

## **ETHNOGERIATRIC CURRICULUM: MODULE ONE INTRODUCTION AND OVERVIEW**

### **DESCRIPTION**

This first module in the Ethnogeriatric Curriculum introduces basic concepts in culturally competent care of elders, summarizes sources and patterns of demographic data on the ethnic diversity of elders in the United States, and reviews central emphases in general geriatric care. Ideas for increasing students' understanding of the impact of culture on health through assignments to explore their own cultural background are presented.

### **LEARNING OBJECTIVES**

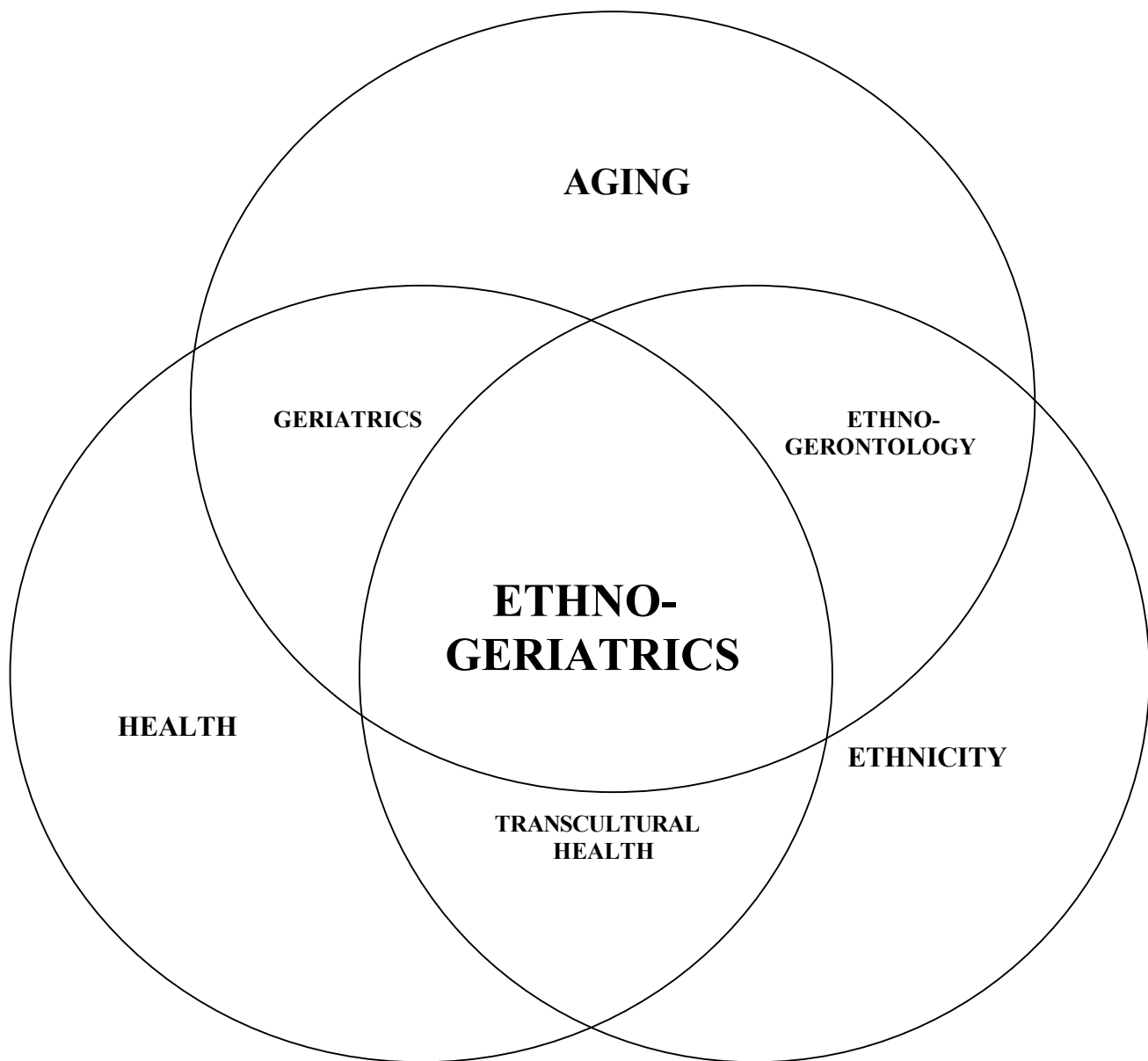
After completion of this module, learners will be able to:

- 1) More nearly understand the effect of their own cultural background on their attitudes toward health care;
- 2) Define major terms used in ethnogeriatrics;
- 3) Identify the major sources of information on the sizes of ethnic populations of older adults in the U.S. and the categories that are used for the populations;
- 4) Describe the sizes and growth trends in the major population categories of ethnic elders;
- 5) Describe factors that affect cross cultural interactions in geriatric health care in terms of the cultural backgrounds of the providers and patients and the culture of the setting;
- 6) List the major components of cultural competence in health care on the system and provider levels;
- 7) List three important principles of geriatric care.

### **CONTENT OUTLINE**

#### **I. Ethnogeriatrics as a Field**

- A. Health care for elders from diverse ethnic background
- B. Intersection of the studies of aging, ethnicity, and health (See Figure 1)
- C. Importance of ethnogeriatrics
  1. Growing diversity of older Americans and of health care providers
  2. Increasing recognition of the importance of cultural issues in health
  3. Heterogeneity within the populations adds to the complexity for health care providers
- D. For explanations of major concepts and terms used in Ethnogeriatrics, see Appendix A.



**Figure 1.**  
**The Context of Ethnogeriatrics**

## II. Impact of Cultural Factors on Geriatric Care

### A. Culture works to create differences in explanations of disease and treatment

1. [Western] biomedical allopathic health care has its own culture (e.g., knowledge, beliefs, skills, values) based on scientific assumptions and processes, producing definitions and explanations of disease. Older patients familiar with other health traditions may rely more on factors such as nature, balance, or spiritual interventions to explain physical states.
2. People may identify conditions that do not match those found in biomedical references, yet these conditions can have a direct impact on health care, adherence to recommended treatment, and full communication between patient and provider.
3. Culturally defined somatic disorders and culture-bound syndromes with their own beliefs about treatment may make the practice of culturally appropriate geriatrics complex.
4. Contrasting values of independence vs. community/ family may result in conflicting expectation of the involvement of others in providing care

### B. Effects of Ethnocentrism

1. May lead practitioners to misinterpret cross-cultural situations, using their own beliefs, which often are different from those with whom they are interacting. Thus, ethnocentrism leads to miscommunication, which leads to stereotypes and disrespect, which lead to breakdown in delivery of culturally competent care.
2. If practitioners do not have experience working with individuals from a different culture, they may be likely to prejudge them, based on stereotypes, hearsay, and emotions. These judgments may lead practitioners to slight an attribute of a person's culture, either their language, beliefs, habits, or behavior, resulting in the patient taking offense and being less likely to adhere to treatment recommendations.

### **III. Demographic Data on Elders from Diverse Ethnic Populations**

#### **A. Sources of U.S. data and their limitations**

1. Federal census data (See Appendix B)
  - a. Traditionally undercounts ethnic subpopulations
  - b. Federally defined minority categories used in most analyses (American Indian or Alaska Native; Asian/Pacific Islanders; Black; Hispanic) lump different populations together making data on individual ethnic groups (e.g., Chinese American, Navajo, Mexican American) difficult to access.
  - c. Overlap and confusion between the racial categories used in census data (American Indian/Alaska Native, Asian/ Pacific Islander; Black and White) and Hispanic, which is an ethnic category; individuals in Hispanic category can be of any race and are counted in those categories as well
  - d. Demographic characteristics available include age, gender, housing, income/poverty, marital status, living arrangements, and education.
2. Other sources
  - a. National data sets from government sources (e.g. National Health Interview, Health Care Financing Administration, Social Security Administration)
  - b. National data sets from individual organizations (e.g. AARP surveys, University of Michigan Institute for Social Research)
  - c. Community or regional data sets are extremely varied based on the size of the sample and the quality of the research
  - d. Immigration and Naturalization Service provide only immigration data
  - e. National Vital Statistics System provide data on births and deaths
3. Data are extremely fragmented and results vary from one source to another, especially for the smaller populations.

#### **B. Most recent numbers and percentages of older Americans in major ethnic populations from census data**

(Use most recent information available. See websites in resource list)

#### **C. Past trends and future projections of changes in sizes**

1. Example (See Table 1-1)

#### **D. Heterogeneity within ethnic populations**

1. Very important, cannot be over emphasized
2. Within all ethnic groups, elders vary in all significant demographic variables

Table 1-1

PERCENT OF PERSONS 65+ IN U.S.  
BY RACE AND HISPANIC ORIGIN

POPULATION CATEGORY	1990	2030 (Projected)
White*	86.7%	74.6%
Black*	7.9%	9.1%
American Indian/ Eskimo & Aleut*	0.3%	0.5%
Asian & Pacific Islander*	1.4%	5.0%
Hispanic Origin	3.7%	10.9%
TOTAL	100.0%	100.1%

\* Not Hispanic

Source: US Bureau of the Census & National Institute on Aging, 1993  
Racial and Ethnic Diversity of America's Elderly Population

#### **IV. Theories Used in Ethnogeriatrics**

##### **A. Dearth of Theoretical Bases**

##### **B. Explanatory Models of Health and Illness**

Introduced by Arthur Kleinman and colleagues in the 1970s to recognize and validate patients' conceptions, explanations, and expectations of their own illness experiences, many of which are based on cultural beliefs

##### **C. History of Double and Triple Jeopardy Hypotheses of Minorities, Aging, and Health**

Discussed extensively in the geriatric literature in the 1970s and 1980s suggesting that as minorities grow older they are even more disadvantaged in health than at younger ages. Studies and discussions in the 1990s have generally suggested there is little documented additional disadvantage with age among minority elders (Markides, Liang, & Jackson, 1990).

##### **D. Bronfenbrenner's Ecological Approach**

A contextual approach that identifies systems within which individuals act, presented as a series of concentric circles. In the center is the individual with his/her bio-psycho-spiritual aspects. Concentric circles from the center are: 1) the Microsystem, including any person or environment with which the person has direct day to day contacts (e.g., family, friends); 2) the Mesosystem involving the interactions of multiple Microsystems, (e.g., family members' lack of agreement with diet prescriptions); 3) the Exosystem involving the larger community, especially decision-making bodies; 4) the Macrosystem, the overarching cultural belief systems which influence how individuals in each context interact with one another (e.g., health care providers' attitudes about aging, ethnic elders' view of themselves) 5) the Chronosystem, the dimension of time, (e.g., the historical embeddedness of aging, health care, and ethnicity).

#### **V. Intercultural Dynamics**

##### **A. Importance of cultural factors in health care encounters and settings**

1. Culture of the health care organizations
2. Diversity among providers and teams
3. Diversity among organizations
4. Diversity among older patients

##### **B. Acculturation Continuum**

The degree to which elders from particular ethnic backgrounds have incorporated the cultural attributes (e.g., values, beliefs, language, skills) of the mainstream culture. Providers should be aware of the vast range in acculturation found among elders within each ethnic population. There are different domains of culture; one person may differ in the degree to which s/he is acculturated in the different domains affecting health care, such as: belief in existence of non-biomedical illnesses or in the efficacy of scientific treatments; dependence of family decision making; respect/deference to medical professionals; emphasis on control over environment; knowledge of bureaucracies and skills in navigating them.

##### **C. Levels of culture and their expression in a health care encounter**

1. Community

2. Health care system
3. Ethnic group
4. Personal
  - a. Unique to individual provider
  - b. Unique to individual older patient
  - c. Different parts of one's culture may be expressed or not expressed in different situations and different times
  - d. Some of culture is implicit, embedded, and unrecognized by individual
5. Intercultural dynamics of the patient/provider interaction within the health care system and community

## **VI. Policy Affecting Health Care for Ethnic Elders**

- A. Major implications of federal, state, and local policies on health care and support for older adults from diverse ethnic backgrounds (e.g., lack of access to SSI and Medicaid by non-citizen immigrants).
- B. Policies of health settings that differentially affect ethnic elders (e.g., lack of interpreters or written health education materials in elder's language)

## **VII. Cultural Competence in Ethnogeriatric Care**

- A. A continuum based on degree of effectiveness of skills and service delivery in caring for elders from diverse ethnic backgrounds
- B. System or institutional level components
  1. Adequate interpreter services and availability of translated forms
  2. Diversity of policy making board and staff
  3. Use of cultural guides or cultural brokers
  4. Training of staff for intercultural interactions
  5. Multicultural expertise in ethics committees
  6. Institutional multicultural task force to identify needs and recommend innovations
- C. Individual Provider Level
  1. Awareness of one's personal biases and their impact on practice
  2. Knowledge base (see Modules Two, Three, & Five for more detailed information)
    - a. Risk factors for disease by ethnic population among older adults
    - b. Major systems of culturally based health values, beliefs, and behaviors
    - c. Variations in response to treatment by ethnic population
  3. Skills (see Module Three for more detailed information)
    - a. Ethnically appropriate methods of showing respect
    - b. Assessment of elders' position on the acculturation continuum
    - c. Methods of eliciting and acknowledging elders' health beliefs or explanatory models
    - d. Culturally appropriate assessment techniques
    - e. Working with families from diverse ethnic backgrounds effectively
    - f. Recognition of culturally related values and needs in terminal care, including spiritual care

C. Ethnic specific vs. multiethnic models of health care

**VIII. Principles of Geriatric Care**

- A. Major emphases in geriatric health care as they relate to ethnically diverse elders
1. Biopsychosocial approach
  2. Use of multidisciplinary teams
  3. Importance of chronic illnesses and geriatric syndromes
  4. Importance of showing respect to older patients (see Module Four)
  5. Goal of maximizing function
    - a. Awareness and sensitivity to sensory changes
  6. Age-appropriate dosing and avoidance of interactions of multiple medications
  7. Continuity through the continuum of care
    - a. Geriatric primary care
    - b. Geriatric acute care
    - c. Geriatric rehabilitation
    - d. Geriatric long-term care
      - (1) Community based
        - (a) Home care
        - (b) Adult day care/day health care
        - (c) Respite care
      - (2) Residential Services
        - (a) Assisted living, board & care, adult care, or residential care
        - (b) Nursing homes
      - (3) Combinations of levels of care
        - (a) Continuing care retirement communities
    - e. Geriatric managed care: integration of primary, acute, and long term care
      - (1) Social Health Maintenance Organizations (SHMOs)
      - (2) On Lok/Program of All-inclusive Care for the Elderly (PACE)
      - (3) U.S. Department of Veterans Affairs geriatric programs

## **INSTRUCTIONAL STRATEGIES**

- A. Especially recommended for this module are techniques encouraging students to examine their own cultural attitudes and values that could affect their interactions with elders from diverse backgrounds. This can be done by assigning: 1) a paper asking students to examine the influence of their own cultural background on attitudes towards people of different cultures; 2) use of reflection (journaling), (See Eyler, Giles, and Schmeide), and/or 3) reflective narratives about their own ethnic background, values and beliefs about health, health care, the interaction between spirituality and health, and death. In-class reports from these assignments and class discussions of similarities and differences are also valuable, especially in a class with students from diverse backgrounds.
- B. In addition to lecture, discussion, and reading assignments, case histories can be used to emphasize the importance of: 1) spirituality in the health of ethnic elders; and 2) cultural competence in the health care setting.
- C. Have students research the health beliefs, customs, and family systems of different ethnicities.
- D. Have students interview an elderly person from an ethnic background other than their own to recognize cultural and religious beliefs and practices.
- E. Ask groups to analyze census data and report the variations in characteristics WITHIN ethnic populations.
- F. Have students analyze the system level indicators of cultural competence within a health care system in their own community.
- G. Assignments to interview members from different generations or times of immigration in the same ethnic population can help illustrate the acculturation continuum.

## **EVALUATION**

Evaluation of student performance can be based on the following factors for this module:

- Objective tests (true/false, multiple choice)

- Essay questions

- Assigned papers, especially to reflect increased self-knowledge of students' own cultural attitudes and values

- Reports from individual or group projects

Evaluation strategies to use for specific learning objectives are listed below  
 Letters refer to the specific projects listed above in the Instructional Strategies\*

<u>Learning Objectives</u>	<u>Suggested Evaluation Strategy</u>
More nearly understand the effect of their own cultural background on their attitudes toward health care.	*Project A
Define major terms used in ethnogeriatrics	Objective test *Projects C & G
Identify the major sources of information on the sizes of ethnic populations of older adults in the U.S. and the categories that are used for the populations.	Essay question Paper *Project E
Describe the sizes and growth trends in the major population categories of ethnic elders.	Objective test Paper, *Project E
Describe factors that affect cross cultural interactions in geriatric health care in terms of the cultural backgrounds of the providers and patients and the culture of the setting.	*Projects A, C, D, F, & G Paper/essay (case histories, journal, reflective narratives, Class discussion/participation
List the major components of cultural competence in health care on the system and provider levels	Objective test, Project F Essay/paper (case histories, reflective narratives) Class discussion/participation
List three important principles of geriatric care.	Objective test, essay question, Paper, Project D Class discussion/participation

### **REFERENCES AND RESOURCES**

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- Villa, M. L. Cuellar, J., Gamel, N., & Yeo, G. (1993) *Aging and Health: Hispanic American Elders, (2nd ed.)* SGEC Working Paper #5. Stanford, CA: Stanford GEC.

Websites:

[www.aoa/stats](http://www.aoa/stats)

Demographic information from U.S. Administration on Aging

[www.census.gov](http://www.census.gov)

Website of U.S. census