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Organizational Strategies for Addressing Disparities Among Marginalized Older Adults

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ORGANIZATIONAL STRATEGIES FOR ADDRESSING DISPARITIES

AMONG MARGINALIZED OLDER ADULTS

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Abstract

As the United States older adult population expands, it is also becoming more
diverse in terms of race, ethnicity, and sexual orientation (U.S. Census Bureau, 2010).
This increased diversity necessitates that social workers research issues of cultural
competency at the organizational level to ensure that community based organizations are
able to meet the unique needs of a heterogeneous population of American elders. This
qualitative study utilized a modified grounded theory approach to conduct individual
interviews and focus groups with over 25 community based organizations serving diverse
elders. This study also included analysis of over 100 agency documents, such as mission
statements and annual reports. The primary research question was "what are the
strategies that key informants within community based organizations attempting to
alleviate disparities use to meet the needs of marginalized older adults?" In alignment
with the Life Course Theory (Elder, 1975) and the Social Determinants of Health
Framework (Marmot, 2006), this research demonstrates that the accumulated
disadvantages often experienced by marginalized elders may also be present at the
organizational level. Agencies that serve marginalized elders face more barriers in
meeting the reporting requirements of funders, demonstrating the use of evidence based
practice, and having enough resources and organizational capacity to successfully
provide for the diverse needs of elders. Study participants also identified over thirty
concrete organizational strategies that they perceived could lead to better services for

diverse elderly clients. In terms of practice implications, this study demonstrates that non-profit, community based agencies serving diverse older adults need to be further supported in their efforts to collaborate, share resources and otherwise increase their organizational capacity. At the policy level, federal programs may need to expand to further promote the networking and collaborative efforts of smaller, community based agencies that may already be culturally aware of the needs of their own communities but lack adequate resources and capacity. Future studies could determine the best methods to implement the organizational strategies identified in this study, identify implementation barriers and supports, and research the specific needs of each unique elder group.

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Chapter One: Introduction

Purpose

The purpose of this paper is to present the results of a qualitative research study, with the aim to identify and analyze strategies that key informants, within community based organizations, use to alleviate disparities and meet the needs of marginalized older adults. This section of the paper will include information about the changing demographics of older Americans and a discussion of the disparities and needs among certain racial, ethnic and sexual orientation sub-populations of older adults.

Older American Population Increasing in Size and Diversity

The older population within the United States is expanding both in size and diversity. It is expected that there will be nearly 79 million older adults by the year 2040, including over 14 million individuals over the age of 85 (U.S. Administration on Aging, 2012a). As the population of adults expands, it is also expected to become more diverse (U.S. Census Bureau, 2010).

Older adults who belong to marginalized racial and ethnic groups are projected to increase from nearly six million (16% of the elderly population in 2000) to over 20 million (approximately 28% of the elderly population) by 2030 (U.S. Administration on Aging, 2012a). Sub-populations of diverse elders are also growing in size.

As of 2000, there were 2 million older Latino individuals living in the United States, with 3 million reported in the year 2010 (Cummings et al., 2011). This number is expected to reach 4 million by 2015 (Cummings et al., 2011). This is a 200% increase, in contrast to a 65% increase in the White senior population during the same time period (Cummings et al., 2011). The Asian American elderly community increased 52% between 2000 and 2007, from approximately 800,000 to 1.2 million individual; this trend is expected to continue as the overall population of all older Americans increases (Asian American Federation Census Information Center, 2007). At the present time, there are approximately 450,000 individual age 65 and older who identify as American Indian or Alaskan Native (Boccuti, Swoope, & Artiga, 2014). This population is expected to double by the year 2060 (Boccuti et al., 2014). The African American older adult population is expected to grow by over 104%, to nearly 10 million by 2050 (U.S. Administration on Aging, 2012a). This "diversity explosion" has great implications for gerontological social work practice as the nation shifts towards one in which no one racial or ethnic group may be in the majority (Frey, 2015).

In terms of sexual orientation, in 2010, there were between 1.4 and 3.8 million older adults identifying as lesbian, gay, bisexual or transgender, with that number expected to grow to between 3.6 and 7.2 million by the year 2030 (National Gay and Lesbian Task Force, 2010). As the United States becomes more diverse in terms of sexual orientation, social workers may need to modify current programs and services to best meet the needs of this specialized community.

As the U.S. older adult population grows in both size and diversity, it becomes even more important that social workers take demographic changes in race, ethnicity and sexual orientation into account as plans are made for the future.

Health Disparities and Community Needs

There is an extensive body of literature regarding health disparities. This introduction will not cover this area of the literature in depth but will provide a summary of its relevant findings and why health disparities are a problem relevant to the field of social work.

Definitions.

Disparities include any outcome that is seen to a greater or lesser extent between individuals differing by age, disability status, race, ethnicity, sexual orientation, income level or other relevant characteristic (U.S. Department of Health and Human Services, 2010). Within the United States, among older adults over age 65, disparities include issues of both mental and physical health status, income level, poverty and incidents of discrimination based on race, ethnicity and sexual orientation.

Within the United States, health care disparities are of particular concern, as they relate to the management of chronic disease. Disparities in health care are defined as,

> …a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage.... (Certain populations) are less likely to get the preventive care they need to stay healthy, more likely to suffer serious illnesses such as diabetes or heart disease, and when they do get sick, are less likely to have access to quality care (National Partnership for Action to End Health Disparities, 2011).

Cross cultural comparisons of health disparities

Many cross-cultural comparisons of disparities find that there are significant

health disparities between persons of color and White individuals. African American and

Latino individuals receive significantly poorer health care when compared to their White

counterparts, on approximately 40% of health care measures researched by the 2012

National Healthcare Disparities Report (U.S. Department of Health and Human Services,

2013). This includes a wide variety of different kinds of health disparities, including

effectiveness of care, patient safety, and access to health care, when compared to their

White counterparts (U.S. Department of Health and Human Services, 2013).   For most

non-White racial and ethnic groups outlined in this annual report, disparities are growing

(U.S. Department of Health and Human Services, 2013). It will be interesting to see

whether the implementation of the Affordable Care Act in 2014 (U.S. Department of

Health and Human Services, 2015) will positively affect these disparities in the future.

Racial and ethnic disparities in health care include fewer visits with physicians,

and less access to health care services such as outpatient surgery and hospitalizations

(Dunlop, Manheim, Song, & Chang, 2002). Other disparities include higher rates of

disability (Dunlop, Song, Manheim, Daviglus, & Chang, 2007), lower access to health

insurance and higher poverty rates leading to poorer health outcomes (James,

Salganicoff, Ranji, Goodwin, & Duckett, 2012; James et al., 2009). Individuals of color

more often experience less desirable medical outcomes (such as amputations), receive a

lower quality of healthcare and have a higher mortality rate than their White counterparts

(Institute of Medicine of the National Academies, 2002). Differences in race and

educational achievement are widening the gap in life expectancy with elders of color

living lives that are significantly shorter than their White counterparts (Olshansky et al.,

2012).

In comparison to non-Hispanic Whites, elders of color have a higher prevalence

of serious mental illness, and less access to mental health services (Sorkin, Pham, & Ngo-

Metzger, 2009). Both Latino and Asian American older adults are more likely to have

limited English proficiency, and are uninsured or without health care coverage that

includes mental health services (Sorkin et al., 2009).

Although there are many commonalities between the different populations of

diverse older adults, there are also differences that are unique to each population, which

will be discussed in the next section. It is interesting to note the wide variety in

information about these sub-communities with some populations having more moderate

bodies of literature and a range of research studies on diverse topics, and other

communities with a very limited literature base, with studies on more exploratory topics

such as basic demographics and needs of the community. Much of the literature appears

to be exploratory in nature, including low to moderate levels of basic demographic

statistics and needs assessments of these unique communities. These issues will be

further explored in the sections below.

American Indian and Alaskan Native elders.

The primary issues of concern within the American Indian and Alaskan Native

older adult population are issues of individual health disparities and a lack of adequate

research and organizational capacity at the more macro level.

At the individual level, approximately 200,000 American Indian/Alaskan Native individuals, under the age of 65, are sufficiently disabled enough to qualify for social security disability or Medicare services (Boccuti et al., 2014). Sixteen percent of older adults report living below the poverty line, which is significantly more than the national average of ten percent for all older adults (Boccuti et al., 2014). Nearly 40% describe their health as fair or poor and nearly a third of them have diabetes, which is more than the 22 percent average seen in the overall population over age 65 (Boccuti et al., 2014). Depression rates are higher in this population, there is more trouble accessing health care, and individuals report more problems with their activities of daily living, when compared to their White counterparts (Boccuti et al., 2014).

At the macro level, there is a lack of specific research regarding the unique needs of this community. This is particularly compounded by the fact that there are 566 different federally recognized tribes in the United States (U.S. Department of the Interior, 2015), all with potentially different needs and strengths.

In order to obtain more information about the individual and organizational health needs within this community, the National Indian Health Board compiled a Tribal Public Health Profile, in 2010, which provided a baseline for future public health studies, developed priorities to be used in allocating future resources, and identified unmet needs, as a means to advocate for policy changes that might positively impact this population (National Indian Health Board, 2010). This exploratory project studied the capacity of tribal health organizations themselves, and it was the first national study of tribal health organizations that was available to the public (National Indian Health Board, 2010).

Broad issues of concern emerged from this study of approximately 145 tribal health care organizations, from a total of nearly 400 such agencies across the country, who responded to this survey (National Indian Health Board, 2010). Access to care was found to be a significant issue within the community, with nearly 60% of the organizations serving individuals who are traveling 50 miles or more in order to obtain health care services (National Indian Health Board, 2010). Respondents felt that federal funds should be directly provided to the tribes themselves rather than to the states; the current process of transferring funds from the federal government, to states, and then to local tribal organizations was perceived to be inefficient and ineffective (National Indian Health Board, 2010). Lastly, the health care organizations stated that they needed assistance with data analysis, program evaluation and quality assurance activities, and that a lack of data was an important concern within their community (National Indian Health Board, 2010).

Studies about American Indian and Alaskan Native elders demonstrate that in addition to a variety of individual disparities involving income, access to services, and health outcomes, health agencies serving the tribes themselves also demonstrate a lack of capacity in best meeting the needs of their clients. There are many reasons attributed to these disparities. One proposed cause of health disparities takes into account the historical trauma and colonization of American Indian lands, leading to accumulated disadvantages over the lifetime (Braun & LaCounte, 2015). It is suggested that improving the cultural competence of providers will increase access to care, improve

capacity, and consequently improve health outcomes of American Indian and Alaskan

Native elders (Braun & LaCounte, 2015).

One example of this strategy is the National Resource Center for American

Indian, Alaska Native and Native Hawaiian Elders (NRCAIANNH), which aims to

alleviate disparities through working with communities to improve cultural competency;

this is achieved by developing a greater awareness of cultural values, understanding

issues of historical trauma and using what the authors refer to as "culture-based

eldercare," based on the unique needs of this population (Brown, Carter, & Gray, 2015).

Asian American elders.

The Asian American community is a widely diverse community with high rates of

immigration from such countries as China, India, and Korea and more recently from

Bhutan and Nepal (Hoeffel, Rastogi, Kim, & Shahid, 2012). Over 80% of Asian

American older adults are foreign born in contrast to only 12% of all older adults over the

age of 65 (Asian American Federation Census Information Center, 2007). The vast

majority of Asian American seniors immigrated to the United States after 1970 (Asian

American Federation Census Information Center, 2007). The education levels of older

Asian Americans vary widely, with a third never graduating high school and 30% having

a bachelor's degree or higher (Asian American Federation Census Information Center,

2007). Compared to a 10% poverty rate for the older adult population as a whole, 1 in 8

Asian American elders live below the poverty line (Asian American Federation Census

Information Center, 2007).

California has the highest number of Asian Americans in the United States, with over 5.5 million Asian Americans residing there (Hoeffel et al., 2012). Due to its demographic importance, many studies of Asian American communities seem to occur within that state. One study describes a collaborative in which government, health providers and senior organizations met to identify the health needs of Southeast Asian American elders and to generate the best practices and unmet needs within this specific community (Igasaki & Niedzwiecki, 2004). Much of this study produced basic demographic data about the community. The highest proportions of Southeast Asians within the state included Vietnamese, Hmong, Laotian and Cambodian ethnic groups (Igasaki & Niedzwiecki, 2004). The majority of elderly Southeast Asian Americans in this state have limited English proficiency skills (Igasaki & Niedzwiecki, 2004). Cultural and language barriers, a fear of government and transportation issues were identified as significant needs within this community (Igasaki & Niedzwiecki, 2004).

There is also quite a variety within the needs and demographics of the Asian American older adult community due to the fact that it is an overarching category that includes a wide diversity of cultures within it. In a study of health disparities in California, Kim (2010) found that Korean elders had the highest rates of psychological distress, Vietnamese older adults were the most disabled, and Filipino seniors demonstrated having the most number of chronic illnesses.

Asian older adults may have more concerns with mental health issues. Another study in California found that even after controlling for English proficiency, education and health insurance status, older Asian Americans had greater odds of mental distress

and less access to mental health services than their White counterparts (Sorkin et al., 2009). Older Asian Americans with limited English proficiency were also found to be more likely to perceive that they had a mental health problem (Nguyen, 2011).

A recent literature review reports that Asian American elders have higher suicide rates, depression, and cancer diagnoses, when compared to other racial and ethnic groups, along with high rates of diabetes and heart disease, comparable to other populations (Yoo, Musselman, Lee, & Yee-Melichar, 2015). Asian American women have the highest rates of suicide in their age group (Centers for Disease Control and Prevention, n.d.), with recent studies aimed at identifying interventions and programs to attempt to ameliorate this issue (O, 2015).

Within the Asian American older adult community, items of concern seem to revolve around identifying the demographics and basic needs of this widely disparate community, while also developing programs to help prevent health disparities, particularly within the mental health arena. Due to the high proportion of foreign born immigrants to the United States, and wide variety in country of origin within this community, limited English proficiency is a concerning issue. Culturally appropriate communication, particularly with health care providers, is offered as one suggestion to help meet the needs of this diverse population (Yoo et al., 2015). It becomes ever more relevant to use culturally competent practice to ensure that the health needs of this unique group are being met (Yoo et al., 2015).

Latino older adults.

A recent literature review about Latino elders stated that Latino older adults are more likely to be foreign born, are often less educated and are less proficient in English than their non-Latino counterparts (Cummings et al., 2011). Nearly 57% of Latino older adults are foreign born which makes language proficiency a critical community issue (Cummings et al., 2011). Latino seniors have lower incomes, lower rates of health insurance coverage and higher poverty rates (Cummings et al., 2011). Latino older adults are also less likely to be college educated (Sorkin et al., 2009). It is this combination of a higher likelihood of lower levels of education, and lower levels of English literacy that can lead to higher rates of poverty within the community, due to a lack of employment that pays a living wage (Cummings et al., 2011).

This dissertation research takes place in the Rocky Mountain region of the United States. Due to the regional nature of the study, local studies in both Denver and Boulder, Colorado are specifically relevant to this study. Latino adults in Boulder County, Colorado, have a strong involvement in their communities with over 14% reporting business ownership and approximately 20% stating that they were actively involved in their community (Latino Task Force of Boulder County, 2013). Latino seniors want to remain more involved in their communities and want more opportunities for civic engagement (Cummings et al., 2011).

Family is important to these individuals, and 85% of them say that they speak Spanish very well (Latino Task Force of Boulder County, 2013). Although Latinos compose approximately 13% of the population in Boulder, nearly 25% of Latino adults

are living below the poverty line (Latino Task Force of Boulder County, 2013). The majority of respondents also reported experiences of discrimination based on their Latino ethnicity (Latino Task Force of Boulder County, 2013).

In Denver, Colorado a local study found that, in terms of strengths, Latino adults over the age of 55 had a positive work ethic, a strong sense of family and an ability to organize within their community (Alvarez, Vanderburg, Garcia, & Kahn, 2012).

In terms of needs, in the city of Denver, it was perceived that there was a lack of services geared to the specific needs of Latino elders, a difficulty in obtaining health care and housing, and a perception that local service providers needed additional training in order to successfully meet their needs in a culturally competent manner (Alvarez et al., 2012). At the national level, a study of the Area Agencies on Aging network found that the majority would be unable to serve a Spanish speaking client at intake, and more than half did not have written materials in the Spanish language (Cummings et al., 2011).

Latino seniors state that they do not know what services are available or how to access them, particularly due to language issues and a lack of bilingual staff members (Alvarez et al., 2012). Citizenship status also may be an issue with some older adults refusing to seek services, when needed, due to a fear of exposure of their undocumented status or that of a loved one (Cummings et al., 2011).

Leaders feel that community based agencies serving Latino older adults are successful, due to their cultural competency and knowledge of the community, but that there is a need to expand and bring in more resources to meet the future needs of this expanding population; mainstream agencies were perceived to not be able to meet the

needs of this diverse population (Cummings et al., 2011). There is a need for additional funds towards programs that target the specific needs of diverse elders, but there is a perception that philanthropies are hesitant to fund these types of programs (Cummings et al., 2011).

The overarching message from these journal articles, demographic studies and government reports is that the most promising programs serving the Latino older adult community took into account the importance of culture, values and family within the Latino community (Cummings et al., 2011). Cultural competency was seen as an integral strategy in successfully meeting the needs of this unique population (Cummings et al., 2011).

African American elders.

It is interesting to note that much of the information about disparities within the African American older adult community seems to be found within studies involving cross-cultural comparisons, rather than studies focusing exclusively on older African Americans as a unique population. As many of these studies of disparities and needs have been discussed within an earlier section of this paper, they will not also be duplicated here. There is a smaller body of literature that discusses this topic directly. This section of the paper will mention a few studies that do focus on African American elders specifically as well as highlight the state and local studies that appear to omit cross-racial comparisons altogether leaving a dearth of information about this important community.

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Within the literature, there are some specific recommendations for culturally competent care with African American elders. Collins (2011) states that within rural communities, the African American elder population is particularly affected by disparities in income, health care, transportation and access to social services, making cultural competence a vitally important issue. Culturally competent work with African American elders should include a proper use of a surname to indicate respect (i.e. using the name Mr. Smith when speaking to an elder, rather than a first name), understanding the use of idioms or parables as a communication style, forming partnerships with community members, and understanding the role of spirituality and religion in the lives of the seniors (Collins, 2011). Becker, Gates, & Newsom (2004) underscores how African American culture, particularly in terms of religious views, plays an active part in self-care and health promotion.

Some state and local studies within the Rocky Mountain region do not collect data about the specific needs of African American elders. The Community Assessment Survey for Older Adults residing in the state of Colorado provides very detailed information about the problems faced by elders, services that they receive, and the positive and negative aspects of the communities in which they live, but only divides this data into racial and ethnic categories such as White, not White, Hispanic, and not Hispanic (National Research Center, 2011). There is no specific data for African American elders which in itself is an interesting result (National Research Center, 2011).

Although some studies did collect information about race and ethnicity, these reports did not make racial or ethnic comparisons of the outcomes; within these reports,

all recommendations made to policy makers and agencies serving elders were assumed to be the same across all racial and ethnic categories. This includes local demographic and needs assessment studies of elders residing in Boulder (National Research Center, 2010) and Denver counties (State of Colorado, 2010).

Local and state planning documents for the state of Colorado also make policy recommendations and set goals and objectives for agencies serving older adults in their regions on such topics as transportation, housing and health care, with no specific mention of how these recommendations might differ by race or ethnicity; this includes planning documents for the cities of Denver and Boulder (Boulder County Aging Services Division, 2010; City of Denver, 2010), the Colorado State Plan on Aging (State of Colorado, 2011), and the Colorado State of Health Report (State of Colorado, 2013).

As the older adult population continues to become more racially and ethnically diverse, it becomes even more critical to attempt to ameliorate the disparities found within these populations. This is particularly true for older adults who have multiple marginalized identities and especially unique circumstances. Utilizing culturally competent practices and ensuring that local and state studies and planning documents take race and ethnicity into account when making policy recommendations are important strategies for attempting to meet these goals.

Disparities within the LGBT community.

Discrimination has been found to have a negative effect on the health and social needs of LGBT older adults (Addis, Davies, Greene, Macbride-Stewart, & Shepherd, 2009). When compared to their heterosexual peers, LGBT seniors have higher rates of

smoking, drinking, obesity, mental health concerns and isolation (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Fredriksen-Goldsen, 2011). Nearly 50% report a disabling condition and virtually one third have experienced depressive symptoms (Fredriksen-Goldsen et al., 2011). Both women and men with same-sex sexual histories report higher psychological distress, when compared to their heterosexual peers (Cochran & Mays, 2007). LGBT elders with financial barriers to health care, a history of smoking or whom were obese were more likely to have poorer general health, were more likely to be disabled, and had higher odds of experiencing depressive symptoms (Fredriksen-Goldsen, Emlet, et al., 2013). A 25 year literature review demonstrates that in addition to some of the disparities exhibited within the LGBT older adults population, there can also be found a sense of resilience (Fredriksen-Goldsen & Muraco, 2010; Grant et al., 2011), and an interdependence with friends and family (Fredriksen-Goldsen & Muraco, 2010).

LGBT elders may be more concerned about their future, when compared to their heterosexual peers. Over 50% are concerned about their financial stability in old age, as compared to 36% of non-LGBT older adults (Services and Advocacy for GLBT Elders, 2014). Nearly 70% are concerned about potential reductions to Social Security, Medicare and Medicaid (Services and Advocacy for GLBT Elders, 2014).

Fears of persecution and crime are also common. Almost two-thirds of LGBT elders report being victimized three or more times (Fredriksen-Goldsen et al., 2011). LGBT older adults report fear of discrimination by their health care providers and being physically vulnerable to subpar care and abuse as their health deteriorates (Stein,

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Beckerman, & Sherman, 2010). Thirteen percent report being denied care or receiving

inferior care due to their sexual orientation (Fredriksen-Goldsen et al., 2011).

Transgender elders have unique needs. Twenty to twenty-five percent of

transgender adults report experiencing discrimination while searching for a home (Grant

et al., 2011; Services and Advocacy for GLBT Elders, 2014). Across the lifespan, over

40% of transgender individuals have attempted suicide (Grant et al., 2011). They are also

four times more likely to have incomes below $10,000 annually (Grant et al., 2011).

Within public schools, transgender individuals report harassment (78% of the sample),

physical assault (35%) and sexual violence (12%). Ninety percent report harassment at

work and over 25% report having lost a job due to being transgender (Grant et al., 2011).

Twenty-nine percent report disrespect or harassment by the police and 19% report

someone refusing to provide them medical care due to their transgender status (Grant et

al., 2011).

There is a small but growing body of literature concerning the intersectionalities

of sexual orientation, age, race and ethnicity (Cronin & King, 2010; Espinoza, 2011).

LGBT elders of color experience increased prevalence of health disparities and

discrimination accumulated over the lifespan (Auldridge & Espinoza, 2013).   They can

feel isolated, and doubly burdened by discrimination faced from within both the LGBT

and racial/ethnic communities (Espinoza, 2011; SAGE; National Hispanic Council on

Aging; Diverse Elders Coalition, 2013). The combination of an individual's

identification as transgender and their belonging to a marginalized racial or ethnic group

is particularly devastating, in terms of higher rates of discrimination and bias (Grant et al., 2011).

As this population grows in size, it is vital that researchers include LGBT older adults in their studies (National Gay and Lesbian Task Force, 2010), and that aging service professionals are trained to provide culturally competent care, so that services can best meet the specific needs of this population (Fredriksen-Goldsen, 2011; Hughes, Harold, & Boyer, 2011; Meyer, 2011; National Gay and Lesbian Task Force, 2010). Multiple researchers have demonstrated a need for further training in this area. Nearly 98% of aging service providers do not target services specifically to LGBT older adults (Knochel, Quam, & Croghan, 2010). A qualitative study of management staff found that the majority of agencies were not aware of the needs of LGBT elders or were "seeking improvement," with a minority demonstrating a high level of competence in this area (Portz et al., 2014). Seventy-five percent of organizations were interesting in having LGBT older adults provide trainings for their staff (Knochel et al., 2010).

Some researchers have begun the process of developing specific competencies for working with LGBT older adults. It is recommended that professionals become aware of their own and others' negative attitudes, are knowledgeable about the history of LGBT elders, are understanding of the intersectionalities found within this community and are willing to identify the ways in which programs or organizations can be either biased or welcoming to these older adults (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014). Other competencies include knowledge of how social policies may negatively impact this population and an understanding of the heterogeneity found with

this community (Crisp, Wayland, & Gordon, 2008). Others recommend specific

interventions for increasing individual cultural competence with LGBT older adults,

including the LGBT Cultural Competency Project (Gendron et al., 2013), the National

Resource Center on Aging (Meyer & Johnston, 2014), the Cultural Safe Places Training

(Gratwick, Jahanian, Holloway, Sanchez, & Sullivan, 2014), and an intervention

targeting mainstream elder service providers (Porter & Krinsky, 2014). Two

interventions began to look at organizational level interventions: Gay and Gray: Our

Community Responds (Anetzberger, Ishler, Mostade, & Blair, 2004), and the Open Door

Project (Landers, Mimiaga, & Krinsky, 2010). Recommended strategies included

targeted outreach, the use of anti-discrimination policies (Anetzberger et al., 2004),

employee trainings and the development of leadership committed to inclusive services

(Landers et al., 2010).

The majority of this research is aspirational in nature, outlining the problems that

may be faced by LGBT elders and describing interventions that may help change

individual attitudes towards LGBT older adults without necessarily addressing

interventions that might work at the organizational level. This study will help to fill that

gap in the literature.

Operational Definitions

For the purposes of this paper, this author will focus (although not exclusively) on

the same five vulnerable populations that are currently the main focus of national

intervention efforts to remedy disparities. Within the Department of Health and Human

Services, the Administration on Aging (AOA) administers evidence based interventions

which attempt to address the needs of older adults, with specific programs tailored to the American Indian, Asian American, Latino, African American and LGBT older adult communities (U.S. Administration on Aging, 2012b). Older adults from other marginalized groups are also included in this study as they are mentioned by participating agencies.

Research Aims

As the population of older Americans increases and becomes more diverse, there is an increased need to determine the strategies that organizations utilize to best meet the needs of marginalized older adults, particularly in regards to addressing disparities. In order to achieve this goal, this study aimed to:

1. Identify a set of strategies that address disparities and meet the needs of marginalized older adults according to key informants from community based aging service organizations. (These strategies included such topics as the development of programs, interventions, services, policies, collaborations and other organizational initiatives or agency characteristics that lead to effective work with diverse older adults).

2. Combine identified organizational strategies into one unified, grounded theory that can explain how best to provide effective services to marginalized older adults.

Primary Research Question

What are the strategies that key informants within community based organizations attempting to alleviate disparities use to meet the needs of marginalized older adults?

Chapter Two: Literature Review

Introduction

   When researching community-based organizations that serve diverse elders, it is important to understand the areas of literature related to this topic. This literature review summarizes and analyzes current research in the areas of cultural competency, organizational development, and aging studies in order to create a foundation and rationale for this dissertation. This section begins with a review and definition of the concepts of cultural competency, followed by a review of journal articles related to cultural competency in health, medical, and multicultural organizations that may serve diverse elders. This section is completed with a rationale and justification for this particular research study.

Definitions & Importance of Cultural Competency

   Definitions.

   The National Association of Social Work (NASW) *Code of Ethics* emphasizes the importance of cultural competency in social work practice (NASW, 2012). The preamble of the *Code of Ethics* states that "the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable,

oppressed, and living in poverty (NASW, 2012)." NASW has outlined specific standards

for working towards culturally competent social work practice, which include self-

awareness, cross-cultural knowledge and skills, empowerment and advocacy, a diverse

workforce, language diversity and cross-cultural leadership (NASW, 2007).

Sue's (2006) definition of cultural competence emphasizes the importance of

macro or systems level changes as well as individual level change.

> Culturally competent social work practice is defined as the service provider's
> acquisition of awareness, knowledge, and skills needed to function effectively in a
> pluralistic democratic society (ability to communicate, interact, negotiate, and
> intervene on behalf of clients from diverse backgrounds), and on an
> organizational/societal level, advocating effectively to develop new theories,
> practices, policies, and organizational structures that are more responsive to all
> groups (p. 29).

Both of these definitions demonstrate the critical importance of working towards

culturally competent social work practice, particularly at the macro, or organizational

level.

The history of cultural competency.

Cultural competency has a long history within the social work profession (Kohli,

Huber, & Faul, 2010). Over the years, social work has evolved from a "melting pot"

ideology, which favored assimilation into the majority culture, to a more constructionist

framework which acknowledges different world views and focuses on strategies for best

meeting the needs of a wide diversity of clients (Kohli et al., 2010). Some argue that as

the baby boomers age and older adult populations become more racially and ethnically

diverse, this nation should focus on this "new aging" phenomenon; focusing on the

research, practice and policy implications of identifying strengths and meeting the needs of diverse older adults (Diverse Elders Coalition and the Insight Center for Community Economic Development, 2012; Torres-Gil & Moga, 2002).

This new aging phenomenon also includes educating the next generation of gerontologists about how to work with diverse communities of older adults (Yeo & McBride, 2008). It is important to integrate the competencies for geriatric practice (Naito-Chan, Damron-Rodriguez, & Simmons, 2005; National Center for Gerontological Social Work Education, 2015), gerontological social work (Rosen, Zlotnik, Curl, & Green, 2000; Rosen, Zlotnik, & Singer, 2003), and macro practice (Gamble, 2011; Hassan, Waldman, & Wimpfheimer, 2012; Wimpfheimer, 2004) with those competencies aimed towards cultural competence (NASW, 2007; Xakellis et al., 2004). Each of these separate disciplines has outlined specific knowledge and skills that are relevant to working within that particular topic area.

When working with organizations that serve diverse older adults, it becomes relevant to identify where these competencies overlap and what strategies will lead to culturally competent, gerontological practice, at the organizational level. The majority of geriatric and gerontological competencies, describing issues of cultural competence, are at the individual, rather than the macro level. Some of the organizational competencies include: a cognizance that special populations of older adults that may have unique strengths and needs (Naito-Chan et al., 2005; Rosen et al., 2000), and an awareness of the importance of hiring bilingual social workers (Naito-Chan et al., 2005). Organizational

cultural competencies for working with older adults also include somewhat vague statements that social workers should "adapt organizational policies, procedures, and resources to facilitate the provision of services to diverse older adults and their family caregivers (National Center for Gerontological Social Work Education, 2015, p. 5)" and understand the "impact of aging policy and services on minority group members (Rosen et al., 2000)." These cultural competencies are primarily aspirational in nature and do not necessarily prescribe strategies for their achievement.

The social work macro practice competencies include topics of cultural competency such as 1) being aware of power and privilege and how policy and procedure can help to alleviate injustices, 2) having a knowledge of the different needs and strengths of diverse groups, 3) using inclusive organizational structures and programs that lead to social justice, 4) utilizing transparent policies that promote collaboration and reduce discrimination, 5) and promoting diverse leadership and lifelong learning opportunities (Gamble, 2011). The social work leadership and management competencies do not include topics of cultural competence per se but instead focus more on broad areas relevant to administrative work, such as the importance of an expertise in governance, financial development and marketing skills (Wimpfheimer, 2004).

The list of strategies for cultural competency do not refer specifically to older adults but do include important organizational strategies such as: 1) valuing a diverse workforce, 2) understanding language diversity, 5) promoting cross-cultural leadership, 6) using cultural brokers, and 7) being aware of disparities and potential lack of trust that

may be present within marginalized communities (NASW, 2001; Xakellis et al., 2004).

The relevant geriatric, gerontological, macro practice, cultural competency and administrative competencies serve an important foundation and set of aspirational goals for organizations serving diverse elders to achieve. This dissertation will help expand upon these goals to include specific strategies that will lead to culturally competent practice at the organizational level.

The value of cultural competence.

The federal government recognizes the value of cultural competency in public service work and advocates for its implementation. This includes national standards for meeting the cultural and linguistic needs of health care clients (U.S. Department of Health and Human Services - Office of Minority Health, 2013), and specific goals and objectives for reducing racial and ethnic health disparities, many of which occur in old age (U.S. Department of Health and Human Services, 2010). This is furthered by the development of a technical assistance program specifically for programs that serve minority elders (U.S. Administration on Aging, 2011).

The Administration on Aging's "Toolkit for Serving Diverse Communities" outlines a four-step strategy for best serving the needs of diverse communities of all ages, including 1) conducting assessments, 2) identifying specific resources about the community, 3) designing services and 4) evaluating the program (U.S. Administration on Aging, 2010). These 4 steps include getting to know the unique needs and cultures of specific populations in order to provide culturally competent care and subsequently

improve the lives of these individuals, in many aspects of life, including health care and the amelioration of disparities (U.S. Administration on Aging, 2010).

The Partnership to End Health Disparities suggests that providing culturally and linguistically appropriate services will help to end health disparities ("National Partnership for Action to End Health Disparities," 2012). Approaches using cultural targeting (interventions aimed at a particular racial or ethnic sub group) and tailoring (customizing an intervention to the needs of one specific person) should be used within health promotion and prevention programs, to improve overall health within diverse elder communities (Krueger & Casey, 2000).

Overall, government agencies, cultural groups and health disparities experts agree that cultural competency is an important component of any plan to help remedy this problem.

Macro cultural competency.

The preamble of the NASW *Code of Ethics* states that one of the primary aims of social work is to "strive to end discrimination, oppression, poverty, and other forms of social injustice....[by] promot[ing] the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems (NASW, 2012)." Within the field of social work, practice that specifically targets interventions at the organizational, community or policy level is referred to as macro practice (Netting, Kettner, & McMurtry, 2008). This is in contrast to micro practice which emphasizes interventions at the individual or small group level (Netting et al., 2008).

Within the literature, little has been said about cultural competency at the macro level. Some authors recommend that both educational institutions (Xakellis et al., 2004) and human service agencies (Goode, Jones, & Mason, 2002) should participate in regular self-assessments in order to measure their progress in achieving cultural competence within their organizations (Goode et al., 2002). Bailey & Aronoff (2004) describe an organizational framework for multicultural competency that assesses for shared values, for the diversity of the staff, for the involvement of stakeholders, and for organizational strategies that reinforce the value of diverse cultures within the organization.

Fox (2013) advocates for the integration of organizational design (OD) processes into human service agencies. She feels that organizational design strategies can be used effectively by community service agencies to move from a reactive, crisis mode, to a proactive, organization with potential for growth and success (Fox, 2013). Nagda & Gutierrez (2000) recommend a praxis method, in which iterative cycles of reflection and action are utilized, as the best approach for implementation of a Multicultural Organizational Model (MOD) process within a human service agency. MOD includes the values of building on strengths, the normalization of cultural competency efforts within an agency structure, and the challenging of oppression (Hyde, 2003).

Nagda & Gutierrez (2000) argue, from a theoretical perspective, that approaches such as MOD can have a positive impact on organizations. For example MOD can lead to more egalitarian decision making, to more value placed on multiple perspectives, and to a more collaborative working environment rather than a competitive working environment.

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MOD approaches increase feelings of empowerment for marginalized individuals both within and outside the organization, and leads to systematic changes within the agency itself, resulting ultimately in better services for diverse clients (Nagda & Gutierrez, 2000).

Multicultural organizational consultation (MOC) is based on the tenet that individual-only focused assessments and interventions may unintentionally "blame the victims of oppression" as the cause of a client's difficulties, rather than also looking at the inherent biases found within the organization itself, such as racism, classism and power imbalances (Sue, 2006). Multicultural organizational consultation

> a) takes a social justice perspective (ending oppression and discrimination in organizations), b) believes that inequities that arise within organizations may not be primarily due to poor communication, lack of knowledge, poor management, person-organization fit problems, and so on, but to monopolies of power; and c) assumes that conflict is inevitable and not necessarily unhealthy (Sue, 2006, p. 229).

As the United States becomes more diverse, it becomes important to understand how to measure organizational cultural competence within agencies specifically serving older adults (Geron, 2002). Many of the instruments that measure cultural competency at the agency level seem to measure more superficial indicators of cultural competence, such as evidence of an awareness of diversity within agency mission statements that is not reflective of actual practice (Geron, 2002). More research and investigation about this topic is needed, in order to determine better ways to both understand and measure organizational cultural competency with older adult populations (Geron, 2002). This

dissertation will attempt to fill this gap in the literature by further investigating the topic of organizational cultural competence within agencies serving diverse elders.

Literature Review

This comprehensive literature review included four databases, searched within the years 2004-2014, using such limiters as peer reviewed, academic journal articles, and written in the English language. These databases included PsychInfo, Soc Index, Social Services Abstracts, and the Social Science Index.

Search terms included a combination of the various permutations of the terms older adults, cultural competency, organizations and the relevant diverse elder groups discussed in this study. Search terms also included important keywords found within relevant journal articles, such as multicultural organizational development and ethnic community based organizations.

Through a process of reviewing article titles and abstracts, journal articles were excluded when they were off topic (did not pertain to the topic of cultural competency), discussed samples outside of the United States (making them less relevant to this study focused in the U.S. Rocky Mountain region), pertained to individuals under age 18, rather than older adults, or were duplicates of other articles already discovered. Please refer to Appendix A for a more detailed table of search terms and exclusions used for this literature review.

This literature review identified 40 journal articles. Three main themes emerged from the analysis of these 40 studies: 1) conceptual articles about cultural competency,

2) articles about cultural competency within public health and medicine, and 3) articles about multicultural organizational development. It is interesting to note that the majority of journal articles discovered in this review were about topics of health care, even though no mention of health was included in the search terms. All three of these themes will be discussed in the next section.

It is also noteworthy that the majority of journal articles within this review are aspirational in nature. Aspirational literature is defined as relevant literature based on a foundation of values and ethics within a particular profession, that may not necessarily include empirical results. These studies outline goals or objectives that culturally competent practitioners should aspire to, without necessarily studying how these goals are to be accomplished. These studies include descriptive, quantitative survey studies outlining the prevalence of disparities, qualitative research about the needs of diverse populations, and theoretical articles defining cultural competence and outlining basic precepts of cultural competency within practice. Many of these studies are government or foundation funded demographic studies outlining the needs of the local populations, and making recommendations for improvements in individual, rather than organizational, level cultural competency.

Cultural competency.

Cultural competence is seen as an essential component of many aspects of work within the field of social services. From a religious perspective, Tobin & Weinberg (2014) emphasize the importance of understanding racial and ethnic diversity within the

Jewish community (of all ages). It is vital that Jewish communities not assume that their

members are White and instead embrace the benefits that come from a heterogeneous and

united religious community (Tobin & Weinberg, 2014). This literature review

emphasizes the importance of cultural competence within practice, education, research

and policy (Yali & Revenson, 2004). Specific strategies for integrating cultural

competence into practice include the use of qualitative research as a means of analyzing

concepts that may be outside of the researcher's normal cultural frame as reference, as

well as working directly with community collaborators to ensure that research and

practice best meets the needs of diverse populations (Yali & Revenson, 2004).

Cultural competence is relevant for working with older adults in the field of social

work (Min, 2005). In this conceptual article, Min (2005) recommends that social workers

should 1) conceptualize and develop a framework about race and ethnicity within

practice, 2) utilize approaches that are interdisciplinary and community and

neighborhood driven, 3) support culturally competent practice with diverse elders and

4) ensure that the practice of gerontological social work includes a discussion of cultural

competence.

Cultural competence is essential in remedying health disparities (Askim-Lovseth

& Aldana, 2010; Lamar-Dukes, 2009). For example, understanding Latino views and

attitudes on health care (Waite & Ramsay, 2010), recent changes in demographics, value

systems, and the unique health risks of the Latino community, are critical in remedying

health disparities within this community (Askim-Lovseth & Aldana, 2010). Disparities

within the Latino population include such issues as a lack of access to both health care and health insurance, and a certain sub-population of undocumented individuals who may fear seeking treatment due to potential exposure of their legal status (Askim-Lovseth & Aldana, 2010). Cultural views such as fatalism, and respect for authority figures (making it less likely that individuals will disrespect physicians by asking questions when they do not understand) are also important factors that may impact health (Askim-Lovseth & Aldana, 2010). In her article, Lamar-Dukes (2009) describe an initiative to help develop and support persons of color, with disabilities, as leaders within disability services organizations, as another strategy for alleviating health disparities.

Cultural competence is an integral component of practice within the social sciences, particularly when working with diverse older adults and attempting to alleviate health disparities. This next section will look at studies specifically focused on the importance of cultural competence within the fields of public health and medicine.

Health or medical studies.

Communication, an awareness of cultural differences and a discussion of potential interventions emerged as themes within this section; medical providers who were able to develop skills in these areas demonstrated higher levels of cultural competence, which led to better overall care for their patients. The majority of recommendations were based on the practice experiences of authors, while the remaining recommendations were based on empirical studies analyzing a variety of relationships between cultural competence and health outcomes.

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It is important for health professionals to integrate culturally competent practice into their work with older adults. This can be achieved through education about these issues, teaching others and ensuring that critical conversations continue (Hinrichsen, 2006). Hinrichsen (2006) demonstrates the importance of these issues through anecdotes from within a psychology practice. O'Connell et al. (2013) developed a conceptual white paper about how integral cultural competency is to the education of pharmacists. Implications for practice include making sure the there is a diverse workforce (O'Connell et al., 2013) and leadership structure (Lamar-Dukes, 2009) that matches the demographics of the populations being served, and that educational and clinical climates are conducive to working with individuals from diverse backgrounds (O'Connell et al., 2013). Shim, Ye, & Yun (2014) write about the importance of cultural competence within psychiatry in their short case note.

Communication between provider and patient is an important aspect of cultural competence. In two qualitative studies of African American adults, communication was found to be the most important factor for an effective provider/patient relationship (Song, Hamilton, & Moore, 2012a), often ranked higher than the race or ethnicity of the provider (Johnson, 2006). One aspect of communication involves the interpersonal sensitivity of the medial provider. Phillips, Chiriboga, & Jang (2012a) found that there was a significant relationship between the interpersonal sensitivity of the provider and patient satisfaction with care, across all racial groups. Latino patients who were interviewed in

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Spanish reported that their providers had higher rates of interpersonal sensitivity (Phillips, Chiriboga, & Jang, 2012b).

Communication involves clearly discussing medical issues with the client and respecting the patient's individual beliefs and attitudes (Johnson, 2006). A discourse analysis of pamphlets and health education materials found that written messages that were clearly communicated and were targeted towards the specific cultural views of a population were more likely to be successful (Kline, 2007). First person narratives or stories were also found to be effective ways to transmit important health messages to consumers (Documét et al., 2008).

Communication also involves the concepts of cultural congruence and language congruence. Cultural congruence, or the relationship between the cultural climate of a health organization and the perceptions of patients, is an important concept of culturally competent practice (Costantino, Malgady, & Primavera, 2009). In order to help measure cultural competency, Costantino, Malgady, & Primavera (2009) developed a scale to measure the congruence between providers' views of mental health services and the specific needs of older Latino clients. They developed the measure using a subset of over 250 Latino adults from a multi-city study of the mental health and substance abuse needs of older adults (Costantino et al., 2009). Results demonstrate that cultural congruence predicts a reduction in physical and mental health symptoms and that the measure was deemed reliable and valid (Costantino et al., 2009).

Language congruence is an important aspect of communication. A secondary analysis of a random sample of non-institutionalized Latino and Asian American older adults in California (approximately 3,000 participants) found that for Latinos, the type of language concordance between provider and patient did not appear to affect health outcomes (August, Nguyen, Ngo-Metzger, & Sorkin, 2011). For Asian Pacific Islanders who speak the same language as their provider, those who speak a language other than English were less likely to discuss mental health issues than individuals who were both speaking English, possibly due to a cultural value of not openly discussing mental health concerns (August et al., 2011).

Discussions of communication also include the topic of cultural sensitivity. Nápoles et al. (2012) developed an instrument to measure the cultural sensitivity of medical providers, using a sample of older Latino patients within primary care settings. Psychometric testing was conducted on this measure and it was found to be moderately valid and reliable (Nápoles et al., 2012). In their development of the Cultural Competence Assessment Tool, with a sample of approximately 140 patients within public health clinics, it was found that using brochures and reading materials that represented the demographics of the patients was very helpful (Pardasani & Bandyopadhyay, 2014). Patients also felt that health clinics should have a diverse staff, have the capacity to converse in different languages and understand their personal, cultural beliefs (Pardasani & Bandyopadhyay, 2014).

It is important that medical health professionals listen and adapt to the unique

needs of their clients. Drake (2013) uses personal anecdotes from within a mental health

practice setting to emphasize the need to educate oneself about diverse cultures and the

personal cultures of their clients. Based on practice experience, Epner and Baile (2012)

recommend using the patient-centered approach with diverse clients. This approach

entails the physician adapting his/her interaction with patients in order to meet their

unique needs, in terms of communication style, manner in which decisions are made and

the role of the family, as well as taking into account issues of racism, sexism,

discrimination and a mistrust of the medical community (Epner & Baile, 2012).

Listening to clients is an important component of cultural competency.

Eisenbruch, de Jong, and van de Put (2004) encourage the use of the Transcultural

Psychosocial Organization (TPO) approach when working with international refugees

and victims of organized violence. This articles describes the TPO approach which

utilizes a specific protocol for conducting action and intervention research, that integrates

a mental health intervention within the specific cultural environment of the host country

(Eisenbruch et al., 2004).

Hauck, Corr, Lewis, & Oliver (2012) encourage medical professionals to learn

more about the specific health care needs of African refugees in order to become more

culturally competent working with this population. This literature review discusses the

major health problems often found in refugee populations (such as Malaria, HIV, anemia

and parasites) as well as potential barriers to their accessing care (such as racial bias and

difficulties with language) (Hauck et al., 2012). It is important for clinicians to

understand the cultures of their clients. A focus group of Afghan elderly refugees finds

that successful medical clinicians understand the importance of religion in their lives, as

well as the cultural value of ensuring that medical professionals and patients are the same

gender (Morioka-Douglas, Sacks, & Yeo, 2004). Case examples in another article

illustrate why culturally competent work with African Americans elders should include

demonstrating respect and dignity, understanding the language needs of African

American older adults, and realizing that spirituality and religion may be important

values within this community (Collins, 2011).

It is important that physicians are educated about the unique needs of persons

with disabilities including making accommodations for individuals without speech,

understanding the cultural values of independence and self-advocacy and collaborating

with community organizations that serve the disabled community (Eddey & Robey,

2005). In this conceptual article, it was suggested that in order to be culturally

competent, physicians have to ensure that they are aware of all methods of

communication (particularly for those individuals who are non-verbal or speak a foreign

language), understand that parental beliefs and attitudes may impact the health of the

patient, be aware of the use of folk health remedies, and realize how the cultural values

might impact a person's health (Eddey & Robey, 2005).

Agencies that want to be more inclusive of persons with disabilities from diverse

backgrounds need to have the desire to discuss issues of cultural competency, the ability

to become more critically aware of bias, the interest in learning about factors that influence diversity and the ability to develop practical skills (Taylor-Ritzler, Balcazar, Dimpfl, & Suarez-Balcazar, 2008). This journal article discusses a conceptual framework that can be used to train organizations and agency professionals to interact in a more culturally competent manner with persons with disabilities (Taylor-Ritzler et al., 2008). Within the sample of nearly 300 staff members who participated in the training, there was a statistically significant improvement in terms of communication styles, attitudes, values and cultural knowledge (Taylor-Ritzler et al., 2008).

Interventions emerged as a sub-theme within the health and medical literature on this topic. Gendron et al. (2013) used the *Gen Silent* film as part of a curriculum for training healthcare professionals about issues of LGBT elders, resulting in a significant increase in awareness of these issues. A similar competency training for employees within area agencies on aging also resulted in an statistically significant increase in both knowledge of public policies that might discriminate against LGBT older adults and factual knowledge about the community (Porter & Krinsky, 2014).

A cultural competence and cultural humility approach was utilized to tailor a support group for Latino caregivers of family members with dementia (Reynoso-Vallejo, 2009). Because of the unique characteristics of this group, changes were made to the intervention to better meet the needs of its participants (Reynoso-Vallejo, 2009). This case study demonstrates that one of these changes was to create audio recordings of pre-recorded radio shows, that provided information and personal stories from other

caregivers (Reynoso-Vallejo, 2009). This strategy acknowledged that the intensive

nature of caregiving made it difficult for caregivers to attend support group meetings

(Reynoso-Vallejo, 2009).

Many of the journal articles in this review demonstrate the importance of cultural

competence within the fields of public health and medicine, particularly when attempting

to alleviate health disparities. The majority of these studies aimed to influence cultural

competence at the individual level. This next section of the literature review describes

how cultural competence can be integrated into organizational or macro level practice.

Multicultural organizational development.

The major components of this theme include aspirational articles about the

importance of organizational cultural competency both in general terms, and using

specific terms such as culturally competent models, multicultural organizational

development, and multicultural organizational consultation. Some of these strategies

describe organizational cultural competency in more general terms, while others make

recommendations for specifically alleviating health disparities. None focused

specifically on working with diverse older adults.

Siegel, Haugland, Reid-Rose, & Hopper (2011) identify multiple components of

cultural competency at the organizational level, within their qualitative study of three

mental health programs. Components of organizational cultural competency include:

1) services specifically targeted to the needs and strengths of clients (Siegel et al., 2011;

Uttal, 2006), 2) a culturally friendly milieu in the agency, including such as aspects as

photographs on the wall and music that is culturally relevant to clients, and 3) the involvement of family member, as culturally relevant (Siegel et al., 2011). It is also important to collaborate with the local community (Siegel et al., 2011; Uttal, 2006), and ensure that there is a diverse workforce that is representative of the clients that are being served (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013; Siegel et al., 2011).

Other recommendations for fostering organizational cultural competency (based on the author's literature review of the topic) include conducting organizational assessments, being aware of language differences, developing agency policies for staff and patient grievances, and maintaining executive support for cultural competency projects (Delphin-Rittmon et al., 2013). A culturally competent, multi-ethnic human service organization is described as one that can work successfully with community members, focus on specific areas of expertise and utilize a diverse board with a variety of skills and expertise; these components are demonstrated through details of case study of the Bayview Hunters Point Foundation for Community Involvement (Joe, Schwartz, & Austin, 2011).

Suyemoto & Fox Tree (2006) describe what they self-label as a "(mostly) failed struggle" to build bridges between different racial and ethnic groups within a community organization whose mission is to train K-12 educators in cultural competency. This organizational case study demonstrated their process in attempting to raise awareness of White privilege and racial hierarchies within an organization (Suyemoto & Fox Tree,

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2006). In order to increase chances of success with new endeavors, these authors

recommend 1) making sure to understand agency goals and objectives, to determine

where these goals overlap and diverge from a social action agenda and then using this

knowledge to tailor strategy choices, 2) being aware of the history of the agency in order

to avoid historical pitfalls and utilize organizational strengths, and 3) identifying how the

agency engages with conflict in order to assist them in better handling future difficult

situations (Suyemoto & Fox Tree, 2006). Although this agency's services were tailored

towards diverse youth, the recommendations seem transferable to agencies serving

diverse individuals of all ages (Suyemoto & Fox Tree, 2006).

Hernandez, Bunyi, & Townson (2007) use a case study to describe the Cultural

Context Model (CCM) which they recommend using when engaging in clinical

supervision of student therapists. Although discussed in the context of training of family

psychotherapists, this approach may be applicable to many fields due to its emphasis on

recognizing power differentials between a supervisor and a student, and developing a

climate of collaboration and collective learning, all of which are important components of

cultural competency (Hernandez et al., 2007).

Multicultural Organizational Development is another important approach to

organizational cultural competency. [In order to define Multicultural Organizational

Development, Hyde (2004) excerpts a quotation from page 14 of Chesler (1994).]

Multicultural Organizational Development is defined as:

> ...a long-term, complex organizational change process that "does not simply
> accept or celebrate differences, but aims at a reduction in the patterns of racism

and sexism [and other oppressions] that prevail in most U.S. institutions and organizations" through a fundamental transformation of an organization's culture (p. 16).

MOD emphasizes fundamental or second order change rather than the superficial or first order changes often is seen with other approaches (Gallop & Este, 2007; Hyde, 2003). Gallop & Este (2007) describe a case study in which multicultural organizational development principles are used within a Canadian social work program, arguing that the MOD approach is a more long-term and substantive model for comprehensive systems change (Gallop & Este, 2007). MOD uses a cultural competence approach that highlights staff development, the acquisition of knowledge and skills for working with diverse groups, and the use of cross-cultural communication (Hyde, 2003).

Multiple strengths and challenges of using a Multicultural Organizational Strategy were identified in this qualitative study of forty practitioners and consultants utilizing this approach (Hyde, 2004). Challenges of the approach include 1) a sociopolitical environment that inhibits change efforts (such as a troubled economy), 2) large workloads and overwhelmed staff members, 3) conceptualizations that the project will be a "quick fix" rather than a long-term process, and 4) consultants that are not properly trained to do this kind of work (Hyde, 2004). Potential solutions to these problems include the 1) forming of collaborations, 2) development of leaders, 3) utilization of assessment and planning strategies, and 4) judicious selection of consultants (Hyde, 2004).

In order to be successful, MOD initiatives need to include the following components: 1) agency values of strengths based work, inclusivity and the challenging of oppression, 2) explicit goals to acquire cultural competence, develop a diverse staff and critically transform agency culture, and 3) specific activities to achieve these goals such as cultural trainings, outreach events, planning sessions and outcomes evaluation (Hyde, 2003).

Multicultural Organizational Consultation (MOC) involves using a consultant to implement MOD principles (Sue, 2008). For the MOC process to be successful, there must be: 1) an awareness of privilege within organizations and how standard operating procedures may maintain the status quo rather than lead to change, 2) an ability of the consultant to understand his/her own biases and world view, and 3) a priority for taking action in order to facilitate and participate in difficult dialogues on topics of racism, sexism and other topics of oppression (Sue, 2008). According to Sue (2008), "the goal of the consultant is to enhance the organization's ability to adapt to and use diversity to maintain or improve effectiveness by providing for equal access and opportunity (p. 159)." This approach differs from a traditional organizational development approach due to its emphasis on long-term rather than superficial changes made to the policies, programs and structures of the organization itself, as a means of fostering equity and dismantling monopolies of power and privilege (Sue, 2008).

This section reviewed both aspirational and empirical journal articles about the topics of organizational cultural competency, culturally competent models, multicultural

organizational development, and multicultural organizational consultation. These

concepts form the basis for further work at the integration of the fields of cultural

competency, organizational development and aging studies and emphasize their

importance in alleviating health disparities.

Study Rationale

It is important that research studies begin to integrate cultural competency within

non-profit and community based organizations (Nagda & Gutierrez, 2000), particularly

within agencies serving older adults (Min, 2005). Individual focused cultural

competency studies alone will not meet the needs of diverse populations; an expanded

focus on the macro or organizational level, is an essential component of culturally

competent practice (Iglehart & Becerra, 2007; Webb, 2012).

This section discusses how this dissertation meets a gap in the literature by using

an empirical study (rather than more aspirational concepts), to integrate the fields of

cultural competency, organizational development and aging studies; this scholarship of

integration uses the intersections of these three fields as a means of generating new ideas

about how best to serve the needs of diverse older adults. Boyer (1990) defines

scholarship and the generation of knowledge as having four primary components: 1) the

scholarship of discovery, 2) the scholarship of integration, 3) the scholarship of

application, and 4) the scholarship of teaching. The scholarship of integration gives some

perspective to a topic, making connections between disparate ideas and conducting

research where the different fields converge (Boyer, 1990), resulting in the generation of

new knowledge and ultimately better services to our clients. This study demonstrates the

scholarship of integration by making connections between cultural competency,

organizational development and programs serving diverse elders; as the demographics

within the United States change by becoming older and more diverse, the connection

between these three areas becomes of critical importance.

Chapter Three: Theoretical Frameworks

Introduction

Life Course Theory and the Social Determinants of Health Framework are both used to examine the onset and persistence of disparities among marginalized older adults (Braveman & Barclay, 2009; Marmot, 2006; Rugh, 2011). Both theories are similar in that they focus on more systemic and macro aspects of disparities such as discrimination and poverty rather than more individual choices or behaviors (Braveman & Barclay, 2009; Marmot, 2006). Moniz (2010) claims that theories such as the Social Determinants of Health Framework (and ostensibly Life Course Theory as well) are best suited to alleviate disparities. She advocates that social workers should become integrally involved in evaluating disparities from a more systemic perspective, rather than solely relying on programs concentrated on deficits in individual decision making (Moniz, 2010).

This study will use existing theory to broadly focus the research questions on the strategies that community based organizations can utilize to remedy disparities. Padgett (2008) defines this application of broad aspects of theory to qualitative research as the use of sensitizing concepts. Sensitizing concepts provide an initial understanding of the

topic but do not specifically delineate or explain how or why something occurs. Life

Course Theory and the Social Determinants of Health Framework outline the potential

macro level aspects of disparities. These theories do not address concrete, community

specific strategies that non-profit organizations can use to help address these problems.

This research study will fill that gap in the literature through the development of

grounded theory based on the actual voices of the organizational employees serving the

needs of marginalized older adults.

The Life Course Model

Life Course Theory, first postulated by Glen Elder (1975), posits that early life

experiences (such as the social disadvantages and economic adversity encountered by

many marginalized individuals) accumulate and negatively impact the future health and

welfare of older adults. Thus, the accumulated disadvantages lead to higher incidences of

chronic disease in old age (Elder, 2003). Many researchers have built on Elder's original

research. The theory has been applied within the context of discrimination, and poverty

as systemic causes of inequities among older adults (Thrasher, Clay, Ford, & Stewart,

2012). Braveman & Barclay (2009) specifically outline the components of the Life

Course Model, based on Elder's original work. Within this model, marginalized

communities are differentially exposed to both hazards (such as lack of health insurance)

and promoting factors (such as safe neighborhoods and lower exposure to crime and

environmental toxins) (Braveman & Barclay, 2009). This exposure if not prevented or

treated can lead individuals to have greater vulnerability to certain illness and

consequently poorer health and well-being outcomes as older adults (Braveman &

Barclay, 2009). Please refer to Figure 1 for a pictorial representation of this theory.

Figure 1: Life Course Model
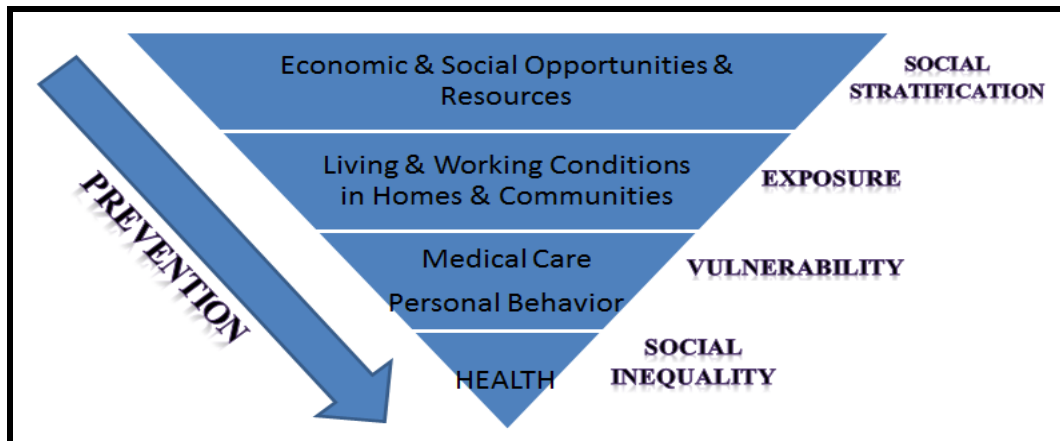
Basic tenets.

As seen above in Figure 1, a person's individual health is affected by 1) economic

and social opportunities and resources, 2) living and working conditions within homes

and communities, and 3) medical care and personal health behaviors (Braveman &

Barclay, 2009). Economic and social opportunities and resources include policies which

promote child development, adequately educate individuals from infancy through college

and initiatives to reduce poverty and promote economic development (Braveman &

Barclay, 2009). Policies which promote healthier schools, neighborhoods and places to

work are included in what Braveman & Barclay (2009) define as adequate living and

working conditions. Within this model, individual health decisions and access to medical

care are also critical to one's health status but are not considered as important as the more

macro factors listed above (Braveman & Barclay, 2009).

Ben-Shlomo & Kuh (2002) provide an example in their article about how a low economic status in childhood may result in a child having poorer health outcomes as an adult. Individuals who grow up within lower income households are more likely to live in neighborhoods with greater amounts of air pollution and to suffer from poor nutrition (Ben-Shlomo & Kuh, 2002). These factors can then lead to infant respiratory and childhood chest illnesses which later may lead to poor educational achievement due to missing class or other outcomes related to poor health; this can then result in the obtainment of lower income employment as an adult (Ben-Shlomo & Kuh, 2002). Lower income in adulthood may then lead to a greater likelihood of working in unsafe environments and living in polluted neighborhoods, which can then lead to rapid declines in lung function (Ben-Shlomo & Kuh, 2002). Childhood lung problems can also directly lead to poor lung function and a tendency towards asthma which can result in higher incidences of adult lung disease (Ben-Shlomo & Kuh, 2002).

As demonstrated in the above example, this theory claims that social inequalities in old age are due in large part to the accumulation of disadvantages over the life course that began in childhood (Braveman & Barclay, 2009). The Matthew Effect states that an already healthy person, with a stable income and adequate education is more likely to have the ability to maintain (or expand) employee health benefits, obtain better positions with higher incomes, and pursue additional educational opportunities, all of which lead to better future health outcomes (Marshall & Mueller, 2003). In contrast, lower socioeconomic status can adversely affect one's health in old age (Crimmins, 2001;

Ferrie & Rolf, 2011). Ironically, intervention effects can sometimes exacerbate or widen these disparities as those who are more advantaged in terms of income, education and other preventative factors, may be more likely to benefit from initial prevention programs (Braveman & Barclay, 2009).

Definition of terms.

Critical periods, life events, cumulative effects and trajectories or pathways are terms with specific meaning within the Life Course Model (Braveman & Barclay, 2009). A critical period is defined as a time period in which exposure to a health hazard may have very profound future effects on individual health (Braveman & Barclay, 2009). For example, connections can be made between fetal malnutrition and adult stroke, hypertension and type 2 diabetes, in large part because pregnancy is seen as a critical period in an individual's lifelong development (Braveman & Barclay, 2009).

Cumulative effects are defined as long term or sequential damage to a person's health due to exposure to environmental, social or behavioral factors (Braveman & Barclay, 2009). Cumulative events can include, amongst other occurrences, 1) a greater number of adverse life events or traumatic experiences in youth increasing the risk of substance abuse problems, mental illness, and risky behaviors in adulthood (Braveman & Barclay, 2009) and 2) lifelong marginalization or discrimination experienced by African American pregnant mothers leading to higher levels of cortisol than would be typical, leading to higher immune responses in utero, which can lead to poorer birth outcomes (Braveman & Barclay, 2009).

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Life events are defined as significant transition periods in an individual's life which may require changes in expectations, roles or behaviors (Alwin, 2012); these transitions often include such areas as education, family, employment, social assistance and retirement (Heinz, 2003). According to the Life Course Model, social stratification within society often leads to different timing and sequencing of these events, which can then impact the future life course of each individual (Heinz, 2003). For example, racism within the education system differentially tracks students into college preparatory versus vocational programs, leading some individuals onto paths towards lifelong careers while others' trajectories include a lifetime of minimum wage jobs (Andersen & Collins, 2007). Differentials in income and accumulation of financial assets further widen the gap between these two groups leading to educational disparities (Andersen & Collins, 2007) and future health disparities (Marshall & Mueller, 2003). An individual's trajectory or pathway through life refers to the sequences and timing of one's exposure to these health hazards and health promoting factors over the course of a lifetime (Braveman & Barclay, 2009).

Overall, the Life Course Model emphasizes the accumulated disadvantages of poverty, lack of education and poor childhood health as causes of adult health disparities (Braveman & Barclay, 2009). Although this model does include individual decision making on health matters, it's main emphasis is on more societal level factors that impact poor health outcomes (Braveman & Barclay, 2009).

The Social Determinants of Health Framework

Within the Social Determinants of Health Framework inequities are caused by the unfair distribution of wealth, power and resources which negatively affect individuals' access to education, good health care and safe communities, all of which affect their health and welfare in later life (Marmot, Friel, Bell, Houweling, & Taylor, 2008). The theory posits that,

> If systemic differences…. for different groups of people are avoidable by reasonable action, their existence, quite simply, is unfair. We call this imbalance….inequity. Social injustice is killing people on a grand scale, and the reduction of …..inequities, between and within countries, is an ethical imperative (Marmot, Friel, Bell, Houweling, & Taylor, 2008, p. 1661).

The Social Gradient is one component of the theory that states that the higher social position that an individual has, the better their health (Marmot, 2006). This relationship between social status and health remains true even when comparing an individual with a more moderate level of income to a person with higher level income; one's position within the social hierarchy does matter (Brunner & Marmot, 2006). The Social Determinants of Health include such components as biology, individual behavior, social and physical environments and the use of health services, all of which affect one's health (Marmot & Wilkinson, 2013). Please refer to Figure 2 for a visual representation of the theory.
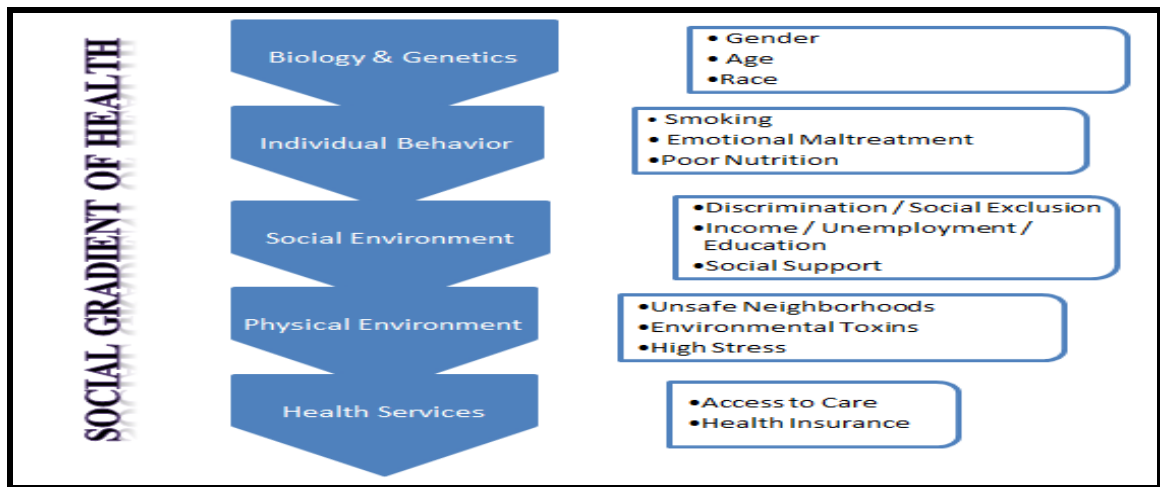
Genetics and individual behavior.

Genetics can have an effect on one's health outcomes (Marmot, 2006). Disease can differentially occur within certain racial or ethnic categories, with certain neighborhoods more likely to experience specific illnesses (Marmot, 2006).

Individual behaviors also serve as an important component of this theory (Wadsworth & Butterworth, 2006). For example, individual decision making such as smoking or drinking during pregnancy can negatively affect the future health of children, resulting in low birth weights, malnutrition or other poor health outcomes (Wadsworth & Butterworth, 2006). Prevention programs to promote positive health decision making such as walking (McCarthy, 2006) or interacting with one's neighbors as a means to increase social support (Stansfield, 2006) can lead to more positive health outcomes.

Individual decision making can also affect mental health (Wadsworth & Butterworth, 2006). For example, parental emotional maltreatment in youth can lead to

poor mental health outcomes as adults, such as behavior problems and mental illness (Wadsworth & Butterworth, 2006). The addition of financial difficulties can worsen these negative outcomes due to the emotional stressors experienced by the family during those time periods, potentially damaging the child's attachment to adults, ability to regulate one's emotions and feelings of self-worth (Wadsworth & Butterworth, 2006). Low self-esteem then can negatively affect future education, employment, personal relationships and one's ability to cope with adverse life events (Wadsworth & Butterworth, 2006).

The social environment.

One's social environments can affect an individual's biology which can then result in poorer health outcomes (Marmot, 2006). For example, the "fight or flight" response is evoked when an individual experiences either acute or chronic levels of stress (Brunner & Marmot, 2006). This can be an effective response when an individual is involved in a life-threatening situation; the body prepares for the emergency with increased levels of cortisol which allow the person to either fight the opponent or have the necessary energy to flee a dangerous situation (Brunner & Marmot, 2006).

The "fight or flight" response can become maladaptive when a person experiences a constant level of stress, resulting in poor health outcomes (Lucey, 2007). For example, under circumstances of chronic stress (for example from financial strain, lack of social support or discrimination) the body routinely responds with higher levels of cortisol; these high cortisol levels raise glucose and fatty acid levels which in turn lead to higher

incidences of such diseases as diabetes and higher cholesterol, often resulting in disability in old age (Brunner & Marmot, 2006). The infections and inflammatory responses that arise from higher levels of cortisol can also damage the walls of blood vessels, potentially leading to atherosclerosis and heart disease (Brunner & Marmot, 2006). The "fight or flight" response causes blood to become more viscous which helps in true emergency situations to reduce bleeding but can lead to arterial plaques when experienced on a regular basis (Brunner & Marmot, 2006).

Individual from more marginalized communities (such as people of color or LGBT individuals) are more likely to suffer from these chronic "fight or flight" responses due to discrimination and social inequities (Brunner & Marmot, 2006). In contrast, ameliorating some of the stigma associated with LGBT families, as one example, often leads to better communication and prevention of sexually transmitted disease, ultimately improving one's physical health (Johnson, Mercer, & Cassell, 2006).

The physical environment.

Sanitation systems, clean water and good nutrition are often pre-requisites for good prenatal care (Wadsworth & Butterworth, 2006). Individual who reside in neighborhoods which lack these basic characteristics have higher levels of low birth weight babies, poor growth in early life and higher rates of childhood obesity (Wadsworth & Butterworth, 2006). These childhood characteristics ultimately lead to negative adult health outcomes (Wadsworth & Butterworth, 2006).

Marmot, Siegrist, & Theorell (2006) write about a differential access to adequate employment in which societal inequities track individuals into certain employment trajectories, often based on race or other demographic characteristics. Communities with high unemployment may produce environments where employed individuals are less likely to question unsafe work environments, or assert their rights as employees, due to a fear of losing their only source of income (Bartley, Ferrie, & Montgomery, 2006). Lower income individuals are often working in assembly line work environments with little control over one's work, and few opportunities for feelings of self-efficacy and mastery, all of which can lead to poor health outcomes (Marmot et al., 2006). In contrast, high levels of employment can serve as a protective factor for communities due to the fact that employment gives individuals a sense of well-being and security which results in improved health outcomes (Bartley et al., 2006).

Environmental toxins, poor housing quality and lack of services all negatively affect one's health (Stafford & McCarthy, 2006). Neighborhoods with high crime, and subsequent social isolation out of fear of one's environment, consistently lead to poorer health (Stansfield, 2006). Social support helps to alleviate the body's reactions to stress and assists individuals with coping with life's challenges (Stansfield, 2006). In contrast, the marginalization of individuals and their exclusion from community life (Shaw, Dorling, & Smith, 2006) as well as racial harassment and discrimination (Nazroo & Williams, 2006) lead to poor health outcomes. Supporting social, cultural and other

community efforts can serve as a protective factor in the prevention of disease (Nazroo & Williams, 2006).

Health services.

Access to adequate health insurance and health care is one important component of this theory (Marmot & Wilkinson, 2013). One example of this is that Latino children and children living below the poverty line are more likely to have no health insurance or insurance that is inadequate to meet their needs (Dubiel, Shupe, & Tolliver, 2010), which in turn affects their access to health services. Health equity, as demonstrated by the greater utilization of health services, increase in likelihood when individuals perceive there to be a high level of neighborhood cohesion; social support acts as a protective factor against poor health outcomes (Nguyen, Ho, & Williams, 2011).

Overall, the Social Determinants of Health framework highlights the more systemic causes of health disparities such as environmental toxins, high crime, and a lack of educational and community resources, all of which result in negative health outcomes which are differentially distributed (Marmot, 2006).

Theory Integration

Both Life Course Theory and the Social Determinants of Health Framework are used to examine the onset and persistence of disparities amongst marginalized older adults (Braveman & Barclay, 2009; Marmot, 2006; Rugh, 2011). As discussed above, disparities are present in such areas as health care, income, educational levels and access to safe neighborhoods. All of these disparities negatively impact the lives of diverse

elders. This dissertation will attempt to identify specific organizational strategies that

have the potential to alleviate these disparities. Please refer to Figure 3 for a visual

representation of how these two theories interact to inform organizational interventions

aimed at ameliorating disparities in old age.

Figure 3: Integration of Theory
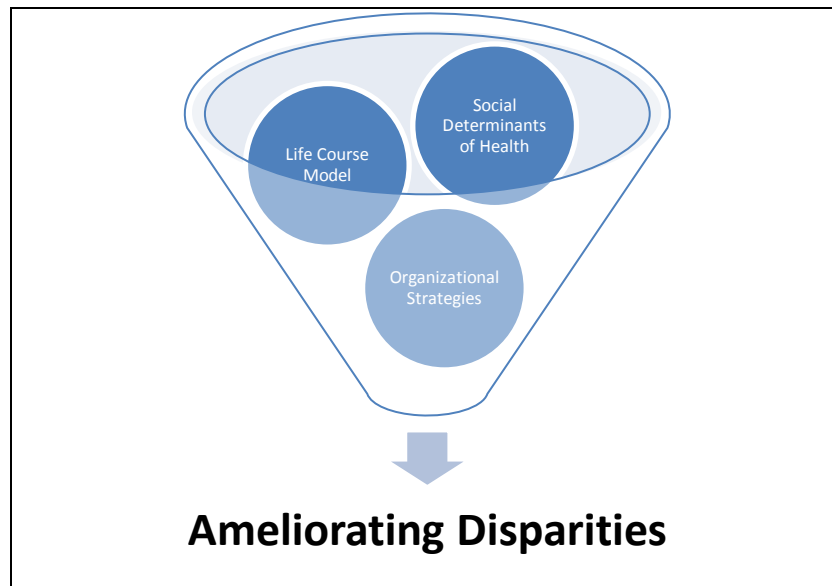
Life Course Theory and the Social Determinants of Health Framework are similar

in that they focus on more systemic causes of disparities (Braveman & Barclay, 2009;

Marmot, 2006) rather than solely relying on deficits in individual decision making. Life

Course Theory is even mentioned multiple times as a component found within the Social

Determinants of Health Framework itself (Blane, 2006; McMunn, Breeze, Goodman,

Nazroo, & Oldefield, 2006).

Although individual decision making is a component found within both of these

theories, it is relegated to a more subordinate position when compared to the more

systemic issues of racism, poverty and differential access to education and adequate

health care (Braveman & Barclay, 2009; Marmot, 2006).

Braveman & Barclay (2009) write,

> The prevailing view has been that individuals are solely responsible for their ...behaviors. In line with that thinking, our... efforts have focused heavily on informing and encouraging individuals to change their behaviors. The contention in this monograph, however, is that we need to take a fresh look, because current approaches have not provided an acceptable return on investment (p. 5).

Individual decisions to improve one's nutrition or to stop smoking in order to

improve one's health are helpful in changing behavior after these initial inequities within

the system are taken into account (Robertson, Brunner, & Sheiham, 2006); "blaming the

victim" and saying that a person is solely responsible for their own poor outcomes,

regardless of other systemic issues, is not helpful and does not adequately address the

true causes of disparities (Jarvis & Wardle, 2006).

Both the Life Course Model and the Social Determinants of Health Framework

will be used in this study as sensitizing concepts (Padgett, 2008) to help focus the

interview questions on more systemic, rather than individual, causes of disparities and

consequently identify potential organizational strategies that could lead to their

elimination.

Chapter Four: Methods

This research aims to identify the strategies that key informants within community based organizations use to alleviate disparities and meet the needs of marginalized older adults. This qualitative study included both individual interviews and focus groups with representatives of community based non-profit organizations serving diverse elders of all types. It also included a review of relevant agency documentation such as mission statements and annual reports. This chapter will further describe the sample and methods used within this study.

Sampling

Purposive sampling (Singleton & Straits, 2010) was used to select organizations that serve marginalized older adults within both the Denver and Boulder Metropolitan areas. All organizations serving marginalized populations listed in the resource guides of both the Denver Regional Council of Governments (DrCOG) and the Boulder County Area Agency on Aging (Boulder County Area Agency on Aging, 2013; Denver Regional Council of Governments, 2013) were asked to be participants in this study. Both of these organizations serve as the Area Agencies on Aging for the Denver and Boulder metropolitan areas, providing resources, services and information and referrals for older adults residing within these specific geographic areas ("The National Association of Area

Agencies on Aging," 2012). Established by the Older Americans Act of 1965, this aging network was developed so that older adults and their family members would have easy access to information about services for older adults within their local communities (U.S. Administration on Aging, 2014); this information and referral feature makes the Area Agencies on Aging network ideal for forming the purposive sample of community based agencies serving marginalized older adults. The purposive sample also included local agencies already known by this researcher to provide services to diverse older adults.

Snowball sampling (Padgett, 2008) was then used, in order to include other organizations serving marginalized adults within the Denver metropolitan area that were unknown to this researcher and/or not included within the two above mentioned directories. Study participants were asked whether they were aware of any other agencies serving diverse older adults within the Denver and Boulder metropolitan areas who should be asked to participate in this study. Adding these agencies that serve marginalized elders but are not affiliated with the local Area Agencies on Aging, or already known to this researcher, may serve as a type of discriminant sampling, to determine if new participants differ significantly from those already sampled (Creswell, 2013).

Within each agency, an executive director, program manager or agency representative was asked to participate in the study as well as to suggest possible key informants within their organizations who may also want to participate. This researcher provided the agency representative with an informational flyer that could be distributed to

agency employees (who could then self-select whether or not they wished to participate in the study) and distributed through relevant list serves, newsletters, and other communication channels that the agency was already utilizing. Please refer to Appendix B for a copy of this marketing flyer.

Grounded Theory Approach

This study utilized a modified grounded theory approach to generate theory from both individual and focus group interviews. Grounded theory is defined as a type of qualitative research in which the researcher develops a conceptual framework or theory that is "grounded" or derived inductively from the words of the study participants (Charmaz, 2006). Saldaña (2009) defines grounded theory as including in vivo, process, initial, focused, axial and theoretical coding. This modified grounded theory included the first level coding strategies of in vivo, process, and initial coding, along with the second level strategy of focused coding. Focused coding replaced the more structured axial and theoretical coding. Each of these distinct coding methods will be described in further detail in the data analysis section below.

Theoretical sampling and subsequent coding is defined as a process in which emerging theory, based on participant interviews, is used to guide future sampling decisions (Glaser & Strauss, 1967). In this study, the entire population of agencies serving diverse elders, within the geographic boundaries of two area agencies on aging, were already invited to participate in this study; consequently, the use of theoretical

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sampling and coding would not have led this researcher to any new agencies that had not already been invited to participate.

Charmaz (2006) defines axial coding as a process in which categories and subcategories of codes are compared and contrasted in terms of the specific properties and dimensions of each theme, as a means of generating theory. Axial coding is quite structured and may actually limit the coding options due to its strict interpretation of the coding process; it may be eliminated if a researcher utilizing grounded theory prefers to use a less structured coding process, such as the constant comparison of categories and subcategories (Charmaz, 2006).

Data Collection

Managers and other self-identified, key stakeholders within organizations serving older adults were asked to participate in both individual (agency specific) and focus group interviews (multiple agencies). All participants had the option of participating, at their own discretion, in an individual interview, and/or a focus group interview with other agency representatives. In order to further triangulate the data, this researcher also reviewed the mission, vision, annual statement and other relevant archival documents pertaining to each organization that participated in the study (using documents recommended by each participant). These documents will be described in further detail within the results section of this paper.

All interviews were conducted by this researcher, utilizing a semi-structured interview guide, and open ended questions (Padgett, 2008). Please refer to Appendix C

for a copy of the interview guide. Follow-up questions varied slightly by participant, based on the content of each interview. Interviews were on average 40 minutes long. Permission was sought for each interview to be audio taped. Each participant was asked to complete a brief demographic survey containing basic questions about both the participant and the agency to which he/she represented. Please refer to Appendix D for a copy of the demographic survey. All interviews were transcribed and documented with analytic and research memos (Padgett, 2008), using the qualitative software Atlas.ti, version 7.5.3.

In order to protect human subjects, potential participant(s) were made aware that the interviews would occur at a location of the participant's choosing, that audiotaping was requested, but not required, and participation in this project was strictly voluntary, with the ability to terminate the study at any time. One potential participant agreed to meet with this researcher but later refused audiotaping and participation in the study. This conversation was not recorded and was not included in the data analysis. Informed consent was verbally obtained at the moment that the organizational representative agreed to participate (typically over the telephone, or in-person) with written informed consent reiterated and obtained at the beginning of each in-person interview or focus group. A copy of the informed consent form can be found in Appendix E.

In order to ensure confidentiality, interview responses (and documents) were identified by code number only and kept separate from information that could identify participants. Only this researcher and the dissertation committee had access to this data.

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Data was reported in aggregate form, or without personal information, so that individual participants and agencies could not be identified. Names of study participants and agencies were not recorded anywhere other than along with the signature on the consent form and within the master participant list kept by the researcher. All study materials were locked in a file cabinet in order to retain participants' privacy and all electronic documents required a password to access them. This study was approved and monitored by the University of Denver Institutional Review Board (IRB).

Data Analysis

To begin the analysis process, Atlas.ti, version 7.5.3 was used to conduct line by line coding of each participant's transcript and archival document; initial, in vivo, process and attribute coding strategies were used at this stage of analysis. Saldaña (2009) defines initial coding as the breaking down of qualitative data into discrete segments or parts, and comparing these bits of information for similarities and differences between them (Saldaña, 2009). Initial coding can include both in vivo and process coding, as well as other coding strategies that break down the data into manageable pieces of information (Saldaña, 2009). In vivo coding includes the utilization of short verbatim quotes or phrases from participants as the qualitative codes. Process coding involves using words ending in 'ing' to designate a variety of processes, emotions or actions used to solve a problem or reach a goal (Saldaña, 2009). Attribute coding (Saldaña, 2009) was used to sort data using demographic information pertaining to each participant.

The next stage of analysis involved using Family and Super Family tools within Atlas.ti to combine the data into larger and larger pieces of information, integrating individual codes into themes and sub-themes for the entire data set; focused coding was the strategy used during this phase. Focused coding is defined as breaking down the data into categories of information used to sort related information into groups (Saldaña, 2009).

As an example, initial reading of the transcripts led to the sorting of participant quotations into categories named "values" and "strategies". Values were defined as goals or objectives of the participant agencies that were aspirational in nature and not tied to specific actions. This included such values as self-determination and a relational rather than a competitive work environment. Strategies were defined as specific, practical recommendations for action at the organizational level. These actions ideally could be implemented by non-profit administrators and included such topics as recommendations for hiring diverse employees, outreach strategies, and the use of marketing materials in multiple languages.

As another part of second level coding, the Network tool in Atlas.ti was used to segment themes into sub-themes. This researcher used an iterative analysis style in which the data was continually expanded and segmented until all codes were sorted into themes and sub-themes, each with associated quotations from a variety of participants and agency documents.

For example, the codes assigned to the category of cultural competency were analyzed and sub-divided into specific components of cultural competency including strategies to ensure cultural competency, examples of institutional bias, and instances of disparity. This iterative process back and forth between the codes, families and super-families led to the creation of specific themes and sub themes within the data.   Please refer to Figure 4 for a pictorial representation of this analytic process.

Figure 4: Iterative Process of Analysis
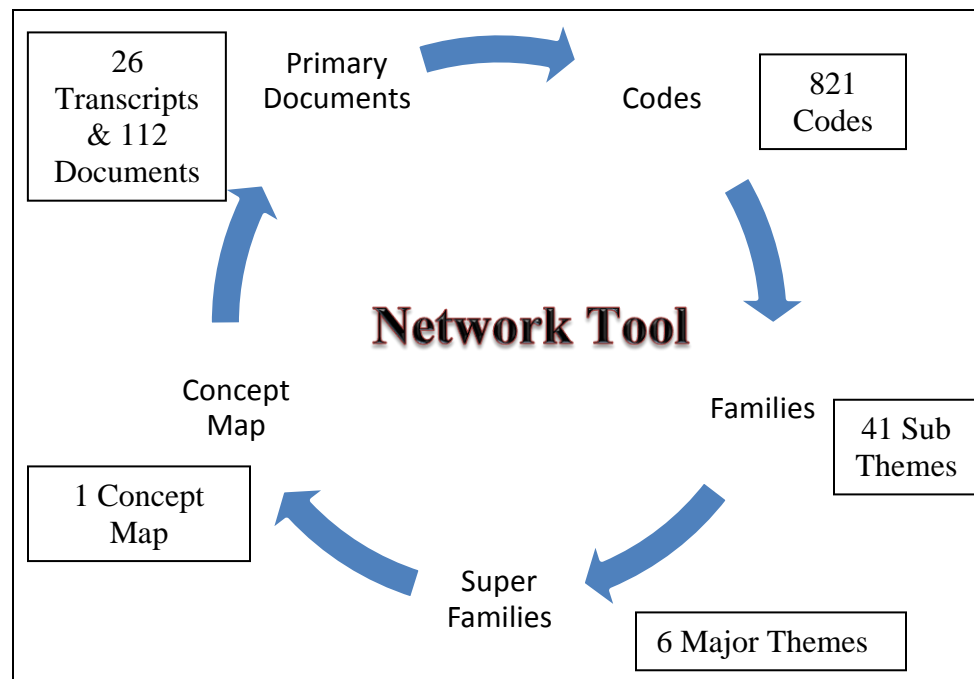
During the last stage of analysis, the primary themes were combined into a pictorial representation or concept map, representing how the main themes were related to each other. This iterative process led to the creation of 6 major themes, each with subsequent sub-themes. Two of the identified themes (background and miscellaneous) were excluded from the final concept map as they functioned as background material for

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the analysis, rather than items for analysis. For example, one of the categories within the miscellaneous theme was named caregiving; this included codes about family or friends providing care to older adults. Quotations about this topic were included as a means of sorting the data into topics, but did not pertain to the research questions of organizational strategies to best meet the needs of diverse elders, so they were not included in the final analysis. One other theme (cultural competency) was also eliminated from the final concept map as this theme described the problem of disparities and lack of cultural competence, rather than organizational strategies to attempt to remedy this issue. Organizational strategies, within the theme of cultural competency, were included in the concept map under "organizational strategies to better serve diverse elders".

The remaining themes were incorporated in some way into the final concept map: bureaucracy, coalitions, and trust. The main theme of bureaucracy was represented by two items on the concept map (bureaucracy and efficiency) as this emerged as one of the major themes within the study and required the differentiation of these two sub-themes. For clarity, the theme of coalitions was reworded within the concept map as collaborations. The remaining theme of trust was pictorially represented as an overarching topic that related to the other themes.

Throughout the process, research and analytic memos describing the decision making and sorting of data were outlined using the memo feature of Atlas.ti. Separate memos were used to document each analysis decision. Each memo was dated, given a title, and provided an outline of the specific analysis decisions that were made on that

day. This information described the step by step analytic process of this study and could be used by future researchers to replicate the analytic process.

Credibility and Trustworthiness

This researcher used the strategies of 1) immersion, 2) member checking, 3) thick description, 4) audit trails (using analytic memos), 5) triangulation and 6) transferability as means of developing credibility and trustworthiness within this study.

As a former practitioner in the field of gerontology and non-profit manager for over a dozen years, this researcher is aware of various acronyms and terms used by the participants, and is thus already "immersed" in the community (Creswell, 2013). This immersion in the non-profit community serving older adults helped this researcher generate appropriate interview follow-up questions, understand basic concepts discussed and overall allowed for a more comprehensive and efficient interview.

Throughout each interview, this researcher repeatedly paraphrased what the participants said, as one method of member checking (Shenton, 2004). As a second form of member checking, invitations were also made to all study participants to attend a presentation, discussion and critique of the preliminary results. All participants, as well as local gerontology professionals were invited to attend these presentations. Advertising of the events occurred through a blinded email to participants (so as to retain anonymity), presentation to a local gerontology conference, postings on a gerontology academic website, Facebook, Linked In, Twitter, and other social media sites, a Denver community

gerontology list-serve, an announcement on a local academic email list, and this researcher's professional web page.

Approximately forty individuals attended the first community event, none of whom had participated in the original study. Approximately 10 individuals attended the second presentation of preliminary results, including 3 participants from the original study. This member checking with non-study participants may serve as a form of peer de-briefing in which preliminary themes, analyses and theories were shared with professional gerontologists in a variety of fields, in order to address the credibility of the results and potentially reduce researcher bias (Padgett, 2008). In addition to the formal presentations of preliminary results, one agency who, due to time constraints, had not been able to participate in the study, asked for an informal in-service for three of their staff members and were provided with the preliminary results. Another participant agency expressed interest in delving further into the results of this study through a 2 hour in-service for approximately twenty of their employees, which will be scheduled for some time later this year. Themes from these member checking events will be included in more detail within the results section of this paper.

Participants who did not attend either of the events were also forwarded the website address of this researcher (Martin, 2014) which included presentation materials, a compilation of organizational strategies, preliminary lists of local agencies serving diverse elders and educational resources about these unique populations. These items

had been requested by participations as both a resource for future community partnerships and education for their employees of the unique needs of diverse elders.

Thick description and generous use of quotes are provided in the results section, consistent with strategies outlined by Shenton (2004) for credibility and trustworthiness.

Research and analytic memos were used to document coding strategies, the process for the development of themes and the generation of theory; this audit trail will serve as a framework of decisions made by the researcher, in order to demonstrate transparency in both methodology and data analysis (Shenton, 2004).

Triangulation, or the use of multiple data collection strategies to confirm that the data collection was in fact a true reflection of the voices of the participants and not the views of this researcher, (Shenton, 2004) was facilitated through a review of relevant agency documents such as such as agency missions, value statements, web pages, and annual reports, in addition to the in-person interviews and focus groups.

Transferability is defined as the potential of the results of this particular study, within its unique context, to be transferred or made applicable to other contexts or situations (Shenton, 2004). The unique transferability of this study was explored through the use of detailed description of the study environment, participants and context, within the results section of this paper, which will allow the reader to determine if study results are transferable to other populations or contexts.

Chapter Five: Results

This section will describe the study sample, main themes that emerged from this study, and description of the final grounded theory as represented by a concept map. All themes will be explained and justified through the use of participant and document quotes. The final section will discuss a series of member checking events that confirmed these themes.

Sample

This section of the paper outlines the sample used in this study, with explanations of the agencies that participated, characteristics of individual participants, a description of documents, and a discussion of the context of the sample that could be used to address the transferability of the results.

Agency sample.

The final sample consisted of 42 individuals, from 25 non-profit organizations serving diverse elders, and 112 documents pertaining to those agencies. Participants were given a choice as to whether they wanted to participate in an individual agency interview, a focus group with representatives from multiple organizations, or both. Most participants chose to meet with this researcher in groups of one to two people representing one specific agency. One agency chose to participate in an all-staff focus

group (with fourteen participants) rather than engage in individual interviews. Three

agencies (four participants) agreed to participate in a multi-agency focus group, in

addition to participating in individual agency interviews. Please refer to Table 1 below

for additional information about the types of interviews included in this sample.

Table 1
SAMPLE - Numbers of Participants & Agencies

Data Collection Method[1]	# of Participants	# of Agencies
Individual Interviews	20	20
Interviews with 2 people	8	4
Agency Specific Focus Group	14	1
Multi-Agency Focus Group	4	3
TOTAL	42[2]	25[3]

[1]Participants chose the data collection method that worked best for their agency. [2] Total number of participants excludes four individuals that participated in both individual interviews and one multi-agency focus group. [3] Total number of agencies excludes three agencies that participated in both individual interviews and one multi-agency focus group.

The populations served by these particular agencies ranged from transgender

elders, to Holocaust survivors, to older adult refugees and elders with developmental

disabilities. Please refer to Table 2 below for a full description of the diverse elder

populations represented in this sample.

Table 2:
Diverse Elder Populations Within this Sample

Diverse Elder Populations Within This Sample
Asian, Asian American, Pacific Islanders
American Indian
African American
Latino
White
Homeless
Medically Frail or Low Income
Persons with Disabilities
Individuals with Mental Health Issues
Transgender / Lesbian / Gay / Two-Spirit
Persons with Criminal Backgrounds, and Crime Victims
Holocaust Survivors or Jewish
Refugees or Immigrants

Participant demographics.

Every participant was asked to complete an optional demographic questionnaire as part of the interview process. Only two participants chose not to complete the demographic survey. Some participants refused to answer specific questions, leaving these answers blank. Response rates differed by question, ranging from 76% to 93% of participants answering each question. Please refer to Table 3 below for detailed response rates.

Within this sample, the average age of participants was 46 years, with a range in age from 24-71 years old. Women composed 72% of the sample, with 26% of the

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participants identifying as men and 1 person who identified as transgender. This sample

of participants was primarily White (61%) with a smaller contingent of individuals

identifying as Asian American (24%) primarily due to one agency specific focus group

where the majority of employees identified as Asian American. Five percent of

participants identified as Latino and 3% self-identified as American Indian. Eight

percent of the participants were categorized in the "other category," which included

participants self-identifying as Jewish, Bhutanese/Nepali and American Indian/African

American. Fifteen percent of the sample identified as lesbian, gay or two-spirit.

Participants had on average, 13 years of experience working with marginalized

older adults (at any agency), with a range from 0 to 40 years of work experience. The

majority (92%) had at least some college education, while the remainder (8%) were high

school graduates. Participants worked an average of 8 years at their specific agency,

ranging from 2 weeks employment to 40 years working within that organization. The

majority of the respondents identified with a job title that was administrative, managerial

or supervisory (59%). Eight participants directly worked with older adults (21%). The

professional category included nurses, social workers, and mental health clinicians,

which was 15% of the sample. Two participants (or 5% of the sample) worked in clerical

positions. Please refer to Table 3 below for further details about the characteristics of the

sample.

Table 3:
Sample Characteristics

| Sample Characteristics | Sample Details[1,2] | | # of Participants[3] (response rate) |
	Mean or %	Range	
Age	46	24-71	39 (93%)
Gender			
Female	72% (N=28)		
Male	26% (N=10)	NA	39 (93%)
Transgender	3% (N=1)		
Race			
White	61% (N=23)		
Asian American	24% (N=9)		
Other[4]	8% (N=3)		
Latino	5% (N=2)	NA	38 (90%)
American Indian	3% (N=1)		
African American	0% (N=0)[5]		

Sample Characteristics	Sample Details[1,2]		
	Mean or %	*Range*	*# of Participants[3] (response rate)*
Sexual Orientation			
Heterosexual	85% (N=28)	NA	33 (79%)
Lesbian, Gay, Bisexual or Two Spirit	15% (N=5)		
Education Level			
At least some college or higher	92% (N=36)	NA	39 (93%)
High school graduates	8% (N=3)		
Job Title			
Management / Executive	59% (N=23)		
Direct Service	21% (N=8)	NA	39 (93%)
Professional[6]	15% (N=6)		
Clerical	5% (N=2)		
Total Years' Experience Working with Marginalized Individuals	13	0 to 40 years	32 (76%)
Total Years' Experience Within Agency	8	2 weeks to 40 years	38 (90%)

[1] As identified by participants. [2] Total numbers may equal more than 100% due to rounding. [3] This refers to the number of participants who answered a specific demographic question, as some questions were left unanswered. Means and percentages were based on this total number of participants. [4] The "other" race category included Jewish, Bhutanese/Nepali, and American Indian/African American, as identified by participants. [5] One participant identified as both American Indian and African American and was counted in the "other" category. [6] Clients self-identified their job titles as part of the demographic survey. Answers were then combined into themes. Management was defined as any position that included a management, executive or supervisory title. Direct service was defined as working directly with clients, as compared to a management position. The professional category included nurses, master's level social workers and other mental health clinicians. The clerical category is defined as administrative or office work, at a non-management level.

Documents.

The documents included in this sample (N=112) were recommended by the
participants themselves and ranged from government sponsored community demographic
studies, to websites, agency newsletters, brochures, mission statements, and annual
reports. Documents were analyzed using the same coding scheme as that of the
individual and focus group interviews. Please refer to Table 4 below for further details
about the sample of documents.

Table 4:
Document Characteristics

Categories of Documents	Number of Documents
Agency Websites	25
Agency Brochures & Client Demographics	14
Local, Regional and State Needs Assessments	13
Budgets / Annual Reports / Funding Reports	13
Client Newsletters	12
Government Strategic Planning Documents	10
Board & Governance Documents	8
Educational Information about Specific Cultural Groups	5
Personal Client Stories / Narratives	3
Information & Referral / Resource Guides	3
Advocacy & Policy Documents	3
Agency Forms	2
Researcher Field Notes (1 agency did not wish to be audio taped)	1
TOTALS	**112**

Sample context.

This study was conducted within two urban areas within a state located within the
Rocky Mountain region of the United States. Transferability for this study will depend

on whether other geographical areas of the United States share the same distribution of agencies serving diverse elders as represented in this region of the country. It is also interesting to note that many of the participants in management positions within these organizations are White and college educated, even though the elders they serve are more likely to be of color and in lower income brackets. The results of this study may be less transferable to more rural areas or agencies in other geographic regions.

Primary Themes

There were five major themes generated from the participants in this study: 1) bureaucracy, paperwork and lack of resources; 2) collaboration; 3) efficiency, 4) trust and rapport; and 5) organizational strategies to better serve diverse elders. These primary themes were combined to form one overall concept map. Please refer to Table 5 for a summary of the first four major themes. Each theme will be described in further detail in the sections after this table. Organizational strategies will be explained in its own section to allow for a more in-depth discussion.

As mentioned in the methodology section, two of the identified themes (background and miscellaneous) were excluded from the final concept map as they functioned as background material for the analysis, rather than items for analysis. The theme of cultural competency was also eliminated from the final concept map as it described the problem of disparities and lack of cultural competence, rather than organizational strategies to attempt to remedy the issue.

Quotations within this results section are attributed to both individual participants/focus group members (sources #1-29) and documents (sources #31-142). One multiple agency focus group (#30) and one within agency focus group (#25) are also discussed. Multiple attributes associated with a quotation (for example, source #4/5) designates that two individuals participated in the same interview.

Table 5:

Summary of Main Themes

Theme	Description	Example Quotation
Bureaucracy, Paperwork and Lack of Resources	Participants describe bureaucracy, paperwork, funder policies and regulations as problems with meeting the needs of diverse elders. These agencies do not have the capacity to meet these ever expanding requirements and have less resources in terms of money, time and status, as compared to their more mainstream agencies. Agencies that had the capacity to respond successfully to these new regulations already have accumulated resources at their disposal. Funding and resources often went to the more resource rich agencies that had received money previously.	"You need money to make money....We are trying to dig out because they want these stats [effectiveness statistics often required by funders]. Well, who is going to do that? Who has got the time? If we had no paid staff to do that, how are we going to collect these stats so we can get money so we can do more stuff? (#30)."

Theme	Description	Example Quotation
Collaboration	In an environment of dwindling resources and greater demands from funders and regulators, collaboration becomes one of the key strategies that participants recommend. Diverse clients may have unique abilities to collaborate on important social justice issues, based on their life experiences.	"Given the upcoming significant growth in the number of seniors..., the need for collaboration is great among government, community-based organizations and the private sector. Whether large or small, well-endowed or under-funded, coalitions help strengthen communities through developing capacity, increasing collaborative problem solving, promoting cooperation, developing advocacy capacity and increasing information access (#43)."
Efficiency	When dealing with fewer resources and more clients with complicated needs, organizations serving diverse elders look to strategies that can help them be more efficient in order to better serve diverse elders. Many participants spoke about the relationship between collaboration and efficiency and how the forming of	"Our...system must deliver a high quality of person-centered care to more people while using resources more efficiently, resulting in better ...outcomes at a lower cost (#100)."

Theme	Description	Example Quotation
	relationships with other agencies led to more efficient services and programs.	
Trust and Rapport	Participants spoke about the importance of developing trust with both clients and diverse community members. Diverse clients are often hesitant to trust agencies or institutions due to past experiences of marginalization. In the same way, community members are also distrustful of non-profits. Trust involves getting to know clients and targeting programs to both the needs and strengths of the community.	"For any organization that's trying to break down that barrier, it's a culture shift.... There's a reason why maybe you don't have a very diverse board, or staff... because you're not maybe trusted in that community...or they just don't know about you, so it's that really targeted outreach... and building a relationship with those communities (#1)".

Bureaucracy, paperwork & lack of resources.

Participants describe bureaucracy, paperwork, funder policies and regulations as problems with meeting the needs of diverse elders. Some of these agencies do not have the capacity to meet these ever expanding requirements and have fewer resources in terms of money, time and status, as compared to their more mainstream agencies. Agencies that had the capacity to respond successfully to new regulations already have accumulated resources at their disposal. Funding and resources often went to the more resource rich agencies that had received money previously. These components of the bureaucracy theme will be described in detail below, with participant quotations as evidence supporting the theme.

Participants describe bureaucracy, paperwork, funder policies and regulations as challenges that make it difficult to meet the needs of diverse elders. Agency #2 tells a story of how bureaucracy can negatively affect services to seniors.

> One of the problems that you've...dealing with... is that there are programs out there, but they're – they're insufficient. [For example] ...you have a mentally ill senior, but they can't get [him/her] into...[the local community center] because there's a wait list...But there's not exactly a list...what they tell people is keep calling on Monday...and we'll see if we get an opening...you can go on for months that way.... When I started 13 years ago... I knew all the technicians for the most part... I could call them up, because I had a list of technicians' phone numbers... and I'd say "Hey, Gloria...I'm trying to work with Joe Schmo... This is what the

problem is". And I could leave a voicemail...get it fixed. Well, with the down in

the economy in '08 that... when the county started having... financial difficulties,

they suffered...losses just like anybody else. So the caseload skyrocketed at the

same time that we're getting more people who needed...to have the benefits

because more and more people...didn't have income... so, now, what happens is

that you shoot around into the darkness, and you hope that...something happens....

We lost...the ability to do things person to person with a handshake.

According to participants, diverse elders, in particular, have more challenges in

regards to interacting with a bureaucratic world. One source reads that "many seniors

struggle to navigate the ever-changing healthcare and social service systems. They often

feel confused or overwhelmed when attempting to acquire these services and as a result,

frequently fall through the cracks of the system (#106)."

When faced with having to provide complex documentation or complete difficult

forms, diverse elders face significant challenges. "Well, why are they marginalized?

Stop and think about it: What do you have to do if you're homeless? And, you know, if

your brain isn't working too well, and you left your I.D. some place, your birth

certificate....(#15)." Participants discussed how unreasonable it was for diverse older

adults to be expected to provide complex documentation as a requirement for services

that they really needed.

Participants from agencies serving unique elder populations reported having

fewer resources in terms of money, time and status, as compared to their more

mainstream agencies. "I have really got my head to my desk... my goals is really to do better outreach, but I don't have the time or the resources (#6)." Another participant agrees,

> You need money to make money... We are trying to dig out because they want these stats [effectiveness statistics often required by funders]. Well, who is going to do that? Who has got the time? If we had no paid staff to do that, how are we going to collect these stats so we can get money so we can do more stuff? (#30)

Client numbers are also increasing while resources are dwindling.

> The majority of [agency] respondents [to a government based survey] indicated that the number of clients they have served as well as the requests for services have increased [67-77%]... while only 13% of ...organizations have seen an increase in funding....while the older adult population in Metro Denver is growing, the financial resources at the state and federal level are in jeopardy of being cut. (#58)

On the other hand, some agencies do have the capacity to successfully respond to these changing regulations and requirements. Agencies such as these had the capacity to respond successfully to these new regulations because they already had accumulated resources (such as reserve income, relationships with affluent benefactors, marketing departments, and banks of volunteers who could provide services to their clients).

> I think an example of something that we developed more recently, is not necessarily a program, it's more infrastructure in terms of how we provide

services. We're getting more complicated clients, clients that need a little bit more intensive care management.... But just looking at the nature of the clients that we have coupled with the increased requirements from funders for more in-depth paperwork and more frequent grant reports and things like that, our documentation needs have gone up higher. And so identifying that we continue to provide the level of service to our clients, and be able to take new clients and not have to have a wait list for care management, it was really helpful to get someone to come in to do some of that behind the scenes work and help running reports for programs and doing billing for all of our homemakers. (#7/8)

Participants stated that funding often went to the more resource rich agencies that had received money previously, not necessarily the smaller, more diverse agencies that really needed the help.

It's become more hectic in some ways... and time consuming now... when I started, it was pre computer so I had a – a sheet... and every time I supposedly did something for somebody, I was supposed to mark...the name and... the activity.... [Now] ...they started a new computerized system and right at the time when our personnel changed.... We didn't have continuity... we tried to figure [it] out....but...in the end...what happened was that... they had a meeting to distribute funds and they said, you know, '[this organization] ...does a good job, but their paperwork is crap, so, let's pass them by this year.' (#2)

Collaboration.

In an environment of dwindling resources and greater demands from funders and regulators, collaboration becomes one of the key strategies that participants recommend. Diverse clients may have unique abilities to collaborate on important social justice issues, based on their life experiences. These components of the collaboration theme will be described in detail below, with participant quotations as evidence supporting the theme.

> Given the upcoming significant growth in the number of seniors..., the need for collaboration is great among government, community-based organizations and the private sector. Whether large or small, well-endowed or under-funded, coalitions help strengthen communities through developing capacity, increasing collaborative problem solving, promoting cooperation, developing advocacy capacity and increasing information access. (#43)

The theme of collaboration was also evident in agency brochures, mission statements and annual reports. One report states that a primary goal of the agency is to "...promote information dissemination among our members by hosting educational trainings, leading advocacy efforts and providing opportunities for coordination and networking (#56)." Another says that, "state agencies are working together to improve coordination and shared data across state government, which enables us to use resources more efficiently and simultaneously improve data collection (#100)." One participant summarized the issue quite well, when it was said that "trying to do it, just on your own, doesn't help (#29)."

Participants reported that diverse clients may have unique abilities to collaborate on important social justice issues, based on their life experiences.

Latino older adults know how to build coalitions to get things done in the community. ...many Latino older adults experienced the civil rights movement and learned how to work with other people in order to solve community problems and fight for their rights, as well as the needs of their families (#58).

Efficiency.

When dealing with fewer resources and more clients with complicated needs, organizations serving diverse elders look to strategies that can help them be more efficient in order to better serve the needs of diverse elders. Many participants spoke about the relationship between collaboration and efficiency and how the forming of relationships with other agencies led to more efficient services and programs. These components of the efficiency theme will be described in detail below, with participant quotations as evidence supporting the theme.

Participants describe bureaucratic processes that seem to be inefficient or waste time and resources.

The lack of fluidity in working within the community around appropriate resources [is an issue]... We typically have to write a grant to an external foundation, that foundation sends the individual check, and then they [another human service agency] have to go out and get the durable medical equipment, whatever it might be. So the process is absolutely not streamlined. (#12/13)

The goal of many of these agencies is to somehow become more efficient in providing

services. "Our...system must deliver a high quality of person-centered care to more

people while using resources more efficiently, resulting in better ...outcomes at a lower

cost (#100)."

Many participants spoke about the relationship between collaboration and

services and how the forming of relationships with other agencies led to services that

better met the needs of diverse elders. Participants stressed that the time and resources

spent in developing these relationships was time well spent.

> When we know each other... and have more experience with one another then...
> I'd like to think... when we're sitting around the table... it's going to be a little
> more effective because we do know each other, and we...have a history or a
> connection. ....Making time to build those relationships and – and seeing that as a
> valuable part of what we're doing with our time and resources [is important]
> (#30).

Trust & rapport.

Participants spoke about the importance of developing trust with both clients and

diverse community members. Diverse clients are often hesitant to trust agencies or

institutions due to past experiences of marginalization. In the same way, community

members, or potential clients, are also distrustful of non-profits. Trust involves getting to

know clients and targeting programs to both the needs and strengths of the community.

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These components of the trust and rapport theme will be described in detail below, with participant quotations as evidence supporting the theme.

Participants spoke about the importance of developing trust with both clients and diverse community members. "[There's] a piece of paper that every agency wants to hand to the client...here's your resource list... a piece of paper that is going to end up somewhere, that they are not using.... [The senior is asking] 'what is this, who are these people?' ...Knowing the population, there is that trust that needs to be developed [first] (#12/13)."

Finding a way to build trust and rapport is an important strategy in working with diverse elders. "We know from experience that Holocaust survivors can be difficult clients to serve. They are often suspicious of strangers, non-compliant with treatment plans, extremely anxious and sometimes demanding (#116)." Document 70 reports the same phenomenon, "Recruiting tends to be a challenge as many of our elders are isolated– sometimes community members has long standing grudges that need to be worked through to make the group a safe space."

Trust also involves getting to know clients and targeting programs to both their needs and strengths. Participants #7/8 say,

> We have the general parameters of our programs, and if it's a grant funded program, there are specific qualifications that we don't have control over. But as much as possible we have to tailor what we do based on the needs of the person we're providing. So, for example I have a client who doesn't speak English.

She's a monolingual Spanish speaking woman, and needed some home based

services, and so I've been able to collaborate with the service coordinator in her

building. A gentleman who works in the maintenance department does translation

for us, so when I do my visits with her, I have to schedule accordingly and we

have a provider that can go in and speak Spanish when she has the in-home

services. So with that particular situation, we had to just look at it a little bit

differently. We do the same thing if a client is hard of hearing or visually

impaired.... So kind of the bigger picture answer is that we look at each case

individually as much as possible.

Trust is the cornerstone of building relationships with the community. Participant 1

states,

For any organization that's trying to break down that barrier, it's a culture shift....

There's a reason why maybe you don't have a very diverse board, or staff...

because you're not maybe trusted in that community...or they just don't know

about you, so it's that really targeted outreach... and building a relationship with

those communities.

Organizational Strategies to Better Serve Diverse Elders

In depth analysis of in-person interviews and documents led to a series of

practical organizational strategies that agencies could use to become more welcoming in

order to better serve diverse elder populations. These strategies broke down into six main

themes, which will be summarized below. These themes included: 1) leadership,

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2) coalition building, 3) developing relationships, 4) diverse marketing and outreach, 5) transparency and fair agency policies, and 6) taking time to plan. Some of these themes overlap in concept with other themes generated by this study, but are unique in terms of providing specific recommendations that can be implemented at the organizational level. Please refer to Appendix F for a comprehensive list of all organizational strategies as identified by study participants.

Leadership.

The leadership theme consisted of strategies for hiring a diverse leadership team that understood the language, culture and lives of diverse elders. In order to be successful in working with diverse elders, leaders need to come from the communities that the organization is serving. These components of the leadership theme will be described in detail below, with participant quotations as evidence supporting the theme.

> We have staff members who themselves might be considered marginalized people who... have really brought their richness of their experience here and so our team is pretty diverse, and...I think that carries over in to our work. [it's also important to have] ambassadors [between communities] – once those seniors come in and find their niche, then they become leaders.... They have that leadership role.... You have an ambassador which could be a little different than a leader and then once you've established those groups those people then take on the task of – of continuing the welcoming process. (#4/5)

It's also important that clients themselves should be part of the process, helping to govern the agency and determine organizational priorities. Participant 30 states,

> The people who you're working with, or for, should be at the table as well. So if you're talking to LGBT seniors, LGBT seniors should be at the table and talking about 'this is what our needs are, and this is what we want'... so that their voice is being heard, too.

Leadership also included establishing ambassadors who could help connect different communities.

> [it's important to have] ambassadors – once those seniors come in and find their niche, then they become leaders.... They have that leadership role.... You have an ambassador which could be a little different than a leader and then once you've established those groups those people then take on the task of – of continuing the welcoming process and inviting them to be part of a group a larger group and then within themselves creating programs for them... now ...they've been welcomed in to other programs where it's not necessarily [just the] Spanish speaking programs. (#4/5)

Participants felt that diversity within agencies was not only ethically sound but was of benefit to the agency as well. According to document #138,

> Intentional diversity provides opportunities for individuals and strengthens organizations.... [This agency] ...welcomes and needs a variety of perspectives. Participants who complete the inclusive leadership development

training [within our agency] shall have the knowledge, skills and experience to create positive system and policy changes that shall enhance and create opportunities for people with developmental disabilities to further their engagement in civic activities in their community.

Document #58 makes the claim that diversity within the governance of an agency leads to better services and greater social justice as a result.

More inclusive and diverse workforces, advisory groups, and decision making bodies will inevitably lead to providing more culturally competent services and addressing the larger systemic issues preventing social equity.

Coalition building.

Coalition building was the second sub theme within the organizational strategies category. Coalition building was seen as an essential component of successful work with diverse elders. Coalitions based on shared issues lead to increased trust and better overall services. These components of the coalition building theme are described in detail below, with participant quotations as evidence supporting the theme.

Given the upcoming significant growth in the number of seniors..., the need for collaboration is great among government, community-based organizations and the private sector. Whether large or small, well-endowed or under-funded, coalitions help strengthen communities through developing capacity, increasing collaborative problem solving, promoting cooperation, developing advocacy capacity and increasing information access. (#43)

Coalition building also allowed agencies to specialize and focus on services in which they had a specific expertise, utilizing referrals to other organizations to meet the varied needs of their clients.

> [We really need to do] ... a better job at collaborating... otherwise, our seniors won't get the services... we don't have the funding to... transport them back and forth to doctor's appointments, pay for their doctor visits. I mean, we have to rely on [the] resources [of other organizations]... (#28)

Participants felt that coalition building was just the "right thing to do".

> I come from a 'let's float everybody's boat kind of mentality'... we're all better off when the boats get floated together. ... but I don't think we've got that, you know, as a country. ... we're still just too much, you know, 'I'm going to save myself, and I'm going to earn a ton of money. If somebody else gets hurt along the way, so be it.'   (#24)

Participants spoke about how outreach to diverse communities and working with local leaders could lead to the development of trust.

> Stakeholders... stressed the importance of conducting a broad range of outreach and enrollment initiatives at the local level and identified a variety of avenues where they successfully reached consumers, including churches, college campuses, beauty and barber shops, local grocery or community stores, libraries, extension centers, small businesses, and even people's homes.   They noted the importance of developing trust when reaching consumers through these avenues

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and finding a local champion within each community to support outreach

efforts.....Assisters indicated that they developed customized outreach materials

and resources to better connect with the specific communities they serve and meet

their specific cultural and linguistic needs. (#96)

Developing relationships.

The theme of developing relationships consisted of ideas around fostering

connections between people, particularly between groups of individuals that might

otherwise not interact. These components of the developing relationship theme will be

described in detail below, with participant quotations as evidence supporting the theme.

And I think part of that, too... the networking, in the community, ...knowing one

another as professionals. And we balance that at our agency, too, with, okay, we

all have X number of clients versus what you need to be working with [this group

of elders] and these other responsibilities.... but we also need to be out there

networking and getting to know people. (#30)

Developing relationships includes allowing both clients and employees to truly be

themselves. Improved authenticity leads to more trust between individuals and a greater

capacity to learn from each other.

When asked which LGBTQ issue is most important to xem, [this person] says

social justice. 'We are in a unique position to cultivate compassion in the larger

society through the self-authorship that is often required to find our path,' xe

explains. 'I'm excited about where our community is headed as we continue to

explore the intersections of our various identities and experiences and create

spaces where all participants are safe to move and live and love as their authentic

selves.' (#129)

Developing relationships includes listening to others' stories. This leads to greater

cultural competency and subsequently better services for these seniors.

Elie Wiesel, in a lecture on the Holocaust Patient, said it so well and it bears

repeating. At the conclusion of Wiesel's lecture in 1981, a doctor stood up and,

following a poignant and overpowering talk said, 'Professor Wiesel, how shall we

treat our survivor patients?' The answer, 'Listen to them, listen to them carefully.

For they have more to teach you, than you them.' So I guess we must continue to

learn from them, to listen carefully and perhaps they will direct us in the path that

will suit their needs at a particular time. If they are properly heard, it is likely you

will properly care for them. (#116)

Storytelling helps build empathy and compassion for those different from us, which is a

key competency when working with diverse elders. Participant 30 says that sharing

stories is helpful,

[One] strategy is storytelling and hearing the stories of people who are different

than you. ...sharing those stories is a way to create change...in order to change

policy, you need to change hearts and minds. And stories are one way to do that.

... I think it starts with you and me, you know, just as two people. Let me tell you

my story, and you tell me yours, and you can change minds that way. ...I think

that story time is how ... we start that shift in...people's perceptions.... And that

can also be how those coalitions and those groups come together is realizing 'I

never knew that you and I had this part of our experience that was shared' and –

and coming together and kind of pooling the knowledge and the resources can

really come out of that story telling. (#30)

Diverse marketing and outreach.

It is important when working with diverse elders to ensure that signs, marketing

materials and brochures are catered to individuals with different languages, literacy levels

and communication styles. These components of the diverse marketing theme will be

described in detail below, with participant quotations as evidence supporting the theme.

If you're walking through the lobby, you'll see a lot of signs, both in Russian and

English. If someone passes away, we're going to announce it both in Russian and

English. If there's a trip, it's gonna be in Russian and English. Our activities

calendar is double the size of most of 'em because, again, it serves both. (#21)

Forms also need to be inclusive of different genders, sexual orientations, racial

categories and other diversities. Participant #6 says that for, "Intake forms, make sure

you're providing an option, because that tells the person that you're transgender

friendly." How we structure the space or environment of our agencies is also important.

[I would recommend] having some artwork that might say, 'Oh.' You walk into a

doctor's office or something, you see a dream catcher, or you see some other type

of symbol that might make you think you might actually be welcomed here, and they might actually see you, culturally. (#9)

The best strategies for working with diverse elders include the integration of cultural competence within the structure of the agency. In fact,

Individual...experiences are influenced by every person with whom a...[person] interacts in the process of accessing care. From the person on the phone or at the front desk, to the provider... [people] expect to be treated with respect, courtesy, and compassion and provided with clinically competent and culturally responsive care. (#130)

Transparency and fair agency policies.

Transparency is an important organizational strategy for working with diverse older adults. Agencies need to have fair policies that prohibit discrimination and explicitly allow complaints and concerns to be discussed. These components of the transparency theme will be described in detail below, with participant quotations as evidence supporting the theme.

So they [the organizations] need to be doing self-assessments. They need to have a reasonable modification policy.... ADA [The Americans with Disabilities Act] requires reasonable modification of policies, practices, and procedures to avoid discrimination.... (#126)

Participants felt that this was particularly true when working with diverse elders.

A few key leaders stated that....bureaucratic practices pose challenges for

[diverse]...elders. For example, if an older adult experiences discrimination, there

is no one enforcing those policies unless a person can get assistance from a

lawyer. (#58)

Organizations need to openly address bias, admit their failings and hold

themselves accountable for their mistakes.

Have that conversation with people. If it's in a staff training – We all have bias.

It's just innate, we've been taught things. Be aware of what the bias is. But look

people in the eye, and treat them with kindness, unconditional positive regard.

Make sure that you're teaching that, modeling that, and following through with it.

(#6)

Overall, an environment of transparency is an integral part of culturally competent

practice.

LGBT people of color have unique concerns, including racism in the LGBT

community and homophobia within communities of color.....[We should be]

talking continuously about the intersection of race and sexual orientation and

gender identity....Holding our community and our organization accountable to our

commitment to racial diversity and inclusion. While we work to change the

hearts and minds of those outside the...community so that we can secure

protections and opportunities for... [diverse] Coloradans and their families, we

will also seek to change hearts and minds in our own community in order to end racism among us. (#129)

Taking time to plan.

Participants expressed frustrations with a lack of time to plan, but felt that it was an essential component of working with diverse older adults. These components of the taking time to plan theme will be described in detail below, with participant quotations as evidence supporting the theme.

Participants spoke about the need for planning to include the development of inclusive and welcoming policies. One source states that "the way we need to be inclusive with the people we work with, we need to be inclusive when we plan, when we write rules... are we meeting the needs? (#107)"

Taking time to plan and develop priorities became one way to provide more streamlined and efficient services to their clients. One participant states,

> How do we prioritize, coordinate, and streamline our work to make this a better city in which to live and grow older? ...[By] focusing through a multifaceted lens that sees all ages, abilities, and cultures. (#33)

In order to be successful, agencies should focus on services that they did best and make referrals to other agencies; this type of collaborative, referral based system required the time and capacity to plan.

> Sometimes it's ...as basic as a lack of the appropriate referral to your sister agency. ...why wasn't the referral to mental health, um, expedited and automatic?

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It shouldn't have to be... rocket science. You should all be working together.

(#17/18).

Concept Map

Previous sections of this paper have presented evidence of each theme, as demonstrated through the voices of the participants. This section will explain how the themes relate to each other, resulting in a grounded theory generated from the data already presented above. This grounded theory will be visually displayed through a concept map. Please refer to Figure 5 below for a pictorial representation of how these primary themes relate to each other.

Figure 5: Concept Map

TRUST & RAPPORT

Efficiency

Collaboration

Bureaucracy, Paperwork & Lack of Resources

Organizational Strategies to Better Serve Diverse Elders

1. Leadership
2. Coalition Building
3. Developing Relationships
4. Diverse Marketing & Outreach
5. Transparency & Fair Agency Policies
6. Taking Time to Plan
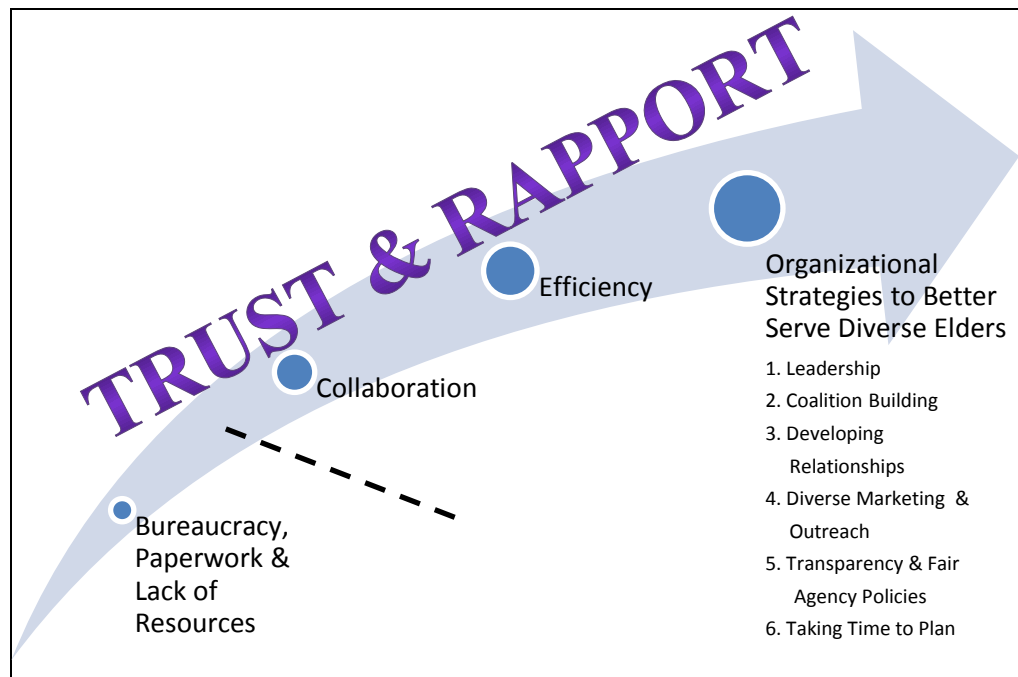
This concept map visually represents how these primary themes relate to each other. The far right dot indicates that the majority of participants outlined specific strategies for successful work with older adults including such items as ensuring a diverse board of directors, using appropriate representations or images in marketing materials and targeting programming to the specific needs and strengths of particular groups that the agency is reaching out to. Agencies that appeared to be most successful in utilizing these strategies, according to an analysis of participant comments, are reflected as being towards the top, far right of the arrow progression within this concept map. These agencies seemed to be on sound financial ground and were successfully conducting outreach to diverse populations. Organizational strategies recommended by participants were grouped into 6 main themes: 1) leadership, 2) coalition building, 3) developing relationships, 4) diverse marketing and outreach, 5) transparency and fair agency policies, and 6) taking time to plan.

Agencies that seemed to be struggling were reflected in the bottom, left hand corner of the progressive arrow, not able to move forward and become better able to provide services to diverse elders. These agencies complained that they were too small and specialized to adequately meet the needs of funders and regulators. They felt that they lacked the skill and personnel to engage in evidence based practice and other monitoring required by funders or government organizations. They felt unable to plan ahead or seek new funding sources due to a constant need to engage in elementary agency activities, just to keep their agency afloat. These agencies at the lower-left of the

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concept map felt that they lacked the capacity and expertise to move up the arrow and were forcibly stopped from moving forward. This lack of forward momentum is marked by a dotted arrow in the concept map and indicates a threshold that smaller agencies feel that they cannot cross. Smaller organizations face added barriers to growing and progressing as an organization.

Agencies that were able to specialize in a particular area of social services, collaborate with other organizations and refer their clients to services not provided by their agency, were able to become more efficient, eventually having the ability to utilize the organizational strategies specifically suited to meeting the needs of diverse elders. Organizations who were not able to transgress the impasse or dotted line did not progress and were kept in a crisis always mode, at the far bottom corner of the concept map, never achieving forward momentum. Some of these agencies feared that they might soon go out of business or end their services all together.

Within this concept map, trust and rapport relate to this entire progression of organizational development.   Diverse elders do not easily trust outsiders to their community due to past experiences of racism, bigotry and oppression. This may make outreach to these populations difficult and often results in a lack of access to services. Agencies specializing in serving diverse elders may also be isolated from more mainstream agencies serving older adults due to their own fear and mistrust, making them less likely to have the ability to collaborate or form partnerships with other agencies. Developing a trust and rapport with diverse elders and the agencies serving them may

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provide a foundation for organizations to progressively move up this arrow, to become more efficient and successful in serving diverse elders.

Member Checking

In order to ensure credibility and trustworthiness for this study, this researcher engaged in multiple instances of member checking. As mentioned within the methodology section, participants' comments were repeatedly summarized and paraphrased back to the participants during each interview, as a means to confirm the data's trustworthiness. All participants were sent information about the preliminary results via email and were invited to participate in two preliminary presentations of the results, before final analysis was completed, to determine if there were any discrepancies between the results and the perceptions of the participants. Community members who specialized in working with older adults also participated in these group member checks. Both participants and gerontology professionals were asked questions which helped to determine the credibility and reliability of the results. Examples of questions included: 1) do these preliminary findings accurately reflect what you are seeing in your agencies? 2) what aspects of these findings do NOT accurately reflect what you are seeing in your agencies? and 3) do these preliminary results make sense?

All participants felt that the results did adequately reflect their experiences of working with diverse elders in the field. The only item that they suggested should be modified was a more concise description of organizational strategies that could be utilized within their agencies, as they felt that the list that was provided duplicated itself

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and was too long. The original handout contained thirty-four organizational strategies, listed in no particular order. Based on the suggestions of participants at the member checking events, the list was reduced to thirty-two strategies (by combining duplicate strategies) and each strategy was made more concise. The strategies were then sorted into subcategories to make the list easier to comprehend. These subcategories included strategies related to issues of 1) leadership, 2) coalition building, 3) developing relationships, 4) diverse marketing and outreach, 5) transparency and fair agency policies, and 6) taking time to plan.

Chapter Six: Discussion

Scholarship of Integration

Boyer's (1990) concept of the scholarship of integration involves making connections between disparate ideas and conducting research where different fields converge, resulting in the generation of new knowledge. This study integrates the fields of aging services, cultural competency and organizational development, through an original, empirical dissertation. Many of the themes that emerged from this study are also present within the literature from a variety of disparate fields. These themes combine into one grounded theory, that states that organizations serving diverse elders may also suffer from the same accumulated disadvantages that diverse individuals face (as described in Life Course Theory, or the Social Determinants of Health framework).

This section of the dissertation will describe how the themes and subsequent grounded theory that emerged from the data matches similar results already present in the literature. This dissertation expands upon that knowledge by integrating a variety of different ideas into one coherent theory that can be used to help organizations improve their cultural competence in working with diverse elders.

The results of this study find that agencies that service marginalized older adults may not have sufficient resources or capacity to meet the ever expanding bureaucratic

needs of funders and regulators. In times of reduced funds and resources, and without the ability to collaborate and become more efficient, these agencies are unable to use the organizational strategies, suggested by participants in this study, to better serve the unique needs of their clients. Agencies that serve diverse older adults are kept stalled at a lower level of organizational capacity, with no way to progress or more forward, due to the accumulated disadvantages afforded them as agencies that serve marginalized communities.

Many of the themes generated from this study, to form the grounded theory as discussed above, match results already present within the literature. For example, bureaucracy has been shown to be an item of concern for many groups of diverse elders. Due to lower levels of English language proficiency, a lack of awareness of services, and a sub-population of older adults who are undocumented and fear seeking services, Latino elders are less able to navigate the complex eligibility requirements and paperwork often required to receive the care that they require (Alvarez et al., 2012). Transgender elders have difficulty obtaining services when they cannot provide documentation of their gender that matches their gender identity, often due to inequities in local and government policies (Grant et al., 2011). American Indian tribes attempt to manage the inherent complexity of existence as a collection of sovereign nations working in collaboration with the United States government. These relationships can include bureaucratic systems that may negatively impact the lives of American Indian elders, such as federal funds that pass from the federal government, to state governments, to local tribes, rather than

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directly to tribes, adding additional complexity to an already convoluted system (National

Indian Health Board, 2010).

Bureaucratic systems can also be related to a lack of trust. Many diverse

populations exhibit a lack of trust of agencies and service providers due to past instances

of discrimination. Black and Latino women are more likely to perceive their health

providers as not being respectful, and thus not worthy of trust, when compared to their

White counterparts (Pardasani & Bandyopadhyay, 2014). LGBT elders are scared of

being discriminated against, are more likely to distrust providers, and thus are less likely

to seek services (Services and Advocacy for GLBT Elders, 2014). Southeast Asian

Americans can have a mistrust and fear of government which can negatively impact their

health outcomes (Igasaki & Niedzwiecki, 2004). Patients of all races who perceive that

their medical providers have high levels of trust and interpersonal sensitivity are more

satisfied with the health care services that they receive (Phillips et al., 2012b).

Relationship building is seen as an important way to develop trust and rapport

between agencies and diverse individuals (Epner & Baile, 2012; Siegel et al., 2011) and

when forming collaborations among different organizations (Joe et al., 2011; Latino Task

Force of Boulder County, 2013). At the macro level, these agency relationships need to

be ones of accountability as well as trust building (Hernandez et al., 2007; U.S.

Department of Health and Human Services, 2011). Fair and just procedures and anti-

discrimination policies can help develop this sense of trust and leads to better services for

diverse clients (Addis et al., 2009; Iglehart & Becerra, 2007; O'Connell et al., 2013). A

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trusting environment consists of inclusive forms (Meyer & Johnston, 2014; One Colorado

Education Fund, 2014), a physical setting that showcases culturally relevant food and

inclusive environments (National Resource Center on LGBT Aging, 2012; Siegel et al.,

2011), a diverse and welcoming staff (Nelson, 2003; Bronheim, 2015), and marketing

materials that are relevant to the populations being served (Alvarez et al., 2012;

O'Connell et al., 2013). This also includes the recruitment and development of diverse

leaders within the agency (Capitman, Hernandez-Gallegos, & Yee, 1991; Gallop & Este,

2007; Pardasani, 2004). The development of ambassadors or cultural brokers between

communities may also be an important strategy in the development of trust and rapport

(Drake, 2013; Lamar-Dukes, 2009).

At the individual level, effective communication and relationship building

includes demonstrations of empathy, caring and respect between medical providers and

patients (Song, Hamilton, & Moore, 2012b). Trust and relationship building also

includes a medical provider understanding his/her clients' decision making preferences,

different styles of communication, and views of family involvement when making

choices about their health (Epner & Baile, 2012).

Collaboration between agencies can be seen as another strategy for developing

inter-agency trust and sharing resources (Delphin-Rittmon et al., 2013; Holley, 2004),

often perceived as resulting in more efficient services (State of Colorado, 2011; U.S.

Department of Health and Human Services, 2013). It is often more difficult for agencies

serving diverse elders to have time to plan (Hyde, 2004; Suyemoto & Fox Tree, 2006) or

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to collaborate with other agencies (Radermacher, Karunarathna, Grace, & Feldman, 2011). Smaller agencies serving diverse individuals strive to meet the unique needs of their clients by collaborating with other, larger organizations in order to share resources, increase funding, and become more efficient, but they lack the capacity to collaborate in a meaningful way, if at all (Radermacher et al., 2011). These diverse, smaller agencies are at a disadvantage due to limited organizational resources, lack of information and guidelines for collaborating with others, and an inequity in power when these agencies form partnerships with larger organizations, resulting in a lack of adequate capacity to engage in successful community collaboration (Radermacher et al., 2011).

Both the themes that emerged from this dissertation study, and relevant bodies of literature as discussed above, demonstrate the accumulated disadvantages experienced by organizations serving diverse individuals. Current theoretical models such as Multicultural Organizational Development and its subset, Multicultural Organizational Consultation, form a foundation for this dissertation. This study builds on these conceptual models to add new empirical knowledge about organizations that specifically serve diverse older adults. This includes the identification of concrete organizational strategies developed by participants from a variety of different marginalized populations. As many of the strategies involve acquiring specific knowledge of cultural groups within their client population, organizations can use these general strategies to tailor their services to the specific cultural groups receiving their services. These strategies are particularly useful for more mainstream agencies that want to better serve their diverse

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clients and may even be useful to organizations providing services to non-elderly populations. As the United States population expands and becomes more diverse, this information will become even more relevant.

Implications for Further Research, Policy and Practice

In alignment with the Life Course Theory (Elder, 1975) and the Social Determinants of Health Framework (Marmot, 2006), this research demonstrates that the accumulated disadvantages often experienced by marginalized elders may also be present at the organizational level. Agencies that serve marginalized elders report facing barriers in meeting the reporting requirements of funders, demonstrating the use of evidence based practice and having enough resources and organizational capacity to successfully provide for the diverse needs of elders.

In terms of practice implications, this study demonstrates that non-profit, community based agencies serving diverse older adults may need to be further supported in their efforts to collaborate, share resources, and otherwise increase their organizational capacity. This could be accomplished through organizations that have capacity and resources (such as academic institutions or larger non-profit agencies) offering to collaborate with smaller, more diverse agencies, by sponsoring collaborative learning initiatives, regional networking opportunities, or other inter-disciplinary projects. This could include such organizations as local area agencies on aging, or state departments on aging serving in this capacity.

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It is also important that managers and administrators within agencies serving diverse older adults ensure that their employees are provided with the time and resources to engage in relationship building with other organizations; even in times of limited funds and resources, these collaborations and coalitions have the potential to help increase the capacity of these agencies to provide efficient services to their clients.

It may be beneficial for agencies to attempt to implement some of the thirty-two organizational strategies suggested by participants in this study (listed in Appendix F of this document). Strategies such as ensuring a diverse workforce and leadership base, making sure that marketing materials are accessible to individuals of different literacy and English proficiency levels, and developing fair agency policies and procedures could positively impact services for diverse older adults.

It may also be helpful to identify better ways to integrate competencies in macro practice, gerontology, cultural competence and social work practice. Currently, these competencies are discussed in the literature as separate components which may make it difficult for practitioners to have a systems view of all of the competencies necessary for working with diverse older adults, at the organizational level. Integrating and testing these competencies as one overarching list of skills and knowledge could prove to be helpful for practitioners working directly with older adults.

At the policy level, programs such as the Administration on Aging (AoA)'s, National Minority Aging Organizations Technical Assistance Program (of the Older Americans Act of 1965) may need to expand (U.S. Administration on Aging, 2011);

programs to further promote the networking and collaborative efforts of smaller, community based agencies that may already be culturally aware of the needs of their own communities, but lack the resources and capacity to most efficiently help their clients. Currently, it may be the practice to award grants and philanthropic funds to those agencies with the highest levels of capacity, due to the assumption that agencies with demonstrated skills in fundraising, collaboration, documentation, and program evaluation may have the most impact on local communities.

The Health Resources Service Administration (HRSA), of the U.S. Department of Health and Human Services, the primary federal agency for improving access to health care and achieving health equity (HRSA, 2015), provides an example of this tendency. In a presentation to potential grant seekers, administrators from the Divisions of Grants Management Operations, Independent Review, and Grants Policy recommend that agencies not apply for funds if they do not have the capacity to do so. This often involves having adequate staff to write the proposal (or funds to hire a grant writer), an infrastructure to implement and monitor a grant, and collaborators that can provide matching funds or letters of support (Buckner, Davis, & Hammond, 2010).

This research demonstrates that these infrastructures may be the very ones that are most lacking in agencies serving diverse elders. This strategy for the awarding of funds may unintentionally eliminate those agencies that may be the most marginalized organizations and most in need of assistance in serving their diverse constituents.

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Federal, state, and local funders may need to take these results into account when determining evaluative criteria for funding decisions.

This study utilized participant perceptions to develop both a grounded theory about organizations serving diverse elders and specific organizational strategies to remedy disparities. Future research could subsequently test each of these strategies for effectiveness not based on participant perceptions but on more objective criteria. Future research could determine the best methods to implement the organizational strategies identified in this study, and research the specific needs of each unique elder group. Studies could investigate specific strategies for increasing agency capacity and an agency's ability to collaborate with other organizations. Potential research questions could include: 1) What is the best manner to implement the organizational strategies identified in this dissertation? 2) What are the potential barriers to implementation? What are the potential strengths? 3) What is the effectiveness of each of these strategies? 4) What is the best way to test these strategies? It might also be interesting to re-analyze this data to compare organizations that identified themselves lower on the concept map to those that identified higher on the concept map. Are agencies that face significant barriers in complying with bureaucratic rules and regulations more (or less) effective than those organizations that do not face such barriers?

As mentioned previously much of the current literature appears to be aspirational in nature or at the more exploratory stage of research, identifying incidence and prevalence rates, without necessarily studying the potential solutions for solving the

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problem of disparities, or testing the effectiveness of specific strategies. This dearth of empirical research is further compounded by the lack of study of organizations that specifically serve diverse elders. Further research in the areas that integrate cultural competency, organizational development and aging services would be of great value to these marginalized communities.

Limitations

Results of this dissertation study should be understood along with a relevant discussion of its limitations. First, there is a lack of prolonged engagement with study participants. According to Padgett (2008), prolonged engagement is a process of triangulation in which a sufficient amount of time is spent with participants so as to gain their trust and gather relevant information; this process often involves more than one interview with each participant. Due to time constraints, this study limited interactions with participants to one interview. Second, although the focus of this study was about manager perceptions, it would have been helpful to add the perspectives of diverse elders themselves as another way to triangulate the data. This study also relied on perceptions and self-report measures; a more objective measurement of the success of a particular organizational strategy may be helpful in the future when exploring the effectiveness of these strategies. It may also be helpful in the future to replicate this study with more mainstream agencies not specifically tailoring their services to diverse elders, to ascertain whether there are any differences in the results. Third, the results of this study may be bound to the specific context of agencies within an urban setting within the Rocky

Mountain region of the United States, and this may affect the transferability of the results. Fourth, immersion itself may function as both a strength of the research and a potential limitation. This author's immersion in the gerontological non-profit community may have included assumptions or biases based on the researcher's personal and professional experiences that may have affected the results. Lastly, this study did not utilize peer debriefers (with the exception of the use of gerontological professionals as peer debriefers, during the member checking process, as discussed previously in this paper). A more extensive use of peer debriefing would have added additional rigor to this research. All five of these limitations should be taken into account when reviewing the results of this study.

Conclusion

This dissertation has integrated the diverse fields of organizational development, aging studies and cultural competence through a qualitative study of agencies serving diverse older adults within the Rocky Mountain region. The results that emerged from the voices of the participants indicate that agencies serving marginalized older adults may suffer from the same accumulated disadvantages experienced by their clients; organizations serving diverse individuals may face barriers in collaborating and engaging in efficient practices that specifically meet the needs of their clientele. Social work policy, practice and research initiatives that attempt to aid smaller, more diverse organizations to increase their capacity and become more efficient through collaborations

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and relationship building will prove to be of great value in reducing disparities among

Latino, African American, Asian American and LGBT communities of older adults.

References

Addis, S., Davies, M., Greene, G., Macbride-Stewart, S., & Shepherd, M. (2009). The
health, social care and housing needs of lesbian, gay, bisexual and transgender older
people: a review of the literature. *Health & Social Care in the Community*, *17*(6),
647–658. doi:10.1111/j.1365-2524.2009.00866.x

Alan Nelson. (2003). Unequal treatment: Confronting racial and ethnic disparities in
health care. *Journal of the National Medical Association*, *94*(8), 666–668. Retrieved
from
http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2594273&tool=pmcentr
ez&rendertype=abstract

Alvarez, J., Vanderburg, J., Garcia, C., & Kahn, E. (2012). *Community assessment of
Latino older adults in Metro Denver*. Denver, CO.

Alwin, D. F. (2012). Integrating varieties of life course concepts. *The Journals of
Gerontology: Series B, Psychological Sciences and Social Sciences*, *67*(2), 206–220.
doi:10.1093/geronb/gbr146.Advance

Andersen, M. L., & Collins, P. H. (Eds.). (2007). *Race, class & gender* (Sixth ed.).
Belmont, CA: Thomson Wadsworth.

Anetzberger, G. J., Ishler, K. J., Mostade, J., & Blair, M. (2004). Gray and gay: A
community dialogue on the issues and concerns of older gays and lesbians. *Journal
of Gay & Lesbian Social Services*, *17*(January 2015), 3–21. doi:10.1300/J041v17n01

Asian American Federation Census Information Center. (2007). *Profile of Asian American seniors in the United States*. New York, NY.

Askim-Lovseth, M. K., & Aldana, A. (2010). Looking beyond "affordable" health care: Cultural understanding and sensitivity-necessities in addressing the health care disparities of the U.S. Hispanic population. *Health Marketing Quarterly*, *27*(4), 354–387. doi:10.1080/07359683.2010.519990

August, K. J., Nguyen, H., Ngo-Metzger, Q., & Sorkin, D. H. (2011). Language concordance and patient-physician communication regarding mental health needs. *Journal of the American Geriatrics Society*, *59*(12), 2356–2362. doi:10.1111/j.1532-5415.2011.03717.x

Auldridge, A., & Espinoza, R. (2013). *Health equity and LGBT elders of color: Recommendations for Policy and Practice*. New York, NY.

Bailey, D., & Aronoff, N. (2004). The integration of multicultural competency and organizational practice in social work education. In L. Gutierrez, M. Zuniga, & D. Lum (Eds.), *Education for multicultural social work practice: Critical viewpoints and future directions* (pp. 1–10). Alexandria, Virginia: Council on Social Work Education (CSWE).

Bartley, M., Ferrie, J., & Montgomery, S. M. (2006). Health and labour market disadvantage: Unemployment, non-employment, and job insecurity. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 78–96). Oxford, UK: Oxford University Press.

Becker, G., Gates, R. J., & Newsom, E. (2004). Self-care among chronically ill African Americans: Culture, health disparities, and health insurance status. *American Journal of Public Health*, *94*(12), 2066–2073.

Ben-Shlomo, Y., & Kuh, D. (2002). A life course approach to chronic disease epidemiology: Conceptual models, empirical challenges and interdisciplinary perspectives. *International Journal of Epidemiology*, *31*, 285–293.

Blane, D. (2006). The life course, the social gradient, and health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 54–77). Oxford, UK: Oxford University Press.

Boccuti, C., Swoope, C., & Artiga, S. (2014). *The role of medicare and the indian health service for american indians and alaska natives: Health, access and coverage*. Washington, DC. Retrieved from www.kff.org

Boulder County Aging Services Division. (2010). *Age well Boulder county: A plan to create vibrant communities*. Boulder, CO.

Boulder County Area Agency on Aging. (2013). Boulder county network of care: Seniors and people with disabilities. Retrieved from http://boulder.co.networkofcare.org/aging/services/category.aspx?cid=31737&target grp=

Boyer, E. L. (1990). *Scholarship reconsidered: Priorities of the professoriate*. San Francisco, California: Jossey-Bass.

Braun, K. L., & LaCounte, C. (2015). The historic and ongoing issue of health disparities among native elders. *Generations*, *38*(4), 60–69.

Braveman, P., & Barclay, C. (2009). Health disparities beginning in childhood: A life-course perspective. *Pediatrics*, *124*, S163–S175. doi:10.1542/peds.2009-1100

Bronheim, S. (2015). *Cultural competence: It all starts at the front desk* (Vol. 5387). Washington, DC. Retrieved from http://nccc.georgetown.edu/

Brown, C. V., Carter, P., & Gray, J. S. (2015). National resource centers focus on indigenous communities. *Generations*, *38*(4), 70–73.

Brunner, E., & Marmot, M. (2006). Social organization, stress, and health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 6–30). Oxford, UK: Oxford University Press.

Buckner, D. S., Davis, J., & Hammond, S. (2010). *Tips for writing and submitting grant proposals: Grant writing: The basics*. Washington, DC. Retrieved from http://www.hrsa.gov/grants/apply/writestrong/grantwritingtips.pdf

Capitman, J. A., Hernandez-Gallegos, W., & Yee, D. (1991). Diversity assessments in aging services. *Generations*, *15*(4), 73–76.

Centers for Disease Control and Prevention. (n.d.). Suicide rates among persons ages 65 Years and older, by race/ethnicity and sex, United States, 2005–2009. Retrieved March 28, 2015, from http://www.cdc.gov/violenceprevention/suicide/statistics/rates05.html

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Los Angeles, California: SAGE Publications.

Chesler, M. (1994). Strategies for multicultural organizational development. *Diversity Factor*, *2*(2), 12–18.

City of Denver. (2010). *Age matters initiative task force: Final report and recommendations*. Denver, CO.

Cochran, S. D., & Mays, V. M. (2007). Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: Results from the California Quality of Life Survey. *American Journal of Public Health*, *97*(11), 2048–2055. doi:10.2105/AJPH.2006.087254

Collins, W. L. (2011). Culturally competence practices: Working with older African Americans in rural communities. *Social Work and Christianity*, *38*(2), 201–217.

Costantino, G., Malgady, R. G., & Primavera, L. H. (2009). Congruence between culturally competent treatment and cultural needs of older Latinos. *Journal of Consulting and Clinical Psychology*, *77*(5), 941–949. doi:10.1037/a0016341

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (Third Ed.). Thousand Oaks, California: SAGE Publications.

Crimmins, E. M. (2001). Socioeconomic differentials in mortality and health at the older ages. *Genus*, *LXI*(1), 163–176.

Crisp, C., Wayland, S., & Gordon, T. (2008). Older gay, lesbian, and bisexual adults: Tools for age-competent and gay affirmative practice. *Journal of Gay & Lesbian Social Services*, *20*(1-2), 5–29. doi:10.1080/10538720802178890

Cronin, A., & King, A. (2010). Power, inequality and identification: Exploring diversity and intersectionality amongst older LGBT adults. *Sociology*, *44*(5), 876–892.

Cummings, M. R., Hernandez, V. A., Rockeymoore, M., Shepard, M. M., Sager, K., & Brownstein-Santiago, C. (2011). *The Latino age wave: What changing ethnic demographics mean for the future of aging in the United States*. New York, NY.

Delphin-Rittmon, M. E., Andres-Hyman, R., Flanagan, E. H., & Davidson, L. (2013). Seven essential strategies for promoting and sustaining systemic cultural competence. *The Psychiatric Quarterly*, *84*(1), 53–64. doi:10.1007/s11126-012-9226-2

Denver Regional Council of Governments. (2013). *Programs funded by the Denver Regional Council of Governments: To serve older adults in 2011-2013*. Denver, CO. Retrieved from http://www.drcog.networkofcare.org

Dilley, J. A., Simmons, K. W., Boysun, M. J., Pizacani, B. A., & Stark, M. J. (2010). Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. *American Journal of Public Health*, *100*(3), 460–467. doi:10.2105/AJPH.2007.130336

Diverse Elders Coalition and the Insight Center for Community Economic Development. (2012). *Securing our future: Advancing economic security for diverse elders*. Washington, DC.

Documét, P. I., Green, H. H., Adams, J., Weil, L. A., Stockdale, J., & Hyseni, Y. (2008). Perspectives of African American, Amish, Appalachian And Latina women on breast and cervical cancer screening: Implications for cultural competence. *Journal of Health Care for the Poor and Underserved*, *19*(1), 56–74. doi:10.1353/hpu.2008.0018

Drake, R. E. (2013). A mental health clinician's view of cultural competence training. *Culture, Medicine and Psychiatry*, *37*(2), 385–389. doi:10.1007/s11013-013-9318-y

Dubiel, H. J., Shupe, A., & Tolliver, R. (2010). The connections between health disparities and the social determinants of health in early childhood. *Health Watch*, *77*, 1–8.

Dunlop, D. D., Manheim, L. M., Song, J., & Chang, R. W. (2002). Gender and ethnic/racial disparities in health care utilization among older adults. *The Journals of Gerontology: Series B, Psychological Sciences and Social Sciences*, *57B*(4), S221–33. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12084792

Dunlop, D. D., Song, J., Manheim, L. M., Daviglus, M. L., & Chang, R. W. (2007). Racial/ethnic differences in the development of disability among older adults. *American Journal of Public Health*, *97*(12), 2209–2215. doi:10.2105/AJPH.2006.106047

Eddey, G. E., & Robey, K. L. (2005). Considering the culture of disability in cultural

    competence education. *Academic Medicine*, *80*(7), 706–712.

Eisenbruch, M., de Jong, J. T. V. . ., & van de Put, W. (2004). Bringing order out of

    chaos: A culturally competent approach to managing the problems of refugees and

    victims of organized violence. *Journal of Traumatic Stress*, *17*(2), 123–131.

    doi:10.1023/B:JOTS.0000022618.65406.e8

Elder, G. H. (1975). Age differentiation and the life course. *Annual Review of Sociology*,

    1(1975), 165–190. doi:10.1146/annurev.so.01.080175.001121

Epner, D. E., & Baile, W. F. (2012). Patient-centered care: The key to cultural

    competence. *Annals of Oncology*, *23*(Supplement 3), 33–42.

    doi:10.1093/annonc/mds086

Espinoza, R. (2011). The diverse elders coalition and LGBT aging: Connecting

    communities, issues, and resources in a historic moment. *Public Policy & Aging*

    Report, *21*(3), 8–13.

Ferrie, J. P., & Rolf, K. (2011). *Socioeconomic status in childhood and health after age*

    70: A new longitudinal analysis for the U.S., 1895-2005 (No. 17016). Cambridge,

    MA.

Fox, H. L. (2013). The promise of organizational development in nonprofit human

    services organizations. *Organization Development*, *Summer*, 1–5. Retrieved from

    http://www.hpu.edu/docs/ohana/OD-Journal-Summer2013.pdf#page=75

Fredriksen-Goldsen, K. I. (2011). Resilience and disparities among lesbian, gay, bisexual, and transgender older adults. *Public Policy & Aging Report*, *21*(3), 3–7.

Fredriksen-Goldsen, K. I., Emlet, C. A., Kim, H.-J., Muraco, A., Erosheva, E. A., Goldsen, J., & Hoy-Ellis, C. P. (2013). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *The Gerontologist*, *53*(4), 664–75. doi:10.1093/geront/gns123

Fredriksen-Goldsen, K. I., Hoy-Ellis, C. P., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014). Creating a vision for the future: Key competencies and strategies for culturally competent practice with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. *Journal of Gerontological Social Work*, *57*(0), 87–107. doi:10.1080/01634372.2014.890690.Creating

Fredriksen-Goldsen, K. I., Kim, H.-J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: results from a population-based study. *American Journal of Public Health*, *103*(10), 1802–1809. doi:10.2105/AJPH.2012.301110

Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., … Petry, H. (2011). *The Aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle, Washington. Retrieved from http://caringandaging.org/

Fredriksen-Goldsen, K. I., & Muraco, A. (2010). Aging and sexual orientation: A 25-Year review of the literature. *Research on Aging*, *32*(3), 372–413. doi:10.1177/0164027509360355

Frey, W. H. (2015). *Diversity explosion: How new racial demographics are remaking America*. Washington, DC: The Brookings Institute.

Gallop, C. J., & Este, D. C. (2007). Multicultural organizational development (MCOD). *International Journal of Diversity in Organisations, Communities & Nations*, *6*(4), 107–117. doi:Article

Gamble, D. N. (2011). Advanced concentration macro competencies for social work practitioners: Identifying knowledge, values, judgement and skills to promote human well-being. *Journal of Community Practice*, *19*(4), 369–402. doi:10.1080/10705422.2011.625914

Gendron, T., Maddux, S., Krinsky, L., White, J., Lockeman, K., Metcalfe, Y., & Aggarwal, S. (2013). Cultural competence training for healthcare professionals working with LGBT older adults. *Educational Gerontology*, *39*(6), 454–463. doi:10.1080/03601277.2012.701114

Geron, S. M. (2002). Cultural competency: How is it measured? Does it make a difference? *Generations*, *26*(3), 39–45.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Walter de Gruyter, Inc.

Glen H. Elder, J. (2003). The life-course in time and place. In W. R. Heinz & V. W. Marshall (Eds.), *Social dynamics of the Life Course: Transitions, institutions, and interrelations* (pp. 57–72). Hawthorne, NY: Walter de Gruyter, Inc.

Goode, T., Jones, W., & Mason, J. (2002). *A guide to planning and implementing cultural competence organizational self-assessment*. Washington, D.C. Retrieved from http://nccc.georgetown.edu/

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force*. Washington, DC. Retrieved from http://transequality.org/PDFs/NTDS_Report.pdf

Gratwick, S., Jahanian, L. J., Holloway, I. W., Sanchez, M., & Sullivan, K. (2014). Social work practice with LGBT seniors. *Journal of Gerontological Social Work*, *57*(8), 889–907.

Hassan, A., Waldman, W., & Wimpfheimer, S. (2012). *Human services management competencies: A guide for non-profit and for profit agencies, foundations and academic institutions*. Los Angeles, California.

Hauck, F. R., Corr, K. E., Lewis, S. H., & Oliver, M. N. (2012). Health and health care of African refugees: An under recognized minority. *Journal of the National Medical Association*, *104*(1/2), 61–72.

Heinz, W. R. (2003). Introduction. In W. R. Heinz & V. W. Marshall (Eds.), *Social dynamics of the Life Course: Transitions, institutions, and interrelations* (pp. xi–xix). Hawthorne, NY: Aldine De Gruyter.

Hernandez, P., Bunyi, B., & Townson, R. (2007). Interweaving ethnicity and gender in consultation: A training experience. *Journal of Family Psychotherapy*, *18*(1), 57–75. doi:10.1300/J085v18n01

Hinrichsen, G. A. (2006). Why multicultural issues matter for practitioners working with older adults. *Professional Psychology: Research and Practice*, *37*(1), 29–35. doi:10.1037/0735-7028.37.1.29

Hoeffel, E. M., Rastogi, S., Kim, M. O., & Shahid, H. (2012). *The Asian population: 2010 census briefs*. *2010 Census Briefs*. Washington, D.C. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf

Holley, L. C. (2004). Emerging ethnic agencies: Building capacity to build community. *Journal of Community Practice*, *11*(4), 39–57.

HRSA. (2015). About HRSA. Retrieved April 9, 2015, from http://www.hrsa.gov/about/index.html

Hughes, A. K., Harold, R. D., & Boyer, J. M. (2011). Awareness of LGBT aging issues among aging services network providers. *Journal of Gerontological Social Work*, *54*(7), 659–677. doi:10.1080/01634372.2011.585392

Hyde, C. A. (2003). Multicultural organizational development in nonprofit human service

agencies: Views from the field. *Journal of Community Practice*, *11*(1), 39–59.

doi:10.1300/J125v11n01_03

Hyde, C. A. (2004). Multicultural development in human service agencies: Challenges

and solutions. *Social Work*, *49*(1), 1–9.

Igasaki, P., & Niedzwiecki, M. (2004). *Aging southeast asian Americans in California:*

Assessing strengths and challenges, strategizing for the future. Washington, D.C:

Southeasat Asia Resource Action Center (SEARAC).

Iglehart, A. P., & Becerra, R. M. (2007). Ethnic-sensitive practice: Contradictions and

recommendations. *Journal of Ethnic and Cultural Diversity in Social Work*, *16*(3/4),

43–63. doi:10.1300/J051v16n03

Institute of Medicine of the National Academies. (2002). *Unequal treatment: What the*

health care system administrators need to know about racial and ethnic disparities

in healthcare. Washington, DC.

James, C., Salganicoff, A., Ranji, U., Goodwin, A., & Duckett, P. (2012). *Putting men's*

health care disparities on the map: Examining racial and ethnic disparities at the

state level. Washington, DC.

James, C. V., Salganicoff, A., Thomas, M., Ranji, U., Lillie-Blanton, M., & Wyn, R.

(2009). *Putting women's health care disparities on the map: Examining racial and*

ethnic disparities at the state level. Washington, DC.

Jarvis, M. J., & Wardle, J. (2006). Social patterning of individual health behaviors: the

    case of cigarette smoking. In M. Marmot & R. G. Wilkinson (Eds.), *Social*

    determinants of health (Second Ed., pp. 224–237). Oxford, UK: Oxford University

    Press.

Joe, E., Schwartz, S. L., & Austin, M. J. (2011). The Bayview Hunters Point Foundation

    for Community Improvement: A pioneering multi-ethnic human service

    organization (1971-2008). *Journal of Evidence-Based Social Work*, *8*(1-2), 235–252.

    doi:10.1080/15433714.2011.540458

Johnson, A. M., Mercer, C. H., & Cassell, J. A. (2006). Social determinants, sexual

    behaviour, and sexual health. In M. Marmot & R. G. Wilkinson (Eds.), *Social*

    determinants of health (Second Ed., pp. 318–340). Oxford, UK: Oxford University

    Press.

Johnson, J. (2006). Perceptions of cultural competency among elderly African

    Americans. *Ethnicity and Disease*, *16*(4), 778–785.

Kim, G., Chiriboga, D. A., Jang, Y., Lee, S., Huang, C.-H., & Parmelee, P. (2010).

    Health status of older Asian Americans in California. *Journal of the American*

    Geriatrics Society, *58*(10), 2003–2008. doi:10.1111/j.1532-5415.2010.03034.x

Kline, K. N. (2007). Cultural sensitivity and health promotion: Assessing breast cancer

    education pamphlets designed for African American women. *Health*

    Communication, *21*(1), 85–96. doi:10.1080/10410230701283454

134

Knochel, K. A., Quam, J. K., & Croghan, C. F. (2010). Are old lesbian and gay people well served? Understanding the perceptions, preparation, and experiences of aging service providers. *Journal of Applied Gerontology*, *30*(3), 370–389. doi:10.1177/0733464810369809

Kohli, H. K., Huber, R., & Faul, A. C. (2010). Historical and theoretical development of culturally competent social work practice. *Journal of Teaching in Social Work*, *30*(3), 252–271. doi:10.1080/08841233.2010.499091

Krueger, R. A., & Casey, M. A. (2000). *Focus groups* (Third.). Thousand Oaks, California: SAGE Publications.

Lamar-Dukes, P. (2009). Reaching the hard to reach: A review of an initiative aimed at increasing participation and supports for people of color with disabilities and their families in disability organizations. *Research and Practice for Persons with Severe Disabilities*, *34*(3), 76–80. Retrieved from http://search.proquest.com/docview/762477436?accountid=14684 LA - English

Landers, S., Mimiaga, M. J., & Krinsky, L. (2010). The open door project task force: A qualitative study on lgbt aging. *Journal of Gay & Lesbian Social Services*, *22*(January 2015), 316–336. doi:10.1080/10538720903426438

Latino Task Force of Boulder County. (2013). *2013 Boulder county Latino community assessment*. Boulder, CO.

Lucey, P. (2007). Social determinates of health. *Nursing Economics*, *25*(2), 103–110.

Marmot, M. (2006). Introduction. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 1–5). Oxford, UK: Oxford University Press.

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinates of health. *The Lancet*, *372*(9650), 1661–1669.

Marmot, M., Siegrist, J., & Theorell, T. (2006). Health and the psychosocial environment at work. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 97–130). Oxford, UK: Oxford University Press.

Marmot, M., & Wilkinson, R. G. (2013, November). Social determinants of health. *Health Affairs*. New York, NY: Oxford University Press. doi:10.1377/hlthaff.2013.1102

Marshall, V. W., & Mueller, M. M. (2003). Theoretical roots of the life-course perspective. In W. R. Heinz & V. W. Marshall (Eds.), *Social dynamics of the Life Course: Transitions, institutions, and interrelations* (pp. 3–32). Hawthorne, NY: Walter de Gruyter, Inc.

Martin, J. (2014). DU portfolio: Jennifer Martin MSW LCSW ABD. Retrieved February 28, 2015, from https://portfolio.du.edu/jmart277

McCarthy, M. (2006). Transport and health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 131–147). Oxford, UK: Oxford University Press.

McMunn, A., Breeze, E., Goodman, A., Nazroo, J., & Oldefield, Z. (2006). Social

    determinants of health in older age. In M. Marmot & R. G. Wilkinson (Eds.), *Social*

    determinants of health (Second Ed., pp. 267–296). Oxford, UK: Oxford University

    Press.

Meyer, H. (2011). Safe spaces? The need for lgbt cultural competency in aging services.

    Public Policy & Aging Report, *21*(3), 24–27.

Meyer, H., & Johnston, T. R. (2014). The National Resource Center on LGBT Aging

    provides critical training to aging service providers. *Journal of Gerontological*

    Social Work, *57*(2-4), 407–12. doi:10.1080/01634372.2014.901997

Min, J. W. (2005). Cultural competency: A key to effective future social work with

    racially and ethnically diverse elders. *Families in Society*, *86*(3), 347–358.

Moniz, C. (2010). Social work and The Social Determinants of Health Perspective: A

    good fit. *Health & Social Work*, *35*(4), 310–313. Retrieved from

    http://www.ncbi.nlm.nih.gov/pubmed/21171538

Morioka-Douglas, N., Sacks, T., & Yeo, G. (2004). Issues in caring for Afghan American

    elders: Insights from literature and a focus group. *Journal of Cross-Cultural*

    Gerontology, *19*, 27–40.

Nagda, B.A., Gutierrez, L. M. (2000). A praxis and research agenda for multicultural

    human services organizations. *International Journal of Social Welfare*, *9*, 43–52.

Naito-Chan, E., Damron-Rodriguez, J., & Simmons, J. (2005). Identifying competencies

    for geriatric social work practice. *Journal of Gerontological Social Work*, *43*(4), 59–

    78.

Nápoles, A. M., Santoyo-Olsson, J., Farren, G., Olmstead, J., Cabral, R., Ross, B., …

    Stewart, A. L. (2012). The patient-reported Clinicians' Cultural Sensitivity Survey:

    A field test among older Latino primary care patients. *Health Expectations*, *15*(1),

    63–77. doi:10.1111/j.1369-7625.2010.00654.x

National Association of Social Work. (2001). *NASW standards for cultural competence*

    in social work practice. Washington, DC.

National Association of Social Workers Code of Ethics. (2012). Retrieved from

    http://www.naswdc.org/pubs/code/default.asp

National Center for Gerontological Social Work Education. (2015). Gero competencies.

    Retrieved April 8, 2015, from

    http://www.cswe.org/CentersInitiatives/GeroEdCenter/TeachingTools/Competencies

    .aspx

National Gay and Lesbian Task Force. (2010). *FAQ sheet on LGBT elders and Outing*

    Age 2010. Washington, DC.

National Indian Health Board. (2010). *2010 tribal public health profile: Exploring public*

    health capacity in Indian country. Washington, D.C.

National Partnership for Action to End Health Disparities. (2011). *Fact sheet: National*

stakeholder strategy for achieving health equity. Washington, DC. Retrieved from

http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=39&ID=288

National Partnership for Action to End Health Disparities. (2012). Retrieved from

http://minorityhealth.hhs.gov/npa/

National Research Center. (2010). *Community assessment survey for older adults*

(CASOA): Boulder county, Colorado. Boulder, CO.

National Research Center. (2011). *Community assessment survey for older adults*

(CASOA): State of Colorado: Demographic subgroup comparisons. Boulder, CO.

National Resource Center on LGBT Aging. (2012). *Inclusive services for LGBT older*

adults: A practical guide for creating welcoming agencies. Washington, DC.

Nazroo, J. Y., & Williams, D. R. (2006). The social determination of ethnic/racial

inequalities in health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants*

of health (Second Ed., pp. 238–266). Oxford, UK: Oxford University Press.

Netting, F. E., Kettner, P. M., & McMurtry, S. L. (2008). *Social work macro practice*

(Fourth ed.). Boston, Massachusetts: Pearson Education, Inc.

Nguyen, D. (2011). Acculturation and perceived mental health need among older Asian

immigrants. *Journal of Behavioral Health Services & Research*, *38*(4), 526–534.

Nguyen, D. D., Ho, K. H., & Williams, J. H. (2011). Social determinants and health

service use among racial and ethnic minorities: Findings from a community sample.

Social Work in Health Care, *50*(5), 390–405. doi:10.1080/00981389.2011.567130

O., C. K. (2015). Preventing suicide among older adult Asian women. *Generations*, *38*(4), 82–85.

O'Connell, M. B., Jackson, A. N., Karaoui, L. R., Rodriguez de Bittner, M., Chen, A. M. H., Echeverri, M., … O'Neil, C. K. (2013). Cultural competency in health care and its implications for pharmacy part 3b: Emphasis on pharmacy education policy, procedures, and climate. *Pharmacotherapy*, *33*(12), e368–e381. doi:10.1002/phar.1352

Olshansky, S. J., Antonucci, T., Berkman, L., Binstock, R. H., Boersch-Supan, A., Cacioppo, J. T., … Rowe, J. (2012). Differences in life expectancy due to race and educational differences are widening, and many may not catch up. *Health Affairs*, *31*(8), 1803–1813. doi:10.1377/hlthaff.2011.0746

One Colorado Education Fund. (2014). *Transparent: The state of transgender health in Colorado*. Denver, Colorado.

Padgett, D. (2008). *Qualitative methods in social work research* (2nd ed.). Los Angeles, California: SAGE Publications.

Pardasani, M., & Bandyopadhyay, S. (2014). Ethnicity matters: The experiences of minority groups in public health programs. *Journal of Cultural Diversity*, *21*(3), 90–98.

Pardasani, M. P. (2004). Senior centers: Increasing minority participation through diversification. *Journal of Gerontological Social Work*, *43*(2-3), 41–56.

Phillips, K. L., Chiriboga, D. A., & Jang, Y. (2012a). Patients' perceptions of the

    interpersonal sensitivity of their healthcare providers: The potential role of patient-

    provider racial/ethnic concordance. *Patient*, *5*(3), 175–183.

Phillips, K. L., Chiriboga, D. A., & Jang, Y. (2012b). Satisfaction with care: The role of

    patient-provider racial/ethnic concordance and interpersonal sensitivity. *Journal of*

    Aging and Health, *24*(7), 1079–1090. doi:10.1177/0898264312453068

Porter, K. E., & Krinsky, L. (2014). Do LGBT aging trainings effectuate positive change

    in mainstream elder service providers? *Journal of Homosexuality*, *61*(1), 197–216.

    doi:10.1080/00918369.2013.835618

Portz, J. D., Retrum, J. H., Wright, L. A., Boggs, J. M., Wilkins, S., Grimm, C., …

    Gozansky, W. S. (2014). Assessing capacity for providing culturally competent

    services to LGBT older adults. *Journal of Gerontological Social Work*, *57*(2-4),

    305–21. doi:10.1080/01634372.2013.857378

Radermacher, H., Karunarathna, Y., Grace, N., & Feldman, S. (2011). Partner or perish?

    Exploring inter-organisational partnerships in the multicultural community aged care

    sector. *Health & Social Care in the Community*, *19*(5), 550–60. doi:10.1111/j.1365-

    2524.2011.01007.x

Reynoso-Vallejo, H. (2009). Support group for Latino caregivers of dementia elders:

    Cultural humility and cultural competence. *Ageing International*, *34*(1-2), 67–78.

    doi:10.1007/s12126-009-9031-x

Robertson, A., Brunner, E., & Sheiham, A. (2006). Food is a political issue. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 172–195). Oxford, UK: Oxford University Press.

Rosen, A. L., Zlotnik, J. L., Curl, A. L., & Green, R. G. (2000). *CSWE SAGE-SW national competencies survey and report*. Alexandria, Virginia, CSWE.

Rosen, A. L., Zlotnik, J. L., & Singer, T. (2003). Basic gerontological competence for all social workers. *Journal of Gerontological Social Work*, *39*(1-2), 25–36.

Rugh, D. (2011). Design of a rural diabetes self-directed care program. *Social Work in Health Care*, *50*(10), 775–786. doi:10.1080/00981389.2011.597496

SAGE; National Hispanic Council on Aging; Diverse Elders Coalition. (2013). *Hispanic LGBT older adult needs assessment*. New York City, NY.

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Los Angeles, California: SAGE Publications.

Services and Advocacy for GLBT Elders. (2014). *Out & visible: The experiences and attitudes of lesbian, gay, bisexual and transgender older adults, ages 45-75: Executive summary*. New York City, NY.

Shaw, M., Dorling, D., & Smith, G. D. (2006). Poverty, social exclusion, and minorities. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 196–223). Oxford, UK: Oxford University Press.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63–75.

Shim, R., Ye, J., & Yun, K. (2014). Treating culturally and linguistically isolated Koreans via telepsychiatry. *Psychiatric Services*, *63*(9), 2012. doi:10.1176/appi.ps.57.5.721

Siegel, C., Haugland, G., Reid-Rose, L., & Hopper, K. (2011). Components of cultural competence in three mental health programs. *Psychiatric Services*, *62*(6), 626–631.

Singleton, R. A., & Straits, B. C. (2010). *Approaches to social research* (Fifth.). New York, NY: Oxford University Press.

Song, L., Hamilton, J. B., & Moore, A. D. (2012a). Patient-healthcare provider communication: Perspectives of African American cancer patients. *Health Psychology*, *31*(5), 539–47. doi:10.1037/a0025334

Song, L., Hamilton, J. B., & Moore, A. D. (2012b). Patient-healthcare provider communication: Perspectives of African American cancer patients. *Health Psychology*, *31*(5), 539–547. doi:10.1037/a0025334

Sorkin, D. H., Pham, E., & Ngo-Metzger, Q. (2009). Racial and ethnic differences in the mental health needs and access to care of older adults in California. *Journal of the American Geriatrics Society*, *57*(12), 2311–2317. doi:10.1111/j.1532-5415.2009.02573.x

Stafford, M., & McCarthy, M. (2006). Neighbourhoods, housing and health. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 297–317). Oxford, UK: Oxford University Press.

Stansfield, S. A. (2006). Social support and social cohesion. In M. Marmot & R. G.

Wilkinson (Eds.), *Social determinants of health* (Second Ed., pp. 148–171). Oxford,

UK: Oxford University Press.

State of Colorado. (2010). *CASOA: Community assessment survey for older adults: The*

Denver Regional Council of Governments, CO 2010: Full report. Boulder, CO.

State of Colorado. (2011). *Colorado's state plan on aging* (Vol. 2015). Denver, CO.

State of Colorado. (2013). *The state of health: Colorado's commitment to become the*

healthiest state. Denver, CO.

Stein, G. L., Beckerman, N. L., & Sherman, P. A. (2010). Lesbian and gay elders and

long-term care: Identifying the unique psychosocial perspectives and challenges.

Journal of Gerontological Social Work, *53*(5), 421–435.

doi:10.1080/01634372.2010.496478

Sue, D. W. (2006). *Multicultural social work practice*. Hoboken, NJ: John Wiley & Sons,

Inc.

Sue, D. W. (2008). Multicultural organizational consultation: A social justice perspective.

Consulting Psychology Journal, *60*(2), 157–169. doi:10.1037/0736-9735.60.2.157

Suyemoto, K. L., & Fox Tree, C. A. (2006). Building bridges across differences to meet

social action goals: Being and creating allies among People of Color. *American*

Journal of Community Psychology, *37*(3-4), 237–246. doi:10.1007/s10464-006-

9048-1

Taylor-Ritzler, T., Balcazar, F., Dimpfl, S., & Suarez-Balcazar, Y. (2008). Cultural

competence training with organizations serving people with disabilities from diverse

cultural backgrounds. *Journal of Vocational Rehabilitation*, *29*, 77–91.

The National Association of Area Agencies on Aging. (2012). Retrieved April 3, 2012,

from http://www.n4a.org/

The National Association of Social Workers. (2007). *Indicators for the achievement of

the NASW standards for cultural competence*. Washington, D.C.

Thrasher, A. D., Clay, O. J., Ford, C. L., & Stewart, A. L. (2012). Theory-guided

selection of discrimination measures for racial/ethnic health disparities research

among older adults. *Journal of Aging and Health*, *24*(6), 1018–43.

doi:10.1177/0898264312440322

Tobin, D., & Weinberg, A. (2014). Racial diversity and the American jewish community:

Best practices to build cultural competence in jewish communal organizations.

Journal of Jewish Communal Service, *89*(1), 68–83.

Torres-Gil, F., & Moga, K. B. (2002). Multiculturalism, social policy and the new aging.

Journal of Gerontological Social Work, *36*(3-4), 13–32.

U.S. Administration on Aging. (2010). *A toolkit for serving diverse communities*.

Washington, DC.

U.S. Administration on Aging. (2011). National Minority Aging Organizations Technical

Assistance Program. Retrieved from

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Minority_Aging/index.
aspx

U.S. Administration on Aging. (2012a). *A profile of older Americans: 2012*. Washington,
DC.

U.S. Administration on Aging. (2012b). Minority aging. Retrieved from
http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Minority_Aging/index.
aspx

U.S. Administration on Aging. (2014). Administration on Aging: National aging
network. Retrieved February 8, 2015, from
http://www.aoa.gov/AoA_Programs/OAA/Aging_Network/Index.aspx

U.S. Census Bureau. (2010). *The next four decades: The older population in the United
States: 2010 to 2050* (No. 0). *Statistics*. Washington, DC. Retrieved from
http://www.aoa.gov/AoARoot/Aging_Statistics/future_growth/DOCS/p25-1138.pdf

U.S. Department of Health and Human Services. (2010, November 1). Healthy people
2020. Washington, DC. doi:10.1044/poa7.1.29

U.S. Department of Health and Human Services. (2011). *HHS action plan to reduce
racial and ethnic health disparities: A nation free of disparities in health and health
care*. Washington, DC. doi:10.1037/e553842012-001

U.S. Department of Health and Human Services. (2013). *National healthcare disparities
report*. Rockville, MD.

U.S. Department of Health and Human Services. (2015). Key features of the Affordable

Care Act. Retrieved March 28, 2015, from

http://www.hhs.gov/healthcare/facts/timeline/index.html

U.S. Department of Health and Human Services - Office of Minority Health. (2013).

National standards for culturally and linguistically appropriate services (CLAS) in

health and health care. Washington, DC.

U.S. Department of the Interior. (2015). Bureau of Indian Affairs. Retrieved January 29,

2015, from http://www.bia.gov/WhatWeDo/index.htm

Uttal, L. (2006). Organizational cultural competency: Shifting programs for Latino

immigrants from a client-centered to a community-based orientation. *American*

Journal of Community Psychology, *38*(3-4), 251–262. doi:10.1007/s10464-006-

9075-y

Wadsworth, M., & Butterworth, S. (2006). Early life. In M. Marmot & R. G. Wilkinson

(Eds.), *Social determinants of health* (Second Ed., pp. 31–53). Oxford, UK: Oxford

University Press.

Waite, R., & Ramsay, J. R. (2010). Cultural proficiency: A Hispanic woman with ADHD

- A case example. *Journal of Attention Disorders*, *13*(4), 424–432.

Webb, R. (2012). Organizational integration of cultural competency: Building

organizational capacity to improve service delivery to culturally diverse populations.

Practice Perspectives, *August*, 1–5.

147

Wimpfheimer, S. (2004). Leadership and management competencies defined by

   practicing social work managers. *Administration in Social Work*, *28*(1), 45–56.

Xakellis, G., Brangman, S. A., Hinton, W. L., Jones, V. Y., Masterman, D., Pan, C. X.,

   … Yeo, G. (2004). Curricular framework: Core competencies in multicultural care.

   Journal of the American Geriatrics Society, *52*, 137–142.

Yali, A. M., & Revenson, T. A. (2004). How changes in population demographics will

   impact health psychology: Incorporating a broader notion of cultural competence

   into the field. *Health Psychology*, *23*(2), 147–55. doi:10.1037/0278-6133.23.2.147

Yeo, G., & McBride, M. (2008). Cultural diversity in geriatrics and gerontology

   education. *Annual Review of Gerontology and Geriatrics*, *28*, 93–110.

   doi:10.1891/0198-8794.28.93

Yoo, G. J., Musselman, E., Lee, Y.-S., & Yee-Melichar, D. (2015). Addressing health

   disparities among older Asian Americans: Data and diversity. *Generations*, *38*(4),

   74–81.

Appendices

Appendix A: Literature Review Table

Database[1]	Database Subject Headings[2]	Years	Limits (and Expansions)	# Articles	Exclusions (# of articles)	# of Articles	Comments[3]
Psych Info	asian american or criminals or convict or offenders or prisoners or poor health and poverty or jewish or refugee or disabilities or victims or homeless or african american or latinos or hispanics or lesbian gay bisexual or transgender

AND
older adults or elderly or seniors or aging | 2004-2014 | Peer Reviewed Articles English Language Linked Full Text Journal Article | 14 | 6 – Off topic 1-Duplicate | 7 | Searched under "all text" not just under subject headings; Search terms were suggested by those used in PsychInfo.

Added an Email Alert for new articles |

	AND cultural competence or cultural literacy or cultural sensitivity or cultural awareness						3, 5, 6, 7, 9, 13 main subject is not about cultural competence 4-Duplicate
Psych Info	"Multicultural Organizational Development" (MOD) from Sue, 2006, as subject	2004-2014	Peer Reviewed Articles English Language Linked Full Text Journal Article	5	Non US – 1 Off Topic -1	3	Searched under "all text" not just under subject headings; Search terms were suggested by those used in PsychInfo. Added an Email Alert for new articles Non US – 4 Off Topic -5

| Psych Info | asian american or criminals or convict or offenders or prisoners or poor health and poverty or jewish or refugee or disabilities or victims or homeless or african american or latinos or hispanics or lesbian gay bisexual or transgender

AND cultural competence or cultural literacy or cultural sensitivity or cultural awareness

AND organizations | 2004-2014 | Peer Reviewed Articles English Language Linked Full Text Journal Article | 17 | 7– Off topic 1-Duplicate 1-Non US | 8 | Searched under "all text" not just under subject headings; Search terms were suggested by those used in PsychInfo.

Added an Email Alert for new articles

1, 3, 4, 5, 11. 13, 14 - main subject is not about cultural competence

6 – Duplicate |

						17 – Non US
SOC Index with Full Text	asian american or criminals or convict or offenders or prisoners or poor health and poverty or jewish or refugee or disabilities or victims or homeless or african american or latinos or hispanics or lesbian gay bisexual or transgender AND older adults or elderly or seniors or aging AND cultural competence or cultural literacy or cultural sensitivity or cultural awareness	2004-2014	Scholarly Peer Reviewed Articles Full Text Publication Type: Periodical English Document Type: Article PDF Full Text Apply Related Words	33	Off Topic 18 Non US 7 Youth 4 Duplicate 1	3	Added an Email Alert for new articles Used all fields, rather than subject only while searching 1, 3, 4, 5, 6, 7, 11, 12, 14, 16, 17, 18, 24, 25, 28, 31, 32 33 Off Topic 2, 8, 13, 20, 21, 27, 30 Non USA 22, 23, 26, 29 Youth

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					Duplicate - 10		
SOC Index with Full Text	"Multicultural Organizational Development" (MOD) from Sue, 2006, as anywhere	2004-2014	Scholarly Peer Reviewed Articles Full Text Publication Type: Periodical English Document Type: Article PDF Full Text Apply Related Words	4	Duplicate 2 Off Topic -1	1	4-Off Topic 1, 3 - Duplicates
SOC Index with Full Text	asian american or criminals or convict or offenders or prisoners or poor health and poverty or jewish or refugee or disabilities or victims or homeless or african american or latinos or hispanics or lesbian gay bisexual or transgender AND cultural	2004-2014	Scholarly Peer Reviewed Articles Full Text Publication Type: Periodical English Document Type: Article PDF Full Text Apply Related Words	24	Youth 5 Duplicate 5 Off Topic 8 Non US 2	4	Added an Email Alert for new articles 3, 5, 6, 11, 18 Youth 7, 12, 15, 20, 21 Duplicate 4, 9, 10, 13,

	competence or cultural literacy or cultural sensitivity or cultural awareness AND organizations					14, 16, 22, 24 Off Topic Non US – 19, 23
Social Services Abstracts	"asian american" or criminals or convict or offenders or prisoners or "poor health" or poverty or jewish or refugee or disabilities or victims or homeless or "african american" or latinos or hispanics or lesbian gay bisexual or transgender AND older or 65 and older or age or older or older age or elderly or seniors aging or aging seniors AND culturally competent	2004-2014	Peer Reviewed Scholarly Journals Journal Articles English	0	0	Used search terms from this database specifically. Even when expanding to all dates and eliminating the specific groups, I still obtained no journal articles, even when expanding the search, to "anywhere", not just

	organisation or competence cultural or cultural competent or cultural competence or cultural competency or cultural awareness or cross cultural awareness or culturally sensitive or culturally sensitive care or cross cultural competence or organizational cultural competence or cultural literacy or literacy cultural						subject headings.
Social Services Abstracts	"Multicultural Organizational Development" (MOD) from Sue, 2006 (anywhere)	2004-2014	Peer Reviewed Scholarly Journals Journal Articles English	0		0	
Social Science Index / Web of Science	"asian american" or criminals or convict or offenders or prisoners or "poor health" or poverty or	2004-2014	English Article	78	39 - Off Topic 18 - Youth 3- Non USA 5-Duplicates	13	Saved search and added an email alert for new

jewish or refugee or disabilities or victims or homeless or "african american" or latinos or hispanics or lesbian gay bisexual or transgender

AND
older adults or elderly or seniors or aging

AND "cultural competence" or "cultural literacy" or "cultural sensitivity" or "cultural awareness"

articles.

This database did not suggest search terms, so I used those from Psych Info.

1, 3, 4, 6, 7, 9, 11, 12, 18, 19, 21, 25, 27, 28, 30, 32, 33, 35, 37, 38, 40, 41, 44, 46, 47, 49, 50, 51, 52, 53, 54, 55, 56, 63, 65, 66, 67, 68, 70 main subject is not about cultural competence

							2, 13, 14, 15, 17, 20, 26, 39, 42, 58, 59, 62, 69, 71, 74, 75, 76, 78 Youth
							5-Australia 48-Canada 60-Switzerland
							16, 31, 45, 61, 77 Duplicate
Social Science Index/ Web of Science	"Multicultural Organizational Development" (MOD) from Sue, 2006 (anywhere)	2004-2014	English Article	2	Duplicate -1	1	1 Duplicate

[1] Social Work abstracts was not included in this review because of a lack of university access to this journal. [2] Additional searches of the above databases, using the same parameters, also included the following terms (identified by analyzing the keywords and search terms of relevant articles found), which did not produce any new documents: Multicultural Human Services Organizations (MHSO), ethnic organizations, ethno conscious agency, and ethnic community based organization.
[3] Within this review journal articles were numbered as a means of identifying them. In this column, the identifying numbers are used to explain which specific

articles were excluded and for what reason, with further details, as needed, accompanying this information. For example, for articles excluded for the reason of "Non-US", this column often listed the country of origin of the journal article. This column also included comments about the searches made within each database.

Exclusions Key	Symbol
Articles that came up in a search but was not relevant to the topic being studied. This included articles that studied a particular intervention, disparity, or condition, by race, but did not focus specifically on cultural competence itself.	Off Topic
Articles pertained to organizations outside of the US	Non US
Articles focused on children, not adults. This also included studies about birth, maternity, pediatrics etc. If age was not mentioned in the title, then the article was initially retained.	Youth
Duplicates of articles already located in another database	Duplicate

Appendix B: Marketing Flyer

HELP US BETTER SERVE DIVERSE ELDERS

ASSIST A SOCIAL WORKER WITH HER <u>DISSERTATION RESEARCH</u> BY <u>JOINING A FOCUS GROUP</u> OF NON PROFIT EMPLOYEES WITH AN EXPERTISE IN SERVING UNIQUE OLDER ADULTS

AS THE UNITED STATES GROWS OLDER AND MORE DIVERSE, IT IS IMPORTANT TO DETERMINE WHAT STRATEGIES ORGANIZATIONS USE TO BEST MEET THE NEEDS OF THESE UNIQUE ELDERS.

Diverse Elders includes older adults who identify as:

- Asian American /Pacific Islander
- Lesbian, Gay, Bisexual or Transgender
- African American
- Native American / Native Alaskan
- Hispanic
- Of Lower Socioeconomic Status
- Any older adult who feels marginalized

STUDY DETAILS

⇒ We are looking for staff members who consider themselves knowledgeable about the strategies that community based organizations use to meet the needs of diverse elders.

⇒ Participants can include employees working directly with seniors, managers, administrative assistants, drivers or any staff member who feels knowledgeable about this issue. We want <u>your</u> opinion!

⇒ Participation includes discussing the topic with participants from other agencies, in a focus group (<u>1-2 hours long</u>), at a location of your choosing. <u>Snacks will be provided!</u>

⇒ There will be <u>separate focus groups</u> for managers, direct service employees and administrative staff

POTENTIAL BENEFITS:

1. Networking with employees from other agencies
2. An opportunity to have your voice heard
3. Participation in research that will help diverse elders
4. A fun activity to do during work time

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http://www.linkedin.com/profile/edit?
trk=nav_responsive_sub_nav_edit_profile

Contact Jennifer for more information or to sign up ► ► ►
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jmart277@du.edu

Appendix C: Interview Questions

1. What services or program do you offer to target disparities among marginalized older adults?

    a. Are these programs targeting specific subgroups of older adults or a mixture of older adults?
    b. How are these programs similar or different from your other services?
    c. Are there specific strategies that you use to respond to the needs of your diverse clients?
    d. Do you envision using different strategies in the future to better respond to the needs of diverse clients?
    e. How do you know if these programs / strategies are working?
    f. What factors make these programs / strategies successful?
    g. What is your process for implementing these programs/ strategies?

2. What barriers do you experience in regards to best meeting the needs of your diverse older adult clients?

3. (For agencies that serve multiple groups of marginalized older adults) Do your services differ by group and if so, how? What are the ways that you differentially respond to the needs of diverse older adults?

4. How are each of your agency's experiences the same as others in this group? How might the experiences of your agency differ from those of others in this group?

5. Some agencies are working together on issues that they find in common. Those who are collaborating, why do you do this? Those who are not, do you think it would be helpful to collaborate with other agencies (why or why not?)

6. What advice would you give to an agency looking to start a program serving marginalized older adults, particularly in regards to health or other disparities?

7. What other questions would you like to ask of each other? What other questions should I have asked to really understand this topic?

8. Are there other community-based non-profit agencies that you are aware of that provide services to marginalized older adults, whom I should ask to participate in this study? If so, please name them and provide any contact information that you may have.

Appendix D: Demographic Survey

Please complete this brief demographic survey about our focus group participants. The survey is optional and <u>not</u> required for participation in this research study. You may skip any questions that you feel uncomfortable answering. Results of this survey will be reported in aggregate at the end of the survey. If this demographic information appears to identify individual participants, this information will be eliminated from the final report so as to ensure confidentiality.

How would you describe your….?

1.   Age: _____

2.   Gender: _____

3.   Sexual Orientation:

_____

4.   Race and/or Ethnicity:

_____

5.   <u>Primary Role(s) Within the Agency</u>
(i.e., Executive, Social Worker, Manager, Intern, Supervisor, Case Manager,

Nurse, etc.):

_____

_____

6.   Length of Time (in years) spent at this agency:

_____

7.   <u>Educational Background</u> (i.e. MSW, high school graduate, B.S., 2 years community college, R.N., L.P.N, MBA, etc.):

_____

_____

8.   <u>Marginalized Populations of Older Adults Served in your Agency</u>
(i.e., LGBT, Asian American, Latino, African American, Native American, Homeless Elders, etc.) – please place an approximate percentage next to each population and the

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number of years the agency has been serving that group (for example: 20% African American and 4 years)

_____

_____

9.   <u>Number of Years Working with Marginalized Older Adults (at any agency)</u>:

_____

The purpose of this study is to explore strategies that organizations utilize to best meet the needs of marginalized older adults, particularly in regards to disparities. Results will be used to discover common themes among participant responses with the intent of academic publication.

Jennifer Martin is the principal investigator on this project; she can be reached at (720) 287-1969 or jmart277@du.edu. Dr. Leslie Hasche, Assistant Professor at the University of Denver, Graduate School of Social Work, is supervising this research. If you have questions regarding the study, you may contact Dr. Hasche at 303-871-4816 or leslie.hasche@du.edu.

Participation in this study should take about 1-2 hours of your time. Focus group and individual interviews will be scheduled to take place at a location of your choosing. Participation will involve an interview consisting of questions about demographics, and experiences serving marginalized older adults. We would like to audio tape the interview, however consent to be audiotaped is not required for participation in this study. Participation in this project is strictly voluntary. The risks associated with this project are minimal. There is minimal emotional risk that might be associated with recalling particularly stressful personal or work-related anecdotes. We respect your right to choose not to answer any questions that may make you feel uncomfortable. Refusal to participate or withdrawal from participation will involve no penalty of any kind. You may experience positive feelings associated with contributing to research that may eventually help other non-profit organizations serving diverse older adults. You may also benefit from the experience of having someone listen to your story.

Your responses will be identified by code number only and will be kept separate from information that could identify you. This is done to protect the confidentiality of your responses. Only members of the research team will have access to your individual data. Any reports generated as a result of this study may present some of your statements under a pseudonym, however your background information will be modified such that the resulting profile will not identify you. The names of study participants and the organizations involved will not be recorded anywhere other than with your signature on the consent form and will not be revealed to University of Denver faculty, or agency representatives, other than the principal investigator and supervising faculty members. All study materials will be locked in a file cabinet in order to retain participants' privacy and all electronic documents will require a password. However, should any information contained in this study be the subject of a court order or lawful subpoena, the University of Denver might not be able to avoid compliance with the order or subpoena. Although no questions in this interview address it, we are required by law to tell you that if

information is revealed concerning suicide, homicide, child (or older adult) abuse and neglect, it is required by law that this be reported to the proper authorities.

If you have any concerns or complaints about how you were treated during the interview, please contact Paul Olk, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-4531, or du-irb@du.edu, Office of Research and Sponsored Programs at 303-871-4050 or write to either at the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-4820.

Please sign the next page if you understand and agree to the above. If you do not understand any part of the above statement, please ask the researcher any questions you have. You will be given a copy of the consent form for your records.

I have read and understood the foregoing descriptions of the study called "Organizational Strategies for Addressing Disparities Among Marginalized Older Adults." I have asked for and received a satisfactory explanation of any language that I did not fully understand. I agree to participate in this study, and I understand that I may withdraw my consent at any time. I have received a copy of this consent form.

Signature _____ Date _____

___ I agree to be audiotaped.
___ I do not agree to be audiotaped.

Signature _____ Date _____

_____ I would like a summary of the results of this study to be mailed to me at the following postal or e-mail address: _____

Appendix F: List of Organizational Strategies

Category	Organizational Strategies	Example Quotations[1]
Leadership	1. Include diverse individuals in all levels of leadership and involve them in significant areas of governance.	"The people who you're working with, or for, should be at the table as well. So if you're talking to LGBT seniors, LGBT seniors should be at the table and talking about 'this is what our needs are, and this is what we want'... so that their voice is being heard, too". (# 30)[2]
	2. Hire bilingual and/or culturally competent staff members who understand the language and culture of your clients.	
		"More inclusive and diverse workforces, advisory groups, and decision making bodies will inevitably lead to providing more culturally competent services and addressing the larger systemic issues preventing social equity." (#58)
	3. Develop leaders from within communities and explicitly educate them about their rights and responsibilities.	"And so I think making sure that you have people of color in all levels of the organization and in all facets - its' just reinforcing...." (#4/5)[3]
	4. Use ambassadors. Ambassadors are defined people who are already known in a community who act as ambassadors between different communities.	
	5. Make sure that the agency has a shared responsibility for diversity; ensure that bilingual staff or employees of color are not taking on more than their share of the task burden.	"Intentional diversity provides opportunities for individuals and strengthens organizations.... [This agency] ...welcomes and needs a variety of perspectives. Participants who complete the inclusive leadership development training [within our agency] shall have the knowledge, skills and experience to create positive system and policy changes that

Category	Organizational Strategies	Example Quotations[1]
		shall enhance and create opportunities for people with developmental disabilities to further their engagement in civic activities in their community." (#138) "An AMBASSADOR program has also been implemented. The Ambassadors are blind/visually impaired individuals who will help business owners one-on-one, throughout the state, better understand the needs of the blind/visually impaired who patronize their businesses. This is an friendly way to help the sighted learn how to be a "guide" for an blind/visually impaired individual attempting to make a purchase, order a meal, enjoy an evening of entertainment, secure a service, etc." (#36) "Sometimes we find that] ...the one bilingual person on staff is saddled with having to translate things...and that's not right. I'm beginning to hear these conversations about how resentful people are when they're the only bilingual staff person, and they are asked to translate everything from flyers to bathroom signs, you know. It's just that they don't like it because it's not always that easy to translate things.... and then [we] wonder why people get burnt out." (#16)
		"[It's important to have] ambassadors – once those seniors come in and find their niche, then they become leaders.... They have that leadership role.... You have an ambassador which could be a little different than a leader and then once

Category	Organizational Strategies	Example Quotations[1]
		you've established those groups those people then take on the task of – of continuing the welcoming process." (#4/5) "We have a staff members who themselves might be considered marginalized people who um have really brought their richness of their experience here and so our team is pretty diverse. And um I think that carries over in to our work." (#4/5)
Coalition Building	6. Collaborate and develop relationships with other agencies (even those that may not serve your clients directly). This is integral to becoming aware of relationships that could be mutually beneficial and subsequently increase organizational cultural competence.	"... [we really need to do] ... a better job at collaborating... otherwise, our seniors won't get the services... we don't have the funding to... transport them back and forth to doctor's appointments, pay for their doctor visits. I mean, we have to rely on [the] resources [of other organizations]..." (#28) "Given the upcoming significant growth in the number of seniors..., the need for collaboration is great among government, community-based organizations and the private sector. Whether large or small, well-endowed or under-funded, coalitions help strengthen communities through developing capacity, increasing collaborative problem solving, promoting cooperation, developing advocacy capacity and increasing information access." (#43)

Category	Organizational Strategies	Example Quotations[1]
Coalition Building	7. Collaborate on issues that affect all communities such as fair housing, health prevention, wages, and quality education. Collaborating on critical issues helps communities learn about each other and increase agency capacity and resources.	" 'I come from a "let's float everybody's boat' kind of mentality... we're all better off when the boats get floated together. ... but I don't think we've got that, you know, as a country. ... we're still just too much, you know, 'I'm going to save myself, and I'm going to earn a ton of money. If somebody else gets hurt along the way, so be it.' " (#24)
	8. Promote inclusive and accessible education, at all levels, for all communities. Fair and equitable services for youth and adults lead to less disparities in old age.	"...[Our] mission is to improve the health and well-being of low income and underserved Latinos, through action and goal-oriented advocacy and interagency coordination and collaboration. Improved health and well-being includes housing, legal issues, education, safety, human rights, physical and mental health, and all basic needs." (#40)
	9. Support policies that encourage aging in place such as allowing non-related individuals of mixed age to live together, funding public recreational programs and adequate transportation systems, and making sure that there are sidewalks and well lit streets.	"[We are] ...committed to addressing the specific needs of the Latino and African American LGBT communities in the following ways: *organizing quarterly community meetings to continue to discuss and address the needs of LGBT communities of color; *Talking continuously about the intersection of race and sexual orientation and gender identity; *Creating an intentional space to educate LGBT people of color about... [our work] and to solicit input on programs and campaigns" (#96)
	10. Collaborate with other organizations on common issues such as grant writing (this is particularly true for smaller agencies with less capacity).	

Category	Organizational Strategies	Example Quotations[1]
		"Another challenge related to Latino older adults being able to age in place has to do with the fact that current policies make it challenging for Latino older adults who in an intergenerational household to access services." (#31)
	11. Organize quarterly community meetings to identify needs, strengths and potential collaboration	"What is needed is to develop more partnerships with other organizations to better serve this community.... [This government agency] also encourages organizations to work together to maximize resources. Additionally, organizations that have successful strategies for reaching vulnerable populations can build on these models and target more narrowly... older adults in the communities they already serve." (#58) "[This organization] actively and affirmatively engages with communities of color to create strong coalitions...[We] must confront racism, classism, etc. in our everyday work. [We strive] ...to create an internal atmosphere where we welcome debate and use it productively." (#53)
Developing Relationships	12. Purposely attend meetings or trainings that you might not normally attend, to connect to other communities, outreach and learn new information.	"And I think part of that, too... the networking, in the community, ...knowing one another as professionals. And we balance that at our agency, too, with, okay, we all have X number of clients versus what you need to be working with [this group of elders] and these other responsibilities....

Category	Organizational Strategies	Example Quotations[1]
	13. Use neighborhood volunteers to help their peers; this allows for older adults to feel needed, fosters relationship building and develops trust with local community members.	but we also need to be out there networking and getting to know people." (#30)

"When asked which LGBTQ issue is most important to xem, [this person] says social justice. 'We are in a unique position to cultivate compassion in the larger society through the self-authorship that is often required to find our path,' xe explains. 'I'm excited about where our community is headed as we continue to explore the intersections of our various identities and experiences and create spaces where all participants are safe to move and live and love as their authentic selves.' " (#129) |
	14. Provide opportunities for different communities to socially interact with each other. With the help of supportive employees to facilitate group discussions, this may allow for increased dialogue between communities.	
Developing Relationships	15. Include storytelling as a strategy, to educate the community and recruit volunteers, clients and funders. Stories also have the potential of teaching cultural competence to others.	"There have been formal things done from time to time. ...it probably just depends on funding, but they used to have a lunch or potlatch after that [meeting]. And then they would have a brown bag, and somebody would present on – it could be anything. It could be historical; it could be their tribe's largest massacre, or something like that; some kind of trauma that happened to them. Or, they might do a session on their artwork, or arts and crafts, or culture, or food, or it could probably be anything that they want to share – beading, bead work. And that was an interesting way to learn about other people's cultures, too. And that helped me because, obviously, I've got people from all over
	16. Listen – ask your clients and employees about their needs, strengths and life stories.	

Category	Organizational Strategies	Example Quotations[1]
	17. Encourage your staff and participants to truly be authentic versions of themselves; this fosters an inclusive work environment and leads to better client outcomes.	the country coming into sessions." (#9) "In getting people to – maybe they don't understand, but they'll support, because they see it's human beings, and their lives, to build that empathy, so I would say storytelling is probably one of the strongest tools." (#1)
	18. Consider monthly in-services where different communities educate each other about cultural issues, even using such simple events as informal brown bag discussion groups.	"I think just...the magnitude of the folks that are working on this shows that... there's people listening out there to all the things that are going on and really trying to find a solution. ..... I think that that's what is working in the community is that you really try to have different conversations with folks and networking and I think that this community is good at that." (#14)
Developing Relationships	19. Use social media and online resources to connect individuals who may be far away from each other, isolated, or few in number; this is particularly true for more specialized cultural groups that may be smaller in size.	"Elie Wiesel, in a lecture on the Holocaust Patient, said it so well and it bears repeating. At the conclusion of Wiesel's lecture in 1981, a doctor stood up and, following a poignant and overpowering talk said, 'Professor Wiesel, how shall we treat our survivor patients?' The answer, 'Listen to them, listen to them carefully. For they have more to teach you, than you them.' So I guess we must continue to learn from them, to listen carefully and perhaps they will direct us in the path that will suit their needs at a particular time. If they are properly heard, it is likely you will properly care for them." (#116)

Category	Organizational Strategies	Example Quotations[1]
		"So that's pretty much what our goal is. And included in that goal is to work with Native American youth leadership and to also bridge the gap between youth leadership and elder relationships." (#3) "The social media aspect of our mission has been really successful... through... Facebook. We also did a social media marketing campaign this past year which we're able to develop a video and also a poster and a Facebook page specifically...to the campaign, which was Two-Spirit, One Community Tradition." (#3) "Our highly-skilled and compassionate nurses, client advocates and trained volunteers provide free and essential health clinics and substantial follow-up care, acting as a bridge to the complex health care and social service systems. [This program] ...gives the most vulnerable seniors tools to live independently, which is integral to preserving their quality of life." (#106)
		"[One] strategy is storytelling and hearing the stories of people who are different than you. ...sharing those stories is a way to create change in – in order to change policy, you need to change hearts and minds. And stories are one way to do that. ... I think it starts with you and me, you know, just as two people. Let me tell you my story, and you tell me

Category	Organizational Strategies	Example Quotations[1]
		yours, and you can change minds that way. ...I think that story time is how we – we start that shift in – in shifting people's perceptions and changing those. And that can also be how those coalitions and those groups come together is realizing I never knew that you and I had this part of our experience that was shared and – and coming together and kind of pooling the knowledge and the resources can really come out of that story telling." (#30) "In getting people to – maybe they don't understand, but they'll support, because they see it's human beings, and their lives, to build that empathy, so I would say storytelling is probably one of the strongest tools." (#1)
Diverse Marketing and Outreach	20. Use images in lobbies, offices etc. that are welcoming, and represent a variety of different cultural groups.	"Intake forms, make sure you're providing an option, because that tells the person that you're transgender friendly." (#6)
	21. Ensure that signs and marketing materials are inclusive, in different languages, literacy levels and accessibilities for persons with disabilities.	"Uh, learn how to make your forms inclusive. Learn how to make the area represent the people you're trying to reach, so if you have pictures, do you have pictures of same sex couples, or is everyone straight? Is everyone White ? You know how do you mix it up?" (#1)
	22. Make sure that forms are inclusive of different sexual orientations, genders, and the presence of inter-	"But I think in order – having some artwork that might say, 'Oh.' You walk into a doctor's office or something, you see a dream catcher, or you see some other type of symbol that

Category	Organizational Strategies	Example Quotations[1]
	generational families.	might make you think you might actually be welcomed here, and they might actually see you, culturally." (#9) [An analysis of the documents indicates that signage, newsletters etc. need to be in other languages relevant to the population that you are serving.] (#123) "Individual...experiences are influenced by every person with whom a...[person] interacts in the process of accessing care. From the person on the phone or at the front desk, to the provider... [people] expect to be treated with respect, courtesy, and compassion and provided with clinically competent and culturally responsive care." (#130)
Diverse Marketing and Outreach		"If somebody walks in, and wants to be served...[then] open mindedness is pretty critical. The attitude is pretty critical.... If you've got a positive... place that's receptive, and welcoming, and has a little hospitality going... you usually also get...some creativity... people who can think outside the box... who can really figure out what it takes to include this person." (#24) "If you're walking through the lobby, you'll see a lot of signs, both in Russian and English. If someone passes away, we're going to announce it both in Russian and English. If there's a trip, it's gonna be in Russian and

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		English. Our activities calendar is double the size of most of 'em because, again, it serves both." (#21)
Transparency and Fair Agency Policies	23. Make sure that your agency has an anti-discrimination policy and that all policies are inclusive of diverse communities.	"A few key leaders stated that....bureaucratic practices pose challenges for [diverse]...elders. For example, if an older adult experiences discrimination, there is no one enforcing those policies unless a person can get assistance from a lawyer." (#58)
	24. Be transparent. For example, if clients and employees know how the agency is spending its funds, how to make suggestions or complain about injustices, and how client eligibility is determined, this may lead to an atmosphere of trust and rapport.	"In April 2013, [this government agency] ...released a bulletin which states that health insurance plans cannot discriminate based on sexual orientation, including transgender status.... Health insurers cannot deny coverage of treatments for transgender policyholders if the same treatments are covered for other policyholders." (#129)
	25. Openly address bias within your programs, in order to create a welcoming and inclusive culture.	"So they [organizations] need to be doing self-assessments. They need to have a reasonable modification policy.... ADA requires reasonable modification of policies, practices, and procedures to avoid discrimination...." (#126)
	26. Develop transparent and fair policies that can address complaints of discrimination and bias. Create review boards that have the power to address these issues.	"Federal law mandates equal access, inclusion, choice, anti-discrimination, and control by individuals with disabilities over their own lives." (#45)

Category	Organizational Strategies	Example Quotations[1]
	27. Hold your agency accountable to the promises that are make; trust leads to collaboration, and longevity of the agency.	
Transparency and Fair Agency Policies	28. Admit your own failings as an agency (particularly in regards to cultural competency); this helps to establish trust and rapport.	"LGBT people of color have unique concerns, including racism in the LGBT community and homophobia within communities of color.....[We should be] talking continuously about the intersection of race and sexual orientation and gender identity....Holding our community and our organization accountable to our commitment to racial diversity and inclusion. While we work to change the hearts and minds of those outside the...community so that we can secure protections and opportunities for... [diverse] Coloradans and their families, we will also seek to change hearts and minds in our own community in order to end racism among us." (#129)

Category	Organizational Strategies	Example Quotations[1]
	29. Talk about the intersectionalities of age, race, sexual orientation, disability and all other unique traits of older adults (particularly within the agency itself).	"Social Justice Issues – Recommendations for Latino Community: •Become informed and support agencies that work for social justice support within the community. •Be willing to bring forward complaints and solutions regarding incidents of bias and/or discrimination. •Become informed of how systems work. •Become involved in supporting social justice in your schools and communities. Document instances of bias/discrimination... •Work with community to create the vision for a socially just [community]." (#58) "Have that conversation with people. If it's in a staff training – We all have bias. It's just innate, we've been taught things. Be aware of what the bias is. But look people in the eye, and treat them with kindness, unconditional positive regard. Make sure that you're teaching that, modeling that, and following through with it." (#6)
Transparency and Fair Agency Policies		"All Coloradans – including people with disabilities and aging adults –should be able to live in the home of their choosing with the supports they need and participate in the communities that value their contributions. [The goals are to]: successfully help individuals who want to transition from institutional settings to community settings; ensure that individuals living in community settings can do so in a stable, dignified and productive manner; prevent initial entry or re-entry into institutional settings when this is unnecessary; [and] ensure the achievement of outcomes and

Category	Organizational Strategies	Example Quotations[1]
		responsive plan modifications through transparent oversight and evaluation efforts." (#98) "We strive to be a leader of integrated care services to benefit our communities; We strive to be community-driven by seeing the needs of the clients as the driving force behind the decisions we make; We treat each client and each other with dignity and respect; We strive to be culturally competent; We are a resource to others; We educate and enhance our clients' livelihoods by promoting their health and well-being; We are accountable to ourselves and to our communities; We strive to provide services that are accessible and affordable; We strive to include the diversity of people represented in our community on our staff and board." (#139)
Taking Time to Plan	30. Take time to plan. It is necessary to plan for the future of the agency at the same time that you are providing services now. If you just react to every emergency that comes along and do not take time to plan, the agency may not survive.	"The way we need to be inclusive with the people we work with, we need to be inclusive when we plan, when we write rules... are we meeting the needs?" (#107) "Creating Connections - Training sessions provided by that help board members and executive directors link their organization's values, mission, and strategic plan with the inclusion of all cultures." (#58)
	31. Focus on services that your agency can do well and can individualize to each client, rather than trying to be	"Sometimes it's ...as basic as a lack of the appropriate referral to your sister agency. ...why wasn't the referral to mental health, um, expedited and automatic? It shouldn't

Category	Organizational Strategies	Example Quotations[1]
	everything to everyone. Then form collaborations of other agencies that you can refer to. Make sure that clients are taking advantage of all the other programs that they are eligible for.	have to be... rocket science. You should all be working together." (#17/18)[b]
	32. Use GIS (geographic information mapping services) to identify patterns of service use, volunteers and outreach, to match resources with need.	"We always set goals and ... before we start we have a measurement.... Whether are they always the right measurements, I don't know. But evaluation is something that we really believe in and try and spend a lot of time focusing on, and making sure that we're counting the right things and measuring the right things." (#53)

"How do we prioritize, coordinate, and streamline our work to make this a better city in which to live and grow older? ...[By] focusing through a mutifaceted lens that sees all ages, abilities, and cultures." (#33) |
| Taking Time to Plan | | "We also help immigrants and refugees access additional services through referrals to other agencies." (#113) |

[1] Example quotations often describe multiple organizational strategies within a category. [2] Numbers in parentheses represent in-person interviews (#1-24 & #26-29), one focus group within a single agency (#25), one multiple agency focus group (#30) and agency documents (# 31-142). [3] A slash indicates an interview in which two individuals participated.