



Delivery of Care

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



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IN THE DIVISION OF GENERAL INTERNAL MEDICINE
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Yeo, G, PhD: Ethnogeriatrics Overview, Delivery of Care http://geriatrics.stanford.edu/culturemed/overview/delivery_of_care/. In Periyakoil VS, eds. eCampus Geriatrics, Stanford CA, 2010.

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
- caregiving
- long-term care
- surgery
- working with families

Disparities and patterns of utilization of health care services by elders from different ethnic populations and barriers to that utilization are also presented.

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

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This edition is based on a version developed by Nina Tumosa, PhD, Levanne Hendrix, MSN, PhD, Andrea Sherman, PhD, and Steve Wallace, 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. Describe major priorities in health promotion and disease prevention for ethnic elders.
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

INTERVENTIONS: ETHNIC ISSUES

Health Promotion/Disease Prevention for Ethnic Elders

Providers should be particularly aware of needs for health promotion/disease prevention strategies for those populations where there are disparities in health status that could be reduced through attention to immunizations and health education and counseling. Some of the more salient examples of the need for health promotion strategies to reduce disparities are discussed below.

Pneumococcal Vaccine

In 2005, the proportion of adults age 65 and over who had ever received a pneumonia vaccine was significantly lower for Blacks (40.4%) than for Whites (58.4%). It was also significantly lower for Asians and Hispanics than for non-Hispanic Whites, and the gaps for those populations had increased during the prior five years. (AHRQ, 2008).

Influenza Vaccine

In 2002, the percentage of elderly Medicare beneficiaries with influenza vaccination in the past year was significantly lower among Blacks compared with Whites; among Hispanics compared with non-Hispanic Whites; and among poor, near poor, and middle income beneficiaries compared with high income beneficiaries (AHRQ, 2007).

Mammograms

In 2005, the rate of screening for breast cancer among women aged 40 and over was significantly lower for American Indian, Asian and Hispanic women than for non-Hispanic White women (AHRQ, 2008).

Pap Tests

Vietnamese women have been found to have higher rates of cervical cancer than non-Hispanic white women and other Asian women and lower rates of Pap screening (Gomez et al, 2005; Wang et al., 2008).



See Table 2-4 for populations in which elders are at higher risks for particular diseases:

http://geriatrics.stanford.edu/culturemed/overview/health_risk_patterns/morbidity.html#table2-4

Screening for Prostate Cancer

Older African American men have the highest prevalence of prostate cancer in the U.S., and present at later stages, so screening is crucial (Williams & Powell, 2009).

Diabetes Prevention

In view of the much higher prevalence of diabetes among African Americans, Hispanic/Latinos, and several of the Asian subpopulations (See Table 2-4), glucose screening, health education and counseling for those at increased risk are very important.

Cardiovascular and Cardiac Disease Prevention

Blood pressure screening, cholesterol screening for dyslipidemia, and health education on diet, exercise, and appropriate weight are very important, especially for older African Americans who are at increased risk for stroke and heart disease (Hummer et al., 2004)

Treatment Issues and Responses

Informed Consent

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.

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.

Advance Care Planning

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?

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.

Medication Issues

Culturally based differences in attitudes toward medication that can influence adherence:

1. Belief that prescription drugs are too strong, leading to taking less than the amount prescribed (e.g. some Chinese and Southeast Asian elders) (Pham, Rosenthal & Diamond, 1999).
2. Belief that medications administered by injection are the most effective ones, leading to expectation that if the provider is competent, a shot will be given (e.g., some Cambodian and Vietnamese elders) (Roundtable Summaries in Llorens, 1988).
3. Cultural values relating to effectiveness of specific medications (e.g. belief that Chinese herbs are more effective than Western medicines for hypertension by some Chinese elders) (Li et al., 2007).

Physiological effects of the medications

Differences in response to some medications:

Lin, Poland, & Nakasaki, (1993), found smaller doses of tricyclic antidepressants, benzodiazepines, and haloperidol than usual in the U.S. were effective in some Asian patients, which they attributed to slower metabolism. Thiazide diuretics and calcium channel

blockers were found in earlier studies to be more effective than beta blockers in treating hypertension in some African Americans (Francis, 1990, Moser 1990). In 2005, there was great controversy when BiDil, a combination drug, was the first pharmaceutical to be approved for a single race, in this case for Black/African Americans for the treatment of congestive heart failure (Brody & Hunt, 2006).

Effect of combining pharmaceuticals with culturally based herbal medications: It is common for elders from cultures with strong traditions of herbal medication use to take Western based prescription and/or over the counter medications at the same that time they are taking herbal medication.

Social and Economic Issues:

1. Financial inability to buy medication.
2. Practice of importing medications from other countries.

Techniques to minimize misunderstanding

1. Discuss patient's and provider's explanatory models for condition being treated. **See Assessment:** <http://geriatrics.stanford.edu/culturemed/overview/assessment/>
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. Assess attitudes to taking prescribed amount while being careful not to give the impression of provider incompetence.
6. Careful follow-up with elders about ability to take prescribed amount and response to medication.

Issues in Dementia and Caregiving

For information on ethnic specific assessment of dementia and information on working with families from specific cultural backgrounds, see Yeo and Gallagher-Thompson (Eds.), 2006.

Paid caregivers are frequently from different cultural backgrounds than the care recipient, which raises the possibility of problems in: communication, diet, and cultural gender taboos concerning body touching.

Providers who work with family caregivers from populations other than non-Hispanic white need to be aware of the following issues (Gallagher-Thompson, in Yeo & Gallagher-Thompson, 2006):

1. Dementia may be defined as part of the normal aging process.
2. Cultural expectations that care for elders be provided by family members (e.g., filial piety) rather than formal services are common in many cultures.
3. There may be many family members who are involved in decision making for elders with dementia; they may be extended family members and/or live in another country; there may be differences between those who are less and more acculturated, so patience is needed with the process.
4. Family members may be reluctant to admit distress related to caregiving.

The Continuum of Long-Term Care for Chronically Ill Elders

Home Care

1. May be the preference for families from many ethnic backgrounds.
2. Cultural expectations for family care may put extreme stress on family members.

Day care, residential/assisted living, and nursing home care concerns (Barresi & Stull, 1993; Kayser-Jones, 1996)

1. Ethnically-appropriate food important for health and healing.
2. Symbolism such as images, color, clothing, décor, numbering, and furniture arrangement can be a source of comfort or discomfort (e.g. room numbers with “4” in them are considered unlucky by some Chinese families).
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.

Surgery

Intercultural concerns that need to be explored in pre-surgical assessment (Gerdner, et al., 2008; Llorens, 1988; personal communication to G. Yeo, 1993) :

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.

Coordinating Biomedical and Traditional Therapies

Ideally, clinicians should attempt to include, or at least seek input from, 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.

Need to recognize, discuss, accept, and respect differences in goals between biomedical and traditional ethnic providers.

Working with Culturally Diverse Elders and Family Members

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 should:

- be preserved by all means despite decreased quality.
- allow time for a "miracle"
- 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).

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:
 - to assist the health care team.
 - to advise on cultural communication patterns (e.g., meaning of eye contact/body language).
 - Familiarize multidisciplinary health care team with cultural explanatory models of elder's condition(s).

HEALTH CARE DISPARITIES

The Agency for Healthcare Research and Quality (AHRQ) tracks disparities in some core measures and reports annually in their Disparities Report (AHRQ, 2003, 2007). The following summary of disparities among elders from minority categories as compared to Non-Hispanic Whites is based on those and other reported sources of disparities in health services for older adults or Medicare patients (Epstein, et al. 2003; Groeneveld, 2003; Schneider et al, 2001; Schneider et al., 2002; Smedley et al., 2003).

African Americans/Blacks compared to Non-Hispanic Whites

Preventive Services

Lower rates of pneumococcal and influenza vaccinations

Acute Illness Treatment

- Lower rates of a wide variety of treatments for cardiac problems and stroke
- Lower rates of antibiotics treatments for pneumonia patients
- Lower rates of recommended treatments (breast conserving surgery plus radiation) instead of mastectomy for local breast cancer
- Lower rates of recommended hospital care for patients with pneumonia
- Hospitalized patients were more likely to have adverse drug events associated with insulin or oral hypoglycemics
- Higher rates of postoperative complications

Chronic Disease Management

- Three times higher rates for lower extremity amputations in patients with diabetes
- Lower rate of eye examinations for patients with diabetes
- Less follow-up after hospitalization for mental illness

- Higher proportion of long stay high risk nursing home residents with pressure sores
- Higher proportion of home health patients who had to be admitted to hospital
- Hospice patients whose families reported that they did not receive end of life care consistent with their wishes was almost two times higher
- Higher percentage of hospice patients whose family reported they did not receive the right amount of medicine for pain

Asians compared to Non-Hispanic Whites

National level data is not available for Asian subgroups, and Pacific Islander populations were included with Asians in earlier data sets (API) but are too small to be covered independently in most of the latest data sets.

Preventive Services

- Lower rates of pneumococcal vaccinations
- Lower rates of mammograms

Acute Illness Treatment

- Less appropriate timing of antibiotics received by patients having surgery
- Lower rates of recommended hospital care for patients with pneumonia

Chronic Disease Management

- Higher rates of being physically restrained among nursing home patients
- Hospice patients whose families reported that they did not receive end of life care consistent with their wishes was more than three times higher
- Higher percentage of hospice patients whose family reported they did not receive the right amount of medicine for pain

American Indians/Alaska Natives compared to Non-Hispanic Whites

Preventive Services

- Lower rates of mammograms

Acute Illness Treatment

- Lower proportion of tuberculosis patients who complete a curative course of treatment

Chronic Disease Management

- Lower proportion of patients with heart failure who received the recommended hospital care
- Higher proportion of long-stay high-risk nursing home residents with pressure sores
- Higher proportion of home health patients who had to be admitted to hospital
- Hospice patients whose families who reported that they did not receive end of life care consistent with their wishes was more than two times higher
- Higher percentage of hospice patients whose family reported they did not receive the right amount of medicine for pain

Hispanics compared to Non-Hispanic Whites

Preventive Services

- Rates of pneumococcal vaccination half that of NHWs
- Lower rates of mammograms

Acute Illness Treatment

- Lower rates of recommended hospital care for patients with pneumonia

Chronic Disease Management

- More lower extremity amputations in patients with diabetes
- Lower proportion of patients with heart failure who received the recommended hospital care
- Higher proportion of home health patients who had to be admitted to hospital
- Higher rates of being physically restrained among nursing home patients
- Higher proportion of long-stay high-risk nursing home residents with pressure sores
- Hospice patients whose families reported that they did not receive end of life care consistent with their wishes was more than two times higher
- Higher percentage of hospice patients whose family reported they did not receive the right amount of medicine for pain

HEALTH CARE UTILIZATION

Utilization Patterns

In general most ethnic minority populations use formal health care services for mental health and long term care less than their white counterparts. Since 2000, however, rates of nursing home utilizations by African Americans have been slightly higher than those of Whites.

Emergency rooms and acute care tend to have higher utilization.

Barriers to Utilization (Damron-Rodriguez et al., 1994)

Availability

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

Accessibility

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 Assessment: <http://geriatrics.stanford.edu/culturemed/overview/assessment/>
7. Transportation difficulties

ADEQUATE UTILIZATION

To assure adequate utilization, providers should:

- Understand key aspects of culture and its relation to behavior of clients
- Educate clients about options available, whether used or not
- Help elder determine most cost effective means to obtain needed services (e.g., prescription medicine, medical equipment or supplies)

Financial and eligibility constraints:

1. Limited income
2. Lack of eligibility for service
3. Co-payments or small charges can discourage the poor

Discrimination

1. Discourages use of services

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

Acceptability

1. Based on patients' satisfaction and having their expectations met
2. **Aspect of care most affected by culture**
3. Interaction between patient expectations and provider performance
4. Most are amenable to change by individual providers

5. Depends upon trust between provider and patient
6. Changes in providers reduce acceptability
7. Managed care can limit degree of acceptability
8. Perception of “welfare” decreases acceptability for some
9. Care of other family member may have priority over accessing care

UNITED STATES HEALTH CARE POLICY

Medicare

For elders eligible for social security the federal Medicare system funds most hospital care, much of the outpatient care, and very little long term care. 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.

Medicaid

A combination federal and state program, Medicaid varies from state to state, but funds health care, including nursing home care for low income seniors. Legislation passed in the 1990’s increased the difficulty in accessing Medicaid by older non-citizen immigrants.

SUCCESSFUL SERVICE MODELS

(See Yeo, 2008 for examples)

Use of indigenous networks for education and outreach

- Churches, temples, places of worship
- Lay leaders
- Beauty salons, barber shops, other gathering places
- Use of ethnic community resources for education and outreach

Community Centers

- Health Fairs
- Promotores/community health workers (non professional community based health advocates)
- Parish Nurses

Published “Best Practice Models”

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 Patterns of Health Risk) that make one type of preventive strategy more or less appropriate for specific populations.

A. Case Histories

Case histories abound in the ethnic literature on the special needs of specific populations. These cases can be used in lectures and as bases for discussion 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.

SAMPLES OF CASE HISTORIES

- **The Doorway Thoughts** series from Ethnogeriatric Committee of American Geriatrics Society (Adler & Kamel, 2002, Adler et al., 2004, and Brangman et al., 2006)
- **Case of Mr. M** from the Ethno Med Latino/Hispanic Module:



http://geriatrics.stanford.edu/ethnomed/latino/instructional_strategies/case_studies/index.html

B. Interviews

Students should have access to family members of older patients with special health problems that they can explore further through interviews (See Interview Strategies). 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

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 STRATEGIES

Evaluation of student understanding of culturally appropriate health care is best accomplished via essay questions or written reports. 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	
Learning Objectives	Suggested Evaluation Strategies
Describe three major strategies used in health promotion and disease prevention for ethnic elders and the process of setting priorities for developing effective prevention.	Essay question Individual or group assignment to develop health promotion/disease prevention program for specific group of elders
Identify cultural or biological factors that might affect medication or surgical interventions with elders from diverse backgrounds.	Essay question Project B
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).	Role play cases of teams with and without alternative providers and family members Project A
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.	Essay question Projects A, B & C
Understand the process and use of translation/back-translation to achieve better conceptual equivalence of materials and assessment tools.	Essay question Paper from Project B Projects F1 & F3
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.	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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LINKS



Agency for Healthcare Research and Quality
<http://www.ahrq.gov>

Healthy People 2010
<http://www.health.gov/healthypeople/>

Office of Minority Health Resource Center
<http://www.omhrc.gov>

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