemented the recommended strategies and programs.

The Eligibility-Benefits Gaps for Aging Californians

The paper by Wallace and colleagues is based on an original data set, the California Health Interview Survey (CHIS), which provides information on the health status and use of medical care among elderly and near elderly, poor and near poor, ethnic/racial minority, and immigrant populations in the state. The paper focuses on a central aspect of limited access to health care and economic insecurity among California's vulnerable elders—many who are eligible for services do not participate, and many persons in need are not eligible.

The authors point out that a substantial number of minority, immigrant, and low-income Californians eligible for health or financial benefits do not access them because of barriers including language, lack of cultural sensitivity, provider bias, and fear of deportation for themselves or family members. As a consequence, a substantial number of eligible Californians delay in seeking care or in investigating their eligibility for programs, such as SSI/Medi-Cal. The authors report that if the national rate of underenrollment for SSI were applied to California's older population, about 300,000 additional older persons in the state would be eligible for the program. This is a substantial potential gap in the safety net for seniors in the state because of the program linkages among SSI, Medi-Cal, in-home supportive services, among others.

Many minority and poor people in need in the state, particularly the near elderly (those ages 55-64) and the near poor (those with incomes or assets slightly above the federal thresholds) are ineligible for services. Substantial proportions of the older and near-elderly populations in

California live just above the poverty line, a fact that is overlooked when focusing only on those below the federal poverty level (FPL). These people, the authors observe, are one illness away from falling into poverty. Indeed, with specific reference to the prevalence of diabetes, hypertension, incontinence, and disability in the state, they document that the need for health care among near-elderly and elderly Californians is highest for the same subgroups that have the lowest incomes.

Addressing these problems requires action at the policy, program, and community levels. The authors make the following recommendations for improving access to care and financial security among vulnerable populations, many of which dovetail with those recommended by the Plumb, et al., paper:

At the policy level:

- Raise asset and payment levels for SSI/Medi-Cal;
- Reexamine age 65 as the age of eligibility for services;
- Go beyond "reasonable outreach" for SSI/Medi-Cal;
- Protect the prescription drug benefit of Medi-Cal recipients;
- Expand Medi-Cal to cover assisted living; and
- Increase the availability of affordable housing.

At the program level:

- Improve cultural competency;
- Increase advocacy activities; and
- Improve health programs.

At the community level:

- Increase volunteerism and civic engagement.

Healthy Aging for California's Immigrant and Low-Income Elders from Diverse Ethnic Backgrounds: Policy Issues and Recommendations

Gwen Yeo's paper documents the diversity of California's older population, especially its older immigrant populations, and discusses the implications of this diversity for providing culturally competent health care services among these populations. Her central premise is that designing policy based on the needs of ethnic-specific populations of California's older adults and addressing the shortcomings of the health care system will reduce disparities in services available to immigrant and low-income ethnic elders in California.

An important analytical and substantive contribution of this paper—which is ignored by much research on the topics of immigration and ethnic diversity—is that it disaggregates into discrete national groups the demographic data of regional populations that are oftentimes lumped together. For example, she details in separate analyses the different historical experiences, known health risks, and traditional health beliefs of thirteen Asian and five Latino cultures. By discussing the various historical, cultural, and health factors that differentiate immigrant groups in California, Yeo speaks directly to the implications of these differences for understanding and improving access to care and economic security among them. And by doing so, she avoids resorting to cultural stereotypes.

Section II of the paper outlines the policy challenges to providing care for immigrant and low-income Californians around the following issues: the array of languages spoken in the state; diverse health care providers; availability of ethnogeriatric training programs; health promotion and community health workers; disaggregated data; diabetes; family care of dependent elders; and access to care for undocumented elderly Californians.

Section III looks at three uniquely successful programs that meet some of the challenges outlined in Section II: On Lok Senior Health Services; the Alzheimer's Association Dementia Care Networks; and the Sacramento Urban Indian Health Project's Diabetes Management Program. She points out two commonalities among them: First, they all have developed a model of care appropriate to the cultural values of the target community, in collaboration with the local community members. Second, they rely on bilingual, bicultural frontline staff members from the target community to provide the important patient/client services.

Section IV enumerates eleven policy recommendations, which include:

- Developing and providing incentives for ethnic-specific community organizations to develop culturally appropriate geriatric services for elders;
- Providing incentives for health care organizations to implement CLAS standards (see Appendix B);
- Advocating for the immediate inclusion of state-provided matching funds for interpreter services for limited-English-proficient Medi-Cal recipients;
- Educating health care plans and physicians about the need to provide and use trained interpreters as a provided service in managed care plans and as reimbursable costs in fee-for-service care;
- Advocating and supporting low cost telephone-based interpreter services to make it more cost effective for health care organizations to meet the needs of limited English proficient elders;
- Providing support for increasing health literacy among elders from diverse populations;
- Providing, supporting, and requiring education in ethnogeriatrics and cultural competence for all health care providers who care for older Californians.
- Developing state collaborations with Indian Health Centers, especially in urban areas, to create comprehensive geriatric health care and caregiver support programs for Indian elders;
- Developing better ethnic-specific data sources for state planning, especially for relatively small populations of disadvantaged immigrant elders;
- Supporting wide-scale community-based culturally appropriate diabetes prevention, early detection, and management programs, especially for older high risk populations; and
- Convening an exploration of methods to finance the recruitment, training, and integration of community health workers/*promotores* from ethnic backgrounds as standard services to provide health promotion, health education, and chronic disease management services for elders.

REFERENCES

1. O'Hara-Devereaux M, Falcon R, Li JDX, Kristensen H. *Fault Lines in the Shifting Landscape: The Future of Growing Older in California—2010.* Menlo Park, CA: Institute for the Future; November 1999. R-110.
2. Scharlach A, Torress-Gil F, Kaskie B. *Strategic planning framework for an aging population: Executive Summary*. Berkeley: California Policy Research Center, University of California; 2001.
3. TCE. *Access Strategic Program Plan*. San Francisco: The California Endowment; 2002.

Improving Care and Assistance Security for Vulnerable Older Women in California

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Introduction

California's aging population is rapidly increasing and is growing in diversity; between 2010 and 2030 the population over age 65 will nearly double.[1] By 2040, the majority of California's elderly population will be ethnic minorities,[2, 3] a phenomenon referred to as the *browning* of the *graying* of the population.[4] Adding complexity is the relatively high percent of California elders who have limited-English proficiency. The changing demographic diversity places additional strains on the public health, long-term care, and economic development systems of the state. Because older women in particular experience greater economic and health vulnerability, meeting their specific needs further exacerbates this challenge.

The purpose of this paper is to provide an overview of the program and policy environments that affect access to care and economic assistance for vulnerable (low-income, immigrant, and ethnic and racial minority) older women in California. The rationale for an emphasis on older women in this report is threefold: (1) the extent and severity of need particularly in diverse and immigrant communities; (2) their high degree of dependency on the California state and local safety net programs; (3) their pivotal role in the care of other older Californians and their families.

The content of this report seeks to recommend strategies that can develop and sustain the capacity to move policy and program agendas forward that have the potential to advance the health and economic well-being of older vulnerable women in California. The report highlights case studies that represent successful implementation of the recommended strategies and programs. Of primacy to the conclusions of this report is the recommendation to strengthen the aging advocacy movement and improve its capacity to address intractable and emerging policy issues over the long term.

This report is not a comprehensive review of health, long-term care, and economic assistance issues or programs for vulnerable older women in California. In recognition that such recommendations would be time-limited and perhaps out of date by publication, this report focuses on the strategies and approaches that can be used to move those policies forward and create an enabling policy environment. Many existing reports have listed California-specific policy recommendations, and references to those reviews are provided throughout this document including an additional list of recommended readings. In particular the reader is directed to the following reports:

- California Health and Human Services Agency. Strategic Plan for an Aging California Population. Sacramento, CA: California Health and Human and Services Agency: Getting California Ready for the "Baby Boomers"; October 14, 2003. Available at: http://www.calaging.org/works/population_files/population.pdf
- O'Hara-Devereaux M, Falcon R, Li JDX, Kristensen H. Fault Lines in the Shifting

Landscape: The Future of Growing Older in California—2010. Menlo Park, CA: Institute for the Future; November 1999. R-110. Available at: http://www.archstone.org/usr_doc/33534.pdf

- California Center for Long Term Care Integration. Improving County Long term Care Systems to Build toward Integration: Final Report to the California HealthCare Foundation. Los Angeles, CA: California Center for Long Term Care Integration; 2003. Available at: http://www.ltci.ucla.edu/ccltciproducts/CHCF%20Final%20report-FINAL.pdf
- Scharlach A, Torress-Gil F, Kaskie B. Strategic planning framework for an aging population. Berkeley, CA: California Policy Research Center, University of California; 2001. Available at: http://www.ucop.edu/cprc/agingreport.pdf

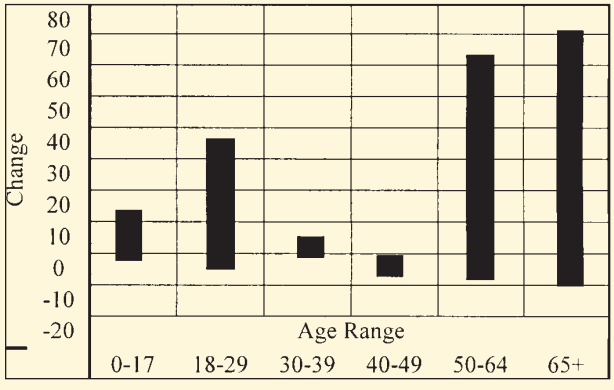
The California Context

California is a uniquely complex state in which to make policy change. The growing racial and ethnic diversity of its elderly population necessitates unique approaches that are community specific and tailored. Any policy changes requiring the appropriation of state funds to meet these challenges are constrained by the realities of an ongoing state budget crisis as well as current efforts to control health care costs by redesigning the state's Medi-Cal program. An environment of opposition to immigration and support for undocumented residents also further complicates efforts to promote the health and economic well being of California's diverse aging population.

THE CHANGING FACE OF CALIFORNIA'S ELDERLY

Currently California is home to almost eight million people over the age of 65.[6] The Institute for the Future predicts that between 2010 and 2030, this population will nearly double, rising from 10 percent of the overall population to almost 17 percent.[1] In the first two decades of the 21st century, the fastest growing age groups in California will be those of older people.[5] More specifically the fastest growing segment of the older populations will be the very old—those age 85 and older—which will increase four-fold between 2000 and 2004.[5] Figure 1 provides overall projected changes in population by age group from 2000 to 2020."

Figure 1
Change in Population by Age Group, 2000-2020[5]



The 'Browning' of the 'Graying' of the Population

As California is aging, it is also becoming more racially and ethnically diverse.[7] By 2040, the majority (nearly 55%) of California's elderly population will be ethnic minorities.[2, 3] Hayes-Bautista and colleagues[4] refer to this as the *browning* of the *graying* of the population. The state is second only to Hawaii in racial and ethnic diversity.[2] Hispanic elderly comprise 13 percent of the aging community, followed by Asian/Pacific Islanders at 10 percent and African Americans at 5 percent.[8] Poverty rates for seniors of color are three times the rate of elderly Caucasians.[3]

There are approximately 12 million undocumented immigrants in the United States; approximately 40 percent of them live in California. California has the fastest growing immigrant older population in the nation.[2] In 2000, one-third of Californian baby boomers were foreign born.[9] More than half of immigrant seniors live within

200 percent of the poverty level.[3, 10]

Many older immigrants have limited English proficiency (LEP). In California there are over one million households living in linguistic isolation.[11] Statewide, 17 percent of the older population has limited English proficiency, although some counties such as San Francisco have as much as 41 percent of the elderly with limited English speaking ability.[12]

The Gendering of the Aging Population

Aging is a gender issue[13] and women are a central force in the aging of California. On average women live 6 to 7 years longer than men. By 2040 the life expectancy for women will rise to 84.6 years, compared to 79.9 for men.[5] Sixty percent of those individuals beyond age 85 are women.[10]

Due to multiple circumstances, California's older women experience serious and pervasive health and economic insecurity. Women face a lifetime of lower wages due to discrimination in the workforce and work gaps resulting from family and childrearing responsibilities. These realities influence the economic security of older women as they receive less in Social Security benefits and have less access to other retirement support such as pensions. In 1999 nationally, women aged 65 and over received on average, $8,224 annually as pension income, compared with $14,046 for their male counterparts.[14] U.S. Census figures show that in 2000, 13 percent of older women (65+) in California had incomes below poverty, compared to 10 percent of older men.

Poverty increases with age and is especially prevalent among older women of color.[15] Poverty rates for older female African Americans and Latinas exceed 28 percent, compared to around 12 percent for white women.[16, 17] Over 60 percent of African American and Latina older women living alone are poor. Older women are more than twice as likely to be poor or near-poor.[13, 15, 18-20]

Another overlooked segment of this population includes older lesbian, bisexual, and transgender women. As a stigmatized and hidden population, it is impossible to have an accurate estimate of this group. The Institute for Gay and Lesbian Studies (IGLS) reports that the 2000 U.S. Census recorded 0.6 percent of the adult population as residing in same-sex unmarried partner households. According to IGLS this statistic underreports the total number of lesbians and gays as it is limited to individuals who are partnered, living with their partner, and not afraid to openly identify on a confidential (but not anonymous) government survey. IGLS suggests that other surveys estimate that 5 percent of U.S. adults might be gay or lesbian.[21] Poverty is a burden for this population as it is estimated that lesbian and bisexual women are spread proportionally among the economic spectrum similar to their heterosexual counterparts.[22] Compounding aging for members of this community are the results of both perceived and institutionalized homophobia.[23] For example, gays and lesbians lack access to partner social security and pension benefits because same-sex couples are denied the right to marry, thereby not qualifying for these and other spousal benefits.

Because of their higher poverty rates, longer life expectancy, substantial family responsibilities, ongoing discrimination, and lower work opportunities, older minority women are the most dependent of all elders who rely on California's public safety net programs such as Medi-Cal and SSI[24-26] as well as the federal Social Security program.[27] Such dependencies make older women more vulnerable to adverse changes in state and local policies, fiscal crises, and expenditure reductions. In recognition of this reality, this report focuses on building capacity to maintain and increase access to these programs for vulnerable older women in California.

The Regionalization of the Elderly

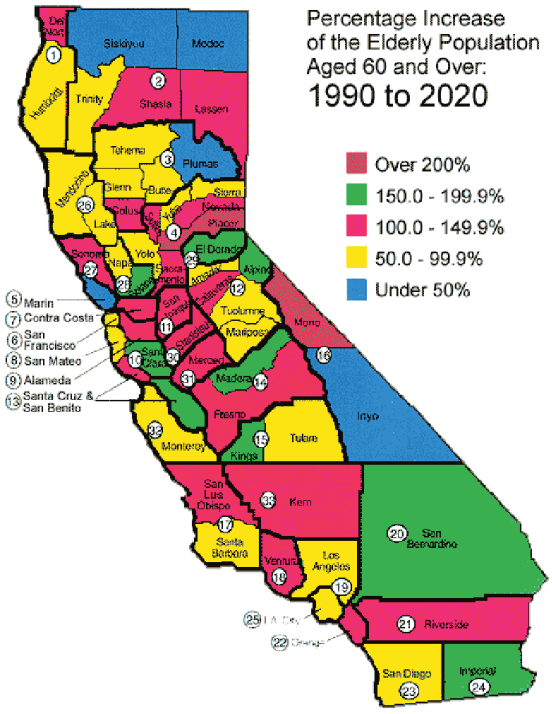
Regional differences within California also exist. According to the latest census report, three

out of four older people lived in metropolitan areas in 2000.[14] Seniors living in high-cost urban regions like the Bay Area have different financial strains than seniors living in rural communities. Working-class seniors, seniors on fixed incomes, seniors without any or with inadequate retirement benefits, and seniors who have not participated in or who currently do not participate in the formal workforce have even greater difficulties paying for the basic living needs of food, shelter and healthcare. Additionally, seniors face economic challenges that are likely to worsen as the growing limited-income senior population places more strain on public services like health care and paratransit. Conversely, large proportions of older adults in rural areas face different structural barriers to accessing a variety of health care and long-term care services. This is often due to the limited service supply and individual socioeconomic factors.[28]

Reflecting the growth in racial and ethnic communities, the distribution of the elderly in California is also shifting. While more than half the counties in the state will experience more than a 100 percent increase in the elderly population, eleven of these counties will have growth rates of over 150 percent. These counties are located throughout the central and southern areas of the State (see Figure 2). By 2040, the number of older people in the San Joaquin Valley is expected to triple.[10]

Figure 2

Growth in the California Elderly, by County



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UNDERSTANDING THE POLICY ENVIRONMENT

California's current ability to provide health, mental health, long-term care and social services to elderly vulnerable women is inadequate[2] and access to these services is insufficient.[29-32] Redressing these inadequacies requires policy changes at the local, regional, state and national levels. Several aspects of the policy environment, however, impede making such changes. These include the ongoing budget crisis, the transitory arena of state politics, a rising backlash against immigration, and characteristics of the senior advocacy movement.

The State Budget "Crisis"

While the state's current fiscal crisis was most acutely felt at the beginning of this decade with the sudden downturn of the economy, precipitated by significant declines in the stock market, the failure of California to keep pace with the nationwide economic expansion from the previous decade points to long-term structural problems that will continue to erode the ability of the state to provide services for its most vulnerable over

time.[33] By 2020, the state's budget may be unable to keep up with the service demands of its over six million Californians aged 65 years and older.[34] Programs that will experience the strain include those that specifically serve the elderly including Medi-Cal, In-Home Supportive Services, and the Supplemental Security Income/State Supplementary Payment (SSI/SSP) Program.

A survey of local health officers conducted by the Public Policy Institute of California[35] found that most officers report that the amount of state revenues available for delivering health and mental health services has declined. State budget actions are perceived to be a major source of budgetary pressure on local health and mental health services. In response to budget pressures, many local health and mental health departments have reduced staffing levels, reduced or eliminated programs, or closed facilities. Many have also approved fee increases to support local health and mental health programs.

California needs additional sources of revenue, tax system overhauls, and major government policy reforms to address the challenges raised by the demographic changes expected in the next twenty years.

The Nature of California State Politics

In 1990 California voters passed term limits for its elected officials. Members of the Assembly can serve no more than three terms for a total of six years (beginning in 1996). Members of the Senate can serve no more than two terms for a total of eight years (beginning in1998). While initially thought to advance the representation of underserved voices within state government, term limits have actually created a transitory environment for state politics. Elected officials no longer develop the clout necessary to push transformative policies. A report commissioned by the California Public Policy Institute concluded that frequent changes in the membership and leadership of legislative committees, especially in the Assembly, diminish their expertise and collective memory in many important policy areas.[36]

Of particular concern is the manner in which the transitory environment further exacerbates the budget crisis discussed earlier. According to Cain and Kousser, as a result of term limits, there is now more room for fiscal irresponsibility in the Legislature and less incentive, experience, and leadership to correct it.[36]

Term limits, however, are not the only contributor to the entrenched environment of state politics. Redistricting has created legislative districts that are largely either democratic or republican, encouraging legislators from those districts to represent more completely the partisanship of their constituency.[37] The bipartisanship needed to pass fiscal bills (requiring a two-thirds majority, which neither party currently holds) and be signed by a governor not of the majority party is largely missing in Sacramento.

Since elected officials no longer can provide the expertise and leadership to innovate proactive long-term solutions to policy dilemmas, the task of clearly and factually stating the problems faced by constituents, of passionately and persuasively articulating policy solutions, and of skillfully navigating the political minefields of the policy arena falls even more heavily on advocates.

Immigration Backlash

The beginning of a backlash against undocumented immigrants in California was marked in 1994 with the passage of Proposition 187, which denied social services to undocumented residents. Support for this new law was often based on the belief among Californians (and throughout the country) that the presence of "illegal" immigrants was a significant problem to communities, state and local budgets, and law enforcement.[38] Further restrictions on undocumented immigrants' access to services were enacted in 1996 with the passage

of the Personal Responsibility and Work Opportunity Reconciliation Act, also known as "welfare reform."[39] The impact on the reduction to services is felt not only by undocumented immigrants but also by many legal immigrants who fear deportation.[40]

Federal strategies to reduce health expenditures by reducing purported abuses by non U.S. citizens may have broader unintended consequences for nonimmigrant populations. In February 2006, President Bush signed the Deficit Reduction Act which contains a provision that would require all citizens applying for Medicaid or renewing their coverage to produce a passport or birth certificate to prove they are U.S. citizens. Such a requirement creates enormous barriers to services for immigrants in the name of ensuring accurate eligibility of beneficiaries. There are no exceptions to the requirement, including for those with severe physical or mental impairments such as Alzheimer's disease. One estimate is that if as little as two percent of Medicaid beneficiaries cannot readily come up with a birth certificate or passport, one million low-income Americans could lose Medicaid coverage and become uninsured or be delayed in obtaining coverage. In California, which has more than 8 million Medicaid beneficiaries, this would mean that more than 160,000 individuals (presumably many of those frail elderly), eligible for Medicaid but unable to comply with the new rules, would be dropped from the insurance plan.[41]

Additional federal policy immigration reform considerations would criminalize undocumented men, women, and children who reside in the U.S. without proper paperwork as well as those individuals and organizations that knowingly provide assistance. One concern is that policies such as those proposed at the federal level will discourage undocumented immigrants from seeking services, even in emergencies such as domestic violence or sexual assault and would cut them off from life-saving services and programs.[42]

Given the rising sentiment of anti-immigration special efforts are needed to secure the health and economic benefits of those residents of California that are foreign born, whether they are in the country with or without governmental sanction. Attention to the needs of non-English speakers should be prioritized.

Senior Advocacy Leadership and Coordination

Currently, aging and women's issues are often separate advocacy arenas. Organizations such as the Older Women's League, the California National Organization for Women, the California Commission on the Status of Women, and the American Association of University Women provide invaluable leadership in the policy arena in regards to older women's policy issues. Inadequate resources limit the ability of these organizations to mount effective public advocacy campaigns. Dissimilar policy priorities, solutions, and strategies among other leading senior advocacy organizations (e.g., AARP, California Alliance for Retired Americans, Gray Panthers, etc.) may also limit their ability to effectively address shared concerns. Key informant interviews suggest a lack of coordination and agenda setting among those concerned with the economic, health, and long-term care policies that affect older vulnerable women in California and inadequate resources to launch such a coordinated effort.

The lack of effective leadership has been cited as potentially the most "damaging factor" in aging.[1] Observers of this issue identify two factors critically hampering the aging movement's ability to have policy impact—the loss of advocacy champions and the professionalization of aging advocacy.[43] Many stalwart aging advocates have either died or have expressed the desire to retire. This has raised concerns about the possibility of a

leadership vacuum within the field of aging. The success of the aging advocacy movement has also created a "professional class" of advocates. There is now a very large service industry of health care,[44] housing, and other service providers and other movements focused on specific aging issues (i.e., Alzheimer's disease, family caregivers, etc.). These organizations are often called on to represent senior issues within policy discussions but have a limited perspective of the issues based on their own work.[45] Additionally, many of these providers and organizations may have conflicting policy positions because of competition for scarce resources or ideological differences.

There is a need for "cultivating new champions" while also building coalitions that could marshal the resources and balance the interests of the various special interest groups in aging.

ASSESSING THE PROGRAM ENVIRONMENT

Program areas that support older women's economic security, health care, and long-term care have the greatest impact. In this section, these three service areas are explored in brief. In addition to general information, several specific gaps are identified within the state programs that substantially affect the health and well-being of older women in California.

Economic Security Programs

Overall older Californians are relatively well off with only about one in ten seniors living in poverty.[5] Three-fifths of the older population rely on Social Security for at least 72 percent of their income. These statistics hide the reality that the impact of poverty is felt more acutely among immigrant communities as well as communities of color.[5] Women are also significantly more likely to be poor; poverty is even higher for unmarried women.[5]

COST OF LIVING. The rising cost of living affects seniors disproportionately whose incomes are affected by retirement, job loss or employment reduction, illness or other changes in their own health, caring for a disabled spouse or loss of a spouse, or in some cases, needing to care for an adult-dependent child or grandchildren. These problems are magnified for older women, who have less access to income and who rely on more of their income from public sources such as Social Security. Programs that raise or lower the cost of living for seniors have greater impact for women.

According to the California Budget Project, the state has suspended SSI/SSP COLAs (cost of living adjustments), delayed SSI/SSP COLAs, and/or reduced SSI/SSP grants in 12 out of the last 17 years, including in each of the last four years. Currently, the Governor has proposed to delay the SSI/SSP COLA until January 2008.[46] As a result of delays in providing federal cost of living adjustments to SSI/SSP recipients and other state cuts in that program, recipients have 21.3 percent less purchasing power than in 1990.[46]

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI). The Personal Responsibility and Work Opportunity Reconciliation Act changed Social Security and immigration laws by narrowing the eligibility requirements for SSI. As a result, many immigrants became ineligible for SSI. To address this situation, California responded by establishing the state funded Cash Assistance Program for Immigrants (CAPI). To be eligible for the Cash Assistance Program for Immigrants an individual must be at least 65 years and four months of age or meet Social Security's definition of disability or blindness.

Over 98 percent of the CAPI recipients are 65 years or older and the average age of the CAPI recipient is 71 years old. About two-thirds of CAPI recipients (64 percent) are female and over 80 percent are Asian. Asian languages are the primary languages for 75 percent of the population.[47]

The program is funded exclusively by state general funds and administered by local county welfare departments. Thus, it is highly vulnerable to changes in the state's budget and a likely target due to immigration backlash.

A MISSING PIECE: AN ECONOMIC SELF-SUFFICIENCY STANDARD. Missing within current programs is a means to assess the level of economic support needed to secure a healthy life for older vulnerable women. When using an economic self sufficiency standard to determine adequate levels of financial support, subsidies provided by current programs for the poor and near-poor are typically found to be inadequate.[33] If the Governor's current SSI/SSP COLA delay is enacted studio rental costs would represent 50 percent of an older beneficiary's income in all but two California counties, over 75 percent in 23 counties, and over 100 percent in nine counties.[48]

Traditionally, the lowest levels of economic well-being for seniors have been estimated using the Federal Poverty Level (FPL). In 2006, the FPL was $9,800 per year for a single person household and $13,200 per year for a two person household. These levels are considered extraordinarily inadequate and inaccurate measures of subsistence-level income for many areas of the country and population segments. For example, they do not account for the disproportionately higher out-of-pocket medical expenses borne by the elderly. As a nationally computed figure, the FPL does not capture the wide range of housing and other cost differentials across the country; nor does it vary by seniors' age, health, or life circumstances.

Without a reliable and realistic measure of minimum economic security, it is difficult for seniors and their families to plan for their needs as they age, and for policy-makers and the public to assess proposals that affect seniors' well-being.

Health Care Programs

Key health care programs for older vulnerable women in California include Medicare, Medicare Part D, and Medi-Cal. A missing piece of the health care puzzle for women is access to care for women prior to Medicare eligibility.

MEDICARE. Medicare currently provides health care for over 3 million residents. Even with Medicare coverage, however, high cost sharing and lack of coverage for some services creates financial hardships for older beneficiaries. In 2002, Medicare covered less than half (45 percent) of beneficiaries' total medical and long-term care expenses.[49] Beneficiaries paid, on average, 19 percent of total expenses, or $2,223, out of pocket. Approximately one in ten older beneficiaries had over $5,000 in out-of-pocket costs. Declining health status and advancing age lead to higher out-of-pocket health care costs, which are higher for those lacking supplemental coverage.

Fifty-six percent of the Medicare enrollees in California are women.[50] Older women have more chronic health problems and functional disability than older men,[15, 18, 51-53] and therefore pay a higher percent of income than older men or younger persons for out-of-pocket health care costs.[18] In California, 61 percent of women aged 65 and higher suffer from arthritis; 51 percent have high blood pressure, and 14 percent have diabetes.[11] These conditions are more prevalent among low-income seniors. Low-income women ages 45 and older are three times as likely to report fair or poor health, and over one-quarter report a disability or condition that limits participation in daily activities.[54] Race and ethnicity also affect the health status of California women. Among women 45 and older, African American women (37 percent) and Latinas (41 percent) are more likely to report being in fair or poor health than white women (23 percent).[54]

MEDICARE PART D. The recent rollout of Medicare Part D in January 2006 illustrates how national policy developments may have unintended adverse consequences for California's population of older vulnerable women. Medicare Part D, the first significant expansion of Medicare since the program's inception in 1965, provides a prescription drug benefit for 40 million persons with Medicare, including 4.2 million individuals in California. Systems and implementation failures caused the State of California to provide emergency relief for one million individuals who were dually eligible for Medicare and Medicaid. Compounding these problems has been an inadequate education and assistance system to ensure that eligible elders understand and exercise their options.

Enrollment problems were even greater for those with limited English proficiency. Although the program is technically required to provide translation services, media reports suggest that these services may not actually exist or exist only for select languages. As such, beneficiaries with limited English proficiency paid more for their medications then they needed or went without their medications altogether.[55]

A MISSING PIECE: HEALTH CARE FOR WOMEN AGES 45-65. Older women's health is substantially affected by the lack of health care in the years that precede eligibility for Medicare. In California health care for low-income women is provided through two programs: Family PACT and Every Woman Counts. Family PACT provides well-woman gynecological care, treatment for cervical dysplasia and sexually transmitted infections as well as breast cancer screening and life style counseling for women of reproductive age, that is, below age 45. After age 45, women in California can receive breast and cervical cancer screening through the state "Every Woman Counts" program (and treatment, if cancer is found, through the state's Breast Cancer Treatment Program) until the age of eligibility for Medicare is reached. While these programs are filling critical unmet needs for uninsured women in poverty, they are not providing for the primary health care needs of women and those of color, particularly during the critical years of age 45 to 65.[56] Receiving needed health care services during those years largely determines how successfully women will age in their later years.[1]

In California, 17 percent of women ages 45 to 54 years, and 12 percent of those ages 55 to 64 years are without insurance.[54] Although specific data are not available for these age groups, income, employment, and insurance patterns suggest that women of color are more likely to be without insurance particularly since health insurance rates are inversely related to income. In 2004, the proportion of uninsured non-elderly Californians was highest for Hispanics (32 percent), followed by African Americans (19 percent), members of other non-White populations (18 percent), and lowest for White Californians (12 percent).[57] More data are needed to better understand the distribution of disease, lack of insurance, and other demographic characteristics of women aged 45 to 64 years.

Long-Term Care

Long-term care includes an array of health care, personal care, and social services generally provided over a sustained period of time to persons with chronic conditions and with functional limitations.[58] California has a relatively rich mix of Medicaid-funded home- and community-based services that allow individuals with long-term care needs to remain in their own homes. The most commonly used programs—In-Home Supportive Services, Multipurpose Senior Services Program, and Adult Day Health Care—allow individuals to avoid or delay nursing home placement by providing a broad range of supportive services. These include assistance with chores, personal care, case management, in-home nurse

visits, respite, and therapeutic services. However, two problems stand out: (1) the structure and financing of these services create barriers for accessing needed services; and (2) no supportive health, financial, or social services are available for the caregivers of elderly individuals.

Unlike other states that have rebalanced their long-term care systems by consolidating administrative and budgetary functions,[59] California's array of services are spread across individually financed programs operated by multiple state and local agencies. A person in need of long-term care faces a bewildering maze of policies, bureaucracies, and programs. Strictly categorical funding streams and fragmented service programs skew decisions toward high-cost, less consumer-desired solutions. The present system is neither consumer-driven nor consumer-focused, resulting in confusion and inappropriate or no services for many people.[29]

Regarding federal and state government funding in aging, Medi-Cal accounted for 44 percent of total LTC expenditures for the aged and adults in 1998. In 1998, the Medi-Cal program paid for $5.89 billion of the total $13.5 billion in public LTC and related services. In that same year, the majority (91%) of total long-term care Medi-Cal participants were living in the community while 9 percent were receiving care in institutions. Home and community-based services (HCBS) 1915(c) waiver programs that provide community-based alternatives to institutional care are also paid for by Medi-Cal. State general funds used in combination with other federal funding, such as Title XX and Older American's Act (OAA) funds, paid for the remainder of public LTC programs in the state. Most of California's public long-term care programs for older adults are administered by three agencies within California's Health and Human Services Agency—the California Department of Health Services (CDHS), the California Department of Social Services (CDSS), and the California Department of Aging (CDA). Medi-Cal funded programs are housed in all three of the departments.[60]

There is evidence that, due to cultural and linguistic barriers, a large population of California's seniors currently do not have access to information and/or services that would contribute to maintaining their health and well-being. A major challenge remains in how to provide access to adequate and high quality long-term care services to the growing racially and ethnically diverse elderly population in the state.[61] Furthermore, gender interacts with race, ethnicity, and income to intensify the need for long-term care services and aggravates access barriers.

Older immigrants often under-utilize such programs because of lack of awareness, language barriers that prevent them from accessing programs, confusion about their eligibility, or fears due to their immigrant status.[3] Other community-based long-term care services are not accessible to low-income women of color due to inadequate or nonexistent Medicaid coverage.

Long-Term Care: Missing Pieces

ACCESS TO AFFORDABLE AND CULTURALLY APPROPRIATE SUPPORTIVE HOUSING. Despite the wide range of home and community-based services described above, individuals with increasing needs and without a live-in caregiver may be challenged to remain at home, particularly when physical care (e.g., toileting, night time care) and cognitive needs (e.g., confusion, wandering) cannot be scheduled. According to the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, the supply of affordable housing has not kept pace with increased demand. More service-enriched housing settings are needed that have the capacity to both provide services on-site and facilitate access to community-based services. The California Department of Health Services (CDHS) is cur-

rently piloting a Medicaid benefit that brings assisted living services into publicly subsidized housing settings in three counties.

Licensed residential care settings are another option of choice for individuals with more intensive, 24 hour service needs that do not require continuous skilled nursing care. While the supply of residential care settings in California is extensive and growing, few have been developed that target lower income seniors. People of color are underrepresented in California residential care settings[60] and national estimates suggest that this gap has been widening.[62] The high cost of residential care in California represents a major access barrier for moderate- and lower-income seniors. Future expansion of the Medicaid waiver benefit currently being tested in licensed settings should help address economic barriers. However, cultural barriers may persist since few settings have environments and services designed to fit the cultures, languages, traditions, and customs specific to members of immigrant and ethnic minority populations. There is also recognition that LGBT seniors needing supportive housing may not be well served due to the lack of LGBT-friendly communities.[63]

Table 1

Recommendations for Building a Comprehensive Caregiver Support System

1. Public education
2. Universal information and referral
3. Staff training in caregiver identification and assessment
4. Caregiver education and training
5. Support for vulnerable caregivers
6. Education for service providers
7. Collaboration with employers
8. Collaboration with health care providers and other organizations
9. Integrated information systems
10. Expanded target population(s)
11. Local and state level coordination
12. Increased funding
13. Advocacy by and for caregivers
14. Quality assurance systems

(Reproduced from Scharlach-Ref #68)

URGENT NEED FOR CAREGIVER SUPPORT AND SERVICES. Binney, Estes, and Humphers[65] have identified a major trend in long-term care, which they termed the "informalization" of care. Informalization of care refers to the substantial and increasing care provided to the elderly by unpaid family members and friends.[64] Informalization not only reflects the transfer of care to unpaid providers, it also produces the transfer of the physical, intellectual, emotional, and economic responsibility for that care to women. Empirical research demonstrates that women are disproportionately affected. About 75 percent of long-term care is provided informally (without pay) by women, many of whom are themselves elderly. Just as aging is a women's issue, so, too, is caregiving for the elderly.

Informal caregivers provide 75 percent or more of the nation's long-term care, and women provide 70 percent or more of the long-term care of the noninstitutionalized elderly.[66]

In California there are an estimated 2.9 million family caregivers.[67] A statewide survey of caregivers found that three-quarters were women, 60 percent were married and the average age was 51 years. The average care recipient was 77 years old and 70 percent of those receiving care were women themselves.[68]

Caring for elders represents a substantial financial, physical, and emotional burden for women. Women lose up to $550,000 in earnings, missed promotions, raises, and benefits over their

lifetimes and $2,100/year in Social Security payments.[69] The General Accounting Office calculated the costs of informal care, mainly provided by women to be $200 billion annually.[70] Moreover, women are more likely than men to "spend down" their lifetime savings to poverty, first, in the years of caregiving and supplementing costs for older spouses and relatives, and second, in their own nursing home care.

It is not hyperbole to say that government policies that reward those engaging in paid labor at the expense of those in unpaid caregiving roles pose a direct attack on women from both the state and capital.[71]

In addition to the economic costs of caregiving, caregivers often report a toll on their health and well-being. Deleterious health consequences have been found to accompany women's informal caregiving.[72] Women may encounter a great deal of stress through caregiving and other multiple and competing roles, and it is common for women to put the physical and mental health needs of those they care for ahead of their own. Family caregivers have more than twice the rate of depression than the general population. Strained elderly spouse caregivers have been found to be at 63 percent higher risk of death than non-caregivers.

Furthermore, the economic and emotional costs of caregiving can also be significantly greater for lower-income women and minority ethnic groups than among Caucasians.[73] And Latinos and Asian/Pacific Islanders are half as likely to use support services as whites and African Americans.[74]

The availability of family caregivers is a major determinant for long-term care recipients to be able to remain at home and avoid nursing home placement.[68] A report from the Center for the Advanced Study of Aging Services made 14 specific recommendations for building a comprehensive caregiver support system in California (see Table 1).

In sum, maintaining a workforce of caregivers for the elderly is essential for the health and well-being of elders in California. Despite the critical role that women play in the care of elders, and despite the financial and personal burdens they face in the provision of that care, no financial, health, or social services currently are in place to support caregivers in California. It is essential, equitable, and right that fair working conditions be provided for family caregivers through a package of health, social, and financial benefits. All family caregivers that provide direct personal care for an elderly person with ADL dependencies or the need for constant supervision should have:

- Medicare health insurance;
- Public disability insurance;
- Credit for working in calculating Social Security benefits;
- Inflation protection on the calculation of their peak earning years for Social Security; and
- Six weeks of on-site or facility-based respite care annually.[75]

Federal policy devolution, state fiscal crises, and Medicaid responsibility for long-term care render older women's economic and health security vulnerable to the whims and uneven results of 50 state governors and state legislatures. It is vital to create and advocate for long-term care policy that empowers both the elderly and the individuals who care for them.

Recommendations

The long-term goal is to increase access to and use of needed resources and care for vulnerable older women in California. Reaching this goal requires a multitiered strategy. Recommendations are split into two primary sections: what can be done to strengthen the current advocacy movement—both the individuals in the movement and the movement itself—and what can be done to expand access to services for vulnerable elders—with a focus on ways to increase access to services for which elders are already eligible. Such recommendations should not require major policy level changes and additional state budget appropriations. For the purposes of this report we are limiting our recommendations to a few key strategies that offer the greatest potential to affect change.

Recommended Capacity Building Strategies

- Capacity Strategy #1: Train older women as policy advocates;
- Capacity Strategy #2: Train older women in research and evaluation skills;
- Capacity Strategy #3: Establish a statewide aging advocacy coalition; and
- Capacity Strategy #4: Invest in strategic placement of older women's policy.

Recommended Strategies to Increase Access to Services

- Access Strategy #1: Increase enrollment of vulnerable older women in safety net;
- Access Strategy #2: Increase compliance with language access requirements in Medi-Cal managed care and LTC;
- Access Strategy #3: Support development and adoption of an economic self-sufficiency standard;
- Access Strategy #4: Fill the access gap for women ages 45-64; and
- Access Strategy #5: Replicate housing models that are affordable and culturally appropriate.

RECOMMENDED CAPACITY BUILDING STRATEGIES

Capacity Strategy #1: Train Older Women as Policy Advocates

We are not at a loss for knowing what needs to be fixed. Countless pages of strategic plans, reports, analyses, and papers are produced each year that list recommendations and priorities for improving the health, economic security, and long-term care of the elderly. The long-term success of aging advocacy requires providing seniors with adequate training and support, thus enabling them to make their voices heard and become active in the legislative process. Three case studies are provided that reflect different methods for training and empowering a new cohort of older

Case Study A
Building a Network of Senior Leaders

The School of Public Health at UC Berkeley is building a network of "Senior Leaders"—individuals age 60 and older who are making outstanding contributions in healthy aging or community building. The individuals who are chosen for this program are typically already active at either the neighborhood or policy level in Sacramento. Meredith Minkler, DPH, professor of health and social behavior, serves as the principal investigator for the California Senior Leaders and Healthy Aging program, which is supported by the California Wellness Foundation.

The 60 leaders, who come from throughout California and range in age from 60 to 96, have been selected from a larger group nominated by health departments, foundations, academia, community-based organizations, and local and state government. The first class of senior leaders began in 2002, and the second in 2005. Awardees participate in a two-day recognition and training event, which includes interactive sessions on media advocacy, healthy aging, influencing policy, fundraising, and related topics.

In addition, the seniors are linked with graduate students in the School of Public Health. The students—each focusing on a different issue area—check in with the seniors regularly over 12 months, learning about their progress and arranging technical assistance if needed.

The project expects to see connections between senior leaders up and down California, senior leaders and university students, and other intergenerational collaborations. The sharing of information among the seniors is a key element of the program. The participants hold reunions in different regions where they share ideas with one another and often apply what they've learned to their own communities. Some of the seniors from the first group also serve as mentors to the second group.

women advocates (see Case Study B and C).

Training projects should be focused on creating both a broad network of older women who will advocate on their own behalf and focused training to increase the pool of women who have policy advocacy expertise. Senior service programs should develop patient advocacy programs through their own agencies, training clients to understand the policies and political environment and supporting their speaking out on issues of concern. And policy advocacy training programs should be developed to select interested individuals who are committed to aging advocacy issues and require training, education, and mentorship to have an impact.

Training programs should focus on the most at-risk elderly populations: women of color, immigrant women, women with limited English proficiency, lesbian/bisexual/transgender women, and low-income and uninsured women.

Capacity Strategy #2: Train Older Women in Research and Evaluation Skills

Older women should be trained and supported in partnering with researchers and evaluators to develop research and evaluation projects

Case Study B
A Policy Training Program for Women

The Women's Policy Institute (WPI) is a public policy training program launched in 2003 by the Women's Foundation of California. Through a year-long fellowship program, WPI is expanding the numbers of women who learn the inner workings of the public policy process. Each year, a class of approximately 28 women learns how to research issues, draft bills, and testify at public hearings, gaining the leadership skills they need to play a direct role in pushing women's priorities into law.

WPI fellows are a diverse group of women in terms of their experience as advocates, their regional representation, their issue focus, and in age and ethnicity. The Fellows work together in teams throughout the year to decide which of their own policy ideas they will pursue and how.

Over the course of a year, fellows participate in four retreats (of 3 to 4 days each), on-going teleconferences, and other activities aimed to provide "learning while doing." Each WPI Fellow works in a small team to jointly develop and implement a policy advocacy project (legislation, legislative hearing, or regulatory advocacy). Each team receives a team mentor who is from among some of the most accomplished women's policy advocates and lobbyists in the state. The retreats reflect and respond to the racial and socio-economic diversity and different learning styles of the Fellows and provide opportunities to share tactics and lessons learned while each team is moving forward on their project. Areas of focus for the program are: health, economic development/justice, environmental health, and reproductive rights.

In the first two years of the program, WPI participants played key roles in introducing, supporting, or sponsoring six bills (four of which were signed into law).

Case Study C
Patient Advocacy Program

In 2003, patient advocacy was identified by Community Health Partnership's Board of Directors as a priority activity. The primary goal is to educate patient advocates on how to effectively participate in the legislative process, empowering them to interact with elected officials and media contacts in a confident manner in order to advocate for:

- Sustainability and viability of community health centers.
- Increased access to and funding for primary, preventive health services.
- Increased awareness by policy makers on the challenges low-income families face when accessing health care.
- Improved patient-clinic relationship.
- Increased patient understanding of the challenges and limitations clinics face and how proposed budget cuts impact health centers, therefore affecting their health.
- Increased patient participation in future advocacy/media activities.

In 2003, Lourie Campos, Assistant Director of Policy, received a $1,000 mini-grant through the Women's Choices Program to begin the process of developing the Patient Advocacy Program. Patient Advocates are recruited from member community health centers and meet once a month. At the meetings, the advocates receive training on different topics and discuss current health issues and advocacy activities. Training topics include: Community Clinic 101; How a bill becomes a law; State budget process; How to talk to legislators; Media training; Public Speaking. Collaboration with community clinic staff is vital and having a contact at the clinic is required. Legislators and their staff have been very receptive to the program.

that would answer questions important to their community. These partnerships are often called Community/Campus Partnerships (CCP) or Community-based Participatory Research (CBPR) which includes evaluation and needs assessment activities.

Community participation in research/evaluation ensures that the knowledge created will be relevant to the community involved in the research, provides useful tools for further evaluation and research, and supports community-driven policy and programmatic changes.[74] Involving the public in addressing public policy problems by using study results they helped create (and therefore more deeply understand) to impact policies, funding, or services has the potential to more greatly improve a community's well-being than traditional research, evaluation, or needs assessments conducted by outside researchers and evaluators.[76-79] (See Case Study D for an example of how community partnerships in research and evaluation can be used to empower communities to advocate for the services they need.)

Partnerships can build capacity for both community institutions and the individuals who participate.[80] By participating in these partnerships, community members can also acquire skills in answering questions of interest, which can be used for ongoing work to improve the community.[77, 79, 81] Providing infrastructure support to community-based organizations (CBOs), CCP projects can play a role in strengthening their credibility among funders and policy makers, and therefore increasing their opportunities for additional financial support.[79] It can also provide funds and employment opportunities for community members.[77, 81, 82]

CCP projects are intended to help ensure that research and evaluation results will be used to improve the public's well-being by: using knowledge gained to direct resources and influence policies that will benefit the community[77, 82-84] enhancing translation, including the appropriateness of interventions; and sustaining research findings.

For the most at-risk and underserved communities, traditionally not included in research

Case Study D
The Grandparent Caregiver Study

The Grandparent Caregiver Study was a collaborative study involving academically trained researchers and graduate assistants from two bay area universities partnering with community members, service providers, and policy representatives. The focus of the study was to gain better understanding of the situation and needs of grandparents who had taken over primary responsibility of raising their grandchildren due to the crack cocaine epidemic and the subsequent incarceration, incapacitation, or death of many living in urban poor communities. The goals of the research study were to: (1) collect useful and timely data for federal, state, local, and organizational policymakers; (2) stimulate the development of a group of advocacy allies who would disseminate and promote the findings and their implications for health and family policy; and (3) nurture and strengthen the policy advocacy capacities and convictions of grandparent caregivers themselves.

Researchers decided to conduct the study using a "participatory" approach in partnership with individuals close to the situations being studied with the additional goal of building partnerships that would utilize the study

and study results to have impact on policies and programs addressing the needs of grandparent caregivers. To that end, the project included a formal Community Advisory Board (CAB) of 12 local health and social service professionals, community organizers, and individuals working with grandparents or their children in Oakland. The CAB actively participated in designing the project, its scope and interview questions, and coordinating the research activities with community education and policy activities. The CAB was also an integral part of an informal policy advisory group that was made up of state and local policy makers or their aides, representatives from advocacy organizations, and service providers. The involvement of the CAB and the informal policy advisory group ensured that the study was responsive to the needs of policy makers, service providers, community advocates, and grandparent caregivers, themselves.

This form of participatory research allows the individual participating in the study to feel ownership of the study and its results, and gives encouragement to take action on the data. The first step in disseminating the results of the study was to present the data back to the participants at a community celebration (funded by over 75 community members and local groups). Sixty-nine of the 71 study participants attended the "gala celebration" where child care, transportation, entertainment, corsages, and gifts were provided. The presentation of the results of the study allowed the participants to realize that they were not alone, that their concerns were not individual "personal problems" but were experienced by many others in similar situations.

Study participants expressed a wide range of policy and programmatic recommendations that addressed issues such as increasing legal equity between grandparent caregivers and foster parents, the need for financial compensation, access to health and social services for the grandparent and grandchildren, educational information for grandparent caregivers about rights and resources, and the need for affordable, high-quality day care and respite.

A coalition on grandparent caregiving was developed to create and push a policy agenda that, despite the economic recession experienced in the state, worked successfully to get legislation on behalf of grandparent caregivers brought before the state legislature. The only piece of legislation that was signed into law was a bill that required the state to distribute an informational brochure for grandparent caregivers and service providers and community members. Policy information was disseminated throughout the emerging advocacy community, members attended public hearings, and coordinated and participated in a demonstration on the state capitol steps.

Participatory research was used in this situation to not only understand a phenomena such as grandparents needing to raise their own grandchildren, but through the community-organizing principles of respectful partnership with those under study, the research itself was able to not only provide data but created an advocacy movement of individuals who could use the data to improve their own lives.

Adapted from: Roe, K. M., Minkler, M., & Saunders, F. F. (1995). Combining research, advocacy, and education: the methods of the Grandparent Caregiver Study. Health Educ Q, 22(4), 458-475.

studies and evaluation programs, learning the skills of knowledge creation will have one of the greatest long-term impacts for these communities.

Capacity Strategy #3: Establish a Statewide Aging Advocacy Coalition

In California, a statewide aging advocacy coalition could help to balance the needs, priorities, and resources of older women, families, policy advocates, service providers, and public policy makers. A principal focus of this coalition should include addressing the needs of the most vulnerable populations of older women. This coalition would provide older women with few resources an equal voice with service providers and other stakeholders. A major rationale for establishing a statewide association would be to move beyond a "responsive" advocacy strategy, in which efforts are primarily directed at defeating or modifying policy recommendations that adversely impact older women, to create a proactive orientation. By adopting a more proactive advocacy strategy, the coalition would set policy agenda priorities and coordinate statewide efforts so that initiatives of importance to older women's issues are able to be moved to the state agenda.

Case Study E provides an example of how such a coalition was developed in California for family issues. This coalition is remarkable in that it had a single philanthropic foundation "cheer-

Case Study E
Building an Association for Targeted Advocacy

The S.H. Cowell Foundation played a pivotal role in establishing a statewide association to advocate for policies to support families, especially low-income families. The plan was well thought out, stakeholder inclusive, and mindful of lessons learned from previous efforts and organizations.

The Demise of Healthy Start. The new association's inception can be traced back to early 2000 when California and the nation suffered a severe economic downturn. Cut-backs in funding resulted in the termination of the Healthy Start Program for School-Linked Services (the largest source of funding for family support at the time). This event reveals the lack of organization and fragmentation of the family support field and the absence of an entity that could effectively advocate for a comprehensive approach to meeting the needs of working-poor families and against crisis-oriented policies.

Foundation Convenes Grantees. In 2001,the Cowell foundation held a convening for its family support grantees. At this gathering, grantees discussed the shifting and grim funding environment and what it would take to be more proactive to prevent such cutbacks in the future and how to have more of an impact on future policies. From this discussion emerged a cry to the foundation for an association that could be a unified policy voice.

Formation of the Family Support Funders. Concerned by this situation, the Cowell Foundation initiated dialogue with other funders to discuss how to address this challenge, which had been compounded by the collapse of Family Support California, a key capacity building organization. In 2001-02, the foundation and its partners decided to convene and establish a Family Support Funders Group. The Funders Group reached a consensus on a shared vision

and began working collaboratively.

In 2002, the Family Support Funders Group joined forces with and asked the Foundation Consortium to provide staffing support and leadership to develop a shared work plan. Their aims were to help establish a unified policy voice and improve program quality and practice. The Funders had a major agenda and they were joined by a distinguished group of public and private funders in the family support field.

Aware that a number of practitioners were beginning to discuss the need to organize, the Family Support Funders Group hired a consultant to interview key informants throughout California to identify the most pressing needs, assess the level of interest in forming an association, and identify options for how such an entity might operate. Convenings and a survey confirmed that advocacy groups supported the creation of a statewide family support association to voice policy and improve program quality and practice.

Establishing the Design Team. The Foundation Consortium was staffing the Family Support Funders Group, and was uniquely positioned to also staff a Design Team. With a planning grant, the Foundation Consortium then brought together a diverse, statewide Design Team charged with:1) developing an organizational plan for the Association including an initial vision, mission, purpose; 2) conducting field outreach to test the components of the organizational plan; and 3) establishing a nomination process for the board of directors. The California Family Resource Association was conceived through this process, which included drafting and finalizing an organizational plan with broad input from the field.

leader" that worked with the different advocacy organizations to move step-by-step through fundamental questions about membership, power, scope, focus, and competition. The foundation funded all phases of coalition development including the convening of advocates' discussions of proposals and recommendations, development and formalization of coalition policies and procedures, development of a policy advocacy agenda, and movement to a more permanent organizational status, which was complicated by the different political ideologies of some of the membership (a hallmark of coalitions that draw from the somewhat disparate political landscape of California). The coalition will be allowed to mature without the added strain of seeking resources immediately.

In 1988, a comparable coalition on aging issues began to form in Southwestern Pennsylvania (Case Study F). This coalition learned that success required: articulating a shared vision through a mission statement that is disseminated frequently and widely; constantly working to build consensus; encouraging an active membership in all coalition activities; and always soliciting new members.

Capacity Strategy #4: Invest in Strategic Placement of Older Women's Policy Analysts

Organizations like the California Budget Project and the Public Policy Institute of California are well respected public interest policy research organizations. Their policy briefs often include data segregated by age. A search of the website for the California Budget Project

Case Study F
Developing an Advocacy Coalition with Varied Interests and Agendas: A Pennsylvanian Experience

Individuals working in the field of aging in Pittsburgh in 1988 began to talk about the idea to create a "neutral place" where others from the various disciplines and areas of interest in their field could come together to network, educate, advocate, and work collaboratively. By the end of 1998 they had formed the Southwestern Pennsylvania Partnership for Aging (SWPPA) and began developing a mission and structure. They brought together individuals from ten counties in and around Pittsburgh. They incorporated as a nonprofit in 1990.

Their membership grew from twenty four in the first year to 393 in 2003. Membership includes older adults, family members, caregivers, and businesses, as well as many different non-profit and for-profit service providers including hospitals, assisted living facilities, homecare agencies, senior centers, universities, and insurers.

SWPPA educates its members through a bimonthly newsletter, conducts topic-focused membership surveys and forums, forms committees to develop positions on different issues, and works on the local, regional, and state level. SWPPA also has partnerships with six local universities to develop an applied-research and technology-transfer program entitled the Community University Partnership for Aging (CUPSA). To date, CUPSA has completed three applied-research efforts: a conditioning program designed to help frail older adults maintain their strength and independence; an outcomes-development and testing project for adult daycare; and a project to develop best-practice-based educational protocol for pain management.

Another SWPPA project is titled "Health Elders...Health Job 2005" and is aimed at sparking culture change within residential and home based programs for older adults. The initiative is engaging twelve residential providers and four area agencies on aging to help them apply the principles of culture change and consumer direction to their system in order to improve the quality of care and quality of life for both older adults and program staff.

Lessons Learned:

- Articulate a shared vision through a mission statement, and disseminate the statement frequently and widely;
- Constantly work at building consensus;
- Promote active, working committees;
- Always solicit new members;
- Hold meetings that feed the needs of coalition members and draw in potential members;
- Provide education to members and the community at large;
- Promote membership networking, information sharing, and cross-referrals;
- Encourage members to participate in all coalition activities;
- Continually assess and reassess the needs of the membership as well as the community;
- Tap into members' expertise;
- Develop short- and long-term internal and external goals;
- Seek ways to make members comfortable with engaging in policy work;
- Work with other individuals and organizations dedicated to the same causes; and
- Value patience and perseverance.

found reports with references to aging issues but only one report that specifically focused on the elderly and no reports that focused on the specific needs of older women. Strategic funding to the top five or six policy research institutions focusing on economics, health care, long-term care, housing, immigrant rights, and access to services would support the development of leadership and the advocacy movement needed to advance a progressive agenda to support older women. Without this data and analysis, advocates are left to fend for themselves in finding and interpreting myriad publications, scouring each for data segregated for older women.

Funding to compile and analyze data specifically about older women would provide significant support to advocates and policy makers attempting to develop programs to meet their needs.

RECOMMENDED STRATEGIES TO INCREASE ACCESS TO SERVICES

Access Strategy #1: Increase Enrollment of Vulnerable Older Women in Safety Net Programs

Services are available in California to assist the elderly in applying for and receiving the appropriate services. The nonprofit Health Insurance Counseling and Advocacy Program (HICAP) uses a volunteer-based model to assist the more than 4.1 million Medicare beneficiaries throughout California. This project is supported by public and private funding and currently hosts approximately 600 volunteers. There is some concern that increased volunteer burden, which is attributable to the growing complexity of the Medicare program, will result in decreasing volunteer participation rates. As volunteers find it increasingly more difficult to understand the intricacies of the program, they may feel less able to provide others with needed enrollment assistance.

Priority should be given to investing in the evaluation and replication of programs such as HICAP, which can assist older women to enroll (and stay enrolled) in safety net programs. A primary concern should be reaching women with low English proficiency and immigrant women who face greater barriers to participation in programs and services. Rather than focusing on encounter data, services must be evaluated on their successful assistance to those they reach, as well as their success in reaching the most isolated and hard-to-find women.

Access Strategy #2: Increase Compliance with Language Access Requirements in Medi-Cal Managed Care and LTC

Currently, recipients of federal funds are legally required to take "reasonable" steps to ensure access to their programs by persons with limited English proficiency (LEP). Title VI of the Civil Rights Act of 1964, including subsequent federal Executive Orders and US Department of Health and Human Services directives, allows health care programs to meet this requirement by balancing four factors: 1) number/proportion of LEP persons served or encountered; 2) frequency with which LEP persons come in contact with the program; 3) nature and importance of the recipient's program to people's lives; and 4) resources available to the recipient and costs.

Effective language assistance plans should include: 1) identifying LEP individuals who need language assistance; 2) providing language assistance measures; 3) training staff; 4) providing notice to LEP persons; and 5) monitoring and updating the LEP plan. California state law, California Department of Health Services and the California Managed Risk Medical Insurance Board have expanded on the federal requirements and provided clearer interpretation of services that would meet the Title VI requirements.

Although these laws exist, many LEP seniors remain greatly underserved. Increased oversight and enforcement of existing policies may compel organizations to address shortcomings in their lan-

guage assistance programs. Efforts could also include exploring options for healthcare institutions to publicly self-report language access efforts and patient satisfaction survey results in online and print "report cards." This would allow agencies, providers, and consumer advocates to compare strategies and performance in terms of an organization's ability to effectively reach traditionally underserved populations.

Access Strategy #3: Support Development and Adoption of an Economic Self-Sufficiency Standard

One step to improving the economic condition of vulnerable older Californians is to develop a more accurate measure for determining minimum income levels needed for seniors to pay for the basic needs of everyday life. Such a measure of seniors' economic well-being would be less outdated and imprecise than those currently used. Ideally it would be: a) comparable across states; b) calculated to reflect the costs of actual goods and services needed by seniors to meet their basic needs in their own communities; and c) grounded in realistic data about actual costs in today's economy.

An effort to develop a Senior Economic Security Standard (SESS) has been initiated to develop the first-ever SESS for California, a tool that will describe the cost of living for seniors on a county-by-county basis. NEDLC is working in partnership with Wider Opportunities for Women in Washington, DC, as well as United Way of the Bay Area.

The goal of creating a California Senior Economic Security Standard is to transform how community organizations, decision-makers, funders, and public agencies see the needs of seniors so that programs are more responsive to the actual economic needs of older Californians. The Senior Economic Security Standard will be based on realistic information about the market costs of goods and services in today's economy. The Senior Standard will answer important questions about seniors' economic health: *how much does it really cost for older adults (aged 65+) to live independently, taking into account differing factors such as age, health, life circumstances, family status, and geography; and what happens to their costs as life circumstances change over time?*

Current plans are that the Senior Economic Security Standard will be computed for different "tracks" of senior households, including low- and modest-income homeowners or renters; and those with different types of supplemental health coverage to Medicare as well as variations in their health status. In addition, the prototype will include variations in the need for long-term care in order to enable seniors to continue living at home.

Issues that should be addressed in the SESS include those specific economic conditions for the most marginalized older women in California including immigrants, non-English speaking older women, older women working in the informal workforce, and LGBT seniors. Additional support may be needed to direct efforts for ensuring that the SESS is responsive to the diverse conditions faced by these segments of the older population.

Access Strategy #4: Fill the Access Gap for Women Ages 45-64

Currently, state and federal healthcare programs for uninsured women are housed in different departments within the Department of Health Services. Among cancer detection services, for example, Every Woman Counts and Family PACT have separate administrative structures that create inefficiencies and inconsistencies in the provision of services.

Several years ago women's health and older women's advocates proposed a bill to require the Department of Health Services (DHS) to combine these two programs for women to better serve women between ages 45 to 64.

Because Family PACT receives a 9:1 federal

match for all monies expended on family planning services including cervical cancer screening, supporters of the bill noted that combining the programs would allow for a better "draw down" on cervical cancer screening in the state. Program integration would also potentially reduce administrative costs. These increased revenues and administrative savings would allow California to extend a greater range of services to low-income uninsured women between the ages of 45-64.

The bill moved through both houses of the state legislature but was vetoed by the governor at the request of the California Department of Health Services, which had not yet done a thorough analysis of the potential savings and costs of consolidating the programs.

Advocacy efforts to keep program consolidation on the top of the agenda for the Department of Health Services, with support from financial and policy analysts, could support and encourage the department to create the needed changes and expand services.

Access Strategy #5: Replicate Housing Models that are Affordable and Culturally Appropriate

Two options that have been pursued by local communities throughout the country include developing affordable service-enriched housing projects, as well as residential care settings targeted to immigrant, ethnic minority, and LGBT groups. Getting such projects developed involves successful partnering between local government, lenders, developers, providers, and other community organizations.

As residents of publicly subsidized housing projects have aged-in-place, several unique models have emerged in California and other parts of the country. These projects have adopted creative strategies for overcoming numerous barriers, such as the lack of funding sources for services and the challenge of effectively integrating housing and service functions. Other projects in California have patched together services from multiple funding sources including on-site service coordinators, meals, adult day health care, and in-home supportive services. Schuetz includes a case study description of how one such project, Presentation Senior Community, was developed in San Francisco.[85] Wilden and Redfoot examine the range of issues faced by publicly subsidized housing choosing to expand their service capacity and include case studies for 17 different projects located in nine states.[86]

As described above, expansion of California's Assisted Living waiver may reduce economic barriers to accessing residential care settings but not other cultural and language barriers. Local community organizations have responded to unmet needs by partnering with experienced residential care developers and operators to develop population-targeted facilities. Case Study G provides an example of one project located in the Warm Springs Tribal Reservation in central Oregon.

Grants to support project development activities would allow local community organizations to secure needed expertise for conducting market research, financing, design, construction and operational activities. The Robert Wood Johnson Foundation's "Coming Home Program for Affordable Assisted Living" is one model program that helped expand the supply of affordable assisted living in underserved and rural areas located in nine states (AK, AR, FL, IA, MA, ME, VT, WA, WI). Nonprofit sponsors of affordable assisted living projects in grantee states received development assistance from NCB Development Corporation. Individual project support included a predevelopment loan fund, consultation on development and operating issues, and building partnerships between facility sponsors, developers, financing agencies, and program operators. State and local assistance resulted in more than 3,300 units of affordable assisted living that were in development or predevelopment, with more than 450 units operational as of 2004.[87]

Case Study G
Developing Culturally Targeted Assisted Living

High Lookee Lodge represents a unique collaboration among local community leaders, developers, and providers to develop a comprehensive program tailored to the unique needs of a community lacking culturally appropriate residential long-term care services. Located on tribal land in Warm Springs, Oregon, the Lodge is a 40-unit assisted living residence with intergenerational programming, convalescent care, hospice and ceremonial facilities. It is the first known setting of this kind designed exclusively for Native American residents.

Recognizing Unmet Needs. The Confederated Tribes of Warm Springs includes the Warm Springs, Wasco, and Paiute Tribes in Central Oregon. In about 1996, tribal leaders began a four-year process to expand local long term care options. The community lacked a residential care facility specifically for older members, a hospital, or a nursing facility. Accessing such services required traveling fifteen miles south to Madras, Oregon where tribal members faced cultural barriers. Providers in Madras did not provide meals that reflected tribal customs or allow overnight stays by family members that were important to tribal elders. Tribal members were often discriminated against in these mainstream facilities. Tribal leaders chose to develop a multipurpose facility with assisted living as its central model but adapted to the needs of community elders.

Project Development and Design. The Tribe hired LRS Architects, which had considerable experience in developing assisted living residences in Oregon. They were responsible for coordinating with the tribe to develop the project, which included project funding, functions and design, and physical construction. The $4.4 million project was mostly funded through a $3.3 million tribal referendum, as well as an Indian Tribal Grant, funds from Indian Health Services, and a HUD Indian Grant. The lack of any remaining debt service or property taxes contributed to the affordability of the project. Typical design features included individual apartments with private bathrooms and kitchenettes, wheelchair accessibility, wide corridors and an enclosed outdoor area.

The Tribal Council remained involved in the planning and design process throughout the project which resulted in several unique design features. A site visit by the Tribal Council to a nearby assisted living residence and focused group meetings with seniors provided valuable feedback that helped determine the multiple purposes that the facility would serve on the reservation. Native, culturally appropriate, and maintenance-free materials were used to construct the 40,000 square foot facility. Unique elements included a tribal ceremonial room, sweat lodge, salmon bake area, and an enlarged dining and kitchen area for other tribal elders and families. The Lodge has an area for senior daycare that provides respite to local community residents. Although not typically found in assisted living residences, a dialysis room was included and made available to all senior community members to address a

higher than normal incidence of kidney failure and the lack of local services. The Lodge's dining area was designed larger than required for on-site residents in order to accommodate all community seniors, who receive a free on-site meal twice per week. High Lookee Lodge's kitchen was also designed to serve the community's Meals on Wheels program. Other unique features include 10 convalescent care studio apartments and a one-bedroom hospice unit.

Unique Service Features. As a leading provider of assisted living services, particularly working with nonprofit organizations and nontraditional populations, Concepts in Community Living, Inc. was hired to operate the residence. In coordinating and providing resident services, the organization applies its own philosophy of promoting individuality, independence, dignity, choice, and privacy. Typical assisted living services include meals, laundry, transportation coordination, and personal care to assist with activities of daily living (e.g. bathing, dressing, toileting, etc.). Routine nursing and behavior management services are also provided as needed. Monthly service costs are covered by the state's Medicaid program for eligible residents. Private pay rates correspond with public reimbursement levels.

As with the physical design of the residence, programs have been personalized to meet the unique needs of the community. For example, special attention has been given to the dietary program so that it meets both regulatory requirements and tribal preferences. Kitchen staples include salmon, venison, native roots and berries. The senior daycare provides services to local elders who prefer to and are able to remain with family. Services for the dialysis area are coordinated with the reservation's Indian Health Services Clinic, eliminating the need for two to three weekly trips for needed treatments up to 50 miles away.

Adapted from Source: Concepts in Community Living, Inc.; NCB Development Corporation.

Conclusions

When you consider that in the past decade California has experienced significant state budget problems (limiting opportunity to pay for solutions), legislative redistricting (which further polarized the bipartisan legislature), and term limits (which have reduced the pool of seasoned legislators who might have been able to put together enough votes to make some substantial changes in the systems of care), it is not difficult to see why the "political will" is lacking to solve some of the most difficult issues facing the elderly.

Redressing this requires the development of capacity within the senior communities to move forward public policy that advances the health and economic well-being of vulnerable women in California.

Glossary

Adult Day Health Care (ADHC) is a licensed and Medi-Cal-certified, community-based day care program providing a variety of health, therapeutic, and social services for frail elderly and functionally impaired adults. The program is designed to prevent inappropriate and personally undesirable placement in nursing facilities.

Adult Protective Services (APS) aims to maintain the health and safety of adults with functional impairments over the age of 18 who live at home or in hotels, or temporarily reside in acute care hospitals, or who use health clinics, or adult day or social day care centers. The goals of the APS program are to prevent abuse and exploitation of adults who are unable to protect themselves.

Assisted Living Waiver Pilot Project (ALWPP) is the Medi-Cal program that pays for assisted living, care coordination, and other specified benefits provided to eligible seniors and persons with disabilities who reside in one of the project's three target counties. Pilot sites include licensed Residential Care Facilities for the Elderly (RCFEs) and publicly subsidized housing.

Health Insurance Counseling and Advocacy Program (HICAP) provides statewide, free, and confidential advice to all Medicare beneficiaries regarding Medicare problems and other health insurance concerns.

In-Home Supportive Services (IHSS) is the largest LTC service program serving individuals in the home and community in the state. The program helps to pay for personal care services for the elderly, blind, and disabled so that they can remain safely in their homes.

Medi-Cal Waiver Programs provide home and community-based care services as alternatives to institutional care by waiving certain Medi-Cal statutes and regulations. Services are targeted to particular populations with special needs.

Multipurpose Senior Services Program (MSSP) provides comprehensive case management services to Medi-Cal eligible frail elderly who are at risk of institutionalization. The program is designed to help individuals live at home by arranging for supportive services, which may include: home delivered meals, health care, homemaker assistance, bathing, non-medical equipment, transportation, personal care items, podiatry, counseling, and emergency housing.

Older Americans Act (OAA) is a federal 1965 law that authorized states to provide a range of programs that offer services and opportunities to older Americans, and established the Area Agencies on Aging (AAAs) to provide community programs.

Residential Care Facilities (RCFs) (aka Assisted Living Facilities) provide basic care in a less restrictive environment than nursing facilities. Most RCFs are private programs in which individuals pay for their own care out-of-pocket or through SSI/SSP or Social Security payments.

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References

1. O'Hara-Devereaux M, Falcon R, Li JDX, Kristensen H. *Fault Lines in the Shifting Landscape: The Future of Growing Older in California—2010.* Menlo Park, CA: Institute for the Future; November 1999. R-110.
2. Scharlach A, Torress-Gil F, Kaskie B. *Strategic planning framework for an aging population: Executive Summary*. Berkeley: California Policy Research Center, University of California; 2001.
3. TCE. *Access Strategic Program Plan*. San Francisco: The California Endowment; 2002.
4. Hayes-Bautista DE, Hsu P, Perez A, Gamboa C. The "Browning" of the Graying of America: Diversity in the Elderly Population and Policy Implications. *Generations*. Fall 2002;26(3).
5. Tafoya SM, Johnson HP. Graying in the Golden State: Demographic and Economic Trends of Older Californians. *California Counts: Population Trends and Profiles produced by the Public Policy Institute of California*. November 2000;2(2).
6. Urban Institute, Kaiser Commission on Medicaid and the Uninsured. California: Population Distribution by Age, states (2003-2004), U.S. (2004). *statehealthfacts.org* [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=California&category=Demographics+and+the+Economy&subcategory=Population&topic=Distribution+by+Age. Accessed April 10, 2006.
7. McGarry K, Kaskie B. *The economic well-being of older Californians*. Berkeley: California Policy Research Center; May 2001. No. 3.
8. Administration on Aging. 2000 Census Figures for the Older Population, for States. http://www.aoa.gov/aoa/stats/2000pop/percent65plusxrace-HO.html. Accessed December 8, 2002.
9. Scharlach A, Torres-Gil F, Kaskie B. *Strategic planning framework for an aging population*. Berkeley, CA: California Policy Research Center, University of California; 2001.
10. Lee R, Villa V. *Population aging in California*: California Policy Research Center; May 2001. No. 2.
11. National Women's Law Center, Oregon Health & Science University. *Making the Grade on Women's Health: A National and State-By-State Report Card*. Washington, DC: National Women's Law Center; 2004.
12. Wallace SP, Pourat N, Enriquez-Haass V, Sripopatana A. *Health of Older Californians: County Data Book*. Los Angeles, CA: UCLA Center for Health Policy Research; October 2003.
13. Weitz T, Estes CL. Adding Aging and Gender to the Women's Health Agenda. *Journal of Women & Aging*. Spring 2001;13(2):3-20.
14. He W, Sengupta M, Velkoff VA, DeBarros KA. *65+ in the United States: 2005: Current Population Reports, P23-209*. Washington, DC: U.S. Census Bureau; December 2005.
15. Administration on Aging. Meeting the needs of older women: A diverse and growing population. http://www.aoa.gov/factsheets/ow.html. Accessed Dec. 1, 2002.
16. SSA, Grad S. *Income of the Population 55 or Older, 1996*. Washington, DC: Social Security Administration; 1998.
17. National Economic Council. Women and Retirement Security. Paper presented at: Interagency Working Group on Social Security; October 27, 1998.
18. Doherty J, Price M. The cost implications of participatory research. Experience of a health services review in a rural region in South Africa. *S Afr Med J*. Mar 1998;88(3 Suppl):390-393.
19. Estes CL, Michel M. Social Security and Women.

In: The America Task Force on Women, ed. *Social Security in the 21st Century*. Washington, DC: Gerontological Society of America; 1999.

20. Scharlach A, Torress-Gil F, Kaskie B. *Strategic planning framework for an aging population*. Berkeley: California Policy Research Center, University of California; 2001.
21. Badgett MVL, Rogers MA. *Left Out of the Count: Missing Same-sex Couples in Census 2000*. Amherst, MA; Washington, DC: The Institute for Gay and Lesbian Strategic Studies; 2003.
22. Badgett MVL. *Income Inflation: The Myth of Affluence among Gays, Lesbian, and Bisexual Americans*. Washington, DC: The Policy Institute of the National Gay and Lesbian Task Force and the Institute for Gay and Lesbian Strategic Studies; 1998.
23. Plumb M. *National Needs Assessment and Technical Assistance Audit*. New York: Senior Action in a Gay Environment; November 2003.
24. Henretta JC, Campbell RT. Status Attainment and Status Maintenance: A Study of Stratification in Old Age. *American Sociological Review*. 1976;41(6):981-992.
25. O'Rand A. The Cumulative Stratification of the Life Course. In: Binstock R, George L, eds. *Handbook of Aging and the Social Sciences*. New York: Academic Press; 1996:188-207.
26. Estes CL. Sex and Gender in the Political Economy of Aging. In: Estes CL, Associates, eds. *Social Policy and Aging: A Critical Perspective*. Thousand Oaks: Sage; 2001:119-135.
27. Older Women's League. *The Color of Money*. Washington, DC.
28. Minkler M, Fadem P, Perry M, Blum K, Moore L, Rogers J. Ethical dilemmas in participatory action research: a case study from the disability community. *Health Educ Behav*. Feb 2002;29(1):14-29.
29. Little Hoover Commission. Long-term care: providing compassion without confusion. http://www.lhc.ca.gov/lhcdir/140/140rpt.html. Accessed Sept. 26, 2002.
30. AARP. Health Care. *AARP Policy Book 2002*. Washington, DC: AARP; 2002:1-156.
31. Halpin Schauffler H, McMenamin S, Zawacki H, Levitt L, Lundy J. *Health care trends and indicators in California and the United States*: Center for Health and Public Policy Studies, UC Berkeley & Kaiser Family Foundation; June 2000.
32. Foley LA, Gibson MJ. *In brief: Older women's access to health care: Potential impact of Medicare reform*. Washington, DC: AARP Public Policy Institute; July 2000.
33. California Budget Project. *Betting on a Brighter Future: The Social and Economic Context of the Governor's Proposed 2002-2003 Budget*. Sacramento, CA: California Budget Project; January 2002.
34. California Budget Project. *Planning for California's Future: The State's Population is Growing, Aging, and Becoming More Diverse*. Sacramento, CA: California Budget Project; November 2005.
35. Baldassare M, Newman M. *The State Budget and Local Health Services in California: Surveys of Local Health Officials*. San Francisco, CA: Public Policy Institute of California; September 2005.
36. Cain BE, Kousser T. *Adapting to Term Limits: Recent Experiences and New Directions*. San Francisco, CA: Public Policy Institute of California; 2004.
37. Canales JE. Harnessing the will for political change in California: 2006 could and should be the year of reform. *San Francisco Chronicle*. February 28, 2006: B7.
38. Talev M. Analysis: Immigrants spread out—so does debate on impact. *Sacramento Bee*. March 31, 2006: A1.
39. Encyclopedia of Everyday Law. Immigration: Eligibility for Government Services. In: Phelps ES, ed. *Gale Encyclopedia of Everyday Law: Gale Group (2003)*. Seattle, WA: eNotes.com LLC; 2006.
40. California Immigrant Welfare Collaborative. *CIWC's 2006-2007 Budget Analysis*. Sacramento, CA: Asian Pacific American Legal Center, Coalition for Human Immigrant Rights of Los Angeles, National Immigration Law Center, and Services, Immigrant Rights and Education Network; January 12 2006.
41. Ku L, Broaddus M. *New Requirement for Birth Certificates or Passports Could Threaten Medicaid Coverage for Vulnerable Beneficiaries: A State-by-State Analysis*. Washington, DC: Center on Budget Priorities; February 17 2006.
42. National Asian Pacific American Women's Forum. *Immigration Reform: The Impact on Asian*

Pacific Islander Women. Washington, DC: National Asian Pacific American Women's Forum; March 2006.

43. Stone R. Where Have All the Advocates Gone? *Generations*. 2004(Spring):59-64.
44. Estes CL. *The Aging Enterprise*. San Francisco, CA: Jossey-Bass Publishers; 1980.
45. Hudson R. Advocacy and Policy Success in Aging. *Generations*. 2004(Spring):17-24.
46. California Budget Project. *Paving the Way: Does the Governor's Proposed 2006-07 Budget Prepare California for the Future?* Sacramento, CA: California Budget Project; February 2006.
47. California Department of Social Services. *Cash Assistance Program for Immigrants: Demographics Caseload and Expenditure Data on Recipients Participating in the CAPI*. Sacramento, CA: California Department of Social Services, Research and Development Division, Data Analysis and Publications Branch; June 2002.
48. California Budget Project. *Governor Proposes to Further Delay Federal COLA*. Sacramento, CA: California Budget Project; March 2006.
49. Cubanski J, Voris M, Kitchman M, Neuman T, Potetz L. *Medicare Chartbook*: The Henry J. Kaiser Family Foundation; Summer 2005.
50. Urban Institute, Kaiser Commission on Medicaid and the Uninsured. California: Distribution of Medicare Enrollees by Gender, states (2003-2004), U.S. (2004). *statehealthfacts.org* [http://www.statehealthfacts.org/cgi-bin/health-facts.cgi?action=profile&area=California&category=Medicare&subcategory=Medicare+Population+Demographics&topic=Medicare+Enrollees+by+Gender. Accessed April 10, 2006.
51. The Women's Foundation. *Failing to Make Ends Meet: The Economic Status of Women in California*. San Francisco, CA: The Women's Foundation; August 2002.
52. Hoffman C, Rice D. *Chronic Illness*. Princeton, NJ: Robert Wood Johnson Foundation; 1996.
53. NCHS. *The 1995 National Health Interview Survey*. Washington, DC: National Center for Health Statistics, U.S. Department of Health and Human Services; 1995.
54. Salganicoff A, Ranji UR, Wyn R. *Women and Health Care: A National Profile*. Menlo Park, CA: The Henry J. Kaiser Family Foundation; July 2005.
55. Lin R-G, II. Drug Plan Doesn't Speak Their Language. *Los Angeles Times*. March 27, 2006; Metro: B(1).
56. California Medical Association. *Bridging Medical Care & Communities to Improve the Health of Women 50+: Executive Summary*. Sacramento, CA: California Medical Association and the California Department of Health Services' California Osteoporosis Prevention and Education Program and Office of Women's Health; March 2002.
57. Kaiser Family Foundation. State Facts. www.statehealthfacts.org. Accessed April 14, 2006.
58. Institute of Medicine (U.S.). Committee on Improving Quality in Long-Term Care., Wunderlich GS, Kohler PO. *Improving the quality of long-term care*. Washington, D.C.: National Academy Press; 2001.
59. Fox-Grage W, Coleman B, Milne D. *Pulling together: Administrative and budget consolidation of state long-term care services*. Washington, DC: AARP Public Policy Institute; February 2006.
60. Harrington C, Newcomer R, Fox P, Tonner MC, Wellin V, Kitchener M. *Publicly Financed Long-Term Care Programs for the Aged in California*. Berkeley: California Policy Research Center, University of California; 2001.
61. Wallace SP, Abel EK, Stefanowicz P, Pourat N. Long-Term Care and the Elderly Population. In: Andersen RM, Rice TH, Kominski GF, eds. *Changing the US health care system: Key issues in health services, policy, and management*. 2nd ed. San Francisco: Jossey-Bass Publishers; 2001.
62. Spillman BC, Liu K, McGilliard C. *Trends in residential long-term care: Use of nursing home and assisted living and characteristics of facilities and residents*. Washington, DC: U.S. Dept. of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy; November 2002.
63. deVries B. Home at the End of the Rainbow: Supportive housing for LGBT elders. *Generations*. Winter 2006;XXIX(4).
64. Estes CL, Zulman DM. Informalization of Long-Term Caregiving: A Gender Lens. *Journal of the American Geriatric Society*. 2001;paper submitted for publication June, 2001.
65. Binney EA, Estes CL, and Humphers, SE. "Informalization and Community Care for the

Elderly." In CL Estes and JH Swan, *The Long-Term Care Crisis: Elders Trapped in the No-Care Zone*. sage Publications: Newbury Park, CA.; 1993.

66. Gregory S, Pandya S, AARP, & Public Policy Institute *Women and Long-Term Care, Fact Sheet*. AARP Public Policy Institute, July 2002.
67. Scharlach A. *Family Caregiving for Older Californians*. Berkeley, CA: California Policy Research Center; May 2001.
68. Scharlach A, Guinta N, DalSanto T, Fox P. *California's Family Caregiver Support System: Findings and Recommendations*. Berkeley, CA: Center for the Advanced Study of Aging Services; January 31 2003.
69. Brandeis University, National Center on Women & Aging, and the National Alliance for Caregiving. *The MetLife Juggling Act Study, 2000*. (This 11-page report looks at how employed caregivers of elderly friends and relatives balance their work and caregiving obligations and the costs involved in reduced wages and benefits. This document is available for free through MetLife's Mature Market Institute; e-mail MetLife for a copy.)
70. U.S. General Accounting Office, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*. GAO-02-544T, 1997.
71. Estes CL, Biggs S, & Phillipson C. *Social Theory, Social Policy and Old Age*, United Kingdom: Open University Press, 2003.
72. Jones VY & Estes CL. 1997. Older Women: Income. Retirement, and Health. In SB Ruzek, VL Olesen, and AE Clarke (eds), *Women's Health: Complexities and Differences*, pps. 425-445, Columbus : Ohio State University Press.
73. National Alliance for Caregiving, AARP. *Family Caregiving in the U.S*. Washington, DC: American Association for Retired Persons; 1997.
74. Hatch J, Moss N, Saran A, Presley-Cantrell L, Mallory C. Community research: partnership in black communities. *Am J Prev Med*. Nov-Dec 1993;9(6 Suppl):27-31; discussion 32-24.
75. Coalition for the Continuum of Care. 2005. *Recommendations submitted to the WHCOA*, Washington, D.C.
76. Horowitz CR, Arniella A, James S, Bickell NA. Using community-based participatory research to reduce health disparities in East and Central Harlem. *Mt Sinai J Med*. Nov 2004;71(6):368-374.
77. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. *Annu Rev Public Health*. 1998;19:173-202.
78. Cornwall A, Jewkes R. What is participatory research? *Soc Sci Med*. Dec 1995;41(12):1667-1676.
79. Lantz PM, Viruell-Fuentes E, Israel BA, Softley D, Guzman R. Can communities and academia work together on public health research? Evaluation results from a community-based participatory research partnership in Detroit. *J Urban Health*. Sep 2001;78(3):495-507.
80. Maselli D, Lys J-A, Schmid J. *Improving Impacts of Research Partnerships*. Berne: Swiss Commission for Research Partnerships with Developing Countries KFPE,; 2004.
81. Alvarez AR, Gutierrez LM. Choosing to Do Participatory Research: An Example and Issues of Fitness to Consider. *Journal of Community Practice*. 2001;9(1):1-20.
82. Nyden P. Academic incentives for faculty participation in community-based participatory research. *J Gen Intern Med*. Jul 2003;18(7):576-585.
83. Aaron KF, Stryer D. Moving from Rhetoric to Evidence-based Action in Health Care. *Journal of General and Internal Medicine*. July 2003;18:589-591.
84. Themba MN, Minkler M. Influencing Policy Through Community Based Participatory Research. In: Minkler M, Wallerstein N, eds. *Community based participatory research for health*. San Francisco, CA: Jossey-Bass; 2003:349-370.
85. Schuetz J. Affordable *Assisted Living: Surveying the Possibilities*. Boston, MA: Joint Center for Housing Studies of Harvard University for Volunteers of America; January 2003.
86. Wilden R, Redfoot DL. *Adding assisted living services to subsidized housing: Serving frail older persons with low incomes*. Washington, DC: AARP Public Policy Institute; January 2002.
87. Murray T, Maher L. Coming Home(R): Affordable Assisted Living Grant Results. August http://www.rwjf.org/reports/npreports/coming-homee.htm. Accessed April 14, 2006.

The Eligibility-Benefits Gaps for Aging Californians

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Introduction: The Eligibility-Benefits Gap for Aging Californians

Older persons age 65 and over are particularly dependent on public programs for their health and well-being. The need for health care—preventive, curative, and chronic care—increases with age at the same time that income and other resources decline. And older persons with limited incomes are the least likely of any age group to be able to increase their incomes in the future. As a result, barriers to enrolling in public programs and in obtaining services through those programs fall particularly heavily on the older population.

There are many public programs that provide essential benefits to the elderly and their families where the state contributes financial, administrative, and/or legal oversight. These include:

- Medi-Cal: health insurance for low-income aged, blind, and disabled persons who have almost no assets, as well as for low-income families with children (about 650,000 elderly in California are covered).[1]
- In-home Supportive Services (IHSS): homemaker services for 360,000 low-income persons of all ages with disabilities. Medi-Cal also funds complementary home and community based services.[2]
- Other long-term care programs include the Multipurpose Senior Service Program (MSSP) of enhanced case management (serving about 12,000 seniors) and Adult Day Health Care (serving 47,000).[3] Newcomer, et al. identified 74 different long-term care programs in six different California state agencies.[4]
- Supplemental Security Income (SSI): cash assistance to very low-income aged, blind, and disabled persons with almost no assets (1.2 million persons total receive SSI in California; about 523,000 are age 65 and over).[5]
- Health Insurance Counseling and Advocacy Program (HICAP): benefits counseling and advocacy for all Medicare recipients. This program averaged 10,000 calls per month before the implementation of the Medicare Part D prescription benefit, when calls peaked at 60,000.[6]
- Adult Protective Services (APS): protection from elder abuse and exploitation for all older adults (clears about 4,000 cases per month, 40% of which are substantiated).[7]
- Health facilities licensing and inspection: monitors quality of care and patient rights for nursing homes, residential care facilities (assisted living), adult day care, and other facilities.
- Long-term care ombudsman: resident advocacy, responding to about 45,000 complaints annually.[3]
- Senior transportation services: including paratransit (dial-a-ride).
- Senior center services: congregate meals (serving 121,000), home delivered meals (serving 57,000), recreation and education (970,000 served) and other health, recreation, and social services.[3]

- Local planning, zoning, and other policies that foster or hinder elder-friendly communities.[8]
- Caregiver support services: serving about 18,000 families annually through the federally-supported Family Caregiver Support Program of the Older Americans Act[3] and 14,000 through the state-supported Caregiver Resource Centers for caregivers of persons with brain impairments such as Alzheimers.[9]

It is difficult to precisely describe the full extent of benefits-eligibility gaps because these programs are provided by many different California state and local agencies, and because there is no statewide needs assessment of older persons that can accurately determine the number of older persons with unmet needs. Identifying the eligibility-benefits gap in the state relies on an understanding of the health and welfare needs of the older population using different data sources, then often comparing those needs to the number of elders receiving particular services. While this is only a rough estimate, it can help identify policy and planning priorities for the state. The exception is the California Health Interview Survey (CHIS), which provides information on the health status and medical care use in the state in a single dataset.

The demographics of the older population raise additional issues.[10] First, a majority of the 3.8 million older persons in California are women (57% of those age 65 and over; two-thirds of those age 85 and over). Among older women in the state, most (60%) are widowed, divorced, separated, or never married. In contrast, the majority (69%) of older men are still married and living with their spouse. This makes the issues of caregiving, income security, and housing options of particular importance for older women. Second, California has one of the most racially and ethnically diverse older populations in the country. One-third of the elderly are Latino, Asian, African American, American Indian/Alaska Native, or multiple race. Access to public services and programs depends on issues such as cultural competence and geographic availability. Third, the percent of older Californians who are foreign born (28%) is almost three times the national rate. This raises issues of language access and comfort levels in using public services that immigrant elders may not yet be familiar with.

As we move further into the 21st century, these demographic characteristics are likely to become even more pronounced. In particular, the "near-elderly" (those age 55-64) are twice as likely to be divorced as the elderly age group (14% versus 7% for men and 22% versus 10% for women), are more racially and ethnically diverse (42% racial/ethnic minority versus 34%), and are more often of foreign birth (32% versus 28%).[10] This suggests that the issues of gender, race/ethnicity, and immigration will be increasingly important for understanding who needs and who receives public benefits among older Californians in coming years.

Who are At-Risk Older Californians?

POVERTY

Poverty is a problem for older Californians because it is a risk factor for poor health, as well as for problems in obtaining needed treatment for health conditions. Focusing only on those with incomes below the poverty line is inadequate, however, because Supplemental Security Income (SSI—a cash assistance program for the aged, blind, and disabled) provides benefits in California at just above the poverty level (in the last part of 2006 SSI in California pays $1,472/month for a couple and $836 for an individual. The federal poverty level (FPL) is $1,100/month for a couple and $817 for an individual).[11, 12] As a result, a substantial number of older persons have incomes just barely above the poverty level. In addition, the poverty level is a uniform national income amount that does not reflect the high housing costs of California and is therefore an inadequate indicator of economic deprivation, especially in urban areas of the state. One study estimated that the poverty rate for persons of all ages in California would increase from 13% to 18% if housing costs were taken into account.[13]

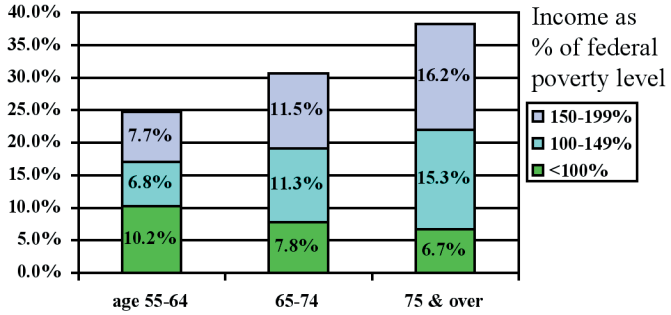
There are 3.2 million residents in the state ages 55-64, 2.0 million ages 65-74, and 1.7 million ages 75 and over. While a similar proportion of each age group has incomes under the poverty level, persons at older ages have higher rates of incomes just above the poverty level (Exhibit 1).[10]

Overall, the rate of persons with low incomes (under 200% of the poverty line) is 24.7% for those age 55-64, 30.6% of those age 65-74, and 38.3% of those age 75 and over. This rate results in 795,000 persons age 55-64 with low-incomes in the state. An additional 1.3 million persons over the age of 65 have low incomes. When combined, over two million Californians who are elderly or near elderly have low incomes.

WOMEN

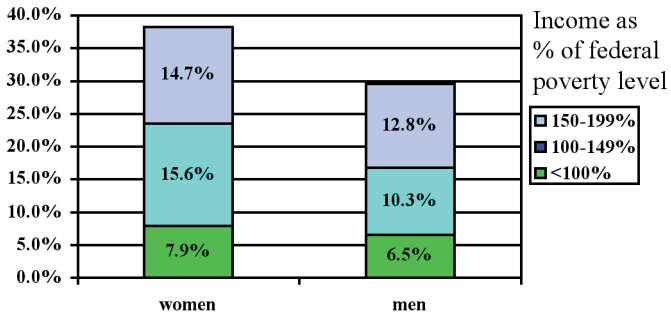
Older women are about 10% more likely than older men to have low incomes (Exhibit 2). Among the total population of 3.9 million elderly men and women in California age 65 and older, 840,000 women (38.2%) and 500,000 men (29.6%) have incomes below 200% of the FPL. Living alone is a particular risk for poverty among

Exhibit 1
Many older Californians have incomes *just* above the federal poverty line.



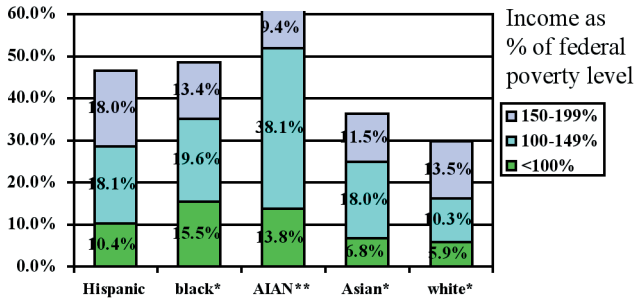
Source: U.S. Census, 2005 Current Population Survey

Exhibit 2
Low-income older Californians are more often women than men.
Age 65 & over



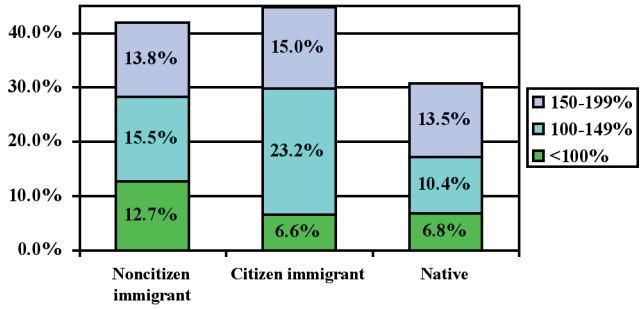
Source: U.S. Census, 2005 Current Population Survey

Exhibit 3
Minority older Californians have lower incomes than whites.
Age 65 & over



* NonHispanic single race **includes multiple race and Hispanic
Source: U.S. Census, 2005 Current Population Survey

Exhibit 4
California immigrants have lower incomes than native citizens.
Age 65 & over



Source: U.S. Census, 2005 Current Population Survey

older women. While 26% of older women who live with others reside in a low-income household, 59% of older women who live alone have low incomes.

RACE AND ETHNICITY

Race and ethnicity are also important characteristics to consider (Exhibit 3). Poverty rates are particularly high among African American and American Indian/Alaska Native (AIAN) elders and lowest for non-Hispanic whites. As noted above, the near poor rate (100-199% of poverty) is several times larger than the poverty rate. The group hardest hit by low incomes are AIAN elders, three-fifths (61%) of whom have incomes near or below the poverty line. Almost half of older African Americans (48%) and Hispanics (46%), and more than one-third of Asian elders (36%) have low incomes. About 30% of non-Hispanic white older persons have low incomes. Because non-Hispanic whites account for the largest number of elderly persons, they constitute the largest group (763,000) of low-income elders in comparison with elderly Hispanics (285,000), Asians (167,000), African Americans (102,000), and AIAN (25,000)).

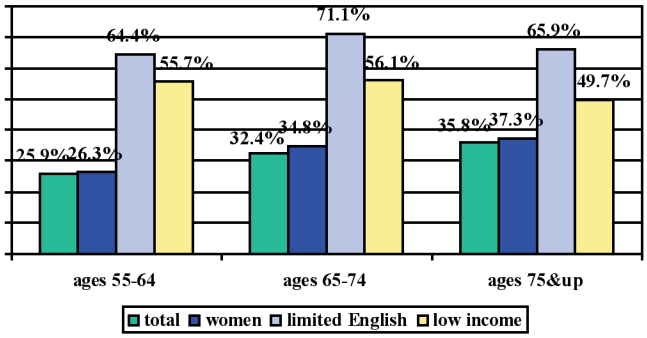
IMMIGRANTS

Immigrants are more likely than native born Americans to have low incomes among older persons in California (Exhibit 4). The 340,000 noncitizen immigrant elders have almost twice the rate of poverty as the 733,000 citizen immigrant elders. Older citizen immigrants have a similar poverty rate to the 2.8 million native born elders. Immigrants look more alike when

considering low incomes. Both noncitizen and citizen immigrants have similar rates of low income (less than 200% of the poverty line, 42% and 45% respectively). Native born older Californians have the lowest, but a still substantial, rate of living in low-income households (31%).

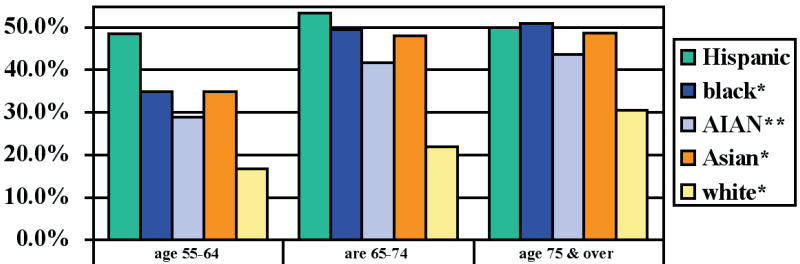
In sum, substantial proportions of the older and near-elderly population in California live just above the poverty line, a fact that is overlooked when focusing only on those below that meager income level. Over two million Californians age 55 and over have low incomes—that is, family incomes under 200% of the poverty line. The groups most likely to have limited incomes include those in the oldest age groups, older women (especially those living alone), racial and ethnic minorities, and immigrants. Their limited incomes constrain their options for obtaining food, housing, and health care, which are important for preserving health and treating disease.

Exhibit 5
Older Californians with limited English proficiency are often in fair or poor health.



Source: California Health Interview Survey 2003

Exhibit 6
Older minority Californians are more likely than whites to be in poor or fair health.



	age 55-64	are 65-74	age 75 & over
Hispanic	48.5%	53.4%	50.0%
black*	35.0%	49.8%	51.1%
AIAN**	28.9%	41.8%	43.9%
Asian*	35.0%	48.2%	48.8%
white*	16.8%	21.9%	30.6%

* NonHispanic single race **AIAN includes multiple race and Hispanic
Source: California Health Interview Survey, 2003

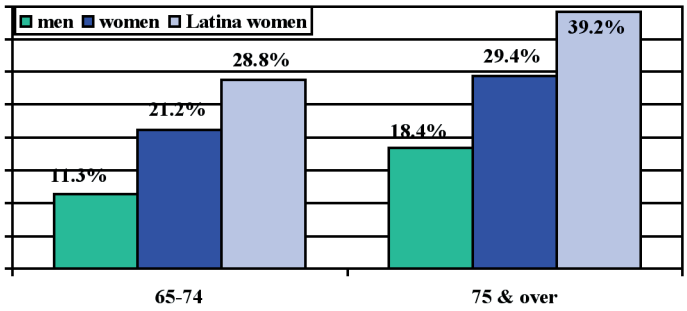
HEALTH STATUS

Limited resources are compounded by high medical needs. This section documents that the need for health care among near-elderly and older Californians is highest for the same subgroups that have the lowest incomes. Self-reported health status is a commonly used global indicator of health, and fair and poor self-reported health status (rather than excellent, very good, or good health) is a good predictor of future poor health outcomes, including mortality. Across age groups (Exhibit 5), persons reporting limited English ability are the most likely to report fair or poor health, with low-income persons also reporting higher rates than the total age group.

Racial and ethnic minority elderly are more likely than whites in all older age groups to report fair or poor health (Exhibit 6). The difference between non-Hispanic whites and other groups is most striking among the near-elderly, those ages 55-64. Among the elderly, about half of Hispanics, Asians, and African Americans report fair or poor health.

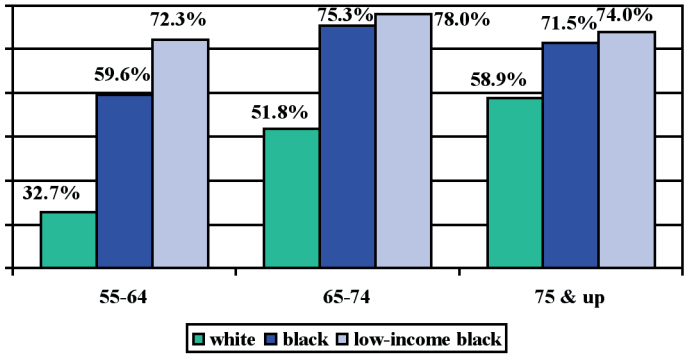
Some health problems are called "ambulatory sensitive conditions." These conditions can be

Exhibit 7
Latinas have a high rate of incontinence.



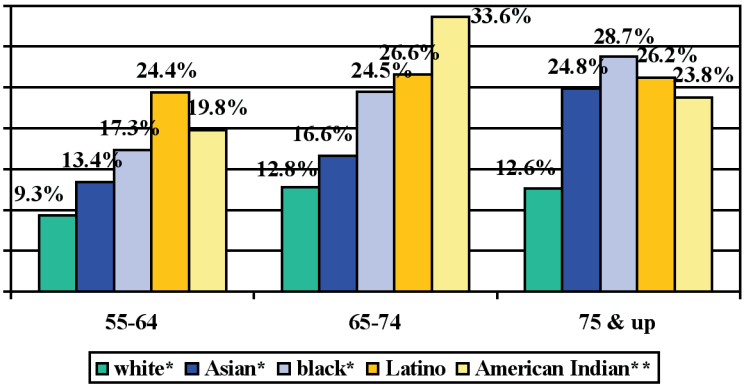
Source: California Health Interview Survey 2003

Exhibit 8
Low-income African Americans have a high rate of hypertension.



Source: California Health Interview Survey 2003

Exhibit 9
The incidence of diabetes is higher among ethnic/racial minorities than whites.



* NonLatino single race **All AIAN, including w/multiple race and Latino
Source: California Health Interview Survey, 2003

controlled with adequate medical monitoring and treatment, but when they are not monitored and treated they can lead to more severe health consequences and even death. Among older persons, these conditions include urinary incontinence, hypertension, and diabetes. Uncontrolled incontinence is a risk for social isolation, functional decline, and institutionalization. Uncontrolled hypertension increases the chances of heart attacks and strokes. And untreated diabetes can lead to blindness, limb amputations, and heart attacks.

INCONTINENCE. (Exhibit 7) varies the most by gender. Women have substantially higher rates of incontinence than men, and the rates increase with age. Latinos report higher rates than other groups, and two-fifths of Latinas age 75 and over report being unable to hold or control their urine multiple times in the past month.

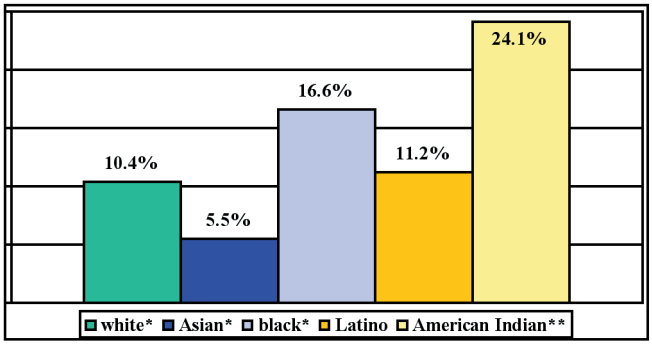
HYPERTENSION. (Exhibit 8) is a particularly significant issue for African Americans and low-income persons. Almost three-quarters of low-income African Americans report hypertension by age 55-64, a rate that is so high it remains relatively constant through older ages. For non-Latino whites and African Americans of all incomes, there is a large increase in the rate of hypertension between the near-elderly and elder age groups, with African Americans having substantially higher rates at every age.

DIABETES. (Exhibit 9) has high rates among all racial and eth-

nic groups. While the rate increases only slightly with age among non-Latino whites, it increases markedly ages 55-64 among all other groups, particularly among Latinos, who have exceptionally high rates. One-third of American Indians ages 65-74 report having diabetes, the highest of any age and race group. Older Asians have a sharp jump in the rate of diabetes for the oldest age group.

More information about the numbers of older persons and others with ambulatory sensitive chronic conditions at the county level in California is available in a report, *Chronic Conditions of Californians*, at http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=162.

Exhibit 10
Among elderly Californians, American Indians have the highest rate of disability.



* NonLatino single race **All AIAN, including multiple race and Latino
Source: California Health Interview Survey, 2003

DISABILITY. Disability that results from a health problem or condition can create the need for special equipment or someone to help with daily activities such as eating, dressing, bathing, getting out of chairs, moving around the house, or using the toilet. Older persons with low incomes are twice as likely to have a disability compared with high-income elders (10.4% versus 4.9%). Low-income Asians have the lowest rates of disability, followed by low-income non-Latino whites and Latinos. Among the low-income population, Blacks have a higher than average disability rate. The AIAN population is too small to allow making a definitive assessment (Exhibit 10). Low-income elders are an important group for public policy since they may qualify for the In-Home Supportive Services (IHSS) program, a public program that pays for someone to assist with those daily activities and other daily needs. Elderly and disabled persons are eligible if they qualify for SSI (see above). Those who qualify for SSI except for their income may be able to "spend down" or pay a "share of cost" of the services and qualify. When they qualify for IHSS they also qualify for Medi-Cal. Of those who report low incomes and a disability, about one-quarter do not have Medi-Cal and are therefore not receiving IHSS assistance either.

In sum, there are a large number of near-elderly and elderly Californians with limited incomes. Poverty and near-poverty rates increase with age, and are higher for women, racial/ethnic minorities, and immigrants. These same groups are also often at higher risk for a number of different health conditions, including fair/poor self assessed health, incontinence, hypertension, and diabetes. These are the groups that are particularly at-risk for complications of health problems when they fall through the cracks of the social safety net and have problems accessing the health and social services that they need. Similarly, low-income older adults with a disability are a high need group, but about one-quarter do not receive coverage that would entitle them to assistance. The next section describes the access to care problems that these high priority groups face.

ACCESS TO CARE BARRIERS

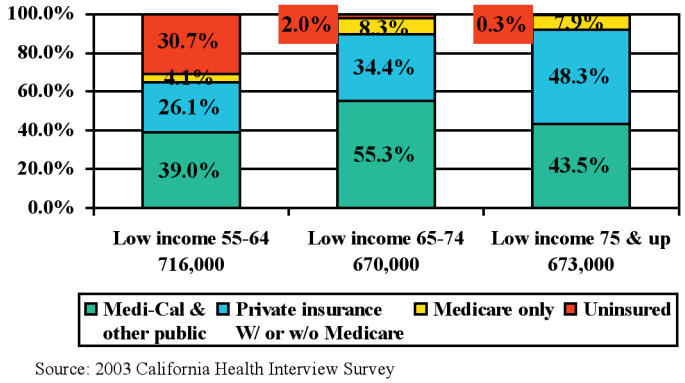
The large numbers of persons with incomes just above the poverty line are one illness away from falling into poverty. While the poverty line itself is unrealistically meager in high cost of liv-

ing areas such as most of California, health problems complicate low incomes for older persons because of the cost of medical care, prescription drugs, and other illness-related needs. Many older persons, and those approaching old age, are at substantial risk because they have low incomes but are not currently covered by Medi-Cal, California's health insurance program for low-income persons.

HEALTH INSURANCE

The group that is at greatest risk for untreated health problems due to financial barriers is the near-old population (55-64 years) with low incomes (below 200% of the FPL). Almost one-third of low-income persons age 55-64 years has no health insurance and little means to pay for health care should they need it (Exhibit 11). Uninsured, low-income, near-elderly also have high needs for health care. While rates of diabetes and hypertension are similar between those with and without insurance, uninsured, the low-income 55-64 year-old group is more than twice as likely as those with insurance to lack appropriate diabetes care (no A1c test in past year among those with diabetes: 23% of the uninsured versus 10% of those with health insurance).[14]

Exhibit 11
Low-income Californians ages 55-64 lack health insurance.



Source: 2003 California Health Interview Survey

Almost all low-income persons age 65 and over have some health insurance since Medicare covers almost all older persons. But those who have only Medicare are at risk of high copayments and deductibles, as well as spending for a number of services such as eyeglasses, hearing aids, and custodial long-term care, which are not covered at all. As a result, the 8 percent of low-income older persons in California with only Medicare coverage are also at risk of facing high out-of-pocket costs that could be a barrier to their use of needed medical care.

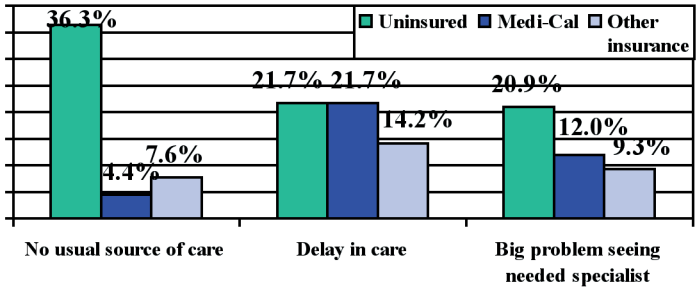
The importance of Medi-Cal for low-income persons is illustrated in Exhibit 11, which shows that two-fifths to one-half of older and near-elderly low-income persons rely on Medi-Cal for their health care, either alone or as a supplement to Medicare. Over one-third of Californians age 55-64 with incomes below 200% of poverty report receiving Medi-Cal, a total of 245,000 persons. Over half of those in this age range with Medi-Cal also report receiving SSI, meaning that they most likely receive Medi-Cal because they are blind or disabled. Of those not reporting SSI, one-third has minor children in the home and probably receive Medi-Cal for that reason. The rest may "spend down," meaning that they are blind or disabled and have significant medical bills that lower their income to the SSI-level, making them eligible for medical assistance even though they do not receive cash assistance.

MEDICAL CARE

The uninsured, low-income, near-elderly face the greatest barriers to obtaining needed medical care. This uninsured group is more likely to need health care than their insured peers since they are more likely to report fair or poor health (53% versus 40%). More

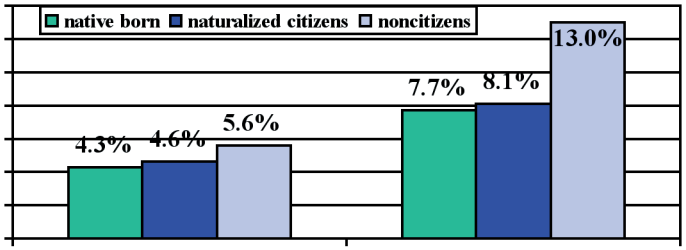
than one-third of those who lack health insurance report having no usual source of care. Two-fifths who needed medical care delayed or did not get it, and two-fifths of those who needed to see a specialist reported that they faced "big problems" getting that care (Exhibit 12). Those with Medi-Cal and those with other types of insurance (primarily employer-provided private insurance) fared much better, although Medi-Cal recipients faced delays in obtaining needed care at a similar rate as those with no insurance. Similar numbers of low-income Californians age 55-64 reported that they had no insurance (220,000), Medi-Cal (244,000), and other insurance (252,000) in 2003.

Exhibit 12
Uninsured low-income Californians ages 55-64 face greatest barriers to access to care.



Source: 2003 California Health Interview Survey

Exhibit 13
Elderly Californians who are not U.S. citizens delay in getting needed medical care.

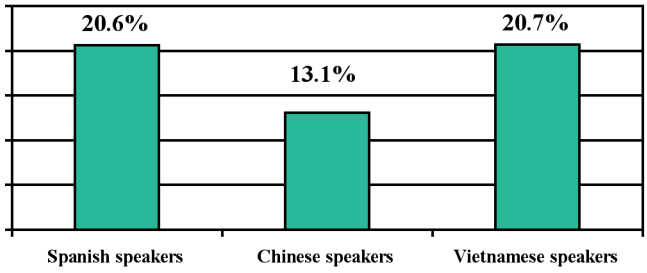


Source: 2003 California Health Interview Survey

The low-income population age 65 and over faces a different set of challenges. Thanks to Medicare and Medicaid, less than 4% of low-income elders report no usual source of care, only 7% experienced a delay in obtaining needed care, and 6% reported a big problem in obtaining needed specialist care. These statistics are all much lower than those of the uninsured younger age group, and the rates do not vary much among the elderly by type of insurance coverage. One subpopulation of older persons where delays in obtaining needed medical care continue to be a problem is those in fair or poor health, especially among noncitizens (Exhibit 13). While having fair or poor health generally doubles the incidence of delays in care, the rates are highest for noncitizen immigrants. In a separate analysis (not shown here), being a noncitizen (not years of residence in the U.S.) increases delays in care. Having a low income modestly increases the odds of experiencing a delay in care, but controlling for low-income does not substantially change the risk of a delay in care for elderly noncitizens. One possible explanation for this is that noncitizen elders may be more likely to have undocumented family members living with or near them, and they may therefore delay care for fear that seeking medical care could put their family at risk from the immigration service. They may also fear being considered a public charge if they use medical care and worry that their own future chances for regularizing their immigration status or becoming citizens could be imperiled.

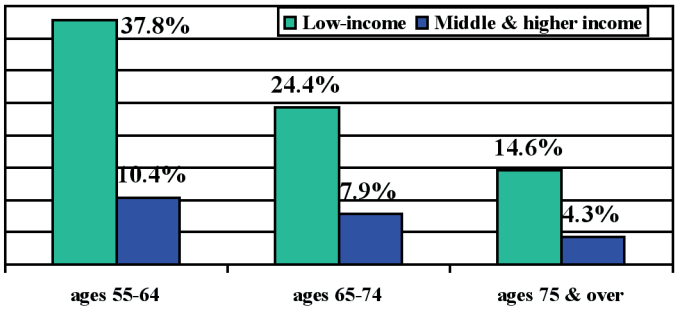
Another type of barrier to health care is communication problems. Having difficulty understanding a doctor complicates the communication necessary for diagnosis, makes following recommended treatment less likely, and impairs the

Exhibit 14
Elderly non-English-speaking immigrants have difficulty understanding their doctors.



Source: 2003 California Health Interview Survey

Exhibit 15
Low-income Californians often cannot afford dental care.



Source: 2003 California Health Interview Survey

doctor-patient relationship, all of which are important components of the therapeutic encounter. Among older persons who do not speak English at home, upwards of one-fifth report difficulty understanding their doctor during their last visit. This is true for older persons who were interviewed in the major languages that the California Health Interview Survey used (Exhibit 14). Similar barriers are probably also experienced by older non-English speakers such as Armenians, Koreans, and Filipinos (each group constitutes more than 5,000 enrollees in Medi-Cal).

DENTAL CARE

Dental care has significant financial barriers for low-income older Californians because Medicare does not pay for most dental services. Low-income persons (in families with incomes below 200% of the FPL) are about three times more likely than higher income persons to report that they could not afford needed dental care in the past year (Exhibit 15). Although the percentage of persons reporting problems affording dental care declines with age, differences between the income groups remain. The decline in financial barriers may result from the circumstance that currently, the oldest old are more likely to wear dentures, which would eliminate the need for dental care. This pattern will probably change in future years as an increasing proportion of elderly people retain most of their teeth until the end of their lives.

A new barrier is likely to exist when the federal requirement for new and renewal Medicaid applications to include proof of citizenship is implemented.[15] At the national level, advocacy groups have expressed concern about the additional administrative burden that will serve as a further barrier to enrollment, especially for the disabled and some older African-Americans who may not have birth certificates. In California the situation is further complicated by the large number of Medi-Cal recipients who are naturalized citizens and will face new paperwork barriers. Approximately one-third of elderly Medi-Cal recipients in the state are naturalized citizens. This means that about 250,000 current older recipients will have new paperwork requirements. This is a group that is likely to be particularly concerned about the legal status of their families. Simply requiring the additional citizenship paperwork is likely to

Access to Care Barriers Reduce Preventive Services

The impact of access to care barriers and the eligibility-benefit gap have a striking effect on the ability of near-elderly and older persons to remain healthy. This is clearly seen for some of the key preventive services and screenings used by these populations.

FLU SHOTS

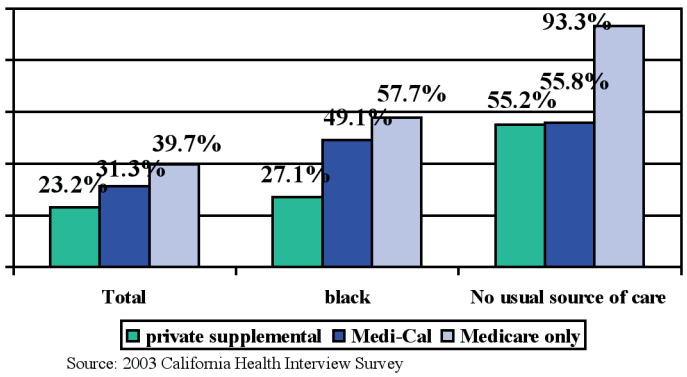
Flu shots are the most common preventive service that older people rely on. This immunization reduces both illness and death during the flu season. In California, the percent without an immunization in the past year is lowest (best) for those who have Medicare with a private supplemental policy, higher for those with Medicare and Medi-Cal, and highest for those with only Medicare (Exhibit 16). While all older persons with Medi-Cal have a lower rate of receiving a flu shot than those with private supplemental (Medi-gap) insurance, the gap is the largest for African-Americans. (Medi-Cal makes almost no difference in the immunization rates among whites; not shown).

Lack of immunization is also much higher among those elders without a usual source of care. Over 90% of the approximately 20,000 older persons in California with only Medicare insurance and no usual source of care report no flu shot in the previous year.

MAMMOGRAPHY

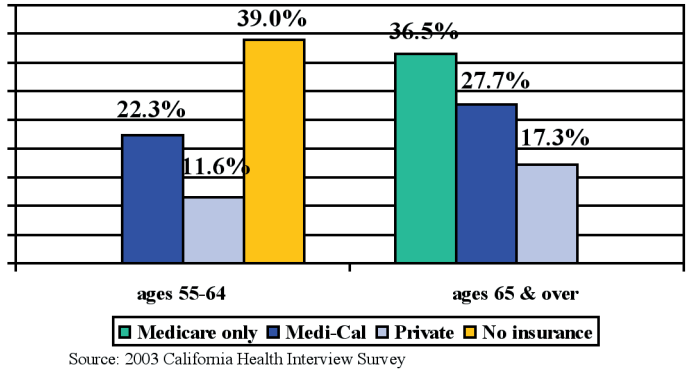
Mammography screening is a proven means to reduce women's mortality from breast cancer. Recommended screening should occur for all women every 1-2 years starting at age 40. There is no upper age recommended for women who are healthy. For women age 55-64 in California, two-fifths of those without health insurance did not receive a mammogram during the previous two years, compared to less than 12% for women with private health insurance (Exhibit 17). Women with Medi-Cal had a worse mammography rate than privately insured women, but much better than that of uninsured women. Among women age 65 and over, more than one-third with Medicare only did not receive the recom-

Exhibit 16
Elderly Californians with no usual source of care have a low rate of flu immunization.



Source: 2003 California Health Interview Survey

Exhibit 17
Rates of mammography screening vary by insurance status.



Source: 2003 California Health Interview Survey

mended screening; more than one-quarter of those women with both Medicare and Medical did not receive screening. This pattern was similar when looking only at older women in good health (data not shown). For both age groups, those most at risk for not having a mammogram are women without a usual source of care. No mammogram in the previous two years was reported by three-fifths of women age 55 and over with no usual source of care, compared to under one-fifth of those with a usual source of care.

In sum, the same barriers to accessing regular medical services—no health insurance, Medicare only, no usual source of care, low income, being a member of a minority group—also serve as barriers to preventive services that protect the health of aging Californians.

Gaps in Receipt of Other Public Programs with State Funding: SSI (Cash Assistance) and Housing Assistance

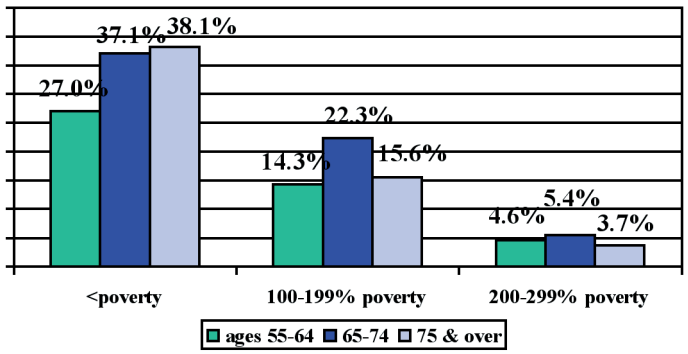
Two other public programs are critical to the health and well-being of low-income older persons in California: Supplemental Security Income (SSI) and housing subsidies.

SSI

SSI provides cash assistance to low-income elderly (age 65 and over), blind, and disabled persons. In December 2004, approximately one-half million Californians age 65 and over received support from SSI; about one-third of them originally qualified for SSI before they turned 65 because of blindness or disability.[5] This program is important because it provides a minimal income to older persons with few or no other resources, and provides automatic eligibility for Medi-Cal. To qualify, older persons must have incomes near the poverty level or less (see poverty section, above), and almost no assets other than the house they live in and a personal car. Other assets are limited to $2,000 for individuals and $3,000 for a couple, amounts that have not changed since 1989. Nationally, about 60% of older persons who *qualify* for SSI in both income and assets participate in the program.[16] Eligibility is difficult to calculate based on survey data, so it is not possible to estimate participation rates from the California Health Interview Survey. What we can examine is the proportion of older persons at different income levels (incomes that include receipt of SSI when applicable). Exhibit 18 shows that SSI receipt is the lowest among the near-elderly because they receive it only if they are disabled or blind. While many of those in poverty who do not receive SSI are not eligible because their assets are higher than the meager limits, many do not apply for other reasons (see policy recommendations, below). If the national rate of underenrollment applies to California's older population, about 300,000 additional older persons in the state would be eligible for SSI. Because of the link between SSI, Medi-Cal, in-home supportive services, and other programs, this is a substantial potential gap in the safety net for seniors in the state.

Older persons with incomes below the poverty level are most likely to qualify for SSI,

Exhibit 18
Many poor Californians ages 55 and older do not receive Supplemental Security Income.



Source: 2003 California Health Interview Survey

unless they have more than the minimal allowable assets. Using those persons without SSI from the 2003 California Health Interview Survey data, we can approximate the regions where the estimated 300,000 elders live who are "eligible but not enrolled" in SSI. About one-third reside in Los Angeles County (especially the San Gabriel and San Fernando Valleys); about one-fifth live in each of the rest of Southern California and the Bay Area; about 10% in the San Joaquin Valley; and less than 5% live in the Sacramento Area and Northern California.

HOUSING SUBSIDIES

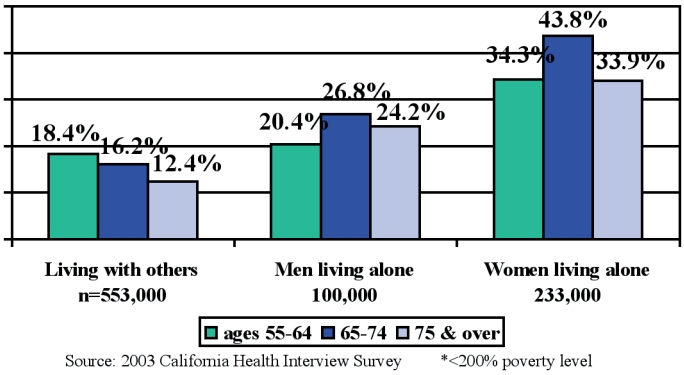
Housing subsidies are another important resource for low-income older persons. The rapidly rising costs of housing in the state continue to put pressure on the resources of many older persons who are on relatively fixed incomes. About three-quarters of all older adults in California own their homes, but only half of low-income older persons (with incomes below 200% of the federal poverty level) own their homes. About two-fifths of low-income elders rent an apartment or other housing and are at particular risk for rising housing costs; less than one-tenth have some other arrangement (e.g., living with children without rent). Most older persons who rent are unprotected against rent increases, which may increase faster than their income. These half-million low-income seniors are most at risk of falling into an eligibility-benefits gap.

The rate of low-income elders who rent varies by county. The lowest proportion of low-income elderly renters resides in the San Joaquin Valley (Kern, Fresno, and Madera) and San Mateo County, where less than one-fifth of low-income elders are renters. In contrast, more than half of low-income elders in San Francisco and Solano counties, and almost half in Los Angeles, Ventura, and Santa Barbara are renters. In sum, large numbers of low-income elders live in high-rental counties, which include some of the most expensive housing markets in the state. The following map shows the rate of low-income elders who rent in each county.

Housing can be subsidized through government support for the construction of low-rent housing, subsidy/voucher programs, tax incentives, and local zoning requirements for affordable housing components within new development projects. Federal funding for construction and subsidies has languished in recent years,[17] although California has a number of supplemental programs to assist with low rent housing.[18] Nonetheless, in San Francisco alone it is estimated by the Senior Action Network that 5,700 seniors are on waiting lists for affordable housing. And an AARP-California survey in 2005 found that 66% of their members were concerned about housing costs.[33]

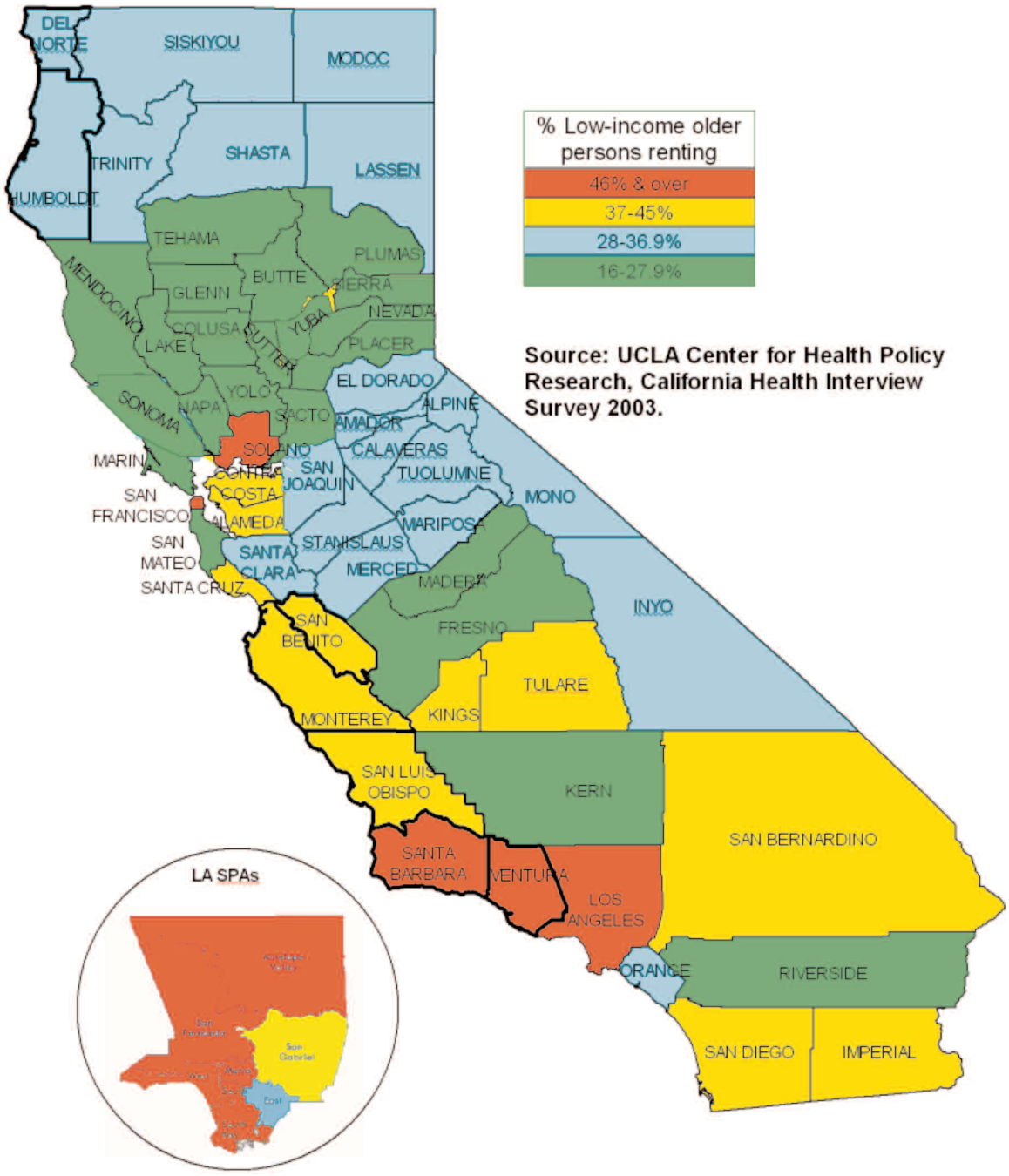
Near elderly and elderly persons with low incomes are more likely to receive housing assistance when they live alone than when they live with others (Exhibit 19). While there is no

Exhibit 19
Low-income* California women who live alone have the highest rate of receiving rent subsidies.



Source: 2003 California Health Interview Survey *<200% poverty level

Map 1
Geographic Distribution of Elderly Low-Income Renters in California



difference between men and women in the receipt of housing assistance when they live with others, when they live alone women are substantially more likely to receive assistance.

MEDICARE PRESCRIPTION DRUGS (PART D)

Medicare Part D is a federal program that subsidizes the costs of private drug prescription insurance. Its implementation has implications for state-level programs. Under the Medicare prescription drug plan that started January 1, 2006, all Medicare recipients who also received Medi-Cal had their prescription coverage shifted from Medi-Cal to no-premium/deductible and low-copayment Medicare Part D plans. The administrative shift was chaotic, leading California to establish an interim program to assist Medi-Cal recipients who were having trouble obtaining their new Medicare benefits (AB132 & AB813, Nunez). These laws provide special prescription drug benefits during 2006 for Medi-Cal recipients who are having trouble obtaining their medications.[19]

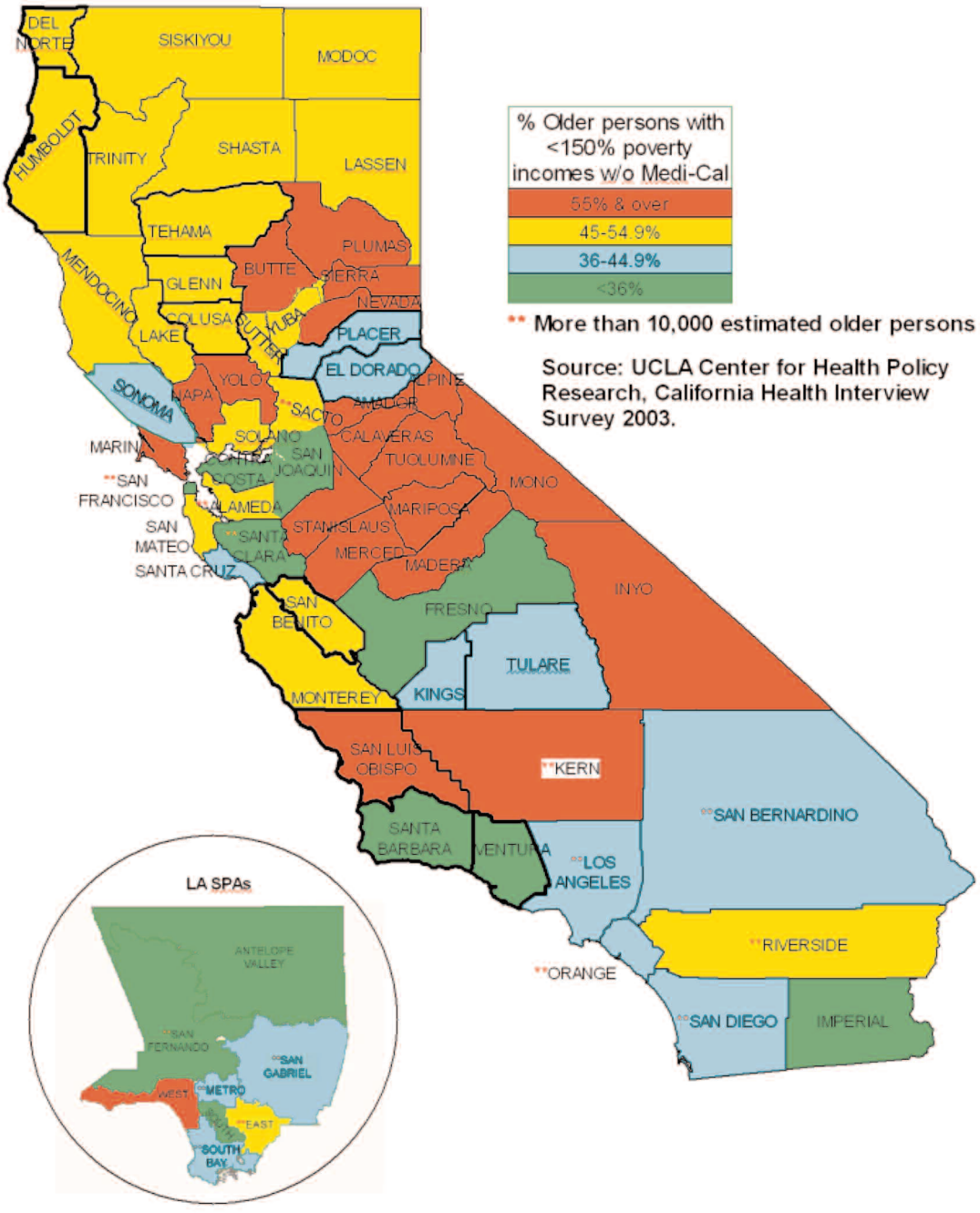
In addition to persons receiving Medi-Cal, who were automatically enrolled in a Part D plan, other low-income older persons are eligible for no-premium/deductible, low-copayment Part D plans (called Low Income Subsidy (LIS) or "extra help"). These elders, with incomes below 150% of poverty ($14,700 for a single person in 2006) and assets of less than $11,500 (not including a home), can apply for the Part D LIS. As of July 2006 there were 106,000 aged, blind, and disabled persons in California who had enrolled in the Part D LIS program, 43% of those who applied.[20] According to the 2003 California Health Interview Survey (CHIS), approximately 385,000 older Californians had incomes below 150% poverty and were not receiving Medi-Cal. Some of them may have had incomes above the Medi-Cal eligibility level, others may have had assets above the Medi-Cal limit (which is one-fifth the Part D LIS level), and still others may not have applied for Medi-Cal because they had retiree health insurance or were deterred from applying (see Medi-Cal outreach recommendations below). It is likely that a large proportion of these individuals are Part D LIS eligible, so it appears that *under half of Part D LIS eligibles are currently enrolled in Part D LIS.*

According to an analysis of the 2003 CHIS, low-income (under 200% of poverty) older persons in California were *less likely* to have Medi-Cal if they:

- Had incomes closer to 200% of poverty
- Owned a home
- Were non-Latino whites
- Better self-assessed health
- Not in a Medicare HMO
- Lived alone
- Lived in Los Angeles, Riverside, Orange or San Diego counties (about half of all older persons in California who may be Part D LIS-eligible without Medi-Cal live in those four counties)

The map on the following page provides information on the percent of older persons with incomes under 150% of the federal poverty level who do not report Medi-Cal coverage. These are the older persons who are likely to qualify for Part D LIS ("extra help") and indicate areas where the most outreach is needed. While the *rates* of those without Medi-Cal are in the lowest tier in San Francisco and Santa Clara counties, and the San Fernando SPA, the large size of their poor and near-poor older populations results in over 10,000 uncovered older persons in each county (note the ★★'s before the county names).

Map 2
Geographic Distribution of Persons Who Do Not Receive Medi-Cal and Earn Less Than 150% of the FPL



IMPLICATIONS FOR POLICY AND PRACTICE

Embedded in the majority of public policies and programs is the view that the elderly and near elderly are a monolithic population with similar health and socioeconomic issues, and access to services. The data presented here suggest that there are significant disparities in socioeconomic status, including relatively high poverty levels, among the elderly and near elderly population in California. Specifically, among the populations aged 55-64 and 65 and older, women, minorities, and immigrant populations represent the greatest proportion of the poor in California. Poverty and low income have deleterious consequences for health and access to health care for these populations.

There are a number of programs that provide a 'safety net" for the poor and low-income populations. Yet, as the above evidence shows, not all eligible individuals participate, and those in "need" are not always eligible. California is one of the most diverse states in the nation. Demographic projections predict that this diversity will increase in the years to come. Therefore, absent intervention to ameliorate economic, health, and access disparities, we will continue to witness a persistent divide in the health and economic well being of the elderly and near elderly population in the state. Addressing the gap in eligibility and use of services among low-income, minority, and immigrant populations is one way of reducing this divide. Doing so requires action at the policy, program, and community/individual level. In the following we examine redefining eligibility for state programs, increasing cultural competency among programs and providers, improving health programs and services, and involvement of the community in the form of volunteerism and civic engagement as strategies for filling the gap in eligibility and access.

Strategies

POLICY STRATEGIES

Raise Asset and Payment Levels for SSI/Medi-Cal

Modernizing SSI was one of the top 50 priorities of the 2005 White House Conference on Aging. While "modernizing" the program can cover a wide range of changes, one mechanism for improving access among low-income elderly populations is redefining assets and means tests under SSI. Current asset and income levels do not accurately reflect the cost of living, particularly in California where the costs of housing and of many goods and services have soared. The asset maximum of $2,000 for single persons has not changed since 1989. If that level had been adjusted for inflation, it would now be $3,250 in 2006, more than 50% higher than the current limit.[21] In addition, the costs of living are estimated to be about 25% higher than the national average in urban California counties such as Los Angeles, and even higher in Bay Area counties.[22] This makes an asset limit of about $4,000 in California a more legitimate comparison to the 1989 national level. Some public benefit programs no longer include asset tests because it was determined that they created unnecessary hurdles to enrolling eligible persons. In California, both Medi-Cal and Healthy Families have no asset test for enrolling low-income persons under age 19. Enacting a similar provision for SSI would decrease the paperwork burden on both the applicant and the government, and increase the proportion of those who are eligible to apply. Simulation studies have shown that increasing the asset test limit is one of the most cost-effective ways of increasing the incomes of older persons, especially women.[23]

Moreover, the federal Poverty Level, which in 2006 was $9,800 for individuals and $13,200 for couples,[11] is extraordinarily low and inaccurately reflects the cost of basic sustenance. The official poverty level fails to accurately reflect the conditions of the elderly. The methodology used to calculate necessary income is outdated because it fails to account adequately for key needs of the elderly such as health care, and it is updated using a general inflation index (the CPI) that does not reflect the buying patterns of the older population.[24] The Medi-Cal and Healthy Families programs for children in California now cover children in families with incomes of up to 250% of poverty, and some county-based programs (Healthy Kids) include children up to 300% of poverty. California has moved in the opposite direction for the older population. Because eligibility for SSI and therefore Medi-Cal for the elderly is tied to much lower incomes, many who are in need, near poor, and vulnerable are not eligible for these programs. Starting in 2006, California *cut* the state-funded portion of SSI by the amount of the federal cost of living increase for three months and totally eliminated the cost of living increase for the state portion, saving state funds at the expense of the lowest-income elders in California.[31] Given the success of children's coverage expansions in California, the state

should work to *increase* both the asset and income eligibility levels for SSI and/or Medi-Cal for the elderly.

Reexamine Age 65 as the Age of Eligibility for Services.

Living in poverty or at a low-income level over the life course often translates into poor health for women, minority, and immigrant populations.[25] As shown in Exhibit 11 above, almost one-third (220,000) of persons age 55-64 with low-incomes have no health insurance. These individuals are more likely to reach age 65 with health problems that have not been adequately treated, and enter the Medicare system sicker than other populations. Lowering the age of eligibility for SSI and/or Medi-Cal to 55 would increase the health insurance rate among these populations and provide them with access to basic health and preventive care, which could help reduce disparities in health and perhaps stave off illness and disability.

Go Beyond "Reasonable Outreach" for SSI/Medi-Cal

Legislation under SSI/Medi-Cal currently requires that programs make "reasonable" attempts to ensure access to populations with limited English proficiency. The focus usually involves developing information about programs in a variety of languages. Clearly, this is insufficient. Often many who are eligible do not participate in the programs because they do not know about the benefits and do not know that they are eligible. Older adults also find the application and renewal process difficult and often intimidating.[32] Legislation should mandate that providers develop a comprehensive targeted out reach plan focused not only on language, but also on culturally competent and comprehensive outreach strategies that are informed by empirical evidence. These efforts go beyond current online efforts to catalog available benefits, such as the National Council on Aging's (NCOA) Benefits Check-up www.benefitscheckup.org.

There are a number of models that have been successful in children's outreach and enrollment that can be modeled for the older population. One successful model is "express lane" eligibility, where enrollment in one public program automatically enrolls a person in Medi-Cal if appropriate. Special outreach efforts could be focused on those who enroll in programs that require low incomes, but not as low as Medi-Cal's requirements. Some of the key programs where special outreach to applicants is warranted include California's homeowner's and renter's assistance programs, which provide tax credits to low-income aged, blind, and disabled persons (see www.ftb.ca.gov/individuals/hra/), Sections 8/202 and other low income housing, brown-bag nutrition services through local AAAs, older persons who apply for lifeline rates for utilities, and the low-income home energy assistance program (www.csd.ca.gov/LIHEAP.html). For example, according to CHIS 2003, about one-quarter of the 160,000 older Californians who report receiving public housing subsidies do not report receiving Medi-Cal. In the 2005-06 California legislative session, SB1534 (Alarcon) proposed a uniform application for all state programs that use family poverty as an eligibility criteria to foster this type of cross-program synergy.

Outreach will become even more important when the state implements new federal requirements that all persons applying for Medi-Cal (both new and renewal applicants) provide proof of citizenship (noncitizens were already required to show proof of legal residence). This is likely to create a significant new burden, not only in terms of paperwork, but also in terms of discouraging eligible applicants because of fears about immigration laws (whether or not the fears are justified). This calls for particularly aggressive outreach to the immigrant communities in California to

assure that naturalized citizens are fully eligible for Medi-Cal, and that accessing public programs carries no risk for other family members.

Protect the Prescription Benefits of Medi-Cal Recipients

The implementation of Medicare Part D for prescription medications has incurred a number of difficulties for low-income older persons in California. The transition process from Medi-Cal to Medicare for drug coverage has been difficult; some medications are not covered in the formularies of the private plans. The state's Emergency Drug Benefit is a short-term (2006 only) transition benefit for Medi-Cal recipients who are unable to obtain their medications under Part D. Continued advocacy and monitoring is necessary to assure that older persons get the medications they need. For elders with Medi-Cal, Medicare Part D LIS brings higher copayments than they had under Medi-Cal. SB503 (Figueroa) would provide state funding to cover the copayments for Medi-Cal recipients starting in 2007. Passage is uncertain however.[19]

Expand Medi-Cal to Cover Assisted Living

Another priority listed by the 2005 White House Conference on Aging was to develop a coordinated, comprehensive, long-term care strategy by supporting public and private sector initiatives that address financing, choice, quality, service delivery, and the paid and unpaid workforce. The data analyzed in this paper are drawn primarily from surveys of the noninstitutionalized population, and, therefore, do not speak to issues of long-term care. While there are significant long-term care *needs* apparent among the low-income elderly population, data about their access to and use of long-term care services in California are limited.

One of the critical gaps in California's long-term care policy is that Medi-Cal does not pay for assisted living or board and care facilities. Some older persons are in situations where it is not feasible for them to continue to live independently in their own homes, despite the home care assistance that can be provided by IHSS. Even if they are not sick enough to require constant medical supervision, their only option is to move into a nursing home. As of 2002, 41 states used Medicaid reimbursement to cover assisted living or related services. Federal legislation allows Medicaid to pay for nonresidential components of assisted living care, and it has proven to be a viable alternative to other institutional care.[26] California has a pilot program to cover assisted living in three counties that is scheduled to begin in 2006. Given the long experience in other states with this benefit, it should be expanded statewide as quickly as feasible.

HOUSING STRATEGIES

The best known low-income housing programs are federal programs, including Section 8 vouchers and Section 202/236 construction grants and loans. The federal government also has tax credits for affordable supportive housing, and other programs. The California Housing Finance Agency provides funding generated from tax-free bonds to help lower-income persons purchase homes, and assists with financing low-income rental property for both families and older adults. These state funds are relatively modest. The state also has bond funding for low-income housing assistance that finances both rental and owner-occupied property, increasing or decreasing according to the passage of state bond issues. State law requires that 20% of tax-increment revenues from local redevelopment districts be used for affordable housing. The California Budget Project has a good summary of major housing programs in California at http://www.cbp.org/2005/0505bb_housing.pdf.

The issue of senior housing needs and policies

is almost as complex as that of health care, and is beyond the scope of this document. It is important to note, however, that affordable housing for the elderly is not keeping up with demand. In addition to the shrinking number of new federally assisted housing units, the loans used to build those units require low-income occupancy for only 30 years. Of the 150,000 units in California, about half are at risk because the low-income requirement lapses within the next five years.[27] Rising housing values drive rents up, and existing nonsubsidized affordable housing stocks in California continue to shrink due to gentrification and population growth. Multiple approaches are needed to address the need for increased affordable and appropriate housing for the elderly in California.[28] As of August 2006, however, the Western Center for Law and Poverty (http://www.wclp.org/housing/billtracker.php) listed no California legislative bills with a focus on senior housing.

PROGRAM/PROVIDER STRATEGIES

Improving Cultural Competency

Improving access to programs that reduce health and economic disparities among the population also involves improving the acceptability of the programs among the population. Eligibility for services does not guarantee use. Often minority, immigrant, and low-income populations will not access services, even if they are eligible for services, because of perceived barriers including language, lack of cultural sensitivity, and provider bias. For the population being served, these barriers are "real" and often are associated with delays in seeking care or delays in investigating their eligibility for programs, e.g., SSI/Medi-Cal.

Providers, including community-based health and social service organizations, as well as county offices that determine eligibility for public programs, need to ensure that staff at all levels are culturally competent and sensitive to the issues facing the populations that they serve. Staff in-service trainings should be required and a prerequisite for employment in the organization. Community-based organizations should take the opportunity to provide a leadership role not only in ensuring that they provide culturally competent and acceptable services, but that doctors, nurses, and other providers are also culturally competent. Providers can partner together with local universities to conduct in-service trainings on cultural competence and best practices for various organizations and providers including hospitals, and doctors that serve low-income and minority communities. Managed care providers in California are starting to move in this direction,[29] and their activities need to be reinforced and more broadly adopted.

Increasing Advocacy Activities

Community-level health and social service providers often have a clear understanding of the issues that impact the populations they serve. Therefore, it is important that they utilize the knowledge and first-hand information that they have about the population to advocate for improvements and expansion of services and eligibility for programs. This can be accomplished by providing individual testimony at city, state, and federal hearings. In addition, community organizations and local providers can become involved in professional organizations and coalitions—e.g., National Council on the Aging that advocates for aging issues at the state as well as federal level.

This level of engagement demands organizational resources that are not typically covered by the overhead reimbursement of public programs or grant-funded activities. California foundations could provide a funding stream to assist community-based service organizations in developing positions in their organizations that are tasked

with grassroots advocacy. This type of development will require both specialized technical assistance to make the organizations comfortable with taking on this role, as well as assistance in strategizing how those positions could eventually generate additional support so that the grant funds are not needed. It might help partnering service delivery service providers with existing advocacy organizations, such as California Health Advocates, to foster increased advocacy in the health policy arena.

Improving Health Programs and Services

Community health providers—including community-based organizations, doctors, and hospitals—need to develop health programs that better mesh with the needs of the communities that they serve. For example, providers serving elderly and near elderly minority and low-income communities need to be adept at managing chronic disease and understand the impact that chronic disease can have on functioning. Diabetes clinics that assist the individual with diet, exercise, and medication management have the potential to reduce diabetes related complications often experienced by these populations.

Attention should also be given to the importance of developing programs aimed at disease prevention. Many illnesses experienced by poor and low-income populations are in part due to exposure to environmental toxins, residential segregation, discrimination and lack of access to goods and services that promote health. For real change to come about, these structural causes of poverty and poor health need to be addressed at the federal and state policy levels. However, local providers can reduce some of the impact that these structural causes of poverty and poor health have on individuals by developing health programs that focus in part on the importance of diet, exercise, and lifestyle choices such as smoking cessation, in combating disease and poor health.

COMMUNITY STRATEGIES

Volunteerism/ Civic Engagement

Strategies for addressing economic/health disparities and reducing gaps in access to services can evolve at the community or individual level as well. Specifically, volunteer organizations can develop civic engagement programs that include senior volunteers who would participate in outreach programs for low-income populations. Senior volunteers could work with local organizations to identify populations in the community that may be eligible for SSI/Medi-Cal. These senior volunteers could participate in outreach activities to underserved communities and also serve as peer counselors that help potential eligible participants navigate the bureaucracy often associated with gaining eligibility for public programs.

For example, additional outreach could involve more seniors in the activities of the Health Insurance Counseling and Advocacy Program (HICAP), an active organization in the state that engages in both individual counseling as well as legislative advocacy (www.cahealthadvocates.org/volunteer/index.html). The financing of this program is particularly innovative, relying in large part on a per-capita fee assessed on every Medicare supplemental policy sold and each Medicare managed care enrollment.[30] This assures a predictable revenue stream that allows for longer-term strategic planning and the development of an extensive volunteer network. There are many groups that engage older adults in advocacy efforts in California, such as the Senior Action Network (www.senioractionnetwork.org/), Older Women's League (www.seniors.org/womensissues.asp?id=300), Gray Panthers (graypanthers.org/graypanthers/network.htm#CA), California Alliance for Retired Americans (www.californiaalliance.org), AARP-CA (www.aarp.org/states/ca/), and the Congress of California Seniors (www.seniors.org). Martinson

and Minkler note that low-income elders may need stipends, transportation vouchers, or other types of financial assistance to be able to engage in this type of activity outside of their families.[34]

Programs that foster senior leadership can also encourage older citizens to work for improving the health and quality of life of others. The California Senior Leaders Project provided training to several statewide cohorts of older persons who were natural leaders in their communities, providing them with additional skills and networking so that they could improve the effectiveness of their work and share their skills with others.[35] An on-going institute such as this would serve as a powerful resource to older persons in information and community-based organizational leadership positions and would foster the continual renewal of this leadership among older Californians.

Local policies on land use and transportation will also have important consequences on the health promotion of low-income communities. The conflict over the fate of a community garden in South Los Angeles highlights the difficulties in maintaining open space in crowded urban areas where low-income residents can both exercise and grow their own food.[36] Community-based organizations should take a lead in creating and supporting efforts to increase community garden and park spaces, while government should modify zoning and tax laws to encourage their spread.[37]

CONCLUSION

California's older population is among the most diverse in the nation. Alike with younger populations, older Californians are a mosaic of rich and poor including a broad rainbow of races and ethnicities born here and abroad. Aging policy, on the other hand, tends to treat the older population as a homogeneous block. The result is a series of eligibility and benefit gaps in aging policies that negatively impact older persons with low incomes, older persons of color, and those born abroad. This group has a series of health and social service needs that call for changes in policy and new efforts on the part of government and philanthropy in California so that all older Californians can have a decent quality of life.

References

1. California Legislative Analyst's Office. Analysis of the 2006-07 Budget Bill, Health and Social Services Chapter. *LAO*. February 23, 2006. Available at: http://www.lao.ca.gov/analysis_2006/health_ss/healthss_anl06.pdf. Accessed July 25, 2006.
2. California Department of Social Services. In-Home Supportive Services Paid Cases, July 2001-June 2006. *CADSS*. Available at: http://www.dss.cahwnet.gov/research/res/pdf/daptrends/IHSSjun06.pdf. Accessed July 26, 2006.
3. California Department of Aging. Aging Services Data Report. *CDA*. Available at: http://www.aging.state.ca.us/html/whatsnew/Aging_Services_Data_Report.pdf. Accessed July 26, 2006.
4. Harrington C, Tonner MC, Wellin V, et al. The Role of Medi-Cal in California's Long-Term Care System. *Medi-Cal Policy Institute*. Available at: http://www.medi-cal.org/publications/view-pub.cfm?itemID=3626.
5. U.S. Social Security Administration. SSI Recipients by State and County, 2005. Available at: http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2005/index.html. Accessed July 25, 2006.
6. California Department of Aging. Total HICAP Toll Free Calls. *CDA*. Available at: http://www.aging.state.ca.us/html/stats/hicap_report2.html. Accessed July 28, 2006.
7. California Department of Social Services. Adult Protective Services and County Block Grant Monthly Statistical Report, April 2006. Available at: http://www.dss.cahwnet.gov/research/res/pdf/soc242/2006/SOC242apr06.pdf. Accessed July 25, 2006.
8. Feldman PH, Oberlink MR. The advantage initiative: developing community indicators to promote the health and well-being of older people. *Family and Community Health*. Oct-Dec 2003;26(4):268-274.
9. Family Caregiver Alliance. California's Caregiver Resource Center System, Annual Report. *California Department of Mental Health*. Available at: http://www.dmh.cahwnet.gov/CRC/docs/FY03_04_AnnualReport.pdf. Accessed August 6, 2006.
10. U.S. Census Bureau. Current Population Survey (CPS) Table Creator. February 15, 2006. Available at: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html. Accessed February 17, 2006.
11. U.S. Department of Health and Human Services. The 2006 HHS Poverty Guidelines. January 24, 2006. Available at: http://aspe.hhs.gov/poverty/06poverty.shtml. Accessed February 16, 2006.
12. U.S. Social Security Administration. Supplemental Security Income (SSI) In California. January, 2006. Publication No. 05-11125. Available at: http://www.ssa.gov/pubs/11125.html. Accessed February 18, 2006.
13. Nelson C. Geographic Adjustments in Poverty Thresholds. Paper presented at the National Research Council Workshop on Experimental Poverty Measures. *National Academy of Sciences*. Available at: http://www7.nationalacademies.org/cnstat/Workshop_on_Experimental_Poverty_Measures.html. Accessed May 2, 2006.
14. Data from 2001 California Health Interview Survey.
15. Ku L, Ross DC. *New Medicaid Requirement is Unnecessary and Could Impede Citizens' Coverage*. Washington, DC: Center on Budget and Policy Priorities; January 4, 2006.

16. Davies PS, Huynh M, Newcomb C, O'Leary P, Rupp K, Sears J. Modeling SSI Financial Eligibility and Simulating the Effect of Policy Options. *Social Security Bulletin*. 2002;64(2):16-45.

17. U.S. House of Representatives. Ways and Means Committee. Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means (Green Book), WMCP 108-6. Available at: http://waysandmeans.house.gov/Documents.asp?section=813. Accessed March 12, 2006.

18. Pynoos J, Matsuoka C, Liebig P. Housing for Older Californians. *California Policy Research Center, University of California*. Available at: http://www.ucop.edu/cprc/sb910house5.pdf. Accessed January 12, 2006.

19. National Senior Citizen's Law Center. California Advocate Alert (July 21, 2006). *National Senior Citizen's Law Center*. Available at: http://www.nsclc.org/news/06/07/partdialert-cal_072106.pdf. Accessed August 4, 2006.

20. Social Security Administration. Status of Medicare Low Income Subsidy Applications Received as of 7/14/06. *Social Security Administration*. Available at: http://www.ssa.gov/legislation/statealphasmallfont.html. Accessed August 4, 2006.

21. U.S. Bureau of Labor Statistics. CPI Inflation Calculator. *U.S. Department of Labor*. June 2006. Available at: http://data.bls.gov/cgi-bin/cpicalc.pl. Accessed June 9, 2006.

22. Relocation Essentials L.C. Cost of Living. Available at: http://www.relocationessentials.com/default.aspx. Accessed June 9, 2006.

23. Rupp K, Strand A, Davies PS. Poverty Among Elderly Women: Assessing SSI Options to Strengthen Social Security Reform. *Journal of Gerontology: Social Sciences*. November 1, 2003 2003;58(6):S359-368.

24. Brady D. Reconsidering the Divergence Between Elderly, Child, and Overall Poverty. *Research on Aging*. 2004;26(5):487-510.

25. Hertzman C. The Life-Course Contribution to Ethnic Disparities in Health. In: Anderson NB, Bulatao RA, Cohen B, eds. *Critical perspectives on racial and ethnic differences in health in late life*. Washington, DC: National Academies Press; 2004:145-170.

26. U.S. General Accounting Office. *Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*. Washington, DC June 2003. GAO-03-576.

27. California Housing Partnership Corporation. Federally Assisted Multifamily Housing. *California Housing Partnership Corporation*. July 2005. Available at: http://www.chpc.net/pdf/at-risk/statewide_summary.pdf. Accessed August 4, 2006.

28. Pynoos J, Matsuoka C, Liebig P. Housing for Older Californians. *California Policy Research Center*. Available at: http://www.ucop.edu/cprc/sb910house5.pdf. Accessed August 2, 2006.

29. Brach C, Paez K, Fraser I. Cultural Competence California Style. *Agency for Healthcare Research and Quality Working Paper 6001*. February 2006. Available at: http://www.gold.ahrq.gov/pdf/70.pdf. Accessed June 10, 2006.

30. California Department of Aging. Centers For Medicare & Medicaid Services, State Health Insurance Assistance Program 2005 Grant Application. *California Department of Aging*. February 18, 2005. Available at: http://www.aging.state.ca.us/html/programs/SHIP_Grant_App_2005.pdf. Accessed 2006, June 10.

31. Szymendera SD, Davis CD. Supplemental Security Income (SSI): Benefit Changes for California Residents, 2006 and 2007. http://www.opencrs.com/rpts/RS22365_20060112.pdf. Accessed 2006, August 2.

32. Perry MJ, Kannel S, Dulio A. *Barriers to Medicaid Enrollment for Seniors*. Menlo Park, CA: Kaiser Family Foundation; January 31 2002.

33. Sauer JH, Nelson BM. Legislative Issue Priorities and Personal Concerns: A Survey of AARP California Members. http://assets.aarp.org/rgcenter/general/ca_leg_2005.pdf. Accessed August 2, 2006.

34. Martinson M, Minkler M. Civic Engagement and Older Adults: A Critical Perspective. *Gerontologist*. June 1, 2006 2006;46(3):318-324.

35. Romero L, Minkler M. Gold in Gray: Senior Volunteer Leaders as an Untapped Public Health Resource. *Generations*. 2005;29(2).

36. Hymon S. Deal to Buy South L.A. Community Garden Running Short on Time. *Los Angeles Times*. May 20, 2006.

37. Trzyna T. A conservation agency creates inner-city "natural parks" in Los Angeles. *The Urban Imperative*. Sacramento, CA: California Institute of Public Affairs; 2005.

Healthy Aging for California's Immigrant and Low-Income Elders from Diverse Ethnic Backgrounds:

Policy Issues and Recommendations

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DIVERSITY OF CALIFORNIA'S ELDERS: POLICY IMPLICATIONS

California is home to more than one-half million older adults who emigrated from dozens of countries around the world, and over 200,000 U.S.-born elders from disadvantaged ethnic populations, many of whom have been victims of discrimination. Between and within each population there is vast heterogeneity in levels of acculturation, education, income and assets, and in religion, health status, and access to health care. The challenge of providing adequate and appropriate health care to these diverse populations to ensure their healthy aging is made even more critical by the projection that by the middle of the 21st century, older populations other than non-Hispanic whites are projected to comprise two-thirds of Californians aged 65 and over (Lee, Miller, & Edwards, 2003).

Because differences in language proficiencies, health beliefs, risks for diseases, education, acculturation, public and private health insurance coverage, income, family systems, and dependency on adult children affect access to appropriate care, it is crucial for policy makers and health providers to be familiar with the diversity and characteristics of the various groups of elders who will need geriatric care if the majority of California elders are to receive effective health care services.

Some of the demographic data available from the 2000 U.S. census on the largest of California's ethnic elder populations are summarized in Table 1. They demonstrate the diversity of California's elders aged 65 and older that policy makers need to take into account.

Before considering specific policy issues, it is appropriate to acknowledge some of the unique issues for different populations that are important for appropriate health care to promote healthy aging. Brief summaries are included in the following sections, with more complete descriptions in Appendix A.

ELDERS FROM IMMIGRANT POPULATIONS

Older Californians who have emigrated from other nations may have come as children or young adults and grown older in California. Many, however, have come as followers of children to be with their adult offspring who have settled here. Approximately 25,000 older adults age 55 and over and 12,000 older adults age 65 and over immigrate to California each year[1] (Office of Immigration Statistics, 2006).

As a consequence, the range of health, economic, language, and acculturation characteristics is vast among these new older Californians, which makes the task of developing appropriate policy to meet their health needs extremely complex. In general immigrants have better health than individuals born in the U.S., but the differences are greater at younger rather than older ages. In fact,

[1] This estimate is based on tables on annual numbers of immigrants by age and numbers immigrating to each state.

Table 1
Selected Demographic Characteristics of Older Californians by Ethnicity, Aged 65 and Over, U.S. Census, 2000

Populations	Number	Percent of 65+ in CA	In Poverty[5]	With Disability	Living Alone	Education[6] <9 yrs.	Education[6] College+	Speak Little or No English[2]
Total Older Californians	3,595,658	100%	8.1%	42.2%	25.7%	15.5%	35.6%	11.0%
African American/Black[1]	182,028	5.2%	15.1%	52.1%	28.3%	17.6%	35.4%	0.9%
American Indian[1]	18,122	0.5%	14.4%	54.4%	21.6%	23.9%	4.0%	7.2%
Asian Americans[1]	353,698	10.1%	10.9%		12.6%	30.8%	35.7%	43.7%
Asian Indian	15,009		7.5%	44.1%	5.3%	36.2%	37.3%	41.6%
Cambodian	3,054		24.2%	69.9%	3.3%	74.8%	7.2%	81.9%
Chinese, not Taiwanese	109,611		14.5%	38.8%	14.8%	37.9%	33.7%	61.9%
Taiwanese	4,288		14.9%	32.4%	6.4%	23.1%	43.8%	76.0%
Filipino	90,800		8.5%	49.0%	6.2%	28.4%	43.7%	22.5%
Hmong	2,082		33.9%	69.6%	3.3%	91.6%	4.8%	84.6%
Indonesian	1,056		8.9%	38.9%	15.9%	8.2%	37.0%	19.5%
Japanese	59,377		6.1%	31.6%	23.0%	7.1%	39.8%	14.9%
Korean	28,250		17.9%	39.3%	21.8%	29.6%	33.9%	66.8%
Laotian	2,583		22.0%	63.8%	2.3%	80.3%	4.1%	79.6%
Pakistani	814		5.4%	43.4%	2.5%	35.4%	34.5%	43.3%
Thai	1,319		14.7%	43.4%	6.4%	36.4%	27.6%	52.5%
Vietnamese	28,202		11.7%	57.4%	5.9%	47.1%	17.2%	75.2%
Native Hawaiian & Other Pacific Islanders[1]	5,586	0.2%	11.6%	49.6%	10.3%	26.4%	26.7%	21.3%
Non-Hispanic White[1]	2,516,139	72.1%	5.7%	40.1%	28.2%	6.6%	51.7%	2.4%
Arab[3]	14,659		11.0%	45.9%	NA	21.3%	40.9%	25.3%
Armenian[3]	28,436		12.8%	54.5%	NA	32.6%	30.4%	48.4%
Russian[3]	60,755		5.2%	38.4%	NA	4.2%	68.1%	9.6%
Latino/Hispanic[4]	472,769	13.6%	13.9%	48.1%	14.6%	50.8%	15.0%	35.9%
Mexican	338,098		13.8%	48.0%	13.7%	55.1%	11.9%	35.9%
Cuban	12,099		13.4%	52.0%	23.0%	36.1%	28.4%	51.5%
Puerto Rican	10,468		12.6%	53.6%	24.6%	34.5%	22.7%	18.0%
Central American	23,057		17.5%	47.1%	11.4%	57.4%	17.1%	61.9%
South American	12,790		12.1%	42.3%	16.6%	27.7%	31.9%	46.2%

[1] Alone (as opposed to in combination with other races)
[2] Speaks English "not well" or "not at all"
[3] Reported as "Ancestry"
[4] Can be of any race
[5] Income below poverty, 1999
[6] Reported as "less than 9 years" and "some college no degree, associate degree, bachelor's degree, or graduate or professional degree"
Source: U.S. Census Bureau, Census 2000 Summary Files 1, 2, 3, & 4, and American Indian and Alaska Native Summary File

foreign born individuals aged 61-80 have worse self-rated health and higher rates of heart disease than those who are U.S. born (Jasso, Massey, Rosenzweig & Smith, 2004). Because the historical experiences, the health risks, and range of resources of elders of each ethnic population differ, it is important to target policy recommendations to the specific situation of each population.[2] Some important policy-relevant background considerations relating to elders in the larger ethnic immigrant populations in California are discussed in the sections below.

Older Asian Populations in California

According to the 2000 census, between 84% and 100% of elders in all the Asian American populations except Japanese are immigrants, or "foreign born" as noted in Table 2 (Yeo & Hikoyeda, 2006). There are, however, major differences in the circumstances surrounding their immigration experiences, and other characteristics such as language preferences, health risks, and health beliefs that affect their current resources, health status, and access to health care that need to be taken into account when developing policy for healthy aging. Some of these differences among the larger ethnic groups are summarized in order of the size of the older population. (See Table 2 and Appendix A for more complete descriptions).

Historically, the earliest Asian immigrants to California today comprise the three largest populations of older Asians in California, and all three (Chinese, Filipino, and Japanese) suffered major episodes of legal and illegal discrimination. The experiences of these three populations likely influenced the characteristics and sense of trust in institutions (including health care) of current older populations. These experiences included the following:[3]

- During a long period of discrimination and limitation on immigration from China beginning with the 1883 Chinese exclusion law, many families were separated, frequently referred to as "mutilated families." In 1946, a law was passed allowing 9,000 "alien wives" of permanent residents or U.S. citizens to immigrate, spiking birthrates in Chinese families along with the more general postwar baby boom in the U.S. Many older Chinese immigrants are part of those generations.
- Japanese men began working on farms and in fisheries during the early 1900s, and later brought "picture brides." Many families were also victims of discrimination including forced internment in concentration camps during World War II (WW II).
- Filipino workers also immigrated to the U.S. in the early 1900s to work in the fields. Some experienced violent attacks. The Tydings-McDuffie Act limited immigration from the Philippines to 50 per year from 1934 to 1965. Post World War II war brides, health care professionals who immigrated in large numbers beginning in the 1970s, followers of children, and WW II veterans recently given long promised U.S. citizenship comprise the extremely diverse older Filipino American population.

Because high rates of Chinese and Filipino immigration continue, the acculturation levels among these elders are extremely varied. Among Japanese Americans, however, immigration since WW II has been minimal, so that most elders are *Nisei* (second generation) or *Sansei* (third generation) and highly acculturated.

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[2] Summaries of relevant issues are provided in the following pages. For more comprehensive descriptions of elders in individual populations, see Appendix 1.

[3] Unless otherwise indicated, the historical and descriptive material related to the older cohorts of Californians from diverse ethnic backgrounds in the following sections is taken from Yeo, Hikoyeda, McBride Chin, Edmonds, & Hendrix (1998) *Cohort Analysis as a Tool in Ethnogeriatrics: Historical Profiles of Elders from Eight Ethnic Populations in the United States*. SGEC Working Paper #12, Stanford, CA: Stanford Geriatric Education Center

Table 2
Summary of Language, History, Health Risks and Health Beliefs: Larger Older Asian Populations in California*

Populations	Major Languages	Percent Foreign Born 65+ (U.S.)[1]	Historical Experiences	Known Health Risks	Traditional Health Beliefs
Asians					
Chinese	Cantonese, Mandarin, English	84.2%	Male immigration and discrimination in late 1800s; 1882 Chinese Exclusion Act; "Mutilated" families till 1940s; Waves of immigration 1970-90; Followers of children	Esophageal, liver, pancreatic, and nasopharyngeal cancer; Vascular dementia; Diabetes, especially in women; Suicide in women	Classical Chinese system: balance of *yin* & *yang* and free flow of *Qi*; Family care of elders
Filipino	Tagalog, English	90.5%	Male immigration in 1920s; Discrimination; 1934 law limiting immigration; Heavy immigration since 1965, especially health professionals; Followers of children; WWII Filipino vets allowed to immigrate in 1990s	Hypertension; Gout; Tuberculosis; Diabetes	Illness as God's will; Family decision making and care of elders
Japanese	English, Japanese	20.0%	1900-1924 immigration; Picture brides; WWII internment; Japanese war brides after WWII; Few recent immigrants; Most highly acculturated	Diabetes; Vascular dementia; Hemorrhagic stroke; Esophageal, liver and stomach cancer; Suicide	Most use Western biomedical system; Japanese American communities provide senior service and health care
Vietnamese	Vietnamese	92.1%	Several waves of immigration after Vietnam War	Cervical cancer; Depression; Post traumatic stress	Family based care; Balance theories; Karma; Wind illness treated by cupping and coining
Korean	Korean	90.2%	Small numbers immigrated in early 1900s and in 1950s; Most came after 1965; Recent followers of children	Diabetes; Hepatitis B & liver damage; Tuberculosis;	*Hanbang* health practices
Asian Indian	Hindi & many other languages from India; English	88.9%	Early 20th Century farmers from Punjab; Recent professionals in electronics and health care; Followers of children	Coronary artery disease and diabetes related to insulin resistance; Loneliness	*Ayurvedic*[2] medicine
Cambodian	Khmer	100%	Came as refugees after Vietnam war and wide scale torture from Khmer Rouge	Headaches with dizziness; Post traumatic stress	Karma; Wind illness treated by coining and cupping; Balance theories
Hmong	Hmong	92.6%	Tribal group fought for allies in Vietnam and brought to U.S. as refugees after the war; Last group from refugee camps in Thailand emigrated in 2005	Post traumatic stress	Effect of spirits on health; Ceremonies with animals by shamans

Major Sources: McBride, Gamel, and Yeo, 1993; Yeo, Hikoyeda, McBride Chin, Edmonds, & Hendrix (1998)
[1] Adapted 2000 Census Data provided to author by A. Locsin, Seattle: National Asian Pacific Center on Aging.
[2] Also spelled "Aryurvedic"
* For demographic characteristics, see Table 1

The smaller populations of older Asian Americans are predominantly more recent immigrants and less acculturated to mainstream U.S. culture, but each has its own unique history and culture affecting their health beliefs and expectations. After the Vietnam War, refugees from different Southeast Asian countries arrived in California, the largest group of which was from Vietnam. It should be noted that the most disadvantaged of all of California's ethnic population are the Cambodian, Laotian and Hmong elders; as indicated in Table 1, they have the highest rates of poverty, lowest education levels, and highest rates of disability.

Policy Implications of Diversity among Asian American Elders

Although there are some similar threads that run through the characteristics affecting the health and health care of most Asian elders, there are many more differences among and between the populations. The most obvious similarity is the strong belief in family care of elders that is common in many Asian cultures, which needs to be taken into account in designing policy. For example, the assumption of individual autonomy that is a cornerstone of ethical decision making in the American health care system must be expanded to include the family as decision maker for those elders who retain traditional cultural beliefs and customs.

Material and emotional support for the family caregivers of dependent elders is extremely important because many elders will reject care in a nonfamily environment. Many caregivers are extremely stressed due to their responsibility for providing the family's income, and because they lack the support of the extended family in the U.S

All the immigrant populations have brought with them their own unique systems of health beliefs and practices that differ dramatically from the Western biomedical, science-based approach to disease management, but there is great variation within each group in the degree to which elders utilize one or the other system, or more commonly—both. Because these various systems of health care, such as *yin/yang*, flow of *Qi, Kampo, hanbang, Ayurvedic* medicine, *Karma*, wind illness, and the Hmong spiritual beliefs and shamanistic healing, are not usually taught in Western medical training programs, the mainstream health care system is not prepared to accommodate the various practices and herbal remedies sometimes prescribed. Most elders do not disclose their non-Western health beliefs, herbal medications, or health procedures (e.g., cupping, coining) to their California providers unless asked. Health care team members need to be educated to elicit elders' explanatory models for their illnesses and the interventions that elders have tried so that providers can reduce medication conflicts, integrate the parts of the traditional practices that are effective, and consider including native healers/providers into the health care team. Major efforts need to be designed to increase the knowledge of providers about these alternative traditional systems and to develop their skills in assessing and incorporating practices into disease management when they are beneficial.

Elders within each population are also characterized by a wide range of acculturation levels, educational backgrounds, occupations, health statuses, assets and incomes, eligibility for Medicare and Medi-Cal, linguistic preferences and proficiencies, and other factors, which affect the degree to which they participate in the American health care system. Some immigrant elders are well-established descendents of prior immigrants who came seeking a better life, while others are the first from their countries of origin to come to the U.S., some of them fleeing violence and danger in their homelands. Yet others in several populations came in their later years to be with adult children. Many of the first generation immigrants, especially the followers of children, travel back

and forth to their countries of origin frequently, and sometimes receive health care there as well as in the U.S. In order to meet the needs of these diverse populations, the California health care system needs to have efficient access to interpreters for the wide variety of languages the elders speak. Providers need to be able to coordinate care internationally and to assess the consequence of traumatic experiences many elders have faced.

While as a group, the health status of Asian elders ranks better than other U.S. populations, some groups are disadvantaged, and their vulnerability to particular conditions differs widely by subgroup. Special attention needs to be given to the most disadvantaged groups of elders (e.g., Southeast Asian groups with the greatest disability, least education, and most poverty) to design culturally appropriate systems of health literacy, health promotion, and interventions for the specific high risk conditions.

Older Latino Populations in California[4]

Just as immigrants to the U.S. from Asian countries are frequently lumped together as "Asians" in spite of their differences, "Hispanic"[5] individuals in California include those whose ancestors predated the Anglo population in what was originally part of Mexico, and those who immigrated, or whose ancestors immigrated, to the U.S. from one of dozens of Spanish-speaking countries. Despite the common language, elders in California classified as Latino are in reality very heterogeneous in terms of their level of acculturation, immigration history and experiences, health status, health care access, economic resources, and educational level. Some characteristics of the largest Latino populations of elders are summarized in Table 3.

Individuals who identify themselves as either Mexican or Mexican American comprise the largest ethnic population in California. The 300,000 elders in this population are extremely diverse, and include descendents of families with Spanish land grants deeded to them before Mexico became a nation and before California became a state, elders whose families immigrated since 1850 and who were born in the U.S., a large number who came across the border as children or young adults, and those who followed their children in late life. With the exception of the 1930s, throughout the 20th century and until the present, the demand for labor in California has overwhelmed the restrictions on immigration from Mexico, and many came informally if they could not come formally. Of note in the current population of older Mexican Californians is the very large number who had no access to significant education in their childhood. More than half have less than 9 years of schooling (Table 1), and in a large epidemiological cohort study of over 1000 Latinos aged 60 and over in the Sacramento area in 1998-99, 13% had no formal education; for those whose primary language was Spanish, 22% had no formal education (Haan, Mungas, Gonzalez, et al., 2003). More than one-third speak little or no English, but a much higher percent prefer to speak Spanish. Many have experienced widespread discrimination, especially in periods of anti-immigrant fervor in the U.S.

A major source of heterogeneity within Mexican Californians has been the increasing undocumented immigration of non-Spanish speaking indigenous populations, especially those from the Oaxaca region, such as Mixteco. Although there are no data on the number of older adults in these populations, there were an estimated 50,000 Mixtecos of all ages in farming communities in California in 1994 (Runsten & Kearney, 1994). It is assumed that they will age in place in California as many other rural farm worker Latino populations have done in the past.

In addition to the very large population of

[4] For more comprehensive descriptions of subgroups of Latino elders, see Appendix A

[5] In California and the Western states the term "Latino" is used more frequently.

Table 3
Language, History, Health Risks and Health Beliefs:
Larger Older Latino Populations*

Populations	Major Languages	Historical Experiences	Known Health Risks	Traditional Health Beliefs
Latino Ancestry				
Mexican	Spanish; English; Tribal languages of indigenous groups, e.g., Mixteco	Descendents of Spanish residents in 1700s & 1800s; Informal migration across border until late 1800s; Waves of migration and repatriation; Discrimination; Now heavily urbanized and heterogeneous	Diabetes; Cervical, liver, pancreatic, and stomach cancer; Lung cancer in men; Depression in women	Hot/cold balance theories; Will of God; Family based care; *Curandismo*
Cuban	Spanish; English	Most came as refugees in various waves after Castro took over Cuba in 1959		Family based care; *Santeria*
Puerto Rican	Spanish; English	Post WWII cyclical immigration	Diabetes; Liver cancer; Heart disease	*Espiritismo*

Major source: Villa, Cuellar, Gamel, & Yeo, 1993
* For demographic characteristics, see Table 1

older Mexican Californians, and much smaller groups from Cuba and Puerto Rico, there are more than 35,000 older Californians who emigrated from Central and South America. Although very little is known about these elders, they are assumed to be very diverse because they came for a variety of economic, educational, or political reasons from six different Central American countries and nine different South American countries, and some were likely asylum seekers from civil wars. Based on census data, elders from Central America are more disadvantaged than other Latino populations due to poverty, low educational level, and limited English proficiency (Table 1).

Policy Implication

As with Asian elders, Latino elders in California represent populations that share some similarities—most prominently language—but differ in many important ways as well, which have important implications for policy. These differences include: their degree of acculturation and English proficiency; the historical period of their immigration to the U.S., the reasons for it, and their immigration status as documented or undocumented; and the unique culture-based health practices from their various countries of origin. The shared values of *familismo* underlie the common practice of family care for dependent elders, making culturally appropriate support for those caregivers (most often daughters) extremely important. To provide effective geriatric care, California's health providers who do not speak Spanish need access to immediately-available interpreter services and low-literacy Spanish language patient education materials. Culturally appropriate diabetes prevention programs are

especially needed since almost one-fourth of Latino elders in California have diabetes compared to about half that many for non-Latino white elders (Wallace, et al., 2003). Special strategies to provide care to undocumented elders who are not Medicare or Medi-Cal eligible need to be developed, especially for those who are part of indigenous groups who speak their native languages and not English or Spanish.

Other Older California Immigrants

A number of other important ethnic immigrant populations exist in California that are not included in the four official minority categories. In most cases, little is known about their demographic characteristics or health status. As examples of the heterogeneity of these elders, three of the populations listed in the census as "ancestries" that would be lumped into the non-Hispanic white racial category are highlighted in Table 1—Arab, Armenian, and Russian.[6] Because elders from these diverse cultures frequently maintain many of their original cultural values and characteristics that affect their health and health care, recognition of their needs should be included in a comprehensive policy discussion. For example, older Arab Californians can come from any of 22 countries from Jordan to Saudi Arabia to Morocco (not, however, from Turkey, Iran, or Afghanistan, where Arabic is not spoken). In California, most have come from Lebanon, Palestine, Iraq, Egypt, and Syria. Although they are frequently thought of as Muslim, many Arabs are Christian, especially those from Lebanon.

Dietary issues in a hospital or nursing home are important to Muslims since most do not eat pork, blood products, lard, meats that have not been slaughtered following the Halal traditions, and drink no alcohol. The contents of medicines and food (e.g., gelatin that might contain pork products) need to be examined to assure Arab elders and their families that they contain no proscribed substances. Providers should be educated about important issues to Muslim families in the care of their elders, such as their preference for same-sex providers, touching restrictions [e.g., an older woman may choose not to shake hands with a male provider and may be very uncomfortable being touched by a man other than her husband (Salari & Balubaid, 2006)], and insulting gestures (e.g., a posture allowing someone to see the bottom of one's shoe).

LOW-INCOME NON-IMMIGRANT CALIFORNIA ELDERS FROM ETHNICALLY DIVERSE POPULATIONS[7]

Older African American Californians

Except for the small number of older immigrants from Sub-Saharan Africa or Latin America, the majority of elders in California classified as black or African American[8] are part of families who came in the early and mid 1900s from the agricultural South to find better jobs and opportunities, and to escape the pervasive oppression and discrimination. The resulting population of older African Americans in California is extremely heterogeneous, consisting of a few athletes, business owners, some well-educated retired professionals, a large number of retired skilled workers, and many who had limited opportunities for intermittent low paying jobs and no retirement benefits. Unfortunately, as a whole, older African Americans still endure significant disadvantage in California with higher rates of poverty, disability, and cardiovascular conditions, and somewhat lower educational levels (see Tables 1 and 4). In spite of the legacy of slavery and widespread segregation and discrimination, older African

[6] For an expanded discussion of the background of these older populations, see Appendix A

[7] For more comprehensive discussions of these populations, see Appendix A

[8] Since some of the literature uses the term "black" and others "African American," and census data uses both terms, they are used interchangeably in this paper.

Table 4
Language, History, Health Risks and Health Beliefs: Older African American and American Indians*

Populations	Major Languages	Historical Experiences	Known Health Risks	Traditional Health Beliefs
Non-Immigrants				
African American	English	Severe discrimination and segregation; Large migrations from U.S. South during and after WWII; Heterogeneous	Heart disease, stroke, hypertension; Diabetes; Cancer (especially prostate); Kidney disease; Septicemia; and Dementia (especially vascular)	Support by church, extended and fictive kin
American Indian	English; Some tribal languages	Policies of extermination; Severe prejudice and discrimination; Boarding schools; Forced urbanization in 1950s and 1960s	Diabetes; Cervical, esophageal, and gallbladder cancer; Cataracts; Kidney disease; Liver disease, Tuberculosis; Accidents; Hearing problems	Healing ceremonies; Sweat lodges

* For demographic characteristics, see Table 1; major source: Richardson, 1996

Americans and their communities have developed very strong support systems and coping mechanisms to survive. A major source of support for many is church, where elders are frequently given great respect. Caregivers of dependent older African Americans have more often been reported to include "fictive kin" (close relationships who are not officially related but referred to with kinship terms) and more extended family members than among other populations, and many express more positive views of caregiving (Dilworth-Anderson, Gibson, & Burke, 2006; Yeo, Gallagher-Thompson, & Lieberman, 1996).

Disparities in health care between older black and white Medicare beneficiaries has been well documented, especially in cardiac services and disease prevention, as summarized in the Institute of Medicine publication *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, & Nelson, 2003). Some authors have suggested the quality of care provided, the choices providers make, and perhaps their unconscious biases contribute to these disparities (Schulman, et al., 1999).

Providing appropriate health services for older African Americans means showing appropriate respect, so that training providers for these skills is recommended. Addressing older men and women by "Mr." and "Mrs." is important, for example, because disrespect was pervasive when many of today's older black Californians were young. They were relegated to poor quality care, segregated facilities, and discriminatory practices. Respect and providing time to answer questions could help establish trust in the provider/patient relationship especially in view of the widespread awareness among African Americans of the Tuskegee Experiment.

In order to reduce the disparities in hypertension, stroke, diabetes, and heart disease, various

cancers, and disabilities, increased investment in ethnic-specific primary and secondary prevention interventions are needed.

Older American Indian Californians

The very small population of elders in California who describe themselves as American Indian is also diverse. It includes pockets of survivors from the native Californians in the Spanish Mission era as well as many from all over the U.S. who moved off reservations to come to California cities during massive relocation programs sponsored by the Bureau of Indian Affairs during the 1950s and 1960s. All come from groups whose histories include pervasive oppression and discrimination, broken treaties, attempts at annihilation, and massive relocation. A large proportion of the current cohort of elders attended Indian Boarding Schools in their youth that were long distances from their homes, and where they were required to give up their Indian names, clothes, and traditions in return for education in American skills and culture. As a result of these experiences there tends to be a high level of distrust of white service providers and institutions by many Indian elders. Although many are highly acculturated and list themselves as from "two or more races," the remaining population of older American Indian Californians is generally disadvantaged compared to older non-Hispanic whites, especially in the areas of poverty, disability, and education. This community has the highest rate of diabetes of any ethnic population in the county, and has high rates of various cancers as well.

Older California Indians have a complicated web of health care services to navigate, including Indian Health Service (IHS) facilities on or near reservations, and very poorly funded small urban Indian Health Centers in some cities; long-term care or geriatric programs are rare in any IHS facility. Traditional healing opportunities such as sweat lodges are available in a few locations, and when they are distressed or ill, it is not unusual for urban Indians to return to their home reservations for healing ceremonies by medicine people. Many older California Indians are eligible for Medicare, some for Medi-Cal, and some have coverage through Health Maintenance Organizations (Hendrix, 1999).

Policy Implications

The most desirable strategy for providing acceptable care for older California Indians is Indian-specific health services by Indian providers in a comprehensive, accessible health care system. In the majority of cases when that is not possible, however, providers need to be trained in appropriate strategies for interaction that: 1) convey appropriate respect and listening to elders in a culturally appropriate way; and 2) allow the integration of traditional healing methods and ceremonies by preferred Indian practitioners (Alvord & Van Pelt, 2000).

Section II: Policy Challenges

POLICY CHALLENGES FOR PROVIDING HEALTH CARE TO CALIFORNIA ELDERS FROM IMMIGRANT AND LOW-INCOME BACKGROUNDS

As the brief descriptions of the relevant issues for older adults in the populations of interest indicate, there is little chance that a "one size fits all" approach can meet the diverse needs of the extremely diverse communities of older Californians. Health care policy for older Californians from ethnic groups characterized by immigration and low income must be tailored to the unique needs of each population to be effective. It is not useful to lump together all national populations within a region into a summary category (i.e., "Asians" or "Latinos"). This may be difficult in many communities because of the small size of the populations in question, the number of language services needed, and the isolation of some elders due to lack of English proficiency.

Language

More than one-third of older adults in almost all of the immigrant populations, and more than 80% in some, speak little or no English. Researchers have has found when communication problems exist between health care providers and patients, access to appropriate care is reduced, excess tests and procedures are ordered (some providers have described it as "veterinary medicine"), patient satisfaction is lower, more misunderstandings and complications occur, and costs are higher (Grants in Health, 2003).

The most common practice in communicating with older adults when the health care provider does not speak their language is to ask family members or friends to interpret. However, this practice does not allow providers to receive accurate information from patients themselves because of the family member's lack of training and vocabulary in one or both languages and potential censoring by family members. In cases such as genito-urinary system complaints or elder abuse, older patients may be hesitant or unable to talk about their symptoms in the presence of their family members because of modesty, taboos or fear. Asking children or grandchildren to interpret for limited English-proficient elders is particularly problematic, even when they are the family member with the best command of English. Children will often have inadequate vocabulary to discuss medical issues. Also, it may be traumatic for the children because they recognize that an elder's health depends on them. (Chen, 2006; Grantmakers in Aging, 2003). A bill to make it illegal to use children as interpreters was introduced in the California state legislature during the 2003-04 session but never passed.

Title VI of the Civil Rights Act of 1964 requires all entities receiving Federal funds, including health care organizations, to provide trained interpreters to ensure that persons with limited English proficiency (LEP) have meaningful access to health services. This requirement is included with the Standards for Culturally and Linguistically Appropriate Services (CLAS) devel-

oped by the Office of Minority Health (OMH) (see Appendix B). Extensive guidelines for implementing language services were released in 2005 by OMH (American Institute for Research, 2005). The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has also set standards requiring organizations to ensure effective communication by providing interpreter and translation services (American Institute of Research, 2005). However, implementing these goals is not easy, even for clinicians committed to appropriate multicultural care.

There are more than 200 languages spoken in California, and it is impossible for even the largest health care organizations to maintain interpreters and translation services for them all. Medi-Cal services are required by federal law to include language access for patients with limited English proficiency, but the state of California has not yet provided the appropriate matching funds to allow Medi-Cal managed care programs to increase their capitation rates or for Medi-Cal fee-for-service providers to obtain reimbursement for language access (The California Endowment, 2003). Based on recommendations by The California Endowment and other advocacy organizations, a bill was introduced in the California legislature (SB 1405) in early 2006 to require the state Department of Health Services to establish a privately funded Task Force on Reimbursement for Language Services to "take specified actions relating to the provision of language assistance services for the population that is LEP and that is enrolled in the Medi-Cal program—." As of July, 2006, the bill had been passed by the Senate and was being considered by the Assembly.

To finance the cost of interpreter or translation services for LEP elders who are not in Medi-Cal, the situation is even more difficult. Some hospitals and large clinics maintain trained interpreters on staff, but only for the most common languages. Some health insurance policies reimburse for interpreter services, but many do not. When providers decide they need an interpreter, they must find out if and how the service will be reimbursed and then make arrangements, all of which is difficult and time consuming (Chen, 2006). Based on the experience reported by Alameda Alliance for Health, even if the health care organization provides competent and available interpreter services for all patients at no cost to physicians, for a variety of reasons including physician preference, they are frequently not used when needed (Grantmakers in Health, 2003).

Some provider organizations utilize telephonic interpreter services when nothing else is available. This technology is very expensive, however, requiring telephones in the examination rooms which are frequently not available, and not regarded as satisfactory by many providers.

A team from the California Academy of Family Practice supported by The California Endowment has developed a Toolkit for Physicians and their Staff Members to help them address language access issues for patients in their practice. This provides step by step assistance in assessing patients' needs and identifying and accessing resources in clinical care (Roat, 2005).

The consequence of inadequate translation services for LEP elders and their families is frequently major uncertainty about the availability of appropriate health care communication and reliance on a patchwork of ethnic specific agencies, faith based organizations, or friends. A survey of 43 Mutual Assistance Associations and Faith Based Organizations in California serving older Southeast Asian Americans, for example, found that because of unmet need in clinical care, 85% of the organizations provided medical interpretation and translation, primarily through untrained staff and volunteers, but only 44% were funded for that service (Niedzwiecki, et al., 2003).

A related issue is health literacy for both English and non-English speaking elders, espe-

cially those with low educational levels. Elders who are not able to understand medical instructions accurately are at increased risk for medical complications and adverse effects of medications. As noted in Table 1 and in the summaries of the individual populations, it is not unusual for ethnic groups to have one-third to one-half or more of elders with less than 9 years of school. In some populations such as Mexican Americans, Hmong, and Cambodians, elders with no schooling are common.

Diversity of Health Care Providers

Because of a lack of highly educated professionals from many of the immigrant and low-income populations, few providers are available from many of the populations California health care organizations serve. The need for more trained providers from diverse backgrounds has been identified as a high priority for a number of governmental agencies for more than a decade, including National Institutes of Health, and the Health Resources and Services Administration which funds health care training programs. Patients who visit doctors of their own race have been found to rate their providers higher on providing respectful treatment (Malat, 2001). Both the IoM report *Unequal Treatment* (Smedley, et al., 2003) and The California Endowment support a more diverse workforce, pointing out that minority providers are more likely to care for underserved and low-income patients, and that a diverse health work force improves cultural competency, patient trust and participation, patient satisfaction, and adherence to treatment. The mismatch between the ethnicity of older minority patients and providers has important consequences. Providers' lack of understanding of their patients' culture-based health beliefs, behaviors, and family systems can result in provider frustration and/or patient misunderstanding of medical regimens and lack of "compliance." The lack of bilingual, bicultural staff also results in lack of individuals to do appropriate outreach, intake, health education, and follow-up. This is especially critical in home care for the large number of elders living alone in some populations. The CLAS standards also include recommendations for increased health care staff diversity.

Ethnogeriatric Training

There is a national shortage of providers trained in geriatrics in all health care disciplines (Hudson, 2003). In addition, very few providers are trained in ethnogeriatrics (health care of elders from diverse backgrounds) and cultural competence.[9]

As noted in the profiles, historical experiences of many populations have tended to erode trust in the mainstream U.S. health care system. Focus groups reported in the IoM report, *Unequal Treatment*, (Smedley, et al., 2003) confirm the experience of continued disrespect experienced by minority patients in a variety of contexts. Black patients were less likely to rate their physicians as respectful than white patients (Malat, 2001), and Asian Medicare patients rate the quality of their care lower than other ethnic groups (Lurie, et al., 2003; Taira, Safran, & Seto, 2001). Communication styles of physicians have been found to differ based on the patients' race. Physicians dominate the conversation more with black patients than with white patients. Research based on analyses of audiotapes suggests that in interactions with minority/immigrant patients both patients and physicians sound less interested, engaged, and friendly (Johnson, Roter, Rowe, & Cooper, 2004).

To help reduce these and other disparities in

[9] There are varying definitions of cultural competence in the literature. The California Endowment website states that "Culturally competent health systems are ones that are engaged with and responsive to diverse individuals and communities." Another commonly used definition of cultural competence is "a set of congruent behaviors, knowledge, attitudes, and policies that come together in an organization, system, or among professionals to enable effective work in cross cultural situations," or some variation of that.

clinical care, the IoM report recommends that "cross-cultural education be integrated into the training of all current and future health professionals" (Smedley, et al., 2003, p. 20.) This type of training is also recommended by the CLAS standards (see Appendix B). Likewise, the Bureau of Health Professions' *A National Agenda for Geriatric Education: White Papers* recommends that "A curriculum in ethnogeriatrics must be required as part of the core knowledge and sills practice base of all health professions caring for older adults" (Kline, 1996, p.96).

Improving providers' knowledge of, attitudes about, and communication skills with immigrant populations is especially important to show culturally appropriate respect, nonverbal communication, working with family members, eliciting patients' perception of problems, integration of culturally and spiritually based health traditions and beliefs, diet and dietary restrictions, home care, techniques for accommodating strict modesty norms, end of life care, providing information on serious or life-threatening conditions, and health care decisions regarding long term care for dependent elders.

Health Promotion

Screening, early detection, health education for prevention and management of chronic disease, and immunizations are all necessary for healthy aging for the diverse California populations. Policies to increase their access to health promotion/disease prevention programs are crucial given the large number of disparities that exist in which minority elders have higher rates of debilitating conditions than non-Hispanic elders, and the fact that, on average, they present at later stages in the illness, Studies have found disparities in the degree to which older members of minority groups receive breast cancer screening, eye examinations for patients with diabetes, osteoporosis screening, flu shots and other preventive interventions (Mudano, et al., 2003; Schneider, et al, 2001; Schneider, Zaslavsky, & Epstein, 2002). In order to be effective, health promotion strategies need to be done in culturally appropriate ways for each unique population. They need to take into account the conditions for which that population is at particular risk and cultural issues affecting preferences for screening, such as modesty norms. The most effective models of health education have been those in which the target ethnic community is heavily involved and helps sponsor and promote the programs in local forums and ethnic language media. *Promotores* and community health workers have also been very effective in increasing participation of elders in their communities in health promotion programs.

Promotores/Community Health Workers

Because of the difficulties reaching and communicating with the large number of elders who interact primarily within ethnic-specific social systems (e.g., family, neighborhoods, and/or religious organizations) and who are not highly acculturated to the mainstream California culture, there is a strong need to provide health-related cultural intermediaries for programs targeted to the elders' health care needs. Many successful Latino oriented health promotion programs have used *promotores*, who are members of the community (usually women) trained to recruit and provide outreach, case management, transportation, and other essential front line services and to train other staff in cultural values and appropriate interactions.

The California Endowment (TCE) has been active in funding and supporting programs using *Promotores* or Community Health Workers (CHWs) throughout the state. In a gathering of representatives from 30 programs using these workers sponsored by TCE in 2000, policy recommendations included the following (The California Endowment, 2000):

1. Institutionalizing the programs so that they are no longer dependent on grants for funding;
2. Developing and sharing resources and models for training *Promotores*/CHWs;
3. Standardizing the pay scale to assure a living wage;
4. Having *Promotores*/CHWs recognized as an integral part of the health care team; and
5. Personal support for *Promotores*/CHWs when they feel overburdened by the needs of their community members.

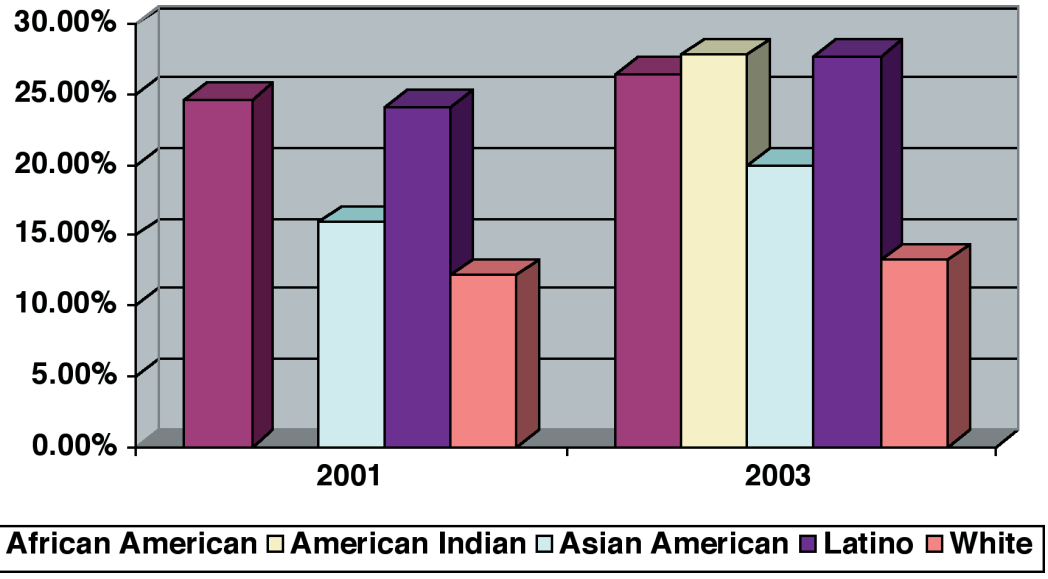
Diabetes

All of the major ethnic populations of older adults in California have increased risk of Type 2 Diabetes. According to a UCLA Center for Health Policy Research bulletin, diabetes is on the rise in California (Diamant, Babey, Brown, & Hastert, 2005). A comparison of diabetes prevalence among elders from the major ethnic and racial categories from the telephone-based California Health Interview survey for 2001 and 2003 (Table 5 and Figure 1) illustrates this increase. The over 65 populations have the highest risk of all the age groups, and with over one in four African American, American Indian, and

Table 5
Diabetes Prevalence among Californians Aged 65 and Over, 2001 and 2003

Population	2001	2003
African American	24.6%	26.5%
American Indian[1]		27.8%
Asian American	15.9%	19.9%
Latino	24.1%	27.7%
White[2]	12.1%	13.2%

Figure 1
Diabetes Prevalence among Californians Aged 65 and Over, 2001 and 2003



Notes: [1]American Indian and Alaska Native data included only for 2001 source
[2] Specified as "Non-Latino White" in 2001 data and "White" in 2003 data.
Sources:
2001: California Health Interview data published in Wallace, S.P., Pourat, N., Enriquez-Haass, V., & Sripipatana, A. 2003;
2003: Diamant, Babey, Brown, & Hastert 2005

Latino elders and one in five Asian elders with diabetes, it has earned the designation of epidemic.

Although some diabetes prevention programs are in place for African Americans, American Indians, and Latinos, much more should be done.

Data about the three largest older Asian populations (Chinese, Filipino, and Japanese) suggest that there is higher risk of diabetes among these populations. The evidence pertaining to Japanese individuals is substantial. In the smaller populations, however, less evidence is available. Asian Indian elders have been found to have higher insulin resistance, so higher risk of diabetes is assumed, but that needs to be confirmed. In Asian populations in which higher rates of diabetes have been found, it appears to be related less to obesity than among other ethnic populations. Because of higher rates of obesity, Native Hawaiian and Other Pacific Islander populations are also at high risk of diabetes (McBride, et al., 1996). Prevention programs for these Asian and Pacific Islander populations in California are not well developed and should be a priority policy issue.

Long-Term Care

Cultural norms of family care of dependent elders in California vary by race and ethnicity. In most Latino and Asian subpopulations, great emphasis is placed on taking care of family members within the home and not using residential facilities or other formal services. Among some Vietnamese families, culture-bound values mitigate against use of nonfamily home care as well (Yeo, et al., 2001). In these populations the need for ethnic-specific programs to relieve the stress of family caregivers is great. In many of the immigrants' home countries, extended family members were available to help provide the expected family-based care, but that is seldom the case in California. At the same time, the strong cultural norms produce a great deal of stress and guilt when this manifestation of filial piety cannot be met by the adult children, especially when all of the adult children and children-in-law need to work full time to afford to live in California.

There are other immigrant populations (e.g., Japanese and Jewish) that have been effective in developing residential and nursing home care facilities that are specific to their cultural needs and where elders feel comfortable in culturally appropriate surroundings. A particular challenge to developing appropriate formal long-term care services among some ethnic communities is the variation in traditions of volunteering. For example, volunteering outside the family is not a part of some cultures, and is sometimes disapproved. Collaboration between ethnic-specific community groups and organizations with successful long-term care models could help provide the important missing resource for the growing number of California elders who need them.

Collection of Race and Ethnicity Data

In order to assess the needs of staff to meet the needs of elders from diverse populations, health care organizations need accurate information on their patient populations. Accurate and uniform data are lacking for many populations. The CLAS standards indicates that "health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated" (see Appendix B).

The California Pan-Ethnic Health Network developed specific recommendations to help California health care organizations design systems for data collection (California Pan-Ethnic Health Network, 2005).

Access for Undocumented Older Californians

Since data are not available for undocumented elders, it is difficult to know to what extent these elders have access to health care services.

Although there are clinics and hospitals that serve ethnically specific populations, such as older Latinos, without considering their legal status, the national debate on restricting immigration has created pressure on health care and other institutions to deny their services to undocumented immigrants. Recipients of Medi-Cal and Medicare are required to be citizens of the United States or to be legal immigrants. On July 1, 2006, federal regulations were implemented to require new and continuing Medicaid (Medi-Cal) beneficiaries who claim to be U.S. citizens to show proof of citizenship. After an outcry from senior advocacy organizations protesting the ruling, especially for many low-income older African Americans and individuals in nursing homes who do not have a way to obtain verified birth certificates or other valid documents, Medicare and Supplemental Security Income beneficiaries were exempted from the requirement (Medical News Today, 2006). As long as there continue to be new undocumented populations (e.g., Mixtecs), there remain the questions of whether appropriate health care for these populations will be available and whether they will feel comfortable using it.

Section III: Models of Culturally Competent Health Care Services for Diverse Older Californians

A number of health care services targeted to ethnically diverse elders in California have developed successful models to meet some of the challenges outlined. Three examples are briefly described below.

ON LOK SENIOR HEALTH SERVICES

On Lok was developed in the 1970s as an innovative response to the need to provide culturally appropriate long-term health and social services to frail and low-income seniors in the Chinatown area of San Francisco. Modeled on the day hospitals in Great Britain, On Lok provides comprehensive, cost-effective health care through adult day health centers to elders who, because of their functional status and income level, are eligible for nursing home care and Medi-Cal. Because one of the On Lok's goals is to reduce the need for nursing home care, it is culturally appropriate for the large number of older frail Chinese Californians who live with their family members. It also serves elders from Chinese and other backgrounds (e.g., Italian) that live alone in small apartments in the same densely populated neighborhood.

Personal care assistants and drivers who speak Cantonese and other Chinese dialects are on staff and trained to provide door-to-door transportation to the adult day care centers and a wide range of services for these elders with multiple needs. Bilingual, bicultural health professionals in multiple disciplines, including medicine, are also recruited and trained. The result is an extremely successful model of health care that is more cost effective than nursing home placement. After documenting the health and fiscal advantages, On Lok obtained Medicare and Medi-Cal waivers to provide a range of services in the adult day health centers that are not usually available on an outpatient basis. On Lok now has seven centers throughout San Francisco and one in Fremont and serves a variety of populations. One is the 30th Street Center, which is in a predominantly Latino neighborhood. It provides Spanish-speaking staff members and multidisciplinary comprehensive health care. Because the model has achieved national recognition for its exceptional level of care at lower cost than nursing homes, it is now replicated in 43 locations nationwide as the PACE program (Program for All Inclusive Care of the Elderly) with many different ethnic and low-income populations of frail elders (see www.onlok.org and www.npaonline.org).

ALZHEIMER'S ASSOCIATION DEMENTIA CARE NETWORKS

Funded in part by the state of California and the Administration on Aging in 1992, the Los Angeles Chapter of the Alzheimer's Association developed *El Portal*, an innovative program to identify and address unmet service needs among underserved persons with dementia and their caregivers (Edgerly & Sullivan, 2006). The successful "*El Portal*" Dementia Care Network

model was replicated in an African American community in 1997 and in three Asian populations in 2000, which included one in Santa Clara County serving Chinese and Vietnamese caregivers and another in Los Angeles County serving Chinese and Japanese caregivers. The original project and each replication of it have been collaborations among the Alzheimer's Association, the Area Agency on Aging, and trusted ethnic health and social service organizations in individual communities. These included Little Tokyo Service Center and the Chinatown Service Center in the Los Angeles area and John XXIII Multi-service Center serving Vietnamese and Chinese families in San Jose. Needs assessments or focus groups were used to gather information to tailor the services to the needs of the community, and to provide recommendations for how to promote culturally sensitive dementia care services.

Four principles guide the Dementia Care Network program: 1) the community must become involved in the development and oversight of the project; 2) the community has a strong sense of what will work and is empowered to individualize the program to match local beliefs and strengths; 3) the project should include capacity building, not just service provision; and, 4) there should be reciprocity between the Alzheimer's Association and the partnering community agencies so that the Association learns how to provide culturally appropriate services to the targeted community and the local providers learn about dementia care and addressing caregivers' needs (Edgerly & Sullivan, 2006).

The centerpiece of the dementia care network model is the use of bilingual/bicultural care advocates who are recruited and hired by the partner agencies to conduct in-depth home-based assessments, provide information and referrals, connect families to diagnostic, support, and community-based services, and provide community education and outreach. They assist families in navigating bureaucracy, help them access services, and are a community resource for other ethnic professionals who need to learn how to provide dementia services. The Alzheimer's Association provided intensive dementia-related training and clinical supervision to the care advocates in collaboration with the partner agencies, and provided caregiver support groups, educational workshops, professional training and safe-return services to families in the program (Edgerly & Sullivan, 2006).

SACRAMENTO URBAN INDIAN HEALTH PROJECT, INC. (SUIHPI) DIABETES MANAGEMENT PROGRAM

SUIHPI, a nonprofit clinic providing health services to American Indians in the Sacramento area, was chosen by a Robert Wood Johnson (RWJ)-sponsored national initiative in 2001 as a "Best Practice" for its diabetes program (Siegel, Berliner, Adams, & Wazongarz, 2003). One of a number of primary care, dental, counseling, and health education programs provided by SUIHPI, the diabetes program began in 1996 with a grant from the Indian Health Service to combat the growing problem of diabetes among Sacramento's Native American population. Their patient population includes American Indians from over 30 tribes, many of whom are transient, moving on and off nearby reservations and *rancherias*. The uninsured comprise 20% of patients, with Medi-Cal and Medicare covering approximately 80%; 75% of the medical and dental patients have incomes below the poverty line.

Patients are recruited to the diabetes program through primary care and dental service staff and through outreach at Indian cultural events, including a pow-wow sponsored by SUIHPI. The "Native American grapevine" has also been a successful word-of-mouth recruiting strategy. Individuals identified as diabetic are contacted, offered information about the program and the

monthly nutrition classes held at SUIHPI and sponsored by the county health department, given free glucometers, and taught how to measure their blood sugar.

The heart of the program is the Native American lay community health workers who are high school educated members of the community. They are given three weeks of training on diabetes, which all involved agree is inadequate. The RWJ report (Siegel, et al., p. 34) states:

> Both the health workers and other staff note the importance of the health workers being Native American, citing the high level of mistrust of whites among the Native American population. In addition, health workers said that having lived on reservations and had life experiences similar to those of their clients, provide them with important insights into their clients' lifestyles, beliefs, and needs, as well as the challenges clients face beyond diabetes management.

They conduct weekly home visits to provide ongoing education about diet, exercise, and disease management for new patients, and less frequent visits after their diabetes is controlled. They also provide transportation to the nutrition classes.

Other cultural issues that are important in the program include: recognizing the importance of family and community networks in Native American culture; framing diabetes management as "consistent with Indian values"; recommending traditional Indian diets; reminding clients that the traditional Indian lifestyle is very active, which makes physical activity culturally appropriate; recognizing that the current high fat diet of many older Native Americans is the direct result of having been raised on reservations where they received cheese and lard among the "surplus" foods supplied by the government; and recognizing the important role of elders in the culture. For example, because elders are viewed as teachers and mentors, it may be difficult for them to admit having an illness such as diabetes when it might be viewed as a sign they have failed as good role models. In interacting with elders, it is inappropriate for a younger person to correct or criticize them, so that a careful line needs to be walked when offering behavioral modification advice to them. Also noted were the issues around shame and privacy that can be barriers to treatment in a community where "the grapevine" is an effective means of communication.

SUMMARY: MODELS OF CULTURALLY COMPETENT HEALTH CARE SERVICES FOR DIVERSE OLDER CALIFORNIANS

It is important to note characteristics that these three successful models have in common: 1) they all have developed a model of care appropriate to the cultural values of the target community in collaboration with the local community members rather than impose a mainstream model; and 2) they rely on bilingual, bicultural front line staff from the target community to provide the important patient/client services. These include the drivers and personal care providers in On Lok, the care advocates in the Alzheimer's programs, and community health workers (CHWs) in SUIHPI, all of whom are well integrated into the health care team and appreciated for the principal role they play in the program.

Section IV: Policy Recommendations

Given the heterogeneity of California's immigrant and low-income elders from diverse ethnic populations, policies and services in support of healthy aging need to take into account their unique history, strengths, and needs. Doing so would likely result in the creation of targeted models for each population. The policies recommended below should be available to the relevant populations in all parts of the state. (See Table 6 for the relationship of policy recommendations to the challenges identified.)

SPECIFIC POLICY RECOMMENDATIONS

1) Develop and provide incentives for ethnic specific community organizations to develop culturally appropriate geriatric services for elders in their own communities, which could be in partnership with mainstream organizations or those from other ethnic communities.

   This might include home care, adult day care or other respite care for caregivers, appropriate models of residential care for frail elders, support for elders with dementia and their caregivers, and end-of-life care, all in a culturally acceptable delivery style.

2) Provide incentives for health care organizations to implement CLAS standards (see Appendix B).

3) Advocate for the immediate inclusion of state-provided matching funds for interpreter services for Limited English Proficient Medi-Cal recipients.

4) Educate health care plans and physicians on the need to provide and use trained interpreters as a provided service in managed care plans and as reimbursable costs in fee-for-service care.

5) Advocate and support lower cost telephone-based interpreter services to make it more cost effective for health care organizations to meet the needs of limited English proficient elders for improved communication with health care providers.

6) Provide support for increasing health literacy among elders from diverse populations to reduce miscommunication with their providers and mistakes in following providers' instructions.

7) Provide, support, and require education in ethnogeriatrics and cultural competence for all health care providers who care for older Californians.

8) Develop state collaboration with Indian Health Centers, especially in urban areas to create comprehensive geriatric health care and caregiver support programs for Indian elders.

9) Develop better ethnic specific data sources for state planning, especially for relatively small populations of disadvantaged immigrant elders with distinctive cultures.

Table 6
Relationship of Policy Recommendations to Policy Challenges

Policy Challenges	Policy Recommendations
A. Language	A. Incentives for ethnic specific organizations to develop geriatric services B. Incentives for implementation of CLAS standards C. Funds for LEP Medi-Cal interpreters D. Educate plans and physicians on need for interpreters E. Lower cost telephone interpreter services F. Increasing health literacy K. Exploration of methods to finance community health workers/*promatores*
B. Diversity of Providers	A. Incentives for ethnic specific organizations to develop geriatric services B. Incentives for implementation of CLAS standards H. Geriatrics in Indian Health Care J. Diabetes programs K. Exploration of methods to finance community health workers/*promatores*
C. Ethnogeriatric Training	B. Incentives for implementation of CLAS standards D. Educate plans and physicians on need for interpreters G. Education in ethnogeriatrics and cultural competence for providers
D. Health Promotion	A. Incentives for ethnic specific organizations to develop geriatric services F. Health Literacy G. Education in ethnogeriatrics and cultural competence for providers H. Geriatrics in Indian Health Care J. Culturally appropriate diabetes programs K. Exploration of methods to finance community health workers/*promatores*
E. *Promatores*/ CHWs	A. Incentives for ethnic specific organizations to develop geriatric services H. Geriatrics in Indian Health Care J. Culturally appropriate diabetes programs K. Exploration of methods to finance community health workers/*promatores*
F. Diabetes	A. Incentives for ethnic specific organizations to develop geriatric services G. Education in ethnogeriatrics and cultural competence for providers J. Culturally appropriate diabetes programs K. Exploration of methods to finance community health workers/*promatores*
G. Long Term Care	A. Incentives for ethnic specific organizations to develop geriatric services G. Education in ethnogeriatrics and cultural competence for providers H. Geriatrics in Indian Health Service
H. Collection of Race & Ethnicity Data	B. Incentives for implementation of CLAS standards I. Better ethnic specific data
I. Access for Undocumented Elders	A. Incentives for ethnic specific organizations to develop geriatric services D. Educate plans and physicians on need for interpreters E. Lower cost telephone interpreter services F. Increasing health literacy J. Culturally appropriate diabetes prevention early detection, and self management programs K. Exploration of methods to finance community health workers/*promatores*

10) Support wide scale community based culturally appropriate diabetes prevention, early detection, and management programs, especially for older high risk populations where they have not been developed.

11) Convene an exploration of methods to finance the recruitment, training, and integration of community health workers/*promotores* from ethnic backgrounds as standard services to provide health promotion, health education, and chronic disease management services for elders from their own ethnic backgrounds in diverse populations.

SUMMARY

By designing policies based on the needs of ethnic-specific populations of California's older adults, and by addressing the shortcomings of the health care system, California can reduce the disparities in services available to immigrant and low-income ethnic elders. By developing these systems of support in collaboration with the ethnic communities, the diverse population of elders, who will soon comprise two-thirds of all California's elders, will be assured of better opportunities to live healthy lives.

References

Alvord, L. & Van Pelt, E. C. (2000) *The Scalpel and the Silver Bell: The First Navajo Woman Surgeon Combines Western Medicine and Traditional Healing*. New York: Bantam

American Institute for Research (2005). *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. Submitted to Office of Minority Health. [http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf. Accessed 7/16/06]. See also the Executive Summary at http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf .

Argüelles, T. & Argüelles, S. (2006). Working with Cuban American families. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed*. Sudbury, MA: Taylor and Francis.

Aroian, K., Khatutsky, G., & Dashevskaya, A. (2006). Older Russian-Speaking Americans. In Adler, R. (Ed.) *Doorway Thoughts: Cross Cultural Care for Older Adults, Vol. 2*. Ethnogeriatrics Committee of American Geriatrics Society. New York: Jones & Bartlett.

Bade, B. (1993). Problems surrounding health care service utilization for Mixtec migrant farm worker families in Madera, California. Davis, CA: The California Institute for Rural Studies.

Brod, M., & Heurtin-Roberts, S. (1992). Older Russian emigres and medical care. *The Western Journal of Medicine*, *157,* 333-336.

The California Endowment (2003). Improving access to health care for limited English proficient health care consumers: Options for federal funding for language assistance services. *Health….In Brief: Policy Issues Facing a Diverse California, 2(1).*

The California Endowment (2000). *Highlights from Promotores/Community Health Workers Grantee Convening; June 7-8, 2000, Los Angeles, CA*. Author. [http://www.calendow.org/reference/publications/cultural_competence.stm. Accessed 7/15/06]

California Pan-Ethnic Health Network (2005). *Using Race, Ethnicity, and Language Data to Eliminate Health Disparities*. Policy Brief. Oakland: Author.

Chen, A. (2006). Doctoring across the language divide. *Health Affairs 25*, 808-813.

Crimmins, E.M., Hayward, M.D. & Seeman, T.E. (2004). Race/ethnicity, socioeconomic status, and health. In National Research Council. *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*. N.B. Anderson, R.A. Bulatao, & B. Cohen, Eds. Panel on Race, Ethnicity, and Health in Later Life. Committee on Population, Division of Behavioral and Social Sciences and Educaton. Washington, DC: The National Academies Press.

Diamant, A.L., Babey, S.H., Brown, R., & Hastert, T.A. (2005). Diabetes on the Rise in California. Health Policy Research Brief. Los Angeles: UCLA Center for Health Policy Research.

Dilworth-Anderson, P., Gibson, B.E., & Burke, J.D. (2006). Working with African American families. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed*. Sudbury, MA: Taylor and Francis.

Dower, C. (2003). Health care interpreting in California. The Center for Health Professions, University of California, San Francisco.

Edgerly, E. & Sullivan, T. (2006). Reaching Diverse Caregiving Families through Community Partnerships. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed*. Sudbury, MA: Taylor and Francis.

Fadiman, A. (1997). *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Strauss & Giroux.

Gerdner, L.A. Xiong, X.X. & Yang, D. (2006). Working with Hmong American Families. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed*. Sudbury, MA: Taylor and Francis.

Grantmakers in Aging (2003). In the Right Words: Addressing Language and Culture in Providing Health Care. *Issue Brief No. 18*.

Handelman, L. & Yeo, G. (1996). Using explanatory models to understand chronic symptoms and of Cambodian refugees. *Family Medicine, 28,* 271-276.

Haan, M.N., Mungas, D.M., Gonzalez, H.M., Ortiz, T.A., Acharya, A., Jagust, W.J. (2003). Prevalence of dementia in older Latinos: The influence of Type 2 Diabetes Mellitus, stroke, and genetic factors. *Journal of American Geriatrics Society, 51:* 169-2003.

Hendrix, L. R. (1999). *Cultural Support in Health Care: The Older Urban American Indian of the San Francisco Bay Area*. Dissertation: The Union Institute. Cincinnati, OH: UMI Dissertation Service, 1-800-521-0600.

Hudson, R. (2003). Emerging crisis: The geriatric care workforce. *Public Policy and Aging Report, 13*. 1-26.

Hummer, R.A., Benjamins, M.R., & Rogers, R.G. (2004). Racial and ethnic disparities in health and mortality among U.S. elderly population. In N.B. Anderson, R.A. Bulatao, & B. Cohen, Eds. National Research Council. *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*. Panel on Race, Ethnicity, and Health in Later Life. Committee on Population, Division of Behavioral and Social Sciences and Educaton. Washington, DC: The National Academies Press.

Jasso, G., Massey, D.S., Rosenzweig, M.R., & Smith, J.P. (2004). Immigrant Health: Selectivity and Acculturation. In National Research Council. *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*. N.B. Anderson, R.A. Bulatao, & B. Cohen, Eds. Panel on Race, Ethnicity, and Health in Later Life. Committee on Population, Division of Behavioral and Social Sciences and Educaton. Washington, DC: The National Academies Press.

Johnson, R. L., Roter, D., Rowe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health, 94*, 2084-2090.

Kline, S. (Ed.) (1996). *A National Agenda for Geriatric Education: White Papers*. Rockville, MD: Health Resources and Services Administration.

Kramer, B. J. (1991) Urban American Indian aging. *Journal of Cross-cultural Gerontology, 6:* 205-217.

Lee, R., Miller, T. & Edwards, R. E. (2003). *Special Report: The Growth and Aging of California's Population: Demographic and Fiscal Projections, Characteristics and Service Needs*. Berkeley: California Policy Research Center.

Lin, I. (1995). Underutilization of health care by Chinese American elders in the South Bay: Factors limiting access. Paper presented at the annual meeting of the American Geriatrics Society, 1995, Washington, DC.

Lurie, N. Zhan C., Sangl, J.. et al. (2003) Variations in racial and ethnic differences in consumer assessments of health care. *American Journal of Managed Care, 9,* 502-509.

Malat, J. (2001). Social distance and patients' rating of healthcare providers. *Journal of Health and Social Behavior, 42:* 360-372.

Maldonado, D. (1985). The Hispanic elderly: A socio historical framework for public policy. *Journal of Applied Gerontology, 4:* 18-27.

Mangaliman, J. (2006). Starting over in America: Last of a series: Finding purpose. *San Jose Mercury News*. January 15, 2006.

McBride, M., Morioka-Douglas, N., & Yeo, G. (1996). *Aging and Health: Asian and Pacific Islander American Elders, 2nd Ed*. SGEC Working Paper #3. Stanford, CA: Stanford Geriatric Education Center.

McCabe, M. & Cuellar, J. (1994). *Aging and Health: American Indian/Alaska Native Elders, 2nd Ed*. Working Paper #6. Stanford, CA: Stanford Geriatric Education Center.

Medical News Today (2006). Exemptions To New Medicaid Proof-of-Citizenship Rules Still Inadequate, Advocates Say. July 12, 2006.

Montoro-Rodríguez, J., Small, J.A. & McCallum, T.A. (2006). Working with Hispanic/Latino American families with focus on Puerto Ricans. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed*. Sudbury, MA: Taylor and Francis.

Moon, A. (2006) Working with Korean American families. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias, 2nd Ed.* Sudbury, MA: Taylor and Francis.

Mudano, A. S., Casebeer, L., & Patino, F. et al. (2003). Racial disparities in osteoporosis prevention in managed care. *Southern Medical Journal, 96,* 445-451.

Niedzwiecki, M., Yang, K.Y., & Earm, S. (2003). *Southeast Asian American Elders in California: Demographics and Service Priorities Revealed in the 2000 Census and a Survey of Mutual Assistance Organizations (MAOs) and Faith Based Organziations (FBOs).* Washington, DC: Southeast Asian Resource Action Center.

Office of Immigration Statistics (2006). 2004 Yearbook of Immigration Statistics. Tables 6 and 11. Washington, DC: Author. http://uscis.gov/graphics/shared/statistics/yearbook/Yearbook2004.pdf. (Accessed 2.26.06)

Periyakoil, V. (2004). Older Asian Indian Americans. In Adler, R. & Kamel, H.K. (Eds.) *Doorway Thoughts: Cross Cultural Care for Older Adults.* Ethnogeriatrics Committee of American Geriatrics Society. Sudbury, MA: Jones & Bartlett.

Reiman, J. O. F., Project Salaam: The Islamic Center of San Diego, San Diego State University Center for Behavioral and Community Health Studies (2006). *Bringing Communities Together for Wellness: An Assessment of Emotional Health Needs of San Diego's Middle Eastern, North African, and East African Groups.* The California Endowment [http://www.calendow.org/reference/publications/pdf/cultural/ProjectSalaamNeedsAssessmentReportRevisedUpdated.pdf. Accessed 7.15.06]

Richardson, J. (1996). *Aging and Health: African American Elders, 2nd Ed.* Working Paper #4. Stanford, CA: Stanford Geriatric Education Center.

Roat, C. E. (2005). *Addressing Language Access Issues in Your Patients: A Toolkit for Physicans and Their Staff Members.* California Academy of Family Physicians and CAFP Foundation. The California Endowment. [http://www.calendow.org/reference/publications/cultural_competence.stm. Accessed 7/15/06]

Runsten, D. & Kearney, M. (1994). A survey of Oaxacan village networks in California Agriculture. http://www.circsinc.org/ (Accessed August 9, 2005).

Salari, S. & Balubaid, H. (2006). Arab American Elders. In Adler, R. (Ed.) *Doorway Thoughts: Cross Cultural Care for Older Adults, Vol. 2.* Ethnogeriatrics Committee of American Geriatrics Society. New York: Jones & Bartlett.

Schneider, E. C., Cleary, P. D., Zaslavsky, A. M, & Epstein, A. M. (2001). Racial disparity in influenza vaccination: Does managed care narrow the gap between African Americans and whites? *JAMA, 286,* 1455-1460.

Schneider, E. C., Zaslavsky, A. M., Epstein, A. M. (2002) Racial disparities in the quality of care for enrollees in Medicare managed care. *JAMA, 287,* 1288-1294.

Schulman, K. A., Berlin, J., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., Dubé, R., Taleghani, C. K., Burke, J. E., Williams, S., Eisenberg, J. M., Escarce, J. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine, 340,* 618-626.

Siegel, B., Berliner, H., Adams, A., & Wazongarz, D. (2003). *Addressing Health Disparities in Community Settings: An Analysis of Best Practices in Community-Based Approaches to Ending Disparities in Health Care.* Final Report to The Robert Wood Johnson Foundation. New School University.

Smedley, B. D., Stith, A. Y., & Nelson, A. R., Eds. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Institute of Medicine of the National Academies. Washington, DC: The National Academies Press.

Sohn, L. (2006). Older Korean Americans. In Adler, R. (Ed.) *Doorway Thoughts: Cross Cultural Care for Older Adults, Vol. 2.* Ethnogeriatrics Committee of American Geriatrics Society. New York: Jones & Bartlett.

Summit Health Institute for Research and Education, Inc. (SHIRE) (2005). *Giving Voice to the Voiceless: Language Barriers and Health Access Issues of Black Immigrants of African Descent.* The California Endowment. [http://www.calendow.org/reference/publications/pdf/cultural/TCE0121-2005_Voices_of_the_.pdf. Accessed 7/15/06]

Taira, D. A., Safran, D. G,. & Seto, T.B., (2001). Do patient assessments of primary care differ by patient ethnicity? *Health Services Research, 36,* 1059-1071.

U.S. Census, 2000. Sample File 4. *www.census.gov.* Accessed January 16, 2006.

Vartanian, N. (2000). A fruitful legacy. *Cobblestone, 21:* 10. http://www.cilicia.com/armo_article_fruitful_legacy.html. (Accessed January 27, 2006)

Villa, M.L., Cuellar, J., Gamel, N., & Yeo, G. (1993). *Aging and Health: Hispanic American Elders, 2nd Ed.* Working Paper #5. Stanford, CA: Stanford Geriatric Education Center.

Wallace, S.P. & Lew-Ting, C.Y. (1992). Getting by at home: Community-based long term care of Latino elders. *The Western Journal of Medicine, 157:* 337-344.

Wallace, S.P., Pourat, N., Enrique-Haass, V. Sripipatana, A. (2003). *Health of Older Californians: County Data Book.* Los Angeles: UCLA Center for Health Policy Research.

Winkleby, M.A. & Cubbin, C. (2004). Racial/ethnic disparities in health behaviors: a challenge to current assumptions. In National Research Council. *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life.* N.B. Anderson, R.A. Bulatao, & B. Cohen, Eds. Panel on Race, Ethnicity, and Health in Later Life. Committee on Population, Division of Behavioral and Social Sciences and Educaton. Washington, DC: The National Academies Press.

Yeo, G. (1993). Ethnicity and nursing homes: Factors affecting use and successful components for culturally sensitive care. In Barresi, C. & Stull, D. (Eds.) *Ethnic Elderly & Long-Term Care.* New York: Springer.

Yeo, G., Gallagher-Thompson, D. & Lieberman, M. (1996). Variations in dementia characteristics by ethnic category. In Yeo, G. & Gallagher-Thompson, D. (Eds.) *Ethnicity and the Dementias.* Sudbury, MA: Taylor and Francis.

Yeo, G. & Hikoyeda, N. (2000). Cultural issues in end-of-life decision making among Asians and Pacific Islanders in the United States. In Braun, K.L., Pietsch, J.H., & Blanchette, P.L. (Eds.) *Cultural Issues in End-of-Life Decision Making.* Thousand Oaks, CA: Sage.

Yeo, G. & Hikoyeda, N. (2006) Asian and Pacific Island Elders. In Maddox, G. (Ed.) *Encyclopedia of Aging, 4th Eds.* New York: Springer, 2006.

Yeo, G., Hikoyeda, N., McBride, M., Chin, S-Y., Edmonds, M., & Hendrix, L. (1998) *Cohort Analysis as a Tool in Ethnogeriatrics: Historical Profiles of Elders from Eight Ethnic Populations in the United States.* SGEC Working Paper #12. Stanford, CA: Stanford Geriatric Education Center.

Yeo, G. Tran, J., Hikoyeda, N. Hinton, L. (2001) Conceptions of dementia among Vietnamese American caregivers. *Journal of Gerontological Social Work. Special Issue on Asian Elders. 36:*1&2. 131-152.

Appendix A

Expanded Descriptions of the Historical Background, Cultural Characteristics, Traditional Health Beliefs, and Health Risks of Elders of California's Ethnic Populations

OLDER CALIFORNIA IMMIGRANTS

Asian Americans

OLDER CHINESE CALIFORNIANS.[10] Elders from the largest Asian subpopulation describe themselves as being Chinese, but they may have come to the U.S. from a variety of countries including mainland China, Hong Kong, Taiwan, Vietnam, or via Canada or some other country. The small minority who were born in the U.S. may be the children or grandchildren of Chinese men who came to California (Gold Mountain) during the gold rush or to work on the very dangerous jobs building the railroads in the 1800s. The Chinese Exclusion Act, which made immigration of Chinese laborers illegal, was passed in 1882 during a period of severe discrimination. It was not repealed until 1943. In the early part of the 20th century many families were divided between China and California because of immigration restrictions,[11] and many current older Californians were part of those "mutilated" families, as they have been called. In 1946 a law was passed allowing 9,000 "alien wives" of permanent residents or U.S. citizens to immigrate, spiking birthrates in Chinese families along with the more general postwar baby boom.

Periodically during the last quarter of the 20th century, Chinese people from Taiwan and Hong Kong have been allowed to immigrate to the U.S. as a result of liberalized emigration policy in mainland China. Many Taiwanese have come to the U.S. to work in computer companies; people from Hong Kong were allowed to emigrate before the transfer of sovereignty from England to China. As a result of these and prior waves, the current cohort of older Chinese Californians is extremely heterogeneous. Linguistically, non-Taiwanese with limited English proficiency (LEP) may speak Cantonese, especially if they are from Hong Kong, the Taiwanese probably speak Mandarin or Taiwanese, and some speak other languages such as Toisanese.[12] Those elders who follow their children to the U.S. frequently live in three-generation households. Since few have pension income if they retired in China, in the absence of considerable family assets, most have little income themselves. Consequently, subsidized senior housing programs are sometimes overwhelmed by the large number of applications from recent-

[10] Unless otherwise indicated, the historical and descriptive material related to the older cohorts of Californians from diverse ethnic backgrounds in the following sections is taken from Yeo, Hikoyeda, McBride Chin, Edmonds, & Hendrix (1998) *Cohort Analysis as a Tool in Ethnogeriatrics: Historical Profiles of Elders from Eight Ethnic Populations in the United States*. SGEC Working Paper #12, Stanford, CA: Stanford Geriatric Education Center and also from the census data reported in Table 1.

[11] Some merchants and their family members were allowed to immigrate but frequently detained for weeks in the infamous "shed" on Angel Island until two credible non-Chinese witnesses testified they were legitimate merchants and not laborers. "Paper sons" could also immigrate if naturalized citizens brought them back from China claiming them as their sons.

[12] It is helpful for many health and social service providers who would like to serve older LEP Chinese American to know that the written language is the same for all the Chinese spoken languages and dialects.

ly immigrated Chinese elders who prefer to not live with their children.

Many 2nd and 3rd generation Chinese American elders are well educated, speak English only, live a comfortable middle class life in the suburbs, and are very acculturated to American culture. There are a few very wealthy Chinese elders, especially those who brought assets from Hong Kong before its transfer to China. Nevertheless, the poverty rate for all older Chinese Californians is almost twice that of older Californians in general (Table 1). It is common to find low-income older Chinese Californians that have lived in urban Chinatowns most of their lives, speak little or no English, and frequently live alone in isolated one room apartments. Many elders are from Taoist and Confucian traditions, which are not organized faith communities, and others are members of Christian or Buddhist congregations.

In general, older Chinese Americans have lower risk for cardiovascular conditions than other older Americans, but there is evidence that the risks increase with longer residence in the U.S. Incidence of esophageal, liver, pancreatic, and nasopharyngeal cancer is higher than their non-Chinese cohorts, and breast cancer is lower. Colon cancer was found to be less prevalent, but some data suggest it increases with acculturation. Vascular dementia has been found to be more prevalent among elderly Chinese immigrants than among elders in general. Diabetes and suicide are also higher among older Chinese American women than older American women in general. (McBride, Morioka-Douglas, & Yeo, 1996). Census data indicate slightly fewer older Chinese Californians are disabled than older Californians in general (see Table 1).

Common health beliefs include: classic Chinese concepts of health as a balance between *yin* and *yang*, (including the need to alter diet to keep the balance); the need to keep *Chi* (or *Qi*), the vital life force, unblocked and flowing; and hesitancy to talk about death or complete advance directives. One study of 106 Chinese elders aged 65 and over attending senior centers in Santa Clara County found that 58% had no regular physician and that 31% had no health insurance (Lin, 1995). Many, but not all, elders from Chinese backgrounds prefer that their children be informed about their health conditions and make the necessary decisions. There is a strong expectation of family care for dependent elders among Chinese American families (McBride, et al., 1996; Yeo & Hikoyeda, 2000).

OLDER FILIPINO CALIFORNIANS. In the 1920s and 1930s many thousands of young Filipino men came to California to work on farms and in other low paying jobs. When jobs became scarce during the Depression, these *"pinoys,"* as they called themselves, suffered widespread discrimination, violent attacks, and legal restrictions, including a law that forbade them from marrying white women. In 1934, the Tydings-McDuffie Act limited immigration from the Philippines to 50 people per year, and in 1935, more than 2,000 U.S. residents were repatriated back to the Philippines.

After World War II, 16,000 Filipino war brides of U.S. military personnel arrived. Then after the 1965 Immigration Law relaxed quotas and allowed for family reunification, large numbers of Filipino health care and other professionals and their families immigrated to California, including older family members. This wave probably accounts for the relatively high proportion (44%) of older Filipino Californians that have some college education (see Table 1), higher than older Californians in general. However, it should be noted that a relatively high proportion (28%) also have less than a 9th grade education. Although 90% of older Filipino Americans are "foreign born," a much higher percentage of them speak English well than most other older Asian Californian groups because they learned English in school in the Philippines. Most also

speak Tagalog (Pilipino), and many speak other native languages as well, such as Ilocano or Cebuano.

As a result of special legislation passed during the 1990s, an estimated 4,000 older Filipino veterans, who had fought for the Allies in the Pacific during World War II but had never received the promised citizenship, were given immediate U.S. citizenship and allowed to immigrate. Most arrived in California, and many arrived alone. They were not given the usual veterans benefits, so most are on Medi-Cal and Supplemental Security Income. Many live in substandard housing, and some are homeless, with many obtaining meals from senior centers and soup lines.

Older Filipino Americans are at higher than average risk for hypertension, gout, diabetes, and tuberculosis, but their risk of most kinds of cancer seems to be lower than average (McBride, Morioka-Douglas, & Yeo, 1996). Almost half of Filipino elders in California reported a disability in 2000 (Table 1). Culturally based health beliefs and practices include a strong reliance on family decision making, family care of dependent elders, belief among the deeply religious segment of the predominant Catholic population that illness can be caused by God's will, and for some, a belief in the power of good and evil spirits to cause or prevent illness (Yeo & Hikoyeda, 2000).

OLDER JAPANESE CALIFORNIANS. The California demand for workers from Japan began in the latter 19th century after the Chinese Exclusion Act prohibited the immigration of Chinese laborers. These *Issei* (first generation immigrants) were the first of several waves of migration; the largest occurred from 1900 to 1920, which provoked substantial discrimination against the *Issei* and their children, the *Nisei*. During this period *Issei* men frequently married "picture brides" by proxy. They were not allowed to own land or become citizens in California, and anyone marrying an *Issei* lost his/her citizenship. The 1924 Immigration Exclusion Act ended all immigration from Asia except from the Philippines.

Most of today's older Japanese Californians experienced internment in "concentration camps" during World War II after the bombing of Pearl Harbor and the declaration of war with Japan. Families were given only 48 hours to arrange to leave their property for an unknown period, pack their belongings and be taken to one of ten camps, most in the remote desert where they lived in crowded conditions with little privacy or amenities for up to four years. While their families were in these conditions, many *Nisei* men volunteered for military service in Europe where several of these units distinguished themselves by their heroism. After the war the interned families were permitted to return to their homes, where many found their property had been vandalized or neglected, and they continued to experience discrimination in housing and employment.

The end of World War II saw the immigration of approximately 45,000 war brides from Japan, many of whom had been disowned by their families for marrying a man who was not Japanese. After the Walter-McCarren Act enabled *Issei* and other Asian immigrants to become U.S. citizens, more than 48,000 Japanese immigrants became naturalized citizens in 1965. Since that time, immigration from Japan has been low, although a small cohort known as *"Shin Issei"* has settled in the U.S. since 1980. As a result, most of today's older Japanese Californians are *Nisei*, and possibly *Sansei* (third generation) and are relatively acculturated to mainstream U.S. culture. Indeed, only 7 percent have less than 9 years of education and only 15 percent (probably *Shin Issei*) speak little or no English. Many older Japanese Californians are Buddhist; others belong to various Protestant denominations.

More is known about the health status of Japanese American elders than any of the other Asian American elders due primarily to the large

longitudinal study of Japanese men in Hawaii begun in the 1960s. They have been found to be one of the longest lived populations in the world, if not the longest. Their risk of hypertension and heart disease is lower than other older Americans, although they are at higher risk for vascular dementia and hemorrhagic stroke. Diabetes is also higher even in the absence of obesity. They are also at higher risk for esophageal, liver, and stomach cancer but lower risk for prostate cancer. Japanese American women have more osteoporosis but fewer hip fractures and less breast cancer than older American women in general. Suicide has been found to be higher among Japanese Americans (McBride, et al., 1996). The traditional Japanese health care system of *Kampo* is similar to the balance theories of the classical Chinese system, but there is little evidence that it is widely practiced in the U.S.

More elders from Japanese backgrounds live alone than from other Asian backgrounds (Table 1). In several California cities, the Japanese American communities have built independent living, assisted living, and/or nursing homes facilities oriented to the Japanese culture so that their elders would feel comfortable there, and in many there are high rates of volunteerism by younger Japanese Americans.

OLDER VIETNAMESE CALIFORNIANS. Vietnamese immigration is a recent phenomenon. The first wave of Vietnamese immigrants came to the U.S. in 1975, after the Vietnam War. Many families who had worked for Americans evacuated Saigon in traumatic circumstances just hours before its fall into Communist hands. The first immigrants were primarily well educated professional and military families, many of whom spoke English. Most immigrants in later waves were neither well educated nor affluent. Many escaped in small, crowded, unseaworthy boats, and many of them who escaped to other countries spent years in refugee camps before they were allowed entry into the U.S.

In addition to the majority ethnic Vietnamese, a few are Khmer Kampuchea Krom who trace their ancestry and traditions to Khmer people who lived in the regions of South Vietnam that were once part of Cambodia. There are also individuals of Chinese and part Chinese ancestry. The largest populations are in Orange and Santa Clara Counties, but large numbers also live in most of the state's metropolitan centers (Niedzwiecki, Yang, & Earm, 2003).

Not much is known about this relatively new population of elders. Three-quarters speak little or no English, and almost half (47%) have less than 9 years of education (Table 1). Predominant religious preferences are Catholic and Buddhist.

Vietnamese American women have very high rates of cervical cancer compared to other populations. Depression and post traumatic stress are more common among Vietnamese immigrants than among the general American population, but for some, stigma has limited their access to mental health services (McBride, et al., 1996). More than half of older Vietnamese Californians report having a disability, which is higher than any other population other than Southeast Asians (Table 1). Balance theories of health, effect of karma, and wind illness treated by cupping and coining are common traditional health beliefs. There is a very strong emphasis on family care in the Vietnamese culture so that there is considerable trauma in families when they cannot manage the care of dependent elders alone. Both members of younger couples frequently work outside the home, and it is not uncommon for a single adult child or a spouse to struggle alone to care for an elder with dementia problems (Yeo, Tran, Hikoyeda, & Hinton, 2001).

OLDER KOREAN CALIFORNIANS. Many of the 10 percent of today's Korean American elders who were born in the U.S. are descendents of the small number of young men who came to Hawaii

and then to the West Coast in the early 1900s and their picture brides who came after proxy marriages arranged by their families, and a small number of political activists who were critical of Japan's annexation of Korea. Between 1910 and 1924 they were allowed by Japan to emigrate and seek political asylum in the U.S.

There were three distinct populations included in the approximately 14,500 Koreans who immigrated in the next wave in the 1950s and early 1960s. Almost half were Korean wives of U.S. service men who had been stationed in Korea during the Korean War; many had low levels of education and occupational skills; family conflict and divorce was common, and they were frequently isolated from the support of the Korean American community. Another large group were war orphans adopted by EuroAmerican families, and a third smaller group were professionals, skilled workers, and students.

About 90% of the current Korean American community came to the U.S. after the immigration law became more lenient in 1965. Almost 20,000 immigrated per year from 1965 to 1970, and increased with family reunification after that. Major portions of immigrants from Korea since 1970 have been followers of children; for example, over 8,000 aged 60 and over entered the U.S. from 1989 to 1992. The result of the differing characteristics of the immigrating groups in different eras is a very heterogeneous population of older Korean Californians. Two-thirds speak little or no English, and 18 percent have incomes below the federal poverty line, which is the highest of any of the Asian communities in California, with the exception of the small Hmong and Cambodian communities. The percent living alone (22%) is almost as high as the highly acculturated Japanese Californians; while the traditional Korean culture is high in familism and filial piety, there is evidence that both older Korean Americans in California and their adult children are moving away from these values (Moon, 2006). The older Korean women in California seem to be particularly disadvantaged. Twenty-nine percent live alone (compared with 10% of older men), 40 percent have less than a 9th grade education (compared with 14% of men), and 22 percent have some college (compared with 53% of men) (U.S. Census, 2000). This disparity may, in part, reflect the disadvantages experienced by the aging cohort of Korean war brides.

It is known that older Korean Americans have higher risks of diabetes (even in the absence of obesity), hepatitis B virus and resulting liver cirrhosis, and tuberculosis than older Americans in general, but the health risks of older Korean Americans have been not well characterized (McBride, et al., 1996). Disability rates are 39% among older Korean Californians (Table 1). Accessing health care may be constrained because of lack of health insurance, especially for those not yet 65 and eligible for Social Security and those followers of children who immigrated at later ages and who are not eligible for Medicare benefits without paying large premiums.

Many also believe in traditional Korean medicine practices known as *Hanbang* and may consult those practitioners (*Hanui*) before Western medical providers. Based on the balance theories of classical Chinese medicine, common treatments include moxibustion, herbs, and cupping (McBride, et al., 1996; Sohn, 2006). Illnesses may be attributed to a failure to fulfill spiritual obligations, whether these are based in Christianity (the most common religious preference of Korean Americans) or in Confucianism, animism, or shamanism. These may include failure to pray, displeasure of ancestors with their burial place, or offending folk spirits. Some may attribute the illness to *Hwabyung* ("fire illness") which is caused by failing to keep their emotions from being expressed openly as traditionally required (Sohn, 2006).

OLDER ASIAN INDIAN CALIFORNIANS. Like the older Koreans in California, very few elders

from East Indian ancestry were born in the U.S. (11%); most of those probably descended from the Sikh farmers who came to the Yuba City area or others who came to work on the railroads from the Punjab area of India as early as 1908. Other migrant streams in the mid to late 20th century brought immigrants to the U.S. from East Africa and Fiji whose families had moved to those areas from India sometimes generations ago. More recent immigrations are frequently professionals and skilled technicians who come to fill jobs in the computer industry or health care. Many of the latter group sponsor their parents who come to join them as followers of children after their retirement in India.

The current cohort of older Asian Indian Californians usually identify themselves as "Asian Indian" or "Indo American." Relatively few (7.5%) have incomes below the poverty line, and almost equal proportions (about one-third each) have less than 9 years of education and a college education (Table 1). In spite of the general impression that most speak English well, 44 percent say they speak little or no English, and their native languages could be one of several from different geographic areas, such as Hindi, Punjabi, Tamil, or Gujarati. Although the religious background of individuals from India is frequently assumed to be Hindu or Sikh, there is also a large Muslim population in India. In California cities with large populations of Asian Indians such as Fremont, there are numerous Hindu and Sikh temples as well as mosques.

Not much is known about the health risks among Asian Indian elders in the U.S. Coronary artery disease and diabetes related to insulin resistance are higher than the average for elders in the U.S. As with other followers of children, they are particularly vulnerable to isolation, loneliness, and depression if they are completely dependent on their adult children for transportation, financial support, and interpretation/translation in their new communities. Many elders chew *pan* (tobacco with spices) which puts them at increased risk of oral submucosal fibrosis. Many practice the *Ayurvedic* health beliefs traditional in India for centuries, which emphasize balance of elements. Hindu health beliefs include the influence of karma from past lives on the causes of illness. Because of issues such as modesty and sacred body ornamentation, it is important for health care providers to be familiar with Indian cultural concepts to care for elders appropriately (Periyakoil, 2004).

OLDER CAMBODIAN, LAOTIAN, AND HMONG CALIFORNIANS. In addition to the larger populations discussed above, there are a number of smaller populations of immigrant elders in California for which the data are too limited to be described in detail. However, three of the populations in greatest need are those other than Vietnamese from Southeast Asia, so it is extremely important to recognize their unique situations. The Cambodian, Laotian, and Hmong populations all came as refugees after the war in Vietnam, beginning in the late 1970s, many times after spending years in terrible conditions in refugee camps. Elders from those populations have the highest rates of poverty (22%-34%), the highest rates of disability (64%-70%), the poorest education (75%-92% with less than 9 years), and are at greatest risk of isolation because of their lack of English skills (80%-85%) compared to other ethnic populations in California. The elders also have the smallest percentages living alone (2%-3%) which reflects the strong norms of family care. The groups have in common the emphasis on spiritual effects on health care, and providers should be particularly mindful of strings or other bodily ornaments that have spiritual connections, so that they should never be removed without permission.

From Laos come ethnic and tribal groups identified as Lowland Lao or Lao Laum, Lu Mien, Khmu and Thaidam in addition to the Hmong for whom data were collected separately in the

2000 census and who are discussed below. The Cambodians are predominantly ethnic Khmer but also include Cham, an ethnic Moslem minority. The largest communities are in Los Angeles and San Joaquin Counties (Niedzwiecki, et al., 2003). They have been found to be at high risk for severe headaches with dizziness they attribute to "sadness from thinking too much," which is assumed to be related to the extreme trauma and loss of family members they experienced under the cruelties of the Khmer Rouge regime in Cambodia (Handelman & Yeo, 1996). This may or may not be related to post traumatic stress disorder and depression, for which they are also at higher risk. Buddhism is the primary religion and priests are frequently community leaders in the Cambodian community.

Hmong populations are largest in the Sacramento, Fresno, Merced, and other Central Valley locations. Their background before coming to the U.S. was primarily as a hill tribe in Laos and Cambodia with a unique culture and with little or no contact with European cultures. They had no written language until the mid 20th century. The men had the reputation as successful fighters, so they were recruited by the Central Intelligence Agency to fight the Communists in Laos during the War in Vietnam. With the fall of Saigon, they were vulnerable to Communist retribution, so most of the population escaped to refugee camps in Thailand and/or came as refugees to the U.S. or Europe. For those who came to California, the abrupt relocation to a completely different cultural environment where they encountered urban communities and unknown technology (e.g., flush toilets, electric stoves, and light switches) and lived in apartments for the first time required a huge adjustment (Fadiman, 1997). Their large extended patriarchal family and clan structure helped provide some stability during the transition, and in spite of many hardships and adjustments, many young members of their families are now successful students and young professionals. The last immigration of several thousand Hmong to California communities occurred in 2004 and 2005 as the Thai government closed the refugee camps (Mangaliman, 2006).

Although there are no specific data on the health risks of Hmong elders, their unique health beliefs and practices have been described (Fadiman, 1997; Gerdner, Xiong, & Yang, 2006). They include strong influences of various spirits and ceremonies with animals conducted by shamans to break spells thought to cause illness.

Older Latino Californians

Just as immigrants to the U.S. from Asian countries are frequently lumped together as "Asians" in spite of their differences, "Hispanic"[13] individuals in California include those whose ancestors predated the Anglo population in what was originally part of Mexico, and those who immigrated, or whose ancestors immigrated, to the U.S. from one of dozens of countries where Spanish is the dominant language. In spite of the commonalities of language, elders in California classified as Latino are in reality very heterogeneous in their level of acculturation, immigration history and experiences, health status, health care access, economic resources, and educational level. This diversity is apparent both within and between the populations who emigrated from countries or regions described separately in the sections below in order of their size.

OLDER MEXICAN CALIFORNIANS. The largest ethnic population in California are those people who identify themselves as Mexican or Mexican American. The 300,000 elders in this population are extremely diverse. They descend from families who had Spanish land grants before Mexico and California were established entities, families who immigrated in the many waves of

[13] In California and the Western states the term "Latino" is used more frequently.

immigration since 1850, a large number who came across the border as children or young adults, and those who immigrated as followers of children in their later years.

Immigration across the California/Baja California border has become increasingly formalized and restrictive since the late 1800s when it was relatively informal with considerable movement back and forth. Because of the restriction on Chinese and Filipino immigration, there was a great demand for Mexican labor during the 1920s, when an estimated 3% of the total population of Mexico came to the U.S. When the Great Depression began, the demand for Mexican labor decreased, and a massive forced repatriation program was established to return residents without legal documents to Mexico, leaving U.S-born spouses and children of repatriates to choose between separating their families or moving to Mexico.

Large numbers of Mexican Americans served with honor in World War II, but on returning, they were subjected to continued discrimination in housing, employment, and education. During the 1970's, when the present cohort of Mexican American elders were middle aged, more women than men came to the U.S. because wives and family members of previous immigrants were given priority, and because there was great demand for domestic workers. During this era urban Mexican Americans increased to 85% of the total due to economic shifts away from agriculture.

With the exception of the 1930s, throughout the 20th century and until the present, the demand for labor in California has overwhelmed the restrictions on immigration from Mexico, and many came informally if they could not come formally. Except for the *Bracero* program for short-term contract immigration during World War II, the few options for legal immigration could not begin to accommodate all those who wanted to come. The informal system frequently involves *coyotes* who charge aspiring immigrants large sums of money to slip them across the border, many times in very dangerous conditions. As a consequence many of today's elders in California from Mexican backgrounds have had the challenge of coming to, and living in, a system that did not recognize their right to residence, and have not had some of the benefits that were available to other older Americans. Although there were periods of amnesty when some were allowed to become naturalized citizens, periodic deportations, the anti-immigration movement, and "Welfare Reform" legislation continue to be sources of anxiety for many older Mexican Californians that affect their utilization of services. In 1985, David Maldonado wrote:

> If older Hispanics...perceive themselves as not belonging and therefore as not sharing in the benefits and entitlements of this society, then it is understandable that they tend to underutilize...programs and benefits that are available (p.25).

Although there are many very acculturated Mexican American elders in California, others have chosen to live primarily within the large Mexican American communities where they seldom are required to speak English or participate in activities outside the Mexican cultural community. Most identify themselves as Catholic, and for many their faith and the church activities are central to their lives, but there are also growing evangelical Mexican American congregations as well. About 14 percent had incomes below the federal poverty line in 1999. Over one-third speak little or no English, and a much higher percent prefer to speak Spanish. The majority (55%) have less than nine years of education (Table 1), and it is not unusual to find a large percent with zero years of school. For example in an epidemiological cohort study of more than 1,000 Latinos aged 60 and over in the Sacramento area in 1998-99, 13 percent had no formal education; for those whose primary language was Spanish, 22% had no formal education (Haan, Mungas, Gonzalez, et al., 2003).

What is known about health risks of older Mexican Americans is characterized by what is referred to as "the Latino paradox." Although they have been found to rate their health as poorer, have more disability (in California 48%) and rates of diabetes twice as high as non-Hispanic whites, their mortality rates are lower than older Americans in general and all the major ethnic categories other than Asian American elders. Possible explanations for this paradox are misreporting of mortality data that results in lower than actual death rates, and migration back to Mexico for individuals who are seriously ill who may wish to die there. In addition to very high rates of diabetes and diabetic complications, older Mexican Americans have been found to have higher rates of cervical, liver, pancreatic, and stomach cancer. Men have higher rates of lung cancer, and older Mexican American women have higher rates of depression. Heart disease is less common among older Mexican Americans than older Americans in general, and older Mexican American women have lower rates of breast and lung cancer and osteoporosis (Hummer, Benjamins, & Rogers, 2004; Villa, Cuellar, Gamel, & Yeo, 1993). An examination of unhealthy behaviors found that Mexican American adults who were born in the U.S. and/or who speak English have a higher prevalence of unhealthy behaviors than those who are born in Mexico and/or who speak Spanish (Winkleby & Cubbin, 2004). Some elders believe illness is caused by sin or will of God. Although most older Mexican Americans use the regular American biomedical health care system, some also use *curanderos*, healers from rural Mexican cultural traditions, who use ceremonies with spiritual content, lifestyle recommendations, and herbs.

Adding to the heterogeneity of Mexican Californians are immigrants from indigenous tribes in very poor villages in Oaxaca who have been migrating to California for agricultural work since the 1960s. For example, the California Institute of Rural Studies estimated that there were 50,000 Mixtec indigenous Oaxacans of all ages in California in 1994 and growing each year. They have been coming to rural areas of California, some as seasonal workers, but many to settle with their families. Because they generally speak their native language and not Spanish or English, they are frequently illiterate. Many came to the U.S. illegally, smuggled across the Arizona border. As a group, they are particularly vulnerable to exploitation and have little contact with health care or financial services (Runsten & Kearney, 1994). Since they are not identified (and few are likely to be included) in statewide or national surveys, there are no demographic data on the age range of the Mixteca population. But since they have migrated to California since the 1960s, it is reasonable to assume that there will be growing numbers of older Californians from Mixtec and possibly other indigenous Mexican populations. No data are available on the health risks of the older Mixtecas, but the cultural health belief system includes the need to maintain balance between "hot" and "cold" qualities and attribution of illness to evil spirits, evil eye or other sorcery, or violation of taboos. The functions of indigenous healers include holding religious ceremonies, prescribing herbs, and making dietary recommendations (Bade, 1993).

Because *familismo* is a major value in Mexican American and other Latino subgroups, much of the decision making for health care for elders is made by family members rather than elders themselves. There is a strong value for family rather than institutional care, and utilization of formal long-term care services for dependent elders is substantially lower by Mexican American families than non-Hispanic white families (Villa, et al., 1993; Wallace & Lew-Ting, 1992).

OLDER CUBAN CALIFORNIANS. Compared to Mexican American elders in California and Cuban American elders in Florida, older Cuban

Americans in California are a relatively small population. Most of the elders came during the massive immigration from Cuba after the revolution that installed Fidel Castro's government in 1959 and through the Mariel boat lift in the 1980s. Cuban American elders are the oldest and least disadvantaged of the three largest Hispanic/Latino populations in terms of education, even though the majority (51%) in California say they speak little or no English. Nationally, Cuban Americans tend to have lower mortality and morbidity than Mexican American or Puerto Rican elders in the U.S. Although the functional status of Cuban elders in California is lower than elders from Mexican backgrounds (Table 1), the opposite has been true in national data. It is especially noteworthy that Cuban American elders tend to have lower rates of diabetes than Mexican American or Puerto Rican elders. In California, almost a quarter of Cuban American elders live alone, although family values remain important (Argüelles & Argüelles, 2006; Villa, et al., 1993). The traditional Cuban healing system of *Santeria*, in which *santeros* perform healing rituals, is utilized by some Cuban elders in the U.S., although probably in conjunction with mainstream American biomedicine. As with other Latino populations, family care of dependent elders is a strongly held value.

OLDER PUERTO RICAN CALIFORNIANS. Of the three largest Hispanic/Latino populations, in California, Puerto Rican elders are the smallest. Those in California seem to be less disadvantaged than the Puerto Rican elders nationally. A smaller percentage of Puerto Rican Californians than Puerto Ricans nationally are in poverty; they are better educated, and are much less likely to speak little or no English than Mexican American elders in California (Table 1). Although the family is highly valued culturally, one-quarter of older Puerto Ricans in California live alone, higher than the other Latino populations in California, and a higher proportion than in the Puerto Rican communities nationally. One possible explanation for this is that older California Puerto Ricans may have few family members in close proximity.

The population of Puerto Rico is a mix of indigenous peoples, Spanish colonialists and African slaves, and Puerto Rican islanders have historically drawn from all three heritages in terms of religious beliefs and cultural practices. Migration from Puerto Rico to the mainland began slowly after the Spanish American war in 1898 and increased dramatically after World War II. Since then migration patterns have been cyclical so that when the economic conditions are better on the mainland than in Puerto Rico, migration to the mainland increases and during economic downturns, many people return to the island (Montoro-Rodríguez, Small, McCallum, 2006). Puerto Rican elders on the mainland have been found to have higher rates of diabetes, liver cancer, and heart diseases than average for older Americans. The folk healing system of *espiritismo* is traditional in some parts of Puerto Rico, and presumably practiced by some in the mainland as well (Villa, et al., 1993).

OLDER CENTRAL AND SOUTH AMERICAN CALIFORNIANS. Although there were over 35,000 older Californians from Central and South American backgrounds enumerated in the 2000 census, very little is known about these elders. They are assumed to be very diverse since some were likely asylum seekers from civil wars, and others came for a variety of economic, educational, or political reasons from six Central American and nine South American different countries with different circumstances. Based on the characteristics available from the census, the elders from Central America are more disadvantaged than other Latino populations based on their poverty, educational level, and the proportion who speak little or no English; however, they have the lowest proportion who live alone (Table 1).

Other Older California Immigrants

Since California has been a magnet for immigrants since the time of the Gold Rush, the native ancestries older Californians claim can run into the hundreds. There is growing recognition among health care organizations in the larger California cities of the diversity of recent immigrant groups, such as those from sub-Saharan Africa (SHIRE, 2005), or from the Middle East, and Northern and Eastern Africa. In a report funded by The California Endowment, the authors cited estimates of 80,000 to 100,000 immigrants of all ages from Afghanistan, Iran, Iraq (including Kurds and Chaldean Christians), Ethiopia and Somalia living in the greater San Diego area (Reiman, 2006). In most cases little is known about the numbers, demographic characteristics or health status of elders in these populations, especially in the newer immigrants. In the San Diego study, however, the younger subjects were found to have numerous mental health needs due to traumatic violence and oppression in their countries of origin and some discrimination in the U.S. Conditions limiting their access to needed services include the social stigma of emotional problems, and some perceived discrimination, especially among the black immigrants from Sudan, Somalia, and Ethiopia.

As examples of the heterogeneity of these elders, three of the populations listed in the census as "ancestries" that would be lumped into the non-Hispanic white racial category are highlighted in Table 1.

OLDER ARAB CALIFORNIANS. American residents who list their ancestry as Arab can come from 22 separate countries from Jordan to Saudi Arabia to Morocco, but in California, most have come from Lebanon, Palestine, Iraq, Egypt, and Syria. Different political and economic factors provided the push and/or pull for immigration at different times in different countries. Although they are frequently thought of as Muslim, many Arabs are Christian, especially those from Lebanon. Although frequently thought of as Arab, people from Turkey, Iran, and Afghanistan are not included in the language-based category of Arabs. One-fourth of older Arab Californians say they speak little or no English, and compared to other immigrant populations, they are relatively well educated (Table 1).

Dietary issues are important to Muslim Arabs since most do not eat pork, blood products, lard, or meats that have not been slaughtered following the Halal traditions, and drink no alcohol. The contents of medicines and hospital food need to be examined to assure Arab elders they don't contain any of the proscribed substances. For example, sometimes gelatins are unknowingly served to patients who are not allowed to eat it because of the pork products that are included.

Another important issue for Muslim elders is their preference for same sex providers. Older women may choose not to shake hands with a male provider and may be very uncomfortable being touched by a man other than their husband (Salari & Balubaid, 2006).

OLDER ARMENIAN CALIFORNIANS. Armenian elders are interesting in that many have stayed in relatively cohesive communities even though the several waves of immigration began around the turn of the 20th century during the Turkish oppression of Armenia from 1894 to 1896. Although most originally settled in rural areas to raise figs and raisins, they gradually moved to urban areas and established Armenian communities in Fresno, Los Angeles, Glendale, and San Francisco where they have established Armenian newspapers, television, churches, schools, and nursing homes (Vartanian, 2000). In spite of the long established Armenian communities in California, in 2000, almost half (48%) of Armenian elders in California reported they spoke little or no English although about one third had college education. Elders who came as Armenian refugees or

immigrants from the Soviet Union after the 1970s tended to be well educated and English speaking. Over half of older Armenians in California report having a disability, a relatively high proportion for an immigrant population.

OLDER RUSSIAN CALIFORNIANS. Many Russian families immigrated during the last decades of the Soviet Union in the 1970's and after the U.S. granted refugee status to religious and ethnic minorities due to their persecution by the Soviet government. Soviet Jews were the largest ethnic/religious minority in this wave. After the dissolution of the Soviet Union in 1991, some immigration continued for economic reasons, but the majority continued to be ethnic and religious refugees. A large proportion came as extended families, including older family members, and about 20 percent were aged 65 and older (Aroian, Khatutsky, & Dashevskaya, 2006; Brod & Heurtin-Roberts, 1992). These later arrivals joined earlier immigrants who had come during the pogroms of the Russian Jewish population in the early part of the century and poor Russian Orthodox immigrants from the 1920s.

The educational level of older Californians who list their ancestry as Russian is the highest of all the older populations included in Table 1, including non-Hispanic whites in general. They are also the least disadvantaged of any of the immigrant populations because of limited English proficiency, with less than 10% reporting they speak little or no English. This probably reflects the fact that many of the refugees and immigrants in the late 20th century were highly educated professionals in the Soviet Union; one in six had been a scientist, engineer, or medial doctor (Aroian, et al., 2006). Many older Russian Californians live in heavily Russian enclaves such as the one in San Francisco, frequently in senior housing.

The disability level in this population is the lowest of any of the listed ethnic elders in California—only 5.2%, slightly lower than for the total category of older non-Hispanic whites. Older Russians in the U.S. are reported to have higher rates of hypertension, cardiac disease, diabetes, cancer, and gastrointestinal problems than older Americans in general. It is not unusual for them to suffer from loneliness, depression, and anxiety, as well (Aroian, et al., 2006). Older refugees from the Soviet era are reported to be frequently concerned about their health and aggressive users of health care services (Brod & Heurtin-Roberts, 1992).

For Russian elders who do become disabled, they more than most immigrant populations are likely to find nursing homes oriented to their cultural traditions. There are excellent Jewish homes in the larger cities in California, and in Northern California there are two known homes run by Russian Orthodox groups that provide culturally appropriate care for Russian Orthodox immigrants (Yeo, 1993).

LOW INCOME NON-IMMIGRANT CALIFORNIA ELDERS FROM ETHNICALLY DIVERSE POPULATIONS

Older African American Californians

The 5 percent of older Californians who describe themselves as "Black" or "African American"[14] are also very diverse. About 5 percent of all ages in this population say they were born in Africa or Latin America, but it would be expected there would be a much smaller percentage among older African Americans. The majority of older African Americans in California were part of families who came in the early and mid 1900s from the agricultural South to find better jobs and opportunities, and to escape pervasive oppression and discrimination. One of the largest of these migrations occurred during World War II, as women and men came to work in the

[14] Since some of the literature uses the term "black" and others "African American," and the census data use both terms, they are used interchangeably in this paper.

defense industry after Executive Order 8802 banned discrimination in defense plants. After the war a large number of railroad porters and veterans of the segregated military units came to California, often with wives and children.

The resulting population of older African American Californians is extremely heterogeneous, with a few very wealthy film stars, athletes, and business owners, a number of retired, well educated professionals, large numbers of retired skilled workers, and many who arrived at old age having had opportunities only for intermittent low paying jobs with no retirement benefits. Unfortunately, as a whole, older African Americans still endure significant disadvantage in California. Their poverty rate is almost three times the rate of non-Hispanic whites, as is the percent with less than nine years of school. Similar to whites, 28% live alone, but it is much higher for women and those in poverty. In national data, over 60% of older African American women in poverty were reported as living alone during the 1990s (Richardson, 1996).

Despite the legacy of slavery and widespread segregation and discrimination, older African Americans and their communities have developed very strong support systems and coping mechanisms to survive. A major source of support for many elders has been their church and the religious community where they are frequently given great respect. The flexibility of the community also provides support for those in need. For example, older African Americans are more likely than others to be caring for grandchildren and great grandchildren (U.S. Census, 2000), and caregivers of dependent older African Americans have more often been reported to include "fictive kin" (individuals with close relationships referred to with kinship terms who are not actually related genetically or by marriage) and more extended family members than among other populations (Dilworth-Anderson, Gibson, & Burke, 2006; Yeo, Gallagher-Thompson, & Lieberman, 1996). Family caregivers of older African Americans with dementia have frequently been found to express more positive views of caregiving and less distress than white caregivers in spite of more problems, and to have developed successful coping mechanisms (Dilworth-Anderson, et al., 2006)

Since the black/white disparities in health and health care have been studied in more depth than other population groups, more is known about their relative health status. Consistently, older African Americans are reported to have the poorest health status of all the major ethnic and racial populations in the U.S. In California more than one-half report having a disability. In national data they also have more disability and poorer self-rated health. Compared to the total population of older adults in the U.S., they have been found to have higher rates of and/or higher mortality from heart diseases, hypertension, cerebrovascular disease and stroke, diabetes, cancer (especially prostate), kidney disease, septicemia, and dementia (especially vascular). They have lower rates of respiratory diseases and osteoporosis and hip fracture (Hummer, et al., 2004; Richardson, 1996). Even though there have been large declines in cardiovascular mortality in the U.S. since the mid 1960s, these declines have been less for blacks than whites, leaving larger disparities. In some diseases such as cardiovascular disease, a convergence or crossover effect is discernable among the oldest old, such that very old whites have similar or higher rates of disease than blacks (Winkleby & Cubbin, 2004).

Given the discrimination experienced by most older African Americans, especially in their younger years, it is reasonable to ask to what extent the resulting poverty and lack of education might be related to their current health status. It is well established that low income and poor education are strongly correlated with higher risks for many diseases and for disability, but controlling for those differences do little to eliminate some of the racial differences in disease or mortality,

although it is more effective in explaining the differences in functioning (Crimmins, Hayward, & Seeman, 2004). However, when Winkleby and colleagues (2004) examined disparities in health behaviors that might influence the prevalence of chronic disease, they found that both white and black individuals with lower income and/or education have less healthy behaviors except high alcohol consumption. In general, white populations have higher levels of some unhealthy behaviors (smoking, second hand smoke exposure, and inadequate Pap and mammogram screening), and blacks have higher levels of others (physical inactivity and obesity).

Providing appropriate health services for older African Americans needs to recognize the importance of showing appropriate respect. Addressing older men and women by "Mr." and "Mrs." is important, for example, even in the informal California lifestyle climate, especially since disrespect was so pervasive in so many interactions when many were young, and they were relegated to poor quality, segregated, discriminatory services. Respect and providing time to answer questions could help establish trust in the provider/patient relationship, which is important in view of the history of the Tuskegee Experiment in which health care providers secretly withheld promised treatment to African American men with syphilis in the name of research.

In summary, if one looks at data for the entire population of over 180,000 older African American Californians, they appear to be relatively disadvantaged in health status, income, and disability. However, the population also includes well-educated, healthy retirees with adequate incomes and stable family situations. Policy implications need to include the unique historical background of severe discrimination and oppression as well as unique strengths of the support systems that have evolved to address the needs of the disadvantaged African American elders.

Older American Indian Californians

The very small population of elders in California who describe themselves as American Indian is also extremely diverse. It includes pockets of survivors from many native California tribes, from the Spanish Mission era. The largest of these groups resides in rural Northern California, but there are also *rancherias* in several areas in Southern California. Some of the large number of Indian men from other tribes who served in World War II settled in California after the war. However, California is also home to many older Indians from all over the U.S. who came during the massive Relocation Programs sponsored by the Bureau of Indian Affairs during the 1950s. In an effort to move Indians off reservations, many were relocated to large urban areas where jobs were available. In California, these included San Francisco, Oakland, San Jose, and Los Angeles. Many who came as young or middle aged adults have stayed and blended into the urban communities as older Californians. A study of elders who were identified through the Indian Health Center as Indian in San Jose included individuals from over 100 of the 500+ federally recognized tribes in the U.S. (Hendrix, 1999).

All come from groups whose histories include pervasive oppression and discrimination, broken treaties, attempts at annihilation, and massive relocation. A large proportion of the current cohort of elders attended Indian Boarding Schools in their youth, many times long distances from their homes, where they were required to give up their Indian names, clothes, and traditions in return for education in American skills and culture.

American Indians were more likely than any other racial group to list themselves as two or more races when the 2000 Census allowed that option. In California, there were over twice as many aged 65 and over who indicated Indian and another racial group as their background (over 37,000) as there were who indicated American Indian alone (over 18,000). This reflects the high

level of acculturation of many individuals with American Indian background. However, the population of older American Indian Californians is generally disadvantaged compared to older non-Hispanic whites. As reflected in Table 1 which includes only those elders who identify themselves as only American Indian, over twice as many are in poverty, and older Indians have the lowest percentage of individuals with some college education of all the ethnic groups listed, even the extremely impoverished recent immigrants from Southeast Asia.[15] Almost one-fourth (24%) have less than a ninth grade education although they have all presumably lived in the U.S. their entire lives.

More than one-half of older American Indian Californians say they have a disability of some kind. In national data, disability rates for older American Indians are high as well, and they have two to three times the rate of diabetes as non-Hispanic white Americans. In addition, they also have higher rates of cervical, esophageal, and gallbladder cancer, cataracts, kidney disease, liver disease, tuberculosis, accidents and hearing problems. Rates of alcoholism are usually found to be higher among American Indians, but in older ages, the differences become less (McCabe & Cuellar, 1994). A study of older American Indians in Los Angeles found higher rates of hypertension (Kramer, 1991), but nationally, they have been found to have lower rates than older Americans in general; also lower are heart disease, cerebrovascular disease and stroke, and respiratory diseases (McCabe & Cuellar, 1994). National mortality data indicate lower rates for older American Indians vs. non-Hispanic whites for all causes except diabetes, kidney disease, and accidents, although some scholars believe the mortality rates are biased due to misreporting and should be substantially higher (Hummer, et al., 2004).

The web of health care services available for older Indians in California is very complicated. The Indian Health Service (IHS) that was developed to meet the treaty obligations when Indian tribes relinquished their lands in return, in part, for life long permanent health care, is available only for Indians living on or near reservations. Although there are small urban Indian Health Centers in a number of California cities, they are poorly funded, and do not provide the comprehensive care such as specialty clinics and hospitalization found on reservations; geriatric care or programs are very rare in IHS facilities on reservations, much less the urban Centers. Traditional healing opportunities such as sweat lodges are available in some locations. Most older California Indians are eligible for Medicare, and some for Medi-Cal. The San Jose study found that two-thirds had coverage through Kaiser or other health maintenance organizations, and one-third relied primarily on the Indian Health Center and other publicly funded care (Hendrix, 1999). It is not unusual for urban Indians to return to their home reservations for healing ceremonies when they are distressed or ill.

In summary, older Native American Californians, although relatively small in number, are widely dispersed throughout the state in rural and urban areas and have other unique historical influences that affect their access to cultural care. Although many have been assimilated into the mainstream culture in California, an unknown number are isolated without culturally appropriate support systems as a result of prior national policy efforts to eliminate Indian culture and reservations. Any statewide policy initiatives need to take into account not only the diverse needs of the elders themselves, but the sovereignty and responsibility issues between tribes, treaty obligations of the federal government, and state and local efforts.

[15] It should be noted that the demographic and education statistics comes from summary files that reflect sample data, so the comparisons of some of the small populations may be not exactly accurate.

Appendix B

Standards for Culturally and Linguistically Appropriate Services (Office of Minority Health, U.S. Department of Health and Human Services)

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a

needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLASstandards and to provide public notice in their communities about the availability of this information.

See <www.omhrc.gov/CLAS> for more information and suggestions for implementation.

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In 2000, The California Endowment began our journey to assess the appropriate role TCE could play in addressing the needs of aging Californians. Through many conversations and our analysis of the existing research, we feel confident that our focus on vulnerable older women is where we should be. The research presented in this anthology of papers commissioned by TCE involved many of the best thinkers and practitioners in the state. I would like to thank those who gave TCE their invaluable time, expertise, and knowledge in helping us complete this phase of our effort to bring the health and wellness needs of California's aging women to the forefront.

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