

Current Conditions Among Older Latinos and African Americans in Low- and Middle- Income Los Angeles Neighborhoods



USC Social Work
*USC Edward R. Roybal
Institute on Aging*

Translating research into practice

Acknowledgements

The University of Southern California (USC) Edward R. Roybal Institute on Aging survey team would like to thank the residents in the East and South Los Angeles communities who welcomed us into their lives to conduct our community survey.

The principal investigators of this pilot community-based research survey were William A. Vega, PhD and Karen D. Lincoln, PhD. The co-investigators were Maria P. Aranda, PhD and Donald A. Lloyd, PhD. The investigators are all on the faculty of the USC School of Social Work.

We owe a special debt of gratitude to Dr. Lloyd, who was the lead author of this report. In addition, we thank members of the USC Roybal Institute staff: Iris Aguilar who reviewed sections of the draft report and provided useful comments, and Vincent Lim for his editorial assistance and work in designing this report for print. We must also thank Brian Goodman, the head graphic designer at the USC School of Social Work, who offered his expert advice and guidance along the way.

We must also express our gratitude to our dedicated survey team who worked tirelessly to collect the data.

The views expressed in this report are entirely those of the USC Roybal Institute research team and do not necessarily reflect the views of the USC School of Social Work.

Suggested Citation

USC Edward R. Roybal Institute on Aging. Current Conditions Among Older Latinos and African Americans in Low- and Middle-Income Los Angeles Neighborhoods. Los Angeles, CA: USC Edward R. Roybal Institute on Aging, 2012.

Funding

This survey was funded by the Southern California Clinical and Translational Science Institute (SC-CTSI grant # 1UL1RR031986-01) and the USC School of Social Work's Frances G. and Ernest P. Larson Endowed Fund for Innovative Research (Institutional Review Board approval # UP-10-00394-AM001).

Foreword

Aging baby boomers and their parents are changing the face of America. Like the rest of the nation, Los Angeles County is growing older. The county's senior population is projected to double in size in the coming decades and look very different than it does today.

In LA County, the ever-graying demographics have meant an increase in the number of older racial and ethnic minority residents among the general population, a trend that is likely to increase local health disparities in the coming decades in the senior population, and also among those currently 45-64 years old. A survey of older Los Angeles County residents conducted in 2007-2008 reported substantial race/ethnic differences in needs across several health-relevant areas: medication management, health information, benefit information and assistance, and caregiving needs.¹ White/Caucasian non-Latino elders reported the least need in each of these areas.

The long-term mission of the USC Roybal Institute is to work with community partners to build a locally-informed evidence base to design and implement more effective prevention and early intervention practices to improve the health and quality of life for older minority residents of Los Angeles. Toward that end, during the first half of 2011, USC Roybal Institute survey interviewers visited neighborhoods to gather information about physical and mental health, neighborhood environment and lifestyle resources, physical activity and recreation behavior, social network availability and adequacy, knowledge and sources of information about medication and nutrition, and health care access and utilization.

The purpose was to uncover the current living conditions and health status among older residents of East and South Los Angeles. The future demographics of Los Angeles will present major challenges and opportunities for health and human service providers. We hope our findings offer valuable insights for community stakeholders and provide guidance to local policymakers, leaders of service organizations, and practitioners who continue working to address the critical needs of Los Angeles County's aging population.



Karen D. Lincoln, PhD
Associate Director

William A. Vega, PhD
Executive Director

University of Southern California
Edward R. Roybal Institute on Aging
School of Social Work
Los Angeles, California
April, 2012



Executive Summary

Our report focuses on a specific segment of the current LA County older adult population and their struggles with economic insecurity and chronic health issues, which may provide a preview of what the future may reveal.

The USC Roybal Institute conducted a community survey to determine—in the wake of the recent economic crisis—the present living conditions and health status of older residents of East and South Los Angeles. More minority older adults in our survey areas are living on low incomes now than a decade ago², which raises serious concerns about how their daily needs are being met.

Among other findings, we found there were no distinct social group differences in the degree to which these residents were impacted by the economic downturn, though it was the least severe for the oldest. Overall, our survey sample had dramatically higher rates of serious psychological distress compared with other Latinos and African Americans in their age group in LA County. The rate of obesity was also greater than the county-wide rate for the same age and ethnic groups.

Despite these health challenges, economic difficulties and the potential threat of social isolation facing older adults, there remain many signs of hope that indicate both personal resourcefulness and opportunities for service agencies to help in improving and enhancing community-based services that will facilitate successful aging in place.

Key Findings

- **Older adults living with others had generally better physical and mental health.** About 21% of those living alone reported “poor” physical health compared to around 8% of those living with others. About 11% of those living alone reported “poor” mental health compared to around 6% of those living with others.
- **Younger elders were impacted the hardest by the recent economic downturn.** Participants aged 60–69 reported the greatest number of adverse conditions related to the economic downturn. We found no significant difference in the average number of economic challenges that were reported between men and women, or between Latinos and African Americans. However, Latinos were significantly more likely to have low incomes than African Americans (66% and 43%, respectively).
- **Women and seniors with lower incomes had higher rates of activity limitations.** There are implications for self-care and independence for those with low income. Among surveyed residents, 73% reported limitations doing vigorous activities and 56% had limitations when stooping, crouching or kneeling. Walking a quarter mile was challenging for 36%.
- **Obesity is a major concern among the older adult population that was interviewed.** Obesity is recognized as a rapidly growing health concern in the U.S. population, and over 80% of participants in our survey were clinically overweight or obese. Women were significantly more likely to be obese (50%) than men (31%).
- **Frailty increases the risk for serious psychological distress.** The prevalence of frailty and the high rate of pre-frail participants we encountered in our research raised some red flags: 18% were frail, and 67% pre-frail. Around 29% of the frail were suffering from serious psychological distress. Nevertheless, the prevalence of frailty was lower among individuals who lived with others.

Introduction

We selected field interviewers who were culturally responsive to the concerns of either older Latinos or African Americans, to conduct in-person interviews with over 250 Latino and African American residents, typically in their homes. The interview followed a brief cognitive assessment; whenever an older adult was unable to perform effectively on the cognitive screener, the caregiver provided information using a shortened version of the questionnaire. Participants were chosen primarily from randomly selected households in South and East Los Angeles to represent older minority group members who live in those communities. However, we caution readers that our statistical findings are not intended to be representative of the complex demographics of South LA and East LA. We hope that the findings in this report will inform decision making by community stakeholders, and provide guidance to local policymakers and leaders of aging and health service-providing organizations.

Who is described in this report?

We conducted face-to-face interviews with 114 Latino and 139 African Americans, whose average age was 74 years and ranged from 60 to 100, residing in South Los Angeles (Crenshaw and Inglewood neighborhoods) and East Los Angeles (primarily Boyle Heights and Northeast LA). Again, we caution readers that our results are not intended to be representative of all of South LA and East LA; the specific areas we sampled were selected because they had the highest rates of resident African American and Latino seniors. Participants had lived an average of 46 years in Los Angeles County. Two-thirds of participants in the survey were born in the United States; the 33% (85 individuals) who were born outside the United States had been in the country for 37 years on average. Just over half (56%) of the foreign-born residents were from Mexico, with the rest coming predominately from Central America (the largest percentage [13%] of Central America immigrants were from El Salvador).

The percentage of married (or in a marriage-equivalent relationship) and sex ratio did not differ across race/ethnicity, however Latino men were somewhat more likely to be married than their African American counterparts.

- 25% of the sample had a spouse or domestic partner;
- 30% of the sample was male
- men (40%) were twice as likely as women (19%) to be currently married or living as married.

Nearly half of our participants had less than a high-school education (45%) overall, with a substantially greater level of attainment among African Americans (79% earned a high school diploma and/or GED) than Latinos (27%); more than half of Latinos had less than an 8th grade education (52%).

Overall Participant Characteristics

- 253 surveys conducted and entered for analysis (12 were proxy interviews)
- 180 women, 73 men; 58% lived alone
- 65 married, 77 widowed, 88 divorced, 23 never married
- average age 74 (range 60 to 100)
- 114 Latino, 139 African American
- 85 born outside the United States, average 37 years here (70% of the Latinos, 5% of Blacks immigrated)
- 95% have lived in LA County for more than 10 years
- 45% have not graduated high school (average 10.6 years of education)

men twice as likely as women to be currently married





more minority seniors live on low income than a decade ago

What are their economic circumstances?

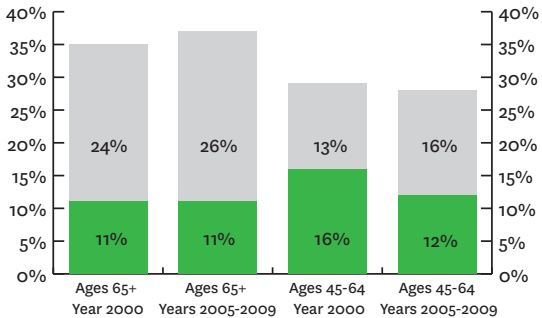
As shown in Figure 1, the proportion of seniors living on modest incomes has increased somewhat in the last decade. According to the most recent 5-year averages (2005-2009) from the U.S. Census Bureau’s American Community Survey, 11.4% of residents aged 65 and older in our survey area had incomes below the federal poverty level (FPL), up slightly from 11.0% in the 2000 Census. However, 37.6% of the older population lived on income below two-times the FPL, an increase of 2.6% since 2000. In contrast, the percentage of residents living in the same area aged 45-64 almost had no change over the decade. (These change estimates are conservative, as the economic downturn began midway through the 5-year averaging period; more recent data are unavailable at the census tract level.)

would still owe money if they could sell everything they own, and 20% said that they would remain in debt.

Over half (52.9%) reported household income below \$15,000 per year. Latinos were significantly more likely to have lower incomes than were African Americans (65.6% and 42.7%, respectively).

Over a third said it was “somewhat difficult” or “very difficult” to pay for their housing (37.7%), food (34.0%), and medical expenses (38.8%), and the proportion with income below \$15K who said that paying is somewhat or very difficult was similar (about 45%) for all three types of expenses. A difference does appear, though, when comparing just those who said it was “very difficult” to pay.

Fig. 1: Poverty Ratio Trend by Age Group
Census Tracts covering Study Areas, 2000 Census
and American Community Surveys 2005-2009



■ below poverty level ■ between poverty level and 2x poverty

More than three-quarters of our sample (78%) reported that they were retired from work, and about 9% were employed (most were part-time). Just 3% reported their status as “unemployed.” Debt was a significant problem for part of this population. A quarter of participants answered that there was at least one month during the past year when they could not pay off a household or personal debt (other than a car loan, business loan, or mortgage); 15% said that had been the case for all 12 months. One-third owned the home they lived in. Everyone was asked if they

Fig. 2: Very Difficult to Pay for...

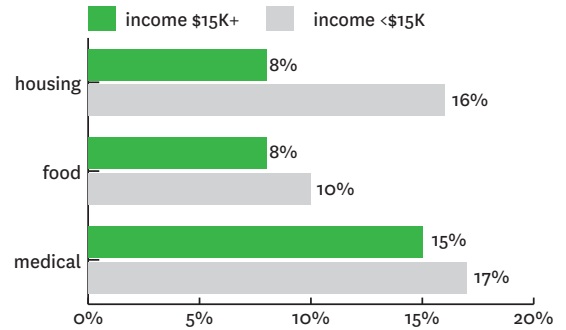


Figure 2 shows that low income is most clearly linked to difficulty with housing expenses, while similar proportions of our respondents above and below the \$15K income level report that it is very difficult to pay for medical expenses. A lower proportion in both income groups said it was very difficult to pay for their food. When asked whether cost had prevented them from seeing a doctor when they needed to during the past year, very few (7.5%) said that it had.

Monthly budgets were extremely tight for most of our participants. We asked, “at the end of the month, do you usually end up with some money left over, just enough to make ends meet, or not enough money to make ends

meet?” While one in five said they had some money left over, 42.2% said there was not enough; Latinos were more likely than African Americans to say “not enough” (48.6% and 37.3%, respectively), while equal proportions said “just enough” (38% and 37%).

Some changes in participants’ economic circumstances were attributed to the recent economic downturn. Of the seven specific changes we asked about, the loss of employment by someone in the family other than the participant was most prevalent at 38.4%, followed by having to sell belongings or use up savings to pay the bills, reported by 29.9%, and having personally lost one’s usual source of income, reported by 24.9%.

What Changes Have Happened Due to the Country’s Economic Situation?

- someone in the family lost a job and has been unable to find another (38%)
- had to sell something important to use up savings (30%)
- have been unable to pay bills that were able to pay before (28%)
- have lost their usual source of income (25%)
- someone in the house lost a job and had to take a lower-paying one (16%)
- someone had to move in for economic reasons (14%)
- had to move from own home to live somewhere else (13%)

Are older minority group members well socialized?

We found that nearly six in ten of the survey participants lived alone. This rate of living alone among our participants was much greater than for the same age group statewide. The California Health Interview Survey (CHIS) reports that 22% of all seniors live alone, with rates of 26% for African American and 16% for Latino older adults.³ This might be attributed to the greater proportion of our survey participants who were widowed, separated, divorced, or who had never married (74%) compared with those of the same statuses in the CHIS sample of Californians aged 60 and older (40%).

Women in this survey were somewhat more likely to live alone (61%) than men (49%), and African Americans were more likely to do so (63%) than Latinos (51%). While just 6% of those who were married lived alone, the greatest rate was for the never-married (83%). Foreign-born (largely Latino) residents were somewhat less likely to live alone (51%) compared with the U.S. born (61%). While 58% of all participants lived alone, those who were interviewed in affordable independent living senior apartments (73 out of 253 participants) were more likely to report living alone (89%) than those in regular housing (45%). When those in affordable independent living senior apartments were excluded the overall rate of living alone was lower, but the demographic patterns remained.

Over half of those living alone reported that they “have contact with family or relatives nearly every day” (57%). We assume that most older people who live with others live with family or relatives; but less than half who live with others (42%) said they had contact almost every day with family or relatives who live elsewhere. The difference in having almost daily contact with friends also favored those who live alone (50% compared with 31%) of those living with others. Similarly, those living with others were three times more likely to report having less than monthly contact with friends (21%) compared with those living alone (7%).

many live alone but maintain their social relationships

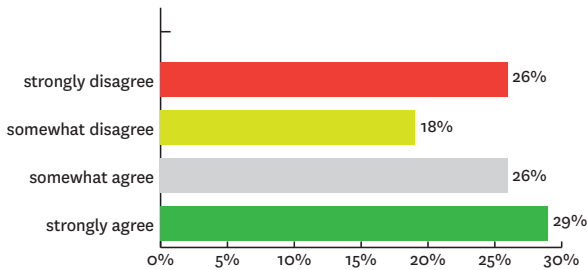




though more than half agree somewhat or strongly that stores are accessible on foot, nearly half do not enjoy that convenience

How accessible are stores in the neighborhood?

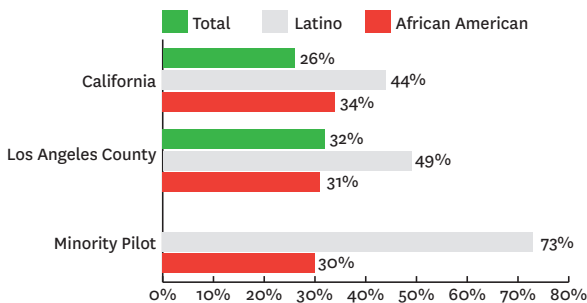
Fig. 3: Stores are within Easy Walking Distance



Is living with others associated with having better health?

We asked, “How would you rate your overall physical health at the present time?” with “excellent,” “very good,” “good,” “fair,” and “poor” as answer categories. The percentage who reported that their physical health was “fair” or “poor” was nearly identical to those who lived with others (48%) and those who lived alone (50%). The general health reported by our Latino participants is more likely to be “fair” or “poor” compared with their ethnic group counterparts of the same age for Los Angeles County, and for the State of California, as shown in Figure 4.

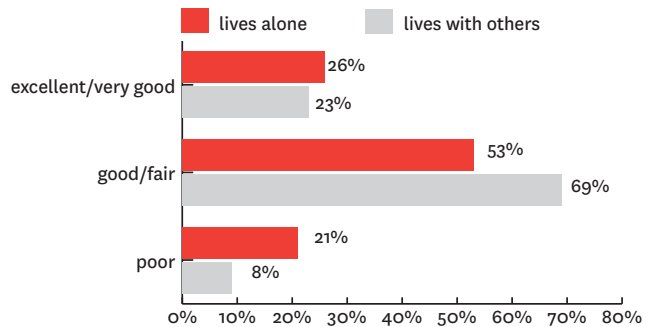
Fig. 4: General Health is “Fair” or “Poor”
Source: state and county rates from CHIS subsample ages 60+



It is significant to note that the total percentage of those reporting “fair” or “poor” health in LA County and California include individuals from all racial/ethnic groups; the minority pilot survey data only includes Latino and African Americans respondents.

However, this picture changed dramatically when comparing “poor” health as a separate category in Figure 5: while 8% of those who live with others report poor physical health, the rate is 21% among those living alone.

Fig. 5: Overall Physical Health



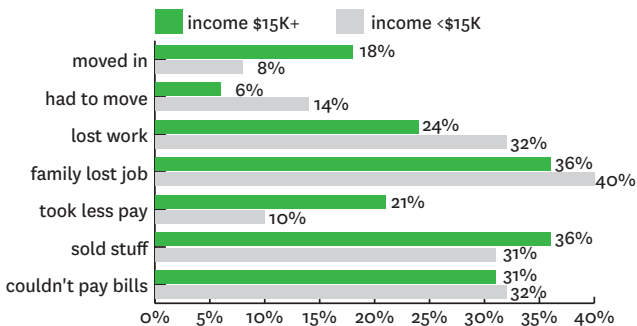
Similarly, when asked about their present mental health, 6% of respondents living with others reported “poor,” while this rating was given by 11% of those living alone. However, the presence of serious psychological distress, using a clinical screening instrument, suggests that there is no great difference (10% vs 12%). Nevertheless, the prevalence of serious psychological distress in our sample was much greater compared with African Americans and Latinos aged 60 and older in the CHIS for LA County, where the combined county-wide rate is only 4%.

Are health status and activities of daily living limitations related to economic circumstances?

We considered two indicators of economic circumstances: household income level and the number of adverse conditions attributable to the economic downturn. To gauge the latter, we asked whether: a) anyone has had to

move in because of job loss or other financial pressure; b) the participant had to move to live somewhere else; c) had lost his or her usual source of employment income; d) a family member had lost a job and been unable to find another; e) a household member lost a job and had to take another that paid less; f) one had to sell something important or use up savings to make ends meet; and g) one had been unable to pay bills that he or she could have paid before the economic trouble started. As noted in Figure 6, the most prevalent economic consequences were someone in the family having lost employment, having had to sell something important or use up savings, and having lost one's own source of employment income. Interestingly, the measure of low household income was unrelated to the number of economic impact indicators reported, but some differences in the rates of individual indicators by income level is more revealing. In our sample of residents 60 and older, the youngest group (60-69) had the greatest number of economic consequences, average 2.3, followed by the next oldest group (70-79) with an average of 1.6, and the lowest exposure among those aged 80 and older, with an average of 1.1. There was no difference in average number of economic consequences between men and women, or between Latinos and African Americans.

Fig. 6: Economic Consequences

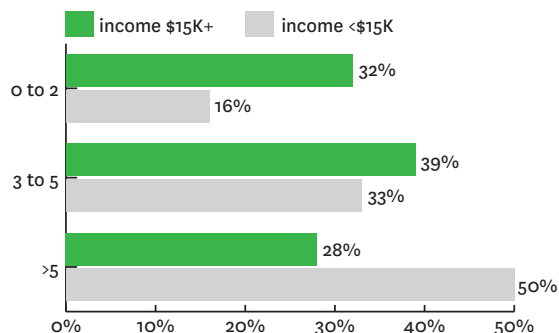


The summary measure of economic impact was not associated with self-rated measures of physical or mental health; additional tests revealed no association between this count and our measures of lifetime health conditions, activity limitations or depression. We found two

associations involving individual economy-related changes and health: having someone move in was related to better self-reported physical health, while someone else in the household losing employment was associated with having more lifetime illnesses.

Of 23 lifetime health conditions we asked about, the most prevalent reported were hypertension (73%), arthritis (63%), diabetes (37%), vision problems (29%), and back trouble (28%). Only four participants reported they had never had any of the conditions on our list, while the median number of lifetime conditions was four. The number of these illnesses was strongly associated with income level. As shown in Figure 7, half of those in the lower income category reported more than five illnesses. A similar pattern occurs in relation to self-rated physical health, with 60% of the lower-income group reporting "fair or poor" compared with 34% of the higher-income participants, and self-rated mental health, with 35% and 18% respectively reporting "fair or poor."

Fig. 7: Lifetime Illnesses



The survey also measured activity limitations, counting how many kinds of daily living activities the respondent could not perform on his or her own without difficulty. Living alone was completely unrelated to these limitations among women, while men who live alone appeared on average to be slightly less limited than those living with others.

physical health and mental health both worse among those living alone

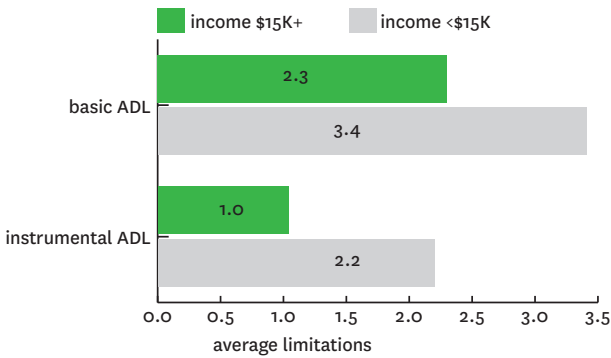




younger elders hit hardest by recent economic downturn

Activity limitations were measured using 10 questions about basic activities of daily living, and 14 instrumental activities, scored by counting the number of activities in each list with which the participant reported having difficulty. Thirty-eight people reported no limitations, while 40 reported just one; 87 had between 2 and 5 limitations, while 88 had more than 5. Both types of activity limitation are associated with household income level, shown in Figure 8.

Fig. 8: Activity Limitations

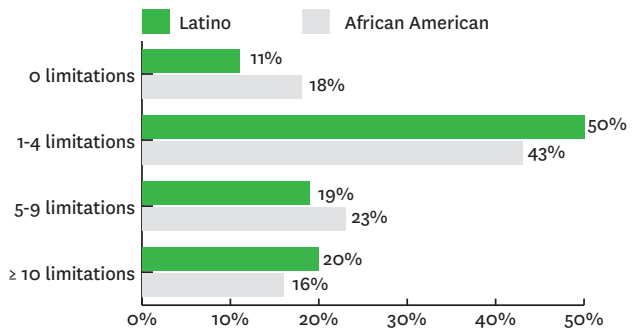


Race/ethnicity differences are shown in Figure 9. In terms of differences according to sex, women had significantly higher average basic activity limitations compared with men, while there was no difference in the level of instrumental activity limitations. The most frequently reported basic activity limitations were:

- in doing vigorous activities (73%),
- stooping, crouching, or kneeling (56%),
- lifting or carrying 10 lbs. (38%),
- walking a quarter mile (36%), and
- being unable to walk up 10 steps without resting (30%).
- difficulty doing light housekeeping topped the list of instrumental activities (25%),
- difficulty doing the laundry (22%),
- shopping for groceries and personal items (20%),

- difficulty in preparing a full meal without help (20%),
- not being able to control bowel and bladder completely (18%).

Fig. 9: Activity Limitations by Race/Ethnicity scores combining 10 basic and 14 instrumental activities of daily living



To what extent are activity limitations, physical health, and mental health interrelated?

Depressive symptoms during the past 30 days were measured using a shortened version of the Center for Epidemiological Studies-Depression Scale (CES-D). The average depression score was significantly higher in the lower-income group. Another measure of psychological malaise that was used, the Kessler-6, also revealed significant differences across income groups. A dichotomous version of this measure that screens for serious psychological distress was elevated in the low-income group (14% positive compared with 8%) but the association was not statistically significant.

Beyond looking at activities of daily living, we also examined the rates of frailty of our participants. Although many community service agencies serve frail older adults, the definition of what constitutes frailty differs widely across service sectors. For the purpose of this survey, we define frailty as a geriatric syndrome that goes beyond measures of functional impairments, and which is marked by significant decreased reserves in multiple organ systems.

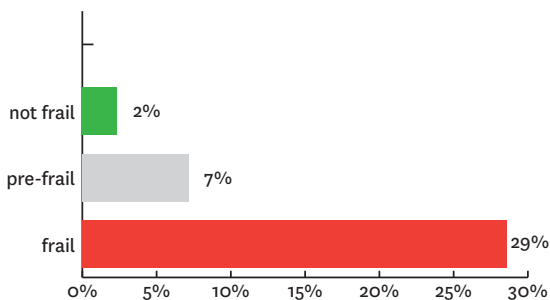
Using a frailty measure comprised of both self-report and performance items, we found the following frailty rates:

- 18% were frail,
- 67% pre-frail, and
- 15% non-frail.

This means that almost 9 out of 10 respondents were categorized as frail or pre-frail. This is important because frailty status has been shown to be associated with increased risk for falls, caregiver burden, hospitalization, and mortality.

We also wanted to examine if frailty was associated with mental health. As shown in Figure 10, we found that serious psychological distress increased with frailty status. In other words, people who were classified as frail (29%) were 4 times more likely to report serious psychological distress than those who were pre-frail (7%), and almost 10 times as likely as those who were not frail (2%).

Fig. 10: Serious Psychological Distress Related to Frailty Status among Older Adults



Not unexpectedly, there was a clear correlation between the number of activity limitations and the number of lifetime illnesses. Using a measure that combined basic and instrumental activities, we found an average 3.0 illnesses among those with not more than one activity limitation, 4.6 illnesses among those having 2 to 5 limitations, and an average of 6.3 lifetime illnesses among participants who reported more than 5 activity limitations. Illnesses that

were most strongly associated with the level of activity limitation were arthritis, stroke, circulatory problems (or “hardening of the arteries”) and osteoporosis.

Consistent with the association between lifetime illnesses and activity limitations, the rate of reporting poor physical health, shown in Figure 11, increased with increasing level of limitation. The self-reported measure of overall mental health showed the same pattern of relationship as physical health, in Figure 12.

Increased activity limitation was associated with higher depressive symptom scores using the CES-D, and with greater body mass index (BMI), which is a ratio of weight to height and an indicator of obesity.

Fig. 11: Overall Physical Health and Activity Limitations

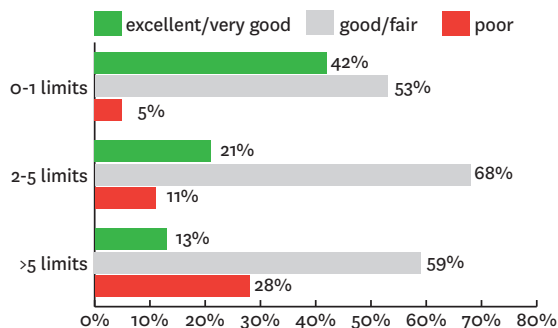
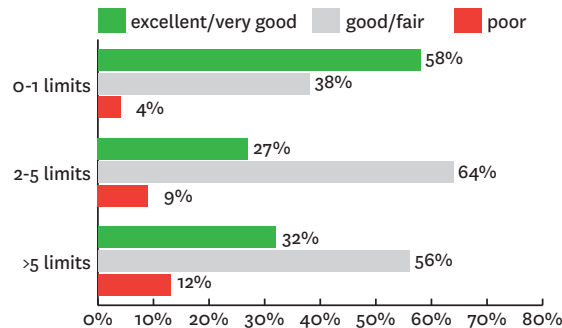



Fig. 12: Overall Mental Health and Activity Limitations



less activity limitations for those with higher income

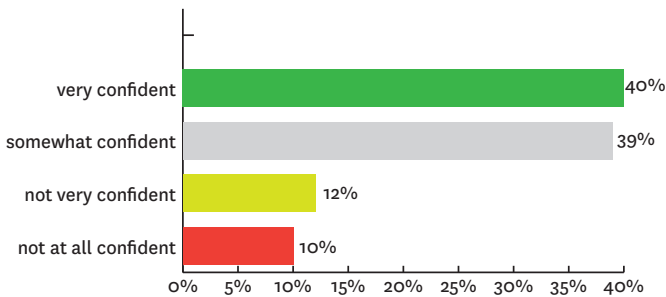




over 80% in this survey were clinically overweight or obese

What factors are related to obesity?

Fig. 13: How Confident are You that You are Eating the Fruits and Vegetables that You Need?



Obesity is recognized as a rapidly growing health concern in the U.S. population, and older minorities are not exempt; in our sample nearly half (45%) had a body mass index score greater than 30, which is the point that distinguishes the obese from those who are overweight. The rate of obesity declined with age. Among those aged 60 to 69, 56% were obese, as were 50% of those aged 70 to 79, and 19% in the oldest group. This may be because obese people have a shortened lifespan. While we found no ethnic group difference, women were significantly more likely to be obese (50%) than men (31%). Compared with the CHIS level of 74% of Latinos and African Americans 60 and older in Los Angeles County who were overweight or obese, our sample had 82% in those categories.

Activity limitations were more common among the obese, as were the number of lifetime illnesses, while we found no relationship between obesity and mental health. Diabetes, which is frequently discussed in conjunction with the obesity epidemic, was reported by 44% of the obese in our sample, compared with 31% among those who were overweight or normal weight. It was a surprise, then, to find that there was no difference in self-rated overall physical health between the obese and those who were not.

Summarizing social group differences

Our survey of minority elders living in the community covered a very broad range of topics. We thought it would be useful to describe how those in different social groups within this population fare in terms of having social and psychological assets to support aging in place. In order to summarize some of the data, we created an index meant to represent what we've called "quality of life (QOL) for aging in place." The measure covers four domains: social integration, community, infrastructure, and one's personal sense of control. Someone who is highly socially integrated has regular communication with friends and relatives, does not live alone, and has an intimate partner relationship. The community dimension of QOL is indicated by living among others who share values, who offer cooperation and assistance, and provide a sense of belonging. Community infrastructure to support aging in place includes adequate transportation, safety, and accessibility to goods and services. Finally, quality of life depends on the capacity to act to maintain what is desirable and change things that are not—an ability that first depends on having a sense of personal control.

We counted seven components to form a score for each survey participant, which can range from 0 to 7. The components are: 1) lives with at least one other person; 2) is married or living as married; 3) is in a neighborhood that is above the median score on neighborhood cohesion; 4) neighborhood is above the median on an accessibility score; 5) has a score above the median on a 5-item index of personal mastery; 6) has daily contact with relatives who live in a different residence; and 7) has at least weekly contact with friends.

The modal score in our sample is 3 out of a possible 7 QOL components; just 4 survey participants had none of these assets, and 9 individuals had all 7. Sixty-one (25.5%) people had the median score of three. In that group, the most common asset was contact with friends, followed by contact with relatives outside the home. Being married (or equivalent) was least common among those at the median QOL. Correspondingly, none of the 28

people whose QOL score was 1 had a spouse or intimate partner. Some group differences in the average level of QOL were apparent. African Americans have a higher average score (3.58) than Latinos (3.07); the average score increases significantly with increasing level of education; not surprisingly the score is greater for married people (4.66) compared with the formerly-married (2.95) and never-married (2.50). It is noteworthy that the difference between the married and others is greater than 1.0, which suggests that marriage is accompanied by additional QOL assets. There was no difference between men and women, but the index declines significantly with age.

The QOL index is correlated with health: we found that it declines with poor self-rated physical health, mental health, and with increasing activity limitations. The strongest correlation is with mental health. (The correlation is $-.35$ with a single-item measure of self-rated mental health, and $-.35$ with a 12-item version of the Center for Epidemiologic Studies Depression scale.)

While having health problems and activity limitations may erode one's QOL assets, it may well be the case that these social-environmental and psychological elements can be protective against health problems in advancing age.

Conclusion

We surveyed 253 Latino and African Americans aged 60 and older who reside in neighborhoods of Los Angeles that were selected for their concentration of Latinos and African Americans. We learned about their present economic situations in the wake of the recent economic downturn, their living situations and social relationships, and patterns of activity limitation and health history. There were no distinct social group differences in the degree to which these residents were impacted by the economic downturn, except that it was least severe for the oldest participants. No significant difference in health was found in relation to differences in circumstances attributable to the recent changes. However, there was greater material hardship among Latinos, who have lower education and income on average, and who live in a more homogeneous

area than our African American sample. Presumably, the current material resources reflect the long-term socioeconomic circumstances of our participants. Difficulty in paying for housing was the most distinctive difference between those with below our survey's median income and those above. Lower income was related to worse physical and mental health and greater activity limitations. We found that those who lived alone generally had at least as frequent contact with friends and relatives outside the home as those who lived with others, but they rated their mental health as poorer on average. Overall, our survey participants had dramatically higher rates of serious psychological distress compared with Latinos and African Americans in their age group in LA County. The rate of overweight and obesity individuals was greater than the county-wide rate for the same age and ethnic groups.

Despite all the challenges facing older adults, there are many signs of hope that indicate both personal resourcefulness and opportunities for service agencies to assist in improving and enhancing community-based services that will facilitate successful aging in place.



older adults in South and East LA are remarkably resourceful



Methodological Appendix

Our sample of respondents was drawn from randomly selected households within pre-selected census tracts in East and South Los Angeles that had been chosen to yield greater likelihood of finding Latino and African American residents aged 60 and older. We purchased address lists for the selected neighborhoods and sent advance letters to the target sample of households to describe the project and to announce that our staff would be visiting the area soon. We hired and trained nine survey-takers, who were themselves either Latino or African American, to conduct in-person survey interviews. An appointment for interview was made with the potential participant when he or she was found to be qualified and agreed to participate. A modest cash incentive of \$20 was paid to those who participated. The interviews lasted approximately 90 minutes on average. The staff were trained in the objectives of the survey, in asking the survey questions in a neutral way, in taking physical measurements including height, weight, and a timed walk task, and in procedures that would ensure participant confidentiality and safety.

Our survey measures came from a variety of social science and psychological survey sources, and some were adapted for brevity as it was our aim to minimize respondent burden. Those that are mentioned in the text are included in the references section at the end of this report.

Several of the concepts mentioned in the report are elaborated here. Competency for personally responding to the survey questions was assessed using the Callahan Brief Cognitive Screen.⁴ K-6 is a set of six questions that elicit psychological symptoms over the past month, designed to screen respondents for the likely presence of serious mental illness.⁵

We used a 12-item version of the original 20-item Center for Epidemiologic Studies Depression Scale, which assessed depressive symptomatology over the past 30 days.⁶ Poverty status is measured in the U.S. Census with a method that considers income along with other factors that determine poverty status. From the Bureau's glossary: "...the Census Bureau uses a set of money income thresholds that vary by family size and composition to detect who is poor. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being 'below the poverty level.'" We report census data that describes the population below this threshold, as well as between that level and a threshold that is set at twice as high. The term "geriatric syndrome" is used to capture those clinical conditions in older persons that do not fit into discrete disease categories. Many of the most common conditions cared for by geriatricians, including delirium, falls, frailty, dizziness, syncope and urinary incontinence, are classified as geriatric syndromes.

Decreased reserves refers to the pathophysiology of diminishing capacity of an organ to perform, leading to organ failure and functional disability, called homeostenosis.

As the survey interviews were completed the staff securely returned the questionnaires and visit records to our office, where student assistants entered the data for computer analysis. The data files and questionnaires are stored securely in compliance with USC's Institutional Review Board guidelines for the protection of human subjects.

References

- ¹ Community and Senior Services, County of Los Angeles. "LA County Seniors Count!: Survey of the Older Adult Population." Los Angeles, CA. County of Los Angeles: 2008.
- ² U.S. Census Bureau. Census 2000; 2009 American Community Survey.
- ³ California Health Interview Survey (CHIS), 2009. University of California [www.chis.ucla.edu, accessed February 2 2012].
- ⁴ Callahan, Christopher M., Frederick W. Unverzagt, Siu L. Hui, Anthony J. Perkins, and Hugh C. Hendrie. (2002). "Six-Item Screener to Identify Cognitive Impairment Among Potential Subjects for Clinical Research." *Medical Care*, 40 (9): 771-781.
- ⁵ Kessler, Ronald C., Peggy R. Barker, Lisa J. Colpe, Joan F. Epstein, Joseph C. Gfroerer, Eva Hiripi, Mary J. Howes, Sharone-Lise T. Normand, Ronald W. Manderscheid, Ellen E. Walters, and Alan M. Zaslavsky. (2003). "Screening for Serious Mental Illness in the General Population." *Archives of General Psychiatry*, 60:184-18.
- ⁶ Radloff, Lenore S. (1977). "The CES-D Scale: A New Self-Report Depression Scale for Research in the General Population." *Applied Psychological Measurement*, 1:385-401.

For additional information about this report, please contact:

University of Southern California
Edward R. Roybal Institute on Aging
School of Social Work
Montgomery Ross Fisher Building
669 West 34th Street
Los Angeles, CA 90089-0411
(213) 740-1887
uscroybal@usc.edu

*Design: Vincent Lim
Printing: Chromatic, Inc.*

University of Southern California
Edward R. Roybal Institute on Aging
School of Social Work

Montgomery Ross Fisher Building
669 West 34th Street
Los Angeles, CA 90089-0411
(213) 740-1887

roybal.usc.edu

USC Social Work
*USC Edward R. Roybal
Institute on Aging*

Translating research into practice