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## Assets and Unmet Needs of Diverse Older Adults: Perspectives of community-based service providers in Minnesota

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### **Cover Page Footnote**

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## **Assets and Unmet Needs of Diverse Older Adults: Perspectives of community-based service providers in Minnesota**

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### **ABSTRACT**

This paper examines assets and unmet needs of diverse older adults and highlights the need for programs and policies that address the social determinants of health. The United States is undergoing an unprecedented demographic shift, becoming increasingly diverse and aging rapidly. Given these changing demographics, it is important to understand the strengths and needs of our diverse population of older adults. This study captures perspectives of diverse service providers who work with older adults in communities, to identify existing assets as well as unmet needs and challenges facing diverse older adults in Minnesota. Qualitative data were collected using key informant interviews with community-based service providers (N=15) as part of a year-long engagement project. Participants were purposively selected to represent African American, East African, American Indian, Southeast Asian, Latino, and lesbian, gay, bisexual, and transgender (LGBT) communities. Interviews were recorded, transcribed verbatim, and analyzed using Braun and Clarke's approach to thematic analysis. Results indicate a number of assets supporting Minnesota's diverse older adults. Assets of cultural communities include culturally specific services, faith communities, and close-knit families. Assets of older adults include their cultural and historical knowledge, wisdom, experience, and resilience. Despite the many assets supporting diverse older adults, results indicate seven primary categories of unmet needs: (1) health (2) healthcare, (3) transportation, (4) housing, (5) education, (6) social support, and (7) financial security. All unmet needs sub-themes address health or social determinants of health, indicating the need for a broad range of policies and programs. As the U.S. population grows increasingly older and more diverse, it is critical that these unmet needs are addressed to ensure equity for aging well.

**Keywords:** Older adults; aging; health disparities; minority health; health equity; social determinants of health

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## INTRODUCTION

The demographics in the United States are changing. By 2035, for the first time in U.S. history, the number of older adults (ages 65 and older) will be greater than the number under the age of 18 (US Census Bureau, 2018). The number of Americans 65 years and older is estimated to grow from 55 million in 2019 to 88 million by 2050 (Alzheimer's Association, 2019). The older adult population, like the rest of the U.S. population, is becoming increasingly diverse. In 2016, immigrants made up 13.5 percent of the older adult population (the majority coming from Latin America and Asia) and their numbers are expected to continue to grow in the coming decades (Population Reference Bureau, 2013; Roberts, Ogunwole, Blakeslee, & Rabe, 2018). Between 2017 and 2060, the share of the older adult population (65 years and older) that is non-Hispanic white is expected to decrease from 77 percent to 55 percent, while the share of the older adult population that is Hispanic/Latino is projected to increase from 8 percent to 21 percent in the same time period (U. S. Census Bureau, Population Division, 2018). Programming and policies that impact older adults have been primarily developed with white older adults in mind, as whites have accounted for the largest share of the older adult population. Due to the changing demographics of the U.S., it is critical to identify the assets and challenges experienced by diverse older adults in order to ensure their experiences are considered when developing policy and programming.

### Health Disparities

Racial and ethnic minorities in the U.S. experience a disproportionate burden of a number of chronic diseases such as diabetes, obesity, hypertension and cardiovascular disease (Bell, Thorpe, Bowie, & LaVeist, 2018; Nadruz et al., 2018; Walker, Williams, & Egede, 2016). It is also well documented in burgeoning research that lesbian, gay, bisexual, and transgender (LGBT) older adults experience significant health disparities in comparison to their non-LGBT peers including higher rates of stroke, cancer, asthma, arthritis, disability, mental distress, and sleep problems (Fredriksen-Goldsen & Kim, 2017).

These health disparities continue throughout the life course, often accumulating in old age (Glymour & Manly, 2008). For example, a national survey of American Indian and Alaska Native older adults (55 years and older) found that 89.7 percent had been diagnosed with at least one chronic disease and almost 70 percent had 2 or more chronic diseases (Adamsen, Schroeder, LeMire, & Carter, 2018). Hispanic/Latino and black older adults (65 years and older) are more likely to need help with personal care from another person than white non-Hispanic older adults (Clarke, Norris, & Schiller, 2019). African American, American Indian, and Hispanic older adults are also at a greater risk for dementia than white older adults (Alzheimer's Association, 2019; Mayeda, Glymour, Quesenberry, & Whitmer, 2016). Disparities in dementia risk are primarily a result of a higher rate of health conditions associated with increased risk of dementia (e.g. cardiovascular disease and diabetes) and disparities in socioeconomic risk factors experienced throughout the life course (e.g. lower levels of education, higher rates of poverty, greater exposure to adversity and discrimination) (Glymour & Manly, 2008). African American and Hispanic older adults are more likely to have dementia that is not diagnosed than their white counterparts (Alzheimer's Association, 2018). It should also be noted that dementia prevalence and incidence are not well understood in Asian American and Pacific Islander older adults because of a lack of data disaggregated by country of origin. (Schafer, Chun, & Lum, 2017).

### Linguistically and Culturally Relevant Services

A lack of culturally and linguistically relevant services is an additional challenge for many diverse older adults. In part because services are not linguistically and culturally relevant, diverse older adults are underrepresented in those seeking social services (e.g. programs funded by the Older Americans Act), even though they have a greater need for these services than older adults in the general population (Diverse Elders Coalition, 2017; National Hispanic Council on Aging, 2015). Many older adults, particularly those who are immigrants, have limited English language proficiency. More than 5 percent of all individuals 65 years and older have limited English proficiency (Ruggles et al., 2019). Approximately 56 percent of Asian American and Pacific Islander, 11 percent of American Indian/Alaska Native, 53 percent of Latino, and 85 percent of Southeast Asian older adults have limited English language proficiency (National Asian Pacific Center on Aging, 2013). With the exception of Spanish, services typically are not available in the native languages spoken by these older adults.

The need for culturally relevant services extends beyond language. For example, LGBT older adults have reported concerns of having to “go back into the closet” in retirement communities or healthcare facilities out of fear of homophobic or transphobic staff and residents. Latino elders have reported a need for services that recognize the value of the family unit and the importance of including multiple generations of the family in their care (Diverse Elders Coalition, 2017).

#### Conceptual Framework

This study was informed by Solar and Irwin’s (2010) Commission on Social Determinants of Health conceptual framework. The framework describes how social, economic, and political mechanisms (e.g. macroeconomic policy, labor market, welfare policy, education policy) impact socioeconomic position whereby populations are stratified based on their income, education, and occupation in addition to stratification by gender and race/ethnicity. Socioeconomic position is considered a fundamental determinant of health, and shapes exposure to intermediate determinants of health (e.g. housing, neighborhood quality, access to healthy food, physical activity).

#### Filling the Gap

Few studies have been conducted in diverse communities that capture the perspectives of community-based service providers who serve older adults. Community needs assessments often use categories defined *a priori*, which may not adequately reflect the realities of diverse populations (Salinas-Miranda et al., 2017). Furthermore, much of the relevant existing literature focuses on needs/deficits and fails to capture existing assets in these communities. Assets are important to identify as they can influence the design of effective policies and programs to promote the health and wellness of older adults (Hornby-Turner, Peel, & Hubbard, 2017). This paper also fills a gap by using the Commission on Social Determinants of Health conceptual framework to inform a study on older adults. Rather than asking questions directly related to health, interview questions were broad, allowing service providers to reflect on the social structures that impact the well-being of older adults in their communities.

The purpose of this study was to capture the perspectives of diverse service providers who work with older adults in their communities. The study objectives were to (1) identify existing assets that support older adults in diverse communities and (2) identify unmet needs and challenges facing diverse older adults. As the population grows increasingly older and more diverse, it is important that these challenges and unmet needs are identified and addressed so that all people have the opportunity to age well. Ultimately, identifying needs, challenges, and assets can inform state-level policies and programs to support older adults in historically underserved communities.

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## **METHODS**

### Study Context

Like the rest of the United States, Minnesota is undergoing an unprecedented demographic shift, becoming increasingly older and more racially/ethnically diverse. Minnesota ranks among the healthiest and best states to age (Leins, 2017; Soergel, 2018), however these rankings fail to tell the whole story. Minnesotans of American Indian, African American, African, Asian, and Hispanic descent as well as LGBT Minnesotans experience worse outcomes in education, economic status and health compared to white Minnesotans (Minnesota Department of Health, 2017).

This community-engaged study was possible due to the highly collaborative environment in Minnesota. Providers of long-term services and supports, researchers, and the state work closely with one another, making Minnesota a useful context for this type of study. This study was conducted in partnership with the Minnesota Leadership Council on Aging (MNLCOA) as part of a year-long community engaged research project. The first author spent one year embedded in MNLCOA, conducting this research, disseminating results to community service providers and stakeholders, and helping to build a coalition of stakeholders to advocate for policy change. MNLCOA consists of 33 members, representing membership/trade associations, non-profits, and advocacy organizations. MNLCOA's mission is to create communities and systems that support aging with dignity and a spirit of well-being. They focus on three primary areas: (1) advocating for policy and systems that support older Minnesotans and caregivers; (2) convening stakeholders; and (3) crafting a shared narrative on aging in Minnesota.

### Data Collection

Qualitative data were collected from key informant interviews with community-based service providers who serve diverse older adults in Minnesota (N=15). Key informants were recruited from a list of contacts compiled by the MNLCOA Health Equity Work Group. Service providers were purposively recruited to ensure representation from the following aging communities: African American (n=3), American Indian (n=2), East African (n=2), Southeast Asian (n=2), Latino/a (n=3), and LGBT (n=3). They worked for a variety of organizations including non-profit organizations, community centers, tribal government, adult day services, and as consultants.

Most interviews were conducted in-person, three were conducted over the phone at the request of the key informants. Interviews were audio recorded with the permission of key informants. Interviews lasted between 20 and 80 minutes (average length = 40 minutes). This project was determined not to be human subjects research by the University of Minnesota Institutional Review Board.

Key informant interviews focused on the assets, unmet needs, and challenges facing diverse older adults in Minnesota. The interviews included questions such as: *What do you think are the greatest strengths or assets for older adults in your community? What resources or services are missing or needed in your community? Is there anything you would change about how older adults in your community are served or treated? If you were given a blank check to spend on the needs of older adults, what would you use it for?* The complete interview guide can be found in the appendix.

### Data Analysis

Recordings were transcribed verbatim and organized into NVivo for analysis. Data were analyzed using Braun and Clarke's (2006) approach to thematic analysis. First, transcripts were read in their

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entirety and an initial coding structure was generated. Next, all material was coded. This was an iterative process with the coding structure being continually refined. Codes were examined and collated into overarching themes. Themes were reviewed and refined to ensure the research questions were adequately addressed. Regular debriefing and audit trials enhanced the transparency and credibility of the analysis. Results focus on themes that were mentioned by all or nearly all communities represented in the sample.

## RESULTS

### Who is an “Older Adult”?

Service providers offered a range of criteria for who they consider to be an older adult. Some mentioned life experience and wisdom or having children and grandchildren. Others mentioned the presence of physical limitations or chronic conditions that may shorten life expectancy. Nearly all mentioned age as part of their definition although many felt age cutoffs were arbitrary. Ages offered as defining of an older adult ranged from 45 years and older to 70 years and older.

### Assets

Service providers mentioned a wealth of assets that support older adults in Minnesota’s diverse communities. Two categories of assets were mentioned: (1) assets of the cultural community and (2) assets of the older adults.

*Cultural community assets.* Many providers said their communities have existing culturally specific services such as adult day services, community centers, and caregiver programs that are an asset to older adults in their community. Latino and African American service providers also mentioned faith communities as an asset supporting older adults, providing trusted information and social support. One African American service provider explained,

*The church community and the role of the church is very important in [older adults’] life. It’s a place of, you know where they receive information... providing first that information, that education component. And it’s also where you get your support. I mean the church community for a lot of people it is their extended family.*

Many providers also said that in their culture, older adults are treated with more respect as they age and hold an esteemed place in the community. Some service providers stated that close-knit families, as customary in their culture, lead to less social isolation of older adults.

*Assets of older adults.* Nearly all service providers pointed to the wealth of cultural knowledge as a key asset of the older adults in their communities. One Southeast Asian service provider explained:

*I mean the asset’s definitely cultural knowledge, historical knowledge, life experiences, leadership, wisdom. Because the Hmong community [has] an oral tradition. And they do carry the living memories, the living history of the Hmong people and the Hmong experience.*

Many providers mentioned experience as an important asset. An East African service provider described the older adults in his community as being “a library of good things.” One African American service provider elaborated:

*The greatest strengths that I see in a lot of the African American seniors is that if young people would listen, they could figure out that these [seniors] have been somewhere. They've experienced some things. And they can help us in a lot of areas that we don't have to go through if we would listen. 'Cause a lot of our seniors have been through some things that [have] been traumatic and [their] lives have been shaped by that... We're the legacy, but they've trail blazed a legacy for us to follow.*

Many service providers also mentioned the resiliency of older adults as being an asset. They gave examples of resiliency in the face of war, violence, and discrimination.

#### Unmet Needs

Despite the wealth of assets in Minnesota's diverse communities, older adults experience a variety of unmet needs. These include (1) health, (2) healthcare, (3) transportation, (4) housing, (5) education, (6) social support, and (7) financial security.

*Health.* Service providers mentioned a variety of health conditions that are prevalent in their communities such as: hypertension, high cholesterol, stroke, diabetes, obesity, memory loss/dementia, depression, and other mental illnesses. Nearly all providers pointed to the trauma experienced by older adults in their communities as a cause of mental illness. Many also mentioned the stigma in their communities around mental illness, preventing many from seeking care. One East African service provider explained:

*That trauma doesn't go away easily... So, there are a lot of mental health issues. The problem is there's also taboo and cultural stigma to say someone has mental illness...It means somebody's crazy. They don't want to be labeled.*

Providers also mentioned a need for an investment in “upstream” interventions to prevent more debilitating and expensive health conditions from occurring.

*Healthcare.* Service providers also cited issues related to healthcare as being an unmet need for older adults in their communities. Many mentioned that the cost of healthcare and prescriptions is not affordable especially for older adults on a fixed income. Lack of health insurance or not having “the right health insurance” is often a barrier to getting medical care. Bias and outright discrimination from medical professionals was cited as another barrier. Providers also explained that in their communities there is distrust of predominately white institutions. One African American service provider explained:

*[What] we have to recognize with the elders is that because of the historical and current trauma that people are experiencing, there are low levels of trust of traditional- I'll say white- agencies and services.*

They cited both current and historical examples such as Henrietta Lacks and the Tuskegee syphilis experiment as cause for distrust. A Latina service provider explained that due to the current rhetoric around immigration, many in her community, regardless of their immigration status, avoid healthcare and other institutions for fear of deportation or separation from their families.

Issues regarding dementia diagnoses were also stated as a problem for many communities. One Latina service provider mentioned concerns that older adults in her community are not receiving appropriate dementia diagnoses because the tests are performed only through an



appointment with a specialist, which many Latino older adults cannot afford. An African American service provider expressed her frustrations with medical professionals not taking the older adults in her community seriously when they report concerns of memory loss and dementia. A Southeast Asian service provider explained that the diagnostic tests are not culturally appropriate for her community:

*I have a lot of elders that are here and they're starting to have memory issues. [But] health professionals say to me "Oh you know [in the] Hmong community rates of Alzheimer's and dementia are really low. What do you guys do in your community to make that happen?" And I'm like "Uh, well we do have [dementia in our community]. And when you use your testing tools and your diagnostic tools, it doesn't ask the questions that get to memory loss issues. And so then you're saying they don't have memory issues when in fact they do."*

As a result, many cases of dementia may be left undiagnosed in these communities.

Providers mentioned a need for more health professionals and personal care assistants (PCAs) who speak their language and know their culture. Some service providers also expressed concerns over lack of regulation over certain aspects of healthcare. They wanted more training, particularly for PCAs and medical interpreters. Two LGBT service providers expressed a need for more training for service and medical providers on how to work with LGBT patients.

*Transportation.* Nearly all service providers mentioned transportation as an unmet need. Many said the older adults in their communities do not drive. The lack of transportation options prevents many older adults from going to medical appointments, picking up prescriptions, getting groceries, and socializing. Several said that they were limited in the number of older adults they could serve at their organization because of lack of transportation.

Several providers explained that the Metro Transit (publicly funded) bus system is difficult to navigate, especially for older adults. This difficulty is often made worse by lower rates of literacy and English language proficiency and higher rates of memory loss than the general population. Many older adults report being fearful they will get lost in the Metro Transit system. The bus system is also not an option for many with mental, physical, and/or mobility limitations.

Service providers also expressed concerns with Metro Mobility (assisted mobility transportation). They said it is not reliable, takes too long to get where you need to go, and is not practical in many instances because of the requirement to call ahead days in advance. An African American service provider explained some of the issues older adults attending her center have experienced:

*I'm not a fan of Metro Mobility...just because of the incidents we have here with it, with seniors waiting and waiting and [Metro Mobility] not coming. Or coming to the wrong side of the building and telling [the seniors] to walk [to the other side of the building].*

Some service providers mentioned the need for door-to-door service, making sure older adults get into their homes safely before leaving. One service provider suggested an additional screening for Uber and Lyft drivers and special training to make them "senior certified," although others mentioned the cost of Uber and Lyft as being prohibitive. A few mentioned that the older adults in their community prefer to walk as a mode of transportation and exercise. However, concerns over safety and weather conditions often makes this not feasible.

*Housing.* Housing is a need expressed by every service provider. Several stated that housing is unaffordable and unavailable, with long waitlists for senior housing and Section 8 vouchers. Others mentioned that older adults in their community are on the verge of homelessness because they cannot afford their current rent. A Latina service provider explained:

*Rents keep climbing up. And even families are being displaced. In families with elders and with little kids. So, the homelessness is going to be a problem unless we can act and stop their rent [from] going up- in the cities, places where people have lived for a long time and now, they are just being chased away- gentrification and all that.*

An African American provider expressed her frustration with housing for the older adults in her community:

*I've been to aging meetings where people are talking about, "I don't know if my dog can go there." This community isn't thinking about their dogs. They're thinking about, "How do I keep my home that we fought for to keep?" Because at the point in time where our families tried to buy homes, their names couldn't go on deeds. You know, so housing is a big thing. But I think housing, let's just be clear, it's a horrible issue for everyone making under \$100,000. It's a horrible issue.*

One Southeast Asian service provider explained that many older adults in her community cannot afford a place of their own and live with extended family. These homes are often overcrowded, resulting in the older adult not having a bedroom or having to share with grandchildren.

Housing concerns also include a need for resources and services to help older adults remain in their homes and communities. Such services include shoveling, home maintenance, housekeeping, home modification services, and resources for family caregivers. Some providers mentioned the need for culturally specific community-based long-term care facilities. One African American service provider elaborated:

*I think the answer to the large number of elders that are gonna need housing and support would be if you had people that wanted to have, I'm gonna call it like a[n] elder home...they can be fairly independent but still need some assistance... And then maybe services come in... You know because that's going to be more attractive, and keep the person connected with the family and healthier.*

She saw potential for policies to incentivize entrepreneurs to open these culturally specific assisted living facilities in their communities.

*Education.* Service providers mentioned a variety of unmet needs related to education. They mentioned the need for educating older adults in their community on topics such as advanced directives, citizenship, English, exercise, finances, mental and physical health, nutrition, renter's rights, and technology. Many also mentioned the need for culturally relevant navigation services that can assist older adults in navigating Medicare, Medicaid, and Social Security, as well as connect them to other culturally specific resources.

Some providers felt that their communities were often last to receive new information about resources or new research. One African American provider expressed her frustration with the lack of information being disseminated to her community:

*We just need the information, the proper and the adequate information given to the population, to the community, so people can know how to take care of themselves better, prevent certain things that can be prevented. Just give us what we need to live better. You know, live a healthier life, live longer. 'Cause we're living longer, but we wanna be healthy.*

A few providers pointed out that although there is a need to provide education for older adults, older adults also have a lot they can teach others. One Southeast Asian service provider explained:

*And then the expectation that [the older adults] always have to learn. And sometimes they get tired of it. Because they do want to learn- but at the same time they're like, "oh, we're so tired of learning, why can't you guys learn something from us? Well you're always expecting us to learn, is it because we're stupid? Are we not wise already?"*

Several mentioned the need for intergenerational and cross-cultural programming, where this wisdom can be shared between generations and across different cultural groups.

**Social support.** Most service providers expressed concerns of social isolation among older adults in their communities. One LGBT service provider explained:

*For LGBTQ folk, a lot of them never had families or are estranged from their families. So that social support system is not as obvious, and hopefully they've created other support systems, other family support systems, not necessarily blood systems- but for many, they have not. So, there's a lot of isolation.*

Many felt that older adults in their community in need of temporary care, such as after a surgery, do not have anyone to rely on due to their thinning social networks.

Providers also expressed a need for outreach programs targeting isolated seniors. One Southeast Asian service provider explained:

*[We need] more support in terms of how [older adults] can get together more and participate in festivals or things happening... There's no organized support to bring [them] to those places... So it ends up that a lot of the [older adults] who really need to socialize and go to those events, don't have the resources to go. So they just stay at home.*

Many said that their communities lack a meeting place where older adults can come to socialize with other older adults.

**Financial security.** Financial security was frequently cited as a concern for older adults. Service providers explained that many older adults in their community live on a fixed income and have difficulty affording necessities such as housing, phone lines, medical care, groceries, and funeral services. Several expressed concerns with Social Security benefits being reduced and concerns that older adults in their communities do not have enough money saved for retirement. One American Indian service provider explained:

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*People in poverty [haven't] saved for retirement beyond Social Security. I think the whole country needs to think of what they gonna do with people who no longer can work. And they keep moving the age up... [but] people have a lot more health concerns and they can't keep working...especially in physical jobs or jobs that require just labor... So I'm worried people are gonna have to work a lot longer than they really should be.*

One African American service provider explained how structural racism has impacted the financial security of older adults in her community:

*We have a lot of people, especially in the African American community, that- let's just be honest, they weren't awarded the same fair education. They weren't allotted the same jobs as other people. Their social security isn't the same. You know, so they don't have the money to pay to move into a housing, you know, senior assisted living. That's very expensive. That's not a reality in this community... So that's the one thing about aging in the community here, in the African American community. You stay, you know, as much as you can, where you can because you can't afford to go somewhere else.*

Providers also voiced their concern that other benefits and programs that their older adults rely on such as SNAP, Meals on Wheels, and food shelf funding are being cut. One African American service provider explained,

*We see a lot of people that come through our food shelf that, a couple years ago, were probably donating to it, but their Social Security isn't going up. The food prices are. Healthy food prices are.*

Service providers were quick to point out the connection between the economic disparities and health disparities in their communities. “You eat what you can afford,” explained one service provider.

## **DISCUSSION**

The U.S. population is aging rapidly and becoming increasingly diverse. As such, it is important to identify the assets and unmet needs of this growing population in order to identify priorities for future interventions and policy efforts. Minnesota's diverse communities have many assets that can be leveraged to better meet the needs of older adults. Service providers identified existing culturally specific organizations as important assets in their communities. More funding should be allocated to these organizations to keep pace with the increasing demand for their services. Many service providers gave specific examples of ways they would expand their services to a greater number of older adults as well as to meet a greater breadth of needs if they had more funding.

Wisdom and experience are also important assets of older adults. Intergenerational and cross-cultural programming is a promising way to harness this wisdom while allowing older adults to contribute in meaningful ways to their community. Faith communities, mentioned as a key asset for African American and Latinos, may be an effective way to disseminate information and provide education for older adults. Utilizing faith communities may also be an avenue to build trust with

historically marginalized communities. This finding is supported by other studies indicating that the use of faith-based health promotion interventions are feasible and hold promise to improve health outcomes (Crook et al., 2009; DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Phillips, Rogers, & Aiken-Morgan, 2017; Ralston, Farmer, Young-Clark, & Coccia, 2016; Rivera-Hernandez, 2015).

Findings from the present study support the relevance of the Commission on Social Determinants of Health conceptual framework (Solar & Irwin, 2010) for older adult populations. Notably, all unmet needs sub-themes address health or social determinants of health, highlighting the importance of programs and policies that modify these upstream determinants in order to improve health outcomes for diverse older adults. This is consistent with a growing body of literature calling for interventions that focus on social determinants. These efforts should focus on social structures and policies such as education, early childhood, urban planning and community development, housing, income, and employment (Marmot, Friel, Bell, Houweling, & Taylor, 2008; Thornton et al., 2016; Williams & Purdie-Vaughns, 2016).

Minnesota's diverse older adults are experiencing a variety of chronic health conditions and mental health issues. Trauma, mental health, and pervasive stigma around such issues, indicates the need for community outreach to educate and dispel stigma. Additionally, training is needed for health providers to recognize and provide treatment in a culturally responsive manner for those experiencing mental health conditions. Providers indicated a need for training providers to better listen to the concerns of patients, developing culturally relevant diagnostic tests, and equipping general practitioners with the ability to diagnose dementia.

Service providers also mentioned that high costs, lack of insurance, being underinsured, and not having "the right health insurance" are barriers to receiving health care. Cost and insurance have been well documented as barriers to receiving healthcare (Dreer, Weston, & Owsley, 2014; Jupka, Weaver, Sanders-Thompson, Caito, & Kreuter, 2012; Molina & Briggs-Malanson, 2017). Many providers also reported that bias, discrimination, and mistrust prevent older adults from seeking care and/or negatively impact the care they are receiving. This is consistent with a number of studies that document stereotyping, discrimination, unequitable care, and mistrust experienced by minority patients (Bliss et al., 2014; Dreer et al., 2014; Jupka et al., 2012; LaVeist, Nickerson, & Bowie, 2000; J. R. Stone, 2012).

Transportation is another pervasive need mentioned by nearly all service providers. Responses from service providers indicate a need for more specialized transportation options rather than more mass transit. The private sector may provide innovative models to fill this gap. Companies such as Uber and Lyft could have senior-specific fleets that provide door-to-door service; however, fees charged by these companies could be prohibitive for many older adults. The present findings are similar to those from another study conducted in Minnesota indicating that transportation is a major concern for both older adults and policymakers. Interviews with older adults indicated a need for better metro transit access and affordable door-to-door transportation options (Finlay, McCarron, Statz, & Zmora, 2019).

Housing is a ubiquitous need that includes the lack of affordable housing, long-term care, and programs to help older adults remain in their homes. Every service provider interviewed mentioned housing as an unmet need for older adults in their community. The availability and quality of housing is one of the most significant social determinants of health and is essential to the well-being and quality of life of older adults (R. I. Stone, 2018). Results indicate diverse older adults in Minnesota, particularly those on a fixed income, are being priced out of their homes

leaving some on the brink of homelessness. A recent Minnesota statewide count of homeless individuals found that homelessness among older adults is on the rise, up 25 percent from 2015 (Wilder Research, 2019) and similar trends exist nationally (Goldberg, Lang, & Barrington, 2016). The U.S. is facing and will continue to face a housing crisis related to the increasing aging population unless policymakers recognize and address affordable housing concerns. Nationally, the availability of publicly subsidized units and vouchers is inadequate for the current population of low-income older adults who need housing assistance. This shortage is expected to increase in the coming decades as the overall population of older adults increases. Section 202 Supportive Housing for the Elderly Program, for example, had been restricted to maintenance levels since 2011. Though it received \$105 million for new construction in 2018, this is still inadequate to address waitlists for existing housing stock and the projected increase in demand over the next twenty years (R. I. Stone, 2018).

There is also a need for culturally relevant community-based long-term care where older adults see their culture reflected in the food, activities, people, and décor. It is important for older adults to have the option to remain in their community, near family and friends (Finlay et al., 2019). Policies to incentivize and assist individuals to open small, community-based long-term care facilities in their communities may help to fill this need. One provider suggested an assisted living model where family members share chores in order to keep costs down. For example, families of the older adults living in the facility could take turns doing laundry and cooking meals. Maintaining funding and increasing awareness of programs that help older adults stay in their homes longer (e.g. home modification and home maintenance services) is also needed to help prevent premature placement in long-term care.

Several issues related to education and health literacy were identified as unmet needs for diverse older adults. Navigating services such as Medicare, Medicaid, and Social Security is difficult for many older adults due to language and literacy barriers as well as the amount of paperwork and changing regulations. Culturally specific navigation services to help older adults navigate these social programs and identify other resources and programs they might be eligible for could help ease this burden. There is also a need for educating older adults on a number of topics related to health, legal issues, and technology. As previously stated, faith communities may be an effective setting for such education to occur. Also as previously mentioned, there is a need for intergenerational and cross-cultural programming, allowing older adults to share their wisdom and cultural knowledge. Such programming could strengthen intergenerational bonds as well as build community across cultural groups. This is supported by the literature indicating the importance of incorporating the wisdom and knowledge of older adults in program and policy development and planning (Satterfield, Shield, Buckley, & Alive, 2012).

Rampant social isolation is another concern for diverse older adults. Social isolation limits access to both instrumental support (e.g. family caregiving) and emotional support (e.g. socializing). Social isolation among LGBT older adults is often amplified as they are more likely to be single and to be disconnected from their family of origin, and less likely to have children than their heterosexual and cisgender peers. This is particularly problematic as family caregivers (e.g. spouse, adult children) are often the primary caregivers for older adults (Adams & Tax, 2017). Outreach that includes both awareness and transportation assistance is necessary in order to include the most isolated individuals. There is also a need for physical infrastructure, such as senior centers and coffee shops, where older adults can come to socialize.

Many older adults in Minnesota's diverse communities struggle with financial security as they age. Many live on a fixed income and have difficulty affording basic necessities. Financial security is also a concern for older adults nationally. An analysis of federal and state poverty data using the Supplemental Poverty Measure found that approximately 45 percent of adults 65 years and older were "economically vulnerable", having an income of below 200 percent of the poverty threshold (Cubanski, Casillas, & Damico, 2015; Goldberg et al., 2016). Financial security tends to impact diverse communities the most. Diverse older adults have higher poverty rates than white, heterosexual, and cisgender older adults (Adams, 2011; Borrowman, 2012). In Minnesota, diverse older adults have incomes far less than white older adults (Minnesota Department of Health, 2014; Minnesota Department of Health, 2017). For example, the 2012-2016 median income for whites 65 years and older was \$41,731 while the median income for blacks was \$24,214 and \$28,589 for American Indians of the same age (Minnesota Compass, n.d.). Similar disparities exist nationally, with white older adults having an average income of \$40,000 annually compared to black and Hispanic older adults with an average of \$28,000 annually (R. I. Stone, 2018). Caregiving for younger generations places additional financial strain on diverse older adults. This is especially a challenge for American Indian and Alaska Native older adults, more than half (56%) of which have grandchildren living with them (National Indian Council on Aging, n.d.).

These economic disparities are largely a product of structural racism, continuing throughout the life course and often exacerbated in old age. As one African American service provider explained, older adults in her community did not have the same access to education and jobs as their white counterparts, which impacts Social Security income and financial security later in life. Homeownership disparities between whites and Persons of Color and American Indians also have profound implications for older adults. Elderly renters are more likely to be black, American Indian, and Hispanic. They are also more likely to be economically disadvantaged than their home-owning peers. Even among low-income older adults, home equity among homeowners provides more financial stability than renters in the same income categories. Many older people use reverse mortgages to pay for increasing care needs or use the funds from selling their home to pay for long-term care. Such disparities in homeownership rates contribute to the economic disadvantages faced by older People of Color and American Indians (Minnesota Department of Health, 2017; R. I. Stone, 2018). The link between economic and health status has been well documented in the scientific literature (Chetty et al., 2016; Kasper et al., 2008; Wilken & Furlong, 2002), affecting access to healthcare and other social determinants of health such as housing.

#### Limitations

This study provides insight into the assets and unmet needs of Minnesota's diverse older adults; however, results should be interpreted in the context of a number of limitations. Results may not be generalizable to other communities that have different demographic compositions and sociopolitical contexts. Minnesota is generally very supportive of older adults through heavy investment in supports and services, care provision, and parks and recreation. However, given the supportive climate of this study's context, it is likely that older adults living in states less supportive of older adults experience similar unmet needs and challenges. Another limitation is that the two or three key informants interviewed in each community are unlikely to capture the full breadth and depth of assets and needs of older adults in their community and we cannot compare results between different cultural groups. Finally, this assessment involved interviews with community service providers, rather than older adults themselves. Although all but one key informant was a member of the community in which they served, service providers may have

different perspectives than older adults. Even so, the purpose of the present study was to capture the perspectives of community-based service providers. Future research should include diverse older adults and could compare their perspectives with the service providers who work with them.

## CONCLUSION

Diverse older adults have a wealth of assets but also many unmet needs. Programs and policies are needed to leverage assets and address unmet needs, specifically those related to health, healthcare, transportation, housing, education, social support, and financial security. Except for health, all other themes are social determinants of health, indicating the need for policies and programs that address these social determinants. As the U.S. population grows increasingly older and more diverse, it is imperative that these unmet needs be addressed so that all older adults have the opportunity to age well.

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## APPENDIX

1. How would you describe someone you consider to be an “older adult”?
  - Probe: Who are considered to be “older adults”? / Who are considered “elders”? Function of age, respect, physical or cognitive ability etc.?
2. What do you think are the greatest strengths or assets for older adults in your community?
3. What are the greatest needs of the older adults in your community?
  - Probe: Are there prevalent physical, mental, emotional health needs? If so, what are they?
4. What do you think keeps them from getting these needs met?
5. What resources or services are missing or needed for older adults in your community?
6. Do you see a need for education for older adults in your community? If so what should that look like? If not, why not?
7. Do you see a need for advocacy for older adults in your community? If so what should that look like? If not, why not?
8. Does <organization> advocate for the diverse older adults you serve at the systems/policy level? What does this look like? If not, why not?
  
9. What barriers, if any, are there for <organization>’s participation in policy/systems advocacy?
10. Is there anything you would change about how older adults in your community are served or treated?
11. If <organization> were given a blank check to spend on the needs of older adults, what would you use it for?
12. In what ways would <organization> be interested in adding its voice to conversations (e.g. planning for policy initiatives, programs etc.) around aging and diverse older adults?