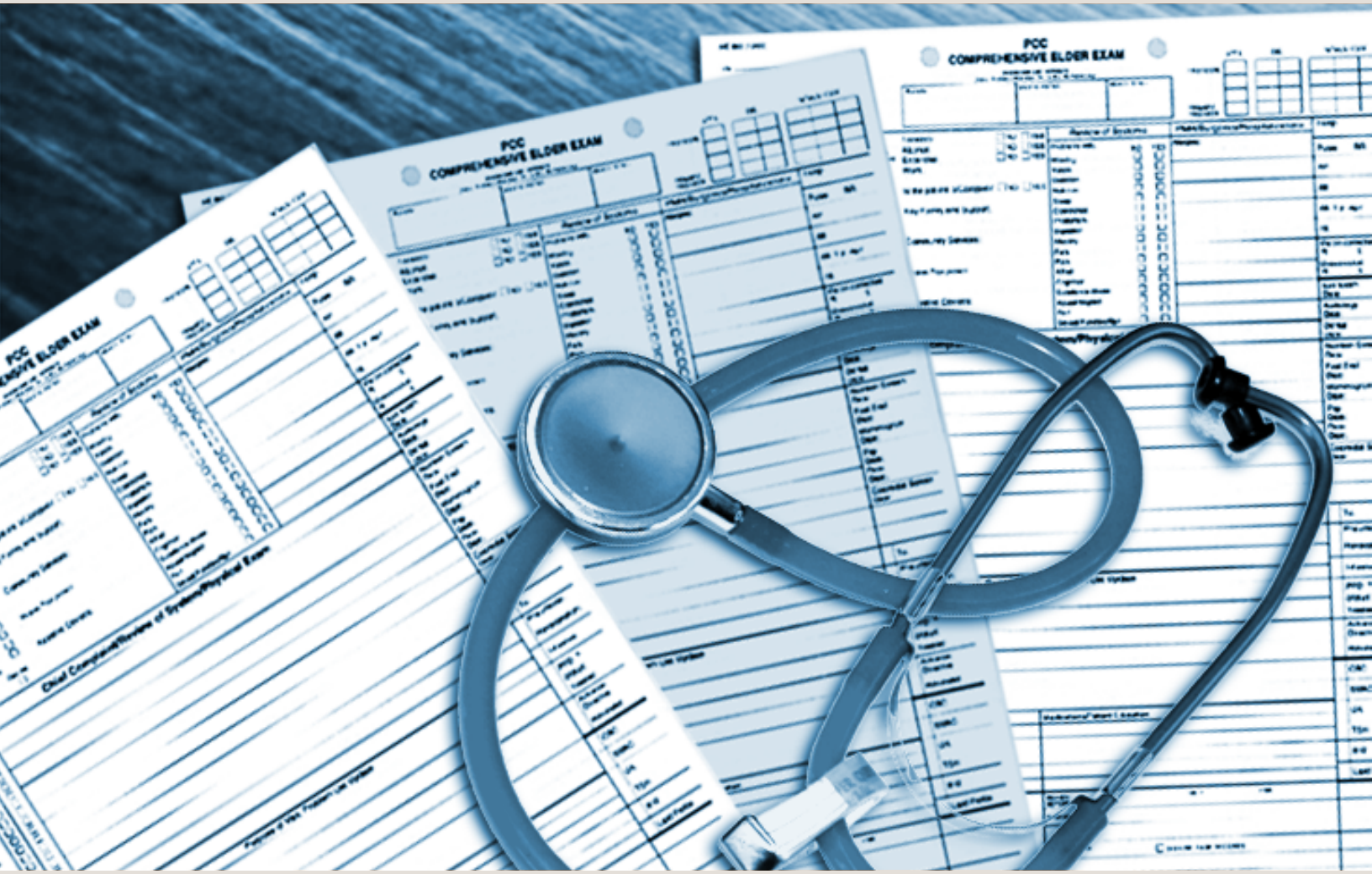
Assessment

http://geriatrics.stanford.edu/culturemed/overview/assessment



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STANFORD SCHOOL OF MEDICINE

eCampus Geriatrics
IN THE DIVISION OF GENERAL INTERNAL MEDICINE
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CONTENTS

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DESCRIPTION

This module introduces the learner to basic background and skills needed to provide a culturally competent geriatric assessment.

Targeted areas within the module include:

1. Strategies for effective communication
2. Guidelines for use of standardized assessment instruments
3. The five domains of ethnogeriatric assessment:
    a. Client background
    b. Clinical domains
    c. Problem-specific information
    d. Intervention-specific data
    e. Outcome criteria
4. This content forms the basis for development of culturally competent geriatric assessment by health practitioners.

Information in the content section is based on evidence from research and citations to the published studies are included.

MODULE CHARACTERISTICS

Time to Complete: 40 mins

Intended Audience: Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.

Peer-Reviewed: Yes

Course Director and Editor in Chief of the Ethnogeriatrics Curriculum and Training

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This edition of the module is based on a version developed by Eunice E. Choi, RN, DNSc, Janet Enslein, RN, MA, Lisa Skemp Kelley, RN, and Toni Tripp-Reimer, RN, PhD and edited by Gwen Yeo, PhD, in 2002. It has been updated, edited, and revised by Gwen Yeo, PhD.

LEARNING OBJECTIVES

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

1. Conduct culturally appropriate assessments that are respectful of individuals and families.
2. Describe strategies for development of culturally appropriate verbal and non-verbal communication skills.
3. Identify advantages and disadvantages of using different types of interpreters.
4. Describe the process and use of translation/back-translation to achieve better conceptual equivalence of materials and assessment tools.
5. Conduct an ethnogeriatric health assessment including elicitation of:
    a. Background/contextual data
    b. Clinical geriatric assessment domains,
    c. Problem-specific information, including explanatory model
    d. Intervention-specific data
    e. Outcomes criteria
6. Identify resources for information on historical experiences of various ethnic cohorts helpful to clinicians.

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COMMUNICATION

In cross-cultural interactions, communication issues become paramount. If the provider is not familiar with the elder's cultural background, the provider needs to have assistance from a cultural guide (sometimes also called a cultural broker or cultural navigator).

This is a bilingual/bicultural person who is from the patient's ethnic community but also knows the health care culture, who can advise the provider on choice of words, pitfalls to avoid, and non-verbal issues. It could be an interpreter, a religious or clan leader, or another health care worker.

Developing Trust

Demonstrating respect to older patients in culturally appropriate ways is crucial to establishing a trusting relationship. Specific strategies to foster development of trust include the following:

1. Ask a cultural guide or informed individual how to greet and show respect to an elder appropriately from his/her specific culture, especially in relation to shaking hands, eye contact, bowing, and touching when the patient is the opposite sex.
2. Generally, acknowledge and greet older persons first.
3. Generally, use formal term of address (Mr., Mrs.), at least initially.
4. Consider use of informal conversation prior to formal assessment. It may not be respectful to ask business-oriented questions without first acknowledging the patient in a more personal way. For example, Mexican Americans may prefer to begin a conversation with questions such as "How is your family?" or "Did you have to travel long to come here?" before they wish to respond to more formal questions such as "What brings you here today?"

These guidelines are general and may not apply to all cultural groups and individuals. Please refer to ethnic-specific modules for additional information:

www.geriatrics.stanford.edu/ethnomed

5. Avoiding the "invisible patient syndrome": Older patients need to be talked to and with, rather than talked about. Talking to someone else in the room as if the patient weren't there, or is incapable of understanding demonstrates disrespect, even if the elder does not speak the language of the provider.
6. Acknowledge the importance of culture in health care interactions and ask for the patients' help as experts in their own cultures, in order for you to understand and incorporate salient cultural components into the plans of care.

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INTERPRETER GUIDELINES

Guidelines for Selecting Interpreters

1. If practitioners do not speak the same language as the patient or the patient has limited English proficiency (LEP), then trained interpreters should be used. In the 2000 census, 38% of Hispanic/Latino elders, and 41% of Asian elders reported that they speak little or no English, and in some populations, this is true for over 80%. **See Table 1-1 in the Introduction Module:** http://geriatrics.stanford.edu/culturemed/overview/introduction/images/Table1_1.pdf

   Four of the fourteen Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) developed by the Office of Minority Health specify language-appropriate services. Title VI of the Civil Rights Act mandates interpreter services, and the Joint Commission is increasingly considering language services and CLAS standards in accreditation of health care organizations.

2. Use of family members, especially children, as interpreters is strongly discouraged because of:
   - Possible lack of appropriate language skills in one or both languages.
   - Culturally-based barriers of modesty or taboos that prevent discussion of certain topics, especially across genders and age hierarchy.
   - Fear (e.g., elder abuse) that may lead to difficulty in discussing family problems (Jackson, 1998).
   - Psychological trauma to children when they hear very disturbing news or when they realize the extreme responsibility they have for the family member's health and they feel unqualified to interpret.

3. Avoid using untrained interpreters.

RESOURCES

The Office of Minority Health has developed a **Health Care Language Services Implementation Guide**. It contains a step-by-step description and resources to help health care organizations assess their need and capability, develop, and implement services for interpretation, written materials, signage, and assistance.

To view the guide, go to:

https://hclsig.thinkculturalhealth.org/user/home.rails

4. Providers can be advocates for effective on-site interpreter services and access to telephone based interpretation services (Villarruel, Portillo & Kane 1999).

5. Always keep in mind that the interpreter is a member of the team to be treated with respect. Develop a means to establish rapport.

6. See **Interpreter Types** for advantages and disadvantages in using different types of interpreters.

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(INTERPRETER GUIDELINES CONT'D)

Basic guidelines for providers working with interpreters

1. The provider should meet with the health care team members who serve as interpreters on a regular basis to review interpreter roles and procedures, provide in-service training, and develop a collegial relationship.
2. The provider should speak in short segments and ask short questions. Interpreters will have difficulty interpreting long, involved statements without forgetting something important.
3. Avoid technical terminology, abbreviations, and professional jargon (or explain them thoroughly).
4. Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.
5. Encourage the interpreter to translate the patient's words as much as possible rather than paraphrasing or polishing with professional jargon. This approach will give a better sense of the patient's understanding and emotional state. Be aware, however, that there are no exact equivalents for some words or phrases in other languages.
6. During the interaction, look at and speak directly to the patient, not the interpreter. It is helpful to position the interpreter beside the provider.
7. Listen, even though you do not understand the language and look for nonverbal cues.
8. Be patient. Interpretation takes time when done right.
9. Have the interpreter ask the patient to repeat as accurately as possible the information the provider has communicated, to see if there are gaps in understanding (the teach back method).

Basic principles for using interpreters during health care situations

1. Professional interpreters are trained to create conceptual transfer rather than verbatim translations.
2. They make sure that concepts get across correctly in both directions of the clinical interaction.
3. Technical clinical concepts in one language are translated into acceptable social terminology that conveys the clinical meaning in the second language.
4. The interpreter knows the technical concepts, preferably in both languages, and how to express them in terms that the patient will understand.

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TYPES OF INTERPRETERS: BENEFITS & LIMITATIONS

Professional In-House Interpreters

Description: Agency employs and trains interpreters who are available for interpreting languages that are most frequently represented in the particular patient population.

BENEFITS	LIMITATIONS
Available during operating hours.	Not a feasible, cost-effective alternative for small agencies.
Consistent personnel fosters rapport and trust with clients and health care providers.	Not all languages covered.

On-Call Interpreters

Description: Agency maintains a list of interpreters of various languages who are willing to interpret as need arises. May be paid or volunteer.

BENEFITS	LIMITATIONS
Covers a broader variety of languages.	May have questionable interpretation abilities unless there is testing or accreditation of interpreters
	May be trained or untrained.
	Untrained interpreters make more errors: omissions of pertinent information, additions of information that the client did not say, substitutions of information, condensed summaries that omit details, and breaches of confidentiality (Lee, 1997; Marcos, 1979)
	Dependent upon the availability of the interpreter at the time one is needed.

PDF Download

To download an 11 x 17 poster with these guidelines, please go to:

http://geriatrics.stanford.edu/culturemed/overview/assessment/downloads/table_4_1.pdf

Bilingual Staff

Description: Health care staff (nurses) or support staff (e.g., dietary aides or security personnel) are temporarily utilized as the need arises to interpret for patients with whom they would otherwise have no contact.

BENEFITS	LIMITATIONS
Availability	Inconsistent availability
	May experience conflict of duties between the roles for which they were hired and the ad hoc interpreter duties.
	May create resentment in staff member or co-workers.
	May be unfamiliar with specialized vocabulary.
	Usually untrained.
	Untrained interpreters make more errors (see above).

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(TYPES OF INTERPRETERS CONT'D)

Family Members or Friends

Description: Family or friends who accompany the patient to the health care organization are used as interpreters

BENEFITS	LIMITATIONS
Availability	Untrained, thus likely to make errors (see Bilingual Staff). Usually unfamiliar with specialized vocabulary. May interfere with family dynamics, confidentiality, or revelation of sensitive information.  Use of children for interpretation is never appropriate except in emergency situations until other alternatives can be arranged.

Telephone and Video-Based Interpreter Services

Description: Commercial companies or local agencies provide off-site interpreting services via phone or video connections either with the patient and provider together or at different locations. Phones with two handsets are available for examination rooms. Multiple companies provide the service. Posted rates range from approximately $2.00 to $4.00 per minute for phone based interpreting, and some companies charge other fees. **Examples of companies include:**

- Language Line Services (formerly AT&T) www.languageline.com
- 1-800 Translate www.1-800-translate.com
- Phone Interpreters www.phoneinterpreters.net

BENEFITS	LIMITATIONS
Cover up to 170 languages. Available 24 hours/day, 7 days/week. Many interpreters are native speakers with training in interpretation and health care terminology. Rapid access. Some companies use interpreters who have been tested for competency.	Examination rooms need to have phones, preferably with two handsets or a speakerphone for easiest use. Otherwise, patient and provider need to hand the handset back and forth. Most agencies require prior arrangement to establish an account. Interpreters may or may not be trained in mental health applications. Video applications have been found to be highly effective, but the equipment and arrangements tend to be expensive.

TRANSLATING WRITTEN MATERIALS

LEP elders who are literate in other languages need to be provided important written information in their own language, such as patient education materials and consent forms.

Many health education materials have been translated to other languages and are available on websites for professional advocacy organizations for specific diagnoses (e.g. Alzheimer's Association).

Translation Toolkit

A toolkit for translating health materials is available at www.hablamosjuntos.org.

HEALTH LITERACY

Definition: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (IoM, 2004).

People with Low Health Literacy (Schwartzberg, et al. 2004)—

- Use screening/preventive services less
- Present for care with later stages of disease
- Are more likely to be hospitalized
- Have poorer understanding of treatment and their own health
- Adhere less to medical regimens
- Have increased health care costs
- Die earlier

Education

While there is a wide range of health literacy in the general U.S. population, over half of elders from Mexican backgrounds and over 30% from all the Asian subpopulations except Japanese and Filipinos have less than a ninth grade education, (many times in schools in their countries of origin) which puts them at special risk for low health literacy in the U.S. health care system.

Suggestions for communicating with elders with low health literacy (Hikoyeda, 2008)

- Entire staff must be involved in lowering health literacy barriers
- Be supportive and sensitive
- Speak to and treat an individual, not "another patient"
- Speak slowly and start with context
- Use a quiet room with minimal distractions
- Use everyday language
- Avoid technical terms
- Be concrete and use the active voice
- Start with the most important information first and limit new information
- Give no more than one or two instructions at a time—and check on each as you go, using the "teach back" method (having the patient repeat the information)
- Be creative (e.g., tape pills to card; color code medications; or draw a sun to indicate taking them in the morning)
- Phone reminders can make a real difference

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NON-VERBAL COMMUNICATION

1. Pace of Conversation

Some cultures (e.g. some American Indian) are comfortable with long periods of silence while others are fast-paced. Some consider it appropriate to speak before the other person has finished talking, which would be very disrespectful in other cultures.

2. Physical Distance

Provide patients with a choice about physical proximity by asking them to sit wherever they like. Individuals from some cultures tend to prefer to be about an arm's length away from another person while those from some others cultures tend to prefer closer proximity or greater distance.

3. Eye Contact

While European Americans typically encourage members to look people in the eye when speaking to them, some others may consider this disrespectful or impolite (e.g., some Asian and Native American groups). Some Muslim groups may consider eye contact inappropriate between men and women. Observe the patient when talking and listening to get clues regarding appropriate eye contact.

4. Emotional Expressiveness

Some cultures value stoicism (e. g. British), while others encourage open expressions of feelings, such as sorrow, pain, or joy. Elders from some backgrounds may laugh or smile to mask negative or other emotions (e.g. Japanese, Filipino).

RESOURCES

Examples given in this section can be found in:

- **The Doorway Thoughts** Series developed by the Ethnogeriatrics Committee of the American Geriatrics Society (Adler & Kamel, 2002; Adler et al, 2004; Brangman et al., 2006),
- **Culture and Nursing Care** (Lipson et al., 1996)
- **Ethnic Specific Modules of the Curriculum in Ethnogeriatrics** (Yeo, 2002):
  www.geriatrics.stanford.edu/ethnomed

5. Body Movements

Bodily gestures can be easily misinterpreted based on what is considered culturally appropriate. Individuals from some cultures may consider some types of finger pointing or other typical American hand gestures or body postures disrespectful or obscene (e.g. Filipino, Chinese, Iranian), while others may consider vigorous hand shaking as a sign of aggression (e.g. some American Indian) or a gesture of good will (e.g. European). When in doubt, ask an interpreter or other cultural guide.

6. Touch

While physical touch is an important form of non-verbal communication, the etiquette of touch is highly variable across and within cultures. Practitioners should be thoroughly briefed about what kind of touch is appropriate for cultures with which they work (e.g., especially in cross-gender interactions, many Muslim women are not comfortable shaking hands).

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ISSUES IN USE OF STANDARDIZED ASSESSMENT INSTRUMENTS

Appropriateness of English Version

Educational Level

Results of the test may be influenced by variables other than culture, such as educational background or socioeconomic status. For example, high false-negative rates of cognitive impairment have been reported among highly educated subjects, whereas high false-positive rates of cognitive impairment have been reported among less educated clients.

Established Population Norms

Norms for validated measures are usually available only for the largest of the specific language groups

Importance of using versions adapted for subgroup of language category (e.g., Puerto Rican, as opposed to generic Spanish)

Appropriateness of Format

Level of Difficulty

A response format (e.g. true false/multiple choice, Likert, semantic differential, or visual analogue may be more difficult for elders not familiar with that type of format) vs. a simpler yes/no format.

Verbal Expression of Feelings

Some elders or family members (especially those from Asian backgrounds) may be more reluctant to express their feelings in interviews than written self-report, and/or may tend be more likely to respond in accordance to social desirability rather than their true feelings/attitudes in interviews compared to self-report format.

PDF DOWNLOAD

For a list of translated standardized instruments, download Table 4-2:

http://geriatrics.stanford.edu/culturemed/overview/assessment/downloads/table_4_2.pdf

Font Size

Some recommendations are 16 point font with capitals for older adults:

16 POINT FONT WITH CAPITALS

Reading Level

Translated Instruments

Adequacy of translated version depends on the following domains:

Content Equivalence: to ensure the content in each item in the instrument has consistent cultural relevance.

Semantic Equivalence: to ensure the meaning of each item remains conceptually and idiomatically the same.

Technical Equivalence: to ensure that the methods of assessment (interviews, observation, self-report) elicit comparable data.

Criterion Equivalence: to establish the normative interpretation of the variable.

Conceptual Equivalence: to ensure the same theoretical construct is being measured in each culture.

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(ISSUES CONT'D)

Culturally and Linguistically Appropriate Measures

Cognitive Screening and Dementia Assessment

The Cognitive Assessment Screening Instrument (CASI) (Teng, et al, 1994) was specifically designed for easy cross-cultural adaptation and has been adapted and validated in the following populations: English-speaking North Americans, English-speaking Chamorros in Guam, Chinese elders in Kimmen and Taiwan, and Japanese elders in Seattle, Honolulu and Japan. It is continually being adapted and used with other populations. The CASI-short (Teng et al.,1998) consists of four items and is particularly good for screening elders with very low levels of education (Dick et al, 2006).

For more comprehensive cognitive evaluation, the **Cross-Cultural Neuropsychological Test Battery (CCNB)** (Dick et al., 2002) includes the CASI and 10 additional tests to assess six cognitive domains. It has been used successfully with African American, Caucasian, Chinese, Hispanic, and Vietnamese elders (Dick et al., 2006).

The Spanish and English Neuropsychological Assessment Scales (SENAS) (Mungas et al., 2005) was developed with the goal of creating psychometrically matched English and Spanish language neuropsychological measures of cognitive abilities. The scales assess seven domains and include both verbal and nonverbal domains (Mungas, 2006).

For discussion of assessment of cognition and dementia in American Indian and African American elders, see Hargrave, 2006 and Jervis, Cullum, & Manson, 2006.

Measures of Depression

The Geriatric Depression Scale (GDS) has been translated into at least 30 languages, many with multiple versions.

Ada Mui developed a revised version of the GDS short form in Chinese, that was found to have greater internal consistency among Chinese American elders than the original GDS shortform (Mui, 1996). She and colleagues subsequently used it successfully also with Filipino, Asian Indian, Japanese, Korean, and Vietnamese elders in New York.

For an excellent review of validation studies of the GDS with diverse populations as well as a description of validation of the Mui GDS short form in multiple languages see Mui et al, 2003.

ETHNOGERIATRIC ASSESSMENT

Background/Contextual Topics

1. Ethnicity
2. Level of Acculturation
    a. Placing older patients on the continuum of acculturation can help providers avoid mistaken assumptions about expected differences or similarities from mainstream elders.
    b. Informal indicators of acculturation that can be used quickly
        i. Length of time older patients or their ancestors have been in the U.S.
        ii. Language used at home, fluency in spoken and written English
        iii. Degree of ethnic affiliation, as reflected in ethnic community participation and use of ethnic media
3. Religion
4. Patterns of Decision-Making (e.g., individual vs. collective)
5. Preferred Interaction Patterns
    a. Language
    b. Direct/indirect communication
    c. Formal vs. informal
    d. Other (see communication section)

The PCC Comprehensive Elder Exam (also available in PCC+) provides a guide to comprehensive geriatric assessment for the individual provider.

To learn more, go to:

http://geriatrics.stanford.edu/culturemed/overview/assessment/assessment_toolkit/pcc_exam/index.html

Clinical Assessment Domains

Domains may vary by practice profession, and not all will be used by every provider.

Health and Social History

(See comments on communication and written measures above)

1. Review historical cohort experiences of elder's population prior to assessment and refer to those experiences in taking the social history (see discussion of cohort analysis in the Fund of Knowledge module).
2. Issues of elder abuse may be particularly difficult to assess in elders from cultural backgrounds in which there are varying definitions of elder abuse or in which family image may be more important that individual health (Tatara, 1999). Indications may emerge anywhere throughout the assessment. Particularly consider when there are:
    a. physical signs (bruises, burns, etc.) and/or
    b. behavioral symptoms (e.g. depression)

Physical Examination

1. Physical examinations by someone of the opposite sex are unacceptable in many cultures.
2. Ask for preference of presence of other family members during physical exam.
3. Throughout the assessment, inform elder of procedures and ask for permission to examine different areas of the body.
4. Preferred amount and type of information communicated to the elders and their family during and after the physical exam varies cross-culturally (Adler, et al, 2004; Adler & Kamel, 2002) (e.g., some Chinese elders prefer that information be given to their son or other family member, and that they be the decision makers about the elders' care, especially in relation to serious illness.) The elders should be

(ETHNOGERIATRIC ASSESSMENT CONT'D)

asked how much information they would like and whom they prefer to have the information.

5. Symptom recognition, meaning, and report is expressed differently by elders of different cultures [e.g. "air heavy" or "air not right" may mean dyspnea for some American Indian elders; "heavy heart" may indicate depression among Chinese].

Cognitive and Affective Status

Dementia and depression are considered to be mental illness in some cultures and are often highly stigmatized. In other cultures, dementia is seen as a normal part of aging and is defined as a minimal problem. (See comments on assessment instruments above.)

Functional Status

The concepts of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) will likely be foreign to many elders from other cultures. In some cases, independence of elders is not highly-valued, so that dependency is expected and assumed. Questions can be translated, if needed, and administered orally or in writing if literacy and reading levels are adequate. Drawings, illustrations, and other culturally appropriate symbols may also be used. Also see comments on translations.

Home Assessment

1. **Living patterns:** Who lives in the home, relationship to elder, and length of time in the home
2. Support from those people who live with the elder
3. Safety, comfort, and convenience of the home to elders' health status
4. Economic stability and adequacy

Family Assessment

1. Composition and structure
2. Kinship patterns and social support: expectations of and for family members (e.g. for elder care) Stereotypes that ethnic families "take care of their own" can be very misleading since some elders from ethnic backgrounds are not part of strong family networks and are vulnerable to loneliness and isolation.
3. Decision-making: In many cultures, there is no assumption of patient autonomy in decision-making as there is the U.S. ethical paradigm, and the family is assumed to be the decision-maker about health care.
4. Spokesperson, if any, for the family
5. Gender sex-role allocation
6. Family connectedness. Culture influences whether the elder and family are more individualistic or collectivistic (allocentric).
7. Community and Neighborhood Assessment
8. Overall features of the community and neighborhood: e.g. involvement of ethnic elders in the community
9. Population characteristics: e.g. ethnic community, length of time in community, proportion of elders, children, and adults in population, intergenerational relations, status of elders.
10. Environmental and safety conditions: (e.g. topography, sidewalks, pavement, air and water quality, crime rate.)
11. Services available and used by elders and their families: e.g. allopathic, folk and alternative health practitioners, social services, religious, shopping (such as food, clothing, banking), educational, transportation, recreational and elder services (such as senior center).
12. Support from neighborhood and community members

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(ETHNOGERIATRIC ASSESSMENT CONT'D)

End-of-Life Preferences (when appropriate)

Since talking about death is considered inappropriate in some cultures (e.g., Chinese, Navajo) the issue should be approached carefully and sensitively, and only in the context of an established trusting relationship. A possible introduction after several visits might be, "In case something happens to you and you are not able to make decisions about your care, we need to know what your preferences are."

1. Availability of advance directives
2. Preference for hospital or home end of life care
3. Death rituals for care of the body and mourning behaviors during and after death
4. Attitudes about organ donation and autopsy

Problem-Specific Data: Elicit Explanatory Models of Illness from Patient and Relevant Family Members

1. The use of explanatory models has been demonstrated to be effective in improving patient-provider communication and showing respect for the patient's point of view. Ultimately, it is argued, its use will increase patients' trust of providers, appropriate clinical management, and likelihood of elder's agreement with and adherence to provider's recommendations.
2. The objective is to elicit the older patient's view of his illness experience, its causes, potential consequences, and possible treatments.
3. To elicit the patient's explanatory model of illness, questions such as the following can be used (Kleinman, Eisenberg, Good, 1978; Harwood, 1981).
    - What do you think caused your problem?
    - Why do you think it started when it did?
    - What do you think your sickness does to your body? How does it work?
    - How severe is your sickness?
    - How long do you think it will last?
    - What are the main problems your sickness has caused you?
    - Do you know others who have had this problem? What did they do to treat it?
    - Do you think there is any way to prevent this problem in the future? How?

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(ETHNOGERIATRIC ASSESSMENT CONT'D)

Intervention-Specific Data (Tripp-Reimer, Brink, and Saunders, 1984)

1. What are you and/or your family doing for this problem? What kinds of medicines, home remedies, or other treatments have you tried for this sickness? Have they helped?
2. What type of treatment do you think you should receive from me?
3. Elicit culturally-specific content as needed for specific interventions. For example, if dietary recommendations are being made, elicit data about food preferences and practices; if discharge planning is needed, elicit information regarding family care patterns, resources, and residential preferences
4. Is there any other information that might help us design a treatment plan?
5. How should family be involved: family structure, roles, dynamics, lifestyle and living arrangements need to be identified. How should family members treat one who has this condition/problem?
6. Does anyone else need to be consulted?

Outcomes-Specific Data: Negotiating Therapeutic Outcome Criteria with Older Adults/Family Members

1. What are individual/family expectations for quality care?
2. What are the most important results you hope to receive from this treatment?
3. What is the best outcome from a family/individual perspective?
4. What is the worst outcome from a family/individual perspective?

INSTRUCTIONAL STRATEGIES

The following are possible methods of instruction for this module:

A. Reading Assignments

B. Didactic Lectures

C. Discussions

D. Modeling through Video Training

E. Case Studies

F. Experiential Projects

1. Assignment to have students use telephone interpreter service with bi-lingual simulated patient.
2. Assignment to practice taking social histories using cohort analyses or eliciting explanatory models, with one student as the interviewer and another role playing an elder with a specific history or set of health beliefs
3. Assignment to have students interviewed in a different language.
4. Assignment to have students conduct an assessment using an interpreter followed up by discussion of the benefits, difficulties, and strategies to promote communication.

G. Group Projects

Students create a cultural competence training manual focusing on use of culturally appropriate assessment tools for older patients from one or more cultural backgrounds.

H. Geriatric Assessments

Conduct geriatric assessments with culturally diverse older adults and elicit feedback from the elder and family members.

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EVALUATION STRATEGIES

1. Structured objective tests
2. Essay tests
3. Presentations from group projects:
4. Demonstrate effective interview techniques (by video or observation) with simulated patient/family
5. Videotaped Ethnogeriatric Assessment with ethnic elder
6. Evaluation of the learner's progress can be based on the chart on pag 20 relating strategies to learning objectives.

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(EVALUATION STRATEGIES CONT'D)

Evaluation Strategies for Specific Learning Objectives

Learning Objectives	Suggested Evaluation Strategies
Conduct culturally appropriate assessments that are respectful of individuals and families.	Demonstrate effective interview techniques (by video or observation) with simulated patient/family. Videotaped ethnogeriatric assessment of ethnic elder. **Presentation from Project G** **Projects F2 & F4**
Describe strategies for development of culturally appropriate verbal and non-verbal communication skills.	Demonstrate effective interview techniques (by video or observation) with simulated patient/family. Videotaped ethnogeriatric assessment of ethnic elder. **Presentation from Project G** **Projects F2 & F4**
Identify benefits and weaknesses of using different types of interpreters.	Demonstrate effective interview techniques (by video or observation) with simulated patient/family. Videotaped ethnogeriatric assessment of ethnic elder. **Presentation from Project G** **Projects F1 F3 & F4**
Describe the model of cohort analysis as a way to understand the historical experiences of various cohorts of elders from diverse ethnic backgrounds.	Structured objective tests, Essay tests **Presentation from Project G** **Project F4**
Understand the process and use of translation/back-translation to achieve better conceptual equivalence of materials and assessment tools.	Structured objective tests, Essay tests **Presentation from Project G** **Projects F1 & F3**
Conduct an ethnogeriatric health assessment including elicitation of: • Background/contextual data, • Clinical geriatric assessment domains, • Problem-specific information (including explanatory model), • Intervention-specific data, and • Outcomes criteria.	Demonstrate effective interview techniques (by video or observation) with simulated patient/family. Videotaped ethnogeriatric assessment of ethnic elder. **Presentation from Project G** **Projects F2 & F4**
List the major components of geriatric assessment and related cultural issues.	Structured objective tests, Essay tests

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