

The Health of The Hispanic Elderly: Mortality, Morbidity, and Barriers to Healthcare Access

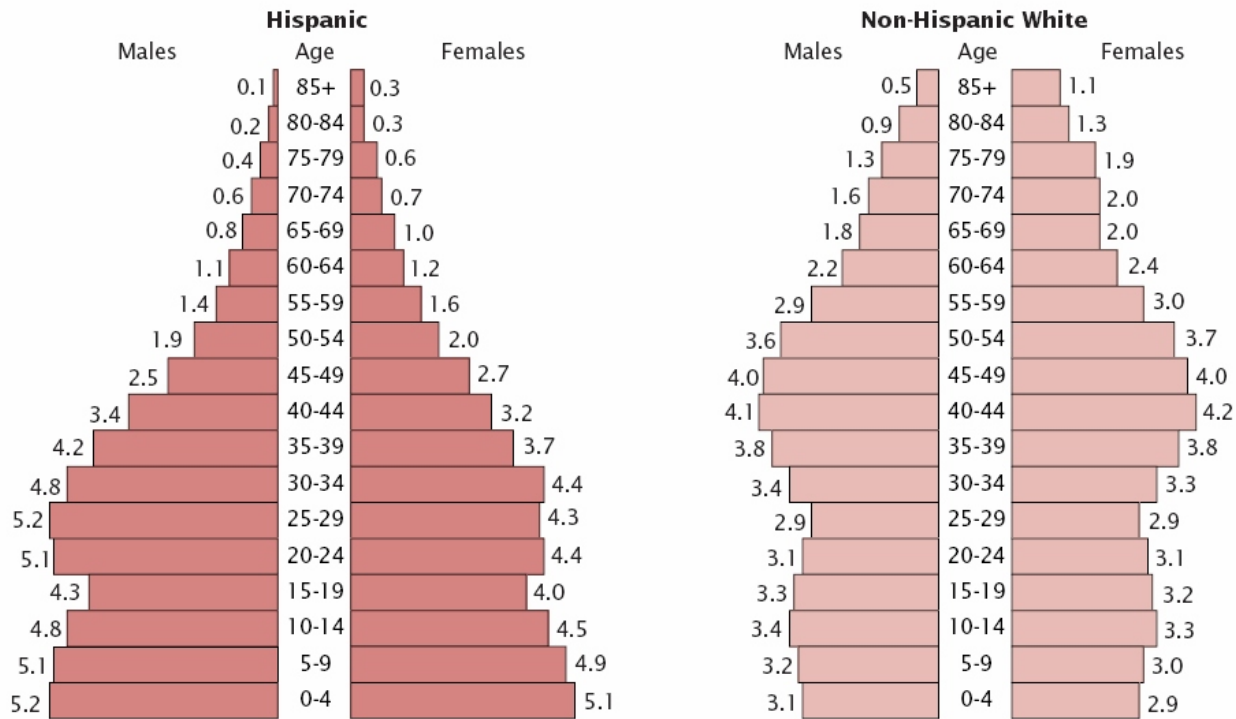
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Demographic Overview of the Hispanic Population

The U.S. Census Bureau estimated that in 2005, nearly 43 million individuals of Hispanic origin resided in the U.S. Now the largest minority ethnic group, the Hispanic population has grown exponentially in recent years, and projections suggest that this growth will continue in the decades to come. With the elderly accounting for only 5.35% of its population, U.S. Hispanics are considerably younger than other U.S. minority groups and non-Hispanic Whites, with a median age of approximately 27.2. Of any U.S. ethnic group, the elderly is least represented among Hispanics, but still represent a significant segment of the population numbering 2,284,279 persons aged 65 and older. In contrast, the elderly account for 13.5% of the non-Hispanic White population in the U.S. (U.S. Census Bureau, 2000). The Black and Asian/Pacific Islander populations have elderly population proportions similar to each other at 8.21% and 8.75% respectively. The graph below demonstrates the differences in age distribution for men and women of Hispanic origin and among non-Hispanic Whites, highlighting the difference in population proportion by age between the two groups. For example, in 2002, elderly Hispanic males accounted for 2.1% of the Hispanic population, while elderly non-Hispanic White males accounted for 6.1% of the White population.

Graph A.

Figure 4.
Population by Hispanic Origin, Age, and Sex: 2002
(In percent)¹



¹Each bar represents the percent of the Hispanic (non-Hispanic White) population who were within the specified age group and of the specified sex.

Source: U.S. Census Bureau, Annual Demographic Supplement to the March 2002 Current Population Survey.

Source: *The Hispanic Population in the United States, March 2002*; Therrien & Ramirez, 2000

In spite of the current disproportionately small number of Hispanic elderly, projections show that Mexican American adults over the age of 65 will number six million by the year 2050 (Masel, Rudkin, & Peek, 2006; Angel & Angel, 1998). Nationally, the U.S. aging population has grown significantly throughout the last century. This is due to a number of factors. For example, the U.S. life expectancy in 1900 was 47, but has now reached 77. In addition, baby boomers have begun to enter the ranks of the elderly. By 2030, estimates show that 70 million, or 20%, of the U.S. population will be 65 or older (CDC, 2004). The U.S. Census predicts that between 1990 and 2030 the white older population will increase by 93% (Fitten, Ortiz, & Pontón, 2001). In comparison, from 1990 to 2030, Hispanics of all races/nationalities are projected to have a growth rate of 555% (Fitten, Ortiz, & Pontón, 2001) with a corresponding growth rate in their aging population.

Hispanic aging statistics already bear out this projection. According to the U.S. Census, Hispanics are the fastest growing portion of the population at or near retirement. In the 20 years between 1970 and 1990, the Hispanic population aged 65 and older grew by 150%, a statistic revealing that elderly Hispanics comprise one of the fastest-growing age-ethnic populations in the U.S. (Hobbs, 2001). According to U.S. Administration on Aging statistics, in 2006, the Hispanic elderly comprised 6.4% of the total United States elderly population. By 2030, it is projected that the Hispanic elderly will comprised 11.2% of the United States elderly population, and by 2050, 17.5 %.

As the Hispanic elderly population continues to grow, mortality, morbidity, and access to healthcare are all important factors that will influence their well being in their later years of life in the U.S. Following is a review of some of the prevalent causes of death, illnesses, disparities in comparison to other racial/ethnic groups, and barriers to healthcare access for the Hispanic elderly.

Leading Causes of Death for Elderly Hispanic Population

Table A.

Top 5 Leading Causes of Death for Hispanics, 65+

	Number	Percentage of Total Deaths
All Causes of Death	66,944	100
Diseases of the heart	21,301	31.8
Malignant Neoplasms	14,013	20.9
Cerebrovascular diseases	4,930	7.4
Diabetes Mellitus	4,180	6.2
Chronic Lower Respiratory Diseases	2,634	3.9
Total (for top 5 causes)	47,058	70.3

Source: National Vital Statistics Report, Heron & Smith, 2007

As noted in Table A, the top five causes of death for older Hispanics account for 70.3% of the all causes of death, making these causes of primary importance in health prevention efforts. The remaining five of the top 10 causes of death among elderly Hispanics were the following: influenza and pneumonia, Alzheimer's disease, nephritis (or nephritic syndrome and nephrosis), accidents (or unintentional injuries), and chronic liver disease/cirrhosis (Heron & Smith, 2007). For non-Hispanic Whites, Alzheimer's disease is the fourth leading cause of death, but this chronic disease is ranked lower for Hispanics. This could possibly be attributed to underdiagnosis within the Hispanic populace (See the *Alzheimer's Disease* section). Diseases of the heart, malignant neoplasms (cancer), cerebrovascular diseases, and chronic lower respiratory diseases are also on listed as top five causes of death for non-Hispanic Whites and Blacks (Heron & Smith, 2007). Approximately 56% of Hispanics over the age of 50 have at least one common chronic condition (Shirey & Summer, 2003). One of the most prevalent of these chronic diseases, diabetes mellitus, ranks as the fourth leading cause of death.

Although not among the three leading causes of death within the Hispanic elderly population diabetes mellitus, Alzheimer's disease, depression, and fatal falls/accidents are address in greater detail below. Because diabetes mellitus affects the Hispanic community at disproportionately high rates, there is an increasing focus within the community and health professionals on the social, economic, and health care access constraints that are associated with the disease. Additionally, diabetes is a strong contributor to heart disease and stroke. Addressing this disease as a risk factor will have a significant positive effect in reducing both death and disability from cardiovascular disease, stroke and other various complications that arise from uncontrolled diabetes. Furthermore, Alzheimer's disease and depression draw attention to the less mentioned, but no less prevalent, mental health issues faced by older Hispanics. Finally, the frequency of fatal falls and their associated consequences are often excluded from the literature on the health of the elderly. This paper seeks to bring attention to these accidents as they may also contribute to our understanding of the health status of elderly Hispanic populations.

Diabetes Mellitus

Diabetes Mellitus, or Type 2 Diabetes, occurs in 10% of adults over the age of 65; however, prevalence rates for Hispanics are an estimated two to four times the prevalence rates for non-Hispanic Whites (Black, Ray, & Markides, 1999; National Council of La Raza, 1991).

In a sample of 3,050 elderly Hispanics living in the Southwest from the Hispanic Established Populations for Epidemiologic Studies of the Elderly (H-EPESE), Black, Ray, and Markides reported a 22% prevalence rate for self-reported diabetes (1999). This chronic disease is also associated with excess diseases, complications, disability, and premature mortality (Wray, Alwin, McCammon, Manning, & Best, 2006). These effects are more severe among Mexican Americans leading to higher mortality rates, peripheral vascular disease and other illnesses (Black, Ray, & Markides, 1999; Wray et al, 2006). According to a report by the American Association of Clinical Endocrinologists combining National Health and Nutrition Examination Survey data from 2000, 2002 and 2004, 44.2% of diabetic Hispanic and Mexican Americans have at least one complication from the disease, compared to 30.9% of Whites and 30.4% of Blacks.

The health burden of diabetes for Mexican Americans is likely greater when compared to their African American and White counterparts (Black, Ray, & Markides, 1999). Myocardial infarction, stroke, hypertension, angina, and cancer were significantly more common in diabetics than in nondiabetics for the elderly Hispanic sample (Black, Ray, & Markides, 1999). Those inflicted with diabetes also reported high rates of obesity, diabetes-related complications, and diabetic medication use. In addition to higher rates of medical illnesses among the diabetes sample, higher levels of depressive symptoms were also reported. Furthermore, diabetes is associated with an increased incidence of stroke and death in older Mexican Americans, particularly those taking insulin (Ottenbacher, Ostir, Peek, & Markides, 2004). For older Mexican Americans, the decreased rates of diabetes prevalence (12%) for the age group 85 years and older could signify greater negative consequences that could potentially result in decreased survival rates (Black, Ray, & Markides, 1999). (With continued research specific to the Hispanic elderly and this chronic disease, more effective prevention and intervention efforts can be undertaken to decrease the disparity between Hispanics and non-Hispanic Whites.

Overview of other Illnesses Prevalent in Hispanic Elderly Community

In addition to the top five causes of death mentioned previously, there are other health issues prevalent, albeit less commonly mentioned, within the Hispanic elderly population: Alzheimer's Disease, depression, and fatal falls.

Alzheimer's Disease

Alzheimer's disease (AD) is a common illness that occurs in late life, and comprises 50% of all dementias diagnoses. Estimates suggest that it affects 1% of individuals aged 60, and 40% of those aged 85 (Fitten, Ortiz, & Pontón, 2001). AD is dramatically underdiagnosed and undertreated in the Hispanic and Black populations (Fitten, Ortiz, & Pontón, 2001; Espino & Lewis, 1998). In 2003, Alzheimer's disease was the seventh leading cause of death among the Hispanic elderly, killing 1,795 people (Heron & Smith, 2007). For the Hispanic oldest-old population, ages 85 and over, AD was the fifth leading cause of death (Heron & Smith, 2007). In a sample of 100 cognitively symptomatic Hispanic residents in Los Angeles aged 55 and older, 65% of the patients were diagnosed with either AD or other dementias (Fitten, Ortiz, and Pontón, 2001). It is believed that this study has a more accurate account of dementia cases because 98% of the interviews and communication with subjects were in Spanish, most subjects' first and primary language. Because 76% had low levels of self-described English proficiency, conducting the interviews in Spanish increased the likelihood of an appropriate diagnosis. Within this group, Fitten, Ortiz, and Pontón (2001) also diagnosed 20% of the total sample with major depression, another pressing health ailment often overlooked within the Hispanic elderly population. The study suggested that various cultural and genetic risk factors for dementia among diverse ethnic/racial groups should be explored in future research.

Although it has been established that AD is under diagnosed within minority populations, less empirical evidence has explained causation. Espino and Lewis (1998) suggest that barriers to accurate and timely diagnosis include, but are not limited to, language barriers, access to quality healthcare, and socioeconomic conditions (i.e. financial strain and education level). Of the Hispanic elderly, 94% of Cuban Americans, 91% of mainland Puerto Ricans, 86% of Mexican Americans, and 76% of all other Hispanic Americans speak Spanish as their principal language (Espino & Lewis, 1998). Language barriers can lead to diagnostic errors and misinterpretations of symptoms of dementia. Mental health services and long-term care may not be a viable option for the poor elderly Hispanic who are often underinsured, sometimes depending solely on Medicaid; consequently, the mental health issues they face may go undiagnosed. In 1998, an estimated 63% of Hispanics over the age of 65 had eight years of formal education or less, compared to 28% of non-Hispanic Whites (Espino & Lewis, 1998). Attempts to ameliorate language and socioeconomic barriers can increase the likelihood of more accurate diagnoses of Alzheimer's disease within the Hispanic elderly population.

Depression

More than two million older Americans have some form of depression, often being undiagnosed or underdiagnosed (Mills & Henretta, 2001). In various studies, the following factors have explained differences in self-reported levels of depressive symptoms among the elderly population: gender, language acculturation, number of years of education, number of years of U.S. residency, health status, income, social isolation, underutilization of health services, and a history of depression (Chiriboga, Black, Aranda, & Markides, 2002; González, Haan & Hinton, 2001; Mills & Henretta, 2001; Falcón and Tucker, 2000; Swenson, Baxter, Shetterly, Scarbro, and Hamman, 2000). When compared to non-Hispanic Whites and Blacks, depression prevalence is higher for the Hispanic elderly. Estimates of depression prevalence for Whites and African Americans range from 9-16%. Research from the H-EPESE data concluded that 25.6% of the Mexican American elderly suffer from depressive symptoms. This translates into a five-state estimate of 120,770 older Mexican Americans who may be in need of treatment (Chiriboga, Black, Aranda, & Markides, 2002). The depression prevalence rate was 25.4% for a sample of 1780 Hispanics (80% Mexican) aged from 60 to 100 in Northern California (González, Haan, and Hinton, 2001). Older age (80+), lower levels of education, female gender, unmarried status, and low monthly income were associated with significantly increased risks of depression. Results indicated that more than one in four older Mexican Americans are experiencing major psychological distress. (González, Haan & Hinton, 2001; Chiriboga, Black, Aranda, & Markides, 2002).

Previous research suggests that there may be differences in depressive symptoms for various ethnic groups within the Hispanic elderly population. Falcón and Tucker (2000) examined depressive symptoms among an elderly Hispanic sample in Massachusetts that included Puerto Ricans, Dominicans, and an Other Hispanic category (Hispanic origin groups within the sample numbered 429, 128 and 149 respectively). Within the sample, prevalence of depressive symptoms was 44% for Puerto Ricans, 32% for Dominicans, and 30% for all other Hispanics. The rate for non-Hispanic Whites was significantly lower at 22%. The researchers concluded that Puerto Ricans, though receiving little empirical attention, experience higher levels of depressive symptoms, social isolation, and financial strain than other Hispanic groups. The factors that contributed to greater depressive symptoms among Puerto Ricans were poverty, lack of participation in community programs, and extremely poor health. Falcón and Tucker also postulated a connection between length of time in the U.S. and acculturation level and depression levels among Dominicans.

Generally, Dominican had spent less time in the U.S. than Puerto Ricans and could have been coping with adjustment to a new country/culture (Falcón & Tucker, 2000).

Mental health issues, including depression and Alzheimer's disease, are both underdiagnosed and undertreated. Studies show that both illnesses should be at the forefront of public health concerns for this targeted population. Additional empirical research and awareness are essential to increasing the quality of life for the Hispanic elderly who fall victims to these illnesses.

Fatal Falls or Accidents

According to the National Vital Statistics Report, 1,213 Hispanic elders died in 2003 due to accidents or unintentional injuries, making this the ninth leading cause of death among older Hispanics (Heron & Smith, 2007). Among older adults, falls are the leading cause of injury deaths (CDC, 2006) with about 31% of unintentional injury deaths caused by falls, although this rate may be an underestimate for the elderly population (Stevens, 2003). Data from the National Health Interview Survey suggest that from ages 65 to 85, the prevalence of functional limitations increased from 3% to 20%; consequently, as the Hispanic elderly population ages, fatal falls will increase in frequency, creating an issue demanding additional awareness and prevention (Stevens, 2003; CDC, 2006). Each year, approximately 8% of all people aged 70 and older are treated in emergency departments for fall-related injuries, and one-third of these will be hospitalized. The total direct cost of all injuries for people age 65 and older in 1994 was \$20.2 billion (Stevens, 2003). Injuries received from a fall can result in death, disability, nursing-home admission, and direct medical costs. The Center for Disease Control (CDC) Morbidity and Mortality Weekly Report does not provide information specific to Hispanics, but the analysis suggests that the prevalence of falls within the elderly population has increased from 1993 to 2005. The CDC outlined four fall prevention strategies. These include regular exercise, review of medications to reduce side effects and interactions, annual eye examinations, and reduction of fall hazards at home.¹

Barriers to Healthcare Access for Hispanic Elderly

The Hispanic elderly population is more likely to contract certain diseases, receive less preventative care, and have less access to health education or health care (National Council of La Raza, 1991; Espino & Lewis, 1998). These factors lead to disparities in health outcomes, morbidity, and, eventually, mortality. Of all racial/ethnic groups, Hispanics have the lowest rates of health insurance coverage (Pew Hispanic Center, 2004).

¹ Additional information available at www.cdc.gov/ncipc

The Pew Hispanic Center reported in 2004 that 20% of native born Hispanics, 25% of foreign born Hispanics and 55% of foreign born Hispanics without citizenship lack health insurance (2004). Because of this lack of health insurance, Hispanics are less likely than Whites to use health services for preventative care. Although many of the Hispanic elderly have access to Medicare, these individuals are often underinsured if they lack supplemental private insurance and/or Medicaid (Shirey & Summer, 2003). Thirty-six percent of Hispanic elderly with chronic conditions rely solely on Medicare to meet their healthcare needs; another 39% have both Medicare and Medicaid. Sixty percent of elderly non-Hispanic Whites with chronic illnesses have both Medicare and private insurance, compared to only 20% of elderly Hispanics with chronic conditions (Shirey & Summer, 2003). Moreover, Hispanic adults with chronic conditions report that they are more likely to have difficulty obtaining health care and are less satisfied with their care, compared to non-Hispanics with chronic conditions.

Insurance coverage may affect non-physician service use for Hispanic elderly. Medicare does not always cover additional costs associated with non-physician services such as patient visits to optometrists, chiropractors, psychologists, physical and occupational therapists, and social workers. These services may be essential to preventing or controlling certain chronic diseases (i.e. diabetes patients should visit an optometrist to prevent complete vision loss). Nationally, less than one-third of older Hispanic adults (50 or older) have insurance coverage for prescription drugs (Shirey & Summer, 2003). In the H-EPESE sample, instability and change in health insurance among older Mexican Americans was common, contradicting the common assumption that one's income and insurance status are fairly well fixed at the age of 65 (Angel R, Angel J & Markides, 2002). Respondents in the sample who reported no insurance were much poorer, more likely to have been unemployed throughout life, and to have come to the U.S. later in life than those in other groups.

In order to decrease the current disparities, it is necessary to determine the barriers to healthcare access. As stated by the National Council of La Raza, “Barriers to healthcare for Hispanics are cultural, linguistic, geographical, and economic (1991).” Following is a brief discussion of the relevance of these three categories of barriers that lead to disparities in health, lack of preventative care, and disparate healthcare access.

Cultural/Linguistic

Because of the diversity of cultural practices within the Hispanic population, the concept of culture is difficult to operationalize. However, language is one component of culture that has a significant influence on healthcare access for the Hispanic elderly. It has been estimated that more than 70% of all Hispanic elderly consider Spanish as their primary language (Espino & Lewis, 1998). Under these circumstances, the effective patient-physician communication that is essential to proper diagnosis of certain mental conditions, medication use adherence, and patient level of satisfaction with health care providers can easily break down (Shirey & Summer, 2003; Espino & Lewis, 1998; Fitten, Ortiz, & Pontón, 2001). In 1991, the National Council of La Raza reported that few health care providers spoke Spanish, and even fewer are of Hispanic origin. In spite of efforts to increase the representation of Hispanics in the medical field, they are still underrepresented, likely contributing to the prevalence of language barriers between patients and physicians. In a sample of Hispanic elderly in Los Angeles, 88% of the uninsured qualified for available health insurance programs. They were unaware of the programs, however, because of language barriers, insufficient insurance knowledge, and not knowing how to process applications, among other similar reasons (Fitten, Ortiz, Pontón 2001). Language barriers then undoubtedly influence access to healthcare, insurance coverage, and perceived quality of care. As the Hispanic elderly population continues to expand, the demand for bilingual healthcare providers will increase.

Culturally-based use of alternative or herbal medicine instead of disease interventions that have been tested and proven to be successful is another barrier to effective healthcare. The number of people using alternative medicine increased from 33.8% in 1990 to 42.1% in 1997 (Eisenberg, 1998). Increasing popularity of alternative medicine could be an attempt to lower health care expenses by using less expensive alternative medicines for prescription medicines. Herbal medicine use has traditionally been associated with ethnic populations, particularly among elders. The use of herbal home remedies is also a factor that may influence the prevalence of healthcare use and preventative care. Loera and colleagues (2001) found herbal medicine usage rates of 9.8% in the H-EPESE sample of elderly Mexican Americans. Chamomile and mint were the most commonly used herbs. The individuals who used herbal medicine were more likely to be women, born in Mexico, over the age of 75, living alone, and experiencing some financial strain. For the people who reported disability in activities of daily living, poor self-reported health, and depressive symptoms, herbal medicine usage was even higher.

Loera and colleagues (2001) also reported that herbal medications were relatively common among older Mexican Americans with chronic medical conditions, particularly among those with limited financial resources.

Certainly language barriers and herbal remedy usage are not the sole cultural barriers that may influence healthcare access and usage within the Hispanic elderly population. However, these factors have received more empirical evidence than other cultural factors that may vary across different ethnic groups within the Hispanic population. Other cultural factors include, but are not limited to, religious beliefs and practices, use of spiritual healers, and significant differences in cultural mores in comparison to U.S. mainstream culture. For these reasons, cultural competency will become an increasingly important topic for health care providers and other professionals in the health education and medical fields.

Socioeconomic

Education, occupation, and income are three of the main predictors of socioeconomic status. These factors also affect insurance coverage and healthcare access. Education, employment, and health insurance are inextricably linked in the U.S. economic system. More than half (53.1%) of Mexican immigrants aged 25 or over have less than 10 years of schooling, four times the percentage of other immigrant groups and Mexican Americans (14%), and 12 times that of U.S. born Whites (4.4%). Undocumented status and lack of education creates further disadvantage that leads to a lowly status in the American occupational hierarchy (Zúñiga, Castañeda, Giorguli, & Wallace, 2006). Less education is usually directly related to employment benefits and insurance coverage. In jobs where the wages are low, employment benefits, such as quality health insurance, are scarce. For the elderly, education levels are considerably lower than that of the overall Hispanic population. An estimated 63% of Hispanics over the age of 65 have only eight years of formal education or less, compared to 28% of non-Hispanic Whites (Espino & Lewis, 1998). Low education levels are directly related to knowledge of medical condition and medicine usage, and use of healthcare and preventative services. Also, lower income levels are associated with several diseases prevalent within the Hispanic elderly population (see *Alzheimer's disease*, *Depression*, and *Diabetes* sections). In the H-EPESE sample, approximately one-third of older Mexican Americans reported personal incomes of less than \$5,000 (Chiriboga, Black, Aranda, & Markides). Because of the prevalence of low socioeconomic status, community health education efforts specific to the Hispanic elderly should be implemented to increase awareness of healthcare provisions and preventative care.

Geographical

Geographical location is also an important factor in the level of healthcare access and preventative care available to the Hispanic elderly. In rural areas, accessing healthcare generally requires traveling a longer distance from place of residence, making it difficult for the elderly, especially the disabled, to seek medical attention. Also, the availability of bilingual healthcare providers may be significantly lower in less populated areas. Also, specific populations may face graver health problems due to the location in which they work and/or live. For example, Hispanics comprise the majority of the migrant and seasonal farm work population in U.S. (National Council of La Raza, 1991). Life expectancy for farmworkers is 49 years of age, compared to 75 for the total population. Farmworker environmental issues including water usage, proximity to toxic exposure, and substandard living conditions can all have a negative influence on health and increase the demand for healthcare services. The need for community health centers, treatment centers, and hospitals is critical for the Hispanic elderly in certain geographical areas as they struggle to survive in face of environmental issues.

Conclusion

As the U.S. prepares for the burgeoning of its older population, defined as those aged over 65, the Hispanic elderly will comprise a significant segment of this growing population. Not only is the Hispanic elderly population growing at a rapid rate, but they often have higher rates of chronic disease and less access to care. As a result, health care providers, especially those specializing in geriatrics, will be called upon to find more effective means of diagnosing and treating the mental and physical illnesses of Hispanic elders and increasing preventative measures so that this population will be privy to a high quality of life for as long as possible. Although still a small portion of the overall Hispanic population, Hispanics over the age of 65 face disparities and barriers to healthcare resulting in poor health outcomes. These poor health outcomes create an urgent contemporary public health concern. Health education and behavioral changes are necessary to prevent some of the illnesses prevalent within the targeted population. However socioeconomic and health disparities will continue to plague minority populations without necessary changes in national social and health policies. Among these changes should be increased access to healthcare and insurance. Currently, the Hispanic elder population tends to be underinsured and tends to not adequately receive preventative healthcare or treatment for health issues. The mortality and morbidity rates of the Hispanic elder population hinge on the mobilization of the healthcare system, healthcare providers, nonprofit organizations and the Hispanic community to address the host of challenges and barriers faced by this population group. Moreover, additional empirical evidence is necessary to examine the differentiations in health outcomes based on Hispanic origin. In spite of the growing body of literature on the Hispanic elderly, additional research is necessary to determine ways in which certain illnesses can be prevented or treated more effectively within the elderly Hispanic populace.

The **National Hispanic Council on Aging (NHCOA)** is the nation's premier constituency-based organization dedicated to improving the quality of life for the Hispanic/Latino elderly, their families, and their communities. NHCOA represents a network of 42 community-based organizations across the continental U.S., the District of Columbia, and Puerto Rico. NHCOA also maintains a broader network of 7,000 individuals and reaches 10 million Hispanics each year through its work and that of its affiliates.

NHCOA focuses on the following program priorities: health promotion and disease prevention, financial security and civic engagement, policy, leadership development, education and housing. Its policy priorities include addressing health disparities, promoting economic security, ensuring availability of affordable and elder accessible housing, and building stronger and more cohesive communities through provision of technical support and financial assistance to community-based organizations serving Hispanic older adults.

NHCOA operates on both a local and national level, working with its network of community-based organizations locally and implementing advocacy on behalf of its broader constituency of Latino elderly on a national level. Specifically, on the local level, NHCOA provides community-based organizations with training, technical assistance, sub-grants, and access to the latest research and best results-producing programs. NHCOA also helps local groups form partnerships and coalitions that enhance their resources, influence, and ability to extend their reach. On the national level, the Washington, D.C.-based NHCOA educates legislators on the aging community's needs and contributions, and helps craft permanent solutions to the problems that compromise the security, health, happiness, and dignity of America's fastest-growing senior population.

NHCOA is an expert in developing interventions based on research and building on work already done by elder- and Hispanic-serving organizations and agencies. The organization follows a proven approach. First, NHCOA conducts original research when needed or draws on professional studies to design effective community interventions. It then implements a needs assessment for participating community-based organizations and provides needed technical assistance and training to prepare the organization to implement the intervention. NHCOA uses program components that have been shown to be effective. For example, NHCOA is known for its use of community health educators or *promotores* in its health education and promotion programs. *Promotores* have been shown to be highly effective with hard-to-reach Hispanic populations, such as the aging population. NHCOA is also known for its dedication to implementing interventions in an age-sensitive, linguistic- and culturally-appropriate manner.

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