

The food habits of Black older adults in New York City: Are there differences between African Americans and Caribbean-born immigrants?

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Abstract

The purpose of this pilot study was to gather data from urban-dwelling African-American and Caribbean-born elders in order to explore their normal food habits, awareness about nutrition, influence of personal health conditions on food habits, and receipt of specific practitioner-initiated personalized nutrition intervention. A series of four focus groups were conducted among 50 Black elders, 36 of whom were African Americans and 14 of whom were Caribbean immigrants. Sessions were audio taped and transcribed. Transcripts were analyzed using ATLAS.ti software. Some elders from both subgroups have maintained lifelong cultural food habits regardless of personal health challenges. It was evident that there were differences in food habits, and health beliefs between the subgroups. Also, a larger percentage of African Americans received individualized intervention from their health practitioners primarily because of exacerbated personal health conditions. Those elders reporting no personal episodic health conditions also reported that they had not received separate and specific practitioner-initiated personalized nutrition intervention. Practice and policy implications were discussed urging attention to differences; a greater need for personalized nutrition interventions; removal of barriers to primary care nutrition coverage.

Introduction and Background

The extent to which healthcare practitioners fully understand the relationship between food habits relative to cultural health beliefs, health behaviors and the personal health status of older adults is extremely important to the provision of appropriate successful client-centered nutrition education intervention strategies. It has been well established that certain foods have beneficial nutritive and disease preventing effects on life-threatening health conditions (i.e., the leading causes of death: heart disease, cancer, stroke, diabetes). Cross-racial studies of U.S. populations indicate that Black¹ older adults have a disproportionately high prevalence of the afore-mentioned health conditions.² Yet, few if any gerontological studies have been done exploring whether Black older adults are aware of the relationship between their health conditions and their food consumption patterns. A study examining 265 nutrition education intervention research studies indicate that among the intervention studies with adults over 65 years of age, only one study measured health outcome expectations and a very few measured nutrition knowledge relative to food consumption.³ None of these studies were cross-cultural examining differences among Black older adults.

¹ **Note:** The term Black/s refers to persons of African ancestry and is specific to race as distinct from ethnicity.

² U. S. Department of Health and Human Services, "Vital and Health Statistics," *Summary health statistics for U.S. adults: National health interview survey, 2002* (2004).

³ I. Contento, J. S. Randell, and C. E. Basch, "Review and Analysis of Evaluation Measures Used in Nutrition Education Intervention Research," *Society for Nutrition Education* 34, no. 1 (2002).

The U.S. Census data indicate that adults 65 years of age and older are the fastest growing segment of the U.S. population. Changing immigration patterns contribute to the graying of the U.S. society in general and in urban areas such as New York City (NYC) specifically. New York City is home to the largest population of foreign-born persons living in the U.S.⁴ Currently, 35% of immigrants residing in NYC are from the Caribbean. Census data also indicate that 40% of seniors in New York State (NYS) reside in NYC. Many Black elders tend to live in large urban areas including NYC. Even though these data have existed for a long time, there are few inter- and intra-cultural studies examining cultural and/or ethnic differences among Black elders.⁵ This is due, in part, to the fact that there is a persistent myth that Blacks in the U.S., particularly in NYC, are a homogeneous group, void of differences in traditions and customs.⁶ As such, many healthcare institutions and practitioners providing services to Black older adults in urban areas such as NYC use a generic approach to gathering nutrition data prior to and during nutrition education intervention, which bypasses important cultural nuances. Indeed, there are cultural and ethnic differences (including food habits,⁷ health status⁸ and cultural health beliefs⁹ among subgroups of Black older adults in the U.S. that can affect their health status.

An insight into the previously stated differences relative to health status is essential to the development of culturally appropriate nutrition interventions aimed at promoting health and preventing disease among these important and growing segments of the U.S. population. The problem of imbalanced nutrition is especially salient to many NYC Black older adults because of their relatively poor health, economic disadvantage and limited access to good quality supermarkets.¹⁰ Also salient is the fact that the consumption patterns of African Americans (AAs) are different from those consumed by Caribbean-born (CA) elders—who might be

⁴ Immigration and Naturalization Service, "2004 Yearbook of Immigration Statistics," (Office of Immigration Statistics: U.S. Department of Homeland Security, 2006).

⁵ B. P. Lyons, *Sociocultural Differences between American-Born and West Indian-Born Elderly Blacks: A Comparative Study of Health and Social Service Use* (New York: Garland Publishing, Taylor & Francis Group, 1997).

⁶ N. Glazer and D. P. Moynihan, *Beyond the Melting Pot* (Cambridge, MA.: The Press and Harvard University Press, 1964).

⁷ K. J. Lancaster, S. O. Watts, and L. B. Dixon, "Nutritional Epidemiology," *The Journal of Nutrition* (2006).

⁸ Ibid.

⁹ E. P. Congress and B. P. Lyons, "Cultural Differences in Health Beliefs: Implications for Social Work Practice in Health Care Settings," *Social Work in Health Care* 17, no. 3 (1992).

¹⁰ J. A. Gilbride et al., "Nutrition and Health Status Assessment of Community-Residing Elderly in New York City: A Pilot Study," *Journal of the American Dietetic Association* 98, no. 5 (1998).

maintaining lifelong ethnic foods habits to preserve cultural identity. Today, many CA elders have access to an abundance of ethnic foods in NYC that facilitate the perpetuation of these habits, some of which are good while others might need to be modified. Very little has been done within the context of public health research even though there have been speculations that some foods, indigenous to the Caribbean, are linked to the very high rate of specific health conditions including certain cancers. For example, certain foods grown only on the Island of Jamaica, are believed to be linked to the very high rate—304/100,000—of prostate cancer among Jamaican men who have the highest rate of prostate cancer in the world.¹¹

Given the multiple factors already acknowledged, any attempt to improve health conditions through the influence of nutritional intervention aimed at older Black New Yorkers must consider the peculiarities associated with AA older adults and their immigrant peers. As such, this gerontological cross-cultural nutrition pilot study (funded by an intramural grant from Long Island University, Brooklyn, NY) is an initial step in gathering data from AA and CA elders to: 1) explore their normal food habits; 2) determine their awareness about nutrition; 3) examine the influence of their personal health conditions on their food habits; 4) investigate whether participants have been the recipients of separate and specific practitioner-initiated personalized nutrition intervention; and, 5) determine if there are differences.

Method

A qualitative descriptive research method (involving focus groups) was used because it is appropriate for exploring participants' perceptions and behaviors. Focus groups are cost-effective/time-efficient group-interviews that stimulate conversations among the participants thereby generating useful information. This process of encouraging participants to engage in discussions about the topics facilitates self-disclosure revealing their behavior, awareness and experience.^{12 13} This technique has been used in nutrition studies,^{14 15} and works well with older populations.

¹¹ F. E. Glover et al., "The Epidemiology of Prostate Cancer in Jamaica," *Journal of Urology* 159 (1998).

¹² R. A. Krueger, *Focus Groups: A Practical Guide for Applied Research (2nd Ed)* (Newbury Park, CA: Sage Publications, 1994).

¹³ J. Kitzinger, "Introducing Focus Groups," *British Medical Journal* 311 (1995).

¹⁴ N. M. Betts, "A Method to Measure Perceptions of Food among the Elderly," *Journal of Nutrition for the Elderly* 4(4) (1985).

¹⁵ C. J. Rainey, "Nutritional Beliefs, Attitudes and Practices of Elderly, Rural, Southern Women," *Journal of Nutrition for the Elderly* 20, no. 2 (2000).

Instrument or Guide

A moderator guide, developed from a review of the literature, was used thematically to guide and facilitate the unstructured group discussion. The themes included normal food habits; awareness about nutrition; the influence of personal health conditions on food habits; and, separate and specific practitioner-initiated personalized nutrition intervention. The guide was pre-tested with middle to older aged Black professionals of AA and CA ancestry with geriatric and health care working experiences. Following pre-testing, the guide was revised to improve the clarity and flow of the questions and to reduce the focus group duration from two hours to one hour per session to minimize potential elder fatigue.

Participants

The participants (N=50) were NYC community-dwelling elders consisting of 36 AA and 14 CA older adults average age 73 years, 80% of whom were women, 36% reported less than a high school education, more than one-half reported living alone and 68% had an annual personal income in excess of \$10,000.

Data Collection

Four focus group sessions were conducted among a convenience sample of community-dwelling elders from two senior citizens' centers in NYC serving predominantly Black older adults. The elders were initially invited to participate in focus group sessions while the Principal Investigator (PI) was attending a health fair at one of the centers. The senior citizens' center director scheduled the focus group sessions on the center's calendar, which was available to all seniors at the site. Follow-up recruitment was done through large posters displayed at the centers. Two weeks following initial recruitment, the first two focus group sessions were held at the first site. Focus groups three and four were conducted three weeks later at a second site within that specific network of senior citizens' centers. Participants volunteered to join a group based on their scheduling availability.

The group moderator is a social work doctoral candidate with focus group experience. Field notes were recorded at the focus group sessions by two assistant moderators, one of whom is a trained medical doctor; the other assistant moderator has a master's degree in health administrator. The PI, who holds credentials in Gerontological Social Work and is a Registered/Certified Dietitian-Nutritionist, was present at every session. Participants signed an

informed consent form that was approved by a university institutional review board. The consent form which was given and read to the participants indicated that the discussions would be audio-taped and transcribed; the data would be shared only in the aggregate; and that their anonymity would be preserved. The sessions were conducted until content saturation was achieved. At the conclusion of each session, participants provided demographic information through a survey; were given a small cash stipend; and participated in a raffle.

Following the sessions, the contents of the audiotapes were transcribed verbatim. Each co-author independently read through the transcripts and field notes looking for emerging themes, developed coding categories and linked the codes according to relationships. Then, the co-authors collaborated and came to an agreement about the codes, after which each co-author again worked independently to code and sort the coded data according to similarities among the themes using ATLAS.ti software. The co-authors analyzed the data according to the agreed-upon themes rather than assigning values or rankings to quantities, since such attribution might be erroneously perceived as significant.¹⁶

Findings

The analyzed data reflect information obtained from the older adults at the senior citizens' centers. The findings are categorized in the four themes delineated earlier: 1) normal food habits; 2) awareness about nutrition; 3) influence of personal health conditions on food habits; and, 4) specific practitioner-initiated personalized nutrition intervention.

Food Habits

The analysis identified several important inter-related factors relative to the participants' food habits. The participants reported that they selected foods according to taste preferences, familiarity, and beliefs about the curative properties of the items. Also, they offered information about how their meals were managed. There were crossovers among some of the participants, with some AAs consuming Caribbean ethnic foods and vice versa. In contrast, some participants from each subgroup were unfamiliar with, and uninterested in, the ethnic foods consumed by their international counterparts.

¹⁶ Krueger, *Focus Groups: A Practical Guide for Applied Research (2nd Ed)*.

Taste preferences and familiarity with foods

Many participants said that they selected foods based on their taste preferences and/or their lifelong familiarity with particular ethnic foods. Some respondents claimed that although some foods are contraindicated due to their personal health conditions, on occasions they ate such foods for reasons already stated. One AA woman reporting a history of high blood pressure said “I love ham.” A man from the same background said that he preferred the taste of foods fried in ‘lard’ (rendered pork fat) and admitted to continuing this practice. Still another said that he had high blood pressure and that his doctor had warned him to “...leave the pork alone... Anything I love he tells me to leave alone.” One CA woman said that she loved ‘bakala’ (salted cod fish) and claimed that she soaks and boils it repeatedly to remove the salt. African-American women reported using this same technique in preparing ‘smoked meats.’ A CA woman with hypertension and elevated blood lipid levels said that even though ‘ackee’ (high fat vegetable with the texture of avocados) is very expensive, she had purchased and prepared it with salted cod fish and ate it as an occasional treat. Others said that they used coconut milk/cream (a source of fat) in preparing several dishes. From this conversation, it appears that some participants of both subgroups with health challenges requiring dietary modification are very conflicted about giving up their preferences for ethnic foods.

Selections based on health beliefs

Some participants incorporated items (including botanical/herbal and other supplements) believed to have curative properties while others avoided foods believed to be harmful to their health. For example, in discussing fruit intake, one CA man said “...when you have a very bad cold...you don’t have to take medicine... you just get some tamarind [tart tropical fruit]... and it moves all of that cold from you.” This same man talked about preferred foods that are problematic. He remarked “...sometimes things are sort of tasty, but in the long run it does not digest as it should... If you eat something that won’t digest in your stomach, you should refrain from it.” The moderator asked whether participants used herbal supplements; most participants said yes. One AA man said “a whole bunch...Saw Palmetto [for prostate health] Glucosamine Chondroitin [for arthritic pain] calcium from oysters [for bone health].” Other participants claimed that for a variety of health reasons, they used “aloe vera,” “ginger,” “mint,” “noni juice,” and other products. Most focus group participants said that they would not voluntarily provide

this information to a health practitioner, including their medical doctor (MD) or registered dietitian (RD) unless they were asked.

Meal management issues

The respondents were questioned about the management of their meals. They were asked such questions as: Where they ate their meals? Who prepared their meals? And, whether they regularly 'ate out' at food establishments, or purchased 'take out' meals from such places. Many said that they ate their lunches at the senior center several days per week. Most of the AAs and a few of the CAs said that they prepared their own meals at home; while a majority of the latter said that their meals at home were prepared by someone else, including a spouse or other family member. Some participants said that they did not eat out, but that they bought prepared meals from food establishments and took it home. One AA woman said that she purchased 'take out' meals regularly from "...one special Caribbean place..." Others said that they did not like prepared foods because they were unable to determine the conditions under which the meals were prepared; further, such meals might include ingredients harmful to their health.

Awareness about nutrition

The analysis concerning nutritional awareness yielded a variety of responses pertaining to participants' general nutrition knowledge. Some respondents said that their nutritional awareness had been heightened through health education media campaigns, lectures at senior citizens' centers and at local churches. The following are some of the descriptive statements depicting nutritional awareness. In response to the moderator's question about the participants' fat intake, an AA woman referring to an earlier statement made by one of her peers about the use of 'fatback' (pork rind, high in fat), said "when I was younger that's the way the greens [collard, turnip] were seasoned"... "But now, I cut back on salt, on sugar, and [on] fat, and just put a little olive oil and garlic..." Another AA woman said that she no longer 'seasons' vegetables with smoked turkey wings due to its (turkey wings) fat content. Rather, she uses smoked turkey necks, which contains less fat. The latter response reflects a general awareness about the harmfulness of excessive amounts of animal fats; less so concerning sodium.

As the conversation continued, an AA man said that he regularly visits several different senior citizens' centers. He remarked "it seems like at the centers, generally speaking...in our society, they don't consider that we're older and we need a decreased amount of certain items

like greasy foods and pork... The meals we eat here are very substantial...but they just do not cater to the needs of older individuals...In general, the senior centers don't consider that we need a different diet than we had when we were seventeen and eighteen years old." A CA woman remarked "if the portions aren't small you don't have to eat it all." The AA man replied "yeah, but I want to know what I really need, if somebody could tell me, say well you need this much of that, or you need that much of this, it is not necessary for you to have so much carbohydrates of which they give you a good amount...we should have some way of judging how much of each item we need at each meal." Both the AA man and the CA woman were expressing their nutritional awareness in different ways. The former was identifying the need for nutritional support by formal services such as the senior citizens' centers; while the latter was demonstrating her understanding of the role of personal responsibility in the promotion of good health.

During an exchange about the merits of starchy tuberous root vegetables, a CA woman said "...The yucca [cassava] is good as they say, and it tastes very good; but, if you are a diabetic, it's too much starch, and that starch kills you." Another woman said "...back home we used a lot of coconut in a thing they call 'bake,' [biscuit]...but [now] I have to stay away from that." Speaking of bake, an AA woman said I make cornbread from scratch because the mixes contain hydrogenated fat. When asked to explain, she said "it's a solid fat that preserves cookies and cakes and things that are baked, and will remain on the shelves for a period of time." While discussing another topic, several participants asked about an occasional drink of alcohol. The AAs asked whether or not it was appropriate for them to have a glass or wine or beer; while some CAs asked about drinking other types of 'malt liquors.' In summary, it is clear that many participants understood that reductions in food portions, fat, starches, salt, sweets and alcohol are necessary for protecting their health during their golden years.

Influence of personal health conditions on food habits

These analyses were somewhat related to nutritional awareness. Some respondents said that they had limited and/or eliminated some foods that their practitioners (i.e. MDs and RDs) have told them would aggravate their respective health conditions and gave testimonials about how following such restrictions alleviated their symptoms. One AA woman said "I went to the dietitian because of the fact that I have gastric acid reflux and I wanted to know exactly what triggers it. She [the dietitian] mentioned that fried foods; tomato-based products, which would be

tomato sauce, ketchup, and barbecue sauce, should be avoided. She also told me to change my milk [from whole milk to low fat soy milk].” This respondent said that she was satisfied with the results of the restrictions since she no longer experiences the discomfort she once did following a meal.

Concerning fat restrictions, an AA woman said “the dietitian said my saturated fat intake should be five percent and under...” Another AA woman described her condition as having to do with high levels of cholesterol. She said that she has had two angioplasty procedures. At the time of the first procedure, her cholesterol level “was 370.” She said that she was given a regimen of medication and diet with which she was somewhat compliant. In her own words “my cholesterol came down considerably...It was 240 when I had the procedure done the second time. Since then, I have been following the instructions of the doctor and dietitian because I don’t want to have a third procedure...Now my cholesterol level is down to 197. So that following the diet, taking the medicine on time, doing the exercise, and not smoking [she knocks on wood, remarking that she is struggling with adhering to smoking cessation] did help. A CA woman said “well back home I loved mangoes, but due to my condition [diabetes mellitus] I do not eat mangoes any more, because they are very sweet.” This same woman also mentioned that she avoids orange juice and concentrated sweets such as cakes and cookies because they elevate her blood sugar. She demonstrated with tools provided by the research team that she was aware of appropriate food portions. The foregoing conversation reflects the fact that personal health conditions influenced the food habits of some participants, particularly those who received counseling.

Practitioner-initiated personalized nutrition intervention

When questioned about communication about nutrition with practitioners including a MD or RD, respondents provided mixed responses. Only a very few respondents (those with poorly controlled diabetes mellitus, heart disease treated with angioplasty and/or Heart Stents and gastric acid reflux disease) reported that their MD initiated a nutrition-related conversation and referred them to a RD. One AA woman exclaimed “you know what I’d like to say! Going to the dietitian like I did, I learned a lot.” A CA woman reported that several months ago, she was diagnosed with, and treated for, blocked heart vessels. The moderator asked her whether she had ever had a conversation with her MD since her diagnosis and treatment. She replied “yes, that’s

why...I'm always like this; he [the MD] said something to me...you have to tone down your eating; you shouldn't have certain foods." She continued "I used to eat a lot of junk...I ate a lot of foods that I shouldn't eat." Earlier in the session, this woman said that she had experienced a substantial weight loss following nutrition counseling with a RD. She attributed the weight loss to increased intake of fiber through—whole grains, fresh fruits and vegetables, small amounts of poultry once or twice per week; eliminating fried foods, red meats, egg yolks and whole milk dairy products; and by walking daily as a form of exercise.

In response to the moderator's question concerning specific practitioner-initiated nutrition intervention, an AA man said "I go to my doctor to find out about my weight and my health." When the moderator inquired further about nutrition counseling, he said "no, he [the MD] doesn't tell me anything about what's best for me to eat." An AA woman said "the only discussion I have with my doctor is about my cholesterol." The AA man then said "he gives me hell too, for that [elevated cholesterol]."

A majority of the participants in the focus groups said that their MD had never specifically initiated a nutrition-related discussion nor referred them to a RD. Most of these respondents said that they would like to have a conversation about nutrition with their MD or would like to be referred to a RD. Given the questions raised during the sessions and the diverse responses and testimonials, some participants expressed the need to seek personalized nutrition intervention for their respective health conditions.

Discussion

This study sought to examine the food consumption patterns and associated factors among Black older NYC city residents and to determine whether there were differences between AA and CA older adults. This section discusses variations in the sociodemographic factors and food habits of the subgroups.

Sociodemographic characteristics

The demographic characteristics of the subgroups in the current study were similar to those found between a comparable sample of AA and CA older adults described in a study by

Lyons.¹⁷ For example, a majority of the participants were women with a slightly higher proportion of AAs compared to CAs being women and living alone. The CAs were slightly older than the AAs, and a larger percentage of them had less than a high school education. However, in contrast to the earlier study, in the current study, a higher percentage of CAs compared to AAs rated their health as being good or better.

Variances in food habits and associated factors

The present study found similarities and differences between the AA and CA elders who participated in the focus groups. With respect to the themes explored, some very interesting patterns emerged. Starting with the participants' reported normal food habits, the two subgroups were similar in that they selected foods based on their taste preferences and lifelong familiarity. We surmise that some focus group participants had higher intakes of fat and sodium than those recommended in the U.S. Dietary Guidelines.¹⁸ This is consistent with findings reported by Cohen and Colleagues.¹⁹ Consistent with other findings,²⁰ there were differences in the fat and sodium intake. In the current study, such differences were linked to ethnic food habits. For the AAs, the sources of fat and sodium were pork fat and smoked meats, respectively. For the CAs, the sources of fat were primarily from tropical plants including ackee, avocado and coconut. The sources of sodium consumed by CAs included bakala (salted cod fish), canned fish and other foods not included in the quotes provided herein. Indeed these are important differences warranting practitioners' attention and culturally appropriate personalized nutrition intervention.

In the current study, both groups reported eating fruits and vegetables daily. The CAs reported eating a variety of deep yellow tropical fruits and vegetables, some of which are not listed in the standard diet history or food frequency protocol, including that which was used by the Women's Health Initiative.²¹ As such, if the standard food frequency check-off form is used to gather data from this subgroup, their fruit and vegetable intake would be under reported. The AA tended to eat more green leafy vegetables. Similar findings concerning the differences in the

¹⁷ Lyons, *Sociocultural Differences between American-Born and West Indian-Born Elderly Blacks: A Comparative Study of Health and Social Service Use*.

¹⁸ U.S. Department of Agriculture and U.S. Department of Health and Human Services, "Nutrition and Your Health: Dietary Guidelines for Americans," *Home and Garden Bulletin*, no. No.232 (1990).

¹⁹ N. L. Cohen et al., "Food Practices, Service Use, and Dietary Quality in Elderly Blacks," *Journal of Nutrition for the Elderly* 17(4) (1998).

²⁰ Lancaster, Watts, and Dixon, "Nutritional Epidemiology."

²¹ R. E. Patterson et al., "Measurement Characteristics of Women's Health Initiative food frequency questionnaire." *Annals of Epidemiology* 9 (1999).

type of fruit and vegetable intake were reported in a large national study.²² One might speculate that the differences in the type of fruit and vegetable consumption might be due to lifelong preference for foods found in abundance in their respective places of birth.

Indeed, the under reporting of some items consumed by Black elders is not uncommon. For example, some botanical and herbal supplements used by the CAs in the study and sold only in Caribbean markets are seldom ever reported to practitioners by this subgroup because these items are consumed routinely as foods and not as supplements. However, the members of this subgroup are unlikely to spontaneously mention such items to their MDs,²³ without solicitation. Likewise, the average practitioner might not know of, nor bother to inquire about, botanicals because there is a myth that among non-White adults, Black adults seldom use herbal remedies.²⁴ As in the case of some tropical fruits and vegetables, herbal products are generally not included in the standard food frequency protocols. When included, they are listed by their botanical names, unfamiliar to some CAs; therefore, the extent to which CAs use such products is not readily ascertainable. The herbal supplements reported by the AAs in the study are the standard herbs listed by their generally recognized botanical names. As in the case of CAs, AAs might not voluntarily provide this information to practitioners because AAs, not unlike the CAs, believe that western medical practitioners associate these compounds with pejoratives such as ‘witchcraft’ and ‘folklore.’²⁵ Practitioners ought to question Black elders about botanicals because the metabolism of some of these products are not well defined and may affect drug-drug and drug-nutrient interactions further worsening some health conditions.

Meal management tended to be connected to social supports or lack thereof and varied along cultural lines. For example, most of the CAs in the study reported that there were others in the home who prepared their meals. This suggests that they might not be eating alone. Eating alone is identified as one of the risk factors for poor nutrition among racial minority older adults.²⁶ Apart from not eating alone, one can assume that CAs’ family supports in the home might be acting as gatekeepers. As such, one might speculate that there was slightly better

²² Lancaster, Watts, and Dixon, "Nutritional Epidemiology."

²³ Congress and Lyons, "Cultural Differences in Health Beliefs: Implications for Social Work Practice in Health Care Settings."

²⁴ D. M. Eisenberg et al., "Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use," *New England Journal of Medicine* 328 (1993).

²⁵ Congress and Lyons, "Cultural Differences in Health Beliefs: Implications for Social Work Practice in Health Care Settings."

²⁶ K. Tucker, "Nutrition and Health," *Food and Nutrition Research Briefs* (1993).

adherence to physicians' general advice resulting in fewer episodes of acute life-threatening conditions requiring hospitalization among this group.

Caribbean-born elders self-reported better health than did AA. Study findings of health status indicate that Black immigrants might be in better health than their AA peers.²⁷ With respect to health status, the focus group participants receiving personalized nutrition intervention were well able to articulate their personal health conditions and the corresponding dietary modifications. This confirms other study findings that personalized nutrition intervention significantly improves comprehension.²⁸ In the current study, there was a rather lengthy exchange concerning food portions and the nature of the ingredients in the meals at senior citizens' centers. This low level of client control over food selection was mentioned as a barrier to dietary behavior change. A team of researchers reported the findings of the nutritional analyses of three months of menus at congregate meal sites reflecting inconsistencies with good dietary criteria including excessive fats.²⁹ These factors suggest the need for personalized intervention accompanied by a comprehensive approach to ongoing nutrition education for older adults involving strategies that create a supportive environment for healthy food choices, particularly at congregate meal sites.

Implications

To our knowledge, a similar qualitative nutritional study has never been done involving cross-cultural comparisons with Black elders, specifically between AA and CA older adults. As such, this study is unique and important because it advances the literature on nutritional nuances relative to these important and growing segments of the population. In discussing the implications of the current qualitative pilot study involving focus groups, it is important to acknowledge that the findings are limited to this study since the focus group participants are not reflective of the population as a whole; neither are they reflective of non-participants belonging to the subgroup of older adults in this study. Thus, inferences must be generalized with caution and only to other Black elders with similar characteristics. Despite the limitations of this study,

²⁷ Lancaster, Watts, and Dixon, "Nutritional Epidemiology."

²⁸ P. A Sharpe et al., "A Nutrition Education Program for Older Adults at Congregate Nutrition Sites," *Journal of Nutrition for the Elderly* 16(2) (1996).

²⁹ R. G. Sargent, P. A Sharpe, and V. L Vaca, "A Diet Composition Analysis of Meals at Congregate Nutrition Sites," (1996).

some practice and policy implications are presented here and are to be viewed as suggestive not conclusive.

One might ask: How can healthcare institutions and practitioners improve their services to community-dwelling diverse Black elders living in urban areas such as NYC?

Practice implications

- *Increased sensitivity to the needs of elders with attention to cultural differences*

Two practice implications will be discussed here. First, there is a need for healthcare institutions and the practitioners they employ including; physicians, registered dietitians/certified nutritionists, and other allied health care practitioners to become more client-centered in matters related to nutrition. These practitioners must realize that an important initial step in promoting health and in preventing disease begins with the needs of the clients. Such needs encompass issues pertaining to the clients' cultural and ethnic backgrounds including food intake patterns, which are not apparent when studying racial groups in the aggregate.

With respect to nutritional intervention, according to the National Academy of Sciences,³⁰ primary, secondary and tertiary prevention of disease, including nutritional therapy, must be emphasized. Definitions for the levels of prevention follow:

Primary prevention addresses the promotion of life-style changes when there are no risk factors and no apparent disease. *Secondary prevention* focuses on early identification and prompt treatment of disease, and promotes life-style changes. *Tertiary prevention* emphasizes reduction in impairment or, disability and prevention of disease progression following diagnosis.³¹ Nutrition services in ambulatory settings play a role in all three areas of prevention.³²

There is “reasonable evidence” regarding the “efficacy of nutrition intervention for the treatment and management of (secondary and tertiary prevention) of many conditions that are among

³⁰ Institute of Medicine (IOM), *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population* (Washington, DC: The National Academies Press, 2000).

³¹ U.S. Preventive Services Task Force (USPSTF), *Guide to Clinical Preventative Services*, 2 ed. (Washington, DC: U.S. Department of Health and Human Services, Office of Public Health, Office of Health Promotion and Disease Prevention, 1995).

³² IOM, *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population*.

Medicare beneficiaries.”³³ As stated earlier in this paper, many Black older adults have health conditions including heart disease and diabetes that are linked to imbalanced nutrition. These conditions rank among those requiring secondary and tertiary intervention which often takes place during hospitalization for an acute health episode. If more Black elders received primary personalized nutrition intervention, a considerable proportion of them would be able to stabilize their health. Yet, primary nutrition intervention—the gateway of early treatment—is inaccessible due to Medicare reimbursement restrictions. This is particularly important since the Black population has tended to bear the brunt of life-threatening disease burdens contributing, in part, to the persistent health-gaps in the U.S.

Second, ambulatory personalized nutrition intervention with at-risk older adults including AAs and CAs might be the appropriate setting in which botanical and herbal supplements might be addressed.³⁴ Of course, practitioners (MDs and RDs) will need to become savvier with some of the nuances of various ethnic groups and with the botanical and herbal products used by older adults including AAs and CAs. As such, the standard food frequency protocol should be “dummy-proofed” through the inclusion of commonly used products consumed by diverse ethnic groups. Such protocols need not be exhaustive, but need to be more inclusive in order to enhance practitioners’ skills-sets for the effective administration of personalized nutrition intervention.

Policy implication

- *Reimbursement, a barrier to nutrition services*

Although nutrition intervention is considered an integral part of comprehensive preventive health care there are inconsistencies in reimbursements for such services through Medicare Part B.³⁵ Therefore, specific coverage for ambulatory nutrition services is a barrier to intervention. As part of the Balanced Budget Act of 1997,³⁶ nutritional therapy for chronic renal insufficiency, diabetes self-management, dyslipidemia, heart failure, and hypertension are among the few conditions covered under Medicare. Given the serious nature of these conditions, barriers to reimbursement for nutritional therapy should be eliminated to improve access to primary nutrition intervention aimed at ‘well’ Black older adults who might be at-risk for life-threatening

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

³⁶ HCFA (Health Care Financing Administration), "Medicare Program: Expanded Coverage for Outpatient Diabetes Self-Management Training Services," *Federal Register* 64 (1999).

health conditions. In the current study, the co-authors noted that participants, regardless of their cultural background, understood the relationship between their respective health conditions and good food habits if they received personalized nutrition interventions.

In summary, this study found some differences in the food habits, and health behaviors along cultural lines. However, the health beliefs of both groups appeared to be similar even though in many instances, the remedies used tended to be different and to be associated with culture and ethnicity. Due to differences in health status, there were also differences in whether or not participants received individualized nutrition intervention. Practitioners must address inter- and intra-cultural differences among Black elders to reduce health disparities between racial and ethnic majority and minority groups in the U.S.

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