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Ethnogeriatrics

Healthcare Needs of Diverse Populations

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Editors
Lenise Cummings-Vaughn
Division of Geriatrics and Nutritional Science
Washington University in Saint Louis
School of Medicine
St. Louis, MO, USA

Dulce M. Cruz-Oliver
Division of Geriatrics Medicine
Department of Internal Medicine
Saint Louis University
St. Louis, MO, USA

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Contributors

Nusha Askari, Ph.D. Department of Neurology & Neurological Sciences, Stanford University, Stanford Alzheimer's Disease Research Center, MC 5979, Stanford Neuroscience Health Center, Stanford, CA, USA

Christina L. Bell, M.D., Ph.D. Hawaii Permanente Medical Group, University of Hawaii Department of Geriatric Medicine, USA

Grace E. Byfield, Ph.D. Department of Biology, North Carolina A&T State University, Greensboro, NC USA

Goldie S. Byrd, Ph.D. Department of Biology, College of Arts and Sciences, Center for Outreach in Alzheimer's, Aging and Community Health (COAACH), North Carolina A&T State University, Greensboro, NC, USA

Sharon W. Cook, Ph.D., M.S.W. Department of Sociology and Social Work, North Carolina A&T State University, Greensboro, NC, USA

Rosaly Correa-de-Araujo, M.D., M.Sc., Ph.D. Division of Geriatrics and Clinical Gerontology, National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, MD, USA

Dulce M. Cruz-Oliver, M.D., C.M.D. Division of Geriatrics Medicine, Department of Internal Medicine, Saint Louis University, St. Louis, MO, USA

Lenise Cummings-Vaughn, M.D. Division of Geriatrics and Nutritional Science, Washington University in Saint Louis, School of Medicine, St. Louis, MO, USA

Kimberly A. Curseen, M.D. Department of Internal Medicine, Emory University/ Emory Healthcare, Emory Palliative Care Center in Wesley Woods Hospital, Atlanta, GA, USA

Lauren Duke, M.A. Meharry-Vanderbilt Alliance, Vanderbilt University Medical Center School of Medicine, Nashville, TN, USA

Christopher L. Edwards, Ph.D. Department of Psychiatry and Behavioral Sciences, Department of Psychology & Neuroscience, and Department of Medicine, Duke University School of Medicine, Durham, NC, USA

Sarah E. Harrington, M.D. Department of Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, AR, USA

Natasha N. Harrison, M.D. Department of Geriatrics and Extended Care, Greater Los Angeles Veterans Healthcare System, Los Angeles, CA, USA

Rosalyn Lang, Ph.D. Department of Biology, North Carolina A&T State University, Greenboro, NC, USA

Milta Oyola Little, D.O., C.M.D. Department of Internal Medicine—Geriatrics, Saint Louis University, St. Louis, MO, USA

Kala Mehta, D.Sc. Department of Epidemiology and Biostatistics, University of California, San Francisco, USA

John S. Mulvahill, M.D. Division of Geriatrics and Nutritional Science, Washington University in Saint Louis, School of Medicine, St. Louis, MO, USA

Lauren Okamoto, M.D., University of Hawaii Department of Geriatric Medicine, USA

William Maurice Redden, M.D. Department of Psychiatry and Behavioral Neuroscience, St. Louis University School of Medicine, St. Louis, MO, USA

Miriam B. Rodin, M.D., Ph.D. Division of Geriatrics, Department of Medicine, St. Louis University Hospital, St. Louis, MO, USA

Sandra Sanchez-Reilly, M.D., A.G.S.F., F.A.A.H.P.M. Division of Geriatrics, Gerontology and Palliative Medicine, The University of Texas Health Science Center at San Antonio, San Antonio, TX, USA

GEC and GRECC, South Texas Veterans Health Care System, San Antonio, TX, USA

Jeannine S. Skinner, Ph.D. Meharry-Vanderbilt Alliance, Vanderbilt University Medical Center School of Medicine, Nashville, TN, USA

Consuelo H. Wilkins, M.D., M.S.C.I. Meharry-Vanderbilt Alliance, Vanderbilt University Medical Center School of Medicine, Nashville, TN, USA

Meharry Medical College, Nashville, TN, USA

Gwen Yeo, Ph.D., A.G.S.F. Stanford Geriatric Education Center, Stanford University School of Medicine, Stanford, CA, USA

Part I
Ethnogeriatrics Foundations

Chapter 1
Why Ethnogeriatrics Is Important

Jeannine S. Skinner, Lauren Duke, and Consuelo H. Wilkins

1.1 Ethnogeriatrics Foundations: Defining Key Terms and Concepts

Ethnogerontology is the study of the causes, processes, and consequences of race, national origin, culture, minority group, and ethnic group status on individual and population aging in the three broad categories of biological, psychological, and social aging [3]. **Ethnogeriatrics** refers to the influence of culture, race, and ethnicity on health care for older persons from diverse ethnoracial populations.

The United States (U.S.) Census and Office of Management and Budget (OMB) defines **race** as a sociocultural construct that is not biologically, anthropologically, or genetically based [4]. Federal taxonomy mandates the minimum categorization of five racial groups (Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, Black or African American, and White). According to this taxonomy, **ethnicity**, a separate construct, is categorized as Hispanic or Latino [5]. Table 1.1 provides detailed description of U.S. federal race/ethnicity classifications. Conventional practices classify race based on phenotypic attributes such as facial features and skin color [6]. Ethnicity focuses less on physical attributes and encompasses cultural, behavioral, and environmental factors, which may be a more relevant construct for examining differences in health [7]. The Office of Minority Health defines **culture** as the "thoughts, communications, actions, customs, beliefs,

J.S. Skinner, Ph.D. • L. Duke, M.A.
Meharry-Vanderbilt Alliance, Vanderbilt University Medical Center School of Medicine, 1005 Dr. D.B. Todd Jr. Blvd, Biomedical Building, Nashville, TN 37208, USA

C.H. Wilkins, M.D., M.S.C.I. (✉)
Meharry-Vanderbilt Alliance, Vanderbilt University Medical Center School of Medicine, 1005 Dr. D.B. Todd Jr. Blvd, Biomedical Building, Nashville, TN 37208, USA

Meharry Medical College, Nashville, TN, USA
e-mail: consuelo.h.wilkins@vanderbilt.edu

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Table 1.1 U.S. Federal Office of Management and Budget race and ethnicity categories

Race or ethnicity	Definition
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
Black or African American	A person having origins in any of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race

Note: Data from U.S. Office of Management and Budget. Revision to the Standards for Classification of Federal Data on Race and Ethnicity 1997

values, institutions of racial, ethnic, religious, or social groups" [8]. Culture also informs lifestyle and health behaviors and thus plays an important role in ethnoracial differences in disease and chronic health conditions. Relatedly, **cultural competence** refers to the knowledge and interpersonal skills that allow health providers to understand, appreciate, and work with individuals from cultures other than their own [9]. Improving cultural competence among health care providers may be a critical step toward addressing health disparities [10]. **Cultural humility** describes the process of self-reflection and self-critique in one's limitations in intercultural understanding and recognition of the power imbalance between patients and providers. Cultural humility helps to facilitate mutual respect and communication between patients and providers [11].

The U.S. Department of Health and Human Services and the Center for Disease Control defines **health disparity** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" [12]. Dressler and colleagues [13] add to the definition by noting health disparities also refer to differences in morbidity, mortality, and health care access by race and ethnicity. Related terms include health inequality and health inequity. **Health inequality** refers to systemic differences in the health of groups and communities occupying unequal positions in society [14], whereas **health inequity** describes inequalities in health that are the consequence of bias or injustice [15]. Despite differences among these terms, they are often used interchangeably [16]. **Social determinants of health** refer to the effect of social and economic factors that both directly and indirectly affect health. Several conceptual models of social determinants of health have been proposed [17–19]. While these models differ in complexity, most express health as the byproduct of downstream and proximal factors such as health-related attitudes

Table 1.2 Definitions of key definitions related to ethnogeriatrics

Term	Definition
Acculturation	The process of adopting the attitudes, values, and behaviors of a different culture
Cultural competence	The knowledge and skill to engage with people from different cultures and backgrounds
Cultural humility	The process of self-reflection in order to understand limitations in intercultural understanding
Culture	A society's collective thoughts, actions, customs, beliefs, and values
Ethnicity	A group based on shared beliefs, cultural, behavioral, and environmental factors
Ethnogeriatrics	The influence of culture, ethnicity, and race on health care in older adults
Ethnogerontology	Study of the causes, processes, and consequences of race and ethnicity on aging
Health disparity	A health difference based on social, economic, and/or environmental disadvantage
Health inequality	Systemic health differences between groups based on differences in societal position
Health inequity	Health differences that are the product of bias or injustice
Race	A social construct to define differences, usually physical attributes, between groups that has no biological basis
Social determinants of health	The direct or indirect effect of social and economic factors on health
Socioeconomic status	A person's or group's position in society based on educational attainment, income, and occupational status

and behaviors, which are influenced by upstream and more distal factors such as socioeconomic opportunities and resources (e.g., housing, income, and food supply) [20]. Table 1.2 presents definitions of key terms related to ethnogeriatrics.

1.2 Between and With-In Group Heterogeneity in Health

Racial and ethnic health disparities exist across the lifespan and compound with age [21, 22]. Generally, racial–ethnic minorities experience shorter life expectancies, and higher rates of morbidity and disability than non-Hispanic Whites [23]. For example, the average life expectancy at birth for African Americans is approximately 4 years shorter than that of non-Hispanic Whites [24]; however, Asian elders have the longest life expectancy compared to all other groups [25]. Table 1.3 provides details on life expectancy by race/ethnic group. With regard to morbidity, Hispanics/Latino, Mexican Americans in particular, have a higher prevalence of cardiometabolic risk factors (abdominal obesity, high cholesterol, and high fasting glucose levels) than non-Hispanic Whites and African Americans [26]. Heterogeneity in health also exists within ethnoracial groups. For example, studies of risk factors for diabetes vary considerably among Hispanic/Latino subgroups [27], and among

Table 1.3 Life expectancy by race/ethnic group

Race and ethnicity populations and life expectancies in the United States			
	Life expectancy at birth	% of Population over age 65 years in U.S. in 2012[a]	Projected % of population over age 65 years in 2050[a]
Race			
African American	74.5[b]	8.8	12.3
American Indian/ Alaskan Native	71.1[c]	0.6	1.2
Asian	85.8[d]	3.8	7.1
Native Hawaiian/ Pacific Islander	79.0[e]	0.1	0.3
White	78.8[b]	86.0	77.3
Ethnicity			
Hispanic	81.2[b]	7.3	18.4

[a]U.S. Census Bureau, 2012 Population Estimates and 2012 National Projections. http://www.census.gov
[b]Center for Disease Control and Prevention. http://www.cdc.gov/nchs/
[c]Indian Health Service. http://www.ihs.gov/newsroom/factsheets/disparities/
[d]Center for Disease Control and Prevention. http://www.cdc.gov/minorityhealth/populations/
[e]Arkansas Department of Health. http://www.healthy.arkansas.gov/programsservices/minorityhealth/

Asian-Americans, the prevalence of coronary artery disease is higher in Filipinos and Asian Indians than Chinese, Japanese, Korean, or Vietnamese Americans [28]. Collectively, these studies highlight the need to further investigate patterns of disease between and within ethnoracial groups.

1.3 Explaining Racial and Ethnic Health Disparities

In this section, we provide a brief overview of the historical context of race in the U.S. Next, we outline major psychosocial and individual level determinants of health. We then discuss how culture intersects with health beliefs and behaviors. Lastly, we review the role of social networks and environmental factors in health disparities.

1.3.1 Historical Context

Historically, disparities in health status between racial groups were attributed to innate biological differences between groups [29], individuals who were not Anglo-Saxons were considered biologically inferior [30]. More recent, evidence-based research has debunked this notion and confirmed racial taxonomy is not discernible based on biological/genetic information [5] and as a result race is now accepted as a sociocultural construct [29]. Because race is socially determined, it is a fluid construct that can change over time and vary by location and culture. Yet it

is common practice to assume race and ethnic classifications are static constructs and infer group homogeneity. Studies of race, ethnicity, and gene variation demonstrate greater genetic heterogeneity within than between racial/ethnic groups [6]. This does not negate the importance of race and ethnicity classifications, but these classifications likely serve as surrogate indicators for more meaningful constructs that explain disparities in health. These constructs include cultural experience and beliefs, educational attainment, experiences with discrimination, and socioeconomic positioning [31].

Race, particularly in the U.S., is associated with different life experiences that affect health. For example, African American history is marked with gross social injustices such as slavery, discrimination, and segregation [32]. Similarly, Native Americans/Alaska Natives have experienced historical traumas including exploitation, loss of land, and enculturation [33]. As a result, these groups often cite mistrust of the health care system as a barrier to both health care and participation in clinical research [34, 35]. Many ethnoracial groups continue to experience disadvantage and a higher burden of psychosocial stress throughout life. These experiences may promote maladaptive coping strategies and increase vulnerability to disease and ultimately exacerbate health disparities in late-life [33, 36].

1.3.2 Psychosocial and Individual Level Factors

Psychosocial stress can be a deleterious or demanding condition that taxes or exceeds behavioral resources [37]. Psychosocial life stressors related to race may have negative effects on health outcomes [38, 39]. Compared to Whites, minorities report greater exposure to stressful life events [40, 41]. Many researchers contend this may be due, at least in part, to differences in socioeconomic position [42–44]. Individuals in low socioeconomic position may be more vulnerable to the effects of maladaptive health behaviors such as smoking, physical inactivity, and alcohol consumption. Smoking rates are highest among Native American/Alaska Natives [45] and physical inactivity rates are higher among African Americans and Hispanics/Latinos relative to Whites [46]. Alcohol consumption in the form of heavy drinking is highest among Native Americans/Alaska Natives and lowest among Asian Americans and African American women [47]. Psychosocial stressors such as perceived discrimination are also more common in minorities than Whites and associated with poorer cardiovascular [48–50] and cognitive health [51]. Many maladaptive behaviors decline with age, yet the effects of health behavior in early-life and midlife may have a cumulative effect on health and well-being in late-life. Moreover, studies of stress physiology show chronic psychosocial stressors activate the hypothalamic–pituitary–adrenal and sympathetic–adrenal–medullary systems, physiological systems designed to adaptively respond to acute episodes of stress [52]. Chronic activation of these systems, which often occurs with chronic psychosocial stress, is associated with metabolic dysfunction, increased susceptibility to diseases and mortality [53].

1.3.3 Culture

It is widely accepted that cultural values and traditions influence health beliefs and behaviors. Older minorities may differ in health behaviors related to self-care and views on illness management. African American elders, a group with a high rate of chronic disease, engage in a range of health behaviors that vary by illness type [54]. For example, a study examining racial differences in self-care behaviors for hypertension showed African American women were more likely to consume recommended amounts of fruits and vegetables but less likely to engage in physical activity to manage hypertension than White women [55]. Furthermore, African American elders are more likely to incorporate nontraditional self-care strategies such as home remedies for chronic illness management than White elders. Similar findings have been reported for Asian and Hispanic/Latino elders [56, 57]. Asian elders, Chinese and Japanese elders in particular, have the longest life expectancy relative to all other groups in the U.S. [25]. Longevity in this group has been attributed at least in part to cultural value placed on health-promoting lifestyle behaviors [58]. A cultural tradition that emphasizes self-discipline also may contribute to the adoption and maintenance of health-promoting behaviors [54]. Hispanic/Latino elders with diabetes are less likely to self-monitor glucose levels than White elders [59].

Acculturation is the process by which one group adopts the cultural attitudes, values, and behaviors of another [60]. Prior work on acculturation has mostly focused on Hispanic/Latino populations of Mexican origin [61, 62]. In many studies, acculturation is determined by measures such as language proficiency and other contextual factors such as immigration status, length of stay in the United States, and number of generations residing within the United States [63]. Lower levels of English proficiency have been associated with decreased utilization of preventative health care access [64] and thus may increase one's risk for disease and disability. Language barriers may also impede communication in patient–provider interactions and health-information seeking behavior. It is important to note English proficiency is not a universal measure of acculturation and measures used vary by immigrant status and racial/ethnic group [65].

1.3.4 Social Networks

Health and aging occur in a social context of family relationships and social ties. Social connections can influence self-care behaviors and these dynamics may differ by ethnoracial groups. A better understanding of how interpersonal relationships impede and promote health in older minority adults may help inform the development of effective and culturally appropriate strategies to leverage the potential benefits of interpersonal relationships in maintaining and improving health in late-life.

African American elders are more likely to live with a child or grandchild than White elders [66]. African Americans are also more likely to care for grandchildren, and less likely to be institutionalized than Whites [67]. Gender differences in

caregiving are well recognized, as women, particularly African American grandmothers, are disproportionately represented in this group. Studies show grandmothers with caregiving responsibilities are more likely to live in poverty and experience functional limitations than their noncaregiving counterparts. Grandparents who are caregivers are also more likely to live in overcrowded conditions [68]. As such, coresidence with other family members may in part reflect socioeconomic positioning. Studies of social networks among African American elders show value is placed on independence, resilience, and spirituality [57]. This may explain why, despite strong familial social networks, African American elders may report receiving less care for their health [69]. Caregiving support for health management among African American elders comes largely from informal networks, namely adult daughters and other female family members [70].

Relative to White elders, Hispanics/Latinos are more likely to live in multigenerational households [71] and assist with caregiving responsibilities [72]. Studies of Hispanic/Latino elders show extended family is the primary support system [73]. Health management is perceived as a diffused responsibility among Latino elders and their family members [58]. However, extended family members may lack sufficient knowledge regarding disease management and this may pose a barrier to implementation of proper self-care activities [71, 74]. Similar to other minority elders, Asian elders are more likely to live in multigenerational households than Whites [54]. Generally, Asian elders are more likely to rely on informal networks of support and may be reluctant to seek help from formal networks, such as health professionals [75]. Family social support is also instrumental in encouraging health-promoting behavior [58]. Less is known about the influence of social networks on health among Native American/Alaska Native elders. However, studies of Native American/Alaska Native communities show that respect of elders and support of family and extended networks are core values. Moreover, health is often viewed holistically and good mental health may be more valued than physical well-being [76].

1.3.5 Environment

Environmental conditions are largely influenced by socioeconomic position and can have a profound effect on health and well-being, especially for older adults. Socioeconomic status (SES) is an indicator of an individual's access to resources and opportunities as a product of social position and has been operationalized using several indicators including educational attainment, income, and occupational status [77]. Epidemiological studies show minorities are disproportionately represented at lower SES levels [78]. Individuals with higher incomes have access to healthier and better quality options in dietary choices, housing environments, and health care. Higher SES status individuals also may experience less psychosocial stress [79, 80]. Some researchers contend that common indicators of SES may not capture key factors such as aggregate data on household occupational status, social relations, and historical context of individual and racial/ethnic group experiences [81].

Other researchers propose the use of occupational status as an index of SES may be suboptimal in aged populations that are no longer working [82]. To address this, a few studies have measured indicators of SES using cumulative wealth, such as house values. These studies show wealth may be a more robust index of SES and may better predict health outcomes than traditional SES indices in older adult populations [83, 84]. These studies have focused exclusively on Caucasian samples; therefore, it has yet to be determined how wealth indicators relate to health in diverse older adult populations.

Racial and ethnic minorities and individuals of lower socioeconomic status are more likely to live in low SES neighborhoods than Whites [85]. Neighborhood characteristics can affect health and well-being especially for older adults. Feelings of safety, mobility, and health status have all been shown to be impacted by local neighborhood characteristics. Perceived neighborhood safety was found to be a predictor of functional decline in a diverse sample of community-dwelling older adults [86]. Older adults who perceive poor neighborhood safety are more likely to be physically inactive [87], which is a predictor of disability and mortality [88]. Neighborhood conditions, such as excessive noise, trash, crime and other environmental hazards, have been comprehensively described as neighborhood disorder [89] and such communities often include resource inequities such as inadequate access to quality food sources, recreation, and health care [90]. Neighborhood disorder is disproportionately experienced by marginalized communities including seniors and ethnoracial minorities [89]. Older adults who reside in disordered neighborhoods report poorer self-rated health [91] and worse neighborhood characteristics have been associated with increased adiposity, hyperglycemia, and low high-density lipoprotein levels [92]. Poor neighborhood conditions have also been associated with an increased prevalence of metabolic syndrome among White and Black elders [93]. Studies show higher perceived social cohesion, the degree of connectedness between members of a community [94], is associated with improved cardiovascular health outcomes in older adults. Researchers propose that neighborhood social cohesion may function as an extended support system to community-dwelling elders.

1.4 Challenges to Providing Health Care in an Aging and Diverse Population

Substantial challenges exist to providing high-quality, equitable health care to older adults. These challenges include a workforce that is not adequately prepared to care for diverse older adults, a health care system that does not easily accommodate the needs of diverse older adults, gaps in research on health among older adults, and policies that do not consider the needs of older adults with diverse cultural beliefs and preferences. In this section, we highlight a few of these challenges and thus underscore the importance of the field of ethnogeriatrics.

1.4.1 Inadequately Prepared Health Care Workforce

Currently, there are too few health professionals with expertise in geriatric care. Because fewer U.S. medical residents are entering geriatric medicine, and overall wages for geriatricians are significantly lower than that of other medical specialties [95], this trend is likely to continue. Lack of diversity in the clinical care and leadership workforce are associated with health care access and quality of care, especially for minorities [96]. Recent statistics indicate that although African Americans, Hispanics/Latinos, and Native Americans collectively make up approximately 25 % of the U.S. population, they represent 13.5 % of U.S. physicians [97] and fewer than 2 % of individuals in senior health care management [98]. Minority physicians are more likely to provide care to minority and underserved patient populations [99], and racially concordant patient–provider interactions are associated with higher rates of patient satisfaction and trust [100, 101].

Implicit and unconscious cognitive processes may influence a physicians' perception of the patients [102, 103] and social categorization based on physical attributes such as race/ethnicity-related stereotypes among physicians [104, 105]. Providing ongoing training in cultural competence is essential to preparing providers to care for diverse groups of older adults.

1.4.2 Organizational and Structural Health System Challenges

Structural factors related to the health care system also impact minority elders' ability to receive health care, navigate the health care system, and effectively communicate with health care providers. Factors such as complex bureaucratic processes to determine insurance eligibility, long waiting times to receive health care [106], and limited availability of culturally and linguistically appropriate services and resources (e.g., interpreter services for elders with limited English proficiency and appropriate health education materials) [107], all compromise the quality of health care minority elders receive.

The racial and ethnic classifications used in many health care settings present a significant barrier to understanding the needs and preferences of diverse older adults. The five racial categories and one ethnic category currently used in many health care and research settings are not comprehensive and may not be linked to culture, health-related attitudes and beliefs, and behaviors [29, 31]. More precise and detailed classifications will advance our understanding of ethnogeriatrics and help health providers better develop more patient-centered approaches, which will ultimately improve geriatric care.

1.4.3 Gaps in Knowledge

Much of the existing literature on disparities among older adults focuses on differences between African American and White elders [108, 109]. This is largely due to historically small sample sizes of other racial/ethnic groups in clinical research