

Chapter 2

Close the Health Gap



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Grand Challenge: Close the Health Gap

Having access to health care is critical to achieving the Healthy People 2020 goals. The US Department of Health and Human Services has identified the main goals of Healthy People 2020 as (1) attaining high-quality, longer lives, free from premature death, preventable illness, disease, and disability, (2) improvement of health across all populations and elimination of health disparities, (3) creating social and environmental conditions that ensure good health for all, and (4) promotion of health behaviors and development (Centers for Disease Control and Prevention (CDC), 2019) across the life span. Being healthy is a state of well-being that flourishes when economic, social, and environmental barriers are removed. The “Close the Health Gap” Grand Challenge for Social Work posits that the development of “a socially-oriented model of healthcare that breaks down and removes the root causes of health inequity and promotes upstream interventions and primary care prevention will eradicate the gap that exists for marginalized populations” (American Academy of Social Work and Social Welfare, 2018). This model suggests that addressing the social determinants of health is part of effective healthcare instead of only employing traditional medical treatment. Health promotion efforts must also extend across the life span with attention to older adults who may be contending with chronic health conditions.

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Overview

Health disparities become health inequities because of systematic inequality between more and less advantaged social groups. Health disparities exist when one population has a higher burden of illness, injury, disability, or mortality in relation to another population. For example, we expect higher rates of chronic health conditions among older adults when compared to younger adults (Healthy People 2020, Internet). Health equity occurs when everyone has the opportunity to be as healthy as possible. Typically, this occurs by addressing economic and social factors that contribute to inequality.

Disparities for older adults exist in mortality and illness rates, behavioral risk factors for disease, environmental hazards, and the social determinants of health (SDOH). SDOH can include poverty, inadequate housing, structural racism and discrimination, food and housing security, limited education, and exposure to crime and violence (Adler et al., 2016). The intersections of race and ethnicity, socioeconomic status, geographic location, immigration status, age, sexual orientation, gender, and disability influence SDOH. SDOH contribute to individual and group differences in life opportunities, stressors, ability to access preventive and curative care, and quality of care. Thus, it is important to note that gerontological social work in health disparities and inequities varies considerably due to the diversity among older adults, including factors related to their biological, behavioral, physical/built, sociocultural, and healthcare environments.

The National Institute on Minority Health and Health Disparities Research (NIMHD) (n.d.) framework identifies five domains of influence that impact health outcomes: biological, behavioral, sociocultural, physical/built, and healthcare environments. Nested within each domain are four levels of influence: individual, interpersonal, community, and societal. In this chapter, we provide a brief review of gerontological social work literature that includes as many marginalized populations as possible based on selected components of the NIMHD framework with the understanding that these domains of influence are inter-related.

Biological The NIMHD Framework calls for an understanding of how biological vulnerability affects health disparities and health outcomes differences. Genetic variations between race and ethnic groups are foci of research to understand how susceptibility to disease may be moderated by these factors among older adults. For example, Latinos are 1.5 times more likely to have Alzheimer's disease (AD) and other dementias as non-Hispanics. African Americans are two times more likely to be diagnosed with AD than non-Hispanic White older adults (Alzheimer's Association, 2018). There are likely biological explanations for these more adverse outcomes related to health behaviors, sociodemographic status, and community-level effects. Specifically, cardiovascular disease and diabetes, which are more prevalent among African American and Latino individuals, also increase risk for AD. Further, depression is also more prevalent among Latinos, and depression is a risk factor for AD (Burke, Maramaldi, Cadet, & Kukull, 2016a, 2016b, 2018).

Behavioral Among behavioral influences of the NIMHD framework are health behaviors. Obtaining cancer screenings is an example of a health behavior. Various psychosocial factors influence cancer-screening behaviors. Maramaldi, Cadet, and Menon (2012) suggest that more present time-oriented Hispanics were less likely to participate in colorectal cancer screening initiatives. Cadet (2015) suggests that breast cancer screenings are positively associated with age and negatively associated with constraints (perceived barriers to accessing services). Findings from a study of urban African American men's screening behaviors also identifies age and access to yearly primary care visits as positive correlates of prostate cancer screenings, in addition to education level (Mitchell, 2011). Many health behaviors, including participating in cancer-screening initiatives, are impacted by older adults' sociocultural environment, which include socioeconomic status and social support.

Sociocultural Environment Socioeconomic impacts on health and well-being for low-income older adults are far-reaching and often intersect with racism, ageism, and ableism to reduce opportunity and access to human services (Anderson, Richardson, Fields, & Harootyan, 2013). Gerontological social work research has explored the significance and extent of demographics, including culture (discussed earlier), literacy, socioeconomic status, and social support in the lives of older adults. Ozawa and Yeo (2008) report that the economic status of older adults was associated with disability rates not race/ethnicity. Further, Mexican-American older adults experience greater disparities in health, the majority of which are explained by socioeconomic status (Villa, Wallace, Bagdasaryan, & Aranda, 2012).

In terms of health literacy, Liechty (2011) notes that research in this area is limited and social workers have an opportunity to do more. Findley (2015) reports that health literacy has been associated with poor health outcomes. Adults 65 and older are among those with the lowest health literacy levels. Finally, findings from Rust and Davis (2011) indicate that participants often face barriers to being fully informed about their health concerns and many did not have adequate financial resources to access all medications.

Social support and religiosity also predict higher life satisfaction scores for minority elders (Roh et al., 2015). Increasingly studies investigating the composition and impact of social support on marginalized older adults' well-being are focusing on lesbian, gay, bisexual, and transgender (LGBT) communities. Early research notes that participants' abilities to be open about sexual orientation increased social support satisfaction levels (Grossman, D'Augelli, & Hershberger, 2000).

Physical/Built Environment Physical or built environments (homes, buildings, streets, open spaces, and transportation infrastructure) affect older adults' daily functioning and behavioral choices. Sidewalks, bike paths, and parks in safe neighborhoods increase options for physical exercise, which reduces risk for multiple chronic illnesses, including cardiovascular disease, diabetes, and certain cancers (Centers for Disease Control and Prevention, 2011). Urban or rural settings and transportation access may impact whether older adults have adequate socialization

or are isolated and lonely and whether they make medical or behavioral health appointments. Older adults often seek to age in place and live in their own homes. However, the home environment is typically not appropriate to support their physical needs based on declines in functional capacity (Greenfield, 2012). The lack of home modifications to accommodate the physical needs of older adults may influence whether older adults remain living safely in the communities.

Healthcare Environment Researchers report obstacles to health equity based on racial and ethnic group. Findings from Lai and Chau (2007) indicate poorer health and mental health outcomes are associated with cultural and language barriers. Choi (2015) reports that non-citizens are less satisfied overall with their healthcare and have more difficulty accessing certain types of care. Considerable evidence exists to demonstrate the health disparities and inequities that exist for older adults from various marginalized populations. Given this evidence, there is a need for the development, implementation, and testing of scalable interventions to address health disparities.

Case Presentation

Maria is a 68-year-old Hispanic woman who identifies as Mexican-American. She is a widow and has lived alone for the past 8 years in a first floor apartment. Her husband died 8 years ago from a stroke due to obesity. She does not have any children. She has a cousin who sees her once a week to bring her to church. Going to church and interacting with the church community is important to Maria although she is not particularly close to anyone in the congregation. She has limited financial support. She receives a small pension from her husband's employment as a banker at a local branch. Maria stopped working as a homemaker after her husband died because she just did not have the energy to leave the house. She was very distraught after her husband's death. She said, "He was everything and all that I had." Maria worked as a homemaker because she had just completed 8th grade when she emigrated from Mexico to the United States with her family.

She decided to go to the community health center (CHC) in her town after "feeling funny." She is skeptical and hesitant about the healthcare system. She has heard horror stories about other people's experiences with doctors and at the hospital. She has this saying, "I might get the doctor who graduated last in their class or last in their internship." She has heard that the doctors do not treat older adults well. She frequently expresses that she has heard "they talk to them as if they are machines." But, she "feels funny," so she decides to go to the CHC. Maria does not have health insurance. She "heard" this CHC would see her without any questions.

Maria is immediately overwhelmed when she enters the CHC. She sits in the nearest chair because she is out of breath. Maria is also obese so walking from the taxicab has made her tired. While she can speak English, it is easier for her to talk and read in Spanish. Once Maria is in a clinic room, she explains that she has not

been to see a doctor in years. She explains that she has not had any signs of being sick so she must be healthy. She meets with a physician who explains that her blood pressure is high (150/90); at 5'4" she is obese (weight: 210); her cholesterol is high (302); and she has not had any recommended cancer screenings. Maria does not understand why the physician is telling her all of this. She came because she is "feeling funny." Her physician says that this feeling is just "part of the normal aging process." She leaves the CHC.

Over the next several weeks, Maria continues to "feel funny." She is also having a harder time walking around the house and dressing herself. She is also now experiencing pain in her breasts. Maria decides to return to the CHC. This time she asks to speak with someone other than the physician she saw last time. She meets with a clinician who asks her why she came to the health center. She explains that she is "feeling funny" and it is interfering with her functional abilities. She also has pain in her breasts, she says quietly. Maria is aggravated and dazed by the whole experience.

Assessment and Intervention

Because the older adult population compared to their younger counterparts are more likely to have a higher prevalence of chronic diseases, physical disabilities, mental illnesses, and other co-morbidities (Boutayeb & Boutayeb, 2005), a comprehensive assessment that accounts for the person-in-environment and uses a strengths-based perspective is necessary. In addition, assessments should value interprofessional, team-based, person-centered care in community-based and institutional settings where older adults may live, work, and play. These perspectives provide social workers with the foundation to engage older adults and their families, assess their care needs, and develop care plans to meet those needs. Further, these perspectives contribute to conducting a biopsychosocial assessment for older adults and identifying potential disparities and inequities.

The biopsychosocial framework for older adults, which is similar to the NIMHD framework, includes seven domains (Christ & Diwan, n.d.):

1. Physical well-being and health assessment can include overall health status, presence of pain, nutritional status, fall risk, incontinence, sleep, substance use, and misuse, oral health, vision, and hearing. For example, poor nutrition habits may contribute to Maria's obesity, which affects her overall health status;
2. Psychological well-being and mental health assessment includes, but is not limited to, screening for depression, anxiety, and dementia. These areas are frequently not diagnosed, underdiagnosed, or misdiagnosed because presenting symptoms are attributed to the physical health problems of the older adults and stereotypical beliefs that aging is associated with increased negative psychological effects. For example, Maria may be experiencing depression as evidenced by her "feeling tired" and "overwhelmed" when she is at the CHC.

3. Cognitive capacity assessment includes screening for normal, gradual decline in memory and/or progressive, irreversible, global deterioration related to Alzheimer's disease. It is important to note behavioral symptoms, such as agitation and sleep disturbance. For example, Maria is experiencing agitation;
4. Functional ability assessment measures an older adult's ability to perform various activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include dressing, bathing, eating, grooming, toileting, transferring from bed or chair, mobility, and continence. IADLs include cooking, cleaning, shopping, money management, use of transportation, telephone use, and medication administration. Given Maria's weight, it will be important to assess these areas;
5. Social functioning assessment includes an older adult's social supports and social networks. These include relationships with family members and friends and social activities. For Maria, understanding whom else may be in her life other than church and her cousin will be important;
6. Physical environment assessment includes examining the condition of lighting and flooring with particular attention to obstacles or possible hazards for falling (i.e., scatter rugs, extension cords), bathing and toileting appliances with particular attention to a possible need for assistive devices (i.e., handheld shower, tub seat), heating and cooling appliances, access to rooms in the home, and access to the house from the outside. For example, Maria has lived alone for the past 8 years and her home may not be safe; and,
7. Caregivers' function assessment examines the level of strain caregivers may be experiencing. Perhaps, Maria's cousin is experiencing caregiver strain, which is why she only sees Maria once a week. Assessing both objective and subjective aspects of caregiver strain provides a more comprehensive understanding of caregivers' needs. An objective assessment includes areas such as financial and family concerns and cultural beliefs and practices. Subjective assessment includes caregivers' perceptions of their caregiving situation.

The domains in the biopsychosocial framework are similar to the domains assessed in comprehensive geriatric assessment (CGA) (Welsh, Gordon, & Gladman, 2014). CGA is a systematic assessment of older adults by an interdisciplinary team of health professionals (including social workers) and consists of six core components: data gathering, team discussion, development of a treatment plan, and implementation of a treatment plan, with monitoring and revision as needed. Evidence-based assessment tools for older adult populations include but are not limited to the following: *LEIPAD*, which assesses the domains of physical, social, and cognitive function, finances, spirituality, environmental domains, and sexuality (De Leo, Diestra, Lonnqvist, Cleirin, & Frisoni, 1998); *Medical Outcomes Study Short-Form Survey*, which measures physical health, mental health, and social domains (Stewart et al., 1992); and *World Health Organization Quality of Life-BREF*, which assesses physical health, mental health, and social and environmental domains. This assessment tool is noted for its cross-cultural competency (Saxena, O'Connell, & Underwood, 2002).

Several assessment tools would be appropriate for use with Maria. To ensure that Maria understands her possible conditions, accounting for her possible cultural beliefs, such as fatalism (Powe & Finnie, 2003), medical mistrust (Rose, Peters, Shea, & Armstrong, 2004), and power distance (Hofstede, 2001) using assessment tools is important. Further, assessing the health literacy level for Maria using a scale, such as the Brief Health Literacy Screen, is critical to providing patient-focused care. To measure possible depressive symptoms, the Center for Epidemiologic Studies Depression scale is commonly used to detect symptoms in older diverse adults (Long Foley, Reed, Mutran, & DeVellis, 2002). To assess cognitive function, the Montreal Cognitive Assessment (MoCA) is a widely used tool (Smith, Gildeh, & Holmes, 2007). To assess Maria's functional ability, the Katz Activities of Daily Living Scale (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963) and IADL scale (Lawton & Brody, 1969) is appropriate. To assess for Maria's social functioning, the Norbeck Social Support Questionnaire (Gallo, Fulmer, Paveza, & Reichel, 2000) is appropriate.

The importance of providing culturally appropriate assessments cannot be overstated. While some assessment tools that might be appropriate for Maria have been previously identified, not every assessment tool accounts for psychosocial or socio-cultural considerations of diverse populations who often experience health disparities and inequities. Because assessment is both a process and a product, it is an intervention in and of itself. Using social work skills, such as establishing rapport, genuineness, acceptance, empathy, and active listening, is one of the ways of engaging older adults. Therefore, utilizing questions that are culturally competent and designed in a way that an older adult, such as Maria, can understand is the first step.

In general, interventions used with older adults should be grounded in individualized assessment. These interventions include: (1) psychoeducation about the aging process and common illnesses that occur in older adulthood; (2) information about community resources for older adults and their families; (3) assistance with applying for services and benefits, such as income related and health insurance benefits (i.e., Medicaid, food stamps, etc.); (4) arrangement of transportation to get to medical appointments; (5) provision of support or identification of possible additional sources of support; (6) assessment of the fit between the older person's capabilities and their home environment; (7) decisional support tools to understand the risks and benefits of specific interventions related to cancer screening and medications; and (8) care coordination. Maria could benefit from several of these interventions, including nutritional psychoeducation regarding obesity, application for Medicaid since she has no health insurance, medical transportation, and culturally competent care coordination.

A particularly relevant aspect of closing the health gap is the consideration that older adults have both non-medical and medical needs that can be barriers or facilitators to positive health outcomes. A thorough CGA can identify these needs. Several social work led interventions include screening and interventions for medical and non-medical needs for older adults. They include the Geriatric Resources for Assessment and Care of Elders (GRACE) (Counsell, Callahan, Buttar, Clark, & Frank, 2006), Programs of All-Inclusive Care for the Elderly (PACE) (Eng, Pedulla,

Eleazer, McCann, & Fox, 1997), and the Ambulatory Integration of the Medical and Social (AIMS) model (Rowe et al., 2016). Findings from studies of these models suggest that they can improve health and healthcare utilization outcomes. For example, Maria would likely benefit from AIMS, a care management model provided by social workers in primary care.

Future Steps: Research, Policy, and Practice

The intersection of policy, practice, and research cannot be overstated. Evidence-based strategies implemented in practice provide a foundation for developing or changing policy. Within the NIMHD framework presented earlier, we offer some examples of population research that gerontological social workers should consider followed by a discussion of policy with suggestions for advocacy to close the health gap. Finally, we will provide further suggestions about practice interventions, including GRACE, PACE, and AIMS.

Research Within the *biological* domain, we discussed Alzheimer's disease (AD). Apolipoprotein E (APOE) 4 is a susceptibility gene most commonly known as a risk factor for AD with alleles expressed as e2, e3, and e4 (Ashford, 2004). These allelic frequencies vary across populations worldwide (Eisenberg, Kuzawa, & Hayes, 2010), which makes APOE a particularly relevant target for health disparities investigations. Given the increased risk of AD in older African Americans, there are limited investigations examining the association between APOE and aging among minority individuals of advanced age. Research that addresses cultural and ethnic differences in AD will be important to contributions to reducing health disparities and increasing inequities. Social workers should have a basic understanding of this biological research and continue to advocate for research that can reduce health disparities and inequities.

While there are a number of descriptive investigations examining the *behavioral* domain that also include the *sociocultural environment* of the NIMHD framework, limited evidence-based social work interventions designed to improve the screening behaviors of older diverse adults exist. Increasingly, decision supports are interventions considered for cancer screening and other healthcare treatments. Current decision supports are often designed for high health literacy adults and older adults (McCaffery et al., 2013). Future research needs to incorporate the perspectives of low health literate adults to modify and/or develop new decision tools so that all populations have access to information to make optimal decisions. Despite the important role of *physical/built environments* in the lives of older adults, disparities-focused gerontological social work research in this domain is limited. Bakk, Cadet, Lien, and Smalley (2017) examined home modification rates and report that older Blacks and Hispanics have lower rates of home modification use when compared to older non-Hispanic Whites. However, much research is still needed to understand

aging in context. In a special edition of *The Gerontologist* focusing on older adults and aging in context, Pruchno (2018) notes that we need a better understanding of how older people define their neighborhoods, including more research about diverse aspects of contexts including the built environment, the natural environment, and the food environment. Finally, in the *healthcare* domain, research should develop effective strategies to recruit and enroll diverse older adult participants (National Institute on Aging, 2018). Overall, research that includes social workers is needed to address healthcare disparities and health inequities and close the health gap.

Policy A number of policy implications for “Closing the Health Gap” for older adults exist. Overall, continuing advocacy and community involvement to create new policies to support access to services, awareness of interventions to increase overall functioning, and coordinated efforts among disciplines that include social workers are needed. Specifically, decision support tools are increasingly recognized as a way to create awareness and the Patient Protection and Affordable Care Act (PPACA) (2010) includes provisions related to the development of decision support (O’Malley, Carrier, Docteur, Schmerling, & Rich, 2011). Findings from studies of interventions, including the Geriatric Resources for Assessment and Care of Elders (GRACE) (Counsell et al., 2006), Programs of All-Inclusive Care for the Elderly (PACE) (Eng et al., 1997), and the Ambulatory Integration of the Medical and Social (AIMS) model (Rowe et al., 2016), suggest that these interventions are effective in addressing social care needs in the healthcare delivery system. This evidence can be used to advocate for the reimbursement of care management services by social workers in both fee-for-service and value-based services environments. Changes in health policy over the last decade (i.e., PPACA, 2010) also provide promising routes for the reimbursement of care management services by social workers (Rowe et al., *in press*).

Practice A number of health disparities affecting older adults and older diverse adults exist, and there are many interventions designed to help them. Shier and colleagues (2013) identify non-medical needs as the major barriers to meeting the medical needs of older adults. As discussed earlier, the AIMS model (see Rizzo, Rowe, Shier Kricke, Krajci, & Golden, 2016 for full description of AIMS model) is a promising intervention that utilizes social workers in primary care to address the social care needs of older adults. In a retrospective study, Rowe and colleagues (2016) report that AIMS has a positive and significant impact on healthcare utilization (emergency department visits, hospitalizations, and hospital readmissions). In a more recent study in which 88% of the participants were non-white, Rizzo and colleagues (2019) report that AIMS reduced symptoms of depression as well as health risk 6-months post-intervention. Documentation of social work activities and skills in the AIMS model, and other similar models, is critically necessary to advocate for the inclusion of social workers as members of interprofessional teams addressing the non-medical and medical needs of older adults to close the health gap.

Conclusion

Health disparities and health inequities are pervasive social and public health concerns associated with the social determinants of health. As evidenced by the current research, social workers have the skills necessary to address the social determinants of health that create barriers for older adults and contribute to the health gap. As a profession, social work is well positioned to continue to advance the health equity agenda in research, policy, and practice in collaboration with other disciplines as part of the “Close the Health Gap” grand challenge.

Discussion Questions

1. How would you explain the possible issues that exist for Maria in terms of patient-provider communication? What assessment questions would be appropriate? What might be some possible interventions? What are the policy barriers?
2. Why do you think some populations seem to have access and awareness to some information and others do not?
3. What is the connection between non-medical (psychological, social, other) and medical needs in prompting health equity?
4. If you had to pick a particular chronic illness that research has shown evidence of inequities across diverse older adult groups, what specific assessment questions and interventions might you consider.

References

- Adler, N., Cutler, D., Fielding, J., Galea, S., Glymour, M., Koh, H., & Satcher, D. (2016). Addressing social determinants of health and health disparities: A vital direction for health and health care. *NAM Perspectives*. <https://doi.org/10.31478/201609t>
- Alzheimer’s Association. (2018). 2018 Alzheimer’s disease facts and figures. *Alzheimer’s & Dementia: The Journal of the Alzheimer’s Association*, 14(3), 367–429. <https://doi.org/10.1016/j.jalz.2018.02.001>
- American Academy of Social Work and Social Welfare. (2018). *Grand Challenges initiatives in social work*. Retrieved from aaswsw.org/grand-challenges-initiative/
- Anderson, K., Richardson, V., Fields, N., & Harootyan, R. (2013). Inclusion or exclusion? Exploring barriers to employment for low-income older adults. *Journal of Gerontological Social Work*, 56(4), 318–334. <https://doi.org/10.1080/01634372.2013.777006>
- Ashford, J. (2004). APOE genotype effects on Alzheimer’s disease onset and epidemiology. *Journal of Molecular Neuroscience*, 23(3), 157–165. <https://doi.org/10.1385/JMN:23:3:157>
- Bakk, L., Cadet, T., Lien, L., & Smalley, A. (2017). Home modifications among community-dwelling older adults: A closer look at race and ethnicity. *Journal of Gerontological Social Work*, 60(5), 377–394. <https://doi.org/10.1080/01634372.2017.1341444>
- Boutayeb, A., & Boutayeb, S. (2005). The burden of non-communicable diseases in developing countries. *International Journal for Equity in Health*, 4(1), 2. <https://doi.org/10.1186/1475-9276-4-2>

- Burke, S., Maramaldi, P., Cadet, T., & Kukull, W. (2016a). Associations between depression, sleep disturbance, and apolipoprotein E in the development of Alzheimer's disease: dementia. *International Psychogeriatrics*, 28(9), 1409–1424. <https://doi.org/10.1017/S1041610216000405>
- Burke, S., Maramaldi, P., Cadet, T., & Kukull, W. (2016b). Neuropsychiatric symptoms and apolipoprotein E: Associations with eventual Alzheimer's disease development. *Archives of Gerontology and Geriatrics*, 65, 231–238. <https://doi.org/10.1016/j.archger.2016.04.006>
- Burke, S., Maramaldi, P., Cadet, T., & Kukull, W. (2018). Decreasing hazards of Alzheimer's disease with the use of antidepressants: Mitigating the risk of depression and apolipoprotein E. *International Journal of Geriatric Psychiatry*, 33(1), 200–211. <https://doi.org/10.1002/gps.4709>
- Cadet, T. (2015). The Relationship between psychosocial factors and breast cancer screening behaviors of older Hispanic women. *Social Work in Public Health*, 30(2), 207–223. <https://doi.org/10.1080/19371918.2014.969857>
- Centers for Disease Control and Prevention. (2011, June). *Impact of the built environment on health*. Retrieved from <https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf>
- Centers for Disease Control and Prevention. (2019). Healthy people 2020. Retrieved from https://www.cdc.gov/nchs/healthy_people/hp2020.htm
- Choi, S. (2015). How does satisfaction with medical care differ by citizenship and nativity status?: A county-level multilevel analysis. *The Gerontologist*, 55(5), 735–747. <https://doi.org/10.1093/geront/gnt201>
- Christ, G., & Diwan, S. (n.d.). Chronic illness and aging section 2: The role of social work in managing chronic illness care. *Chronic Illness*, 24.
- Counsell, S., Callahan, C., Buttar, A., Clark, D., & Frank, K. (2006). Geriatric Resources for Assessment and Care of Elders (GRACE): A new model of primary care for low-income seniors. *Journal of the American Geriatrics Society*, 54(7), 1136–1141. <https://doi.org/10.1111/j.1532-5415.2006.00791.x>
- De Leo, D., Diestra, R., Lonnqvist, J., Cleirin, M., & Frisoni, G. (1998). LEIPAD, an internationally applicable instrument to assess quality of life in the elderly. *Behavioral Medicine*, 24(1), 17–27. <https://doi.org/10.1080/08964289809596377>
- Eisenberg, D., Kuzawa, C., & Hayes, M. (2010). Worldwide allele frequencies of the human apolipoprotein E gene: Climate, local adaptations, and evolutionary history. *American Journal of Physical Anthropology*, 143(1), 100–111. <https://doi.org/10.1002/ajpa.21298>
- Eng, C., Pedulla, J., Eleazer, G., McCann, R., & Fox, N. (1997). Program of All-inclusive Care for the Elderly (PACE): An innovative model of integrated geriatric care and financing. *Journal of the American Geriatrics Society*, 45(2), 223–232.
- Findley, A. (2015). Low health literacy and older adults: Meanings, problems, and recommendations for social work. *Social Work in Health Care*, 54(1), 65–81. <https://doi.org/10.1080/00981389.2014.966882>
- Gallo, J., Fulmer, T., Paveza, W., & Reichel, W. (2000). *Handbook of geriatric assessment* (3rd ed.). Gaithersburg, MD: Aspen Publications.
- Greenfield, E. (2012). Using ecological frameworks to advance a field of research, practice, and policy on aging-in-place initiatives. *The Gerontologist*, 52(1), 1–12. <https://doi.org/10.1093/geront/gnr108>
- Grossman, A., D'Augelli, A., & Hershberger, S. (2000). Social support networks of lesbian, gay, and bisexual adults 60 years of age and older. *The Journals of Gerontology: Series B*, 55(3), P171–P179. <https://doi.org/10.1093/geronb/55.3.P171>
- Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited [January 2019]]. Available from: [\[https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services\]](https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services)
- Hofstede, G. (2001). In Retrieved from https://digitalcommons.usu.edu/unf_research/53 (Ed.), *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations* (2nd ed.). Thousand Oaks, CA: Sage.

- Katz, S., Ford, A., Moskowitz, R., Jackson, B., & Jaffe, M. (1963). Studies of illness in the aged: The Index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association*, *185*(12), 914. <https://doi.org/10.1001/jama.1963.03060120024016>
- Lai, D., & Chau, S. (2007). Effects of service barriers on health status of older Chinese immigrants in Canada. *Social Work*, *52*(3), 261–269. <https://doi.org/10.1093/sw/52.3.261>
- Lawton, M., & Brody, E. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, *9*(3_Part_1), 179–186. https://doi.org/10.1093/geront/9.3_Part_1.179
- Liechty, J. (2011). Health literacy: Critical opportunities for social work leadership in health care and research. *Health & Social Work*, *36*(2), 99–107.
- Long Foley, K., Reed, P., Mutran, E., & DeVellis, R. (2002). Measurement adequacy of the CES-D among a sample of older African-Americans. *Psychiatry Research*, *109*(1), 61–69.
- Maramaldi, P., Cadet, T., & Menon, U. (2012). Cancer screening barriers for community-based older Hispanics and Caucasians. *Journal of Gerontological Social Work*, *55*(6), 537–559. <https://doi.org/10.1080/01634372.2012.683237>
- McCaffery, K., Holmes-Rovner, M., Smith, S., Rovner, D., Nutbeam, D., Clayman, M., ... Sheridan, S. (2013). Addressing health literacy in patient decision aids. *BMC Medical Informatics and Decision Making*, *13*(Suppl 2), S10. <https://doi.org/10.1186/1472-6947-13-S2-S10>
- Mitchell, J. (2011). Examining the influence of social ecological factors on prostate cancer screening in urban African-American men. *Social Work in Health Care*, *50*(8), 639–655. <https://doi.org/10.1080/00981389.2011.589891>
- National Institute on Aging. (2018). *PAR-18-749: Examining diversity, recruitment and retention in aging research (R24 clinical trial not allowed)*. Retrieved from <https://grants.nih.gov/grants/guide/pa-files/par-18-749.html>
- National Institute on Minority Health and Health Disparities. (n.d.). *NIMHD minority health and health disparities research framework*. Retrieved from <https://www.nimhd.nih.gov/about/overview/research-framework.html>
- O'Malley, A., Carrier, E., Docteur, E., Schmerling, A., & Rich, E. (2011). *NIHCR policy options to encourage patient-physician shared decision making*. Retrieved from <https://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/shared-decision-making/>
- Ozawa, M., & Yeo, Y. (2008). Race/ethnicity and socioeconomic class as correlates of disability in old age. *Journal of Gerontological Social Work*, *51*(3–4), 337–365. <https://doi.org/10.1080/01634370802039700>
- Patient Protection and Affordable Care Act, Pub. L. No. P.L. 111–148 C.F.R. (2010).
- Powe, B., & Finnie, R. (2003). Cancer fatalism: The state of the science. *Cancer Nursing*, *26*(6), 454–467.
- Pruchno, R. (2018). Aging in context. *The Gerontologist*, *58*(1), 1–3. <https://doi.org/10.1093/geront/gnx189>
- Rizzo, V., Rowe, J., Newman, M., Rothschild, S., & Golden, R. (2019). *The impact of the Ambulatory Integration of Medical and Social (AIMS) model on depression and health risk*. Platform Presentation. National Academies of Practice Annual Meeting & Forum. Pentagon City, VA.
- Rizzo, V. M., Rowe, J. M., Shier Kricke, G., Krajci, K., & Golden, R. (2016). AIMS: A care coordination model to improve patient health outcomes. *Health & Social Work*, *41*, 191–195. <https://doi.org/10.1093/hsw/hlw029>
- Roh, S., Kim, Y., Lee, K. H., Lee, Y.-S., Burnette, C. E., & Lawler, M. J. (2015). Religion, Social Support, and Life Satisfaction Among American Indian Older Adults. *Journal of Religion & Spirituality in Social Work: Social Thought*, *34*(4), 414–434. <https://doi.org/10.1080/15426432.2015.1097094>
- Rose, A., Peters, N., Shea, J., & Armstrong, K. (2004). Development and testing of the Health Care System Distrust Scale. *Journal of General Internal Medicine*, *19*(1), 57–63. <https://doi.org/10.1111/j.1525-1497.2004.21146.x>

- Rowe, J., Rizzo, V., Kand, S., Kukowski, R., Ewlad, B., Newman, M., & Golden, R. (in press). Time contributions of social workers in care management: Value for older adults. *Professional Case Management*.
- Rowe, J., Rizzo, V., Shier Kricke, G., Krajci, K., Rodriguez-Morales, G., Newman, M., & Golden, R. (2016). The Ambulatory Integration of the Medical and Social (AIMS) model: A retrospective evaluation. *Social Work in Health Care, 55*(5), 347–361. <https://doi.org/10.1080/00981389.2016.1164269>
- Rust, C., & Davis, C. (2011). Health literacy and medication adherence in underserved African-American breast cancer survivors: A qualitative study. *Social Work in Health Care, 50*(9), 739–761. <https://doi.org/10.1080/00981389.2011.585703>
- Saxena, S., O'Connell, K., & Underwood, L. (2002). A commentary cross-cultural quality-of-life assessment at the end of life. *The Gerontologist, 42*(suppl_3), 81–85. https://doi.org/10.1093/geront/42.suppl_3.81
- Shier, G., Ginsburg, M., Howell, J., Volland, P., & Golden, R. (2013). The care span: Strong social support services, such as transportation and help for caregivers, can lead to lower health care use and costs. *Health Affairs, 32*, 544–551. <https://doi.org/10.1377/hlthaff.2012.0170>
- Smith, T., Gildeh, N., & Holmes, C. (2007). The Montreal Cognitive Assessment: Validity and utility in a memory clinic setting. *Canadian Journal of Psychiatry (Revue Canadienne De Psychiatrie), 52*(5), 329–332. <https://doi.org/10.1177/070674370705200508>
- Stewart, A., Sherbourne, C., Hays, R., Wells, K., Nelson, E., Kamberg, C., ... Ware, J. (1992). *Summary and discussion of MOS measures [productPage]*. Retrieved from https://www.rand.org/pubs/external_publications/EP19920054.html
- Villa, V., Wallace, S., Bagdasaryan, S., & Aranda, M. (2012). Hispanic baby boomers: Health inequities likely to persist in old age. *The Gerontologist, 52*(2), 166–176. <https://doi.org/10.1093/geront/gns002>
- Welsh, T., Gordon, A., & Gladman, J. (2014). Comprehensive geriatric assessment – a guide for the non-specialist. *International Journal of Clinical Practice, 68*(3), 290–293. <https://doi.org/10.1111/ijcp.12313>