



# AARP Kentucky:

Health outcomes and root causes for  
those 50+ in Louisville

January 2022

# Acknowledgments

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# I. Executive Summary

This report addresses some of the most significant poor health outcomes and leading causes of death experienced by Louisville’s population of individuals 50 years and older. To understand these inequities, root causes including income, housing, transportation, food access, healthcare and social connectedness are examined for how they impact those 50+ in Louisville. This report uses statistical analysis of existing data sets and new survey research, community story telling sessions, and literature review of existing research. Funded through AARP Kentucky, the work draws from over a decade of local efforts to create structural shifts which would improve health outcomes and quality of life for all Louisville residents.

Most disparities in the health of those aged 50 and older are associated with disadvantage that has accumulated over the life course. In other words, they are not random. This report highlights systems of power such as racism and sexism that impact the conditions – or root causes – residents experience that shape these health outcomes.

About 35.7% of the population in Louisville is aged 50 or older. This population is disproportionately White and located in the Eastern part of the county, which underlines how health inequities across the lifecourse can shape who lives longer in our community.

## Health outcomes

Typically, the outcomes that are seen are an accumulation of inequities experienced over the lifecourse. While different age groups might experience different health outcomes, these patterns can often be explained by access to resources both earlier in life as well as the current conditions residents are experiencing (often predicted by root causes earlier in life).

Cancer and heart disease respectively are the leading causes of death across all age groups and make up the largest proportion of deaths in our community.

However, there are differences in which outcomes are more prevalent by age. For example, those under 70 see accidents as a top six cause of death, whereas those over 75 see an increased prevalence in Alzheimer’s-related deaths.

Health inequities in older adults are a result of a lifetime of compounding inequities in the root causes of health (housing, food access, income, and employment, etc.) In the US, this is particularly driven by race-based discrimination, causing older adults from communities of color to experience more rapid physical dysregulation and therefore differences in quality and length of life.

1	Cancer (Malignant Neoplasms)							
2	Heart Disease							
3	Accidents		Lung Disease					Alzheimer's
4	Self Harm	Lung Disease	Diabetes		Stroke	Alzheimer's		Stroke
5	Liver Disease	Stroke	Accidents	Stroke	Diabetes	Stroke		Lung Disease
6	Lung Disease	Diabetes	Liver Disease	Accidents	Kidney Disease			Accidents
	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Figure 1: Leading Causes of Death to the 50+ Population by 5-year Increments in Jefferson County								

## Root causes

Root causes are the conditions that residents experience that help determine what types of resources they will have access to, and therefore the degree and type of health outcomes they might experience. Below are some key takeaways from the report:

- Employment and Income
  - As residents age, they often leave the workforce and rely on supplemental sources of income like Social Security to reduce economic instability and provide for their basic needs.
  - There are persistent racial and ethnic inequities in labor participation and income over the lifecourse which remain as people age, contributing to racial inequities in financial instability for those aged 50+.
- Housing
  - Regardless of housing type, many of those aged 50+ have a desire to age in place, however many cite financial difficulties that prevent housing upkeep or modifications.
  - Although housing constitutes a significant financial cost for all, renters are more cost-burdened than homeowners, and across both categories, Black and Hispanic/Latinx residents are more likely to experience financial difficulties.
- Transportation
  - Many people rely on vehicles to have access to other needs like food, employment and healthcare. There is a racial/ethnic gap, where White residents are more likely to have access to a working vehicle or some other form of reliable transportation.
- Food access
  - Healthful, nourishing food is critical to health at all ages, and especially as adults age to avoid or better manage chronic illnesses such as heart disease, diabetes, and kidney disease. Inequitable health outcomes are perpetuated by the underlying inequities in food systems faced by older adults. Supportive services can help fill in gaps, but ultimately older adults need a food system that adequately supports them.
- Health care
  - An affordable, accessible healthcare system that has the flexibility to adapt to the needs of an aging population is necessary to ensure preventative care and treatment are readily available. Our existing healthcare system must also prioritize anti-racist approaches to patient care, as older adults of color continue to experience discrimination and inequitable quality of care as they age.
- Social Connectedness
  - Social isolation is a critical issue for older adults, with a quarter of those over age 65 reporting social isolation. Social isolation also perpetuates poor mental health and unhealthy coping mechanisms.
  - Further, isolation leads to a lack of social support including those who may be able to provide support for older adults who may need assistance with things such as transportation or food access.

## II. Project Methodology

Our team used a mixed methods research design to explore inequities in health outcomes in Jefferson County for people 50 and older. The multi-pronged approach included conducting a literature review, analyzing existing quantitative data such as Vital Statistics, CDC WONDER population estimates, and Public Use Microdata Sample, and Louisville Metro Department of Public Health and Wellness COVID-19 data, conducting a public survey and conducting interviews with a subset of Louisville residents aged 50+.

Using a mixed methods approach with multiple data sources allows for a more nuanced understanding of what residents are experiencing and helps explain patterns that are occurring as well as why they might be occurring. For more details on the methodology as well as the survey and focus group questions see the appendix.

# III. Framework

## A framework for understanding aging and health

The concept of “successful aging” was created in the late 1990s to address the growing aging population in the United States.<sup>1</sup> This concept understands aging as a natural process, but one that can be supported so that residents can experience better conditions as they age.

Components of aging include:

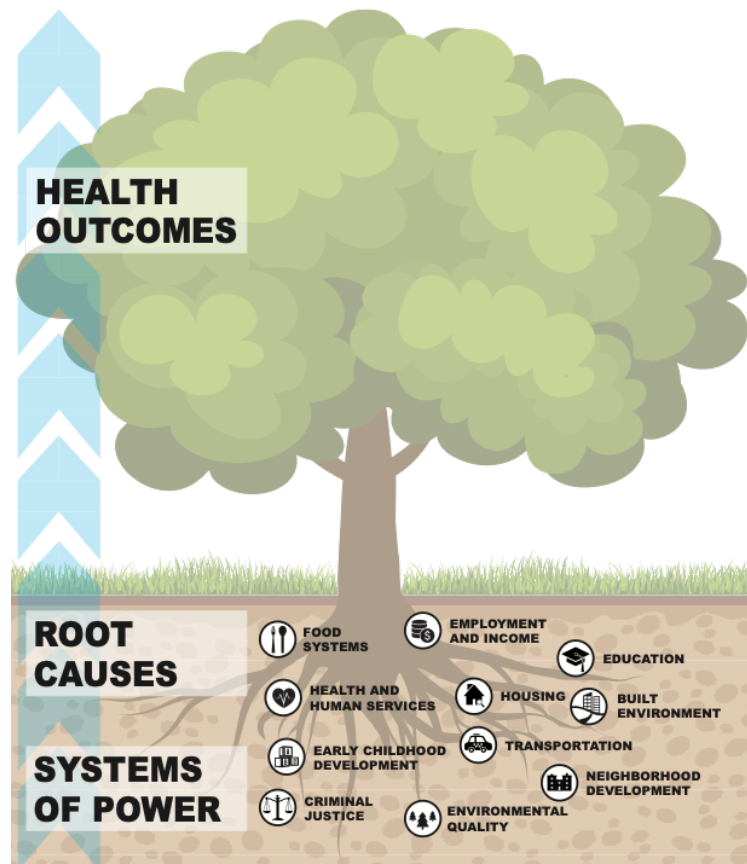
- Health status
- Functioning
- Social inclusion

“Successful aging” would mean that a resident would experience good health – for example a lack of disease or injury, high functioning – for example the ability to maintain physical and cognitive activities, and finally active social connections in their life.

This describes optimal outcomes but does not necessarily describe what that means for the types of interventions needed across a community, or why inequities exist among older adults.

This report builds upon framing from Center for Health Equity’s 2017 Health Equity Report to better understand how it applies to a specific population – in this case, Louisville residents aged 50+. Frameworks help understand how systems shape the health outcomes our residents experience. Center for Health Equity explains health inequities using the tree metaphor.

- In this analogy, health outcomes (the leaves) are the result of a system designed to create different patterns.
- Root causes (the roots) are conditions like employment, housing, and healthcare (which will be discussed in this report) that can create advantage or disadvantage depending on how populations and subpopulations experience these root causes.
- Systems of power (the soil) are the values and therefore historical through present day decisions that are made that then impact the way residents experience root causes, therefore the resources available to them, and finally the health outcomes they might experiences.



Several other frameworks help describe some of the health inequities documented in this report. The lifecourse framework<sup>2-3</sup> focuses on how the accumulation of positive and negative social, physical, and environmental exposures impact health and well-being across and within generations.<sup>4</sup> This framework helps explain why early life experiences impact health at an older age, or how employment history in adulthood might impact later life outcomes.

Weathering<sup>5</sup> was identified by Dr. Arline Geronimus in the early 1990s as a way to describe how constant stress might “weather” and therefore create worse health outcomes for Black infants compared to White infants when their mothers were same age. People of color often face premature biological aging, “driven by the cumulative impact of repeated exposures to psychological, social, physical, and chemical stressors in residential, occupational, and other environments, and coping with these stressors”.<sup>6</sup>

Intersectionality,<sup>7</sup> coined by Kimberlé Crenshaw, is an important framework for addressing the root causes that shape health for the 50+ population in Louisville. Intersectionality “references the critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities.”<sup>8</sup> In other words, people do not experience inequities in a vacuum and people experience racism, classism, and sexism simultaneously. This means people experience interactions and root causes in ways that cannot simply be added up, but often combine in synergy to create a totally different effect. Certain populations of 50+ may have more life stressors to contend with than other age groups and thus layers of inequities leading to potentially worse health outcomes. This is why this report outlines and discusses statistics and data on root causes connected to health and break this data down by race, ethnicity, gender, and age group where available.

This study was conducted during the COVID-19 pandemic, and as such COVID-19 was at the forefront for many participants during conversations about health and aging in Louisville. Nationally and locally, COVID-19 and its cascading social and economic effects has disproportionately impacted people of color and low-resourced communities.<sup>9,10</sup> Many inequities that existed before COVID-19 were exacerbated, and therefore it is referenced throughout the report.

Taken together, this means that while everyone ages, not everyone experiences it in the same way or at the same rate because there are social policies and environmental conditions that might help create better supports for some or additional barriers for others.

In this report you will see an exploration of who Louisville’s 50+ community is, what health status they are experiencing, and which root causes might contribute to the ability to age successfully.



## IV. Demographics

### Demographic Overview of Louisville's 50+ Population

Those aged 50+ in Louisville are dynamic and diverse. According to 2019 ACS Public Use Microdata Set (PUMS) estimates, 273,761 people in Louisville (35.7% of total population) are 50+. Over half of those (56%) are 50–64 years of age and (6%) are aged 85+ (Figure 2).

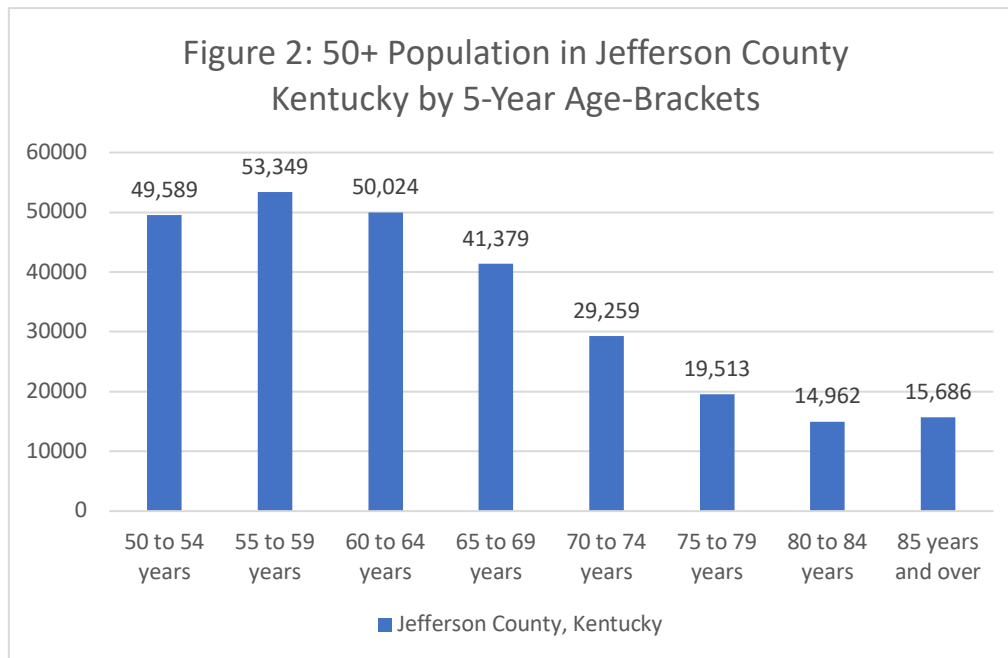


Figure 2: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

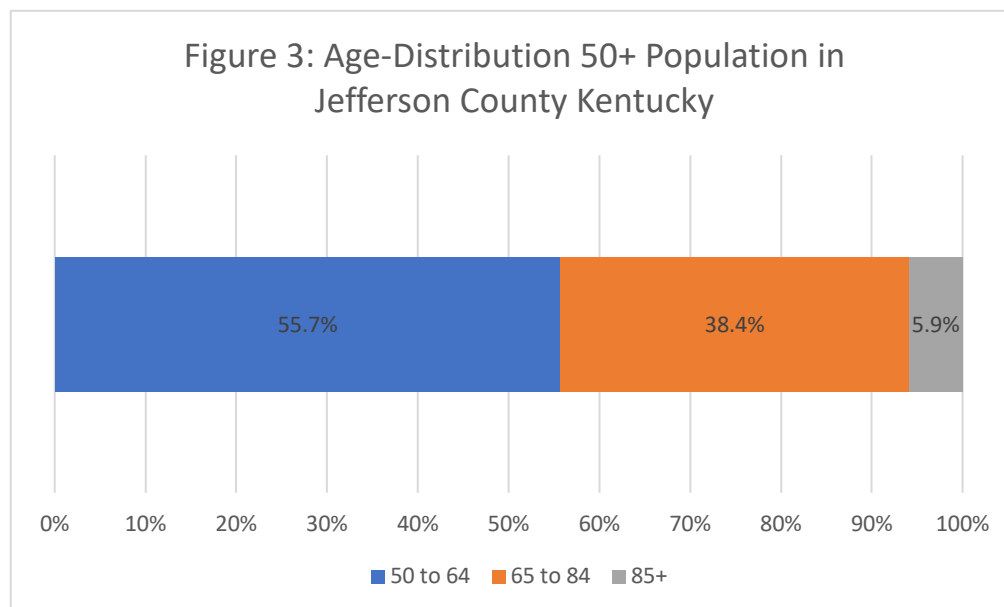
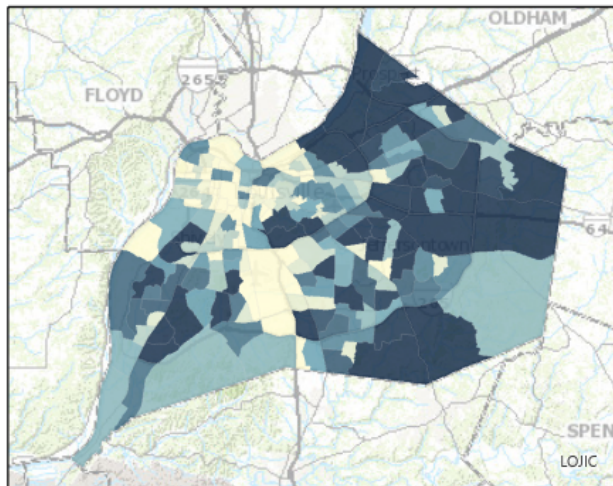


Figure 3: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample



50+ Population Jefferson County

50+  
 > 2,105  
 < 762

Figure 4:  
 estimates based on  
 2019 5-year  
 American  
 Community  
 Survey Estimates.

## Age & Race

When comparing the older age groups to younger age groups in the 50+ cohort, the percentage of the population that is Black decreases whereas the percentage of the population that is White increases as cohorts age (Figure 5). Ultimately, White residents represent 89% of the 85+ population while Black residents represent only 11% of the 85+ population in Jefferson County (Figure 5). This may be an indicator of “weathering,” premature death, and inequities faced between population groups.

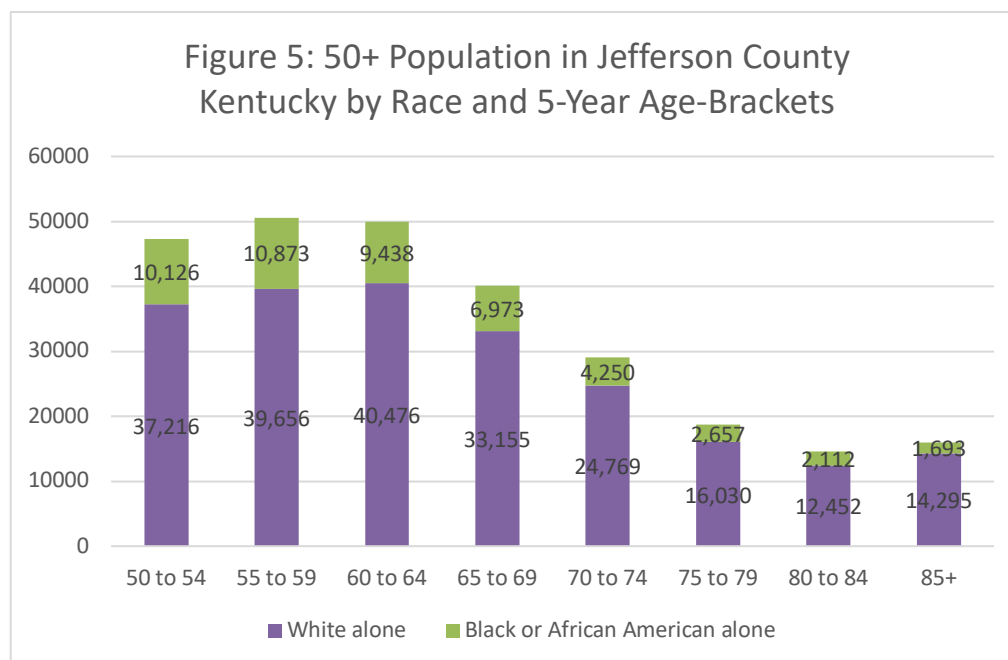
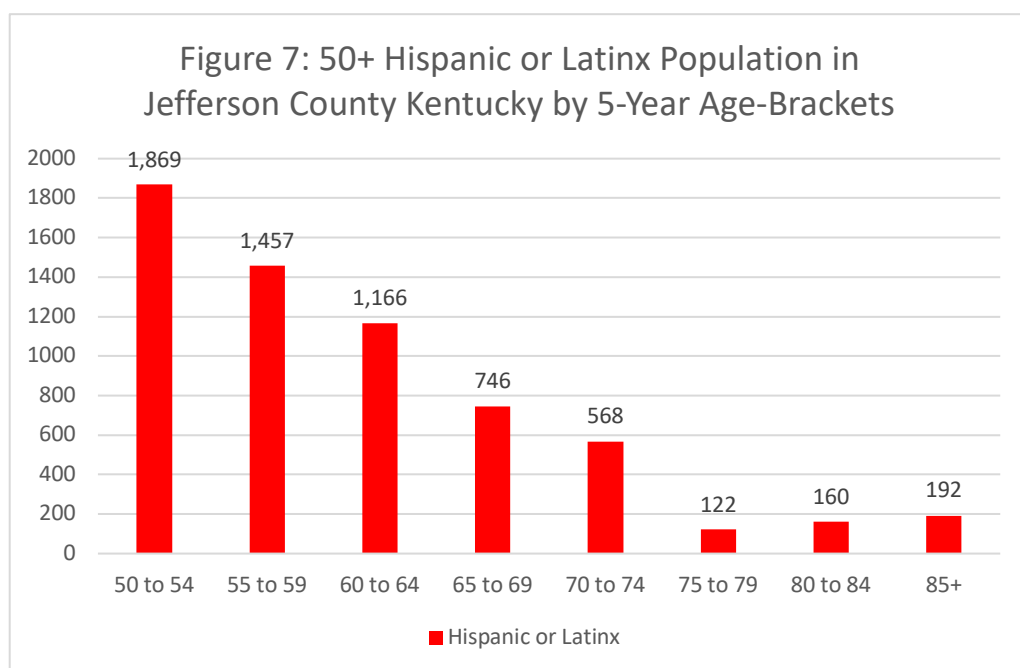
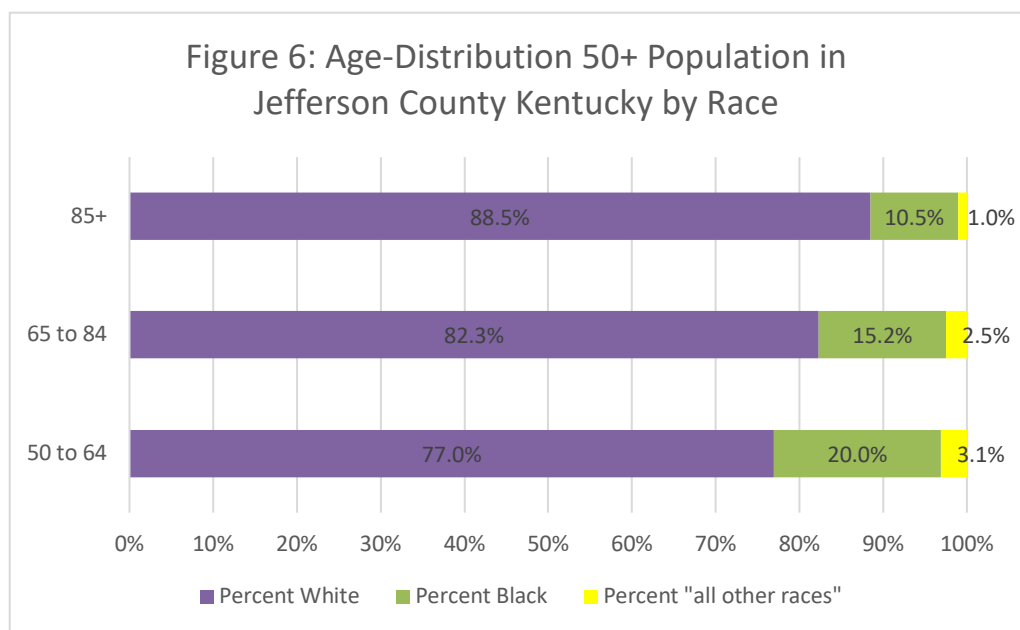
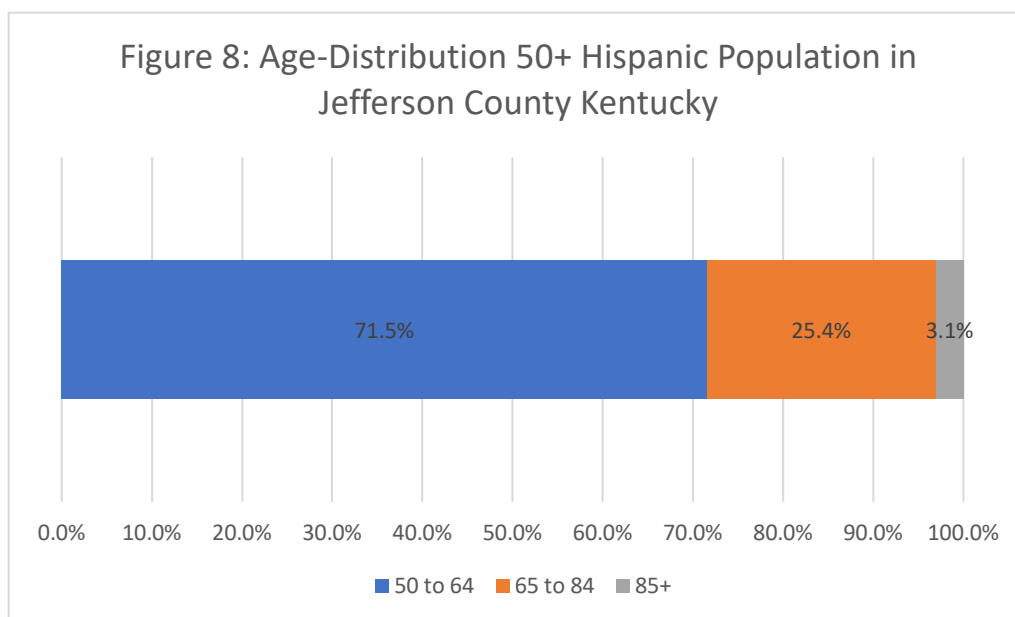


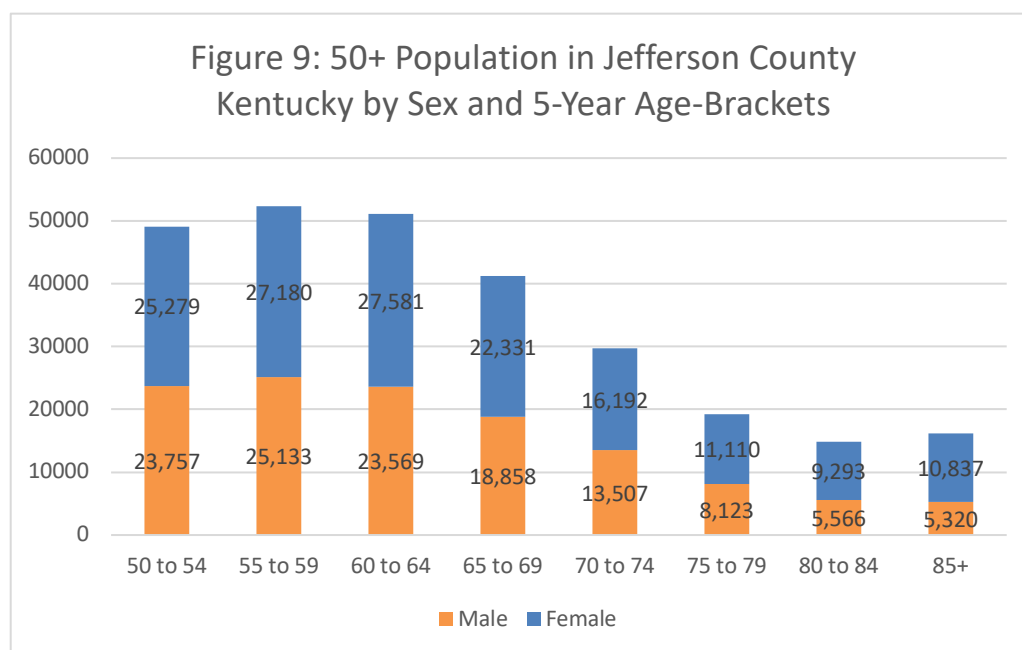
Figure 5: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample





## Age & Gender

Similar to national and state trends, women in Louisville tend to live longer than men. This disparity grows within each successive age bracket. Women represent 52% of the population of those aged 50–64. By age 85+, this has expanded to 67% (Figure 9).



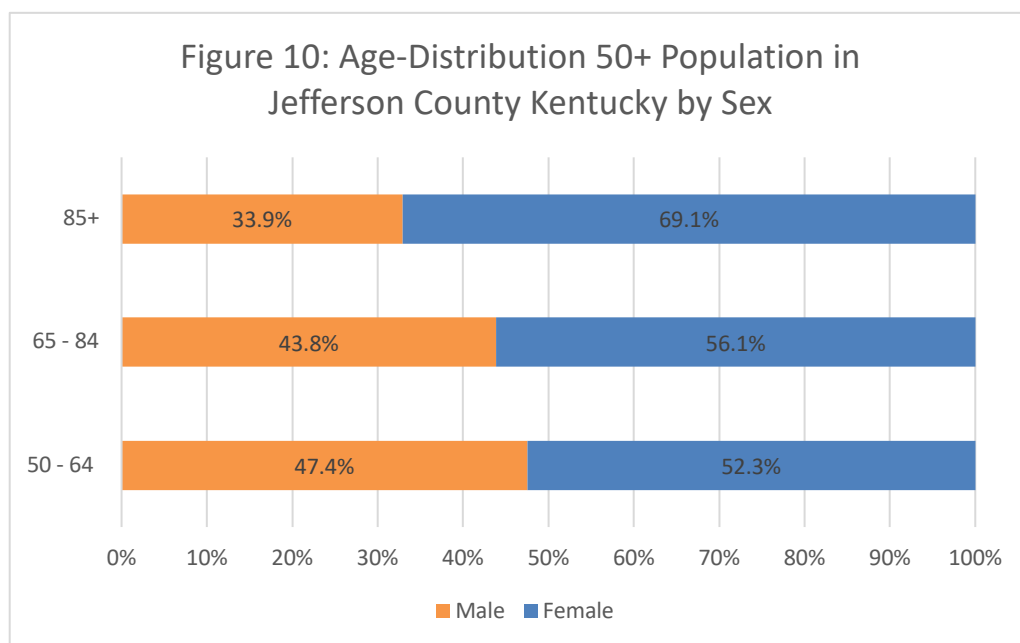


Figure 10: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

## V. Health Outcomes

Aging is a natural process, but the root causes and systems of power that residents experience can contribute to how quickly they age over time (weathering) and therefore what types of health outcomes they experience, and at what age they experience them. According to a 2015 Association of State and Territorial Health Officials (ASTHO) report, “The state of being older, with its unique set of disadvantages, can therefore be multiplied by contemporary disparities, a legacy of historical inequities, and, for many, a lifetime in poverty.”<sup>11</sup> This section reviews the health outcomes and inequities that exist for those aged 50+ in Louisville.

### Louisville Data

In the 2017 Health Equity Report, the Center for Health Equity reported age-adjusted death rates for various health outcomes. However, for this report, we focus in on just those adults age 50+, and report age-specific death rates (ASDR) instead.

As shown in figure 10, the eight leading causes of death for 50 + residents of Louisville / Jefferson County from 2015 to 2019 were cancers (malignant neoplasms), heart disease; lung disease (specifically, chronic lower respiratory diseases, or CLRD), Alzheimer’s disease, stroke (cerebrovascular diseases), accidents (unintentional injuries), diabetes mellitus, and kidney disease (nephritis, nephrotic syndrome, and nephrosis). This largely reflects the trends for Louisville / Jefferson County.<sup>12</sup> Because the eight leading causes of death change as populations age, this report provides age-specific leading causes of deaths and ASDRs for each five-year age increment in figure 12.

Figures 16 through 31 shows the age specific death rates for the eight leading causes of death. This illustrates the changing impact of each cause of mortality over the life course. Generally, death due to Alzheimer’s disease and cerebrovascular disease are more likely to occur among older members of the cohort, while accidental deaths occur among the youngest members of the cohort.

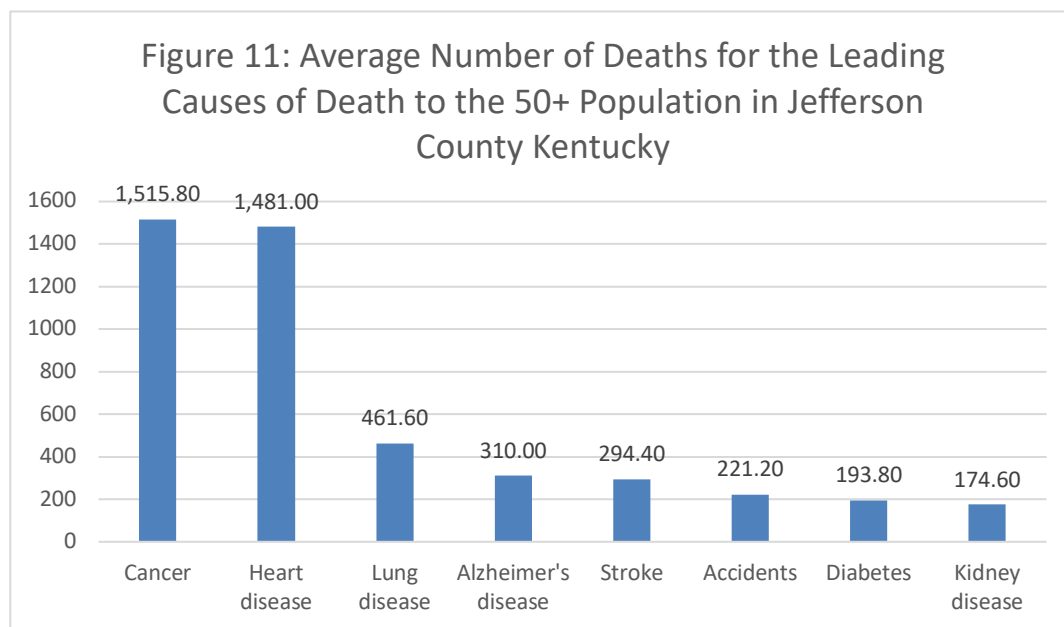


Figure 11:  
calculated from  
2015 to 2019  
vital statistics  
records

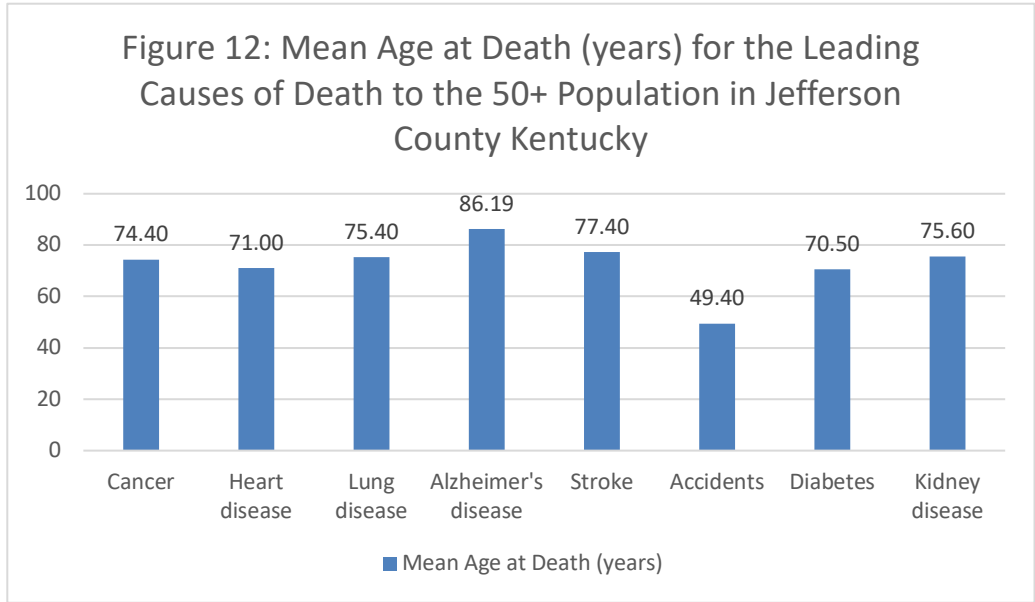


Figure 12: calculated from 2015 to 2019 vital statistics records. \*Note: Mean ages of death are not standardized by population and should be interpreted with caution. For more information about age adjusted rates and age specific rates please visit the CDC website.

1	Cancer (Malignant Neoplasms)							
2	Heart Disease							
3	Accidents		Lung Disease					Alzheimer's
4	Self Harm	Lung Disease	Diabetes		Stroke	Alzheimer's		Stroke
5	Liver Disease	Stroke	Accidents	Stroke	Diabetes	Stroke		Lung Disease
6	Lung Disease	Diabetes	Liver Disease	Accidents	Kidney Disease			Accidents
	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Figure 13: Leading Causes of Death to the 50+ Population by 5-year Increments in Jefferson County								

Death rates increase for all race/ethnic groups as they age, as expected. However, death rates themselves vary by race/ethnicity group. For those aged 50–79, death rates are highest among the Black community. For those age 80+, rates among the “other” race/ethnicity groups are highest and are somewhat equivalent for the White and Black communities. Notably, death rates for the Hispanic/Latinx community are lower across all age brackets compared to their counterparts in other race/ethnic groups (Figure 13).

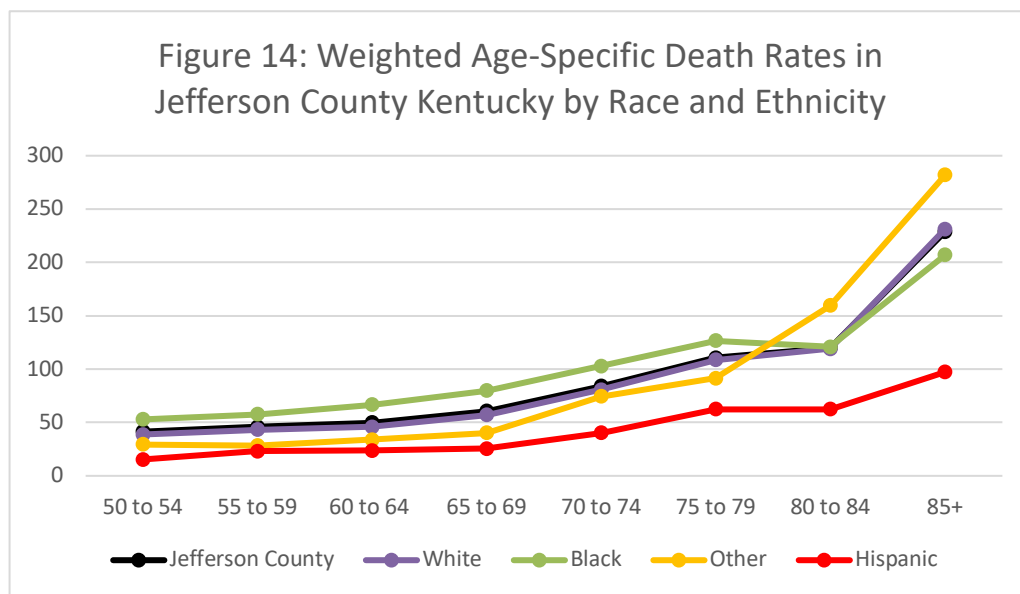


Figure 14: Weighted age-specific death rates are per 100,000 population and are calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

As Center for Health Equity has outlined in other reports, there are persistent inequities in Jefferson County with respect to life expectancy. The five-year average life expectancy among the Hispanic/Latinx community is 12.5 years higher than the non-Hispanic group, and White residents experience a longer life expectancy compared to Black residents by nearly 4 years (Figure 14).

National trends show women tend to live longer than men on average, and the same is true in Jefferson County where the five-year average life expectancy for women is 5.7 years longer compared to men. Inequities persist between race groups here as well, where, on average, White women live over 10 years longer than Black men (Figure 15).

Figure 15: Life Expectancy in Jefferson County by Race and Ethnicity	
Jefferson County	76.04
White	76.90
Black	73.39
*Other	75.52
*Hispanic	88.31
Non-Hispanic	75.81

Figures 15: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

Figure 16: Life Expectancy in Jefferson County by Race and Gender	
Male	73.13
Female	78.88
White Male	74.43
White Female	79.31
Black Male	68.95
Black Female	77.5

Figure 16: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates



# Breaking Down Inequities in the Eight Leading Causes of Death

## Cancer

Cancer death rates among the 50+ Black community in Jefferson County are higher at every five-year age category for the 50+ population except for 50 to 54 and 85+ when compared to White residents (Figure 17). The average age of death for Black residents who die of cancer is 67.6 years old compared to 72 years old for White residents. Taken together, this implies Black residents die from cancer at younger and at higher rates on average compared to White residents. There is a similar trend for men compared to women, who die from cancer younger and at higher rates on average compared to women (Figure 18).

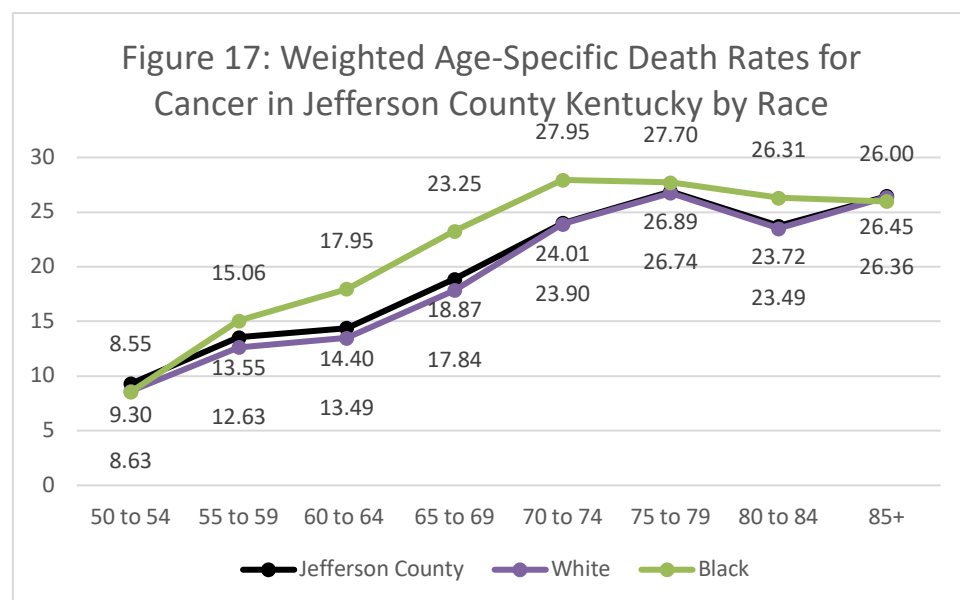


Figure 17: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

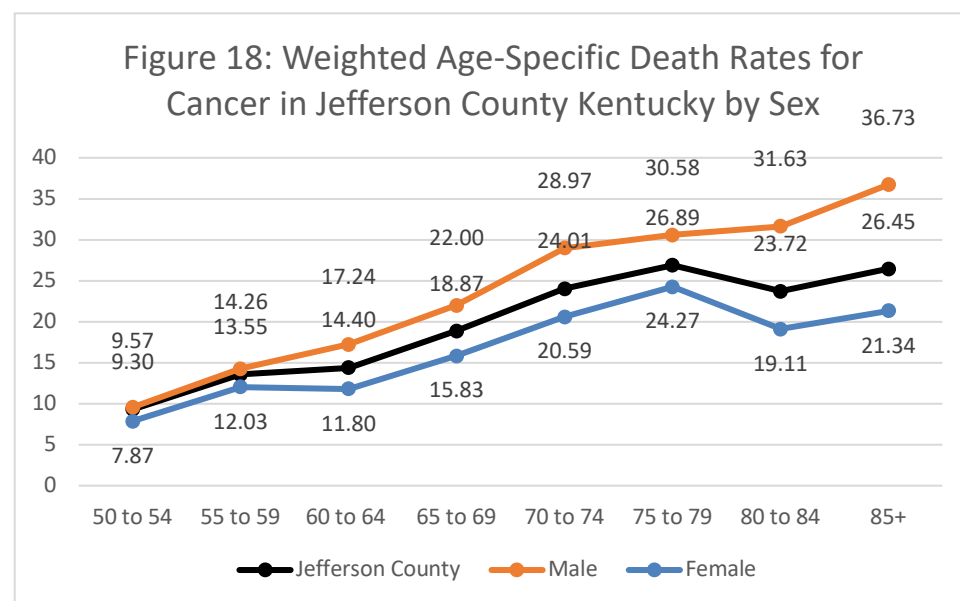


Figure 18: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Heart Disease

Heart disease death rates among the 50+ Black community are higher among the younger cohort, until the age of 80, compared to White residents (Figure 19). The average age of death for Black residents who die of heart disease is 67.3 compared to 76.1 for White residents. Taken together, this implies Black Jefferson County residents die from heart disease younger and at higher rates compared to White residents. There is a similar trend among men who die from heart disease younger (71.3 years vs. 78 for women) and at higher rates compared to women (Figure 20).

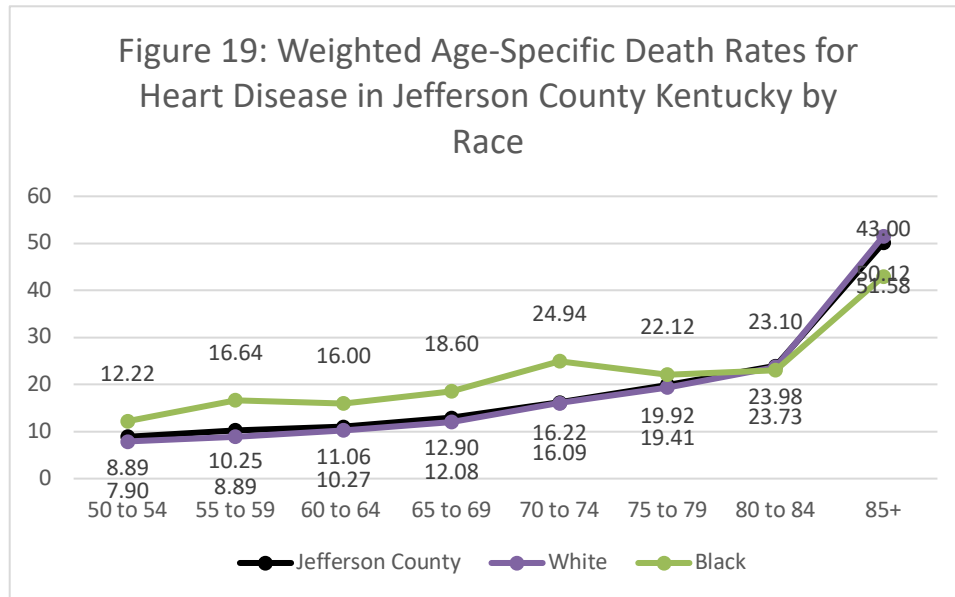


Figure 19: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

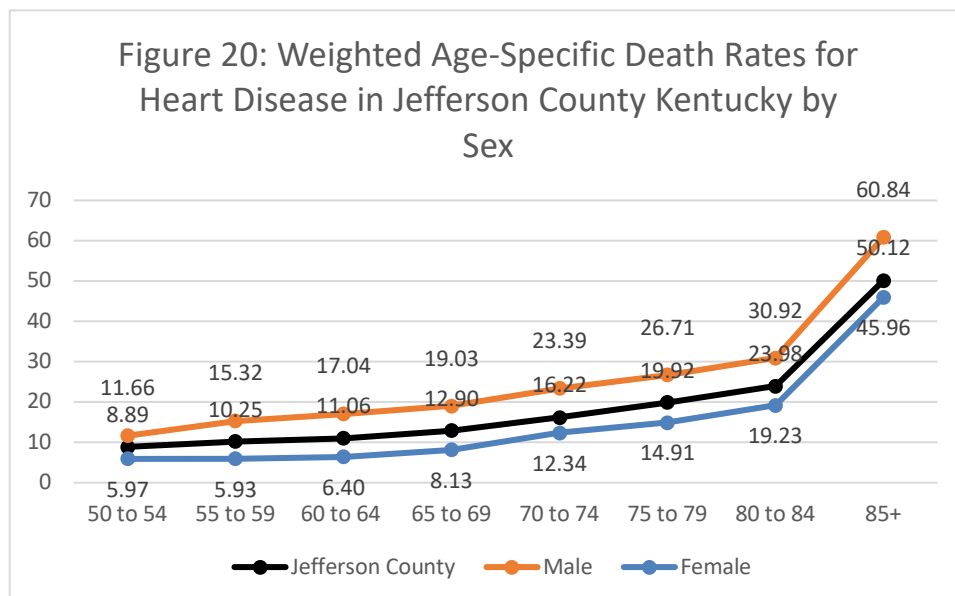


Figure 20: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Lung disease (Chronic lower respiratory diseases)

Lung disease death rates among the 50+ Black community trend higher for the younger groups of the cohort before age 65 in Jefferson County compared to White residents (Figure 21). The mean age for Black residents who die from lung disease is 71.9 years old, compared to 75.9 for White residents. Therefore, Black residents die earlier at higher rates of lung disease than White residents. Later in life, White residents in Louisville die at higher rates than Black residents. Overall, rates trend very similarly for males and females in Louisville, aligned with the Jefferson County average.

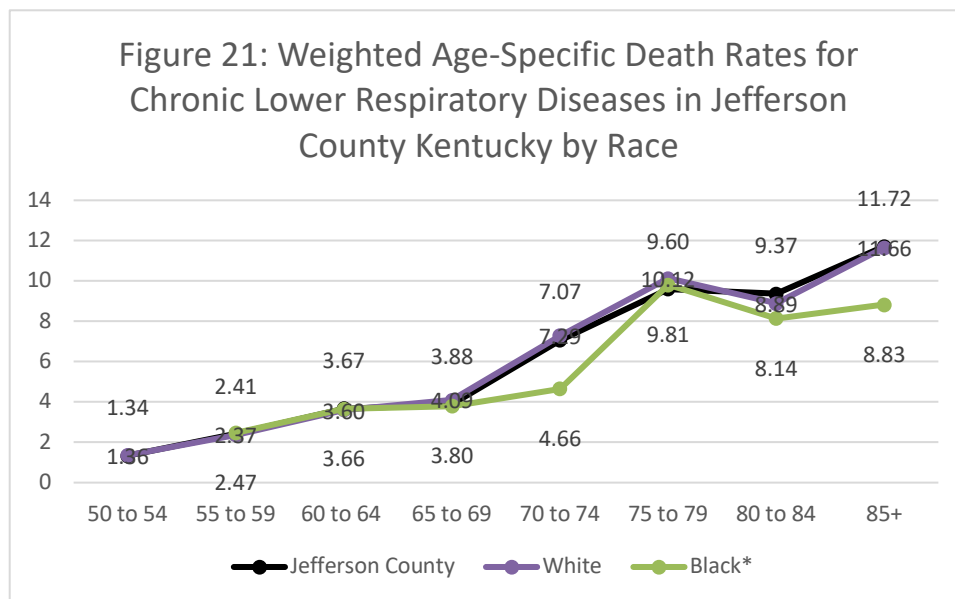


Figure 21: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for Black residents age 50-54

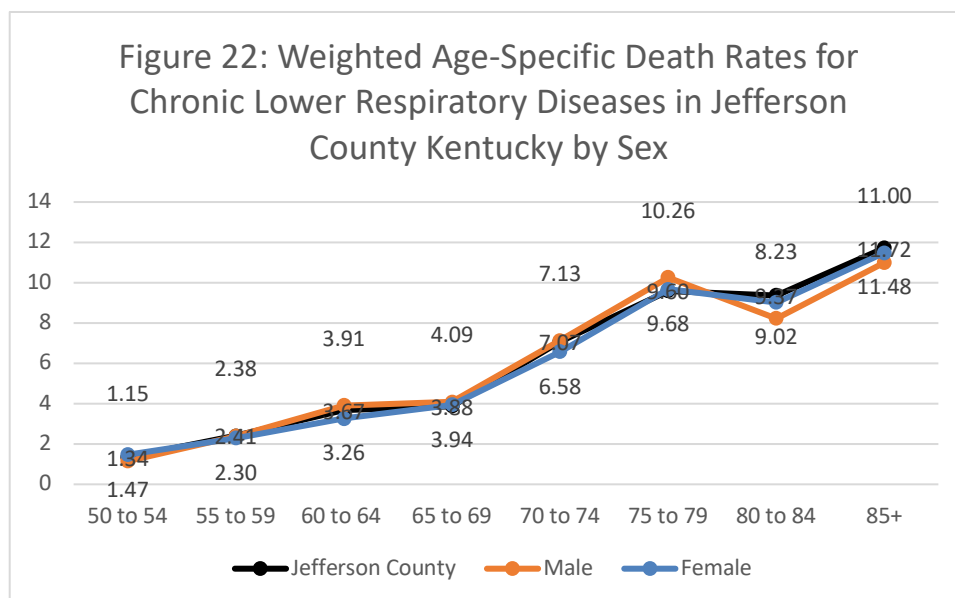


Figure 22: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Alzheimer's Disease

Alzheimer's disease typically does not cause mortality until much later in life. Additionally, White residents die at higher rates from Alzheimer's disease compared to Black residents. (Figure 23). However, Black residents tend to die at younger ages from Alzheimer's disease—85.7 years of age compared to 86.2 years for White residents. Death rates for White residents may be higher than Black residents because Alzheimer's disease occurs later in life and because White residents live longer than Black residents on average. Additionally, women tend to die at higher rates from Alzheimer's disease than men, particularly among the 85+ age group. Men also die younger from Alzheimer's disease where the mean age of death 84.4 years of age compared to 86.8 years for women. Similar to trends in race-specific death rates, men may die from Alzheimer's disease at lower rates in older age groups due to the longer lifespan of women (Figure 24).

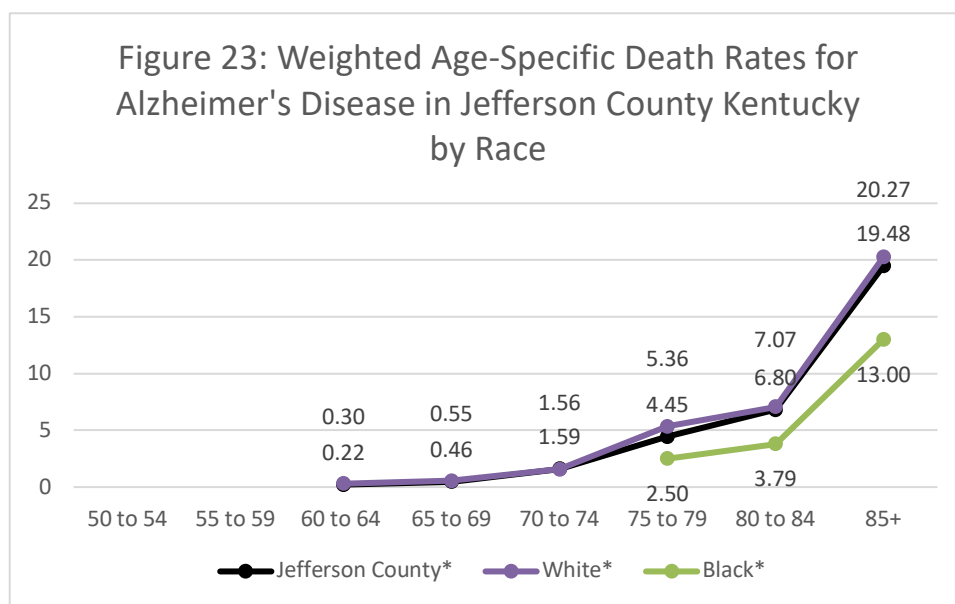


Figure 23: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for age<60 and Black residents age<75

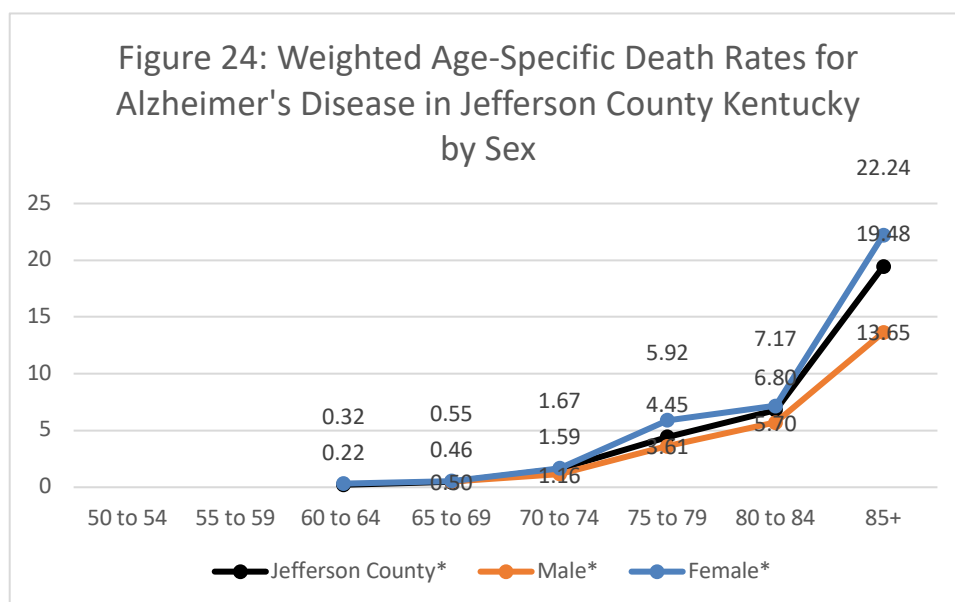


Figure 24: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for age<60 and men age<75.

## Stroke (Cerebrovascular disease)

The death rate for stroke (cerebrovascular disease) among Black residents are higher at every stable five-year age category for the 50+ population in Jefferson County except for the 85+ age category when compared to White residents (Figure 25). The mean age at death among Black residents who die of stroke is 70.4 years of age compared to 79.3 years for White residents. This trend suggests Black residents in Jefferson County die at higher rates and earlier in life on average from stroke than White residents.

In a similar trend, death rates for stroke among males are higher at every five-year age category for the 50+ population when compared to women except for the 80+ groups (Figure 26). The mean age at death for due to stroke is 74.4 years of age for men, compared to 79.8 years for women. This trend suggests men in Jefferson County die at higher rates and earlier in life on average from stroke than women.

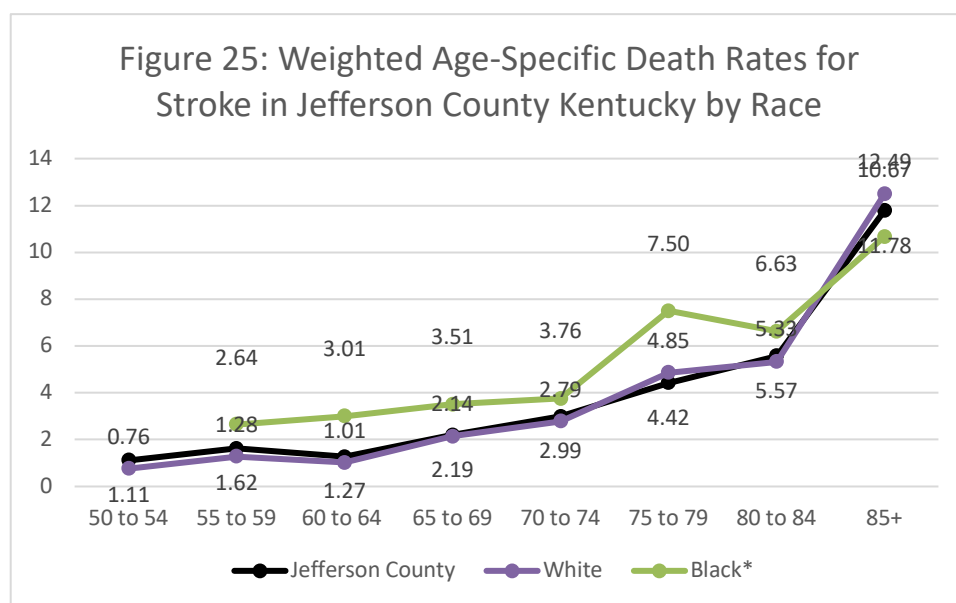


Figure 25: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates \*Rates are unreported due to a small number of deaths (n<10) for Black residents age 50-54.

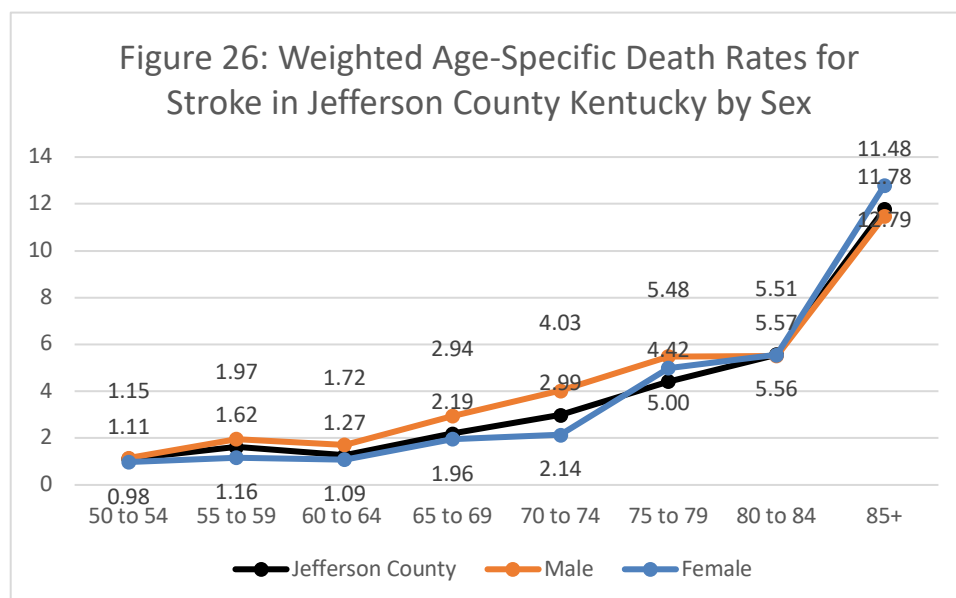


Figure 26: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Accidents and Unintentional Injury

Typically, deaths due to accidents and unintentional injury occur earlier in life, although the types of accidents that lead to death may change during the life course. Age groups past 70 appear to be at an increased risk for accidents that lead to death as the risk of dying from injuries sustained from accidents increases. Because ASDRs for Black residents for accidents or unintentional injuries are too unstable to report for the 70 to 74 and 80 to 84 age categories, it is difficult to interpret comparative trends based on ASDRs for Black people as compared to White people in Jefferson County (Figure 27). The mean age of death for Black residents in Jefferson County who die of accidents is 42.7 as compared to 51.5 for White residents.

Similarly, the male ASDRs for accidents or unintentional injuries are higher at every five-year age category reported for the 50+ population when compared to women (Figure 28). The mean age of death for men due to accidents or unintentional injuries is 47.4 compared to 53 for women. That means that men in Louisville / Jefferson County die at higher rates and earlier in life on average from accidents or unintentional injuries than women.

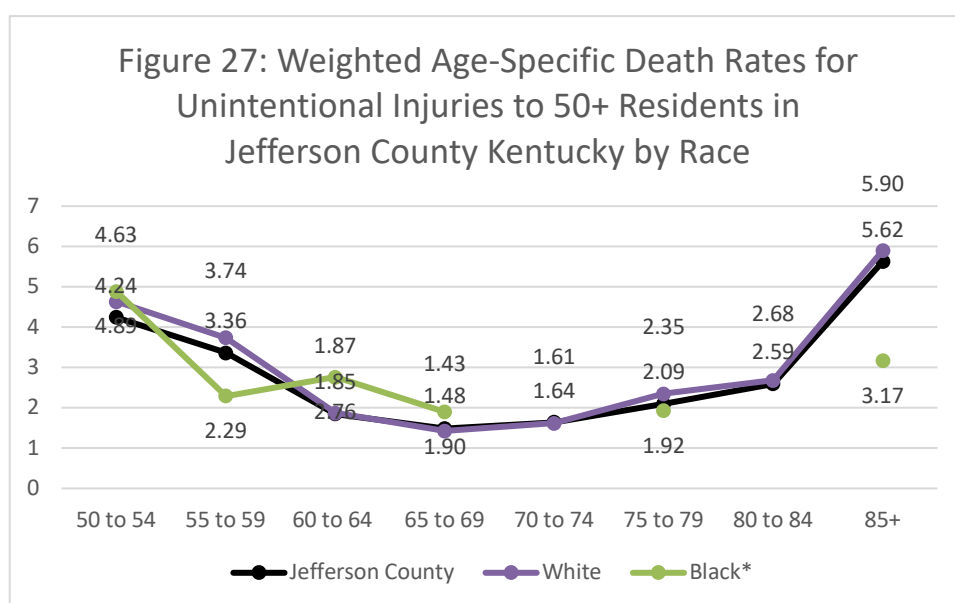


Figure 27: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates \*Rates are unreported due to a small number of deaths (n<10) for Black residents age 70-74 and 80 to 84.

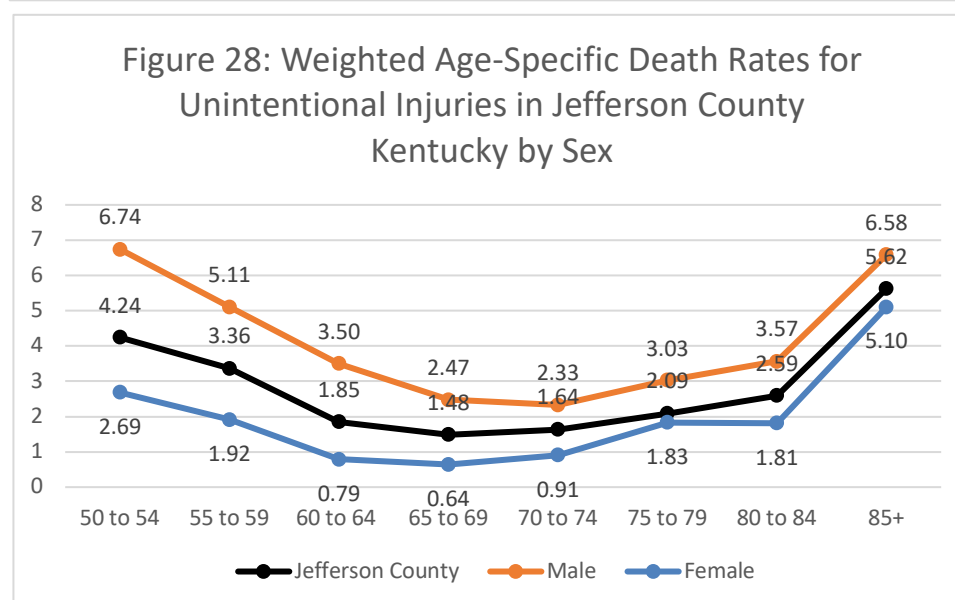


Figure 28: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Diabetes

The Black ASDRs for diabetes mellitus (diabetes) are higher at every reported five-year age category for the 50+ population in Louisville Jefferson County when compared to White residents (Figure 29). The ASDR for Black residents who are 50 to 54 was too unstable to report. The mean age for Black residents who die of diabetes mellitus is 65.9 compared to 71.9 for White residents who die of diabetes mellitus. This means that Black residents in Louisville / Jefferson County die at higher rates and earlier in life on average from diabetes mellitus than White residents.

Similarly, the male ASDRs for diabetes mellitus are higher at every five-year age category for the 50+ population when compared to women (Figure 30). The mean age of death for men due to diabetes mellitus is 68 compared to 73.4 for women. That means that men in Louisville / Jefferson County die at higher rates and earlier in life on average from diabetes mellitus than women.

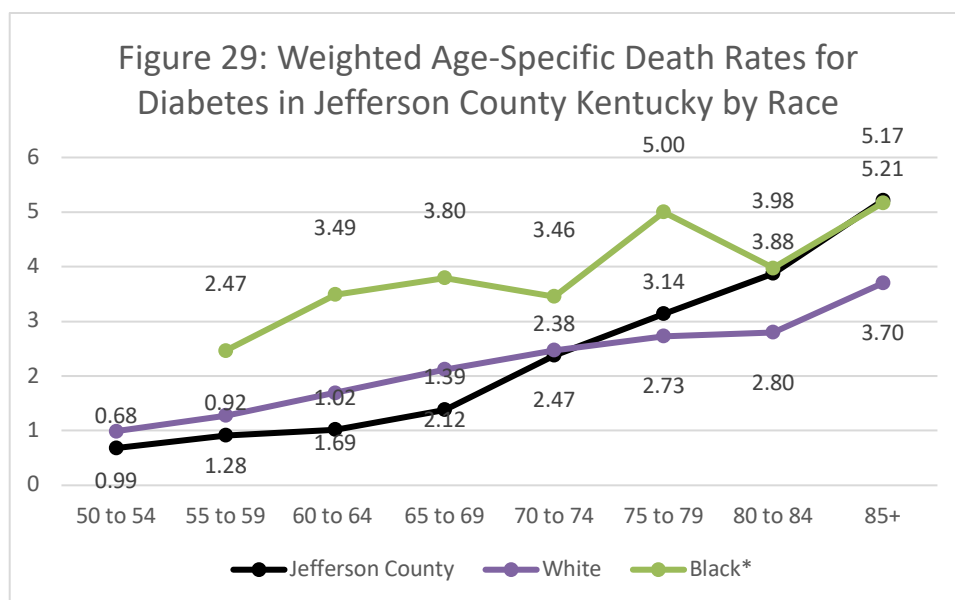


Figure 29: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for Black residents age <55.

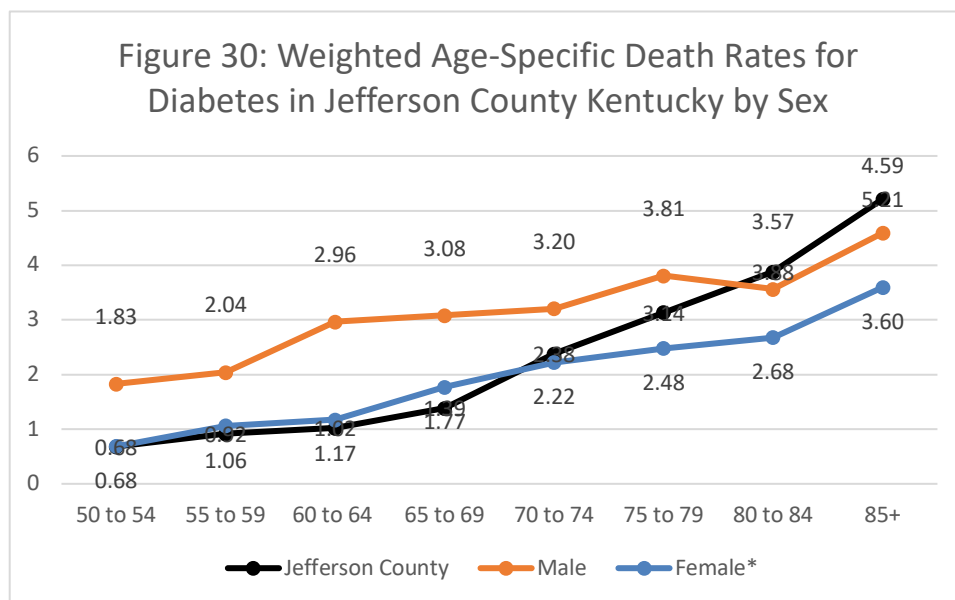


Figure 30: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates

## Kidney disease

The ASDRs for Black residents for nephritis, nephrotic syndrome, and nephrosis (kidney disease) are higher at every reported five-year age category for the 50+ population in Louisville Jefferson County when compared to White residents (Figure 31). The ASDR for all groups who are 50 to 54 was too unstable to report. The mean age for Black residents who die of kidney diseases is 71.1 compared to 77.4 for White residents. This means that Black residents in Louisville / Jefferson County die at higher rates and earlier in life on average from kidney diseases than White residents.

Similarly, the male ASDRs for kidney disease are higher at every reported five-year age category for the 50+ population except for the 70 to 74 age categories when compared to women (Figure 32). The mean age of death for men due to kidney disease is 75 compared to 76.2 for women. That means that men in Louisville / Jefferson County die at higher rates and earlier in life on average from kidney disease than women.

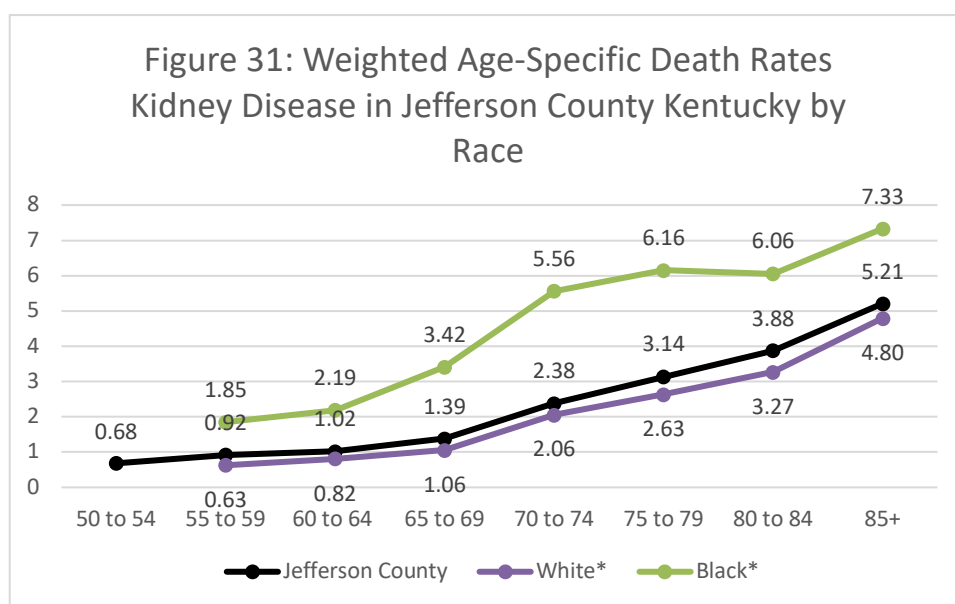


Figure 31: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for White residents age <55 and Black residents age <55.

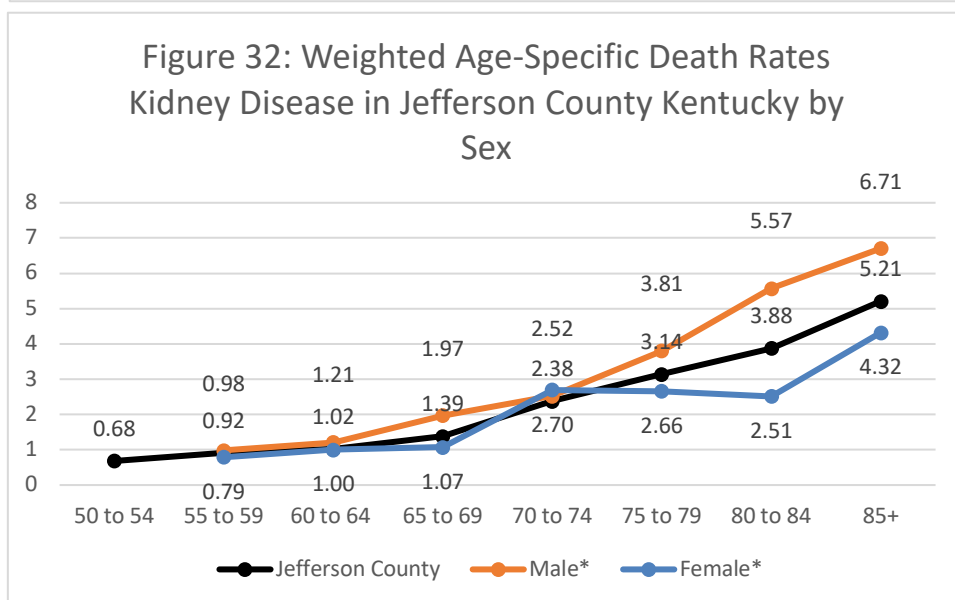


Figure 32: calculated from 2015 to 2019 vital statistics records using CDC WONDER population estimates. \*Rates are unreported due to a small number of deaths (n<10) for men age <55 and women age <55.



## COVID-19

Since early 2020, the world has been immersed in the COVID-19 pandemic. People with pre-existing conditions and older adults have been at highest risk for severe illness and death. According to the Centers for Disease Control and Prevention (CDC), over 80% of COVID-19 deaths occur in people 65+, with more than 95% of COVID-19 deaths occurring in people over 45.<sup>13</sup> Many of the chronic illnesses associated with serious cases of COVID-19 are disproportionately experienced earlier in life by people of color, driving younger deaths in this population.<sup>14</sup> In addition, people of color are more likely to live in larger households, be employed in jobs where they are unable to telework or social distance, may lack paid sick leave or health insurance, and are more likely to rely on shared or public transportation. All of this contributed to early virus exposure and community spread within those populations. A [story map created by the Center for Health Equity](#) demonstrates and discusses how root causes have driven this inequity.<sup>15</sup>

### Louisville Data

People of color within Jefferson County's 50+ age group have face disproportionately higher rates of infection and death from COVID-19.<sup>15</sup> Black/African Americans have a greater share of COVID cases than their population (22% versus 18%) compared to White residents who represent 80% of the population but only 68% of the cases. To gain a clearer perspective on death rates by race, we will explore COVID-19 age-specific death rates (ASDR) for COVID-19. For the 50+ population these rates are higher at every point for Black residents than the county as a whole and White residents except for the 75–79 age group, (where it is statistically similar) and the 85+ age group (Figure 33). In fact, Black residents have a rate that is double that of White residents from 60–74 years of age and a 1.5 rate within the 55–59 age grouping. The only age group where Black residents do not lead White residents in death from COVID-19 is in the 85+ category.

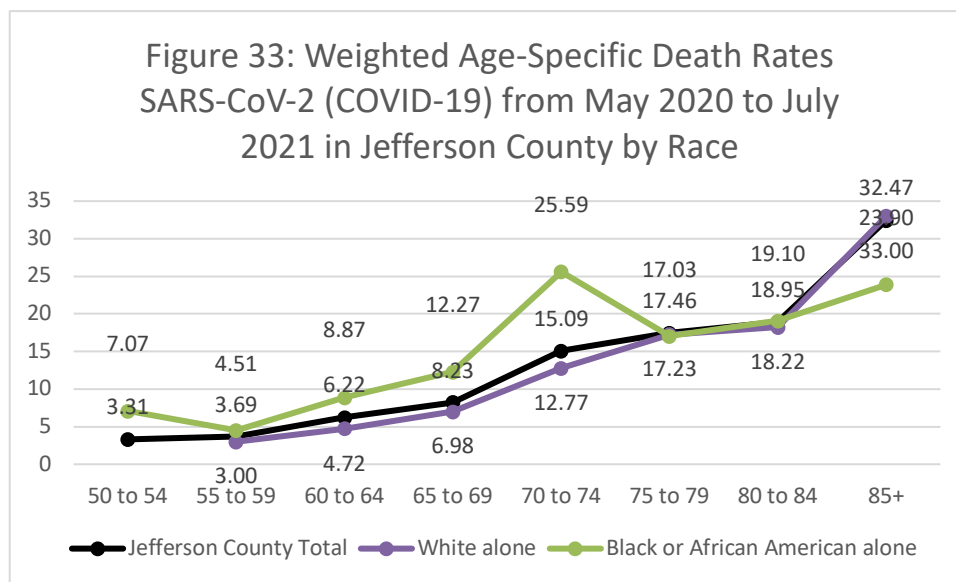


Figure 33: calculated from Louisville Metro Department of Public Health and Wellness SARS-CoV-2 data from May 2020 to July 2021. \*Rates are unreported due to a small number of deaths (n<10) for White residents age <55.

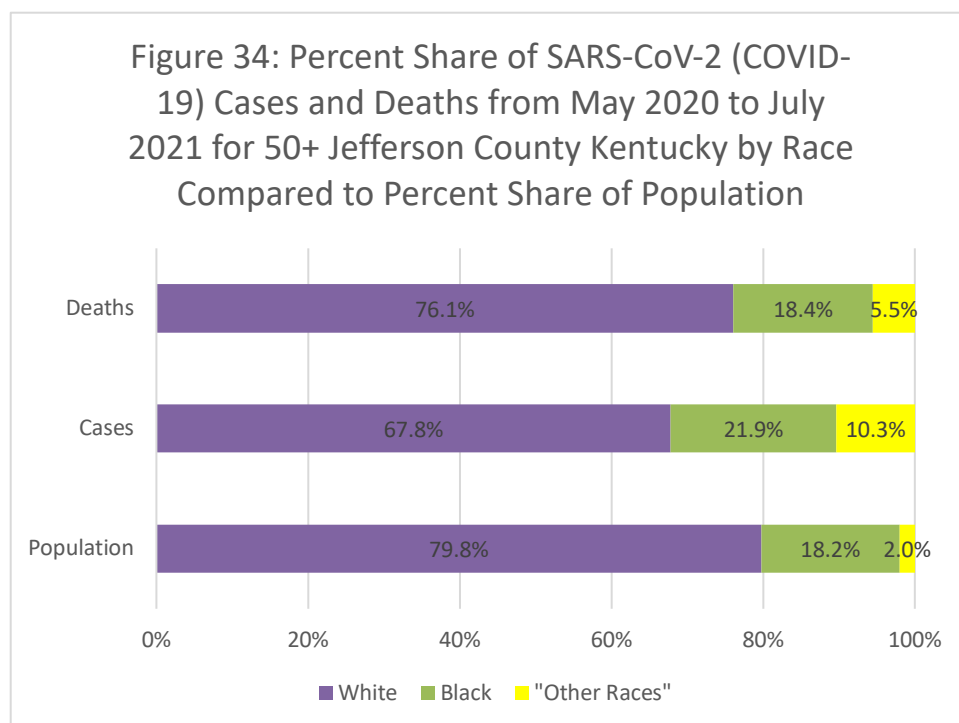


Figure 34: calculated from Louisville Metro Department of Public Health and Wellness SARS-CoV-2 data from May 2020 to July 2021

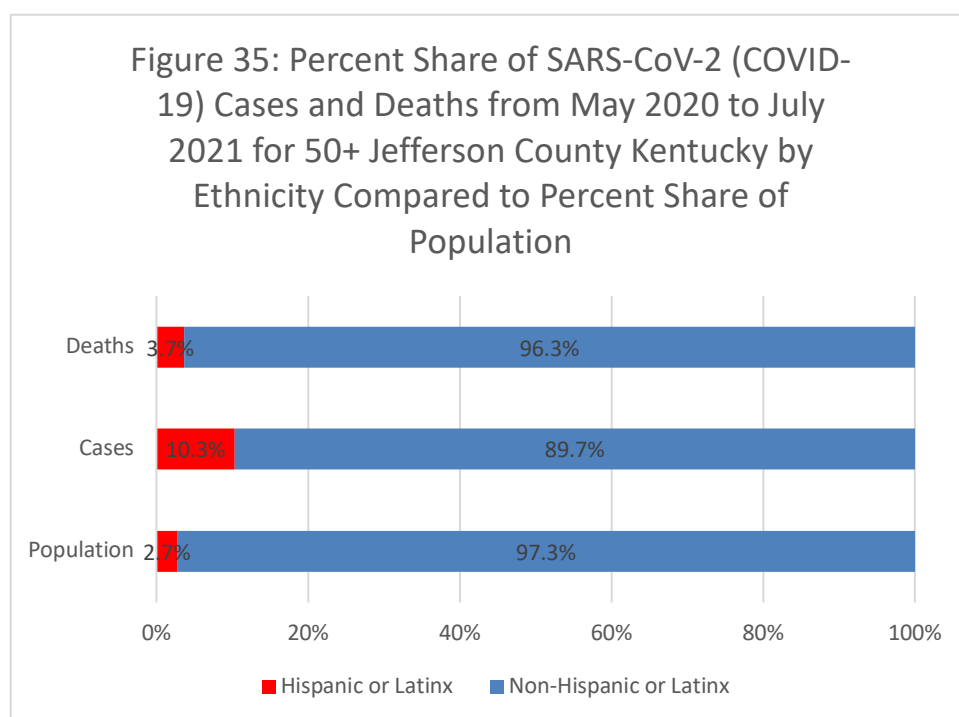


Figure 35: calculated from Louisville Metro Department of Public Health and Wellness SARS-CoV-2 data from May 2020 to July 2021

An AARP study assessed how Jefferson County 50+ residents are coping with the pandemic, its impact on their behaviors, and new demands on their lives.<sup>16</sup> They conducted a random sample phone survey in August/September of 2020. This report discussed concerns, behavior changes, personal experience with COVID-19 as well as its impact on employment, volunteering, caregiving, and

charitable contributions. A majority of respondents expressed concern about COVID-19, particularly a fear that they or someone in their family would become infected (73%) or die from COVID-19 (63%). To address this, many sheltered at home (73%), washed their hands more often (92%), and/or wore a face mask (96%). Over half (52%) of the respondents changed how they work to avoid virus exposure. Almost 4 in 10 older have provided unpaid care for a friend or family member, and 11% cared for someone due to the coronavirus pandemic. These older Jefferson County residents kept in touch with friends (70%) and secured food or medicine for someone 42%.

## What we Heard

The pandemic impacted social connections and mental health, interrupting normal activities and creating new fears. Focus group and storytelling respondents related heartbreaking stories of loss of friends and family, and how that impacted their beliefs and mental health. Some reduced who they were around due to fears of exposure to the virus. The vaccine helped provide some sense of security, but some expressed hesitancy before they ultimately got the vaccination.

- “I had quite a few friends that I knew that passed. What cut me the most was I couldn’t go to the funeral. That really did something to me. For a minute I started wondering is there really a God that will allow this to happen you know. So, then I got to thinking I know there is a God. Because what I been through, he had brought me. Not being able to do this and that really messed me up for a minute. I thought I was losing my mind.” – Black focus group participant
- “We rode around every day,” he said. “I didn’t know he had COVID, but I had my mask on. He died like 3 days later when he went to VA hospital. So, everyone was on pins and needles.” Getting vaccinated gave him some security even though he said, “I still don’t feel 100 percent.” – Black focus group participant
- “It [COVID-19] kept me away from my family, and I prayed to God every day for a cure from the COVID. I listened to Beshear every evening at 4:00. I listened to my pastor every day, because he was putting points out there and things that he said was very inspirational. But I wasn’t going to take the shot. And then I have to question myself. I’m praying to God every day for a cure and I’m not going to take the shot. That’s being a hypocrite. So, I took the shot.” – Black storyteller
- “I had to stay in the house. I had people telling me don’t take the vaccine, it’s going to kill you, I have a lot of medicine. I was locked in the house. See, I don’t have siblings. I just have my kids and my grandkids, and my grandkids are 19, 17, 14, and 6. So they were going around multitudes of other people. And I couldn’t be around them because I was scared. They had to understand. “Could I come over to your house?” I had to say no, and they had to understand. My granddaughter said I was selfish”. – Black focus group participant

## VI. Root Causes

Root causes can be a mitigating and protective factor as residents age. Weathering occurring across the lifecourse can mean that White adults experience less stress and their bodies are able to recover from stress or damage.<sup>17</sup> Root causes over the life course, including early childhood, can determine what outcomes residents experience later in life. However, root causes can also determine how well residents are able to cope with aging in the moment. For example, having access to resources and income can help an individual more successfully equip their home to age in place. Previous research from AARP nationally has found that at least 51% of those aged 50+ experience at least one unmet need – lack of social support and loneliness, food insecurity, inadequate transportation, and challenges with mobility and finances.<sup>18</sup>

Racism and other inequitable systems of power have impacted how Louisville communities are patterned and resourced across neighborhoods.<sup>19</sup> Segregation through processes like redlining, has helped create neighborhoods that see disinvestment and lack of resources while other neighborhoods have an abundance of options.<sup>20</sup>

This section will explore several of the root causes that came up with residents and in the literature review as challenges to successful aging. Root causes include employment and income, housing, transportation, food access, healthcare and social connectedness.

## Employment and Income

Within those aged 50 and older, there is a lot of variability for how people experience employment and income. The likelihood of voluntary and involuntary retirement increases as individuals age, even when accounting for those who leave the workforce because they live in a group home such as a nursing home. According to the Bureau of Labor Statistics, 93% of those aged 50–65 are considered part of the labor force; that is, they are either employed or are unemployed but looking for work.<sup>21</sup> Among those above age 65, that percentage drops to 19%, which does not even account for the approximately 20% of this population residing in nursing facilities.<sup>22</sup> The Census estimates the median household income in 2020 for those aged 45–55 as \$90,000, but for those over 65, that estimate drops to \$46,000, reflecting not only a withdrawal from the workforce but also a reduction in household income as spouses pass away.<sup>23,24</sup>

The impact of the large difference in workforce participation and median income on poverty rates between the 50–65 age group and the 65+ population is significantly helped by the income support provided by Social Security. Since its inception in 1935, the Social Security program has made large strides in accomplishing its intended goal of reducing poverty rates among seniors, moving from a subpopulation with one of the highest poverty rates (over 25%) to a subpopulation with one of the lowest.<sup>25–26</sup> Using the “official” poverty threshold, the Census Current Population Survey estimates the poverty rates in 2020 as 10% and 9% for those below and above age 65, respectively—almost identical.<sup>27</sup> Without the income provided by Social Security, a much larger percentage of seniors over 65 would be living under the poverty threshold—20–30% more according to some estimates.<sup>28,29</sup>

While the United States has made progress in reducing poverty overall as residents age, inequities remain. The same income and employment inequities by race, gender, and ethnicity that characterize the working age population are evident also among those aged 50+. Women face higher poverty rates than men, especially over the age of 75, and those identifying as Black or Hispanic/Latinx face higher poverty rates than those identifying as White. For example, among White men over the age of 65, only 5.4% live under the poverty threshold, while among Black or Hispanic/Latinx women, the rates are 20% and 18.6% respectively.<sup>28</sup> This reflects lifelong gaps in income and wealth accumulation<sup>30–31–32–33</sup> as well as additional income loss that might become more severe as spouse pass away.

### Louisville Data

While work force participation declines as cohorts age (Figure 36), not all groups are able to leave the labor market in the same ways. According to 2019 ACS data, labor force participation is higher among the White population compared to the Black population for most of the 50+ population. However, the gap narrows among the older members of the cohort. (Figure 36). Workforce participation is the highest among the Hispanic/Latinx community for all age groups 50+ (Figure 37). A report from Brookings<sup>34</sup> attempts to categorize the multiple factors that contribute to workforce inequities including educational and workforce training opportunities, incarceration, discrimination in hiring and employment, and negative health impacts. Higher percentages of Black and Hispanic/Latinx workforce participation in later life may be linked to racial inequities in wealth accumulation,<sup>35</sup> but there are few studies that attempt to understand this trend.

Figure 36: Percent of 50+ Population who have Worked in the Last 12 Months in Jefferson County by Race and 5-Year Age-Bracket

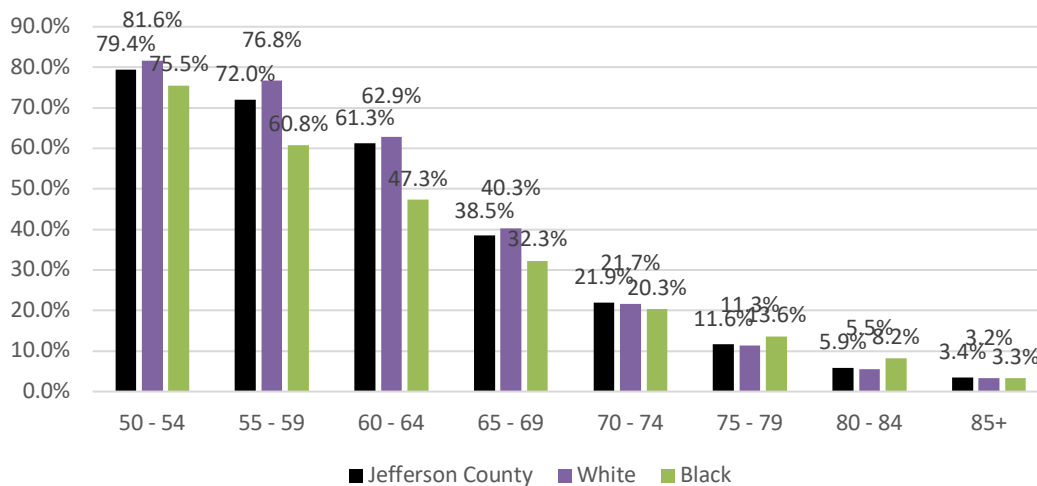


Figure 36: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

Figure 37: Percent of 50+ Population who have Worked in the Last 12 Months in Jefferson County by Race, Ethnicity, and Age-Group

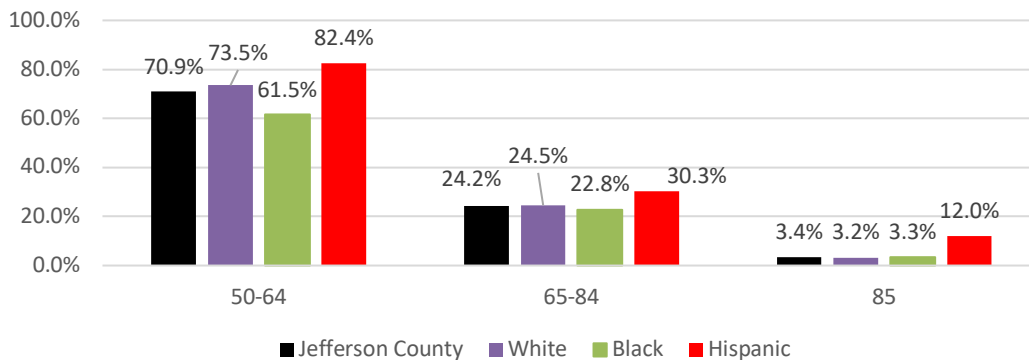


Figure 37: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

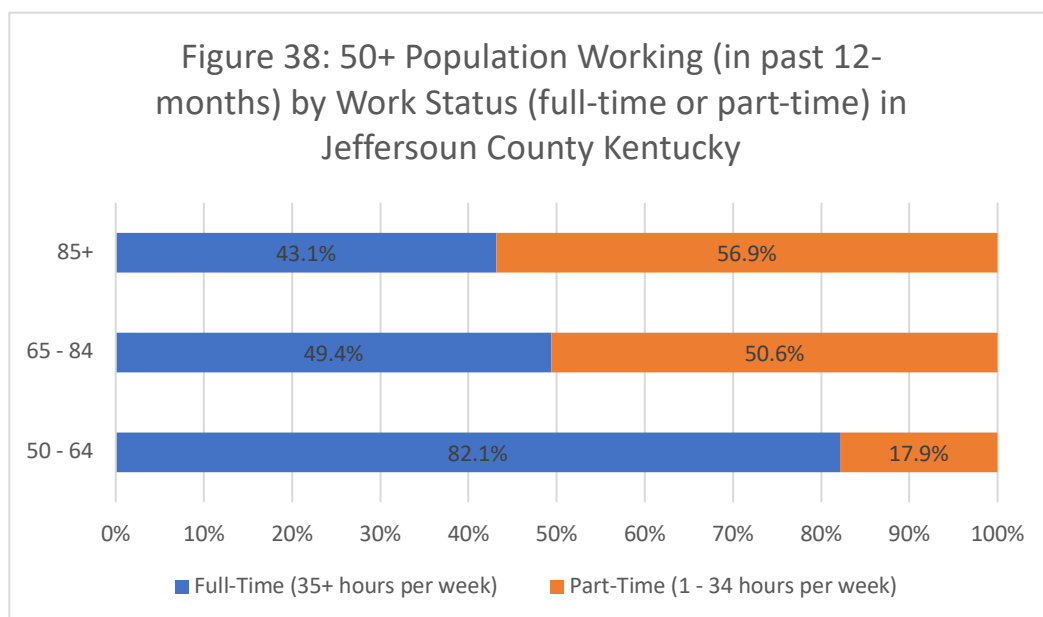


Figure 38: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

Median household income tends to decline in older age (Figure 39). For instance, the median household income for Louisville is \$79,397.40 for residents in the 50 to 54 age-group and it steadily declines to \$34,850 for residents in the 85+ age group. Across all age brackets, White households had higher incomes than all of Louisville (Figure 40). Income inequalities between White households and the rest of Louisville are the most pronounced in the younger groups of the 50+ population. Among those aged 50 to 64, White households have nearly double the median income of Black households while Hispanic/Latinx households earned 18.1% less than the Louisville median. Later in life, disparities between White and Black households with respect to income decrease. However, this may be attributable to Black residents being more likely than White residents to work later in life (Figure 36). The income gap between Hispanic/Latinx households and the rest of the county decreases for residents aged 65 to 84 and increases again in late life where Hispanic/Latinx households with 85+ year old residents earn 31% less than all Louisville residents. These income differentials allow White households to accumulate greater wealth as they age.

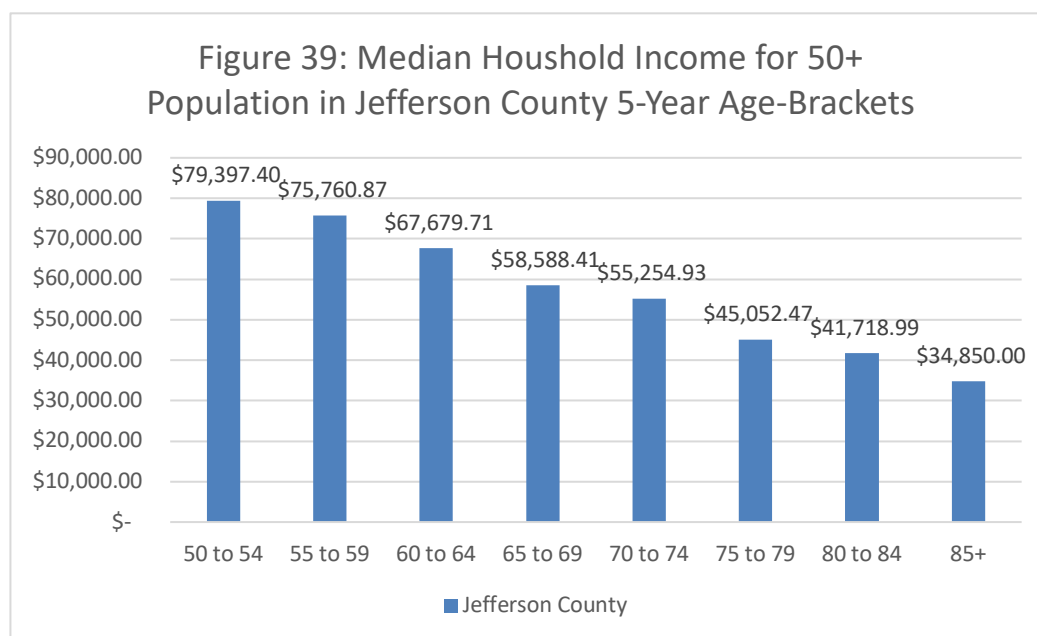
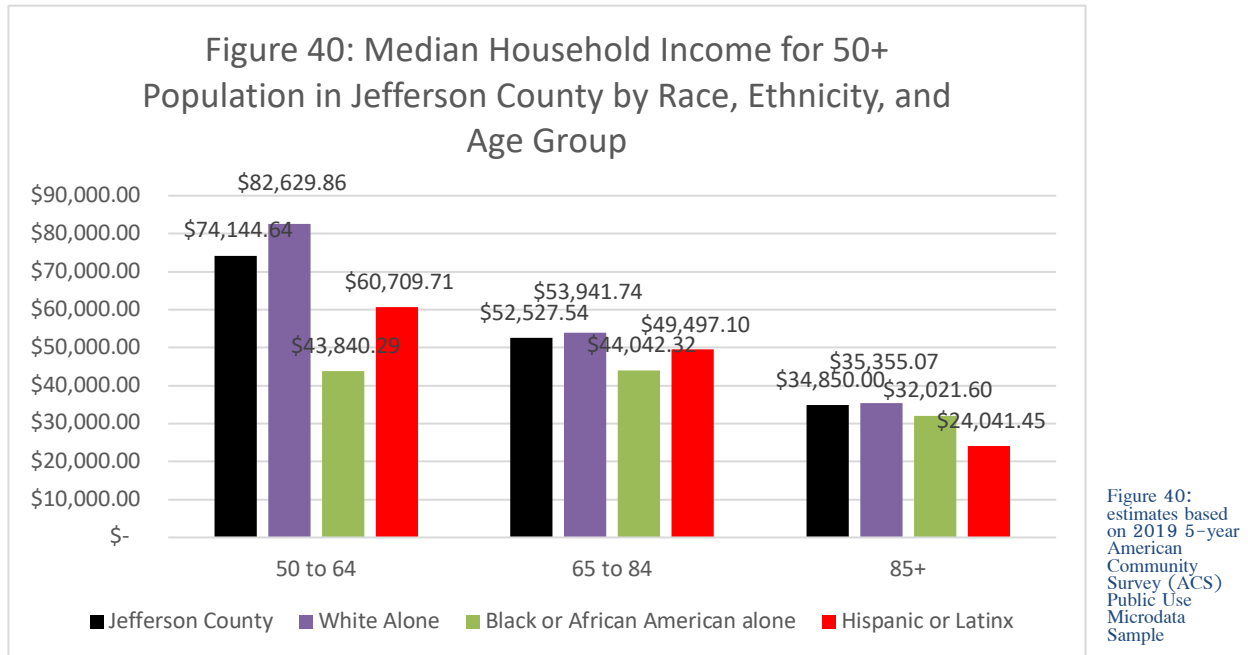
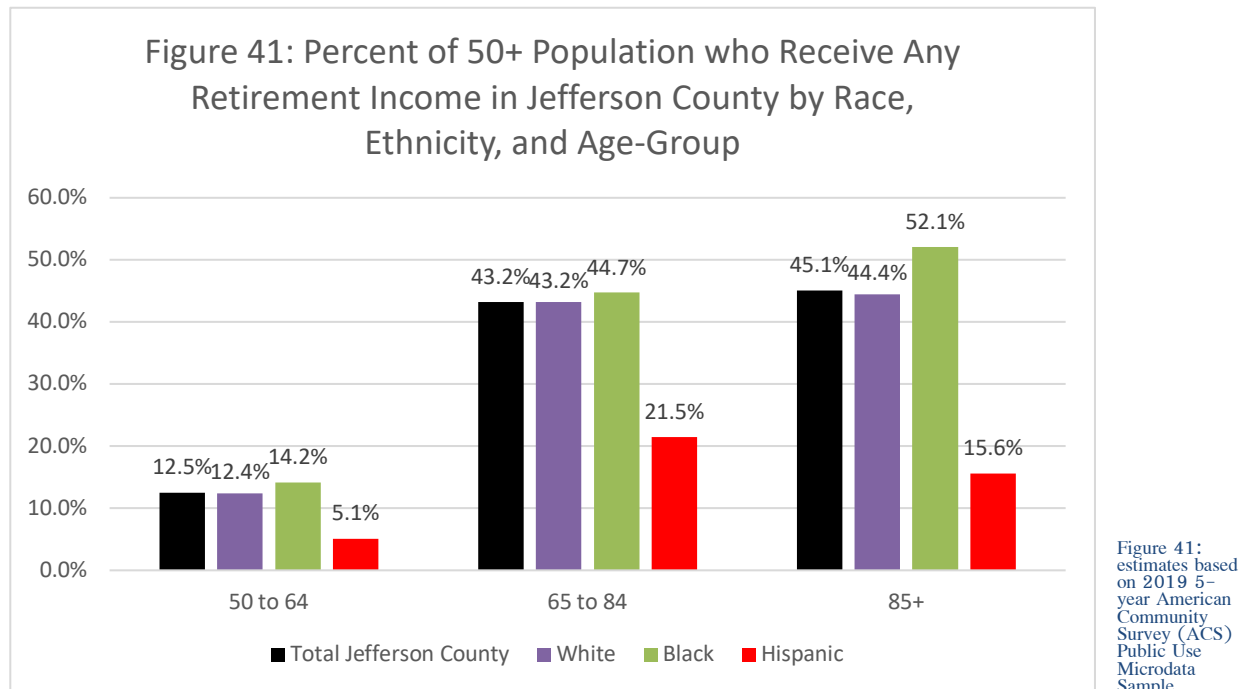


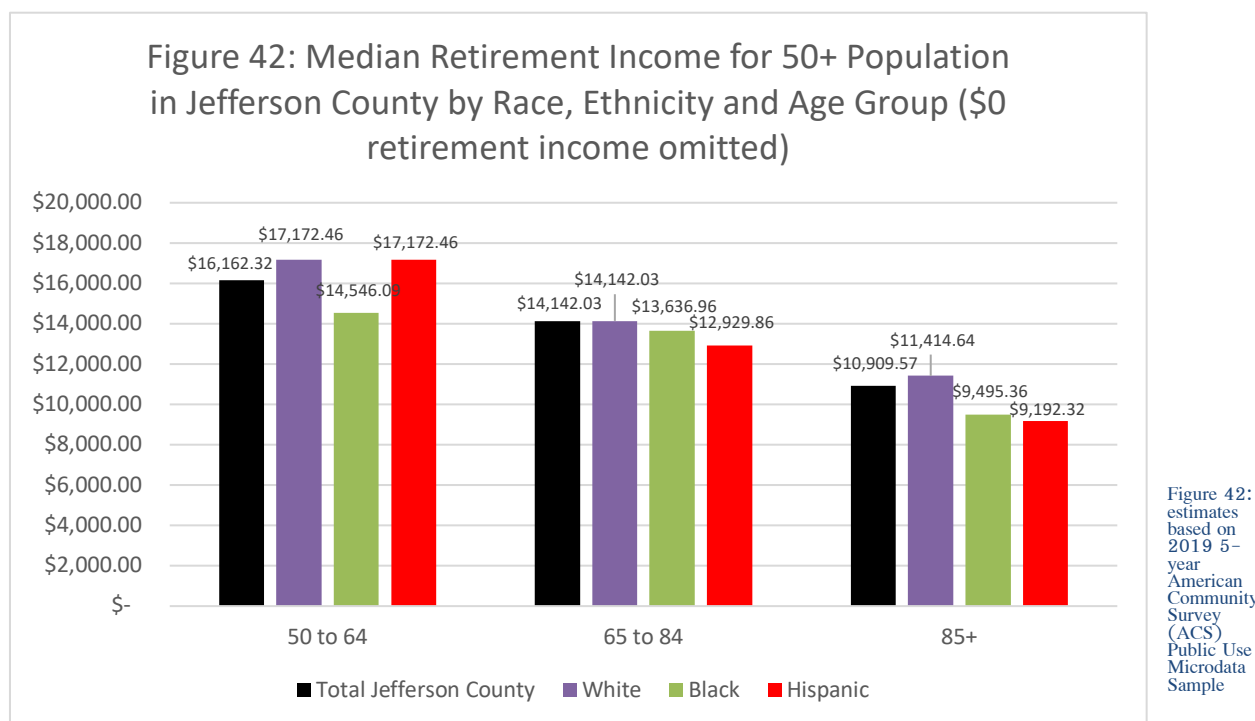
Figure 39: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample



As increasing proportions of cohorts leave the workforce as they age, the source of income that residents receive also change. Figure 41 displays the percent of the 50+ population in Louisville that receive any retirement income by age group and the median retirement income. Figure 42 displays the median retirement income by race, ethnicity, and age group that is earned by those residents who receive retirement income. As can be seen in figure 41, the percent of Black Louisville residents who receive any retirement income is higher at all reported age groups for the 50+ population than White residents. However, Black residents earn less on average from retirement income at every reported age groups.







## What We Heard

Focus group participants, interviewees, and survey respondents shared their financial experiences over the past year. Family economics were discussed quite a bit. Respondents described financial constraints created by the pandemic and their health. Some people shared that they experienced tough times and had to make hard decisions about how to allocate fixed incomes. Residents lost income which impacted their quality of life, such as having to obtain odd jobs to make ends meet and being scared about their long-term finances. Others were able to keep their jobs and were able to make accommodations for the pandemic work situations. Several entitlement programs like unemployment insurance, food stamps, and emergency rent relief, and stimulus were mentioned as helpful in being able to pay bills and stay afloat. However, for some these supports were insufficient and they experienced long delays in obtaining their benefits.

- “I’m on disability now and with a fixed income. I can’t pay all by bills. It’s hard to find part-time jobs for older [folks]. My truck went down, so I have no way to get around. People seem too busy to help. It makes me feel bad because I have always had a job but now, I can’t take care of myself or my bills.” – Black survey respondent.
- “I was looking at it like I’ve worked for 35 years, and what is \$1,400 what is \$600, why give me one drop out of the bucket that I done filled up all these years. This political thing during the pandemic has been bad. That money came from our blood sweat and tears, y’all living in mansions, eating good, they didn’t want to do nothing to help a poor soul out. God still got us.” – Black focus group participant.
- “I was on SSA and SSI and they cut me off ... and that forces you to stay in like that. Because I couldn’t draw SSI, I was out picking up cans and stuff like that.” – Black survey respondent
- “I have been trying to get unemployment from last year. It’s been 15 months.” – Black survey respondent.

### **Key Takeaways:**

- As residents age, they often leave the workforce and rely on supplemental sources of income like Social Security to reduce economic instability.
- Physical disability reduces the ability to remain in the workforce and to supplement a fixed income.
- Wealth accumulation impacts financial security later in life.
- There are persistent racial and ethnic inequities in labor participation and income over the lifecourse which remain as people age, contributing to racial inequities in financial instability for those aged 50+.

# Housing

Stable, affordable, quality housing plays an important role in health across the life course. Those aged 50+ experience an array of housing situations from renting, owning a home, living in federally subsidized senior housing, or living in some type of supportive housing such as assisted living or nursing homes.

Overall, as incomes decline with retirement, many residents become housing cost-burdened, which is defined as spending more than 30% of income on housing. These costs range from increasing rents, home repairs or accessibility modifications, and property tax increases.<sup>36</sup> An increasing number of those aged 50+ are going into retirement with debt, specifically mortgage debt, which is then reducing ability to pay for other needs like healthcare.<sup>37</sup> However, for those aged 65 and up, around a quarter of homeowners are cost-burdened compared to over half of all renters.<sup>38</sup>

Home modifications are often necessary for people to age in place; modifications include ramps, grab bars, and wider doorways. Many seniors prefer to age in place rather than move; those who do move tend to move to similar neighborhoods.<sup>39</sup> For those who rent, those in subsidized housing are more likely to have more accessible units than those in the private market.<sup>40</sup> However, public housing in the United States faces many quality issues, and less than 20% of subsidized units are considered accessible.<sup>41</sup> Many homeowners are living in older housing stock, and ability to improve living conditions is correlated with income.<sup>39</sup>

## Louisville Data

In the United States one of the primary means through which individuals and families are able to accumulate wealth is through homeownership. As such, homeownership is both an important measure for both housing and economic stability. There are persistent inequities in Louisville in home ownership, renters, and those who experience foreclosure or eviction (Figure 43). A majority of White residents age 50+ in Louisville live in homes they own (81%), compared to about half of Black residents age 50+ (54%) and of Hispanic/Latinx residents age 50+ (49%).

**Figure 43: Percent 50+ Household Tenure in Jefferson County Kentucky by Race and Ethnicity**

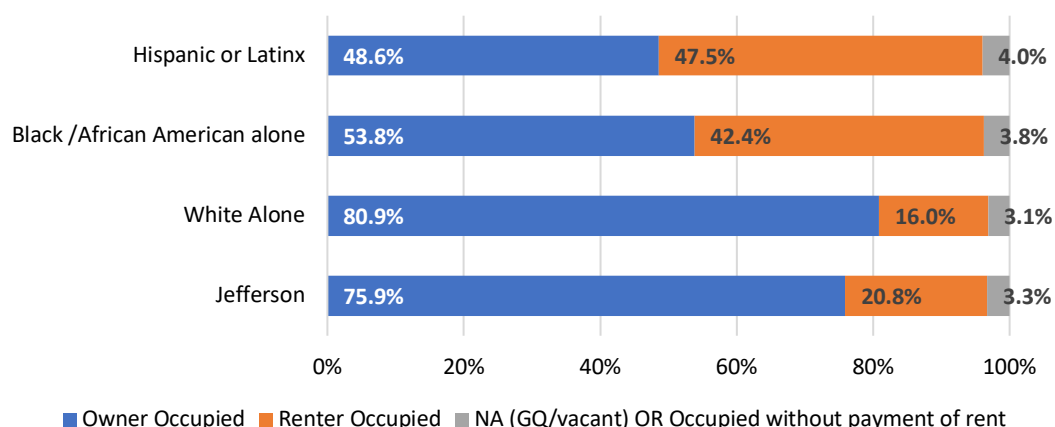
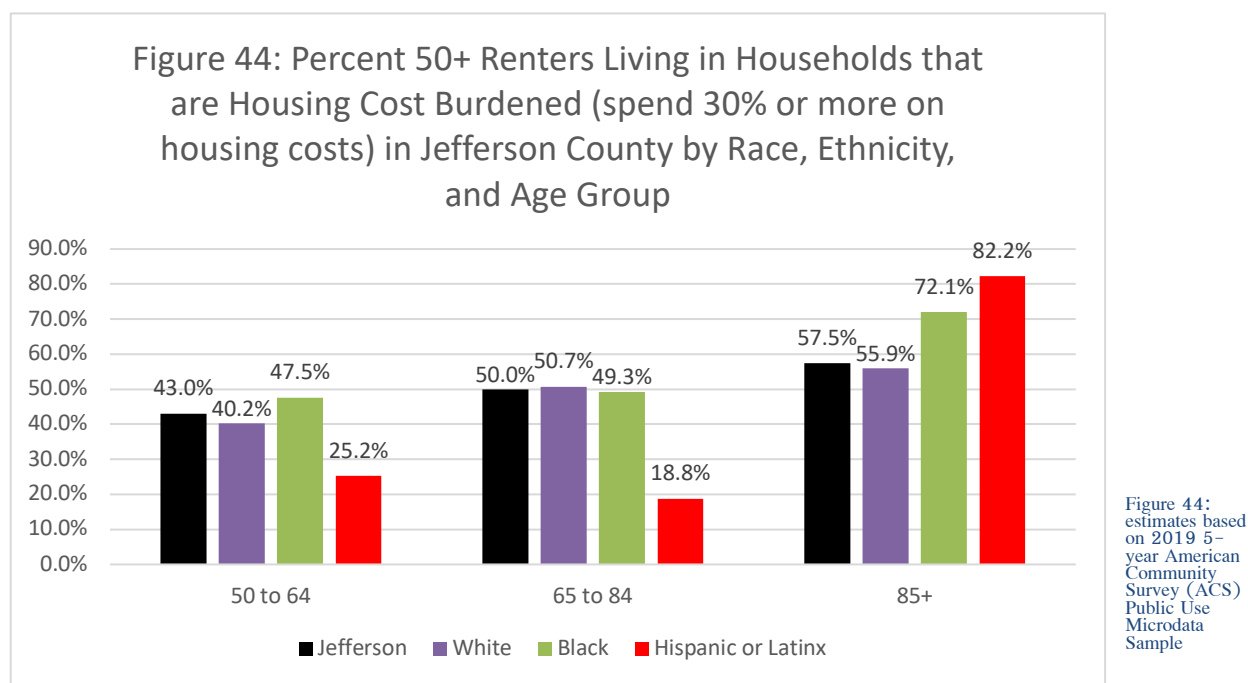


Figure 43:  
estimates based on  
2019 5-year  
American  
Community  
Survey (ACS)  
Public Use  
Microdata Sample

Renters face rising costs and a lack of affordable housing in the rental market. According to the Metropolitan Housing Coalition, housing affordability is typically measured as a percent of income. Households are considered to be housing cost burdened when they spend 30% or more of their income towards shelter costs. Metropolitan Housing Coalition reports that “almost 46 percent of renter households with seniors are rent-burdened in the U.S.”<sup>42</sup> (MHC 2017). As can be seen in Figure 44, the percent of renters living in households that are housing cost burdened consistently increases from 43% for the 50 to 64 year age group to fully half of the 65 to 84 year age group, and increasing to 58% among those age 85+<sup>43</sup> (CITATION: PUMS ACS).

Black renters are more likely in earlier in life to be housing cost burdened than White families<sup>43</sup> (CITATION: PUMS ACS). Figure 44 also highlights inequities in who is housing cost burdened in Louisville in later life. For those aged 85+, a majority of renters who are Black (72%) and Hispanic/Latinx (82%) are much more likely than renters who are White (56%) to be housing cost burdened.



### Survey findings: Housing

Survey respondents largely felt their housing was safe with the vast majority reporting it was “completely true” when asked if they had safe housing. Those who rated the statement as “mostly true” declined with age, suggesting older adults in the survey felt more sure of the safety of their housing.

Figure 45: Survey Results: I had safe housing, by age  
(N=681)

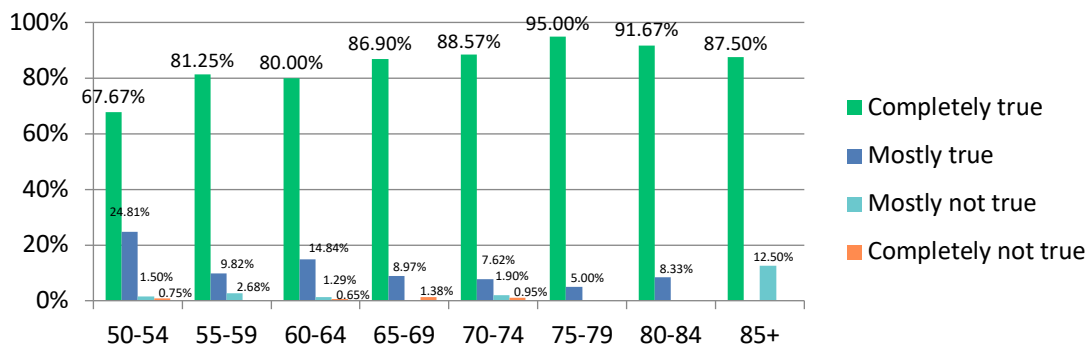


Figure 45:  
Data reported  
from Public  
Survey

## What We Heard

Respondents discussed how aging in place was difficult. The need for financial help with home upkeep, repairs, and finding the resources to “age in place” was difficult in the past year. People shared their fears of not being able to afford their housing and how that creates a feeling of insecurity. People talked about not having access to in-home care or affordable and safe nursing home care. Several people talked about the mental and physical burden of being sheltered in place at home with family members who had more severe health care needs. Many folks were either experiencing homelessness themselves or had concerns about others who were experiencing homelessness.

- “We do not have access to good affordable in-home nursing care. Or house care.” – White survey respondent.
- “I need help with ramp for my house.” – Black survey respondent.
- “Spouse has passed away and affordable stand-alone senior housing in Jefferson County is virtually nonexistent.” – White survey respondent.
- “Partially Homeless and Employed with no car. Out looking for higher paying jobs to afford a car and eat.” – Black survey respondent.
- “I am an amputee and need housing immediately and financial assistance.” – Black survey respondent.
- “Housing is a worry. Disabled and retired and use Section 8 voucher assistance. There are few (if any) safe and/or suitable options.” – White survey respondent.

## Key Takeaways:

- Regardless of housing type, many of those aged 50+ have a desire to age in place. However many cite financial difficulties that prevent housing upkeep or modifications.
- Although housing constitutes a significant financial cost for all, renters are more cost-burdened than homeowners, and across both categories, Black and Hispanic/Latinx residents are more likely to experience financial difficulties.
- Those aged 50+ experiencing homelessness face more instability; the threat of housing instability creates worse mental health outcomes.

# Transportation

Transportation is a root cause that helps explain someone’s ability to access other root causes. In addition to the need for reliable and accessible transportation to access healthy food options<sup>44</sup> and to preventative and necessary healthcare appointments,<sup>45</sup> robust public transit systems also help to foster social connectedness,<sup>46</sup> encourage physical activity, and can be helpful for reducing air pollution and automobile injuries and fatalities by reducing the number of individual vehicles on streets.<sup>47</sup> Decreases in personal automobile use have been shown to reduce chances of obesity, high blood pressure, high cholesterol, and heart attack.<sup>48</sup> The need for accessible non-personal-automobile transport increases within an aging population as these health outcomes increase in prevalence and the need for preventative and necessary healthcare becomes more urgent. Although many adults above the age of 50 are still able to safely transport themselves to these necessary health amenities, prevalence of chronic conditions and disability that prevent the ability to drive oneself increases within aging populations.<sup>49</sup>

Therefore, it is important that public transportation be spatially accessible and reliable, but also physically accessible and usable for aging populations. Factors to consider for aging and disabled people using transit include reliability and frequency of stops, places to sit on transport vehicles and at stops, and ease of getting on and off transport vehicles. Specialized van transport, or “paratransit”, is integral for the mobility of those with serious disabilities and all public transit agencies are legally required to provide this service through the Americans with Disabilities Act. However, researchers have identified a service gap for aging populations who do not have serious disabilities but still rely on some form of public transit.<sup>50,51</sup> Transportation for America estimates that there were over 15.5 million seniors aged 65–79 with poor access to transportation across metropolitan areas of all sizes in 2015. This is an increase of nearly 4 million with poor transportation access since 2000.<sup>52</sup>

## Louisville Data

In Louisville individuals aged 80–85+ have less access to vehicles compared to their younger counterparts age 50–79. (Figure 46). This means older residents may rely on others or public transportation when they need to travel throughout the community. Members of the Black community, regardless of age, are overwhelmingly less likely to have access to vehicles—at some points over double the percentage of White residents (Figure 47). Hispanic/Latinx adults aged 65 or older are also much more likely than their White counterparts to lack access to vehicles.

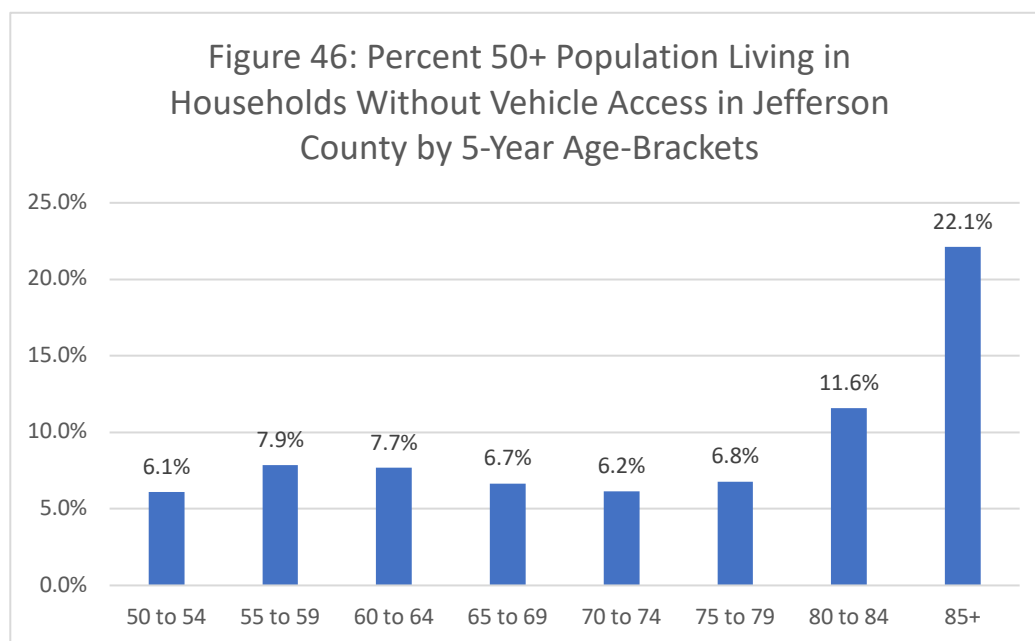
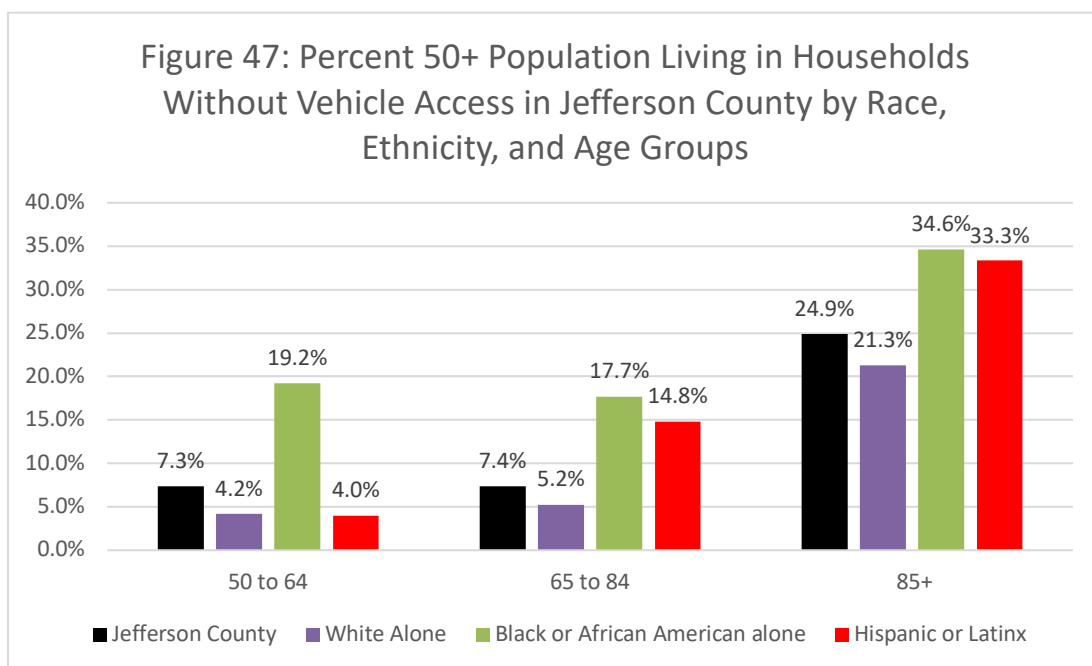


Figure 46: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample



### Survey findings: Transportation

The survey asked whether people had access to reliable transportation during the last year. Figure 49 shows, for the most part, both Black and White survey respondents reported having reliable transportation over the past year, although Black respondents were less likely to have reliable transportation. Younger survey respondents were more likely to report reliable transportation, with the percentage stating “completely” or “mostly” true declining among older respondents.

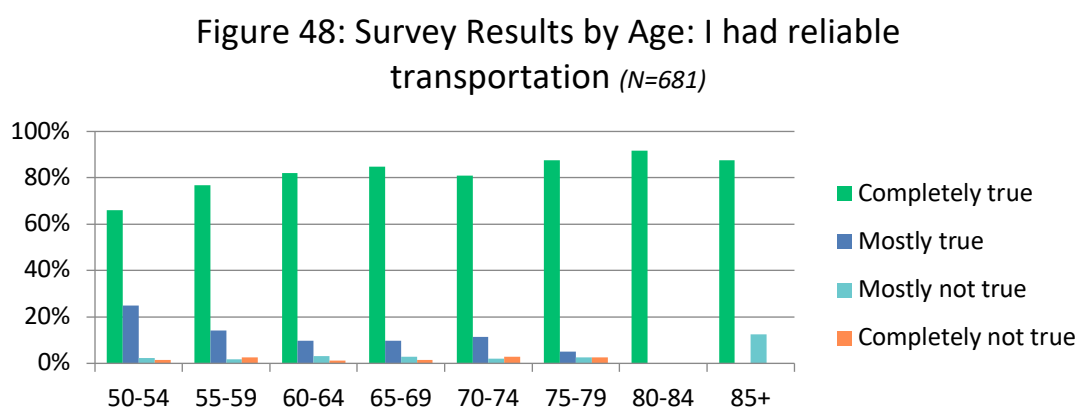


Figure 49: Survey Results by Race: I had reliable transportation (N=681)

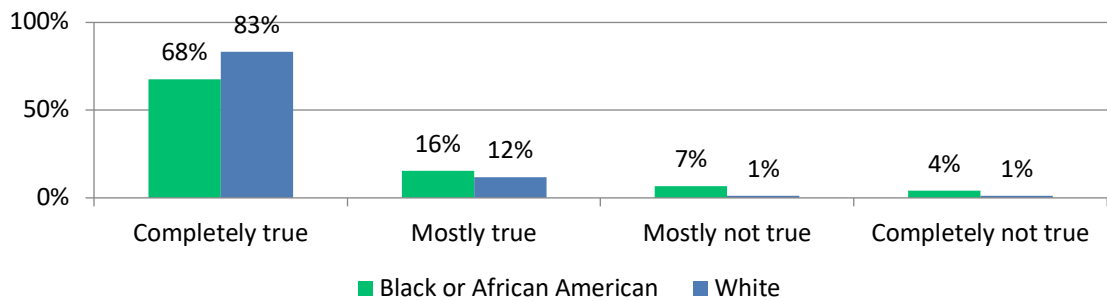


Figure 49: Data reported from Public Survey

## What We Heard

People discussed the need for better transportation options for people with mobility needs and disabilities. Several mentioned the need for more walkable options near their homes for exercise and for daily necessities. Some had vehicles that needed repairs that they could not afford which created difficulties in getting to work and other necessary appointments.

- “Need better transportation options for elderly plus better options to decrease isolation.” – White survey respondent.
- “I’m on disability now and with a fixed income I can’t pay all my bills. It’s hard to find part time Jobs for older. My truck went down so I have no way to get around people seem too busy to help. It makes me feel bad because I have always had a job but now, I can’t take care of myself or my bills.” – Black survey respondent
- “I wish Louisville had better and safer pedestrian and biking options for alternative transportation. The car is overused in the city.” – White survey respondent.
- “Been unemployed since 1/1/2021 and not received my first check. Bills unpaid, vehicle broke.” – Black survey respondent

## Key takeaways:

- Many people rely on vehicles to have access to other needs like food, employment and healthcare. There is a racial/ethnic gap, where White residents are more likely to have access to a working vehicle.
- However, many residents would prefer to have more robust options for public transportation, which could be used more safely with age and are more environmentally sustainable.
- Having a form of reliable transportation is more likely for White residents than Black or Hispanic/Latinx residents.



## Access to Food

Access to healthy, nutritious food impacts the ability to live healthy lives. As people age, their physiological food intake is likely to decrease, which can lead to nutritional deficiencies.<sup>53</sup> Many factors contribute to decreased nutritional intake in aging populations, such as: decreased sense of taste and smell, poor oral health, loss of vision or hearing, and osteoarthritis.<sup>54</sup> These factors make it difficult for aging populations to access and consume fresh, nutritious foods.

Other barriers to accessing fresh healthy foods for older adults include cost and transportation. From 1993 to 2018, the Supplemental Nutrition Assistance Program (SNAP) saw a 10% increase in households with elderly individuals.<sup>55</sup> This steady increase highlights the increased cost burden of food on aging populations<sup>56</sup>; financial insecurity often leads to tradeoffs in what residents are able to pay for such as forgoing medicine to have food, or buying lower quality food to pay for housing. Individuals without vehicles or access to public transportation face another barrier in accessing healthy, nutritious food.<sup>57</sup> In the United States, older adults are more likely to live alone or just with their spouse,<sup>58</sup> which leaves those unable to physically go shopping for groceries vulnerable to food insecurity.

Figure 50: Map of Grocery Stores and the ½ and 1 mile buffers around them

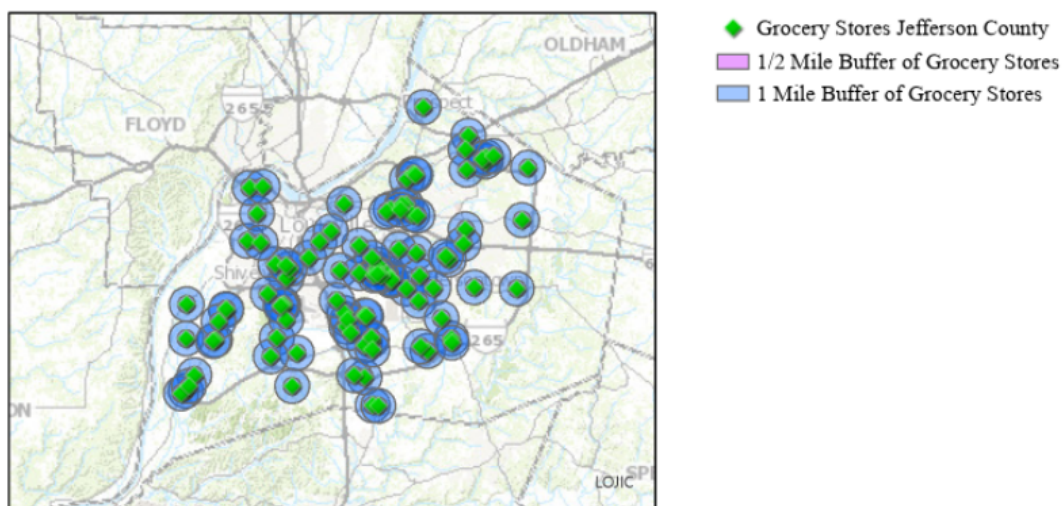


Figure 50: information used pulled from the Env Health Management Information System in 2021.

### Louisville Data

In Louisville, Black individuals age 50+ are much more likely than their White counterparts to receive SNAP benefits (Figure 51). The proportion declines as individuals age, but the disparity between the two groups remains. Individuals reliant on SNAP are subject to changing political agendas that may restrict or reduce SNAP benefit dollars. They may also have less access to resources such as farmers markets where vendors may not accept SNAP (although some markets in Louisville do participate in SNAP double-dollars, allowing individuals to make use of their benefits and make locally grown and raised food more affordable.)

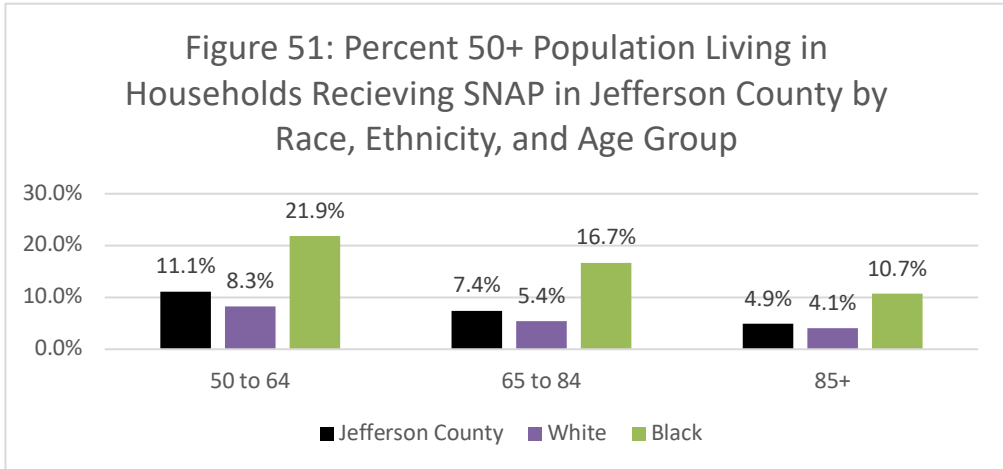


Figure 51: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

### Survey findings: Food security

The proportion of individuals who indicated it was “completely true” they had access to nutritional food increased among the older age groups, with a declining proportion rating the statement “mostly true.” This suggests older survey respondents felt more secure in their ability to access healthful food for themselves. Nearly two-thirds (66%) of Black survey respondents indicated it was “completely true” that they had access to nutritional food. By comparison, 84% of White respondents reported the same (Figure 52 & 53).

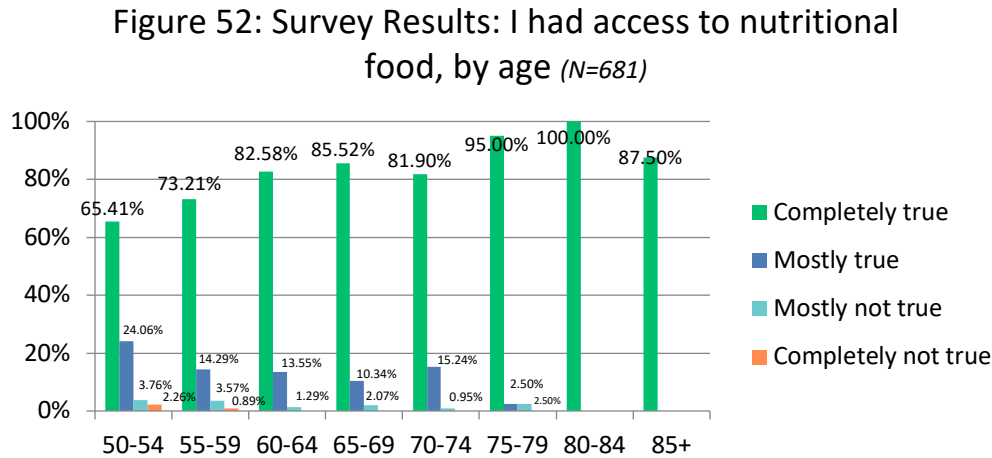


Figure 52: Data reported from Public Survey

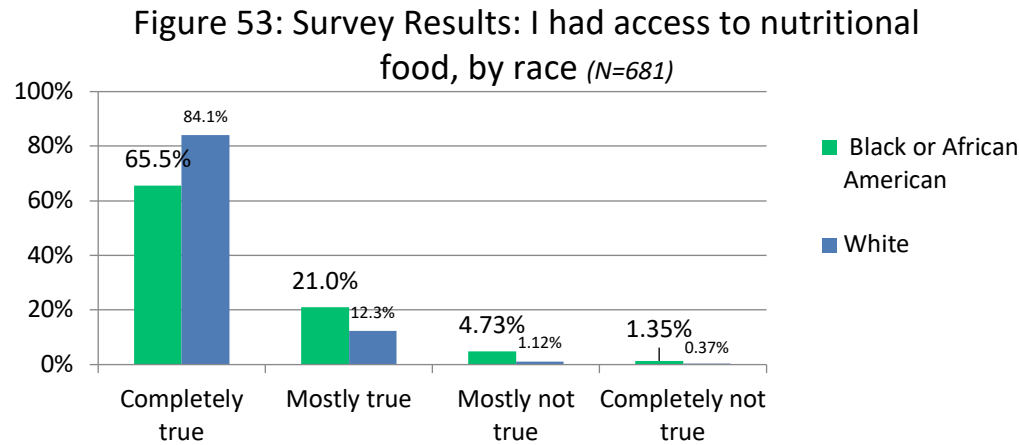


Figure 53: Data reported from Public Survey

## What We Heard

Respondents cited the need for better access to healthy food that is closer to where they live. This lack of access to quality affects the quality of life, health, and a feeling of being connected to the community. Several people shared their desires for more options for groceries near their houses. Food costs and other basic necessities were perceived to have risen during the last year. Food assistance programs such as Dare to Care were cited as being helpful during the pandemic, but sometimes this was not enough to meet long-term food needs.

- “They was bringing in food every week. Yeah, anytime someone brings you some food that’s free helps. My church was out for a while, but we’ve been back in about three months.” – Black storytelling participant.
- “It’s like living in an apartheid area. West Louisville has no nice stores like Trader Joe’s, and our Kroger’s have low quality produce and goods. If my partner had not grown organic collard greens, we would not be as healthy.” – Black survey respondent.
- “Post COVID I am still stressed about what might be ahead, the huge rise in food costs is adding to the worry and how to cope as I get older.” – White survey respondent.
- “Quality of life sucks right now. Not enough money for medicine, groceries, and gasoline, not even mentioning home improvements.” – White survey respondent.
- “Would like services provided to me that are not income based. Such as utility assistance and food when needed. Dare to Care in my area only every 3rd Saturday of the month. Unlike other areas of the city which offer better selections/variety.” – Black survey respondent.

### Key Takeaways:

- Older adults face unique challenges in accessing healthy affordable foods, particularly:
  - Safe transportation to retailers – urban infrastructure is built around a car-centric culture where older adults who cannot drive are left without adequate public transportation, safe pedestrian access, or inaccessible delivery services
  - Affordability – SNAP benefits for those who qualify may not stretch far enough, and many older adults may face a “benefits cliff” where they no longer qualify for SNAP but still struggle to afford groceries.
- Healthful, nourishing food is critical to health at all ages, and especially as adults age to avoid or better manage chronic illnesses such as heart disease, diabetes, and kidney disease. Inequitable health outcomes are perpetuated by the underlying inequities in food systems faced by older adults. Supportive services can help fill in gaps, but ultimately older adults need a food system that adequately supports them.

# Healthcare Access

Healthcare access for those aged 50+ has a strong relationship not only with accessible financing, but is also impacted by socio-economic support systems,<sup>59</sup> structural racism, and complex health care systems.<sup>60</sup> Decreased access could be due to lack of financial ability to pay, lack of trusted provider, or lack of transportation and more.

When older adults do not have access to affordable quality health care, they often delay visits to their health provider. Delaying or forgoing care often results in the advancement or preventable disease or an increase in severe illness and death.<sup>61</sup> An estimated 20% of elderly in U.S. forgo healthcare treatments due to cost related issues.<sup>54</sup> Older White adults are more likely to have private insurance and Black adults are more likely to use Medicaid or Medicare, which leads to differences in coverage and treatment providers.<sup>62</sup> Healthcare systems are often not designed to accommodate complicated long term healthcare needs which older adults typically have.<sup>54</sup> Lack of primary care provider responsiveness, and transit to appointments are also major barriers to healthcare access among seniors.<sup>63</sup>

Trust plays an important role in access to care as well. While lack of trust creates delays in care for all populations, those who have had poor experiences with health care systems are more likely to put off getting treatment.<sup>64</sup> Black residents are less likely to have a provider of color, and more likely to experience mistrust due to a history of racially-based medical experimentation such as the Tuskegee Syphilis study.<sup>62</sup> Physicians have been demonstrated to have biases that are positive towards White patients and negative toward Black patients; this has implications for how patients are treated and the type of care they receive.<sup>65</sup>

## Louisville Data

Typically, health insurance becomes less of a burden for all populations when they become eligible for Medicare at 65. Across all age categories, however, Hispanic/Latinx individuals participate in the workforce at higher rates than non-Hispanic/Latinx individuals, they are less likely to have insurance coverage from their jobs and therefore to be enrolled in a public benefit like Medicaid (Figure 54).<sup>66</sup> This lack of insurance is particularly an issue for those Hispanic/Latinx individuals in the 60–64 age group – where they are not yet eligible for Medicare but are almost 6 times less likely to have insurance as their White counterparts. Though a small proportion, Black residents are nearly twice as likely to be uninsured in the 60–64 age bracket compared to their White counterparts.

Figure 54: Percent of 50+ Population without Health Insurance, Race, Ethnicity, and Age Group

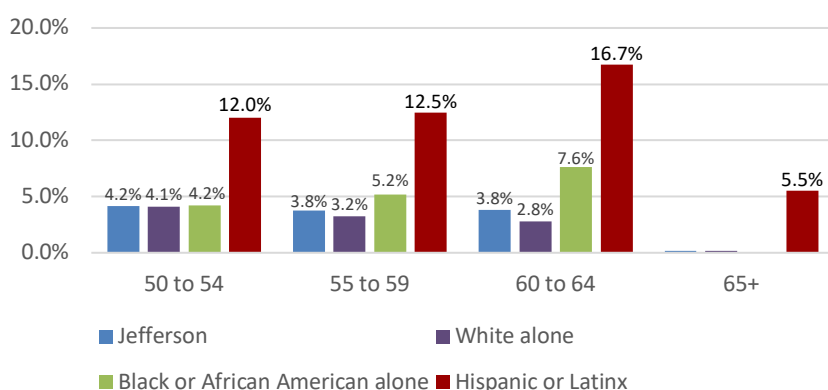


Figure 54: estimates based on 2019 5-year American Community Survey (ACS) Public Use Microdata Sample

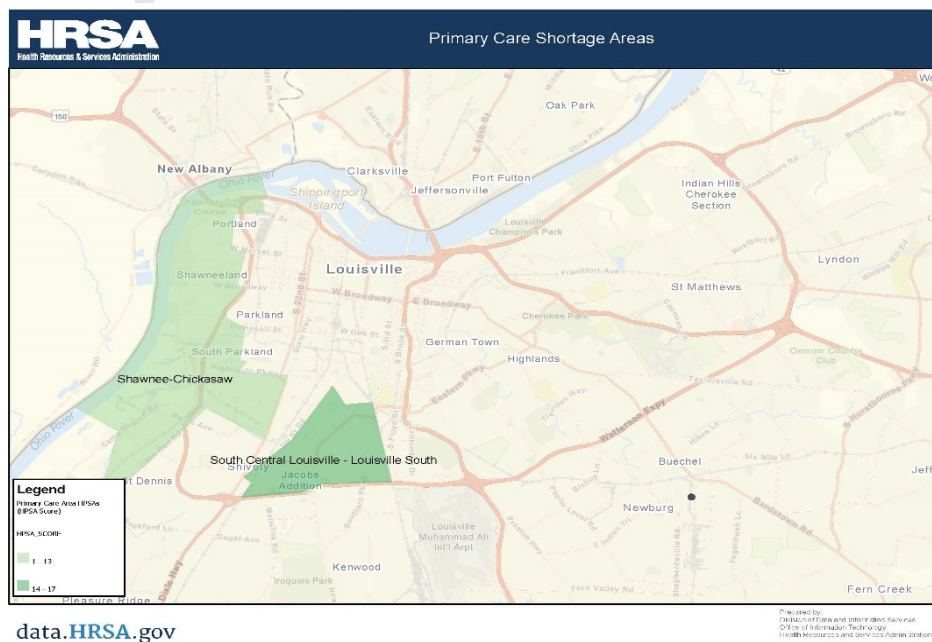
Even with insurance, certain populations have limited access to health care providers—including behavioral health, dental services, primary care providers, and medical specialists. The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, designated two Health Professional Primary Care Shortage Areas (HPSAs) in Louisville; Shawnee-Chickasaw and South-Central Louisville (Figure 55). HRSA designates these communities as areas without enough primary care providers to meet local needs.

### Survey findings:

### Healthcare access during COVID-19

Healthcare access plays a particularly pivotal role during the pandemic because it can facilitate diagnosis as well as decrease transmission and mortality within populations. The overwhelming majority of survey respondents indicated they had access to reliable health care during COVID. Although small percentages, nearly twice as many Black/African American respondents indicated it was “not true” that they had reliable healthcare access compared to their White counterparts.

Figure 55: Primary Care Shortage Areas Fuel Inequities



data.HRSA.gov

Figure 55: Figure pulled from Health Resources and Services Administration (HRSA)

Figure 56: Survey Results by Race: Access to Reliable Health Care During COVID (N=681)

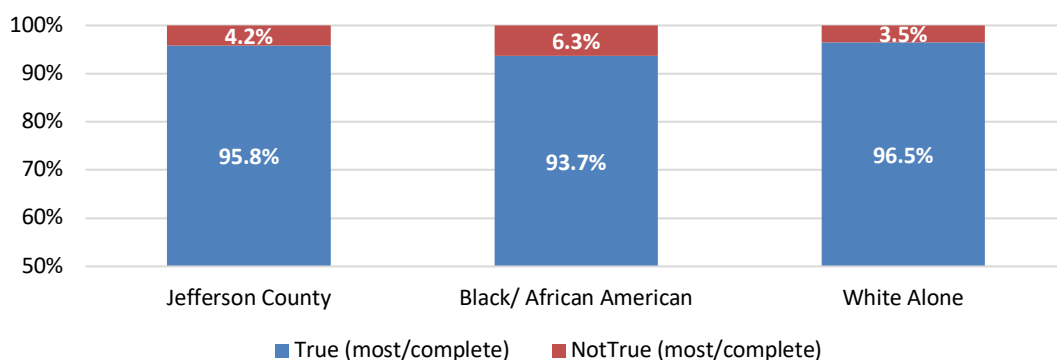


Figure 56: Data reported from Public Survey

## What We Heard

When asked about health care, the qualitative data gathering focused mostly on the experiences and impact of COVID on the people we talked to in Louisville. When asked about what it is was like to follow the recommended COVID protocols, most of the responses focused on being able to follow the guidelines such as hand washing, social distancing, wearing masks and staying at home. Many people discussed not being certain about taking the vaccine because of fear of the vaccine itself, how quickly the vaccine was created, or the historical context of the health care system conducting experiments on the Black population. Some people lifted up that trusted people in their lives suggested not getting the vaccine and then having to decide what they were going to do. Listening to the Governor's mandates and having trust in their faith were strategies that people used as well in getting through the pandemic. There was a theme of people feeling a sense of relief after getting vaccinated.

The focus groups, interviewees, and survey respondents discussed challenges being able to access their health care through to online systems, and that sometimes their health providers were not able to see them as quickly as they needed. People talked about the loss they experienced with family members getting COVID and many talked about their family members and friends dying due to COVID. Chronic health care needs did not stop during COVID and sometimes they were hard to manage given the challenges of COVID, the root causes of health inequity, and the taxed health care system. For others, lack of affordability and negative experiences with health professionals lead residents to delay seeking medical treatment.

- A Black survey respondent noted that his biggest problem was, “finding a medical doctor that respected my concerns and [the] way they talk to me.”
- “I think I had COVID in April 2020, but there weren’t testing facilities nearby and my doctor didn’t see me (I messaged her). Now when I would like to be seen, appointments are months away”. – White survey respondent.
- “My mental health is not good and it’s hard to get an appt. to see about it”. – White survey respondent
- “My mom died in December 2019 and during the pandemic, my hypothyroidism got a lot worse and I’m perimenopausal, so it was a really sad time. Bless my husband, and thanks to my doctor, who listens.... and helps so much”. – White survey respondent
- “I had quite a few friends that I knew that passed. What cut me the most was I couldn’t go to the funeral. That really did something to me. For a minute I started wondering is there really a God that will allow this to happen you know. So, then I got to thinking I know there is a God. Because what I been through, he had brought me.” – Black storytelling participant.

### Key Takeaways:

- Health inequities in older adults are a result of a lifetime of compounding inequities in the root causes of health (housing, food access, income, and employment, etc.) In the US, this is particularly driven by race-based discrimination, causing older adults from communities of color to experience more rapid physical dysregulation and therefore differences in quality and length of life.
- Older adults face challenges in accessing services within the health care system – a necessity which becomes more urgent as individuals age. Loss of employment may be a particularly critical factor for those relying on their job for health insurance, but not yet old enough to qualify for Medicare. Transportation barriers and navigating a complex healthcare and insurance system may also prevent older adults from seeking or receiving the quality of care needed to maintain a high quality of life as they age.
- An affordable, accessible healthcare system that has the flexibility to adapt to the needs of an aging population is necessary to ensure preventative care and treatment are readily available. Our existing healthcare system must also prioritize anti-racist approaches to patient care, as older adults of color continue to experience discrimination and inequitable quality of care as they age.



## Social Connectedness

Individuals rely on social connectedness as an aspect of overall good health and well-being through every stage of life. The Centers for Disease Control defines social connectedness as “the degree to which an individual or group is socially close, interrelated, or shares resources with other individuals or groups.”<sup>67-68</sup> The feeling of social connection can be experienced in many ways including among individuals such as friends, family units, community organizations, or groups that share a common culture or background. The degree to which an individual is socially connected depends on three factors: structural (marital status, co-habitation, social integration), functional (perceptions of loneliness and social support), and quality (social inclusion, relationship strain, marital quality).<sup>69</sup> As these factors of social connection begin to decline, individuals become more susceptible to social isolation and feelings of loneliness.<sup>70</sup>

As older adults continue to age, they become more likely to experience negative factors that reduce their overall levels of social connection such as losing family and friends, living alone, suffering from serious illnesses, and declination of physical senses. According to data from the National Health and Aging Trends Study analyzed in 2011, nearly a quarter of adults aged 65 and older who reside in community-dwellings experienced social isolation.<sup>71-72</sup> Decreases in social connection put older adults at risk for many different health complications including depression, anxiety,<sup>73</sup> heart disease,<sup>74</sup> dementia,<sup>75</sup> and suicidal ideation.<sup>73</sup>

## Louisville Data

According to the Age Friendly Index from 2017, Jefferson County scores 60% in their domain of social participation, respect, & inclusion, which met the required 50% threshold for age friendliness.<sup>76</sup> The survey in Louisville asked a few questions to gauge feelings of isolation in the past year including being able to get help from family and friends; being able to connect with others when needed; and feeling nervous for the future (Figures 57, 58, and 59). We found that Black survey respondents indicated not being able to get help from friends and family at higher rate than White survey respondents, 14.2% versus 6.7%. The older respondents indicated being able to get help from family and friends at a higher rate than the younger respondents. When asked about being able to connect with others when they need help, it was found that slighter fewer White respondents said they were not able to get help than Black respondents. Again, younger respondents shared that they were more likely to not have help when needed.

Figure 57: Survey Results by Race: I Could Get Help From Friends/Family (N=681)

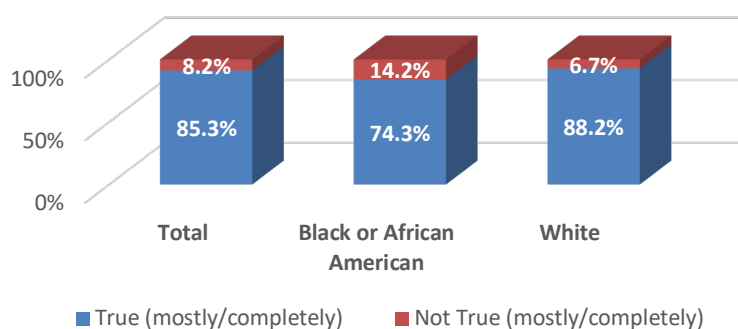


Figure 57: Data reported from Public Survey

Figure 58: Survey Results: I could get help from family and/or friends when needed, by age (N=681)

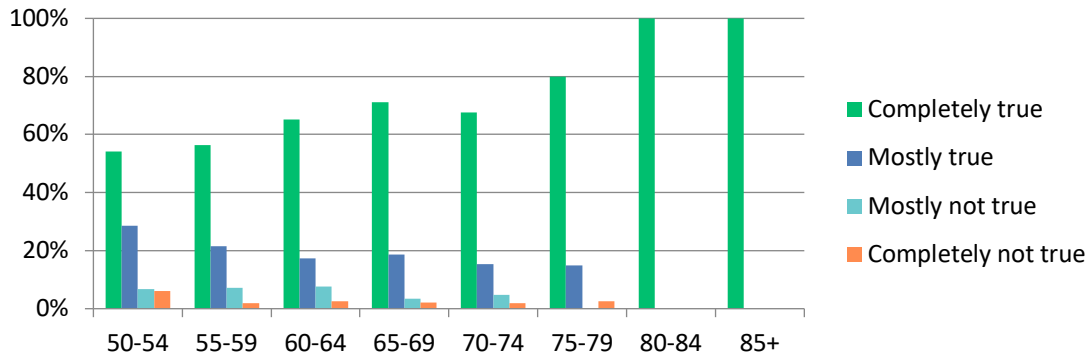


Figure 58:  
Data reported  
from Public  
Survey

Figure 59: Survey Results: I have been able to connect with others when I need it, by race (N=681)

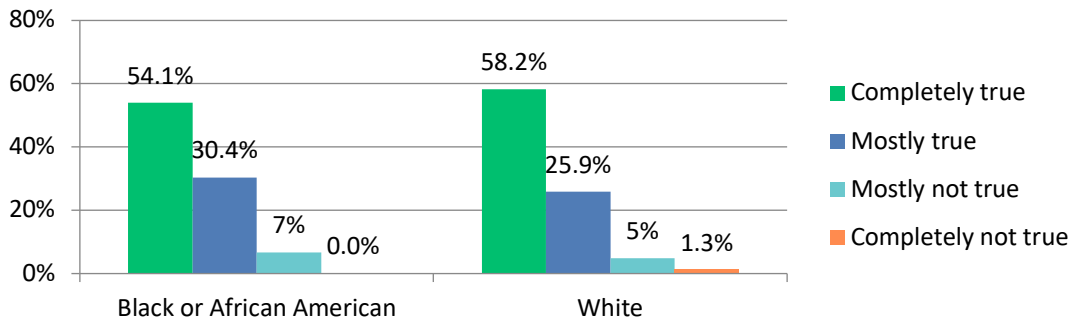


Figure 59:  
Data reported  
from Public  
Survey

Figure 60: Survey Results: I have been able to connect with others when I need it, by age (N=681)

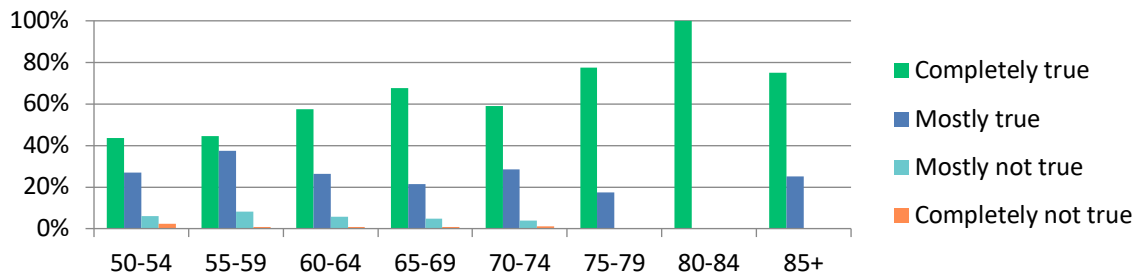


Figure 60:  
Data  
reported  
from Public  
Survey



Figure 61: Survey Results: I have been nervous for the future, by race (N=681)

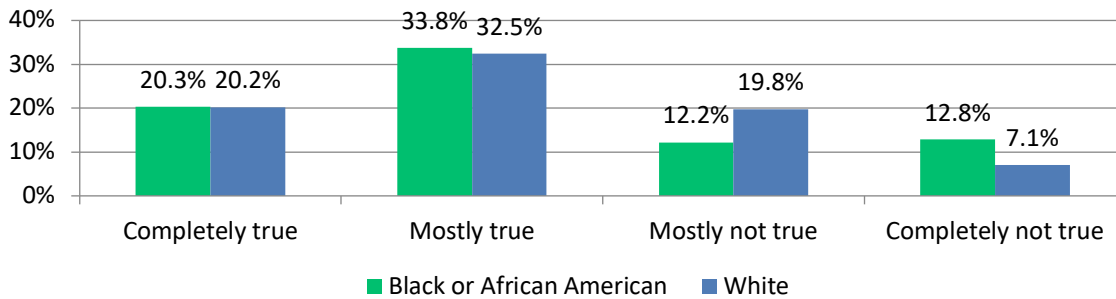


Figure 61: Data reported from Public Survey

Figure 62: Survey Results: I have been nervous for the future, by age (N=681)

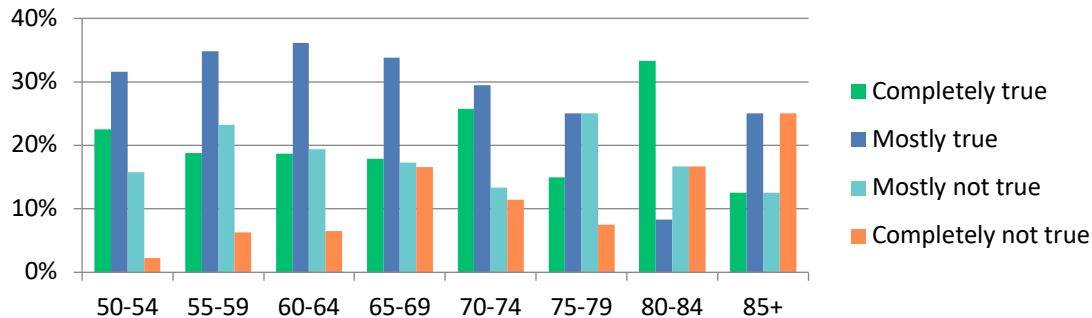


Figure 62: Data reported from Public Survey

## What We Heard

In terms of isolation and loneliness, several people mentioned missing physical touch like hugs, from their friends and loved ones. The restrictions of preventing COVID were cited as taking a toll on social activities. There was an appreciation for the small things in life. They talked about isolation limiting their ability to help others. There was a feeling of loneliness and fear of going around others which was hard on people who many times are already isolated. Some people talked about using technology for church or family or health. These technologies were appreciated but did not replace the feelings and social needs of people with people. The data revealed an openness to not only use technology but there was a reliance on it to stay connected during the pandemic.

Many people shared their experiences with mental health issues, like anxiety stress, and lack of relief during this time. When asked about they dealt with these issues they talked about how the lack of resources increased anxiety. Some mentioned being stuck at home with people who were sick or had dementia or other mental health issues which was difficult to cope with without respite.

The importance of family came through as a theme in getting the support they needed. Specifically, people mentioned feeling fortunate to have family to help them and that they could also help their family when needed. Having strong ties with family also helped the older Louisvillians we spoke to, have a needed connection during the days of having to stay home due to COVID. There was also a sense of resilience that came through the interviews and survey data that showed that even during the uncertain and difficult times in the past year, that people were still able to see their loved ones virtually, get through it, and offered some time for things that maybe they hadn't had enough time for in the past.

- “The joy of anticipating. I just want to be there, just be among people. You know it’s like the conversation... I’m 87... Its spontaneous... You feel like when it’s all over you realize what personal contact means.” – Black Storytelling Participant.
- “Well, I’m 90 years old, my kids come and take me where I need to go. I like to walk but I don’t walk as much as I used to walk, I got something like gout, but I don’t know what it is, everything though my lifestyle is pretty much the same. I do my own cooking and cleaning, everything else.” – Black Storytelling Participant
- “Older persons were severely isolated during the pandemic, whether in nursing homes or living at home. New strategies need to be created to enhance contact with older persons.” – White survey respondent.
- “The way that COVID affected me was, it kept me away from my family.... But I had seven members in my family to die from COVID.” – Black Focus Group Participant.
- “It was nerve wracking. It kept me from being with my family like I wanted to keep us from the socials that we usually have.” – Black Storytelling Participant
- “My mental health is not good and it’s hard to get an appt. to see about it.” – White survey respondent
- “I am very fortunate; I have family and friends that care about me.” – White survey respondent.
- “I am doing well working and taking care of myself and my needs. I have been blessed with parents, family, faith family and friends who are supportive of me and me of them.” – Black survey respondent

### **Key takeaways:**

- Social isolation is a critical issue for older adults, with a quarter of those over age 65 reporting social isolation. Social isolation also perpetuates poor mental health and unhealthy coping mechanisms.
- Further, isolation leads to a lack of social support including those who may be able to provide support for older adults who may need assistance with things such as transportation or food access. Additionally, COVID-19 exacerbated these feelings of loneliness and social isolation.
- Social, emotional, and mental well-being are critical to maintaining high quality of life and good physical health as adults age.
- In Louisville, residents were able to adopt new technologies to remain connected, but many still rely on physical connections to help them access resources.

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# VIII. Appendix

## Methodology

### Literature Review

The team gathered and analyzed AARP health disparity reports from around the country, local issue-based data reports (i.e., transportation and housing) and planning reports from various agencies, as well as national literature on health equity as it relates to the population of people aged 50+.

### Analysis of Existing Data

The research team conducted an analysis of data from 2015 to 2019 Vital Statistics records for Jefferson County, CDC WONDER Population Estimates, 2019 American Community Survey 5-year estimates, Public Use Microdata Sample, and Louisville Metro Department of Public Health and Wellness COVID-19 data (from May 5, 2021 to July 14, 2021). The research team used these data sources to calculate Weighted Age Specific Death Rates (ASDR) for the leading causes of death for the 50+ population in Jefferson County. These measures allow for a comparison of rates of death between groups and at different ages. The research team also calculated rates of infection and death for 50+ Louisville residents to COVID-19 and analyze the various root causes that contribute to inequitable health outcomes.

Vital statistics records include all of the deaths reported in a locality. CDC WONDER population estimates are population estimates pulled from U.S. Census Data by the CDC. ASDRs for each successive age-category are generally higher because rates of death increase as populations age. In what follows, this report provides a more nuanced look at rates of mortality due to certain leading causes of death and for certain groups.

This report breaks the 50+ population of Louisville into five-year increments where possible because doing so affords us an opportunity to address the ways that health outcomes change as groups age. Doing this allows the research team to address differences between age groups and understand how groups experience root causes and health outcomes as they age. In some places sample sizes are too small to be able to address rates in five-year increments for certain measures and groups. For example, in many cases rates of death due to any particular cause of death for certain groups is too small to release to the public. The Center for Health Equity does not report rates publicly where cases are less than 10.

Data presented in this report disaggregate results by age group, race, and gender wherever possible. Whenever possible, health outcomes report White, Black and Hispanic/Latinx against the whole (Jefferson County). Other racial/ethnic groups have counts that are too small and result in rates that are considered unstable over time; this data may not be presented or is presented with this caveat.

### Collecting new data

Researchers considered ethical issues and challenges involved in participatory research and this specific project. This meant included informed consent procedures, specific protocols for engaging vulnerable persons and groups, and enacting measures to guarantee confidentiality and protect the identity of some research participants.

### Survey

The research team released an online survey on Survey Monkey, entitled the “Quality of Life Survey for People over Age 50 in Louisville” in June and July of 2021. The survey was disseminated by partnering with many community groups and over 30 community organizations that serve the 50+ population in Louisville. These groups and community organizations shared links to the survey through email and social media. The research team arrived at a convenience sample of 681 respondents.



This sample is therefore not generalizable to the entirety of Louisville's 50+ population because it was not randomly generated. There are similarities COur sample is similarly though not perfectly distributed with respect to race and age as the racial and age distribution of residents in Louisville. For example, 79% of survey respondents were White compared to 78% of 50+ Louisville residents according the 2019 ACS PUMS estimates. 22% of survey respondents were Black compared to 17% of 50+ Louisville residents according to 2019 ACS PUMS estimates. We received responses more frequently from women than men. Respondents may be more likely to report access to health care than the general population because many respondents were recruited through health care systems.

The survey included both quantitative questions as well as open ended survey questions that were analyzed.

Limitations for the survey included balancing the desire for a short survey that would not overly burden respondents. Surveys were not translated, which may have prevented non-English speaking or English as a second language populations from participating.

### **Storytelling Session / Interviews**

The research team also made targeted efforts to hear from Louisville residents aged 50+ who may be the most impacted by health inequities and who may lack access to resources and services necessary for living a healthy life. A local facilitator facilitated conversations with over 35 people in June and July 2021. These sessions were held at the California Senior Housing Center and participants received a \$25 gift card for their time.

Participant ages ranged from 50 to over 85, with the majority aged 60–64. All of the participants identified as non-Hispanic Black and lived in the 40210 zip code. All participants reported receiving the COVID–19 vaccine. The income range of the participants fell mostly in the \$1–\$9,999 range followed by the \$10,000 to \$24,999 range. Over half of the participants were female (59%) and reported that their economic condition stayed the same throughout the COVID–19 pandemic. Less than one-fifth (16%) reported their situation got worse during the last year.

New data collection was impacted by uncertainty and the need for creativity to reach community members to participants due to COVID–19 pandemic. This project began in January 2021 at the beginning of the vaccine rollout and while the state was just beginning to lift COVID–19 restrictions. Planning for hearing from a diverse set of voices from a population of people that may not have access to or ability to utilize technology for virtual interviews was challenging.

### **A Focus on 50+ Residents**

Whenever possible, the report focuses on those aged 50+. However, this is not always possible for all reports or literature because not all agencies or researchers use the 50+ population as a proxy for older populations. For example, the United Nations (Department of Economic and Social Affairs, N.D.) refer to 'old age' as 60+. Other researchers who focus on elders, seniors or the aging population often use 65+ to define this population. However, AARP discusses older adults as those who are 50+ and use this delineation from which they conduct their national research and develop policy briefs. Whenever there is a difference in who the research refers to, this is noted.