Achieving Cultural Competence

A Guidebook for Providers of Services to Older Americans and Their Families

January 2001

Purpose

This guidebook is designed for use by providers of services to racially and ethnically diverse older populations. There is growing interest in learning how effective, culturally appropriate services can be provided by professionals who have mastered culturally sensitive attitudes, skills, and behaviors. We hope you will find this document a helpful introduction. However, it is only an introduction and not intended to substitute for more rigorous and on-going study. We hope that you will find each chapter both enlightening and useful. For readers who have taken more formal courses to acquire cultural competence, this guidebook might serve as a review--a tool to engage you further and to enable you to evaluate current programs with a critical eye towards your staff achieving cultural competence.

In designing service programs, we cannot assume that methods designed for majority group older persons will automatically apply to minority elders. This poses a challenge and opportunity for all of us to design culturally appropriate interventions that are responsive to the needs of minority communities and to offer support that withstands the changing needs of diverse populations over time.

Racial and ethnic minorities face many barriers in receiving adequate care. These include difficulties with language and communication, feelings of isolation, encounters with service providers lacking knowledge of the client's culture and challenges related to the socio-economic status of the client. Often, service providers have a responsibility to provide a voice for clients who cannot speak for, or represent, themselves.

The guidebook is divided into six chapters and five appendices. Each of the first three chapters takes a particular perspective or point of view critical to understanding cultural competence. For example, in Chapter Two we explore the meaning of cultural competence. Part A provides a definition of culture and discusses the intervening factors that determine the impact of culture. Part B provides a definition of cultural competence, Part C outlines the barriers to accessing services experienced by minority elders, and Part D gives an overview of research accomplished in this area.

Chapter Three examines the importance of cultural competence, and is divided into three sections. Part A introduces the reader to the importance of providing services and programs that exemplify cultural competence. Part B evaluates demographic information pertaining to various racial and ethnic minorities, and Part C discusses the demographic information with relation to disparities among racial and ethnic minorities.

The focus of Chapter Four is to demonstrate the way in which agencies can conceptualize culturally competent practice within their organizations, set goals, and move on to the development and implementation of interventions by culturally competent professionals. Part A is a basic introduction to the principles of cultural competence. Part B explains the five elements essential in developing culturally sensitive programs.

In Chapter Five, the reader is given illustrative examples to gain a better understanding of individual and broad cultural differences between racial and ethnic groups and the process of acculturation. Part A presents profiles of people with regard to age, education, gender and geographic location. Part B provides profiles of programs, and Part C concludes the chapter with a discussion of the implications.

Appendix One summarizes the national laws relevant to cultural competency. Appendix Two provides a brief overview of executive orders related to the concerns of minority groups. Appendix Three describes the Healthy People 2010 effort to improve the health status of racial and ethnic minority populations.

No guidebook would be complete without accompanying hand–outs, and these are provided in Appendix Four. The hand–outs are intended as aids for providers during presentations in training workers to implement culturally appropriate programs within their agencies and can also be used as overhead slides.

Appendix Five concludes the guidebook with references for readers who would like to receive more in-depth information on culturally competent practice and how professionals can be culturally competent in their provision of services and programs for an increasingly diverse aging population.

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Ø Introduction

There is consensus that social services, health promotion/disease prevention, and health services should be culturally sensitive to better meet the needs of older minority Americans. Compelling evidence indicates that race and ethnicity correlate with persistent, and often, increasing health and socioeconomic disparities among U.S. populations. Although there is progress in the overall health of the nation, there remains a continuing disparity in the burden of illness and death experienced by African Americans, Hispanic Americans, Indians and Alaska Natives, and Asian and Pacific Islanders. These disparities are believed to be the result of the complex interaction among genetic variation, environmental factors, specific health behaviors, and factors of service delivery.

Health disparities, and other disparities which set racial and ethnic minority populations apart from the mainstream, are due, at least in part, to problems experienced in accessing and effectively utilizing health and human services. However, a solid and growing body of research now indicates that one of the major reasons that services remain inaccessible and under utilized is because they are not responsive to the needs of the group being served....they are not “culturally sensitive.”

Additional, research is needed to better understand these relationships and to acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge to this goal. Improving access to quality services will require working with communities to identify culturally sensitive implementation strategies.

Understanding culture helps service providers avoid stereotypes and biases that can undermine their efforts. It promotes a focus on the positive characteristics of a particular group, and reflects an appreciation of cultural differences. Culture plays a complex role in the development of health and human service delivery programs.

Approaches that build on the strengths of minority communities and understand and respect minority cultures result in interventions which can lead to healthy practices and behaviors. Some call this an “emic” approach--working from the inside, using the strengths, perspectives, and strategies which elders and their families identify for themselves as being most effective.

It is important for direct service providers to acknowledge the significance of culture in people’s problems as well as their solutions. Although there is some research to suggest

that the optimal situation is one in which there is similarity between the service recipient and worker, such matches are a rare luxury. Consider the second–generation Vietnamese–American mental health social worker whose clients consist of Japanese-American and African-American families.

It would not be feasible for the social worker to try to memorize cultural traits while trying to become familiar with these families. Subgroups and individuals within particular groups are quite diverse. Instead, the social worker must have an appreciation of the cultural differences between her culture and her clients', respect her clients' culture, and behave in a manner that exemplifies this respect.

The goals in becoming more culturally competent are to continue to learn about differences and to rid oneself of stereotypes. Cultural competence demands an approach to service recipients in which assumptions are few. The hand-outs provided in Appendix Four of this guidebook can be used to begin a discussion of cultural competence and what this means for you and your staff.

Ù What is Cultural Competence?

A. What is Culture?

Culture has been defined as "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people." Why should we even be concerned about culture? First, understanding culture helps us to understand how others interpret their environment. We know that culture shapes how people see their world and how they function within that world. Culture shapes personal and group values and attitudes, including perceptions about what works and what doesn't work, what is helpful and what is not, what makes sense and what does not.

Secondly, understanding culture helps service providers avoid stereotypes and biases that can undermine their efforts. It promotes a focus on the positive characteristics of a particular group, and reflects an appreciation of cultural differences. Finally, culture plays a complex role in the development of health and human service delivery programs.

Factors that Influence Culture

While we know that cultural influences shape how individuals and groups create identifiable values, norms, symbols, and ways of living that are transferred from one generation to another, it is important for us to distinguish the differences created by such factors as age, gender, geographic location, and lifestyle. Race and ethnicity are commonly thought to be dominant elements of culture, but a true definition of culture is actually much broader than this. For example, ethnic and racial groups are usually categorized very broadly as African American, Hispanic, American Indian and Native Alaskan, or Asian American and Pacific Islander. These broad categories are sometimes misleading, because they can often mask substantial differences within groups. The larger group may share nothing more than common physical traits, language, or religious backgrounds. We often fail to consider the distinct factors which influence culture within larger populations that determine how people think and behave.

Intervening Factors

The cultures of patients and providers may be affected by:

- < educational level
- < income level
- < geographic residence
- < identification with community groups (e.g., religious, professional, community service, political)
- < individual experiences
- < place of birth
- < length of residency in the US
- < age

Source: AMA, Culturally Competent Health Care for Adolescents, 1994

B. What is Cultural Competence?

Cultural competence is defined as "a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency, or its professionals, that enables them to work effectively in cross cultural situations." Cultural competency is achieved by translating and integrating knowledge about individuals and groups of people into specific practices and policies applied in appropriate cultural settings. When professionals are culturally competent, they establish positive helping relationships, engage the client, and improve the quality of services they provide.

It is important to understand that the concept of cultural competency has two primary dimensions: *surface structure* and *deep structure*. Borrowed from sociology and linguistics, these terms have been used to describe similar dimensions of culture and language.

Surface structure involves matching intervention materials and messages to observable, "superficial" (though nonetheless important) characteristics of a target population. For audiovisual materials, surface structure may involve using people, places, language, music, food, and clothing familiar to and preferred by the target audience. Surface structure also includes identifying which channels (e.g., media) and settings (e.g., churches, senior centers) are most appropriate for the delivery of messages and programs.

Deep structure involves sociodemographic and racial/ethnic population differences in general as well as how ethnic, cultural, social, environmental and historical factors may influence specific behaviors. Whereas surface structure generally increases the "receptivity" or "acceptance" of messages, deep structure conveys relevance. Surface structure is a prerequisite for feasibility, while deep structure determines the efficacy or impact of a program.

Cultural Competence Checklist for Success

- / Makes the environment more welcoming and attractive based on clients cultural mores.
- / Avoid stereotyping and misapplication of scientific knowledge.
- / Include community input at the planning and development stage.
- / Use educational approaches and materials that will capture the attention of your intended audience.
- / Find ways for the community to take the lead.
- / Be an advocate - strike a balance between community priorities and agency mission.
- / Understand there is no recipe.
- / Hire staff that reflect client population.
- / Understand cultural competency is continually evolving.
- / Be creative in finding ways to communicate with population groups that have limited English-speaking proficiency.

Adapted from material developed by the National Center for Cultural Competence, Georgetown University Child Development Center.

C. Barriers to Service Access

Structural Barriers

A significant external barrier to health care access is lack of health care insurance and out-of-pocket health care costs. Factors that have been shown to significantly affect out-of-pocket health care costs include poor health, high levels of functional impairment, limited education, and low income. Because minority elders are in general in poorer health, suffer more functional impairments, have more limited educations and lower incomes than the general population, they may face significantly higher burdens for out-of-pocket costs. Out-of-pocket costs also account for a much higher proportion of income for lower income groups than higher income groups. The current average out-of-pocket costs amount to 19 percent of total income for all Medicare beneficiaries, but account for 28 percent of income for those in poorer health, 24 percent for those with one or more functional impairments, 21 percent for those who did not complete high school and 31.5 percent for those at the lowest income levels.

Another set of structural barriers is logistical difficulties, including a lack of transportation, language difficulties and illiteracy. Transportation difficulties disproportionately affect lower income racial and ethnic minority elders, many of whom do not have automobiles and, even more importantly, may not have the language skills and information necessary to get a driver's license and navigate through their community. Many of these elders also experience confusion regarding public transportation and other resources available to help them access services.

Cultural Barriers

Some barriers to services can be considered 'internal' because they are characteristics of the minority groups, and they include styles of interaction and expectations, as well as misconceptions. Traditional Chinese culture, for example, values shielding patients from discussing the full severity of an illness, which is in direct conflict with contemporary Western medical practices.

The most common cultural misconception among policy makers, program planners and service providers is an underestimation of the needs for formal support for ethnic elders. This misconception is based on the assumption that minorities "take care of their elder" within the family. Research does confirm that a significant proportion of minority elders live with their family. Unmarried older African Americans are twice as likely to live with family members as whites, Hispanic American and Asian American elders are three times as likely, and half of urban Native American elders live with family members (controlling for income, health status, and other characteristics).

There is reason to question whether the existence of a family living arrangement precludes the need for formal service support for minority elders. Research shows that the many responsibilities of minority families may make caregiving for ethnic elders overwhelming without any additional support.

Clearly, health disparities, and other disparities which set racial and ethnic minority populations apart from the mainstream, are due, at least in part, to problems experienced in accessing and effectively utilizing health and human services. However, a solid and growing body of evidence indicates that one of the major reasons that services remain inaccessible and under utilized is because they are not responsive to the needs of the groups being served, they are not culturally competent.

D. Research on Cultural Competence

Comprehensive research on health and social services and minority elders is scarce. Most of the research is done on health care service utilization because this can be readily measured. However, this is not enough. There needs to be a greater focus on other services. In addition, research is not available for all racial/ethnic groups for each type of service. For example, research varies what they compare. Some studies are linked to a single group. Other studies only compare between ethnic groups. Some compare within an ethnic group and others compare the minority population with the majority population.

Primarily, national data collection systems on the minority aging population are limited to the Bureau of the Census and the National Center for Health Statistics. Efforts are underway in the US Department of Health and Human Services, however, to incorporate collection of more racial and minority data in its many surveys and data collection instruments. For example, there is a large epidemiological study on the health of Mexican American elders in the southwestern United States, entitled the Hispanic Established Populations for Epidemiological Studies of the Elderly, or Hispanic EPESE.

Due to insufficient research and data, it is a challenge to fully generalize the research findings across the populations of ethnic elders. For example, simple rates of utilization of any service cannot necessarily be used to understand the health and socio-economic status of a population. Differences in service utilization across racial and ethnic groups can be understood only within the context of the status of the population measured.

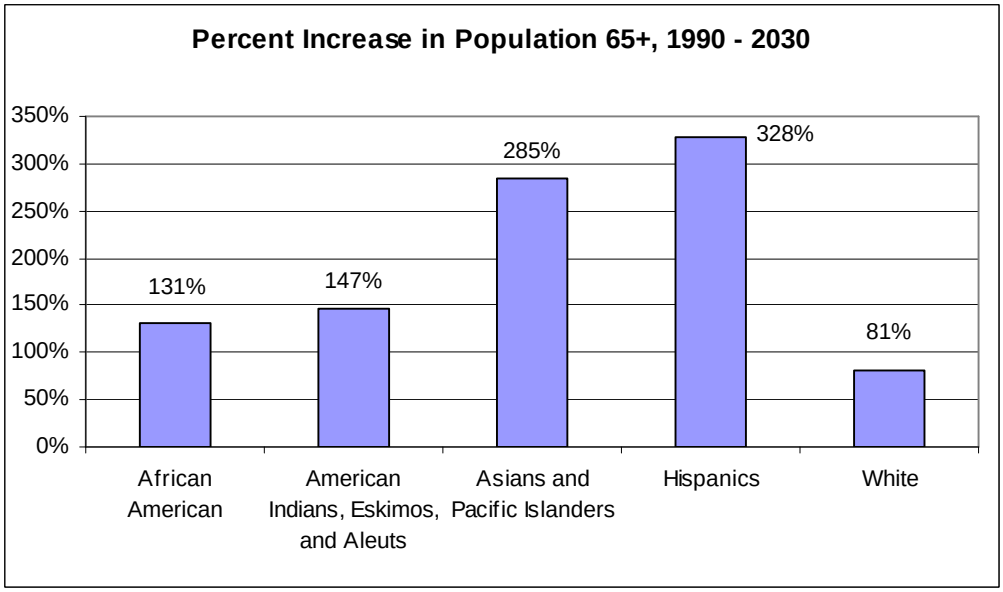
A few selected studies provide a beginning foundation for scientifically-based evidence to support culturally competent social service and health care program design and development. The research indicates that both structural and cultural barriers exist that influence access, utilization, and acceptance of services. However, more research needs to be done on the effectiveness of different approaches and strategies.

Ú Why is Cultural Competence Important?

A. Introduction

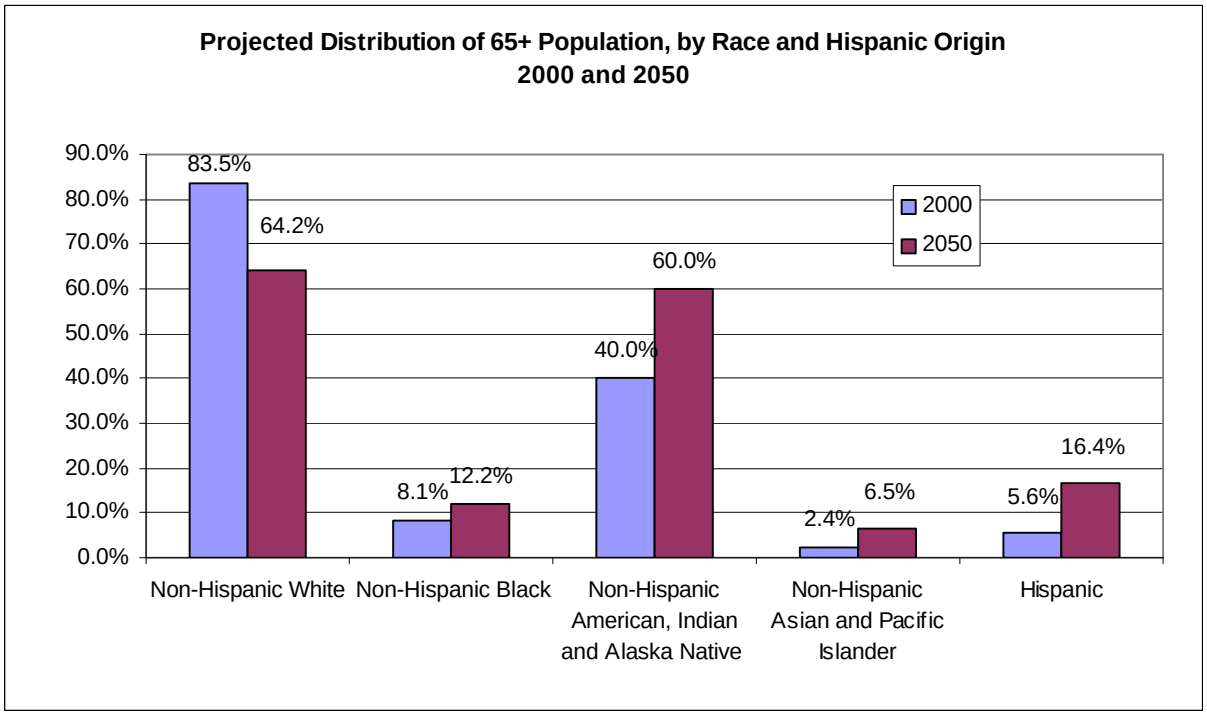
The demographic composition of the United States population will change dramatically in the next few decades. Within the next ten years, the population will grow significantly older and more diverse. This demographic shift has important implications for direct service providers. A greater number of elderly individuals will be in need of health and human services. Racial and ethnic minority elders will constitute a growing proportion of this group. It is critical for direct service providers to be aware of the current and projected characteristics of this diverse population to prepare for addressing their changing needs into the future.

B. Demographics



Source: U.S. Census Bureau, population projections of the United States by age, sex, race, Hispanic origin, and nativity: 1999 to 2100; published January 2000.

The United States is a nation with a rich mix of persons who come from different racial, ethnic, and cultural backgrounds. That mix is becoming even more dynamic. The minority older population will triple by 2030. By then, about one quarter of the elderly population will belong to a minority racial or ethnic group. In some parts of the United States, such as California, the upsurge in the number of older minority adults will be dramatic.



Source: U.S. Census Bureau, population projections of the United States by age, sex, race, Hispanic origin, and nativity; published January 2000.

Although the older populations will increase among all racial and ethnic groups, the Hispanic older population is projected to grow the fastest, from about 2 million in 2000 to over 13 million by 2050. In fact, by 2050, the Hispanic population age 65 and older is projected to outnumber the non-Hispanic black population in that age group.

C. Racial and Ethnic Disparities

Education Level

Percentage of the 65+ Population with a High School Diploma or Higher and a Bachelor's Degree or Higher, by Race and Hispanic Origin, 1998

	High School Diploma or Higher	Bachelor's Degree or Higher
Total	67.0	14.8
Non-Hispanic White	71.6	16.0
Non-Hispanic Black	43.7	7.0
Non-Hispanic Asian and Pacific Islander	65.1	22.2
Hispanics	29.4	5.4

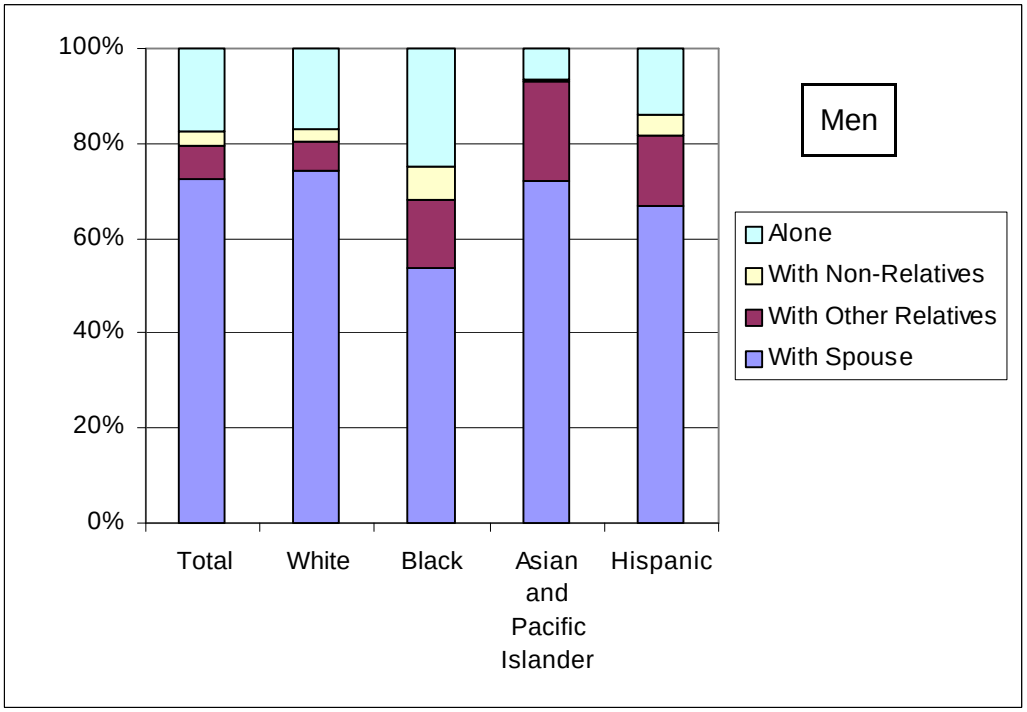
Source: March Current Population Survey

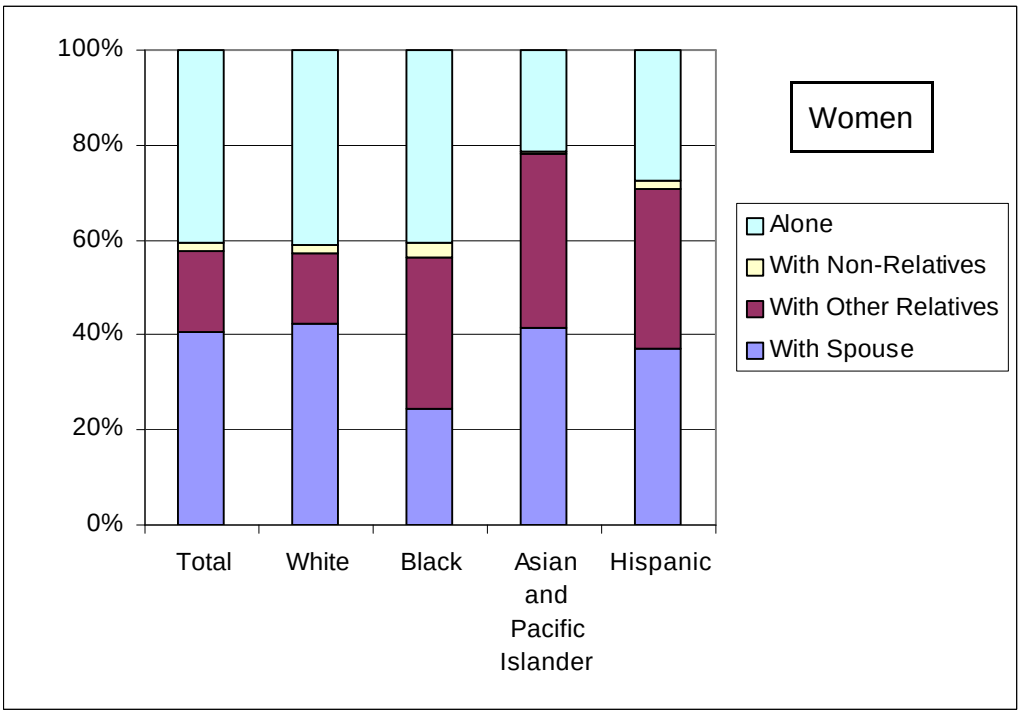
Despite the overall increase in educational attainment among older Americans, there are still substantial educational differences among racial and ethnic groups. In 1998, about 72 percent of the non-Hispanic white population age 65 and older had finished high school, compared with 65 percent of the non-Hispanic Asian and Pacific Islander older population, 44 percent of the non-Hispanic black older population, and 29 percent of the Hispanic older population. In 1998, 16 percent of non-Hispanic white older Americans had a bachelor's degree or higher, compared with 22 percent of older non-Hispanic Asian and Pacific Islanders.

Living Arrangements

In 1998, 73 percent of older men lived with their spouses, seven percent lived with other relatives, three percent lived with non-relatives, and 17 percent lived alone. Older women are more likely to live alone than are older men. In 1998, older women were as likely to live with a spouse as they were to live alone, about 41 percent each. Approximately 17 percent of older women lived with other relatives and two percent lived with non-relatives. Living arrangements among older women also vary by race and Hispanic origin. In 1998, about 41 percent of older white and older black women lived alone, compared with 27 percent of older Hispanic women and 21 percent of older Asian and Pacific Islander women. While 15 percent of older white women lived with relatives, approximately one-third of older black, Asian and Pacific Islander, and Hispanic women lived with other relatives.

Living Arrangements of the 65+ Population, by Sex, Race and Hispanic Origin, 1998

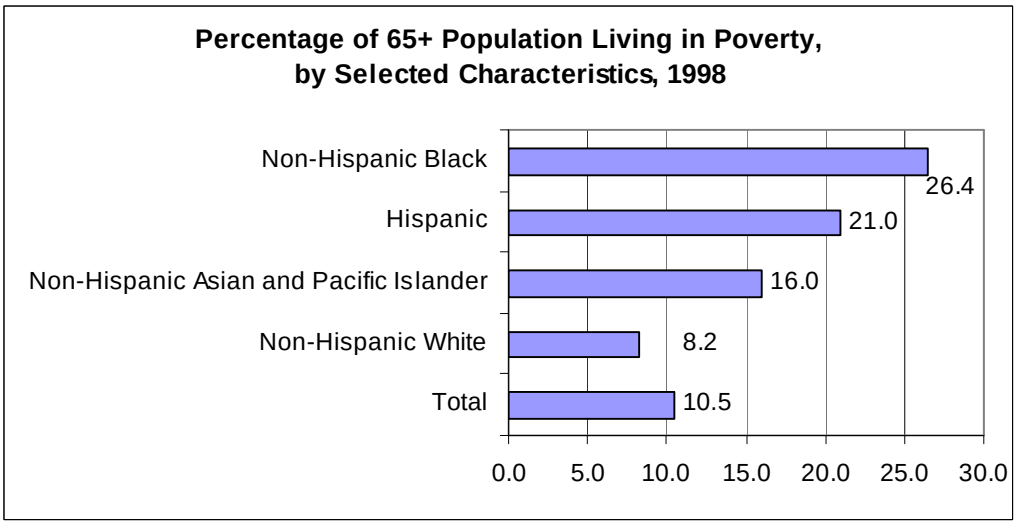




Source: March Current Population Survey

Poverty

Among older Americans, the poverty rate is higher at older ages. In 1998, poverty rates were nine percent for persons ages 65 to 74, 12 percent for persons ages 75 to 84, and 14 percent for persons ages 85 and older. Among the older population, poverty rates are higher among women (13 percent) than among men (seven percent), among the non-married (17 percent) compared with the married (five percent), and among minorities compared with non-Hispanic white persons. In 1998, divorced black women ages 65 to 74 had a poverty rate of 47 percent, one of the highest rates for any subgroup of older Americans.



Source: March Current Population Survey

Life Expectancy

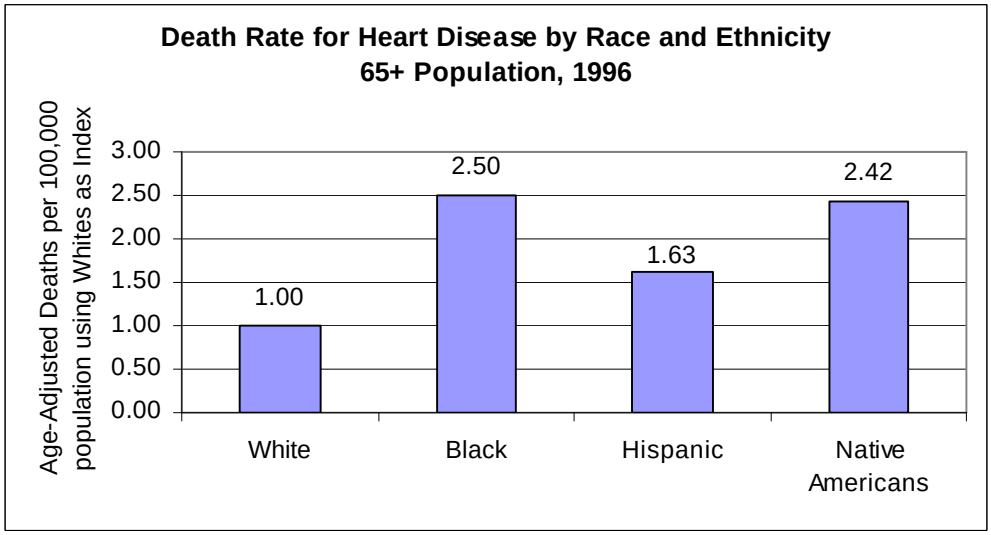
Life expectancy varies by race, but the difference decreases with age. In 1997, life expectancy at birth was six years higher for white persons than for black persons. At age 65, white persons can expect to live an average of two years longer than black persons do. Among those who survive to age 85, however, the life expectancy among black persons is slightly higher than among white persons. The declining race differences in life expectancy at older ages are a subject of debate. Some research shows that age mis-reporting may have artificially increased life expectancy for black persons, particularly when birth certificates were not available. Other research, however, suggests that black persons who survive to the oldest ages may be healthier than white persons and have lower mortality rates. Data is not available on the life expectancies at different ages for the American Indian, Alaska Native, Asian and Pacific Islander populations.

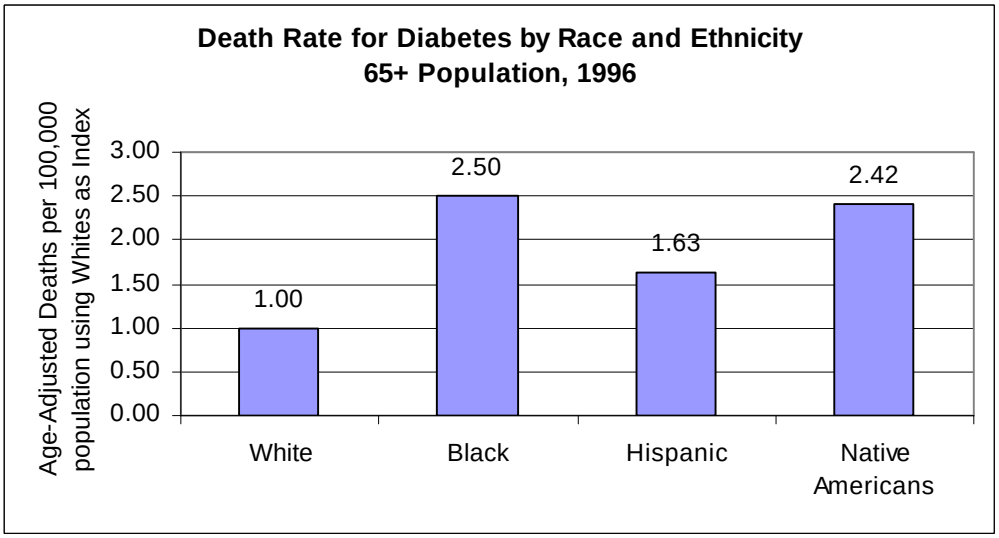
Life Expectancy by Age Group and Race, in Years, 1997

	White	Black
Life Expectancy at Birth	77.1	71.1
Life Expectancy at Age 65	17.8	16.1
Life Expectancy at Age 85	6.2	6.4

Source: National Vital Statistics System

Death Rates by Condition





Source: National Center for Health Statistics, CDC

In 1997, the leading cause of death among persons age 65 and older was heart disease (1,832 deaths per 100,000 persons), followed by cancer (1,133 per 100,000), stroke (426 per 100,000), chronic obstructive pulmonary diseases (281 per 100,000), pneumonia and influenza (237 per 100,000), and diabetes (141 per 100,000). Among persons 85 and older, heart disease was responsible for 40 percent of all deaths. In 1997, death rates were higher for older men than for older women at every age except the very oldest, persons age 95 or older, for whom men's and women's rates were nearly equal.

The relative importance of certain causes of death varied according to sex and race and Hispanic origin. For example, in 1997, diabetes was the third leading cause of death among American Indian and Alaska Native men and women age 65 or older, the fourth leading cause of death among older Hispanic men and women, and ranked sixth among older white men and women and older Asian and Pacific Islander men. Alzheimer's disease was the sixth leading cause of death among white women age 85 or older; however, it was less common among black women in the same age group or men of either race.

Self-Rated Health Status

During the period 1994 to 1996, 72 percent of older Americans reported their health as good, very good, or excellent. Women and men reported comparable levels of health status. Positive health evaluations decline with age. Among non-Hispanic white men ages 65 to 74, 76 percent reported good to excellent health, compared with 67 percent among non-Hispanic white men aged 85 and older. A similar decline with age was reported by non-Hispanic black and Hispanic older men, and by women, with the exception of non-Hispanic black women.

Percentage of Persons Who Reported Good to Excellent Health by Age, Sex, Race and Hispanic Origin, 1994-1996

	All Persons	Non-Hispanic White	Non-Hispanic Black	Hispanic
Total				
65 or older	72.2	74.0	58.4	64.9
Men				
65 or older	72.0	73.5	59.3	65.4
65 to 74	74.6	76.3	61.6	68.7
75 to 84	68.3	69.4	56.4	59.7
85 or older	65.0	67.3	45.0	50.9

	All Persons	Non-Hispanic White	Non-Hispanic Black	Hispanic
Women				
65 or older	72.4	74.3	57.8	64.6
65 to 74	75.2	77.5	59.3	68.5
75 to 84	69.8	71.7	55.3	59.3
85 or older	65.1	66.4	56.0	55.1

Source: National Health Interview Survey, data are based on a three-year average.

Access to and Satisfaction with Health Care

Percentage of 65+ Medicare Beneficiaries Reporting Access to and Satisfaction with Health Care, by Race and Hispanic Origin, 1998

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic
Percent Reporting Difficulty Obtaining Care	2.3	2.1	3.8	2.9
Percent Reporting They Delayed Getting Care Due to Cost	5.5	5.0	9.6	7.3
Percent Reporting They Were Unsatisfied or Very Unsatisfied with Health Care	3.0	2.9	2.5	3.7

Source: Medicare Current Beneficiary Survey

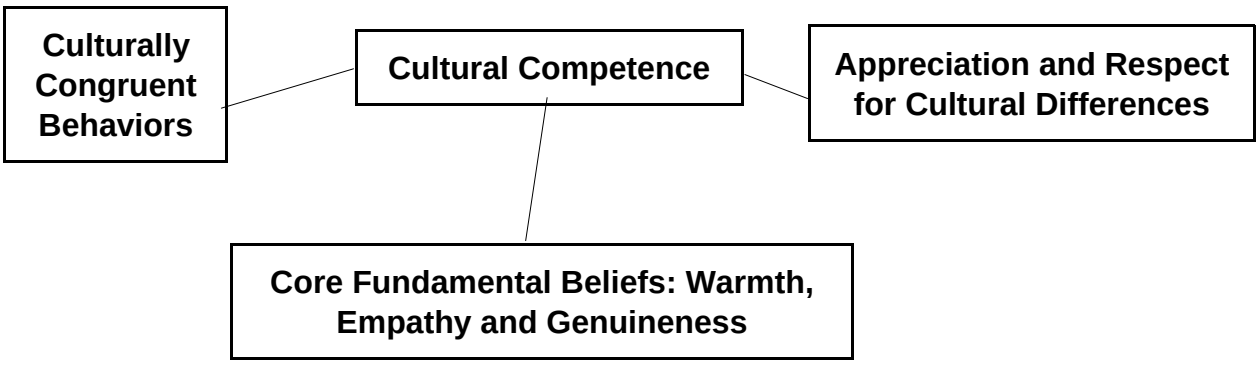
In 1996, about seven percent of persons age 65 to 74 reported delays in obtaining health care due to cost, compared with five percent of persons age 75 to 84, and three percent of persons age 85 and older. Access to health care varied by race. In 1996, the percentage of older Americans who reported delays due to cost was highest among non-Hispanic black persons (ten percent), followed by Hispanic persons (seven percent), and non-Hispanic white persons (five percent). About two percent of non-Hispanic white persons reported difficulty in obtaining health care, compared with four percent of non-Hispanic black persons and three percent of Hispanic persons.

Û Developing Culturally Appropriate Programs

A. Principles of Cultural Competence

Culture plays a complex role in the development of health and human service delivery programs. As indicated earlier, the need for the provision of culturally appropriate services is driven by the demographic realities of our nation. Understanding culture and its relationship to service delivery will increase access to services as well as improve the quality of the service outcomes. Research has begun to provide the underpinnings for the development of standards for the delivery of services to diverse populations. The following Principles are drawn from research material on the role culture plays in providing services to older adults.

There is an ethic to culturally competent practice. When professionals practice in a culturally competent way, programs that appropriately serve people of diverse cultures can be developed. Each person must first posses the core fundamental capacities of warmth, empathy and genuineness. This guidebook argues that to achieve cultural competence, professionals must first have a sense of compassion and respect for people who are culturally different. Then, practitioners can learn behaviors that are congruent with cultural competence. Just learning the behavior is not enough. Underlying the behavior must be an attitudinal set of behavior skills and moral responsibility. It is not about the things one does. It is about fundamental attitudes. When a person has an inherent caring, appreciation and respect for others they can display warmth, empathy and genuineness. This then enables them to have culturally congruent behaviors and attitudes. When these three essentials intersect, practitioners can exemplify cultural competence in a manner that recognizes, values and affirms cultural differences among their clients.



Values and Attitudes

Culture shapes how people experience their world. It is a vital component of how services are both delivered and received. Cultural competence begins with an awareness of your own cultural beliefs and practices, and recognition that people from other cultures may not share them. This means more than speaking another language or recognizing the cultural icons of a people. It means changing prejudgments or biases you may have of a people's cultural beliefs and customs.

It is important to promote mutual respect. Cultural competence is rooted in respect, validation and openness towards someone with different social and cultural perceptions and expectations than your own. People tend to have an "ethnocentric" view in which they see their own culture as the best. Some individuals may be threatened by, or defensive about, cultural differences. Moving toward culturally appropriate service delivery means being:

- knowledgeable about cultural differences and their impact on attitudes and behaviors;
- sensitive, understanding, non-judgmental, and respectful in dealings with people whose culture is different from your own; and
- flexible and skillful in responding and adapting to different cultural contexts and circumstances.

Also, it means recognizing that acculturation occurs differently for everyone. This means more than different rates among different families from the same cultural background; it means different rates among members of the same family as well.

For example, the beliefs, customs, and traditions of people from other cultures are often at odds with Western medicine and its heavy emphasis on science. Consistent with the Anglo-American emphasis on scientific reasoning, Western medicine tends to emphasize biological explanations for illness (such as bacteria, viruses or environmental causes); whereas in other cultures the natural, supernatural or religious/spiritual reasons explain the cause of the problem (the yin and yang are out of balance; you have broken a taboo; or you have been thinking or doing evil).

Communication Styles

Communication provides an opportunity for persons of different cultures to learn from each other. It is important to build skills that enhance communication. Be open, honest, respectful, nonjudgmental, and - most of all - willing to listen and learn. Listening and observational skills are essential. Letting people know that you are interested in what they have to say is vital to building trust. When giving presentations to minority groups, be prepared to spend time listening to needs, views and concerns of the community. Pay

attention to what the community says and do not assume that you know what is best for the group or community you are being targeted.

Communication strategies have to capture the attention of your audience. This means not only using the language and dialect of the people you are serving, it means using communication vehicles that are proven to have significant value and use by your target audience. Multilingual brochures and other written material do not help those persons who cannot read no matter what language they are written in. In addition to traditional pathways such as television, radio and print media consider "moving" information through e-mail, internet and mass transit advertisements. Also remember that people can act as communication vehicles because of their ability to move through communities and connect with your target audience. Keep the following points in mind when developing and using communication vehicles:

- Develop publications in the language of the population you are targeting. Have an individual from the same ethnic group you are trying to reach review any publications you intend to use for outreach. This will help to ensure the materials are both meaningful and do not include potentially offensive passages.

- Avoid literal translations of existing material as they lose their meaning when syntax and vocabulary are not within cultural contexts.

- In publications, use pictures including the targeted group to promote identification of the issue as “being important to people like me.”

- Explore the use of community-based media outlets (such as minority newspapers and magazines, minority college campus newsletters, local minority radio, cable television programs, etc.) and use prepared public service announcements, sample articles, flyers and posters as a way to get information out to minority populations.

- Find places that your target audiences frequent. Identify places that are natural sites for presentations, brochures, flyers and posters. Take your information and presentations to areas where you find a high volume of "people traffic".

- Distribute program literature at hair salons, barber shops, day spas, laundromats, dry cleaners, video stores, grocery stores, libraries and restaurants. Recruit minority volunteers to target these distribution sites.

- Arrange for minority staff to conduct outreach in targeted churches, communities, sororities and clubs. Community service announcements during the church service are an excellent way of attracting interest for after service discussion groups.

- Look for ways to penetrate trusted pathways. For example, use religious radio broadcasts for public service announcements and pow wows for circulating print materials as well as announcements during ceremonial dance breaks.

- Identify key minority-focused information web sites as a way of educating younger caregivers and the growing population of minority elder website users.

- Exhibit information and educate minority caregivers through professional meetings, conferences and publications. There are national associations of minority physicians, nurses, media professionals, attorneys, etc. that hold regular meetings, produce publications and seek to educate their memberships through association activities.

Community/Consumer Participation

Community can be defined in several different ways. It can refer to the people who live within a geographic boundary. It can refer to those who are served by a certain agency or program. It can also refer to a group of people who have similar beliefs, a similar culture or shared identity and experiences. Getting to know the community, its people, and its resources will help you identify useful strategies for service delivery. If the church is an important institution in a particular community, developing a preventive health partnership with the church may help you reach a group of people that you are trying to serve.

Establish partnerships and relationships with key community resource people. Put accurate information and adequate print materials into the hands of people who can actively promote your interests. Try to report back the results or outcomes of your initiatives to any groups or individuals that help you in the process. People will feel more vested in initiatives when they know about outcomes that they have helped to achieve and will be more likely to assist you again. Keep the following points in mind:

- Use traditional data sources like the Census to identify counties and neighborhoods with high concentrations of minority groups or identify other sources of aggregate data from community planning agencies, social service departments, school district planning offices and services for new immigrants. Use this data to identify locations where special outreach could be focused and concentrate outreach efforts in these areas.

- Assist minority representatives to make contacts and plan events for outreach in their communities. They are the most knowledgeable about the best way to reach community members.

- Learn who are the most effective resource people in minority communities (such as local neighborhood government advisory group representatives, church committee chairs, local business owners, restaurateurs, booksellers, musicians, funeral planners, teachers and school administrators) and enlist their support for your program.

- Have volunteers or staff, who speak the same language as the population you are trying to reach, conduct outreach presentations for your program.

- Ask clergymen to identify principle people in the congregations who are motivators for their activities. Invite them to become volunteers, conduct informal outreach in their communities and distribute information about your programs. For example, the church may be an appropriate site to convene a family support group for those whose family members are residents of long term care facilities.

- Seek bilingual and minority volunteers from established volunteer organizations, such as AmeriCorps and Retired Seniors Volunteer Program (RSVP) to enhance your minority outreach efforts.

- Develop relationships with community colleges and historically minority colleges and universities. Utilize students and faculty who are often leaders in their communities. Consider stipends or part-time salaries for students and others who have community access. Utilize their expertise on Saturdays and Sundays when and where target audiences gather.

- Team up with the local affiliates of disease-specific groups that focus on minority health risk factors. Consider partnerships for outreach with organizations such as the American Diabetes Association and the American Heart Association.

Physical Environment

Culturally and linguistically friendly interior design, pictures, posters and art work make your facilities more welcoming and attractive to the consumer. Providing services in a comfortable setting enhances program participation.

Display material and information through the use of props that are recognizable, hold significance, value, and interest to your target audience. Use color, print size, language and pictures on props that will attract attention. Put this material in the hands of people that will maximize their distribution and circulation.

Principles of Interpreter Services

***** Unless the staff is thoroughly fluent and effective in the target language, a qualified interpreter should be used.

* Do not use family members or friends to interpret unless the resident knows of the option of having a qualified interpreter and prefers to use a family member or friend.

* Never use young children or youth to interpret.

* Do not rely on untrained health care workers or employees of the provider to interpret.

* Use qualified interpreters, who have passed qualification standards and who complete continuing interpreter education programs. Meet with interpreters regularly to assess services.

* Minimize the use of telephone language lines to those occasions when it is absolutely necessary.

(Adapted from Jane Perkins et al., Empowering Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. Published by the Henry J. Kaiser Family Foundation, January 1998, p. 89.)

Policies and Procedures

Cultural and linguistic competence must be infused throughout everything organizations and individuals do. Policies, planning, structures and procedures must be the underpinning and support for culturally competent services at the community level. This includes:

- mission statements that articulate principles, rationale and values for culturally and linguistically competent service delivery;
- structures to assure consumer and community participation in the planning, delivery and evaluation of services;
- policies and procedures for staff recruitment, hiring and retention that will achieve a goal of a diverse and culturally competent workforce;
- policies and resources to support training and staff development; and
- adequate fiscal resources to support outreach, translation and interpretation services.

Population-Based Service Delivery

The driving force behind cultural competency is population-based service delivery; i.e., knowing and understanding the people that you serve. It means appreciating the importance of culture, while avoiding stereotypes. It means understanding the socio-political influences that helped to shape your consumers' attitudes, beliefs and values. It means that cultural awareness efforts are a part of a system-wide program within your organization. It is a process that is continually evolving.

Training and Professional Development

Staff development is essential to both cultural and linguistic competence. Staff attitudes and beliefs can be in conflict with the values of the people that you are trying to serve. It is important, therefore, to provide informal opportunities like "Brown Bag" lunches for staff to explore their attitudes, beliefs and values. Finally, it is important to recognize that cultural sensitivity is a continuum. Where staff are on the continuum may be different with each minority group.

Also, specialized training for staff involved in the interpretation process is often overlooked. There is an assumption that if you are bilingual you can interpret. Training bilingual staff in interpreter skills enhances their ability to effectively communicate in both directions.

The Cultural Sensitivity Continuum

- *Fear*: Others are viewed with trepidation and contact is avoided.
- *Denial*: The existence of the other group is denied.
- *Superiority*: The other group exists but is considered inferior.
- *Minimization*: The group is acknowledged, but the importance of cultural differences is minimized (e.g., "we're all human after all").
- *Relativism*: Differences are appreciated, noted and valued.
- *Empathy*: A more full understanding of how others perceive the world and how they are treated is achieved.
- *Integration*: Assessment of situations involving members of other cultures can be accomplished and appropriate actions undertaken.

B. Creating Programs That Work

Developing culturally appropriate programs is an evolving process. In a society as diverse as the United States, health and social service providers and others in the delivery of services to older persons need the ability to communicate with diverse communities. They need the knowledge to understand culturally influenced behaviors. In this regard there are five essential elements that contribute to an organization's ability to become more culturally competent.

1. Value diversity: You cannot begin to put in place the policies and procedures needed to become a culturally sensitive organization if staff members do not value diversity.

2. Have the capacity for cultural self-assessment: In order to determine what you need to do, you must first know where you are.

3. Be conscious of the dynamics inherent when cultures interact: This is a critical component in the design of service delivery. Just making the service available is not enough. How and where the service is provided must also be taken into consideration.

4. Institutionalize cultural knowledge: This means that everyone in the organization must be culturally competent - from the receptionist to the agency head to the custodian.

5. Adapt service delivery based on an understanding of cultural diversity: The bottom line is that your programs and services are delivered in a way that reflects the culture and traditions of the people you are serving.

The Three M's

There are three main points of influence at which a provider can create culturally competent interventions – the macro, mezzo, and micro levels. The first point of intervention is at the macro level. This level of influence includes policies, laws, and regulations. Examples of macro level interventions include Title VI of the Civil Rights Act, Executive Orders, Healthy People 2010, and the Older Americans Act, as well as accrediting organizations for managed care and health care organizations, such as NCQA and JCAHO.

The second point is the mezzo level, which is the community-based involvement in the design and delivery of programs and services. Examples of mezzo level interventions include community-based organizations, such as churches, schools, civic organizations, and social organizations.

The micro level is where individual providers understand the importance of and are trained to serve in a culturally competent manner. Micro-level interventions prepare health and other professionals to interact effectively and appropriately with individuals from diverse cultures. Examples include understanding the values, attitudes, and beliefs of others and demonstrating culturally congruent behaviors.

Characteristics of Culturally Competent Service Delivery

In general the research indicates that culturally competent service delivery includes these attributes.

- Cultural appropriateness
- Cultural accessibility
- Cultural acceptability

Culturally appropriate service delivery incorporates an understanding of the needs of the ethnic elders and the types of services provided. For health services, the characteristics of the individual that need to be measured include health status, functional level, and the level of acuity, and health conditions. This understanding can be maximized by using multi-disciplinary assessment methods, comprehensiveness in assessing the problems, a rehabilitative approach, and service provision longevity.

Culturally accessible service delivery in essence “opens the door” to services for minority elders. Culturally acceptable services are those that ethnic elders would want to walk through the door to receive. Many service doors have signs that say welcome but the place is not culturally competent. Opening the door requires that services be located in the community where the elders live and that admission procedures do not exclude elders based on such criteria as immigration status and language ability.

Culturally accessible service delivery is created by addressing the structural barriers, which includes affordability, availability of service hours, location of service, transportation, as well as outreach and public information. An example of cultural inaccessibility is Native American elders’ abhorrence of the ‘white’ tape that surrounds services and elders’ unwillingness to accept services delivered as charity.

To create culturally acceptable services, cultural barriers must be addressed. These include consideration of ethnic factors, such as language, religion, family, and acculturation. Some provider interventions include: outreach, translation, interpretation, transportation, cultural training for health professionals, and the use of bilingual/bicultural para-professionals.

There is a demographic imperative to improve the health and longevity of minority elders through the provision of culturally sensitive programs and services tailored to meet the differing racial/ethnic needs of minority elders. It is necessary to understand and internalize cultural concepts, utilize research-based evidence regarding effective service delivery, and address structural and cultural barriers in designing culturally competent service. Research studies indicate that populations differ and service providers need to identify and incorporate these differences into their programs. However, the studies also indicate that to focus exclusively on between group differences without appreciating between group similarities does not lead to appropriate design and implementation. Thus, service providers must appreciate not only how groups differ, but also how they are alike in designing culturally sensitive services.

Ü Illustrative Examples

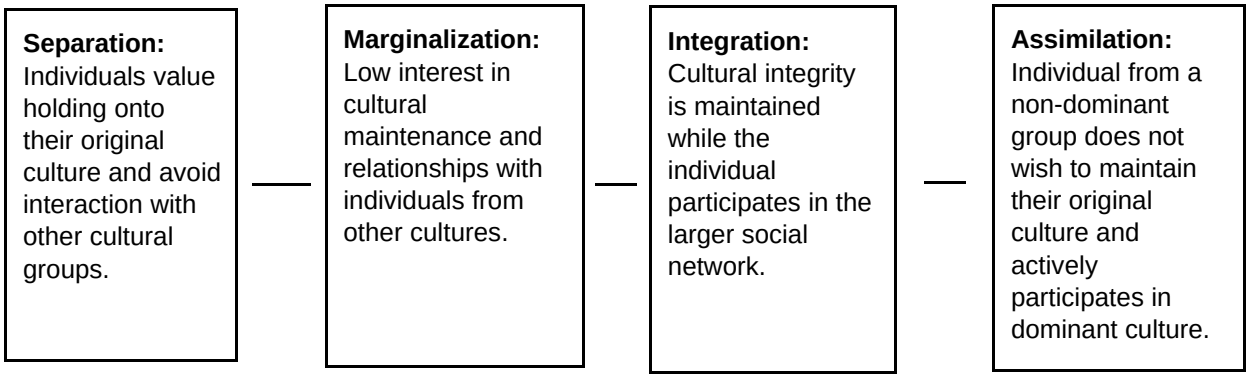
A. People Profiles

Culturally competent service providers must take into account the full range of factors that influence how any one individual service recipient behaves and communicates. The two levels of influencing factors are:

- overall cultural differences between racial and ethnic groups, as well as
- individual-level differences (based on age, education, literacy, income, gender and geographic location).

Acculturation is a process that occurs when two distinct cultural groups have continuous first-hand contact, resulting in subsequent changes in the original cultural patterns of either or both groups. The degree to which acculturation takes place is influenced directly by both the cultural and individual-level differences. The following examples are provided to illustrate this process and the type and level of influence that specific socio-cultural variables may have in a given situation.

Continuum of Acculturation



Illustrative Examples

[SECTION UNDER CONSTRUCTION]

B. Program Profiles

One of the difficulties that has presented itself to direct service providers over the years is the development of a relationship with service recipients that supports the achievement of positive outcomes. The key to success in developing this type of relationship is to practice the underlying behaviors that make such relationships possible.

The positive outcomes associated with the communication of these characteristics are sought by providers across numerous settings and with a wide variety of service recipients. The presence of these relationship qualities have been shown to influence the individual's overall level of health.

A strong focus on the development of these characteristics must be at the heart of delivering culturally competent services. Studies show that these "characteristics" can be learned by direct service providers. Systematic training is necessary in which each of the three characteristics are studied independently.

The core facilitative characteristics of a culturally competent service provider include:

Warmth: Acceptance, liking, commitment, and unconditional regard.

Empathy: The ability to perceive and communicate, accurately and with sensitivity, the feelings of an individual and the meaning of those feelings.

Genuineness: Openness, spontaneity, and congruence - the opposite of "phoniness."

Illustrative Examples

Following are examples of culturally competent service delivery that exhibit the facilitative characteristics of warmth, empathy and genuineness. These examples are provided to illustrate a few of the ways in which service providers have practiced these behaviors to provide culturally competent services.

- A social service agency with a predominantly Caucasian staff began a new program in a neighborhood with high concentrations of Hispanic elders. The staff implemented focused and intensive outreach efforts to ensure that all ethnic groups in the community were aware of the services they had to offer for individuals with Alzheimer's Disease and their families. Their outreach efforts were based on a value for diversity, a commitment to cultural competency, an understanding of the importance of culturally sensitive staff, and an understanding of the need for culturally specific materials. The program was successful in impacting service delivery methods and achieving broad systems changes.

- A national-level minority organization facilitated local collaboration to implement a new public education / public health project. The project was designed to increase the awareness among African American women of the importance of breast and cervical cancer screening and encourage active responsibility for their health. The local community agencies included African American women's groups in the planning and development stages of the project. These groups became invested partners as a result and played a critical role in recruiting women to participate. Workers in housing projects provided peer counseling to residents regarding breast and cervical cancer screening. The success of this project is a result of the high level of community involvement that built on the traditional African American concepts of the spirit of family, sisterhood, and sharing.

- A county-based Area Agency on Aging provides funds for an ethnic dietician. The dietician conducted focus groups and addressed the nutrition service needs of Chinese, Japanese, Cambodian, Laotian, Filipino, Hmong, Hispanic, African American, American Indian and Samoan older clients. The result is a program that offers culturally appropriate meals that may be adaptations of some traditional food preparation techniques. In addition, the dietician is preserving and adapting traditions plus including new scientific knowledge on nutrition to improve the lives of older residents of the county.

- An Area Agency on Aging coordinates an annual conference for the older members of the twenty tribes it serves. The conference is designed to emphasize the role of traditional culture in service programming. The conference uses traditional dance to focus on exercise and its benefits. Traditional storytelling was used to transmit the traditional culture and language to younger generations and encourage their active engagement in the practice. Traditional healthy foods were also served at the conference to reinforce the need to practice healthy eating behaviors that are also culturally appropriate.

- An Area Agency on Aging (AAA) developed a successful bilingual and bicultural program for Hispanic elders residing in the county. The AAA trained Hispanic elders from the community, mostly women, to serve as Promotores or community ambassadors. The Promotores in turn would teach the AAA staff about Hispanic culture. The result is culturally acceptable and accessible services such as long-term-care and caregiver support. They developed materials that met the cultural and language needs of the elderly clients. AAA staff are also multilingual and multicultural. They have copied the project in other parts of their state, and a similar program is being considered for the Asian and Russian communities.

Appendix 1: Laws

Minority elders have a legal right of access to federally funded services and programs. This section provides information about the Civil Rights Act of 1964, which governs this access; the Older Americans Act which provides for programs and services to elders; and the Executive Orders that facilitate access to other government-funded programs and services for minorities.

It is important for service providers to understand these laws and orders, as the Civil Rights Act of 1964 affects how the Federal government and its grantees administer programs. Service providers of Older Americans Act sponsored programs are bound by the anti-discrimination provisions of the Civil Rights Act. Likewise, obligations that federal agencies must meet under an Executive Order are extended to grantees of the federal agency.

The Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 provides, "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." This means that elders cannot be denied access to federally funded health care, public assistance, or other social services based on race, color, or national origin.

What Is Title VI?

Title VI of the Civil Rights Act of 1964 is a national law that protects persons from discrimination based on their race, color, or national origin in programs and activities that receive Federal financial assistance. If you are eligible for Medicaid, other health care, or human services, you cannot be denied assistance because of your race, color, or national origin. The Office for Civil Rights (OCR) in the U. S. Department of Health and Human Services (DHHS) enforces Title VI as well as other civil rights laws.

Some of the institutions or programs that may be covered by Title VI are:

Extended care facilities
Nursing homes
Hospitals
Mental health centers
Medicaid and Medicare
Alcohol and drug treatment centers
Public assistance programs
Adoption agencies
Day care centers
Senior citizen centers
Family health centers and clinics

Prohibited Discriminatory Acts

There are many forms of illegal discrimination based on race, color, or national origin that frequently limit the opportunities of minorities to gain equal access to services. A recipient of Federal financial assistance may not, based on race, color, or national origin:

- **!** Deny services, financial aid or other benefits provided as a part of health or human service programs.
- **!** Provide a different service, financial aid or other benefit, or provide them in a different manner from those provided to others under the program.
- **!** Segregate or separately treat individuals in any matter related to the receipt of any service, financial aid or other benefit.

The Older Americans Act

The Older Americans Act (OAA) was enacted in 1965 to give older Americans increased opportunities to fully participate in the benefits of American society. Over three decades later, it continues to be a major influence on programs for older Americans. The OAA established the Administration on Aging (AoA) which awards grants to States and tribal organizations to develop comprehensive and coordinated supportive and nutrition services that meet the needs of older persons and improve the quality of their lives. The States then award these funds to area agencies on aging (AAAs) for community planning, advocacy, and services that help older persons.

Title III of the OAA requires that the States and AAAs target services toward those elderly individuals with the greatest economic or social need, particularly low-income minority elderly. The State must set specific objectives for providing services to low-income minority older individuals and undertake specific program and outreach efforts to focus on the needs of those individuals.

Title VI of the Act specifically addresses the needs of elderly Native Americans in this context. In addition, the OAA requires that AAAs develop plans that take into consideration the number of low income minority individuals residing in an area and set specific objectives regarding providing services to low income minority individuals. Also, the AAA must provide an assurance that provider agencies satisfy the service needs of low income minority individuals.

Title I, Older Americans Act

The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States, of the several States and their political subdivisions, and of Indian tribes to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives:

(1) An adequate income in retirement in accordance with the American standard of living.

(2) The best possible physical and mental health which science can make available and without regard to economic status.

(3) Obtaining and maintaining suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.

(4) Full restoration services for those who require institutional care, and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals needing long-term care services.

(5) Opportunity for employment with no discriminatory personnel practices because of age.

(6) Retirement in health, honor, dignity - after years of contribution to the economy.

(7) Participating in and contributing to meaningful activity within the widest range of civic, cultural, education and training and recreational opportunities.

(8) Efficient community services, including access to low-cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed, with emphasis on maintaining a continuum of care for vulnerable older individuals.

(9) Immediate benefit from proven research knowledge which can sustain and improve health and happiness.

(10) Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection against abuse, neglect, and exploitation.

Appendix 2: Executive Orders

The President issues Executive Orders to Agencies within the Executive Branch of the federal government to aid in the administration of the law. It is important for providers who are recipients of federal funding to be aware of these Orders, as the obligations that a Federal Agency incurs as the result of an Executive Order are extended to Agency grantees.

Below you will find brief descriptions of Executive Orders that address the concerns of minority groups. First is an Executive Order that requires federal agencies to have a plan to make their programs accessible to people with limited English proficiency. In addition, you are provided with Orders that address minority access to educational opportunities, and an Executive Order to increase participation of Asian American and Pacific Islanders in all federal programs.

- **Executive Order 13166**
  "Improving Access to Services for Persons with Limited English Proficiency"

Minority elders may have a difficult time accessing federally funded programs and services due to a lack of proficiency in the English language. To address this concern, President Clinton issued Order 13166, requiring that each federal agency prepare a plan by December 11, 2000, to improve access to its federally conducted programs and activities by limited English proficiency (LEP) persons.

In response to the Executive Order, the Department of Justice (DOJ) and the Department of Health and Human Services, Office of Civil Rights (HHS/OCR) issued written policy guidelines. The guidelines define the legal responsibilities of providers who receive federal monies, and outline a range of flexible options available to agencies to comply with the law.

- **Executive Order 12876**
  "Historically Black Colleges and Universities"

- **Executive Order 12900**
  "Hispanic Serving Institutions"

- **Executive Order 13021**
  "Tribal Colleges and Universities"

Overall, the goals of these Orders are to increase participation of minority students in federal education programs; strengthen the capacity of educational institutions that serve minority students to provide excellence in education; and to improve recruitment of minority students for federal employment. These Orders are important to providers and minority elders as they result in improved research on minority issues, better educated minority students, and increased employment opportunities for minorities. This in turn will lead to a delivery of federal services to minority elders in a more culturally competent and sensitive manner.

- **Executive Order 13125**
  "Increasing Participation of Asian Americans and Pacific Islanders in Federal Programs"

President Clinton signed this Executive Order to improve the quality of life of Asian Americans and Pacific Islanders (AAPIs) through increased participation in all Federal programs where AAPIs may be underserved. This goal is to be achieved through increasing and improving research about AAPI populations and subpopulations, providing culturally competent outreach to AAPIs, and increasing AAPI participation in Department of Health and Human Services training and employment.

Appendix 3: Healthy People 2010

Launched in January 2000, Healthy People 2010 represents the nation's disease prevention agenda. Healthy People 2010 builds upon a national effort initiated over twenty years ago to develop comprehensive health objectives that can be used to effectively direct health promotion and disease prevention efforts. Like its predecessors, Healthy People 2010 identifies the most significant preventable threats to the health of America's people and establishes a singular framework for use by States, communities, organizations and individuals. Most importantly, Healthy People 2010 reinforces the concept that improving the health of the Nation requires the long-term commitment and participation of all.

Developed through a broad-based community process, Healthy People identifies significant opportunities to improve health, and focuses long overdue attention upon special populations, including minority and older Americans. For the first time, specific objectives are accompanied by corresponding baseline data that provide evidence of health disparities that place specific populations at higher risk than the general population.

In order to promote health and eliminate health disparities among older persons and in particular minority elders, the Administration on Aging has encouraged the national Aging Network to participate in the Healthy People 2010 initiative by using it as both a planning and evaluation tool for programs and services. The Administration on Aging is targeting its efforts to address health disparities in three areas:

- diabetes (Focus Area 5),
- cardiovascular disease (Focus Area 12), and
- adult immunization (Focus Area 14).

Potential partners for local collaborative efforts include public and private sector organizations as well as state and local public health departments, many of whom have developed state plans based upon the Healthy People 2010 template.

Appendix 4: Hand-outs and Overheads

Appendix 5: References

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