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Meaningful Lives As We Age

Addressing Brain Health in Asian American Communities

Applications from the GSA KAER Toolkit for Primary Care Teams

Momentum Discussions Podcast from the Gerontological Society of America

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Announcer:
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Jen Pettis:
Welcome to this GSA Momentum Discussions podcast titled, Addressing Brain Health in the Asian American Communities. Momentum Discussions highlight topics experiencing great momentum in the field of gerontology. We're grateful to Genentech, Lilly, Eisai, and Otsuka for their support of the GSA KAER Toolkit for Brain Health and today's podcast episode. My name is Jen Pettis, and I'm the Director of Strategic Alliances at the Gerontological Society of America (GSA). I'm pleased to serve as the host for today's Momentum Discussion. Today I'm joined by Diane Ty. Diane is the Managing Director for the Milken Institute Future of Aging, where she oversees the strategic direction and operations of its focus on healthy longevity and financial wellness and leads the alliance to improve dementia care. GSA appreciates Diane's contributions to our brain health work as one of our expert advisory panel members. Welcome, Diane. I'm so glad you could join me today.

Diane Ty:
Thanks so much, Jen. I'm grateful to be here.

Jen Pettis:
Wonderful. Let's get started Diane, by talking about Asian Americans as the fastest-growing major racial group in the us. Can you help our listeners understand who we're talking about when we refer to Asian Americans?

Diane Ty:
Asian Americans represent more than 30 nationalities and ethnic groups with origins from East Asia, Southeast Asia, and the Indian subcontinent. Yet typically we're categorized as Asian Americans or Asian Americans and Pacific Islanders (AAPIs) for data capture and tracking purposes.

Jen Pettis:
Why is classifying Asian Americans as a single group perhaps problematic for health data research and reporting?

Diane Ty:
If you classify Asian Americans as a single kind of monolithic population, it does hide our immense diversity. This has significant implications for the health and wellness of our communities, particularly when it comes to diagnosing and treating chronic diseases like Alzheimer's disease or other dementia. When you think about it, Jen, where you're born, where you live, where you work, and where you go to school impacts your health outcomes as these factors are closely aligned with income, educational attainment, and access to housing, health resources, to green spaces and healthy foods. But I think there's good news here. The Office of Management and Budget (OMB) oversees the data collection across all federal agencies. The good news is in March of 2024, they released updated standards that require all federal agencies to collect more detailed data beyond the minimum race and ethnicity required categories. This is going to update and create more subcategories for our AAPI community.

Jen Pettis:
Diane, you mentioned chronic disease when we're talking about classifying this single monolithic group that has intense diversity. But let's focus on one of those chronic diseases that you mentioned, and that's Alzheimer's. How does an Asian American's risk of developing Alzheimer's disease and other dementia compared to that of other race groups? How does this vary among subgroups?

Diane Ty:
I'm glad you asked this question, Jen. We know from research that Blacks are two times more likely to have Alzheimer's disease and related dementia compared to Whites, and we know Hispanics are one and a half times more likely. However, we do not have the data or any sense of risk for Asian Americans, despite our being the fastest-growing population of older Americans in the US. In terms of variability among subgroups, I think there is significant variability. Again, we don't have the data. We have six major origin groups including Chinese, Indian, Filipino, Vietnamese, Korean, and Japanese who account for 85% of all Asian Americans. They're very different and distinct subgroups because of their languages, cultures, immigration histories, and socio-economic statuses. Thinking about immigration history, there is a big difference if you come over here for graduate school versus if you are a refugee and experienced trauma while coming over here. The differences are dependent on all these variables. And then there are other smaller subgroups including Bhutanese, Nepalese, Cambodian, and Laotian who are undercounted. We don't know the risk for those various subgroups.

It's super important that we get to that.

Jen Pettis:
Diane, you spoke of the variability of risk for developing Alzheimer's disease and other dementia among those subgroups. Can you share some examples of what contributes to that risk variability?

Diane Ty:
We know that there are 12 modifiable risk factors for dementia. Education is one of them. High educational attainment is a stereotype of Asian Americans, and the numbers back this up with 54% of Asians having a bachelor's degree higher than Whites at 36%, Blacks at 23%, and Hispanics at 16%. Yet the high school dropout rate among some Southeast Asian American subgroups is troubling. A 40% dropout rate of the indigenous Hmong population, 38% of Laotians, and 35% of Cambodians don't complete high school. If you're just put together in this one data point of higher education, you're obscuring where there are groups at risk with lower educational attainment. Another risk factor for dementia is diabetes. We see significant variability in the prevalence of Type 2 diabetes. It ranges anywhere from nearly 35% for Pacific Islanders, Native Americans, and native Hawaiians to 14% for East Asians.

What's interesting about diabetes as well as obesity, which is another risk factor, is that the BMI cutoff for overweight is 25 and over, for obesity it's 30 and over. This is all based on people of White, European descent. There is evidence to discuss and guidelines to say that Asian Americans should maybe look at 23 as the BMI cutoff for overweight and 25 for obesity. We think there's probably underdiagnosing of both diabetes and obesity, which are risk factors for dementia. Lastly, when you think about social determinants of health, income is another factor. Similarly to what I described in the educational attainment, is the median household income of Asians. While it’s the highest among all racial and ethnic groups, it doesn't tell you about the economic insecurity of some subgroups. You've got poverty rates of 40% for Hmong and 30% for Cambodian Americans. If you're only looking at medians or averages, you're obscuring what is happening with some of our subgroups.

Jen Pettis:
Diane, you mentioned missing diagnoses of perhaps diabetes or obesity, but let's talk about the diagnosis of Alzheimer's in Asian Americans. What are some barriers that may prevent Asian Americans from receiving an early accurate diagnosis of mild cognitive impairment or dementia, as well as appropriate dementia care?

Diane Ty:
That's a good question, Jen, and I don't think there's an easy answer. Generally, there's a lack of understanding about dementia, not just among the AAPI community, but among the general public. Within the Asian American community, Alzheimer's disease, in particular, might be perceived as a mental illness or maybe an embarrassment among certain Asian subgroups. There's a cultural stigma that really might deter people from seeking information or seeking a diagnosis. And then I think most will not report symptoms of dementia to a medical professional unless some family members are there to do so. That’s an overall lack of understanding. I think there are also cultural biases around cognitive testing due to the inadequate translation of the tools. If English is not your first language, and we know some subgroups have less English proficiency, that is also a factor regarding utilization of the tools. Lastly, there's evidence for unconscious bias as another possible reason. The Alzheimer's Association reports that 34% of Asian Americans report experiencing discrimination when seeking Alzheimer's care compared to just 9% among White Americans. Is that because of language issues? That’s a big opportunity for us.

Jen Pettis:
Thinking about the primary care team, what is their role? What can they do to address those barriers?

Diane Ty:
There's a lot of emphasis on getting primary care teams involved in earlier detection, diagnoses, and even high-level screening. What I think they can do is be more cognizant of some of the potential language barriers or not having cultural competency. We have a shortage of bilingual medical professionals as well. Another thing I think primary care practices can do is have that cultural awareness. Often, you'll see an adult-aged child accompanying their parent to these exams. I know I've done that many times. Having those children as well as the older adults themselves be aware that if you are having a memory issue, that doesn't necessarily mean that you have dementia. There could be other causes: a thyroid issue, vitamin B12 deficiency, sleep apnea, and my favorite - hearing loss.

We know that hearing loss happens as we age, and hearing loss is a risk factor for dementia. It can close down your world; it could lead to greater social isolation and loneliness. Even just being able to be open to having that conversation about "How's your hearing?" might be a way in instead of just saying, "Are you having memory issues?" I say all of this though, recognizing that there's so much time pressure in primary care. We can say what's good for primary care teams to do, but we also need to be sensitive that they're dealing with so many requirements right now. That's pretty much what I think our primary care can be doing to help.

Jen Pettis:
Well, Diane, this has been a great discussion. The information that you share about how many diverse groups there are, as well as the diversity within those groups, and how important it is to identify the subgroups beyond the kind of six major origin groups that you mentioned. And then how different those risk factors are that we think of when we speak of the Asian Americans, the higher income, but then look at those subgroups, and how important it is that OMB has started to take some steps to improve the data.

Diane Ty:
Not only as you start collecting that data, but imagine as we begin to do that, it's going to inform the care needs in the communities, which we all know are being underserved. I'm excited about that initiative.

Jen Pettis:
That's terrific. What are some other things that you'd perhaps want to leave our listeners with today?

Diane Ty:
Let's put the stigma aside and know that screening for brain health is something we should all be doing, not just at 65 at your annual wellness visit, but just as a practice, brain health is something we should all be thinking about. Having a cognitive screen as a baseline, and then repeating it every year. Knowing that just because you might have cognitive impairment does not mean you have dementia, because we know there are some addressable causes, as I mentioned earlier.

Jen Pettis:
Normalizing those conversations in primary care but understanding that time is of the essence. Making those conversations productive is so important. By making sure folks feel comfortable and welcome, and addressing that cultural competence.

Jen Pettis:
I think having the awareness and mindfulness of challenges that people face is important to stress and to have that understanding. Diane, I want to thank you so much for joining me today, and for all your contributions to both GSA brain health and obesity work. Thank you. We appreciate your participation in our work. And thank you also to all those listening to this episode of the GSA Momentum Discussions podcast. We hope you found it informative and enjoyable. Have a great day, Diane.

Diane Ty:
Great. Thanks so much, Jen.

Jen Pettis:
Take care. Bye.

Announcer:
The Gerontological Society of America was founded in 1945 to cultivate excellence in interdisciplinary aging research and education to advance innovations in practice and policy. For more information about GSA, visit geron.org.