Achieving High-Quality Multicultural Geriatric Care

Developed by the American Geriatrics Society Ethnogeriatrics Committee

As the ethnic diversity of the U.S. population increases, there is a growing awareness of healthcare disparities and the need to address them. This position statement that the American Geriatrics Society (AGS) Ethnogeriatrics Committee developed outlines healthcare disparities in the United States and the minimum quality indicators that healthcare organizations and healthcare providers should adopt to ensure that all older adults receive care that is culturally appropriate and takes into account level of health literacy. **J Am Geriatr Soc 2016.**

Key words: culturally competent care; quality indicators; ethnogeriatrics

By 2050, the older adult population is projected to be 39.1% minority, up from 20.7% in 2012. Although the percentage of the Hispanic population aged 65 and older will more than double between 2012 and 2050, it will continue to be a relatively young population. The largest increases in the proportion of older adults will be in the Asian, Native Hawaiian, and other Pacific Islander populations.[1]

OUR VISION FOR CARE OF ETHNICALLY DIVERSE OLDER ADULTS

Health Providers

The American Geriatrics Society believes that providing high-quality health care for ethnically diverse older adults will require that all clinicians, regardless of the setting of care in which they practice be self-aware of their biases and perceptions, have the interpersonal skills to transcend these barriers and allow compassionate understanding to care effectively for individuals from cultures other than their own, and become skilled in eliciting and meeting the care needs of an increasingly diverse older adult population.

Culturally Sensitive Indicators

Incorporating a set of culturally sensitive indicators into the care of this population is an important component of efforts to improve health outcomes in a diverse older adult population while concurrently curbing ineffective care.

The following questions are recommended as the minimum culturally sensitive quality indicators for older adults across healthcare delivery systems. Documenting the responses to these questions in the patient record should be standard of care.

What is your ethnicity?

What is your preferred language?

Do you know that interpreter services are available free of charge? Do you want to choose one of the available interpreter services (online, telephone, in person)?

How much education did you complete (none, <7th grade, ≥7th grade)?

BACKGROUND

The U.S. Department of Health and Human Services (HHS) established standards for data collection on race, ethnicity, sex, primary language, and disability status, as mandated in Section 4302 of the Patient Protection and Affordable Care Act of 2010.[2] The law requires that data collection standards for these measures be used to the extent practicable, with respondents self-reporting information or a knowledgeable person responding for members of a household. This represents an opportunity for providers and health systems to collect information on the race and ethnicity of older adults to facilitate data analyses and comparisons, identify gaps, develop and implement interventions to improve care (e.g., establishing clinics for larger minority populations in certain geographic areas), and ultimately eliminate disparities.

The provision of culturally and linguistically appropriate services is another strategy to eliminate health inequities. When health services are customized to an individual's culture and language preference, providers can

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DOI: 10.1111/jgs.13924

0002-8614/16/$15.00

bring about positive health outcomes for diverse populations. The HHS National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining Culturally and Linguistically Appropriate Services Policy and Practice (the Blueprint) is an implementation guide to advance and sustain culturally and linguistically appropriate services in healthcare organizations. These national Standards were rereleased in April 2013 after undergoing a 2-year enhancement initiative.[3]

POPULATION DIVERSITY

In 2050, the population of adults aged 65 and older is projected to be 83.7 million, almost double the estimated population of 43.1 million in 2012. The baby boomers are largely the reason for this increase; they began turning 65 in 2011, and many will survive and reach the age of 85 and older by 2050. Although the older adult population is not anticipated to turn into a majority in the next 4 decades, it is projected that minorities will account for 39.1% in 2050 (up from 20.7% in 2012). As mentioned in the introduction, the largest increases in the proportion of older adults are projected to be in the Asian, Native Hawaiian, and other Pacific Islander populations, rather than the Hispanic population.[1]

Specifically, 77.3% of those aged 65 and older in 2050 are projected to be white (down from 86% in 2012), 12.3% to be black (up from 8.8% in 2012), and 7.1% to be Asian (up 3.8% in 2012). The American Indian and Alaska Native populations are projected to be 996,000 (up from 266,000 in 2012) and the Native Hawaiian and other Pacific Islander populations to be 220,000 (up from 42,000 in 2012).[1]

Of the population aged 85 and older, 29.7% are projected to be minority in 2050 (up from 16.3% in 2012). Specifically, in 2050, 81.5% are projected to be white (down from 88.9% in 2012), 10.8% to be black (up from 7.2% in 2012), and 5.2% to be Asian (up from 2.9% in 2012). The American Indian and Alaska Native populations are projected to reach 173,000 (up from 22,000 in 2012) and the Native Hawaiian and other Pacific Islander population to reach 34,000 (up from 3,000 in 2012).[1]

The proportion of older Hispanics is projected to increase considerably and rapidly over the next 4 decades. In 2050, 18.4% of the population aged 65 and older will be Hispanic (up from 7.3% in 2012; 3.1 million to 15.4 million), and the oldest-old Hispanic population will increase by approximately 7% between 2012 and 2050.[1]

PROVIDER AWARENESS AND COMMUNICATIONS SKILLS

Clinicians need to understand how best to communicate with people from various ethnic groups in a culturally sensitive manner and to understand the diversity of approaches to health that different ethnicities have. Specifically, many people of various ethnicities use complementary and integrative modalities of care, including indigenous healing therapies and techniques.[4]

Providers should be mindful of known barriers to cultural competency in care delivery and strive to develop and implement strategies for overcoming them. There is a growing body of literature that confirms that people who consider themselves to hold minimal prejudice tend, in cross-cultural encounters, to demonstrate overt prejudice.[5] Individuals' values and beliefs about equality may often be inconsistent with their observed behaviors. Providers need the knowledge, self-awareness of their biases and perceptions, and interpersonal skills to help transcend these barriers. This compassionate understanding will promote effective provision of care to individuals from diverse cultures. Awareness and acceptance of the provider's own cultural background is the first step, because each person brings personal biases to clinical encounters and toward other ethnicities caused by sex, ethnicity, religious beliefs, and their upbringing. Provider awareness requires honest self-reflection about personal prejudices and biases. As health professionals, we are well acculturated to the biomedical system and generally belong to a higher socioeconomic status than many patients. Additionally, the culture of biomedicine has inculcated in us certain beliefs, values, and prejudices that may unknowingly distance us from the people we serve.

Ask yourself what stigmas are associated with the sociocultural group you most closely identify with? How has the group you grew up and live in influenced the dominant values you now hold? How do your perceptions differ from those of people who come from other cultural backgrounds? What is your attitude toward older adults who are from a lower socioeconomic status, have limited English proficiency or minimal health literacy, who are immigrants with an accent or are difficult to understand? How do you respond to a patient who requires an interpreter?

In addition to the providers' personal biases, language can be a barrier. When caring for any older adult of a different ethnicity, as a first step, a clinician should gauge the patient's English proficiency and health literacy and make arrangements to facilitate the support needed to optimize the clinical encounter.

Finally, some minority groups may be mistrustful because of past abuses at the interpersonal and systemic level. Among the remedial strategies are honest self-reflection by providers, use of interpreters to facilitate communication, provision of information at an appropriate level of clarity, eliciting and incorporating input from older adults in decision-making, and involvement of community leaders to rebuild trust. As we work within interprofessional teams, in a variety of settings and diverse facilities such as acute care, ambulatory care, assisted living facilities, nursing homes, and home health, it is important for the healthcare team to acknowledge and recognize the individual's and team's biases and beliefs and how these may affect the care of older adults.[6]

Decision-Making and Perceptions of Health

Medical decision-making is complex and involves patients, providers, families, caregivers, and social and medical factors. The experience of diverse populations varies. Audiotaped communication analysis between oncologists and individuals with breast cancer revealed communication disparities in minorities with less language proficiency, older

age, and less education. Providers have been found to communicate differently depending on the minority group they are encountering.[7] Patient factors may also influence communication; for example, Hispanic women with breast cancer may identify a family member as their decision-maker. It has been reported that completion of advance directives and surrogates' experiences of the challenges of end-of-life decision-making are similar for white, black, and Hispanic Americans.[8] Predictors of advance directive completion are established primary care, personal experience with mechanical ventilation, knowledge about the process, and physician willingness to initiate the discussion. A randomized controlled trial showed that a video-based support tool on preference for future medical care in older adults with advanced dementia resulted in a greater preference for comfort care than did oral narrative alone.[9]

Although literature on differences in perceptions of health beliefs across diverse groups is limited, there are data about integrative medicine perceptions. Based on the 2002 National Health Interview Survey, white people prefer mind–body medicine, alternative medical systems, and biological-based therapies. Hispanics prefer biological-based therapies, and Asians and Pacific Islanders are generally more likely to use herbs than Caucasians. Studies report differences between minorities about decision-making and health perceptions that may be elicited simply by asking older adults what their preferences are (e.g., individual or family decision-making) and whether they agree with the provider's recommendations and what other modalities (e.g., healers, herbs) they use.[10]

ETHNICITY AND HEALTH DISPARITIES

Despite improvements in the overall health of the U.S. population, racial and ethnic minorities and other populations suffer disproportionate burden of illness and premature death. Public Law 106–525 defines a population as having health disparities when there is significant difference in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates from the health status of the general population. As such, older racial and ethnic minorities, individuals with low socioeconomic status, and rural persons are currently designated as having health disparities.[11]

Health inequities for older adults are well documented.[11] Although life expectancy and overall health have improved for most Americans, not all older adults benefit equally. The health status of older Americans varies according to race and ethnicity, socioeconomic status, and sex. Older minority Americans have consistently been shown to have worse health than whites of the same age group on measures of disease, disability, and self-assessed health. For example, older Hispanics have higher rates of diabetes mellitus and disabilities, and older blacks have more chronic conditions. Studies have shown that certain healthcare services such as breast and cervical cancer screening and management of anticoagulation and diabetes mellitus may not be provided equally to people of different cultures and ethnicities.[12–14] Documenting health disparities is critical to help monitor progress, identify gap areas, allocate resources, and implement interventions to eliminate them.

EDUCATION LEVEL AND HEALTH LITERACY

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[15] According to the 2003 National Assessment of Adult Literacy Survey,[15] 36% of Americans have limited health literacy. Most of them are aged 65 and older (59%), with less than high school education (76%), and not white (Hispanic 66%, Black 58%, Native American 48%). For this reason, the Institute for Healthcare Advancement recommends that printed patient education materials and oral health information be at the sixth-grade reading level or lower if possible. Patient and provider factors contribute to inadequate health literacy. Patient factors include being unfamiliar with medical concepts, having limited English proficiency, having beliefs about their health and preferences as to the type of treatment they should receive, and having experience with group-based discrimination. Provider factors include lack of awareness, ineffective verbal or cross-cultural communication skills, and the complexity of the healthcare system.

Nearly half of all U.S. adults—some 90 million people—have difficulty understanding and using health information. Observational data suggest that limited health literacy increases mortality, but not hospitalization, in outpatients with heart failure.[16] Limited health literacy has also been found to be associated with poor understanding of medications at discharge, especially in older adults. Latinos, Asians and Pacific Islanders, and individuals with limited literacy are more likely to be uncertain about their treatment decisions.[17] Furthermore, low literacy has been associated with lower likelihood of using preventive health measures for older adults.

Limited data are available on why older adults have lower literacy rates. Differences in frequency of reading the newspaper, visual acuity, chronic medical conditions, and health status do not fully explain lower literacy, and it is suggested that the influence of cognitive decline as a factor in lower literacy must be further explored.[18] Nevertheless, good evidence is available on effective interventions to overcome low literacy, particularly in Hispanic-Americans with diabetes mellitus.[19] Individual and collective interventions suggest that a universal approach ensuring that people understand oral and written communications (e.g., "teach-back" technique) should be the norm.[20]

PREFERRED LANGUAGE

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities can easily understand. Despite federal regulation[21] and evidence of adverse outcomes of ineffective communication,[22] data suggest that the use of interpreters or a language-concordant provider is low in U.S. hospitals and primary care settings.[23–25]

Assessing preferred language or effectively using interpreter services is critical to enhancing patient–provider communication. Language is inclusive of culture, and culture is encoded in language. Even well-educated people

with strong reading and writing skills may have difficulty navigating the healthcare system and understanding a medical form or doctor's instructions regarding a medication or procedure.

USING AN INTERPRETER

When using an interpreter, seek the most-qualified person available: trained interpreters, other medical staff who speak the required language, followed by a language line interpreter. Family members should not be asked to interpret. Trained medical interpreters are consistently better at communicating medical information to individuals with limited English proficiency and in promoting shared decision-making. Providers should not leave the medical interpreter alone with the patient, nor should the interpreter explain any procedures or obtain informed consent without the provider being present.

Before going into a room with an interpreter, brief the interpreter on the topic to be discussed; discuss logistics, known concerns, and the goals of the encounter; refrain from telling the interpreter, "This is going to be quick."

While in the room with the patient and the interpreter, introduce everyone in the room; position the patient in front of you with the interpreter to the right or left and a little in front, in the shape of a triangle; ensure you are able to see and be aware of nonverbal response; ensure that the interpreter also has visual access to all participants; maintain eye contact mainly with patient and family, not just the interpreter, keeping in mind that direct eye contact may not be culturally congruent with some ethnic groups, especially with persons of the opposite sex. Eye contact and a calm intent attitude may be very helpful with Latin Americans, but lack of eye contact while listening to Asian patients may be a sign of respect and concentration.[26] Pace the discussion based on the needs of the patient and family as well as the interpreter. Avoid medical jargon to the extent possible. When describing complex medical procedures, ensure that the interpreter is also able to understand the information. It is helpful to speak in short simple sentences, which allows for rapid and accurate interpretation. Be watchful for the patient's body language and nonverbal behavior; 60% of rapport is the result of nonverbal communication. Leave the room with the interpreter. It is helpful to debrief with the medical interpreter after the encounter.

Mistrust and Participation in Clinical Research

Despite investigators' efforts, mistrust among minority populations has been a persistent barrier to minority research participation. Interpersonal mistrust in clinical research may be based on personal experiences with providers and interactions of patients with the healthcare system or clinical research settings. For older blacks in particular, this may reflect an overall mistrust o the healthcare system, due to their awareness of prior research abuses (e.g., U.S. Public Health Service Tuskegee Syphilis Study). Potential interventions to overcome mistrust by minority populations require investigators to improve communication and share information with minorities about clinical research in a way that facilitates informed decision-making. Potential study participants should be informed about prior successful interventions that have improved outcomes for minorities (e.g., hypertension). In addition, investigators or team members should be available to answer questions or concerns of minorities. Investigators may choose to seek minority physician referrals to build on the trust already forged in physician–patient relationships. By focusing efforts on specific communities, investigators may raise awareness of targeted healthcare conditions and the critical role clinical research plays in advancing health care. Community outreach efforts in addition to study recruitment may counteract negative preconceived ideas about clinical research. The use of churches or other community leaders and cultural brokers may also rebuild trust and increase participation of minorities in clinical research.

FUTURE RESEARCH AND EDUCATION

The pursuit of health equity must remain at the forefront of our efforts. Provision of healthcare services that are respectful of and responsive to the health beliefs, practices, and needs of older adults of diverse backgrounds may minimize or close the gap in healthcare outcomes. Minorities' use of healthcare services and low participation in clinical trials have often been attributed to socioeconomic factors and cultural beliefs. One recent review study assessed whether cultural competency can improve the management of diabetes mellitus, hyperlipidemia, or hypertension in ethnically diverse individuals.[27] This study found that trust in physicians leads to better glycemic control but has no effect on hyperlipidemia or blood pressure control. This study also showed greater doctor communication and health promotion were associated with poor glycemic control, highlighting the complexity of culturally competent care. Future research should focus on the effectiveness of culturally customized interventions to modify behavior or treat specific conditions with the ultimate goal of improving care and health outcomes of older adults.

Clinicians, other healthcare providers, and trainees must be educated to care for ethnically diverse individuals. Nursing educators have played a vital role in developing curricula and workshops designed to train nurses to be culturally competent.[28–31] Undergraduate medical education has also focused on ways to improve medical students' awareness of how cultural and ethnic beliefs play an integral role in care.[32] Dental, physician assistant, and pharmacy students have recently begun to receive education in cultural competency.[33–36] Teaching cultural competency is a required curriculum in U.S. dental schools as of 2013. Cultural competency is taught in didactic lectures, case scenarios, objective structured clinical examinations, and standardized patient interactions,[37] but no standard assessment tools are available to evaluate the effectiveness of any of these teaching modalities. Some students appear to learn better using a combination of methods. Future research is necessary to develop a validated assessment tool to evaluate the effect of teaching methods on cultural competency.

CONCLUSION

The U.S. older adult population has become more culturally diverse, and minority groups represent the fastest-growing segment. As healthcare providers, we are challenged and should commit to providing culturally sensitive care by recognizing provider and patient barriers and using culturally sensitive quality indicators in every patient–provider encounter to establish a patient's cultural identity and avoid potential undesirable disparities in healthcare delivery.

ACKNOWLEDGMENTS

Rosaly Correa-de-Araujo, MD, MSc, PhD; Dulce M. Cruz-Oliver, MD, CMD; Michi Yukawa, MD, MPH; and Vivyenne Roche, MD led the initiative by conceptualizing and drafting the position statement and incorporating recommended edits throughout the process. Ethnogeriatrics Committee Chair Carmel Bitondo-Dyer, MD, and Vice Chair VJ Periyakoil, MD, provided additional support.

AGS Ethnogeriatrics Committee Members: Carmel Bitondo-Dyer, MD; Charles Cefalu, MD; Rosaly Correa-de-Araujo, MD, MSc, PhD; Dulce Cruz-Oliver, MD; Lenise Cummings-Vaughn, MD; David Elliott, PharmD, AGSF; Ashish Goel, MD; Seema Limaye, MD; Douglas Miller, MD; Irene Moore, MSW, LISW-S, AGSF; Wadie Najm, MD; Joseph Nnodim, MD, PhD; Mary Beth O'Connell, PharmD; Ugochi Ohuabunwa, MD; Thuan Ong, MD, MPH; VJ Periyakoil, MD; Ravi Ramaswamy, MD; Vivyenne Roche, MD; Brooke Salzman, MD; Pushpendra Sharma, MD; Marie L. Villa, MD; Blythe Winchester, MD, MPH; Michi Yukawa, MD, MPH.

The views expressed in this article are those of the authors and do not necessarily represent the views of the National Institutes of Health, National Institute on Aging, the U.S. Department of Health and Human Services, or the U.S. federal government.

Conflict of Interest: The editor in chief has reviewed the conflict of interest checklist provided by the authors and has determined that the authors have no financial or any other kind of personal conflicts with this paper.

Author Contributions: All authors contributed to this paper.

Sponsor's Role: None.

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