LATIN@ ELDERS: Securing Healthy Aging Inspite of Health and Mental Health Disparities

Catherine K. Medina and Lirio K. Negroni

Abstract The elder population is the fastest growing subgroup of the U.S. This demographic reality has been referred as the "graying of America" and is the result of improved and longer life expectancy of elders because of the medical advances, technology, lifestyle choices and the "baby boomer" generation. The "graying of America" is also ethnically and racially diverse, and Latin@s are the fastest growing segment of the elder population. This chapter discusses the diversity among Latin@ elders and addresses their perceptions of aging and well-being given their diverse realities and existing health and mental health disparities. Using a social justice frame, the authors examine Latin@ health and mental health disparities and the intersectionality of particular social determinants of health: acculturation and health status, chronic illness and the Hispanic mortality paradox, poverty, adjustment to daily living and health literacy. In spite of health disparities that result from structural inequalities, the authors emphasize three positive influences that affect healthy aging by Latin@ elders: (1) family relationships, (2) social support networks, and (3) health/mental health service delivery system within a community context. The authors illustrate community programs as best practice models that include cultural competence and interprofessional collaborations that challenge the structural inequities to reduce health and mental health disparities within the Latin@ elderly population.

Since the twentieth century, the United States (U.S.) and the global world have experienced an unprecedented growth in the number and proportion of older adults (Vincent and Velkoff 2010). The elder population is the fastest growing subgroup

Latin@s is used in this chapter. The @ sign is the deference to the quite recent determination to develop and use nonsexist language and to identify with Latin America (Wallerstein 2005).

C. K. Medina (✉) · L. K. Negroni
University of Connecticut, Connecticut, USA
e-mail: catherine.medina@uconn.edu

H. F. O. Vakalahi et al. (eds.), *The Collective Spirit of Aging Across Cultures*, International Perspectives on Aging 9, DOI: 10.1007/978-94-017-8594-5_5,

of the U.S. This demographic reality has been referred to as the "graying of America" and is the result of improved and longer life expectancy of elders because of medical advances, technology, and lifestyle choices. Another factor influencing the number of elders is the "baby boomer" generation, consisting of individuals born from 1946 to 1964, when our nation experienced an unusually high post-World War II increase in birthrates. As the austerity of the Great Depression and the war years was replaced by economic security, the baby boom was a temporary aberration in the long-term trend of declining fertility in the U.S. (Barusch 2009). Since the 1970s, the U.S. has experienced a decline in fertility and an increase in longevity. Therefore, increases in the elder proportion of the population are attributed to a decline in both death and birth rates. By 2030, it is forecasted that one in five Americans will be over the age of 65 and this will put unprecedented demands on social programs serving elders.

The "graying of America" is also ethnically and racially diverse, and Latin@s are the fastest growing segment of the elder population. Minority populations have increased from 16.3 % of the elder population in 2000 to 20 % of elders in 2010, and are projected to increase to 24 % of elders in 2020. Between 2010 and 2030, the White population 65+ is projected to increase by 59 % compared with 160 % for older minorities, with Latin@ growth projected at 202 % (U.S. Census Bureau Decennial Census 2010). The Latin@ elder population 60 and over is projected to quadruple over the next quarter century, and by 2030 it will be the largest population of minority elders (Tucker et al. 2010). Currently, Latin@ elders constitute a large group (8 %) and by 2019, the Latin@ population 65 and older is projected to be the largest racial/ethnic minority in this age group [Administration on Aging (AOA) 2010]. This Latin@ boom is driven by the fact that Latin@s live longer than their White counterpart. Contrary to expectations based on Latin@s' lower socio-economic profile and living conditions, national studies have documented lower-age adjusted and income-adjusted mortality rates due to heart disease, stroke, and cancer among Latin@s relative to Whites (Falcon et al. 2009; Stratton et al. 2009). This phenomenon of longevity has been termed the *Latin@ or Hispanic epidemiological paradox* and will be further explained in the acculturation and health status section.

Despite longer life expectancies, Latin@ elders face mental health disparities. There is some evidence that depression among Latin@ elders is slightly higher than for the general population and that depression is strongly associated with physical illness for Latin@ elders (Chavez-Korell et al. 2012; Falcon and Tucker 2000; Areán et al. 2005). According to the Center for Disease Control and Prevention (CDC 2012) Behavioral Risk Factor Surveillance System (BRFSS), Latin@ elders had a higher prevalence (13.2 %) of frequent mental distress (FMD) compared to their White (8.3 %), and Black and non-Hispanic counterparts (11.1 %). This same study indicated that Latin@ elders (14.5 %) were slightly more likely to report a lifetime diagnosis of anxiety disorder compared to White (12.6 %), Black (11 %) and other non-Hispanic older adults (14.2 %). Latin@ elder mental health status can be impacted by many factors such as coping with life changes and loss, impact of acculturation within the family, lack of supports

and limited access to services. These factors create conditions for the development of depression and anxiety in Latin@ elders which affects health and well-being.

This chapter discusses the diversity among Latin@ elders and addresses their perceptions of aging and well-being given their diverse realities and existing health and mental health disparities. Aging is a fundamental aspect of the life cycle, and one of continuing development. According to Rowe and Kahn (1998), the goal of healthy aging is to minimize decline by emphasizing the importance of maintaining health, mental functioning and active engagement in life. Yet Cohen (2005) recognizes the huge potential for positive growth in later life. Using a social justice frame, the authors examine Latin@ health and mental health disparities and the intersectionality of particular social determinants of health. Social determinants are defined as the conditions in which people are born, grow, live, work, and age, including the health system [World Health Organization (WHO 2011)]. Social justice promotes a fair and just society that upholds the right to equality of access, opportunity, and outcomes for all individuals (Rawls 1971). This view of social justice refers to egalitarian theories that contend that distributive justice redress existing social and economic inequalities by redistributing resources. As a moral imperative, distributive justice calls for distributing goods to provide the greatest benefits to the least advantaged members in society in a fair and just matter (Rawls 1971; Iatridis 1994). The authors discuss the following social determinants of health in relationship to the well-being of Latin@ elders: acculturation and health status, chronic illness and the Hispanic mortality paradox, poverty, adjustment to daily living and health literacy from a social justice perspective.

The final section of the chapter proposes ways in which Latin@ healthy aging can be promoted with particular consideration of community interventions and interprofessional collaborations. These proposed practices will be discussed from a social justice perspective because the national and global health environment requires social scientists and healthcare providers to expand their knowledge base about health and well-being and to promote health equity for all.

Theoretical Framework: Well-Being and Healthy Aging from a Social Justice Perspective

The U.S. health care delivery system, especially in older life, focuses on health as the absence of disease by curative treatment, and in the presence of disease that directs care to stabilizing acute exacerbation of chronic disease by symptom management (Day 2010). The definition of health as the absence of disease keeps the discourse in the realm of the health care industry, as it is currently structured, with an emphasis on medical and technological efforts to diagnose and cure disease. An alternative system of care views healthy aging as one that centers on the multidimensional human capacity to thrive and flourish from prenatal to end-of-life. For example, healthy aging would be a normal life span that emphasizes

well-being as a dynamic state. The elder continues to develop their potential, works productively and creatively, builds strong and positive relationships and contributes to their society. When theorists argue that healthy aging encompasses human thriving, human dignity and self-determination, they are connecting health and social justice (Day 2010; Powers and Faden 2006; Nussbaum 2006). Social justice promotes a fair and just society that upholds the right to equality of access to goods and resources, opportunities, and the probabilities of life chances for actualizing successful outcomes for all societal members. Healthy aging is a function of a just society, allowing all members of society their human capacity to thrive and flourish.

Diversity Within Latin@ Elders

Although the research literature refers to the Latin@ elder population as one group, Latin@ elders are quite diverse and culturally fluid. Latin@ elders represent 21 nations from Central and South America (including Brazil), Mexico and the Spanish speaking Caribbean. Among Latin@ subgroups Mexicans are the largest group in the U.S., followed by Puerto Ricans, Cubans, Salvadorans, and Dominicans (CDC 2012). Increasingly, Latin@ immigration to the U.S. is coming from Central and South America. Within-group differences exist on the basis of sociopolitical and economic histories within their countries of origin, immigration and migration experiences, specific customs, and their mixed racial backgrounds (Negroni-Rodríguez and Morales 2001). Most Latin American populations have White (European), Black (African), and Native Indian heritage. Most Latin@ elders share a history of colonization by Spain, a connection to the Catholic Church and Spanish as the primary official language, except for Brazil, and the diversity of indigenous languages spoken in mainly Mexico and Central America (Náthuatl, Zoque, Chontal, Miskito, and Mayan languages). Their self-identity as members of the same ethnic group is influenced by this history and by the sharing of similar cultural values, beliefs and traditions such as *confianza* (trust in relationships), *familismo* (centrality of family) and *respeto* (respect for elders or individuals with experience) .

Latin@ elders residing in the United States comprise of two groups: those who were born and raised outside the United States and immigrated at some point in their childhood or adulthood (foreign-born) and those who were born in this country (native-born). In regards to Puerto Rican elders, because they are U.S. citizens, they have a different migration history that occurred in two different cohorts. The first cohorts are Puerto Ricans from the mainland (Puerto Rico) who migrated to stateside (U.S) in the 40 and 50s because of the need for economic security. The second cohorts consist of those Puerto Ricans who arrived at stateside in the last decades for education and health reasons or to accompany or reunite with relatives. Latin@ elders are more likely to be foreign-born than native-born (Motel and Patten 2013). This distinction is important because

membership to each category presupposes different challenges concerning social determinants of health for healthy aging, such as health status, level of acculturation, access and use of services, health literacy and language proficiency in both languages (Spanish and English).The intersectionality of social determinants and health and mental health disparities will be further discussed.

Also depending on the period of immigration or migration to the U.S., many Latin@s elders may have experienced racism and discrimination resulting in a lack of access to goods and resources. Racism and discrimination were more openly practiced and accepted than in present times (Ramos 2007). Elders with an African heritage may have experienced additional burdens, given the prejudices and racism against Blacks (Aguirre and Turner 1995, cited by Ramos 2007, p. 49). The discrimination might have denied access to employment, health care, housing, insurance and a living wage. The interpersonal (person to person) and institutional (inherent in structural systems) racism presents major challenges to illness prevention, healthy outcomes, and overall well-being in Latin@ elders.

Latin@ Elders Perceptions of Aging and Well-Being

In the Latin@ culture old age is highly valued and considered a time when the elder enjoys the rewards for a life lived according to one's cultural values (Beyene et al. 2002). For many Latin@ elders aging is not just about chronologically maturing into old age, it is a twofold process. Aging is viewed from the perspectives of one's physical conditions (functional role) and one's "spirit" (relational function). For Latin@s there may be a difference between "being old" and "feeling old". "Being old" is associated with the person's inability to carry out daily activities while "feeling old" depends on the person's spirit based on perceived self-esteem derived from their relational status with family members (Beyene et al. 2002). Feelings of well-being may be influenced by the type of family interactions and sense of fulfillment based on culturally defined roles they have in family interactions. The elders' sense of morale is supported by their perceived closeness with their adult children, family and extended family members. Latin@ elders who expressed unsatisfactory family relations defined their health status as poor. These Latin@ elders expressed feeling lonely, and perceived aging as a very sad phase of their life. On the other hand, those who had satisfactory family relationships defined their health status as good, and portrayed a positive perception of aging (Beyene et al. 2002).

In most Latin@ families, respect (respeto) for elders is an important value taught to children very early in life (Sanchez-Ayendez 1988). Because Latin American cultures have norms and values that reflect a high level of positive valuation for the elders, children have social and moral obligations to support elder parents (Ortiz 1995; Vega 1995; Sotomayor 1992; Paz and Applewhite 1998; Beyene et al. 2002). Therefore, it is common for Latin@ elders to live with family members not only as a result of health or economic necessity, but because of

culturally bound expectations governed by norms of mutual reciprocity among families (Vega 1995; Angel and Tienda 1987). Latin@ elders expect to be respected and valued. In the Latin@ community there is the cultural expectation that family members take care of the needs and best interests of their older adults (Vélez and Cole 2008), and treat them with respect. Children feel an obligation and responsibility to reciprocate for the care and love they received. Female family members may encounter a higher level of stress in caring for their elders, as they are the ones expected to provide most of the care.

Acculturation aand other factors can influence how a Latin@ elder is cared for and treated. Some families lack awareness of the elder's value orientation about family and aging; others may not realize the challenges faced by their elders as a result of their immigration, migration and acculturation process (Negroni 2012). Sometimes the younger generations do not understand what it means for their elders to grow old in a new country and culture. This can be a source of stress and pain both for the elders—who may feel they are not as important to the family—and for the family. In turn, there is a strain on the relationship and this can trigger feelings of insecurity, fear, incompetence, frustration, anger, grief, and separation for both generations.

Although many Latin@ elders rely on their families for support during this life span, Rosnick and Reynolds (2003) note the importance of control for Latin@ elders in decision making about the course of their life. Other researchers have examined the importance of autonomy and the desire to control their lives (Heyman and Gutheil 2010). Control and autonomy are factors that influence self-determination to promote healthy aging, human thriving, and well-being. The human capacity of Latin@ elders to control bodily health, bodily integrity, and engage in practical decision-making about their health is to maintain dignity and self-determination throughout the aging process (Nussbaum 2006).

Another factor that influences the relational function of "spirit" and a positive aging process is the Latin@ elders' relationship to religion. Religious and spiritual beliefs and faith play an important role in helping Latin@ elders cope with the stressors of old age (Negroni 2007; Krakauer et al. 2002; Phipps et al. 2003). Because of their religious roots they believe that God will help them deal with their problems (Aranda and Knight 1997). They often state "*Está en las manos de Dios*"—meaning the issue is in God's hands. This cultural expression is within the context that the Latin@ elder is in a spiritual relationship with a supreme being and that the locust of control about a situation is restored. It is not in the context of fatalism or helplessness, but rather in the context of a spiritual relationship with a source of power. Aging is regarded as a gift from God even when people's health status is poor (Beyene et al. 2002). According to Heyman and Gutheil (2010), research indicates that older Latin@ adults often turn to their churches and embrace the concept of God's will.

Health and Mental Health Disparities: Intersectionality of Social Determinants of Health

According to the Institute of Medicine (IOM), there has been a long-standing and well-documented pattern of health disparities for certain groups in the U.S. These health disparities refer to differences in the incidences, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the U.S. (National Institute of Health 2000). Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantage.

The discussion on Latin@ elders' health and mental health requires a multi-dimensional view and analysis of the different social determinants of health that occur within the context of power and oppression and how these determinants are the cause of health disparities (World Health 2011). Social determinants include the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (World Health 2013). When examining the intersectionality of these determinants among Latin@ elders, it is essential to remember their status as an underrepresented and oppressed group. Different social determinants that impact elders' potential for health and well-being come from the larger societal system both in their countries of origin and the U.S., their families and themselves (Parra-Cardona et al. 2007).

Higher rates of chronic illnesses and longer years of disabling conditions may define the aging experience of many Latin@ elders (Angel et al. 2005; Ruiz and Ransford 2012). Findings from the 2011 National Health Interview Survey and other research indicate that Latin@ elders have higher poverty rates, lower education and greater risk factors related to environmental barriers (physical health, language, access to quality care). In the context of health disparities, social justice refers to the minimization of the social and economic conditions that adversely affect the health and well-being of Latin@ elders. In the next section, relevant social determinants of health that influence Latin@ elders aging and well-being are discussed. Among the factors that intersect and can increase health disparities for Latin@ elders are: acculturation and health and mental health status, language and health literacy, chronic illnesses and the Hispanic mortality paradox, limited adjustment to daily living, poverty, lack of access to quality health care, and social supports (CDC 2012).

Acculturation and Health and Mental Health Status

Franzini et al. (2002) define acculturation as the process by which an individual raised in one culture enters the social structure and institutions of another, and internalize the prevailing attitudes and beliefs of the new culture, while simultaneously retaining aspects of one's culture of origin. Several studies demonstrate that

there is a relationship between acculturation, health and mental health, and findings indicate that the more a group acculturates to the dominant culture, their physical and mental health disparities move closer to minority health disparities in the U.S. (Coonrod et al. 2004). The research suggests that Latin@ foreign-born have better health outcomes than U.S. native-born because they are less acculturated and have not adopted U.S. health risk behaviors (smoking, consumption of alcohol or other drugs), nor have the extended exposure to the cumulative social stress resulting from U.S. racism and structural discriminatory practices toward low-socio-economic status minority populations previously mentioned.

Too often the native Latin@ in the U.S. knows the burden of economic insecurity, lack of access to health care, lack of health insurance, and lack of health literacy because of poor language proficiency. The cumulative stress for native Latin@ elders come from years of exerted energy to respond against difficult odds when one does not have the necessary resources to cope when confronted with an external stimulus [(stressor i.e. lower social status, racism, discrimination, lack of resources) (LaVeist 2005)]. This experienced stress can lead to emotional, behavioral and physiological changes that can put the native Latino elder under greater risk for developing mental disorders and physical illnesses. Latin@ adults consistently show that they have poorer health than Whites of the same age group across measures of disease, disability, and self-assessed health (Dilworth et al. 2012).

Existing findings raise questions regarding the role of acculturation and other factors on self-assessed physical well-being. For example, in the study by Beyene et al. (2002) with foreign-born mostly Central American and Mexican elders, most of whom had lived in the U.S. for 20 years or longer, participants rated their health as good to excellent (61.7 %), fair (25 %), and poor (13.6 %). Yet in the study by Negroni-Rodriguez and Bok with mostly Puerto Ricans who had lived in the U.S. an average of 30 years, participants rated their health as fair (65 %), and poor to very poor (17.3 %). Min and Barrio (2009) found a significant difference on self-assessed health status with 60 % of Mexican-Americans rating their health as either "fair" or "poor", compared with only 23.3 % of non-Latino Whites. These findings suggest that more research needs to be conducted with the different Latin@ subgroups because of the varying socio-political factors that influence the relationship between acculturation and self-assessment of physical well-being.

Although there is a dearth of recent data on Latin@ elder's acculturation and mental health status, researchers acknowledge that Latin@ elders' help-seeking patterns and English language limitations, along with the experiences of immigration and adjustment to a new country are stressors that can influence the development of mental health problems. Studies document a slightly higher level of depression among Latin@ elders than among the general older adult population (Arean et al. 2005; Falcon and Tucker 2000; Gonzalez et al. 2001). In the Negroni-Rodriguez and Bok (2004) study, Latina elders reported feeling depressed (65.2 %), having anxiety problems (60.9 %) and having problems with their memory (43.5 %). These women were born and raised outside of the United States (100 %), lived alone (61 %), identified family as their primary source of support (74 %) and primarily spoke and preferred to be addressed in Spanish (100 %).

Most research on Latin@ elders' mental health and acculturation generally focuses on caregivers (Janice et al. 2009; Min and Barrio 2009). The study by Min and Barrio (2009) addressed caregiver's preferences and showed that Latin@ elders (45.4 %) are more likely to prefer informal caregivers such as *promotores (as)* than formal/paid helpers compared to non-Latin@ whites (16.7 %). Regarding cultural values about the role of caregivers, more Latin@ elders than non-Latin@ elders agreed that adult children should be more responsible than the elders parents themselves for making long term care arrangements (74.2 % vs. 33.3 % respectively); and that care should be provided by family members, not by an outsider (73.3 % vs. 32.6 %). Those who agreed to these two statements were three times more likely to select an informal caregiver than those who disagreed (Min and Barrio 2009).

Language and Health Literacy

For many Latin@ elders, language discordance between their medical provider and themselves has been cited as a particular structural barrier to accessing quality health services (Born et al. 2004). Communication with health care providers may not be effective because of the language barrier or sometimes medical information is lost in translation. A recent study to understand cultural competence found that Latin@s experienced language-based discrimination related to their medical encounters (Napoles-Springer et al. 2005).

There is a growing interest in health literacy as a major factor contributing to medical adherence. Health literacy refers to "the degree to which individuals have the capacity to obtain, process, and understand basic health and service needed to make appropriate health decisions" (Hispanic Health Council 2006, p. 14). According to this profile, current research indicates that over 90 million people (including English speaking individuals) in the U.S. struggle to understand basic health information such as reading materials, prescription labels, filling out medical and insurance forms, and communicating with their providers. The disproportionate low level of educational attainment and the large portion of Latin@s elders who are monolingual in Spanish are factors that influence their degree of health literacy and their adherence to medical treatment.

Chronic Illness and the Hispanic Mortality Paradox

Among Latin@ elders there is a prevalence of chronic illness with 85 % reporting at least one chronic illness, while others reported two to four chronic illnesses (Villa and Torres-Gil 2001). In a study of 83 Latin@ elders, Beyene et al. (2002) reported that the most frequent chronic illnesses were arthritis (88 %) followed by heart disease and hypertension (34.2 %), and diabetes (30.1 %). On the favorable

side, Latin@s tend to have lower mortality rates. This finding has been referred to as the *Hispanic epidemiological paradox* or the *Hispanic mortality paradox* (Franzini et al. 2002). Franzini et al. offer four different explanations for the Hispanic epidemiological paradox. The first is poor-quality data reporting. Prior to 1978, death rates for Latin@s were not collected by providing a separate category for Latin@s; instead, they were estimated by Latin@ categorized surnames. This resulted in inconsistencies in counts of Latin@-origin decedents that may have a European sounding surname such as one of the authors of this chapter. This type of data collection leads to misclassification and underestimation of deaths that occur among Latin@s. Often the data on death rates among Latin@s is under-reported or not collected at all (LaVeist 2005; Medina 2011).

The second plausible, and most common, explanation given is the "salmon bias" phenomenon. The coining of the "salmon bias" hypothesis is based on salmon swimming upstream to spawn before their death (LaVeist 2005, p. 277). Similarly, it is hypothesized that Latin@s return "home" (to their country of origin) when they become seriously ill or reach mature age. Therefore, their deaths are not recorded in U.S. statistics, producing an artificial death rate for Latin@s. This hypothesis has been refuted by some studies (Abraido-Lanzo et al. 1999). The third explanation is that only the healthiest individuals will migrate to the U.S. from other countries. Studies support that newly arrived migrants have better health status than persons in their country of origin (Marmot et al. 1984). This healthy migrant effect has been argued by Abraido-Lanza et al. who state that all migrants from Europe should have this selective migration advantage. The final explanation of the Hispanic mortality paradox is the distribution of health risks and protective factors among Latin@s. Although many Latin@s have definite health risks through their life span such as lower rates of immunizations, higher prevalence of hypertension, unintentional injuries, and living in environments with poorer quality of air and exposure to biological, chemical and other toxin elements, they also show lower rates of smoking, a higher proportion of women getting prenatal care, and a higher fruit and fiber diet than Whites (LaVeist 2005; Medina 2011).

The resiliency of the Latin@ population through their family and community networks has been a source of strength, and can be a protective factor for cumulative stress in their environments (Stratton et al. 2009). How these factors contribute to lower mortality rates or healthy outcomes for Latin@s is an area for future research. An understanding of the Hispanic epidemiological paradox is worth investigation, because how health risks and protective factors translate into health outcomes may play a role in lowering incidence rates of certain diseases in Latin@s.

Limited Adjustment to Daily Living

Similar to other elders, maintaining functional independence is important for Latin@ elders and their families. The process of dependence can be slowed down if elders are able to successfully adjust to life changes, and if they are cared for

appropriately. In 2008, 9.2 % of Latin@ elders aged 65+ needed help from other persons for personal care as compared to 5.7 % for non-Hispanic Whites and 10.3 % for non-Hispanic Blacks (AOA 2010). A study by Villa and Torres-Gil (2001) found that 45 % Latin@ elders reported difficulty with adjustment to living tasks such as: managing hygiene, toileting, dressing, or ambulating around the house. Other research indicated that compared to Whites, twice the number of Latin@ elders reported difficulty in performing instrumental activities of daily living such as: using the phone, shopping, managing their money, or doing light housework (AOA 2012; Hazuda and Espino 1997). The ability to perform these ADLs competently can be threatened by the presence of diseases and disability. Collins et al. (2002) found that Latin@s elders reported their health as fair to poor because of their high level of physical disability and functional limitations. From a social justice perspective, the high level of poverty along with low educational levels, can limit Latin@ elders' access to the resources that can guarantee quality of life. When elders cannot perform their daily activities they will need help. Conditions such as the lack of support systems and limited care giving services resulting from the structural factors discussed in this chapter can make this needed help less available.

Poverty

In 2010, almost 3.5 million elders (9.0 %) in the U.S. were living below the poverty level (AOA 2012). Another 2.3 million (5.8 %) were classified as "near-poor" (calculated as income between the poverty level and 125 % of this level). Among those who fell below the poverty level, 6.8 % were Whites, 18 % were African Americans and 18 % were Latin@s. Higher poverty rates were found in cities (11.2 %) compared to rural areas (10.4 %). Most Latin@ elders live in cities with a majority residing in the following four states: California (27 %), Texas (19 %), Florida (16 %) and New York (9 %). Older women had a higher poverty rate (10.7 %) than older men (6.7 %); and older persons living alone were more likely to be poor (16 %) than older persons living with family members [(5.3 %); (AOA 2012)].

According to the National Hispanic Council on Aging (NHCOA), Latin@ older adults are more likely to be wholly dependent on Social Security than any other racial or ethnic group and without this financial support, 50 % or more Latino elders would fall into the poverty level. When faced with such economic insecurity, elders alter their behaviors to save money. Despite their hard work throughout their life, they are not able to save enough money to support their basic needs in older age. In a national survey of older adults with diabetes in which the majority of respondents (51 %) were of Latin@ descent, severe measures were taken by these elders to meet their economic needs. Nearly one in five (19 %) cut back on the use of medications, 20 % limited food intake and other essentials, 14 % increased credit card debt, and 10 % borrowed money from family and

friends for medications (Piette et al. 2004). Lack of economic resources has been shown to contribute to cost-related medication non-adherence (Heisler et al. 2007).

Because many older Latin@s do not live alone or reside in nursing homes, families pool resources to meet basic needs (Fennell et al. 2010). According to the AOA (2010) statistical profile of Hispanic Older Americans, 67 % of Latino older men lived with their spouses, 15 % lived with another relative, 5 % lived with a non-relative, and 13 % lived alone. For Latina women, 41 % lived with their spouses, 32 % with another relative, 1 % with a non-relative and 27 % lived alone. Although, the percent of older Latin@s living alone is lower than that of the general population, the highest poverty rate of any elder group was experienced by Latina women living alone. However, the percent of Latin@ elders living with other relatives is almost twice that of the total general population (AOA 2010). The high number of elders living with relatives may be related to the cultural values of *familismo* and *respeto* which increases adult children's sense of responsibility for caring for their elder parents and the emphasis on the collective in Latin@ families (Fennell et al. 2010).

Lack of Access to Health Care

Latin@s tend to underutilize health and mental health, social services, and other public delivery systems, and drop out early after beginning treatment (Ortega et al. 2006; Sue 2003; Vega and Alegria 2001). Latin@s throughout the life span have substantially lower rates of healthcare insurance compared to other ethnic and racial groups (Medina 2011), and it has been reported that 31 % do not have a usual source of health care (LaVeist 2005). Some of the difficulties with service utilization may stem from the actual helping process itself. For a patient to adhere to medical treatment, the process is dependent on the level of health literacy—"the degree to which individuals have the capacity to obtain, process, and understand basic health and service needed to make appropriate health decisions" (Hispanic Health Council 2006, p. 14). Because the United States has a complex health care delivery system which involves many specializations and coordination of services, the consumer is dependent on their level of health literacy to navigate their healthcare (Medina 2011). For many Latin@ elders this can be a challenge because of their low education attainment and lack of language proficiency in English and sometimes Spanish will influence their level of health literacy and their ability to access and utilize health care.

In Latin@ communities, many elders seek a natural helper—individuals that people naturally turn to for advice, emotional support, and tangible aid (neighbor, *bodega* (grocery) owner, *botanica (herb shop with spiritual meanings)* spiritualist and/or healer) to help access and utilize healthcare services. Because of their skill sets and expertise, natural helpers assist with referrals to external resources (DiClemente et al. 2002). They are local residents that provide informal, spontaneous, culturally relevant healthy advice associated within the context of everyday

living. Community residents will refer to them as madrinos/madrinas (godfathers/godmothers) because of their access to resources based on their networks and ties to local services and leaders that are central to many activities in the community. The health prevention field has realized that the collaboration of formal systems of care with natural helpers can influence health promotion and outcomes for Latin@ communities (DiClemente et al. 2002).

Viewed as a community support system of care not to replace specialized or professional services, but to complement and foster an appropriate and cultural response to clients' and community needs, natural helpers are often trained by health professionals. Medical providers will refer to the natural helpers as promotores (as) who integrate information about health and the health care delivery system into the Latin@ community's culture, language and value system, thus reducing many of the barriers to health access and utilization of services (Migrant Health Promotion 2013). They also help make health care systems more responsive to Latin@ elders. In a collective spirit, promotore (as) with the appropriate resources, training and support influence the meaning of health, prevention, and well-being. They link Latin@ elders to health/mental health care and social services; educate elders about disease and injury prevention, and work to make available services more accessible (Migrant Health Promotion 2013). Promotores (as) mobilize Latin@ communities to create positive change toward well-being.

Latin@ elders generally are undertreated for mental health (Chavez-Korell et al. 2012), and mental health services are usually provided by a primary health care physician (Negroni-Rodríguez and Bok 2004). Understanding Latin@ elders' use of health and mental health services requires an integrated inquiry that incorporates factors such as views about well-being, health and mental health problems, help-seeking patterns, availability of supports, and availability of services. In their review of the literature, Kim et al. (2009) found lower rates of mental health service use and different quality of care from mental health service providers in foreign-born as compared to native-born adults. Their comparison study between Asian and Latin@ elders documented that for Latin@ elders four factors influenced their use of mental health services: being a younger elder, a woman, having a mood disorder and self-rating their mental health as poor.

Social Support Networks

One of the many factors that leads to good health and long life is the amount of social support a person enjoys (Donelly et al. 2001). Research documents that individuals get innumerable benefits when they have adequate social supports (Vega 2010), and social support networks are important social determinants of health particularly for aging adults (Forster and Stoller 1992). Support systems provide emotional, informational and instrumental assistance on an every-day basis as well as at times of crisis. They also serve as a mechanism for helping individuals maintain their cultural heritage. Their support systems can influence

Latin@ elders' view of their needs and problems and influence help-seeking patterns and access to health care services (Negroni-Rodríguez and Bok 2004; Negroni 2007). Negative interactions with those support systems, such as constant criticism and belittlement from other people, can undermine emotional well-being. Older adults who perceive themselves as socially engaged and supported are in better mental and physical health than those socially isolated (Siebert et al. 1999). The types of social support networks that Latin@s use include: nuclear and extended family, friends, close neighbors, and church members. Religious activities, social clubs, merchants (markets, botanical shops, restaurants, and beauty parlors) and senior centers are important sources of social support networks (Delgado 1998; Negroni-Rodríguez and Bok 2004).

Although Latin@ elders depend primarily on their families, the availability of family members to care for them may be limited. Different factors account for the scarcity of such support, for instance, children facing their own stressors may find it difficult or impossible to fulfill their filial responsibility (Moody 1998; Gallagher-Thompson et al. 2003, 2008); social support declines as a result of family members becoming more Americanized and changing their views about aging and caring for their elder; and/or because elders' face the loss of significant supports for instance, the death of a spouse or a significant other (Vega 2010). The stressors and changes faced by caregivers not only can limit their availability but cause negative interactions with the elders, such as constant criticism and belittlement, and can undermine elders' emotional well-being. Thus, the support provided by non-family members is quite important and more now than in the past, Latin@ elders may seek their needed social support through their connections and networking with community resources (Gallagher-Thompson et al. 2008).

Best Practices: Community Efforts that Include Cultural Competence and Inter-professional Collaborations to Increase Latin@ Healthy Aging

Health disparities may be reduced through community participation that addresses social determinants of health. As previously indicated, family, friends, and neighbors represent the primary care givers and advocates of Latin@ elders. Latin@ community organizations represent the next layer of support and help. Throughout the United States local community efforts have been implemented in cities, at the state level and nationally as a result of communities' concerns about the well-being of Latin@ elders. In the following section the authors will provide examples to describe the focus of these efforts.

The National Hispanic Council on Aging (NHCOA) is considered the leading national organization working to improve the lives of Latin@ older adults, their families, and caregivers. NHCOA promotes, educates, and advocates for research, policy, and practice in the areas of economic security, health, and housing. It has been in existence for more than 30 years. The organization has identified four

priority areas to work on: Health, Economic Security, Leadership Development and Empowerment, and Housing. Within each area the organization has been developing initiatives, addressing policy issues and conducting research. In the area of health, NHCOA has been active in influencing the national agenda around health and health care by implementing health promotion and education programs; providing cultural competency training to physicians and patients; working on a national level to prevent Medicare fraud within the Hispanic community; and advocating on issues of critical importance to the health of Hispanic older adults, their families, and caregivers, including the equitable implementation of the Affordable Care Act or health care reform on Capitol Hill.

As indicated in 2007 by the U.S, Department of Health and Human Services (DHHS), Latin@ elders may look to the leaders and staff in community organizations for referrals to a wide range of services and for services themselves. In different states there are community organizations focused on helping to educate Latin@ elders on Medicare benefits, helping address language barriers and advocating for optimal health/mental health service delivery. These community organizations may provide medical care, counseling, nutrition programs, exercise classes, or other programs (DHHS 2007).

The Latino Geriatric Mental Health Group of New York City (2007) was organized with the representation from the Association of Hispanic Mental Health Professionals, The Geriatric Mental Health Alliance of New York, the NYC Department for the Aging, and the NYC Department of Health and Mental Hygiene. They convened a meeting of more than 100 individuals to discuss how services for the Latin@ elder population could be improved. Their discussion resulted in seven major areas of focus: (1) language, (2) cultural competence, (3) workforce development, (4) outreach and education, (5) home and community-based services, (6) family support, (6) best practices, and (7) limited service capacity. Together these organizations seek to better serve Latin@ elders. Among their accomplishments are: involvement in the New York Governor's Commission on Hispanic Affairs leading to the development of the first bilingual/bicultural psychiatric impatient and out-patient units in the City of New York; increased awareness of Hispanic mental health issues by disseminating cutting edge Mental Health knowledge through conferences (Association of Hispanic Mental Health Professionals 2013); and advocacy for laws and programs that support older adults (Geriatric Mental Health Alliance of New York 2012). Also, the Department for the Aging (DFTA) has become the lead agency for implementation of the 59 strategies for improving New York's livability for older persons.

In 2007, various federal organizations in the United States joined efforts and created The Hispanic Elders Project, a pilot project that involved eight teams from different metropolitan areas with large numbers of Latin@ elders. These teams were charged with the task of assisting local communities in developing coordinated strategies for improving the health and well-being of elder Latin@s. The major purpose was to link Latin@ elders and their families with service providers, medical care providers, community organizations, and public agencies to promote

the use of the new benefits, prevention programs, and other initiatives that would reduce health disparities among Latin@ elders (DHHS 2007).

The Latino Age Wave Initiative in Colorado and California is a project developed by the Hispanics in Philanthropy (HIP) organization and supported by grants under their HIP Hispanic Aging program. The initiative's goals are to expand and strengthen services, advocate on behalf of Latin@ elders and raise awareness of Latin@ aging issues. Another focus of this initiative is to engage Latin@ older adults as advocates for policies that improve their health and well-being (Global Policy Solutions LLC 2011). The Latino Center on Aging in New York, established in 1991, has a similar focus: to improve the lives of Latino seniors through advocacy and education, increase knowledge on the hardships faced by these elders, and assist in the creation of new programs and services. Another organization serving Latin@ elders is the Institute for Puerto Rican/Hispanic Elderly also in New York. In 2006, the Institute was administering 23 programs with services for Latin@ elders (Institute for Puerto Rican/Hispanic Elderly 2013).

Senior centers are a strong support network for Latin@ elders, and often the staff and elder become part of the family (Negroni-Rodríguez and Bok 2004). The centers coordinate different activities and services that address the cultural, social, emotional and physical needs of the Latin@ elders in their geographical locations. For example, The Ethel Macleod Hart Senior Center in Sacramento, California has created the *Manitos* Program. *Manitos (*Spanish term used in Mexico to refer to one's pals, buddy or friends) is a club open to older adults who speak Spanish. The program features games, food, songs, exercise, and educational activities.

In the state of Connecticut where Latin@s represent 14 % of the population, there are several local centers for Latin@ elders. Casa Otoñal, a nonprofit organization, consists of senior housing, a senior center, housing for grandparents who have custody of their grandchildren, companion and homemaker, information and assistance, benefits counseling, translation, and other social and support services to traditionally underserved Latin@ elders in the south side of the state. Senior centers provide for the many needs of older adults (Miltiades et al. 2010).

Another strategy to increase Latin@ healthy aging is for interdisciplinary teams to participate in an Interprofessional Collaborative Practice (IPCP). This is a model of collaboration of various disciplines (medicine, dentistry, pharmacy, physical therapy, social work, and public health) to train students and to improve health outcomes for a geriatric population. Using the various expertise, the threefold goals are: (1) to facilitate access, (2) to promote a continuum of services that insure healthy outcomes, and (3) to provide and coordinate culturally and linguistically appropriate services in primary, dental and mental health care, while training students for the growing geriatric population in global societies. The intersectional framework of the IPCP model offers an opportunity to effectively increase access to care and achieve high quality patient and population-centered outcomes by providing coordinated care from multiple perspectives and disciplines in their homes and communities.

This health promotion strategy will also increase the number of nurses skilled in interprofessional collaborative practice and promote the development of diverse

and culturally competent skills needed to practice in existing and emerging health care systems. These partnerships, in doing interventions in the homes of the elders, can improve direct health outcomes for an underserved aging population through meaningful collaborations with other faculty and students from various disciplines. Working collectively, the team can enhance the training outcomes of an emerging healthcare workforce in geriatrics and reduce the inappropriate and high utility of emergency room visits by older adults. This health promotion strategy is interprofessional collaborative practice that promotes the development of diverse and culturally competent skills needed to practice in existing and emerging health care systems.

Conclusion

This chapter focuses on the health and mental health realities of aging for Latin@ elders in low-income communities, and advocates for community intervention strategies that promote equity for Latin@ elders in aging well. The authors examine several social determinants of health and note that social support networks and community strategies influence and secure healthy aging within the Latin@ elder community in spite of health and mental health disparities. The networks of social support lead Latin@ older adults toward well-being while "aging in place". Vega (2010) refers to this process as Latin@ elders' "ability to retain an appropriate level of independent living in one's community and place of residence and have personal control over one's lifestyle" (p. 3). In spite of health disparities that result from structural inequalities, the authors emphasize three positive influences that affect healthy aging among Latin@ elders: (1) family relationships, (2) social support networks, and (3) health/mental health service delivery system within a community context. The authors illustrate community programs as best practice models that include cultural competence and interprofessional collaborations that challenge the structural inequities to reduce health and mental health disparities within the Latin@ elder population. In a collective spirit, community programs respond to ensure conditions for Latin@ elders to lead healthy lives and sustain optimal functioning.

References

Abraido-Lanza, A. F., Dohrenwen, B. P., Ng-Mak, D. S., & Turner, J. B. (1999). The Latino mortality paradox: A test of the "salmon bias" and health migrant hypotheses. *American Journal of Public Health, 89*(10), 1543–1548.

Administration on Aging. (2010, January). *A statistical profile of Hispanic older Americans aged 65*. Retrieved from www.aoa.gov/AoAroot/Aging_Statistics/minority_aging/Facts-on-Hispanic-Elderly-2008.aspx

Administration on Aging. (2012, February 10). *A profile of older Americans: 2011*. Retrieved from http://www.aoa.gov/Aging_Statistics/Profile/2011/10.aspx

Angel, J., Kahlert, R., & Whitfield, K. (2005, September). *Hispanic and Mexican American health and aging in a new century, an overview*. Key issues in Hispanic health and health care policy research, Lyndon B. Johnson School of Public Affairs. The University of Texas at Austin.

Angel, J. L., & Tienda, M. (1987). Determinants of extended household structure: Cultural pattern or economic need?. *American Journal of Sociology, 87*, 1360–1383.

Aranda, M. P., & Knight, B. G. (1997). The influences of ethnicity and culture on the caregiver stress and coping process: A sociocultural review and analysis. *The Gerontologist, 37*, 342–354.

Areán, P., Ayalon, L., Hunkeler, E., Lin, E., Tang, L., Harpole, L., et al. (2005). Improving depression care for older minority patients in primary care. *Medical Care, 43*(4), 381–390.

Association of Hispanic Mental Health Professionals. (2013). *Our accomplishments*. Retrieved on July 19, 2013 from http://www.ahmhp.org/accomplishments/index.php

Barusch, A. S. (2009). *Foundations of social policy: Social justice in human perspective* (4th ed.). Connecticut: Wadsworth Press.

Beyene, Y., Becker, G., & Mayen, N. (2002). Perception of aging and sense of well-being among Latino elderly. *Journal of Cross-Cultural gerontology, 17*, 155–172.

Born, W., Gerniner, K. A., Sylvia, E., Butler, J., & Ahluwalia, J. S. (2004). Knowledge, attitudes and beliefs about end-of-life care among inner-city African Americans and Latinos. *Journal of Pallatiative Medicine, 7*, 247–256.

Center for Disease Control and Prevention. (2012, October 11). *Hispanic or Latino populations*. Retrieved from http://www.cdc.gov/minorityhealth/populations/REMP/hispanic.html

Chavez-Korell, S., Delgado-Rendón, A., Beer, J., Rodríguez, N., Garr, A. D., Pine, C. A., et al. (2012). Improving access and reducing barriers to depression treatment for Latino elders: Un Nuevo Amanecer (a new dawn). *Professional Psychology: Research and Practice, 43*(3), 217–226.

Cohen, G. D. (2005). *The mature mind: The positive power of the aging brain*. New York: Basic Books.

Collins, K. S., Hughes, D. L., Doty, M. M., Ives, B. L., Edwards, J. N., & Tenney, K. (2002). *Diverse communities, common concerns: Assessing health care quality for minority americans* (pp. 1–68). New York: The Commonwealth Fund.

Coonrod, D., Bay, C., & Balcazar, H. (2004). Ethnicity, acculturation and obstetric outcomes: Different risk factor profiles in low-and high acculturation Hispanics and in White Non-Hispanics. *Journal of Reproductive Medicine, 49*(1), 17–22.

Crist, J. D., McEwen, M. M., Herrera, A. P., Kim, S. S., Pasvogel, A., & Hepworth, J. T. (2009). Caregiving burden, acculturation, familism, and Mexican American elders' use of home care services. *Research and Theory for Nursing Practice: An International Journal, 23*(3), 165–180.

Day, L. (2010). Health care reform, health. and social justice. *American Journal of Critical Care, 19*(5), 459–461. doi:10.4037/ajcc2010742.

Delgado, M. (1998). Puerto Rican elders and merchant establishments: Natural caregiving systems or simply businesses? In M. Delgado (Ed.), *Latino elders and the twenty-first century: Issues and challenges for culturally competent research and practice* (pp. 33–46). New York: The Haworth Press Inc.

Department of Health and Human Services. (2007). *Improving Hispanic elders' health: Community partnerships for evidence-based solutions: Project overview*. Retrieved on April 30, 20113 from http://www.academyhealth.org/ahrq/elders/overview.pdf

DiClemente, R. J., Crosby, R. A., & Kegler, M. C. (Eds.). (2002). *Emerging theories in health promotion practice and research: Strategies for improving public health*. San Francisco, CA: Jossey-Bass, John Wiley & Sons.

Dilworth-Anderson, P., Pierre, G., & Hilliard, T. (2012). Social justice, health disparities, and culture in the care of the elderly. *Journal of Law, Medicine, & Ethics, 40*, 26–31.

Donelly, J. W., Eburne, M., & Kittleson, M. (2001). *Mental health: Dimensions of self-esteem and emotional well-being*. Boston: Allyn & Bacon.

Falcon, L. M., & Tucker, K. L. (2000). Prevalence and correlates of depressive symptoms among Hispanic elders in Massachusetts. *Journal of Gerontology: Psychosocial and Social Sciences, 55*(2), S108–S116.

Falcon, L. M., Todorova, I., & Tucker, K. (2009). Social support, life events and psychological distress among the Puerto Rican population in the Boston area of the United States. *Aging and Mental Health, 13*(6), 863–873.

Fennell, M. L., Feng, Z., Clark, M. A., & Mor, V. (2010). Elderly Hispanics more likely to reside in poor-quality nursing homes. *Health Affairs, 29*(1), 65–73. doi:10.1377/hithaff. 2009.0003.

Forster, L., & Stoller, E. P. (1992). The impact of social support on mortality: A seven-year follow-up of older men and women. *Journal of Applied Gerontology, 2*(2), 173–186.

Franzini, L., Ribble, J. C., & Keddie, A. M. (2002). Understanding the Hispanic paradox. In T. A. Laveist (Ed.), *Race, ethnicity, and health: A public health reader* (pp. 280–310). San Francisco: Jossey-Bass.

Gallagher-Thompson, D., Coon, D., Solano, N., Ambler, C., Rabinowitz, Y., & Thompson, L. (2003). Change in indices of distress among Latino and Anglo female caregivers of elderly relatives with dementia: Site-specific results from the REACH national collaborative study. *The Gerontologist, 43*(4), 580–591.

Gallagher-Thompson, D., Gray, H., Dupart, T., Jimenez, D., & Thompson, L. (2008). Effectiveness of cognitive/behavioral small group intervention for reduction of depression and stress in Non Hispanic White and Hispanic/Latino women dementia family caregivers: Outcomes and mediators of change. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 26*(4), 286–303.

Geriatric Mental Health Alliance of New York. (July, 2012). *Geriatric mental health news*. Retrieved on June 13 from http://archive.constantcontact.com/fs073/1101456716765/archive/1110464920159.html#LETTER.BLOCK7

Global Policy Solutions LLC. (February, 2011). *The Latino age wave: What changing ethnic demographics mean for the future of aging in the United States*. Report by Hispanics in Philanthropy (HIP). Retrieved on May 1, 2013 from http://www.hiponline.org/storage/documents/HIP_LatinoAgeWave_FullReport_Web.pdf.

Gonzalez, H. M., Haan, M. N., & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results of the Sacramento area Latino study on aging. *Journal of the American Geriatrics Society, 49*(7), 948–953.

Hazuda, H. P., & Espino, D. V. (1997). Aging, chronic disease, and physical disability in hispanic elderly. In K. S. Markides & M. R. Miranda (Eds.), *Minorities, aging, and health* (pp. 127–148). Thousand Oaks: Sage.

Heisler, M., et al. (2007). Mechanisms for racial and ethnic disparities in Glycemic control in middle-aged and older Americans in the health and retirement study. *Archives of Internal Medicine, 167*(17), 1853–1860.

Heyman, J. C., & Gutheil, I. A. (2010). Older Latino's attitude toward and comfort with end-of-life planning. *Health and Social Work, 35*(1), 17–26.

Hispanic Health Council. (2006). *A profile on Latino Health in Connecticut: The case for change in policy & practice.* Retrieved May 1, 2013, from http://www.hartfordinfo.org/issues/wsd/health/Profile_Latino_Health.pdf

Iatridis, D. S. (1994). *Social policy: Institutional context of social development and human services*. Pacific Grove: Brooks/Cole Publishing.

Institute for Puerto Rican/Hispanic Elderly. (2013). Retrieved July 19, 2013 from http://www.iprhe.org/

Kim, G., Jang, Y., Chiriboga, D. A., Ma, G. X., & Schonfeld, L. (2009). Factors associated with mental health services use in Latino and Asian immigrant elders. *Aging & Mental Health, 14*(5), 535–542. doi:10.1080/13607860903311758.

Krakauer, E. L., Crenner, C., & Fox, K. (2002). Barriers to optimum end of life care for minority patients. *Journal of the American Geriatrics Society, 50*, 182–190.

Latino Geriatric Mental Health Workgroup of New York City. (2007). *Meeting the mental health needs of Latino elders.* Network of Care of Behavioral Health Online Newsletter. Retrieved

on A pril 29, 2013 from http://losangeles.networkofcare.org/mh/library/article.aspx?id=2587&cat=42
LaVeist, T. A. (2005). *Minority populations and health an introduction to health disparities in the United states* (1st ed.). San Francisco: Jossey-Bass.
Marmot, M. G., Adelstein, A. M., & Bulusu, L. (1984). Lessons from the study of immigrant mortality. *Lancet, 2*, 1455–1457.
Medina, C. (2011). Creating the Latino agenda for eliminating health disparities in communities: A call to action. In J. H. Schiele (Ed.), *Social welfare policy: Regulation and resistance among people of color* (pp. 271–291). Thousand Oaks: Sage.
Migrant Health Promotion. (2013). Retrieved July 19, 2013, from http://www.migranthealth.org/
Miltiades, H. B., Grove, S. A., & Drenovsky, C. (2010). *Understanding the impact of senior community center participation on elders' health and well-being*. Commonwealth of Pennsylvania—Department of Aging. Latino Center on Aging (nd). Mission. Retrieved on April 25, 2013 from http://www.gerolatino.org/english/5552/5615.html
Min, J. W., & Barrio, C. (2009). Cultural values and caregiver preference for Mexican-American and Non-Latin@ White elders. *Journal of Cross-Cultural Gerontology, 24*, 225–239.
Moody, H. R. (1998). *Aging: Concepts and controversies*. Thousand Oaks: Sage Publications Incorporated.
Motel, S., & Patten, E. (2013). *Statistical portrait of Hispanics in the United States, 2011*. Pew Hispanic Center, Washington, DC. Retrieved on April 12, 2013 from http://www.pewhispanic.org/2013/02/15/statistical-portrait-of-hispanics-in-the-united-states-2011/
Napoles-Springer, A. M., Santoyo, J., Houston, K., Perez-Stable, E. J., & Steward, A. L. (2005). Patients' perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations, 8*(1), 4–17.
National Institutes of Health. (2000). *NIH strategic research plan to reduce and ultimately eliminate health disparities.*
Negroni, L. K. (2007). [Latin@s stories of growing older in the United States]. Unpublished focus group data. Puerto Rican and Latin@ Studies Project, University of Connecticut School of Social Work.
Negroni, L. K. (2012). The Puerto Rican family. In R. Wright, C. H. Mindel, R. W. Habenstein, & T. V. Tran (Eds.), *Ethnic families in America: Patterns and variations* (5th ed., pp. 129–147). New York: Pearson Education Inc.
Negroni-Rodríguez, L. K., & Bok, M. (2004). *Understanding the impact of natural support networks on the physical and mental health of Latina elderly and the utilization and satisfaction with services*. Unpublished findings report, Puerto Rican and Latin@ Studies Project, University of Connecticut School of Social Work.
Negroni-Rodríguez, L. K., & Morales, J. (2001). Individual and family assessment skills with Latino/Hispanic. In R. Fong & S. Furuto (Eds.), *Culturally competent practice: Skills, interventions and evaluations* (pp. 132–146). Boston: Allyn and Bacon.
Nussbaum, M. C. (2006). *Frontiers of justice: Disability, nationality, species membership*. Cambridge: The Belknap Press of Harvard University Press.
Ortega, A. N., Feldman, J. M., Canino, G., Steinman, K., & Alegría, M. (2006). Co-occurrence of mental and physical illness in US Latinos. *Social Psychiatry and Psychiatric Epidemiology, 41*(12), 927–934.
Ortiz, V. (1995). The diversity of Latino families. In R. Zambrana (Ed.), *Understanding Latino families: Scholarship, policy, and practice* (pp. 18–39). Thousand Oaks: Sage.
Parra-Cardona, J. R., Meyer, E., Schiamberg, L., & Post, L. (2007). Elder abuse and neglect in Latino families: An ecological and culturally relevant theoretical framework for clinical practice. *Family Process, 46*(4), 451–470.
Paz, J., & Applewhite, S. L. (1998). Culturally competent practice. *Journal of Gerontological Social Work, 30*, 1–15.
Phipps, E. J., True, G., & Murray, G. F. (2003). Community perspectives on advance care planning: Report from the community ethics program. *Journal of Cultural Diversity, 10*(4), 118–123.

Piette, J. D., Heisler, M., & Wagner, T. H. (2004). Problems paying out-of-pocket medication costs among older adults with diabetes. *Diabetes Care, 27*(2), 384–391.
Powers, M., & Faden, R. (2006). *Social justice*. Oxford: Oxford University Press.
Ramos, B. M. (2007). Housing disparities, caregiving and their impact for older Puerto Ricans. *Journal of Gerontological Social Work, 49*(1/2), 47–64.
Rawls, J. A. (1971). *A theory of justice*. Cambridge: Harvard University Press.
Rosnick, C. B., & Reynolds, S. L. (2003). Thinking ahead: Factors associated with executing advance directives. *Journal of Aging Health, 15*, 409–429. doi:10.1177/0898264303015002005.
Rowe, J. W., & Khan, R. L. (1998). *Successful aging*. New York: Pantheon Books.
Ruiz, M. E., & Ransford, H. E. (2012). Latino elders reframing familismo: Implications for health and caregiving support. *Journal of Cultural Diversity, 19*(2), 50–57.
Sanchez-Ayendez, M. (1988). The Puerto Rican family. In C. H. Mindel, R. W. Habenstein, & R. Wright Jr (Eds.), *Ethnic families in America*. New York: Elsevier.
Siebert, D. C., Mutran, E. J., & Reitzes, D. C. (1999). Friendship and social support: The importance of role identity to aging adults. *Social Work, 44*, 522–533.
Sotomayor, M. (1992). *Empowering Hispanic families: A critical issue for the 90s*. Milwaukee: Family Service of America.
Stratton, A., Hynes, M. M., & Nepaul, A. N. (2009). *The 2009 Connecticut health disparities report.* Hartford: Connecticut Department of Public Health.
Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58*, 964–970.
Tucker, K. L., Mattei, J., Noel, S. E., Collado, B. M., Mendez, J., Nelson, J., et al. (2010). The Boston Puerto Rican health study, a longitudinal cohort study on health disparities in Puerto Rican adults: Challenges and opportunities. *BMC Public Health, 10*, 107. doi:10.1186/1471-2458-10-107.
U.S. Census Bureau Decennial Census. (2010). *American fact finder*. Retrieved July 19, 2013, from http://factfinder2.census.gov/faces/nav/jsf/pages/wc_dec.xhtml
Vega, W. A., & Alegria, M. (2001). Latino mental health and treatment in the U.S. In C. W. Molina & R. E. Zambrana (Eds.), *Health issues in the Latino community* (p. 179). San Francisco: Jossey-Bass.
Vega, W. A. (1995). The study of Latino families: A point of departure. In R. E. Zambrana (Ed.), *Understanding Latino families: Scholarship, policy, and practice* (pp. 3–17). Thousand Oaks: Sage Publications.
Vega, M. (2010). *Latinos "aging in place": Issues and potential solutions*. Unpublished paper presentation by the University of Southern California. Retrieved on 4/12/2013 from http://www.utexas.edu/lbj/caa/2010/presentations/VegaW.pdf
Vélez, D., & Cole, S. A. (2008). Culture, place of origin, and service delivery for older adult Latino immigrants: The case of Puerto Rican older adults. *Journal of Gerontological Social Work, 51*, 300–314.
Villa, V., & Torres-Gil, F. (2001). The health of elderly Latinos. In M. Aguirre-Molina, C. W. Molina, & R. E. Zambrana (Eds.), *Health issues in the Latino community* (pp. 157–178). San Fancisco: Jossey-Bass.
Vincent, G. K., & Velkoff, V. A. (2010). *The next four decades, the older population in the United States: 2010–2050*, Current Population Reports, P25-1138, U.S. Census Bureau, Washington, DC.
Wallerstein, I. (2005). Latin@s: What's in a name? In R. Grosfoguel et al. (Eds.), *Latin@s in the world-system: Decolonization struggles in the twenty-first century U.S. empire* (pp. 31–39). Boulder: Paradigm Press.
World Health Organization (WHO). (2013). *Commission on social determinants of health.* Retrieved May, 1, 2013 from http://www.who.int/social_determinants/thecommission/en/index.html
World Health Organization. (2011). *Social determinants of health: Key concepts*. Final Report of the Commission on Social Determinants of Health. Retrieved on May 1, 2013 from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html