DESCRIPTION
This fifth module of the curriculum presents cultural issues in the delivery of geriatric health care after assessments are completed, including health promotion, informed consent, medications, dementia and caregiving, long-term care, surgery, and working with families. Patterns of utilization of health care services by elders from different ethnic populations and barriers to that utilization are also presented.

LEARNING OBJECTIVES
After completion of this module, learners will be able to:
1. Describe three major strategies used in health promotion and disease prevention for ethnic elders and the process of setting priorities for developing effective prevention.
2. Identify cultural or biological factors that might affect medication or surgical interventions with elders from diverse backgrounds.
3. Understand that the most effective health care team includes the older patient, all health care providers (including alternative providers being used by the patient), and the patient's family member(s).
4. Describe issues that geriatric providers should be sensitive to in working with families of elders from diverse cultural backgrounds and techniques that might be used to avoid problems.
5. List at least one factor that may affect utilization of health care services by ethnic elders in each of the following categories: availability, accessibility, acceptability.

CONTENT OUTLINE
I. Ethnic Issues in Health Care Interventions for Older Patients
   A. Health Promotion Strategies Recommended for Ethnic Elders
      1. Reducing racial and ethnic disparities in health has been identified as a national goal. Health promotion techniques that can help accomplish that goal among older adults are identified in Tables 5-1, 5-2. and 5-3 on the following pages.
## 2. Preventive Screenings Recommended for ALL Elders

<table>
<thead>
<tr>
<th>Preventive Screening</th>
<th>Examples of Ethnic Populations in Which Elders Have A High Incidence of the Target Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>African-American, Filipino-American, Pacific Islander</td>
</tr>
<tr>
<td>Blood Diseases</td>
<td>African American</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>African American, Mexican American, Pacific Islander, American Indian</td>
</tr>
<tr>
<td>Cancer:</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>African American, European American</td>
</tr>
<tr>
<td>Cervical</td>
<td>Mexican American</td>
</tr>
<tr>
<td>Prostate</td>
<td>African American</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>African American, Puerto Rican, (young old, not for 75+)</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td></td>
</tr>
<tr>
<td>Functional Impairment</td>
<td>African American, Mexican American, Puerto Rican</td>
</tr>
<tr>
<td>Depression</td>
<td>South East Asian</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>American Indian</td>
</tr>
<tr>
<td>Vision Loss</td>
<td>African American, American Indian</td>
</tr>
<tr>
<td>Diabetes</td>
<td>African American, American Indian, Mexican American, Chinese American, Japanese American, Filipino American, Pacific Islander</td>
</tr>
</tbody>
</table>
### 3. Immunization and Prophylaxis Recommended for ALL Elders

<table>
<thead>
<tr>
<th>Immunization and Prophylaxis</th>
<th>Examples of Ethnic Populations in which Elders Have A High Incidence of the Target Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcus</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>American Indian, Immigrants from Africa, Asia, and Latin America</td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Korean American</td>
</tr>
<tr>
<td>Hormone replacement</td>
<td>Japanese American, African American, Puerto Rican, European American</td>
</tr>
<tr>
<td>Aspirin</td>
<td>African American, Puerto Rican</td>
</tr>
</tbody>
</table>

### 4. Counseling Recommended for ALL Elders

Note: Counseling and education includes consideration of different learning styles, preferences, and literacy levels for ethnic elders

<table>
<thead>
<tr>
<th>Type of Counseling</th>
<th>Examples of Ethnic Populations in Which Elders Have A High Incidence of the Target Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance, Alcohol, and Other Drug Abuse (Including Polypharmacy)</td>
<td></td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>American Indian</td>
</tr>
<tr>
<td>Domestic Violence Prevention and Elder Abuse Prevention</td>
<td>All Ethnic Groups</td>
</tr>
<tr>
<td>Nutrition</td>
<td>All Ethnic Groups</td>
</tr>
<tr>
<td>Exercise</td>
<td>African American, Mexican American, Chinese American, Japanese American, Filipino American, Pacific Islander</td>
</tr>
<tr>
<td>Sexually Transmitted Disease Education</td>
<td>Immigrants from Africa, Asia, and Latin America</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Mexican American Males, African American, Puerto Rican</td>
</tr>
<tr>
<td>Osteoporosis Prevention</td>
<td>Japanese American Females, European American Females</td>
</tr>
</tbody>
</table>

### 5. Process of Setting Priorities for Prevention Strategies
a. Measure frequency and severity of health condition in target population
b. Measure magnitude of risk associated with identified risk factors
c. Determine accuracy of screening tests
d. Weigh evidence in support of the intervention
e. Determine effectiveness of the intervention
f. Use answers for a-e to set health care priorities for individual patients and populations

B. Issues in Treatment and Response to Treatment

1. Informed Consent
   a. Intercultural dynamics producing possible misunderstanding
      (1) Recitation of possible negative outcomes in some cases is believed to “call forth” negative outcome.
      (2) Explanation of possible negative outcome produces loss of hope.
      (3) Family expectations that elders should be protected from bad news.
      (4) Family/patient answering "yes" to questions in order to show respect or not to appear foolish.
      (5) Cultural family hierarchical patterns in which a family member other than the patient is expected to be the decision maker.
   b. Techniques to minimize confusion and misunderstanding.
      (1) Use cultural guides to determine acceptability of talking to older patients directly.
      (2) Ask older patients if there is a preferred spokesperson.
      (3) Ask patients if they would like to consult with, or appoint someone else as decision maker.
      (4) Ask patients to explain in their own words what they understand about the procedure

2. Advance Directives
   a. Intercultural dynamics leading to misunderstanding
      (1) Lack of acceptability of discussion of death or disability in the culture
      (2) Cultural, social, economic, educational, and linguistic differences between provider and patient/family
      (3) Historical persecution or oppression of the patient/ethnic group leading to distrust of providers
      (4) Variation by ethnic group and sub-group in knowledge of advance directives
      (5) Cultural rituals and traditions at the time of death
      (6) Biomedical model of autonomy in decision making that does not recognize cultural expectations that others (e.g., family, son, clan leader) would make health care decisions for elder
      (7) Multicultural influences during lifetime of patient
         (8) Is patient capable of identifying person(s) responsible for medical and financial decisions?
      (9) Does the family accept the identified decision maker?
   b. Techniques to minimize confusion and misunderstanding
(1) Self-assess provider’s own values and culture about death
(2) Use cultural guides for culturally appropriate interaction
(3) Ask patients to describe their customs, concerns, and beliefs about death, if appropriate

3. Medication Issues
   a. Culturally based differences in attitudes toward medication
      (1) Belief that prescription and over-the-counter (OTC) drugs are too strong, leading to taking less than prescribed
      (2) Belief that medications administered by injection are the only effective ones, leading to expectation that if the provider is competent, a shot will be given each visit
      (3) Cultural values relating to particular medications (e.g., antihypertensive pharmaceuticals that may contribute to sexual dysfunction)
   b. Physiological effects of the medications
      (1) Differences in response to some medications, such as antihypertensives, antidepressants, benzodiazepines, and neuroleptics between some racial/ethnic populations (Lin, Poland, & Nakasaki, 1993)
      (2) Effect of combining pharmaceuticals with culturally based herbal medications
   c. Social and economic issues
      (1) Financial ability to buy medication
      (2) In some ethnic groups it is common to “share” medications among family and friends.
      (3) Practice of importing medications from other countries
   d. Techniques to minimize misunderstanding
      (1) Discuss patient’s and provider’s explanatory models for condition being treated (See Module Four)
      (2) Investigate meaning of condition in the culture (e.g., is it hidden?, is there a word in the language for the condition?)
      (3) Assess literacy level, then give culturally appropriate written information in appropriate reading level
      (4) Prescribe for elder’s individual characteristics, using geriatric prescription guidelines - "start low and go slow"
      (5) Careful follow-up for elders with different medication response
      (6) Assess different attitudes to taking prescribed amount

4. Issues in Dementia and Caregiving
   a. Paid caregivers are likely to be culturally different from patient
   b. Culturally determined behaviors of bathing, eating, and toileting
   c. Cultural gender taboos concerning body touching/viewing by family
   d. Cultural “normalizing” of dementia behaviors
   e. Need for culturally sensitive cognitive testing (See Module Four)

5. Long-Term Care
   a. Home Care
(1) May be preference for families from many ethnic backgrounds
(2) Cultural expectations for family care may put extreme stress on family members.
b. Day care, residential, and nursing home care (See utilization below)
   (1) Ethnically appropriate food important for health and healing.
   (2) Symbolism can be a source of comfort or discomfort (e.g., images, color, clothing, decor).
   (3) Monolingual non-English speaking elders can be very isolated
   (4) Cultural celebrations, holidays, activities are important.
   (5) Cultural taboos need to be learned and respected.

6. Surgery
   a. Intercultural Concerns.
      (1) Cultural beliefs in sanctity of body
      (2) Belief that the body must be whole to “cross over”
      (3) Cultural beliefs concerning blood loss (e.g., that blood is not replaced)
      (4) Belief that organs are being harvested illegally

7. Coordinating Biomedical and Traditional therapies
   a. Include all health care providers valued and used by patient and family in the therapeutic team, including healers from non biomedical traditions
      (1) For education of biomedical team members
      (2) To honor patient's needs for healing practices or ceremonies
   b. Need to recognize, discuss, accept, and respect differences in goals between biomedical and traditional ethnic providers

8. Working with Culturally Diverse Elders and Family Members
   a. Common cultural differences in expected participation by family members in elders' health care
      (1) Disclosure of terminal/ serious condition to family members but not to elder
      (2) Decision making by family member(s) instead of by patient
      (3) Cultural show of respect to elder through family caregiving rather than encouraging independence
      (4) Spiritual/religious beliefs by family that elder's life
         (a) should be preserved by all means despite decreased quality
         (b) should allow time for a "miracle"
         (c) should allow God to control the time of death
      (5) Importance of presence of large numbers of family members, which may interfere with medical or nursing routines
      (6) Cultural expectations of behavior (e.g., cross-gender touching)
   b. Techniques to minimize conflict
      (1) Ask older patient’s preference for decision making early in care
      (2) Ask older patient to identify family spokesperson(s)
      (3) In emergencies, ask the family to appoint a spokesperson
      (4) Respect appointment, even if the person is not a family member or does not live nearby
(5) Use a cultural broker or cultural guide from the elder’s ethnic or religious background
(a) To assist the health care team
(b) To advise on cultural communication patterns (e.g., meaning of eye contact/body language)
(6) Familiarize multidisciplinary health care team with cultural explanatory models of elder’s condition(s)

II. Access and Utilization

A. Patterns of Utilization

1. Studies indicate that on average elders from most ethnic minority populations use most formal health care services less than their white counterparts
   a. Primary care, including preventive screenings, immunizations and prophylaxis
   b. Health education and counseling
   c. Mental health services

2. Exceptions: emergency rooms and acute care tend to have higher utilization

3. Formal long-term care services have lower rates of utilization by elders from most ethnic minority populations

B. Barriers to Utilization

1. Availability:
   a. Services not available where ethnic elders live
      1) Sometimes a problem for primary care
      2) A more common problem for specialty care,
      3) Most common for long-term care.
      4) Will require policy advocacy to effect change

2. Accessibility:
   a. Care is available, but the elder cannot use it for a variety of reasons:
      1) Lack of knowledge of services or interest in care
      2) Distrust of the system
      3) Fear of punitive action (immigration status or loss of benefits)
      4) Inability to deal with bureaucracy
      5) Assumptions by providers of lack of motivation or interest
      6) Being victims of elder abuse or mistreatment (See also Module 4)
      7) Transportation difficulties

   b. Financial and eligibility constraints
      1) Limited income
      2) Lack of eligibility for service
      3) Co-payments or small charges can discourage the poor
   c. Discrimination discourages use of services
   d. Language barriers
      1) Lack of available interpreters
2) Isolation of monolingual non-English speaking elders in residential and day care settings
3) Acts as disincentive to use of assisted living/board and care or nursing homes.

3. Acceptability:
   a. Based on patients’ satisfaction and having their expectations met
   b. Aspect of care most affected by culture
   c. Interaction between patient expectations and provider performance
   d. Most are amenable to change by individual providers
   e. Depends upon trust between provider and patient
   f. Changes in providers reduce acceptability
   g. Managed care can limit degree of acceptability
   h. Perception of “welfare” decreases acceptability
   i. Care of other family member may have priority over accessing care

4. To assure adequate utilization, providers should:
   a. Understand key aspects of culture and its relation to behavior of clients
   b. Educate clients about options available, whether used or not
   c. Help elder determine most cost effective means to obtain needed services (e.g., prescription medicine, medical equipment or supplies)

C. United States Health Care Policy
1. The federal Medicare system funds most hospital care, much of the outpatient care, and very little long term care for elders eligible for social security
2. To obtain Medicare, elders who have immigrated as “followers of children” and not paid into U.S. social security system must either buy into the system or become eligible for Medicaid.
3. Medicaid, a combination federal and state program, varies from state to state, but funds health care, including nursing home care for low income seniors.
4. Legislation passed in the 1990 increased the difficulty in accessing Medicaid by older non-citizen immigrants.
5. Prevention Policy - President’s Initiative to Eliminate Racial and Ethnic Disparities in Health, 1998, emphasizes:
   a. elder cancer screening and management
   b. cardiovascular disease
   c. diabetes
   d. immunizations

D. Successful Models of Service
1. Use of indigenous networks for education and outreach
   a. Churches, temples, places of worship
   b. Lay leaders
   c. Promotores (non professional community based advocates)
   d. Beauty salons, barber shops, other gathering places
2. Use of ethnic community resources for education and outreach
INSTRUCTIONAL STRATEGIES

The instructor should have a working knowledge of the differences in the risk of diseases related to different racial, ethnic, social, and gender groups (see Module Two on Health Risks) that make one type of preventive strategy more or less appropriate for specific populations.

A. Case histories abound in the ethnic literature on the special needs of specific populations. These differences can be used in lectures to provide vignettes of special needs and concerns. This knowledge will give students a working background upon which to research their own "special" cases. Especially if the class is ethnically diverse, health-related stories about operations, diseases, doctors, and hospitals, can be shared as learning experiences, with emphasis on the cultural attitudes toward health care interventions.

B. Students should have access to family members of older patients with special health problems that they can explore further through interviews. (See Appendix C: Instructional Strategies for Interviewing Elders from Diverse Ethnic Backgrounds.) However, because health is often a sensitive issue with elders, especially if their health is not good, care needs to be used when assigning students to interview people about their health concerns. Often it is better to ask elders about their attitudes toward health (disease) rather than their experiences. Students can be asked to write the results of the interviews based on previously assigned topics or questions.

C. In-class discussions about these interviews give students a sense of belonging because everyone has a story. On the other hand, every story is different and that emphasizes the differences between individuals and populations. After the initial assignment is shared, students can be asked to compare and contrast the stories and experiences keeping ethnic backgrounds in mind.

Evaluation

Evaluation of student understanding of culturally appropriate health care is best evaluated via essay questions or written report. This format allows the student to explore differences more fully. Objective tests are often too restrictive to assess learning in this type of module.

EVALUATION STRATEGIES FOR SPECIFIC LEARNING OBJECTIVES

<p>| Describe three major strategies used in health promotion and disease prevention for ethnic elders and the process of setting | Essay question |
| Individual or group assignment to develop |</p>
<table>
<thead>
<tr>
<th>Priorities for developing effective prevention.</th>
<th>Health promotion/disease prevention program for specific group of elders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify cultural or biological factors that might affect medication or surgical interventions with elders from diverse backgrounds.</td>
<td>Essay question</td>
</tr>
<tr>
<td>Understand that the most effective health care team includes the older patient, all health care providers (including alternative providers being used by the patient), and the patient's family member(s).</td>
<td>Role play cases of teams with and without alternative providers and family members</td>
</tr>
<tr>
<td>Describe issues that geriatric providers should be sensitive to in working with families of elders from diverse cultural backgrounds and techniques that might be used to avoid problems.</td>
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<td>List at least one factor that may affect utilization of health care services by ethnic elders in each of the following categories: availability, accessibility, acceptability.</td>
<td>Essay question</td>
</tr>
</tbody>
</table>

*Letters refer to instructional strategies listed above*

**REFERENCES AND RESOURCES**


WEBSITES
Healthy People 2010
http://www.health.gov/healthypeople/
Office of Minority Health Resource Center
http://www.omhrc.gov
Clinical Pearls in Cross Cultural Medicine
http://healthlinks.washington.edu/clinical/ethnomed/pearls.html