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The Role of Culture in Engaging the Senior Population in Omaha, NE

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Abstract

In recent years, the senior care industry has become the focus of many public health initiatives as we have come to better understand the significance of our aging population (Olivari et al., 2020). Between the years 2010 and 2050, the population of the United States over 65 years is expected to more than double, from 40.5 to 89 million (Dall et al., 2013). While this data provides a national outlook, further research is needed to determine local impacts. This project centers on developing a better understanding of the demographics of seniors in the Omaha-Council Bluffs Metropolitan Statistical Area and how to best serve this growing population, as well as the impact that race/ethnicity and culture may have on the ability of seniors to access high-quality healthcare and to maintain a high quality of life. The census data revealed that the two largest groups of residents of the metropolitan area that were born outside of the United States were of Latin American and Asian origin. This coincides with the population that attends the Intercultural Senior Center in Omaha, primarily Latino and Karen immigrants. The heath care access and implications for seniors for each of these groups are discussed as well as possible ways to increase their access to high-quality care.

The Role of Language in Engaging the Senior Population in Omaha, NE

When considering the challenges our society and healthcare system will face moving forward, one important factor to acknowledge is the age of our population. Projections show that between 2010 and 2050, the population of adults over the age of 65 in the United States will likely more than double from approximately 40.5 million to 89 million (Dall et al., 2013). Although this increase in older adults represents the positive impact of improvements to healthcare, technology and public health, it also presents challenges to the same fields. With this increase of older adults, the healthcare system will need to be equipped to handle an increase in conditions related to aging, such as cardiovascular disease, neurodegenerative disease and cancer.

It is important to consider that although aging is a universal human experience, not all cultures or individuals experience it in the same way. In addition to a general increase in older adults projected in the United States, the proportion of older adults belonging to racial and ethnic minority groups, who often face worse health outcomes, is expected to grow in the coming years (Dilworth-Anderson et al., 2012). This is true not only of physical health outcomes, but also of mental health outcomes. Seniors belonging to minority groups or experiencing language barriers have been found to have higher incidence and prevalence of mental health conditions, such as anxiety, depression and substance use disorders (Llorente & Valverde, 2019). With an increase in older adults belonging to racial and ethnic minority groups comes an increase in diversity of beliefs regarding aging. As belief systems and lifestyle vary by region and culture, so will the experience of aging within those same parameters. While the term ethnogeriatrics was created in the late 1980's to describe the care of diverse seniors to promote research and cultural competency, gaps in research on this diverse population still exist (Mehta & Yeo, 2017).

Although more explicitly physical health determinants, such as eating habits and exercise, play a large role in aging-related health, it has been shown that social engagement also plays a significant role in physical and mental health of the aging population (Rowe et al., 2016). While it is known that social engagement is important for seniors, many barriers still exist which may prevent some from accessing opportunities for engagement. Although there are no longer official policies in place to reinforce segregation, data shows that many US minorities are still living in neighborhoods at least partially segregated by race/ethnicity, with African Americans living in metropolitan areas being the most likely to face this possible barrier to resources (Lichter et al., 2015). Living in isolated neighborhoods or far from public transportation create the potential for social isolation. These societal barriers to mobility, when combined with potential physical barriers to mobility, such as illnesses or injuries which may impact the ability of an individual to walk, combine to create a barrier to high quality of life for the aging population.

One important resource for seniors seeking social enrichment is senior centers. In a study of two multipurpose senior centers, both of which offered educational activities, it was found that 98% of the center attendees who responded to the study felt that the senior center was somewhat or very important in their lives, with many citing mental and physical health benefits as well as the formation of meaningful relationships (Aday et al., 2017). This effect was found to be especially strong for those seniors who were living alone rather than with family. It has also been found that senior centers play an important role in promoting intergenerational programming, which connects senior citizens with youth in activities that are mutually beneficial and can positively impact the mental and physical health of seniors (Weaver et al., 2017).

One metric of healthy aging is subjective, or perceived, age, which compares the chronological age of an individual with how old they perceive themselves to be based on attitude and behavior. Subjective age has been found to be a predictor of physical and mental health in older adults, with younger subjective age being associated with better outcomes (Ambrosi-Randić et al., 2017). In a study of socioeconomically disadvantaged African American and Hispanic adults at a United States senior center, it was found that participants reported staying social and physical activities as reasons they felt younger than their chronological age (Choi et al., 2020). On the other hand, financial hardship and physical disabilities were found to prevent participation in some activities and also contribute to a higher subjective age. This implies that more broad societal programs might be needed to reach adults whose basic needs are not being met in order for them to experience the benefits of these programs.

When discussing the goal of healthy aging, it is important to also acknowledge some of the age-related pathologies that can contribute to reduced quality of life for older adults. Two common pathologies associated with aging are cardiovascular disease and memory disorders. Dementia is the broad term used to describe symptomology related to memory and social functioning and is seen in disorders such as Alzheimer's disease, vascular dementia, and Parkinson's disease. While health education is very important for the early detection of these disorders, it can also lead to health anxiety. Studies have found that an increased societal awareness of dementia has also created an increased worry about dementia, especially in older adults who may perceive normal neurological changes associated with aging as symptoms of dementia (Kinzer & Suhr, 2015). Additionally, strokes, which are a type of cardiovascular disorder, serve as a fairly strong risk factor for dementia (Kuźma et al., 2018).

While all populations are subject to an increased risk of cardiovascular and neurological disorders with age, some groups are more vulnerable than others. Data shows that ethnic minorities are not only more likely to be at risk for cardiovascular complications, but also that they have a higher death rate from cardiac disease (Leigh et al., 2016). Studies have also shown that some of the criteria used to screen for metabolic and cardiovascular disorders, such as BMI, are based off of a European population and therefore may not accurately identify elevated risk in minority populations (Perini et al., 2019).

Due to the potential for decreased quality of life in our growing senior population, this study aims to investigate the demographics of the Omaha metropolitan area using census data so that the needs of this specific population can be identified. The hypothesis of this investigation is that significant numbers of Latino and Asian residents will be present in the data. It is also hypothesized that there will be a significant number of individuals facing a language barrier that could further prevent them from accessing the care and resources that they may need for healthy aging.

Methods

The data used in this study was collected from the U.S. Census Bureau's database at data.census.gov. By using the advanced search feature, a specific geographic area was selected. The data for the Omaha-Council Bluffs Metropolitan Statistical Area (see Figure 1) was chosen as opposed to just the city of Omaha due to the geographic proximity of the two cities and their ability to share resources and access to programing. The data discussed in this paper was collected through the 2018 American Community Survey (ACS) Demographic and Housing Estimates.

To determine the race and ethnicity of the population, race and ethnicity was selected and variables to indicate whether someone identified as one race or two or more races. In addition, the specific races and ethnicities of respondents were added to the dataset. To better define the population, populations and people were selected as well as the variables of age and sex, language spoken at home, older population, ancestry, and native and foreign born. These variables added to the dataset information on gender and age distribution of the population, whether or not English was spoken in the home and at what level the participants spoke English, and place of birth if not the United States.

Further information on the population came from the categories of health, families and living arrangements, and income and poverty. From these categories, data was collected on health insurance status, median household income, and poverty rates. The data produced from this search was presented in a table, with each category having an N value, or number of people included in the count, as well as a margin of error and percentage breakdowns for each subcategory. To find the approximate number of people in each subcategory, the percentage for that category was multiplied by the number of participants included in the measure.

The original goal of this study was to supplement this statistical data with oral interviews from staff and participants at the Intercultural Senior Center located in Central Omaha; however, it was not possible to complete more than a few conversations with staff members prior to the beginning of social distancing measures in an effort to contain the spread of COVID-19. The Intercultural Senior Center aims to serve seniors, particularly immigrant and refugee adults over the age of 50, by providing transportation and food as well as access to educational, social, and physical activities.

Figure 1

Omaha-Council Bluffs Metropolitan Statistical Area
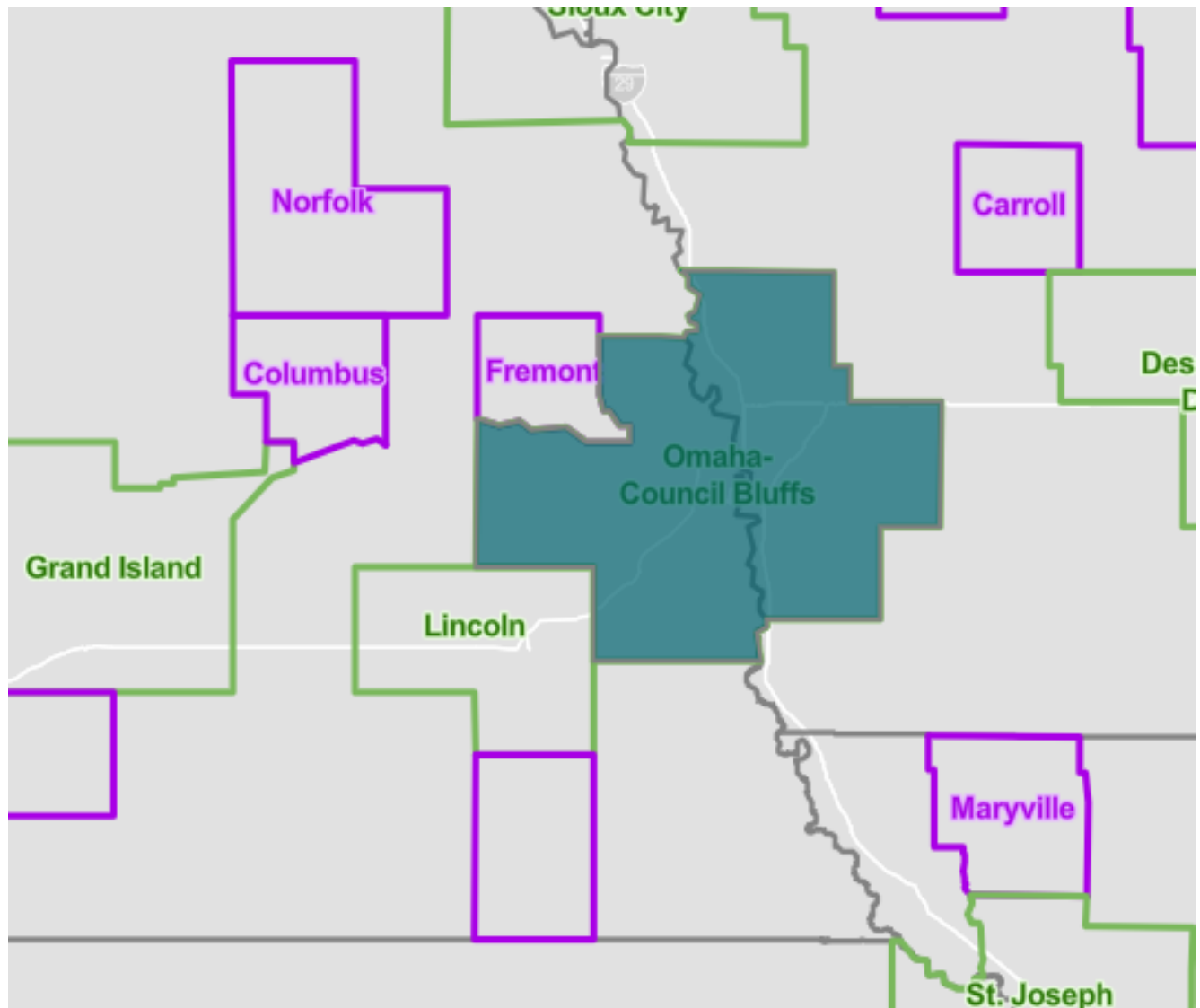
Note. The Omaha-Council Bluffs Metropolitan Statistical Area, as depicted by the United States Census Bureau, includes Cass, Douglas, Sarpy and Washington counties in Nebraska as well as Harrison, Pottawattamie, and Mills counties in Iowa.

Results

  The first important aspect of this data is the general demographics of the Omaha-Council Bluffs Metropolitan Statistical Area. Included in the figures below is information on the population size, gender distribution, race and ethnicity, age distribution, and educational attainment. The total population of the area is an estimated 941,924, and the ratio of males to females is very nearly even, with just a .5% skew towards female (see Table 1 and Figure 2). The ACS does not collect data on those who identify as non-binary or non-gender conforming, therefore data on these groups was not available. Around 31.9% of the population over the age of 25 had completed high school or less, while the remaining 69.1% had completed at least some college (see Table 2 and Figure 3). Additionally, all but 8.6% of the population had either private or public medical insurance coverage (see Table 3 and Figure 4).

Gender Distribution
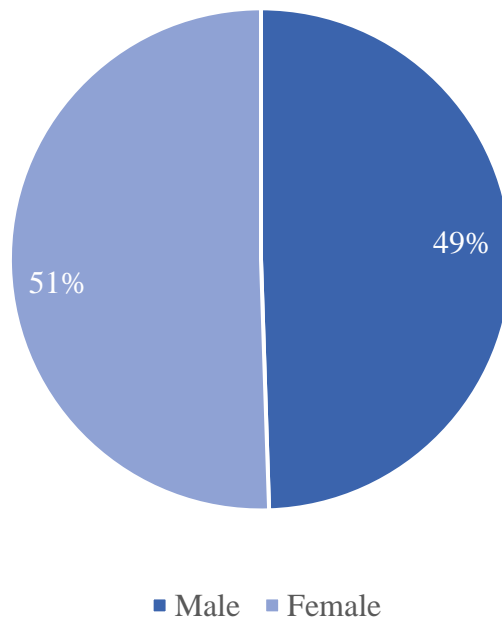
Table 1

Gender Distribution in Statistical Area

Aspect	N	%
Total Population	941,924	100.0%
Male	466,123	49.5%
Female	475,801	50.5%

Note: Shows the nearly equal distribution of males and females of all ages in the statistical area. Statistics on non-binary or non-gender conforming individuals were not collected as a part of the ACS and therefore are not included in this table.

Figure 2

Gender Distribution in Omaha-Council Bluffs Area

Note: Visual representation of gender distribution.
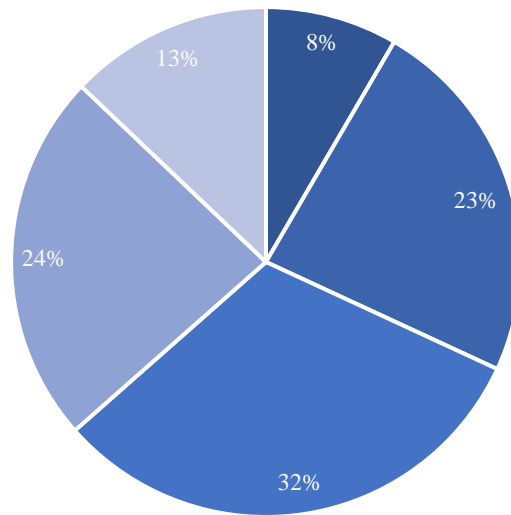
Educational Attainment

Table 2

Educational Attainment of Adults in the Statistical Area

-	N	%
Population 25+	618,013	100.0%
< High School	51,913	8.4%
High school	145,233	23.5%
Some College	195,292	31.6%
Bachelor's Degree	145,851	23.6%
Graduate Degree	79,724	12.9%

Note: This data was collected on those over the age of 25.

Figure 3

Educational Attainment of Adults in the Omaha-Council Bluffs Area

■ Less than high school ■ High school ■ Some college ■ Bachelor's degree ■ Graduate degree

Note: Visual representation of educational attainment with the largest group having completed

some college as their highest level of education.

Insurance Coverage

Table 3

Insurance Coverage Status of Noninstitutionalized Civilian Population

-	N	%
Population	927,832	100.0%
Private insurance	694,018	74.8%
Public coverage	254,226	27.4%
No insurance	79,794	8.6%

Figure 4

Insurance Coverage of Residents in Omaha-Council Bluffs Area
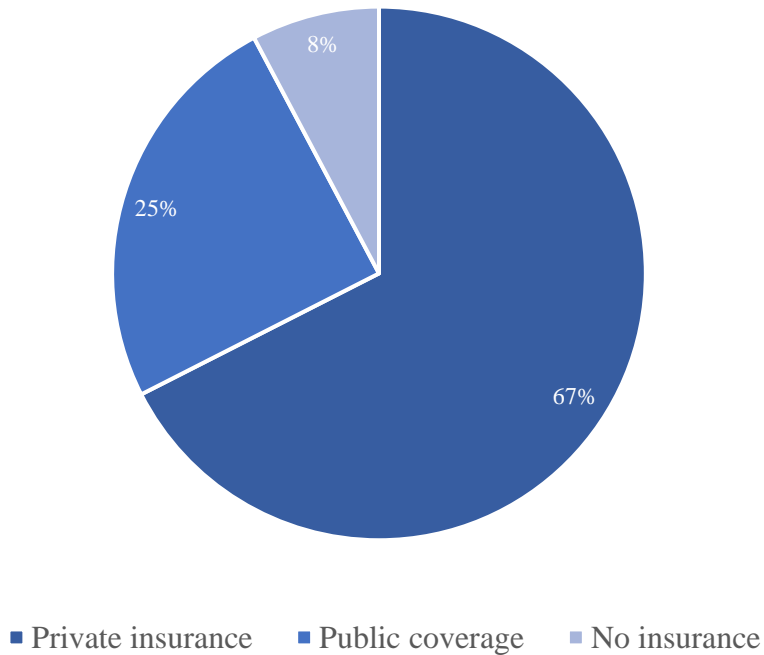
Note: Visual representation of the insurance coverage of residents in the statistical area with the majority being covered by a private insurance policy.

The age distribution of the metropolitan area is skewed toward younger adults with a median age of 36. The largest age group was 25-34 with 134,778 residents or 14.3% of the population. The smallest group in the population was those aged 85 and above with only 16,979 residents or 1.8% of the population. Although the distribution was skewed toward younger adults, the number of adults age 65 and older was 130,302, or a cumulative 13.8% of the population (see Table 2 and Figure 3).

Disability status was also reported as a function of age, with 10.9% of the noninstitutionalized civilian population reporting a mental or physical disability. While the largest number of residents with a disability fell into to the 18-64 years of age category, the percentages of each age group reporting a disability was reported to control for differences in group size. The 65 and older age group had the largest proportion of residents with one or more disability with 31.8%, compared to 9.3% in the 18-64 group and 3.8% in the under 18 group (see Table 3 and Figure 4).

Age Distribution

Table 4

Age Distribution of the Statistical Area

-	N	%
Total Pop	941,924	100.0%
< 5	67,178	7.1%
5-14	134,311	14.3%
15-24	122,422	13.0%
25-34	134,778	14.3%
35-44	125,844	13.4%
45-54	112,530	11.9%
55-64	114,559	12.2%
65-74	78,165	8.3%
75-84	35,158	3.7%
85+	16,979	1.8%

Figure 5

Age Distribution in Omaha-Council Bluffs Area
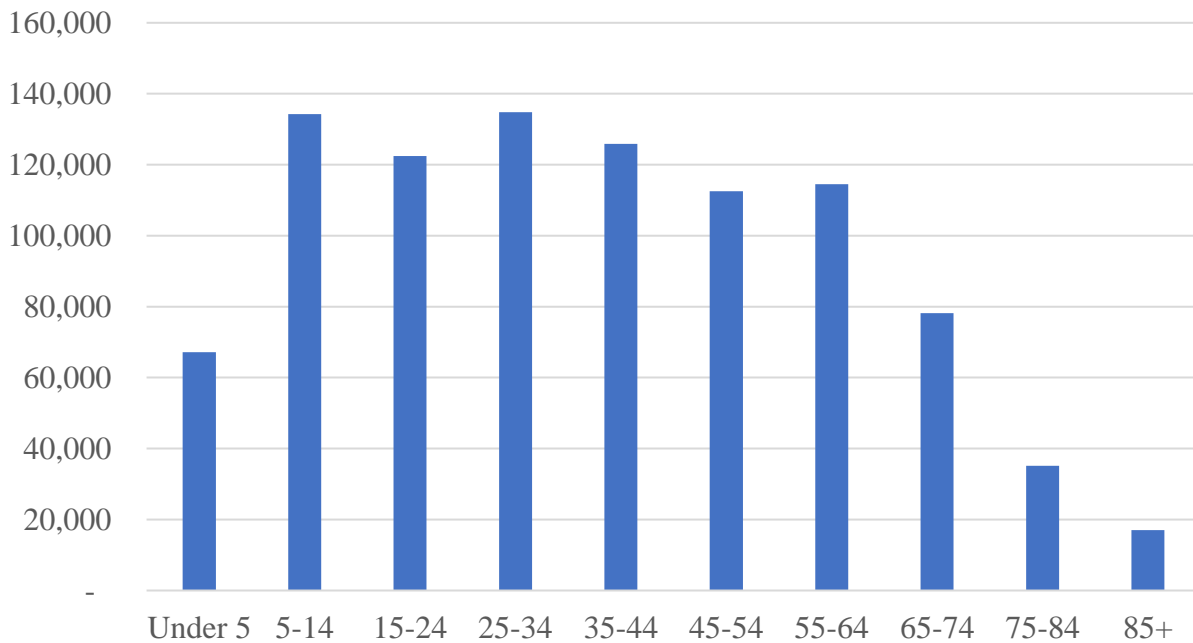
Note: The median age of the metropolitan area was 36.

Disabilities

Table 5

Number of People with Mental or Physical Disabilities by Age Group

-	N Total	w/ Disability	%
Total	927,832	101,134	10.9%
<18	239,565	9,103	3.8%
18-64	562,057	52,271	9.3%
65+	126,210	40,135	31.8%

Figure 6

Disability Status by Age Group in Omaha-Council Bluffs Area
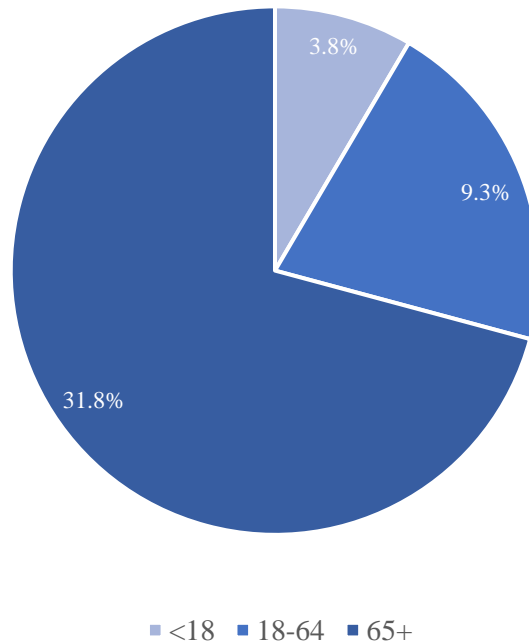
Note: Visual representation of the proportions of each age group with a disability, with the 65+ age group having more than double the proportion of the others.

While data was not available for the general race/ethnicity of residents of the metro area, there was information on the region of birth for current residents who were born outside of the United States. The majority of residents born abroad were from either Latin America, representing 45%, or Asia, representing 32%. Smaller groups of residents were from Africa, Europe, Northern America and Oceania (see Table 6 and Figure 7). Also available was data on whether or not English was used in the home. The majority, or 88.5% of residents, of the metropolitan area indicated that English was the language spoken at home with 11.5% indicating another language was more commonly used. Additionally, an approximate 4.8% of residents, or 41,962 residents, speak English less than very well (see Table 7 and Figure 8).

The metropolitan statistical area did not provide data on the specific languages used in the home other than English, but this was available for Douglas County, which contains 571,327 of the residents of the metropolitan area. Within this population there are approximately 77,273 residents who speak a language other than English in the home. Amongst the language categories, Spanish had the most speakers 46,821 (61%) followed by Asian and Pacific Islander languages at 13,977 (18%). Other Indo-European languages and other non-specific languages made up an additional 21% of languages spoken (see Table 8 and Figure 8).

This data is congruent with the information received from the Intercultural Senior Center. The majority of their participants are either Hispanic or Karen and many are also first-generation immigrants. These groups may be underrepresented on census data due to language barriers, as the ACS, from which the data was collected, is conducted in English. The census has also historically undercounted racial and ethnic minorities as well as immigrants, which could impact the data (Kissam, 2017).

Place of Birth if Outside of the United States

Table 6

Place of Birth of Foreign-Born Residents of Statistical Area

-	N	%
Born outside of US	71,251	7.6%
Asia	22,943	32.2%
Latin America	32,134	45.1%
Europe	6,484	9.1%
Africa	7,838	11.0%
Oceania	356	0.5%
Northern America	1,568	2.2%

Figure 7

Place of Birth of Foreign Born Residents
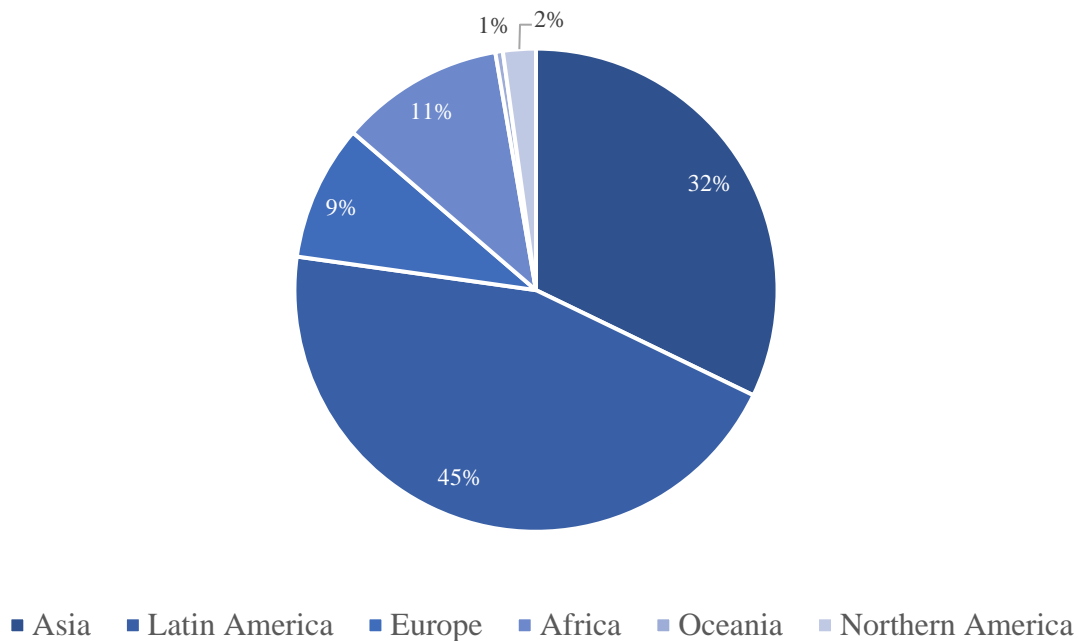
Note: Visual representation of region of origin for residents born outside of the United States with the majority having been born in Latin America or Asia.

Language Use in the Home

Table 7

Languages Used in the Home in the Statistical Area

-	N	%
Population above 5 yrs	874,218	100.0%
English	773,683	88.5%
Other Language	100,535	11.5%
English less than Very Well	41,962	4.8%

Table 8

Languages other than English Spoken in Douglas County

-	N	%
Non-English Speakers	77,273	100%
Spanish	46,821	61%
Asian and Pacific Islander	13,977	18%
Other Indo-European	9,632	12%
Other	6,843	9%

Figure 8

Languages Other Than English Spoken at Home in Douglas County

■ Spanish ■ Asian and Pacific Islander ■ Other Indo-European ■ Other
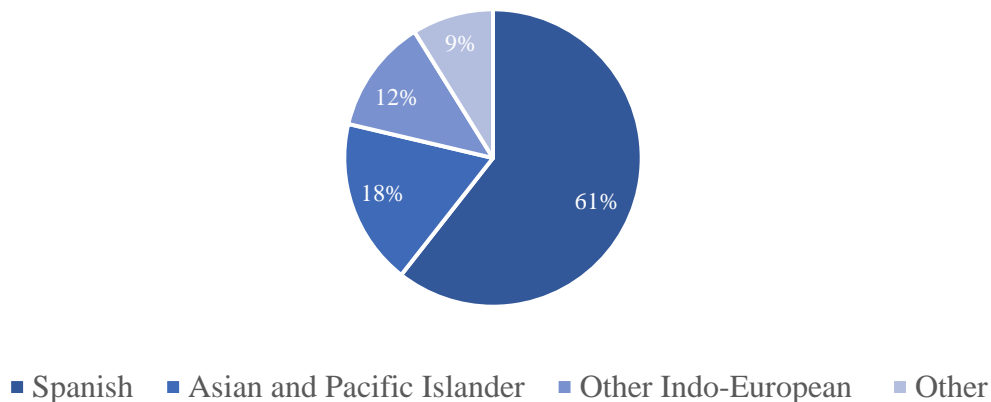
Note: Visual representation of language families spoken in Douglas county, with Spanish being spoken by more than half of all non-English speakers.

Discussion

The census data shows that the demographics of Omaha include a significant number of adults over the age of 65 as well as substantial immigrant populations, both of which are projected to grow in the coming years as discussed in the introduction. By better understanding this population, we can hope to develop better programs which can be implemented to help seniors maintain a high quality of life. This is particularly important for groups such as the Hispanic and Karen populations discussed in the results because immigrants face additional health risks, including institutional discrimination. One barrier to high-quality healthcare that immigrants may face is lower health literacy, or a lower understanding of health conditions and ability to get care when needed. One study found that a significant population of Hispanic immigrants had a low health literacy, particularly immigrants of low socioeconomic status or those facing a language barrier (Becerra et al., 2017). In addition to these barriers, it is important that health practitioners are trained on cultural competency and willing to work with the beliefs of these populations to improve adherence to treatments and improve health outcomes.

Implications for Latino Immigrants.

The current political environment surrounding immigration, specifically attitudes and policies regarding the Latino population, has consequences not only on the legal status of immigrants, but also on their health. The Latino population is also not homogenous; Latinos arrive in the United States from a variety of countries and for a variety of reasons.

Health literacy also plays a significant role in creating barriers to quality healthcare for Latino immigrants. Latino immigrants have been found to have lower health literacy than other racial and ethnic groups in the United States, which has been consistently correlated with a lower quality of care (Calvo, 2016). In addition, English proficiency has been identified as a predictor

for health literacy (Jacobson et al., 2016); however, it is important to note that this may be less significant in places where more bilingual resources are available (bilingual staff at health clinics, educational materials in multiple languages, etc.).

Despite these disadvantages, it has been found that Hispanic seniors have a higher life satisfaction than their white counterparts, possibly due to higher levels of contact with children and family and higher levels of social connection, particularly through church attendance (Calvo et al., 2017). This reinforces the importance of social engagement in healthy aging. On the other hand, Latinos tend to have longer life spans and higher levels of morbidity but rely less on outside help or institutions in caring for aging relatives, especially first-generation immigrants (Angel et al., 2014). Serving as a caregiver for a family member can be emotionally, physically, and financially difficult for all of those involved; however, a study of Mexican American caregivers found that the majority viewed their actions as a choice rather than a responsibility (Mendez-Luck & Anthony, 2015).

While widespread education and policy change remain important in improving healthcare outcomes, smaller scale measures based in essential support networks, such as churches and neighborhoods, may serve as the best vehicles for improvement in health literacy and healthcare for the Latino population. One possibility is implementing health education and outreach programs through churches. Studies have found that these programs often find success through the trust that the population already has in the church as well as their ability to reach people who may not have access to preventative care, where education and planning can take place (Schwingel & Gálvez, 2016). Another technique that has shown promise is the use of promotoras de salud, or community-based health promoters and educators, in combination with creating access to community resources. One study found that by using promotoras to increase awareness

of health complications in older adults, giving the adults in the community access to community resources (such as a membership at a YMCA), and following up with the promotoras, led to the attendance of multiple sessions geared toward fitness and nutrition each month (Balcázar et al., 2015). The same study also found that the promotora model was particularly effective for first-generation immigrants. Finally, in addition to increasing access to community-based resources, it is essential that activism and policy-change occur in order to reduce stigma and improve Latino's access to high-quality healthcare.

Implications for the Karen Immigrants.

The nation of Burma, or Myanmar, has been the site of ethnic conflict and human rights violations for many years. For clarity, this paper will refer to the country as Burma, as the name Myanmar was put in place by military power and is not preferred by the majority of Burmese refugees (Fike & Androff, 2016). The same article describes the origin of the conflict, where previously coexisting heterogenous ethnic groups were forced into homogeneity by colonialism and a military dictatorship. The Karen people, who practice a variety of religions, are one of the minority ethnic groups who were discriminated against once the conflict began.

As a result of this conflict, an increased number of Karen refugees have settled in the United States in the past few years (Lee et al., 2015). With this resettlement comes the responsibility of helping ensure that the Karen people have access to the resources they need to be successful in this new environment, including access to quality healthcare. One challenge with providing healthcare to the Karen people is the distinct difference between the medicine practiced in the US and what is normally practiced in Burma. Influenced by both tradition and their rural location, the common practice of the Karen people in Burma was traditional medicine, using natural remedies passed down through generations to cure sickness. Despite this, the

majority of refugees who resettle in the United States transition to using western medicine; although, the transition is not perfect (Wodniak, 2018). Wodniak (2018) noted that Karen refugees experienced confusion regarding insurance, appointment scheduling, and inadequate explanations of health problems and test results by both practitioners and translators. In addition, they reported fear that their continued use of traditional medicine would be stigmatized by practitioners and affect their quality of care.

Knowing the barriers that these refugees face can help guide the development of interventions moving forward. Specifically concerning the aging population, these challenges suggest a need for both systemic and community-based change. On the systemic level, access to affordable and straightforward insurance coverage is important to reduce confusion regarding the availability and cost of healthcare. It is also important that health literacy education is implemented to help alleviate uncertainty and increase compliance with treatment plans. Additionally, as this population has become increasingly present in the United States, it is important that practitioners, including those in training and those practicing, receive cultural competency training in order to improve their awareness of the lived experiences of these groups as well as their cultural practices to allow for more open conversations. Finally, a compromise needs to be found that can involve both traditional remedies and western medicine, as this may increase the older adults' comfort with treatment plans while still giving them access to modern remedies when appropriate. This should also include further scientific studies into the common natural remedies to better understand any active ingredients, which could prevent negative interactions with western medications and could even lead to medical discoveries that could help the population as a whole.

Conclusions

        The road to providing access to quality healthcare and improving the access of seniors to a high quality of life is not the same for every individual or group. Differing beliefs and practices, as well as differing risk factors and barriers to quality care, mean that a uniform approach to senior care is not the most effective. Despite this, the implementation of some measures would likely have an impact on a large number of seniors, especially those in populations with more risk factors, such as Karen or Latino immigrants. The first important goal is to create and implement additional cultural competency education for healthcare professionals and those working in senior care. Raising awareness about these populations and increasing the working knowledge of professionals may lead to increased patient satisfaction and outcomes. Health literacy education for seniors is also important, as an increased understanding of what they read or hear during doctors' visits may lead to better outcomes. Additionally, systemic change to improve the treatment of immigrants and their access to the healthcare system would allow more seniors to seek professional help for mental and physical health conditions.

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