



Cornell University
ILR School

Cornell University ILR School
DigitalCommons@ILR

Federal Publications

Key Workplace Documents

6-11-2010

A Toolkit for Serving Diverse Communities

U.S. Administration on Aging

Follow this and additional works at: https://digitalcommons.ilr.cornell.edu/key_workplace

Thank you for downloading an article from DigitalCommons@ILR.

Support this valuable resource today!

This Article is brought to you for free and open access by the Key Workplace Documents at DigitalCommons@ILR. It has been accepted for inclusion in Federal Publications by an authorized administrator of DigitalCommons@ILR. For more information, please contact catherwood-dig@cornell.edu.

If you have a disability and are having trouble accessing information on this website or need materials in an alternate format, contact web-accessibility@cornell.edu for assistance.

A Toolkit for Serving Diverse Communities

Abstract

[Excerpt] This Toolkit provides the Aging Network and its partners with a replicable and easy-to-use method for providing respectful, inclusive, and sensitive services for any diverse community. The Toolkit consists of a four-step process and a questionnaire that assists professionals, volunteers and grassroots advocates with every stage of program planning, implementation and service delivery for older adult communities, their families and caregivers. The core principles of the toolkit include respect, inclusion and sensitivity as the hallmarks of quality service. This Toolkit is an invitation to make a cultural shift in service provision, to learn, to grow and fully appreciate the diverse community of older adults that agencies and their partners serve.

Keywords

Aging, diversity, community, communication, human resources

Comments

Suggested Citation

United States Administration on Aging. (2010). *A toolkit for serving diverse communities*. Washington, DC: Author.

http://digitalcommons.ilr.cornell.edu/key_workplace/734



A TOOLKIT FOR SERVING
DIVERSE COMMUNITIES

U.S. ADMINISTRATION ON AGING

TABLE OF CONTENTS

Preface	2
Foreword	3
Acknowledgements	4
Introduction	6
Illustration: The Steps of Planning Services for Diverse Communities	7

PART I

Step 1: Assessments

Introduction to Step 1	8
Presentation	9
Diverse Community Questionnaire	12

Step 2: Identifying Resources About the Community

Introduction to Step 2	16
Presentation	17
Diverse Community Questionnaire	20

Step 3: Designing Services

Introduction to Step 3	24
Presentation	25
Diverse Community Questionnaire	28

Step 4: Program Evaluation

Introduction to Step 4	32
Presentation	33
Diverse Community Questionnaire	38

PART II: APPENDICES

Appendix A: Diverse Community Questionnaire	42
Appendix B: Definitions	54
Appendix C: Diversity Concepts	56
Appendix D: Discussion Scenarios	58
Appendix E: Companion Presentations	66
Appendix F: Companion Exercises	104
Appendix G: List of Online Resources	108
Appendix H: Diversity Training Tips	128

P R E F A C E

GOLDEN RULE.

Treat others the way you want to be treated.

PLATINUM RULE*.

Treat others the way they want to be treated.

So often as professionals, we unwittingly use our own culture and values as a measuring stick to determine how and why we treat people the way we do. We frequently forget to ask ourselves, “How does this person want to be treated, not based on my values and culture, but theirs?” Or, “Do I even know their culture and values well enough to know if I’m treating them with respect?” These questions, which are the basis of ethical human interaction, are also at the core of providing quality service.

Although it might not seem obvious that we should treat people the way they want to be treated and not the way individuals,

institutions, or systems want to treat them, we can change how we view people of different cultures. Helping to facilitate this change is the purpose of this Toolkit.

This Toolkit is an invitation to make a cultural shift in your perspective: to learn, to grow, and to fully appreciate the people you have dedicated your career to serving. And you don’t have to do it alone. Making a cultural shift takes partnership and collaboration. This Toolkit supports the full participation of professionals, their agencies, and partners to work together to serve all diverse populations with respect, inclusiveness, and sensitivity.

* Bennett, M. J. 1998. “Overcoming the golden rule: Sympathy and empathy” in M. J Bennett 1998 *Basic concepts of intercultural communication: Selected readings*. Yarmouth, ME: Intercultural Press.

F O R E W O R D

As the National Aging Services Network continues to meet the needs and expectations of increasingly culturally and ethnically varied populations, a better understanding of cultural differences and their relationship to the hallmarks of quality service—respect, inclusiveness, and sensitivity—becomes essential. Serving diverse populations, after all, is not a “one size fits all” process. Diversity includes all differences, not just those that indicate racial or ethnic distinctions. And addressing the needs and concerns of specific service populations—African-American, Asian-American, American Indian, Hispanic, as well as older adults with disabilities, immigrant elders, and lesbian, gay, bisexual, and transgender (LGBT) older adults—begins with asking appropriate and timely questions.

This Toolkit provides Aging Agencies and their state and local partners with a starting point for conversations regarding how to better serve diverse populations of older adults. It is hoped that the dissemination and use of this Toolkit will enhance Older Americans Act services. Additionally, it is anticipated that this product will facilitate broader interest in developing other community-based tools and strategies that improve services for all populations and build the network’s value and expertise in advocating for and supporting older adult Americans, their families, and caregivers.

Kathy Greenlee

Assistant Secretary for Aging

ACKNOWLEDGEMENTS

We would like to thank and acknowledge the following individuals for dedicating their time and energy to this project as reviewers. Treat others the way they want to be treated.

Greg Case

Aging Program Specialist
Office of Planning and Policy Development
U.S. Administration on Aging
U.S. Department of Health and Human Services

Carol Crecy

Director of Communications
Office of Communications
U.S. Administration on Aging
U.S. Department of Health and Human Services

Tina Howe

Web Content Manager
DB Consulting Group, Inc.

David A. Ishida

Regional Administrator, Regions IX & X
U.S. Administration on Aging
U.S. Department of Health and Human Services

Faith T. McCormick

Acting Commissioner
Administration on Developmental Disabilities
Administration for Children and Families
U.S. Department of Health and Human Services

E. Percil Stanford, Ph.D.

Sr. Vice President and Chief Diversity Officer
Office of Diversity and Inclusion
AARP

Omar R. Valverde, Esq.

Office of Elder Rights
U.S. Administration on Aging
U.S. Department of Health and Human Services

Sherri Clark

Aging Services Program Specialist
Office of Communications
U.S. Administration on Aging
U.S. Department of Health and Human Services

Commander David A. Dietz

Senior Public Health Analyst
Office of Minority Health
Office of Public Health and Science
U.S. Department of Health and Human Services

Bernice Hutchinson

Diversity Policy Consultant

Darrick Lam, M.S.W.

Aging Services Program Specialist
U.S. Administration on Aging
U.S. Department of Health and Human Services

Anthony Sarmiento

Executive Director
Senior Service America, Inc.

Carmelita Tursi

Program Manager
Office of Diversity and Inclusion
AARP

Jose Velasco

Aging Services Program Specialist
Office of Regional Operations
U.S. Administration on Aging
U.S. Department of Health and Human Services

A special thanks to Leslie Swann, Ph.D., U.S. Administration on Aging, Program Specialist, for her dedication and energy in the conceptualization and development of this Toolkit.



PART ONE

A TOOLKIT FOR SERVING DIVERSE COMMUNITIES

I N T R O D U C T I O N

What is the Toolkit for Serving Diverse Communities?

The Toolkit consists of a four-step process and a questionnaire that assists the Aging Services Network and its partners with every stage of program planning, implementation, and delivery of diverse population services. The four steps are (1) Assessments, (2) Identifying Resources About the Community, (3) Designing Services, and (4) Program Evaluation. The Diverse Community Questionnaire provides questions to assist agency staff through each step of the process (see Appendix A). These questions enable agencies and their partners to consider how to improve services for diverse communities.

What is the goal of the Toolkit?

The goal of the Toolkit is to provide the Aging Network with a replicable and easy-to-use method for providing respectful, inclusive, and sensitive services for any diverse community.

Who should use this Toolkit?

This Toolkit should be used by the Aging Network and its partners. This includes professionals who serve in a broad range of roles while assisting older adults and their families. Besides directors and managers of State Units on Aging (SUAs) and Area Agencies on Aging (AAAs), program managers, policy advisors, information specialists, outreach workers, options counselors, ombudsmen, and many others may find this Toolkit useful.

How should the Toolkit be used?

The Toolkit should be used to help agencies and their partners to start a conversation on how to provide better services for diverse communities. That conversation begins with the Diverse Community Questionnaire that provides a series of questions to address which pieces may be missing from services. The questionnaire allows an agency and its partners to design service plans based on their own experiences and stages of learning in the process of serving diverse communities better.

What are the principles of the Toolkit?

1. Respect, inclusion, and sensitivity are the hallmarks of quality service.
2. Delivering outreach and services based on the population's values and perceptions is at the core of successful service delivery.
3. Serving diverse populations is not a "one size fits all" process. It involves asking the right questions to help address the needs and concerns of any population.
4. The meaning of diversity goes beyond race and ethnicity. It includes individuals with disabilities; lesbian, gay, bisexual, and transgender (LGBT) older adults; homeless seniors; older adult immigrants; and many other populations.
5. Diversity is all around us. It is a part of daily life and offers us opportunities to grow and learn about others.

THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



STEP 1: ASSESSMENTS

INTRODUCTION



Purpose

The purpose of this step is to encourage discussion of the significance of organizational, staff, and self-assessment concerning your agency's readiness and capacity to serve diverse communities.

Summary

This section explains Step 1 by providing brief questions, answers, and discussion points. This information can assist your agency and its partners with understanding the value of assessments that identify gaps in agency capacity and knowledge regarding diverse communities.

Core Learning Question

What types of experiences, resources, and knowledge do your agency and its partners have with providing services to diverse communities?

Supplemental Toolkit Resources for Step 1

To learn more about assessments, see:

Appendix G: List of Online Resources for Step 1

Performing in-depth assessments is the first step in serving diverse populations. It is critical for your agency to understand what types of skills and knowledge you have and what types of skills and knowledge you will need to add to serve a community with a diverse population.

PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



Assessments should be provided at every agency level.

Your agency can conduct its own assessments. However, some experts recommend that a third-party consultant conduct assessments. A consultant can ensure objectivity and reduce staff anxieties about confidentiality.

Assessments can answer questions such as:

- *What skills do we have?*
- *What skills do we need?*
- *How and where can we get those skills?*

ORGANIZATIONAL ASSESSMENT

Who?

The agency.

Why?

Provides a process to assess the policies, procedures, mission statements, and community perceptions of an agency.

Value?

Helps design a formal plan to assess, review, and revise policies and procedures to make them culturally responsive for the agency's service populations. It also helps align policy with practice.

It is not enough to simply train staff members without considering how policies directly impact the service delivery needs of diverse communities.

Organizational assessments can help your agency understand how policies, procedures, and mission statements are aligned with service populations' ideas of quality services and delivery.

STAFF ASSESSMENT

Who?

All staff, managers, board members, committee members, consumer boards, and volunteers—anyone who influences policy and provides services.

Why?

Provides a process to assess the knowledge, skills, and practices of staff and helps identify gaps in knowledge and practice.

Value?

Helps design a formal plan to establish goals and set milestones for staff education. Provides an opportunity for open dialog regarding staff attitudes about serving diverse communities.

Staff assessments help your agency understand gaps in collective staff knowledge.

Staff assessments can be used as tools to provide a comprehensive picture of your agency's skills and assets in serving diverse communities.



SELF - A S S E S S M E N T

Who?

All staff, managers, board members, committee members, consumer boards, and volunteers—anyone who influences policy and provides services.

Why?

Provides a confidential process for an individual to assess personal attitudes, behaviors, and beliefs connected with serving diverse communities.

Value?

Helps establish personal milestones for gaining knowledge and acquiring a level of comfort with serving diverse communities.

Self-assessments provide a confidential, individual measurement of a person's comfort with interacting with members of diverse communities.



STEP 1: ASSESSMENTS

DIVERSE COMMUNITY QUESTIONNAIRE

The Diverse Community Questionnaire is a tool that allows your agency, its partners, and stakeholders to have a conversation about what respectful, inclusive, and sensitive services are to a particular community. We encourage your agency to use this tool with flexibility, and tailor this questionnaire to meet the particular needs of the communities it serves.

Target Population:

What is the service population's neighborhood/community location?

Organizational, staff, and self-assessments allow an agency to understand its collective experience and knowledge about a particular community. Whether your agency wants to improve its services for a specific group or wants to establish a visible and trusted presence in a neighborhood, the questions below help your agency understand how assessments provide a comprehensive snapshot of your ability to provide services for that community.

Has your agency provided services to this community?

Yes ☐ No ☐

If yes, did your agency include this community's perspectives in its planning of program mission statements, policies, and procedures?

If no, what steps does your agency plan to take to include this community in its planning of program mission statements, policies, and procedures (e.g., consumer advisory boards, community advisory councils, advocacy groups)?

If your agency has served or currently serves this community, what did it learn about the community that could be helpful in providing better services?

If your agency has served or currently serves this community, what feedback has it received about this community's perspectives of your services?

How can your agency improve or enhance this perspective?

Are any of your agency's staff, board members, committee members, and/or consumer advisory-board members from this community?

Yes ☐ No ☐

If yes, what knowledge and skills do they have that can help your agency better serve this population?

How do individual staff members characterize this community (e.g., difficult to serve, informal caregiving network)?

What is this characterization based on (e.g., data, feedback from individuals outside of the population's community, feedback from individuals within the population's community, service providers, staff observation)?

If no, what steps does your agency plan to take to provide representation from this community while offering services to its older adult population?

Have any of your staff had experience serving this population, either with your agency or with other agencies? Yes ☐ No ☐

If yes, what knowledge and skills did they gain to help your agency provide better services to this population (e.g., bilingual skills, established relationships with trusted community organizations, knowledge of neighborhood advisory board members)?

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

I N T R O D U C T I O N



Purpose

The purpose of this step is to foster discussion on identifying resources that can help your agency find reliable information on diverse communities.

Summary

This section explains Step 2 by providing brief questions, answers, and discussion points. This information can help your agency identify a variety of reliable and factual resources about the characteristics of a particular community.

Core Learning Question

What resources can assist your agency with gaining knowledge about a particular community?

Supplemental Toolkit Resources for Step 2

To learn more about identifying resources, see:

Appendix E: Companion Presentations

- Factors that Influence Culture
- World View

Appendix G: List of Online Resources for Step 2

Part of providing quality services is finding out as much information as your agency can about a particular diverse community.

Understanding the community's needs and values can help your agency develop more appropriate and valuable services.

PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



Identifying resources about a service population can answer questions such as:

- *What do we need to know about this population?*
- *What groups does this population trust?*
- *What types of data can help us improve our services?*

AGENCY KNOWLEDGE OF THE SERVICE COMMUNITY

Who?

All staff, board members, committee members, partnering agencies, and volunteers.

Why?

Ensures that an agency understands the community it is serving.

Value?

The agency's staff can find out the values of the community to tailor its services to meet the community's needs.

Your agency and its staff can gain knowledge about a service population by reviewing assessments to find out what types of experiences you already have with a particular community. Also look to your board members, volunteers, and partners that work in the client's community for their levels of expertise.

Managers should track staff's previous and current experiences in working with diverse communities. Some types of relevant knowledge and skills, such as knowledge of trusted community organizations or bilingualism, can be invaluable and provide opportunities for cultural brokering and peer-to-peer training.

PARTNERSHIPS AND COALITIONS WITH REPRESENTATIVES FROM DIVERSE GROUPS

Who?

Trusted and valued representatives from diverse service areas.

Why?

Creates an opportunity to gain credibility through association with individuals and groups the diverse community trusts.

Value?

Provides an authentic opportunity for learning: cross-training, consulting, and providing collaborative services.

Build partnerships effectively by learning the art of the "hand-shake meeting."

- *Let the potential partner know you have an authentic interest in serving the community.*
- *Have something to offer. If the potential partner is valuable to your agency, then how can your agency be of value to the potential partner?*
- *Focus on commonalities: "We all want to work together to serve this community."*

Partners can play key roles in helping your agency learn about a community:

- *Cross trainings*
- *Collocation of services*
- *Seminars, webinars, teleconferences, brown bag lunch exchanges*
- *Site visits (physical and virtual)*

Make sure the service community trusts these partners by understanding the difference between those who are perceived as trusted inside a service population's community versus those merely perceived as trusted from outside of the community.

CLIENT DATA

Who?

Aging agencies, research partners, local colleges and universities, research firms, and local, state, and Federal agencies.

Why?

Determines the best types of services for a particular community.

Value?

Increases understanding of the types of services to administer that can save time and energy by avoiding costly mistakes.

In addition to trusted community groups, these organizations may also be helpful in identifying sources of information on diverse communities:

- Colleges and universities
- Research firms
- Local, state, and Federal agencies

Websites, fact sheets, email lists, and newsletters are all valuable resources that can help your agency and its staff obtain the latest information on data and trends.

CLIENT INPUT

Who?

Older adults, their families, and caregivers who will receive the services.

Why?

Reveals how consumer expectations and values relate to service provision.

Value?

Understanding what types of services diverse communities value and delivering those services can enhance and improve an agency's reputation and trustworthiness within a community.

Client input can provide a realistic snapshot of the service population's needs and expectations.

Client input can come from consumer advisory boards, focus groups, surveys, interviews, case studies, and other sources.



STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

DIVERSE COMMUNITY QUESTIONNAIRE

The Diverse Community Questionnaire is a tool that allows your agency, its partners, and stakeholders to have a conversation about what respectful, inclusive, and sensitive services are to a particular community. We encourage your agency to use this tool with flexibility, and tailor this questionnaire to meet the particular needs of the communities it serves.

Target Population:

**What is the service population's
neighborhood/community location?**

Knowing where to find accurate information about a service community is invaluable when planning service delivery. The questions in Step 2 assist your agency with identifying resources, (such as data, research, and studies) that help it understand the characteristics of the service population (such as family structure, community resources, and health disparities). Understanding the characteristics of a service population prepares your agency for Step 3, Designing Services.

Which resources does your agency's staff use to obtain current information and training on providing services to this population?

Has your agency offered staff opportunities to learn about this particular population? Yes ☐ No ☐

If yes, please describe how these learning opportunities can help your agency provide better services to this population.

Can staff identify additional training or technical assistance that would be helpful in serving this population?

Which organizations, including current partners, can assist your agency and staff with learning how best to serve this population? (As you think about these organizations, consider whether or not they are organizations that are visible, respected, and trusted by the community your agency serves.)

What do national, state, and local data reveal about the needs of this community (e.g., education, income, living arrangements)?

U.S. Census Bureau: www.census.gov

AoA Aging Statistics: www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

What do disease and illness (morbidity) data reveal about the needs of this population?

AoA statistics: www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

AHRQ National Healthcare Quality & Disparities

Reports: www.ahrq.gov/qual/qdr08.htm

CDC National Health Statistics home page:
www.cdc.gov/nchs

Based on state and community level data and community partners, how would your agency characterize the following? These answers might change as your agency gets more information from partners and verifies this information with the community.

a. Community-based supports

(e.g., family, church, grassroots organizations)

Good ☐ Fair ☐ Poor ☐

b. Social service resources

Good ☐ Fair ☐ Poor ☐

c. Environmental conditions

(e.g., pollution/air quality)

Good ☐ Fair ☐ Poor ☐

d. Public transportation

Good ☐ Fair ☐ Poor ☐

e. Economic stability

Good ☐ Fair ☐ Poor ☐

f. Opportunities for community involvement

(e.g., socialization, volunteerism, clubs)

Good ☐ Fair ☐ Poor ☐

How does this information (a – f) influence the types of services your agency provides for this population?

Community's most common family structure:

Nuclear ☐ Extended ☐ Other:

What are this community's religious/spiritual beliefs and practices?

How will these religious/spiritual beliefs and practices influence the services your agency provides?

These answers might change as your agency gets more information from partners and verifies this information with the service population.

Check all that apply:

- ☐ Decisions are made by the client.
- ☐ Decisions are made by the client and family member(s) (adult children/spouse/partner).
- ☐ Decisions are made by the group consensus of various loved ones.
- ☐ Decisions are made by another (in the case of homelessness, mental health issues, guardianship).
- ☐ Females are the primary caretakers in this community.
- ☐ Males are the primary caretakers in this community.
- ☐ Adult children are the primary caretakers in this community.

☐ Spouses/partners are the primary caretakers in this community.

☐ Caretakers could be any loved one and/or individual in the community.

☐ Another provides primary care (in the case of homelessness, mental health issues, guardianship).

What are the primary languages (including sign language) of this community?

Is this population historically an immigrant community? Yes ☐ No ☐

If yes, how will the issue of immigration influence the types of services your agency provides (e.g., legal services, housing, employment)?

What are your agency's plans to ensure that client input is used in the planning of services and their delivery (e.g., focus groups, interviews, consumer advisory boards, surveys)?

STEP 3: DESIGNING SERVICES

INTRODUCTION



Purpose

The purpose of this step is to facilitate discussion about issues that should be considered when planning services for diverse communities.

Summary

This section explains Step 3 by providing questions, answers, and discussion points. This information can help your agency consider what kinds and types of services are appropriate for a particular group.

Core Learning Question

How should your agency design respectful, inclusive, and sensitive services for this specific community?

Supplemental Toolkit Resources for Step 3

For more information on designing services, see:

Appendix D: Discussion Scenarios

Appendix E: Companion Presentations

- Acculturation
- Barriers to Serving Diverse Communities

Appendix F: Companion Exercises

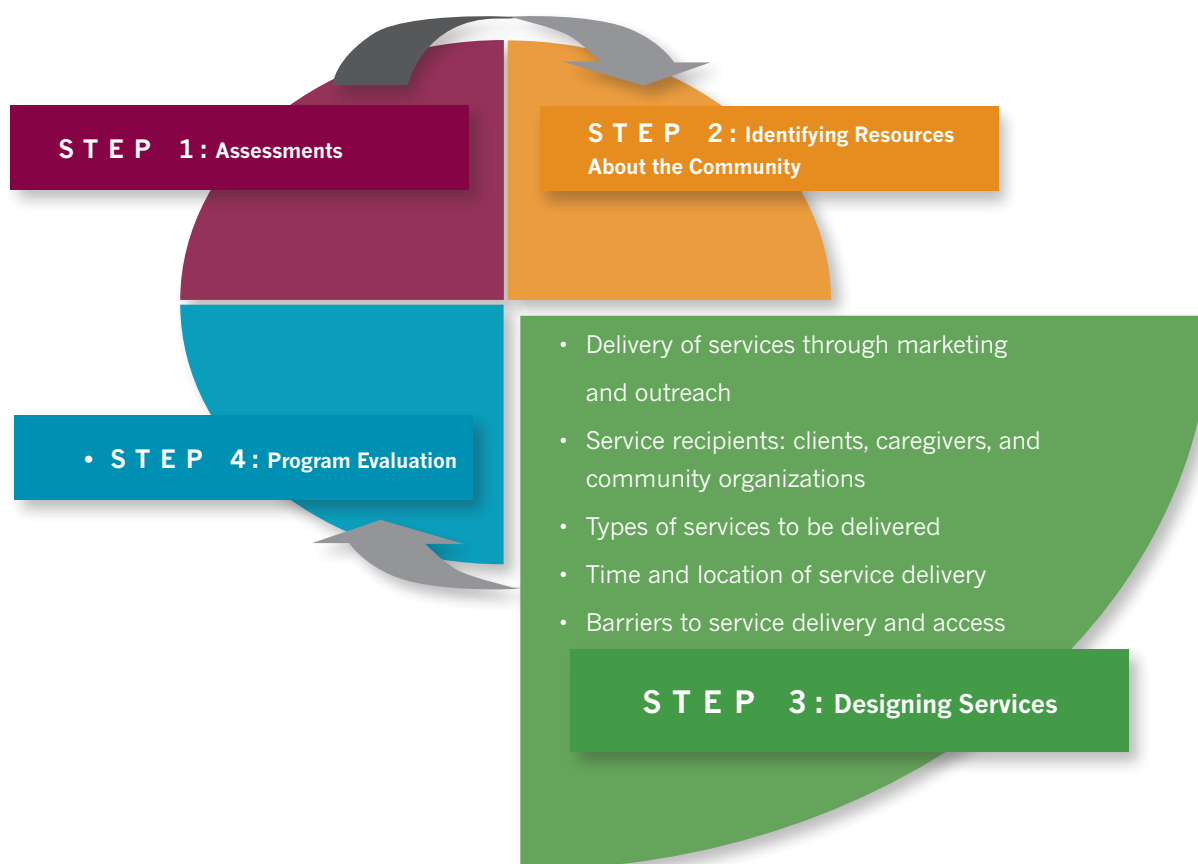
- Technical or Operational Knowledge
- Structural or Cultural Barriers to Accessing Services

Appendix G: List of Online Resources for Step 3

Using the information your agency has gathered in Steps 1 and 2 of this process is critical when designing services for diverse communities.

- *Your assessments help your agency identify experience and knowledge gaps.*
- *The resources you identify about the community can help fill these gaps.*

PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



The topics covered in Step 3 help your agency design services based on the hallmarks of quality service: respect, inclusiveness, and sensitivity.

DESIGNING SERVICES

How should services be designed and delivered to this population?

Colors, language, images, pictures; with the assistance of family and/or life partners, caregivers, community organizations, etc.

Who should receive your agency's services?

Clients, caregivers, community organizations, etc.

What types of services should be delivered, and which services are most valued and appreciated?

Caregiver support, meals, older adult activity centers, transportation, medication management, health education, etc.

When is service delivery the most valued?

Social activities during holidays, meals at the end of the month, energy assistance during summer/winter months, etc.

All of these questions ensure that there is no “cultural misalignment of services.” This occurs when a specific community does not value the services provided and therefore does not use them.

For example, if a particular community values adult children as the primary caregivers for elder parents, sending a home health aide (a stranger) to care for an elder parent creates a cultural misalignment of services. Training and supporting adult children to better care for their parent aligns with the values of this particular community.

Include the perspective of the community when designing outreach materials and services. Your agency can use focus groups and consumer advisory boards to test the effectiveness of outreach materials.



DESIGNING SERVICES (CONTINUED)

Where should services be delivered?

At trusted community providers, through churches and social groups, in the home, etc.

What are the structural and cultural barriers to services?

- Family role: grandparent, caregiver, etc.
- Income
- Transportation
- Health status/condition
- Cultural/group values
- Health literacy/language
- Geography/rural environment
- Access for individuals with disabilities
- Environmental conditions/home setting

Think about non-traditional locations for providing services to better target your outreach.

Understanding barriers in the community can save valuable time and money and help shift resources to where they are most needed in a community.



STEP 3: DESIGNING SERVICES

DIVERSE COMMUNITY QUESTIONNAIRE

The Diverse Community Questionnaire is a tool that allows your agency, its partners, and stakeholders to have a conversation about what respectful, inclusive, and sensitive services are to a particular community. We encourage your agency to use this tool with flexibility, and tailor this questionnaire to meet the particular needs of the communities it serves.

Target Population:

**What is the service population's
neighborhood/community location?**

Designing services that are respectful, inclusive, and sensitive is the hallmark of quality service delivery. The questions below assist your agency with defining what quality service means to a particular community based on its characteristics, which were explored in Step 2.

Based on the data your agency has collected about this service population, its community, and trusted organizations (e.g., churches, social clubs, grassroots nonprofit social services):

How should outreach and marketing materials be improved or implemented to better serve this population?

Do marketing/outreach materials show pictures of individuals from the community ? Yes ☐ No ☐

Are marketing/outreach materials language-appropriate/bilingual? Yes ☐ No ☐

Other marketing/outreach strategies:

Do marketing/outreach materials discuss public accessibility of services (e.g., building accessibility and which bus line, subway stop, transportation companies provide access to the service area)?

Yes ☐ No ☐

If no, what steps does your agency plan to take to inform the service population of service accessibility?

How will marketing/outreach materials be pilot tested/reviewed, and by whom in the community (e.g., focus groups, interviews, surveys, consumer advisory board)?

Do marketing/outreach materials indicate the availability of bilingual staff, including sign language interpreter(s)? Yes ☐ No ☐

Which group in this population's community would benefit most from your agency's services (e.g., clients, caregivers, community organizations)?

Which services does your agency provide that would be the most valuable to this population?

How and where should services be delivered (e.g., with the assistance of family/life partners or caregivers, through a visible and trusted partnering agency in the community, in the home)?

Which legal requirements (e.g., anti-discrimination laws, population targeting requirements, translation requirements) **regarding service accessibility apply to services you provide to this population?**

Which steps does your agency plan to take to ensure that its policies, procedures, and services are aligned with legal requirements regarding service accessibility for this group (e.g., anti-discrimination laws, service population targeting requirements)?

What are the structural barriers* that limit services for this group (e.g., transportation, childcare for grandchildren, health literacy/education, income)?

* Defined in Appendix B: Definitions

This image shows a single page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, leaving small margins at the top and bottom. There are no vertical margin lines, text, or other markings on the page.

A TOOLKIT FOR SERVING DIVERSE COMMUNITIES

STEP 4: PROGRAM EVALUATION

I N T R O D U C T I O N



Purpose

The purpose of this step is to promote discussion on the significance of program evaluation.

Summary

This section explains Step 4 by providing brief questions, answers, and discussion points. This information helps your agency consider which program evaluation methods and tools will best assess your agency's effectiveness and client satisfaction.

Core Learning Question

What types of program evaluation methods are best suited to measure program effectiveness and client and community satisfaction?

Supplemental Toolkit Resources for Step 1

For resources and guidance on program evaluation, see:

Appendix G: List of Online Resources for Step 4

It is important to evaluate the quality, delivery, and performance of your program—from both your viewpoint and client and community perspectives.

PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



Program evaluation data helps your agency make the case that it is being true to its commitment and mission to serve all older adults.

ORGANIZATIONAL AND CLIENT EVALUATION OF SERVICES

What should be evaluated?

Services (provided by both the agency and its partners); client and community perceptions of the quality and effectiveness of services.

Why?

Evaluates the process of service delivery and the quality of services.

How?

Process evaluation.

Outcome evaluation.

Value?

Ensures that program process and outcomes align with the values and needs of the client and community.

The value of measuring both delivery and quality helps your agency evaluate whether its perceptions of its services are aligned with the perceptions of diverse clients and communities.

PROCESS EVALUATION

What?

Evaluates the way a program is implemented and how effectively it is being managed.

Depends on . . .

How well program components and activities are defined and identified.

Asks . . .

“How does our agency manage the program to get things done?” and “Are we managing the program in the most effective way?” *(continued on next page)*

By appreciating how a program is implemented and managed, your agency can understand its program components and the way those components are being delivered and meeting diverse client and community needs.

(continued from last page)

Value?

Helps to identify:

If the program is operating in the most effective way.

The program's strengths and weakness.

Program components that need to be added, changed, or eliminated.

O U T C O M E E V A L U A T I O N

What?

Determines the program's effectiveness for its intended client and whether goals were met and desired outcomes were accomplished.

Depends on . . .

How clearly program goals and objectives are defined.

Asks . . .

"What were the program's results?" and "Did we meet our goal?"

Value?

Helps to identify:

If the program is meeting its intended goals and objectives.

If services are meeting client expectations and reflect community values.

Unanticipated outcomes and/or effects that can be positive or negative.

Outcome evaluation allows your agency to go beyond output (counting the number of times an activity occurs) and begin to move toward measuring results and service quality.

Outcome evaluation should include both qualitative (descriptive) and quantitative (numeric) data. Each can reveal something valuable about the service population.

DATA

What?

Data is information that comes in two forms:

Quantitative – in the form of numbers (statistical information)

Qualitative – in the form of words (descriptive information)

Data sources are all around us

Case management database, records and files, existing statistics, and input from clients and partners.

How do I collect the data?

- Documenting and tracking activities
- Database queries
- Questionnaires and surveys
- Interviews
- Observation
- Focus groups

HOW DOES YOUR AGENCY START?

1. Develop a model or description of your program.

Clarify program goals and objectives.

Clearly identify program components and activities.

2. Determine what type of evaluation (process and/or outcomes) is needed.

3. Choose the type of data collection method.

4. Choose the data source(s).

5. Select an evaluation team and define specific roles and tasks.

It's important that primary source data (data from the original source—the client) is compared to secondary source data (sources other than the client).

Comparing both data sources allows your agency to see inconsistencies in results. Asking clients to clarify any inconsistencies in the data can further support a robust analysis of evaluation data.

Your agency should think about cost and capacity:

- *Does your agency include evaluation as a regular part of a program's budget?*
- *Does your agency have supports and systems in place to manage evaluation easily?*

Identify partners and agencies whose expertise your agency can leverage.

Don't forget to include client and community representation.

6. Make sure evaluation questions are aligned with:

The program goals, objectives, and/or outcomes you are measuring.

The program's components and activities.

The clients' and community's identified needs, expectations, and values.

7. Create data collection protocols and review data collection capacity.

Develop a guidance document for consistent data collection (i.e., everyone is collecting the same type of data and that data is clearly defined).

Check telephonic and case management system's ability to capture the type and quality of data needed.

Good questions are at the core of a solid evaluation. Make sure your questions are aligned with specific program components, activities, goals, and results (which should have been defined at the beginning of your evaluation plan).

A good evaluation process is characterized by support.

- *Does your evaluation team have agreed-upon guidelines to support the staff involved in the data collection process?*
- *Does your evaluation team have access to systems that make it easy to capture and collect data?*

LESSONS LEARNED

Who?

Everyone involved in the process, including the community.

Why?

Helps an agency identify how to make programs better for a particular diverse community.

Value?

Demonstrates that an agency is invested not only in its programs, but the community it serves.

Strengthens the community's role as a stakeholder.

Your agency can use evaluation data to educate staff, advisory and other boards, partners, volunteers, and the service community on how to improve services—it's a collaborative process.

When clients and their community are involved in program evaluation, it gives any agency the opportunity to empower stakeholders to share the responsibility for improving services.



STEP 4: PROGRAM EVALUATION

DIVERSE COMMUNITY QUESTIONNAIRE

The Diverse Community Questionnaire is a tool that allows your agency, its partners, and stakeholders to have a conversation about what respectful, inclusive, and sensitive services are to a particular community. We encourage your agency to use this tool with flexibility, and tailor this questionnaire to meet the particular needs of the communities it serves.

Target Population:

**What is the service population's
neighborhood/community location?**

Program evaluation helps your agency make the case that it is being true to its commitment and mission to provide quality service to *all* older adults. The questions to follow allow your agency to consider how program evaluation can help it improve its services.

Is a program evaluation approach established for the services this community needs and values the most?

Yes ☐ No ☐

If yes, which resources has your agency identified that can help with evaluating services for this community?

If no, how does your agency plan to evaluate those services?

Which partners or potential partners can help your agency evaluate services for this community?

What is your agency's plan for verifying evaluation results with partner, client, and community perceptions of your agency's services (e.g., focus groups, interviews, surveys, questionnaires)?

Does your agency know the data collection barriers for this community (e.g., trust, confidentiality, previous negative experiences with research)?

What type of data collection methods align with the communication traditions of this community (oral tradition, written tradition, or both)? Should there be any special considerations made based on communication traditions?

Does your agency plan to collect quantitative (numeric) data, qualitative (descriptive) data, or both? Why or why not, and what does your agency think is best for this community?

Does your agency plan to use both output (counting the number of times or occurrences of an activity), as well as outcome (results) measures? Yes ☐ No ☐

If no, how does your agency plan to measure data? Which data measurement methods will it include?

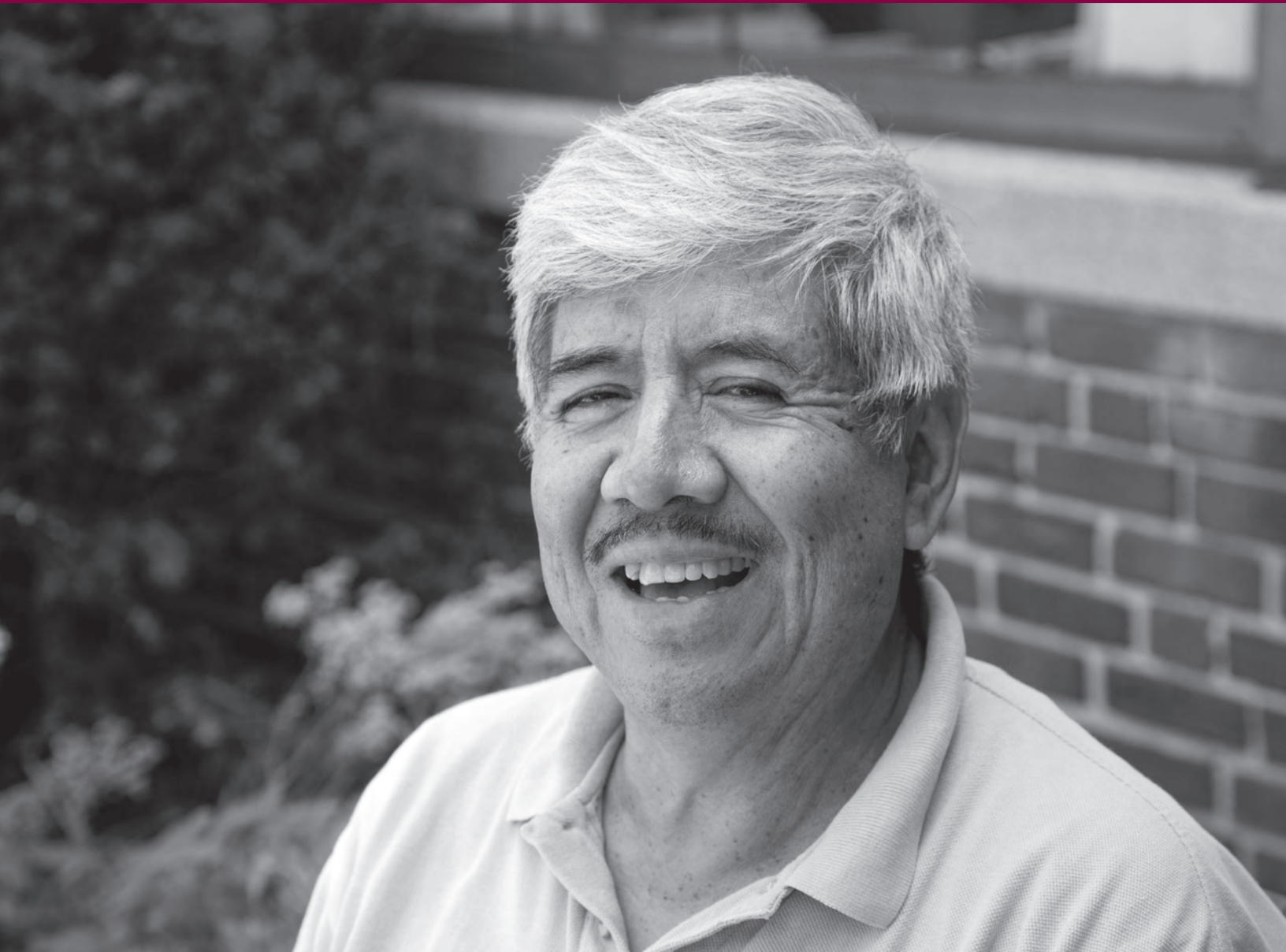
How does your agency plan to use the data to improve services for this community? What is the data's value to your agency, its partners, and the community?

How does your agency plan to share or disseminate its evaluation data and lessons learned to empower the community to engage in better self-advocacy?



A TOOLKIT FOR SERVING DIVERSE COMMUNITIES

APPENDICES



PART TWO

The Diverse Community Questionnaire is a tool that allows your agency, its partners, and stakeholders to have a conversation about what respectful, inclusive, and sensitive services are to a particular community. We encourage your agency to use this tool with flexibility, and tailor this questionnaire to meet the particular needs of the communities it serves.

Target Population:

**What is the service population's
neighborhood/community location?**

STEP 1: ASSESSMENTS

Organizational, staff, and self-assessments allow an agency to understand its collective experience and knowledge about a particular community. Whether your agency wants to improve its services for a specific group or wants to establish a visible and trusted presence in a neighborhood, the questions below help your agency understand how assessments provide a comprehensive snapshot of your ability to provide services for that community.

Has your agency provided services to this community?

Yes ☐ No ☐

If yes, did your agency include this community's perspectives in its planning of program mission statements, policies, and procedures?

If no, what steps does your agency plan to take to include this community in its planning of program mission statements, policies, and procedures (e.g., consumer advisory boards, community advisory councils, advocacy groups)?

If your agency has served or currently serves this community, what did it learn about the community that could be helpful in providing better services?

If your agency has served or currently serves this community, what feedback has it received about this community's perspectives of your services?

How can your agency improve or enhance this perspective?

Are any of your agency's staff, board members, committee members, and/or consumer advisory-board members from this community?

Yes ☐ No ☐

If yes, what knowledge and skills do they have that can help your agency better serve this population?

If no, what steps does your agency plan to take to provide representation from this community while offering services to its older adult population?

Have any of your staff had experience serving this population, either with your agency or with other agencies? Yes ☐ No ☐

If yes, what knowledge and skills did they gain to help your agency provide better services to this population (e.g., bilingual skills, established relationships with trusted community organizations, knowledge of neighborhood advisory board members)?

How do individual staff members characterize this community (e.g., difficult to serve, informal caregiving network)?

What is this characterization based on (e.g., data, feedback from individuals outside of the population's community, feedback from individuals within the population's community, service providers, staff observation)?

STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

Knowing where to find accurate information about a service community is invaluable when planning service delivery. The questions in Step 2 assist your agency with identifying resources (such as data, research, and studies) that help it understand the characteristics of the service population (such as family structure, community resources, and health disparities). Understanding the characteristics of a service population prepares your agency for Step 3, Designing Services.

Which resources does your agency's staff use to obtain current information and training on providing services to this population?

Has your agency offered staff opportunities to learn about this particular population? Yes ☐ No ☐

If yes, please describe how these learning opportunities can help your agency provide better services to this population.

Can staff identify additional training or technical assistance that would be helpful in serving this population?

What do disease and illness (morbidity) data reveal about the needs of this population?

AoA statistics: www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

AHRQ National Healthcare Quality & Disparities Reports: www.ahrq.gov/qual/qdrdr08.htm
CDC National Health Statistics home page: www.cdc.gov/nchs

Based on state and community level data and community partners, how would your agency characterize the following? These answers might change as your agency gets more information from partners and verifies this information with the community.

a. Community-based supports

(e.g., family, church, grassroots organizations)

Good ☐ Fair ☐ Poor ☐

b. Social service resources

Good ☐ Fair ☐ Poor ☐

c. Environmental conditions

(e.g., pollution/air quality)

Good ☐ Fair ☐ Poor ☐

Which organizations, including current partners, can assist your agency and staff with learning how best to serve this population? (As you think about these organizations, consider whether or not they are organizations that are visible, respected, and trusted by the community your agency serves.)

What do national, state, and local data reveal about the needs of this community (e.g., education, income, living arrangements)?

U.S. Census Bureau: www.census.gov

AoA Aging Statistics: www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

d. Public transportation

Good ☐ Fair ☐ Poor ☐

e. Economic stability

Good ☐ Fair ☐ Poor ☐

f. Opportunities for community involvement

(e.g., socialization, volunteerism, clubs)

Good ☐ Fair ☐ Poor ☐

How does this information (a – f) influence the types of services your agency provides for this population?

Community's most common family structure:

Nuclear ☐ Extended ☐ Other:

What are this community's religious/spiritual beliefs and practices?

How will these religious/spiritual beliefs and practices influence the services your agency provides?

These answers might change as your agency gets more information from partners and verifies this information with the service population.

Check all that apply:

- ☐ Decisions are made by the client.
- ☐ Decisions are made by the client and family member(s) (adult children/spouse/partner).
- ☐ Decisions are made by the group consensus of various loved ones.
- ☐ Decisions are made by another (in the case of homelessness, mental health issues, guardianship).
- ☐ Females are the primary caretakers in this community.
- ☐ Males are the primary caretakers in this community.
- ☐ Adult children are the primary caretakers in this community.

- _____ Spouses/partners are the primary caretakers in this community.
- _____ Caretakers could be any loved one and/or individual in the community.
- _____ Another provides primary care (in the case of homelessness, mental health issues, guardianship).

What are the primary languages (including sign language) **of this community?**

Is this population historically an immigrant community? Yes ☐ No ☐

If yes, how will the issue of immigration influence the types of services your agency provides (e.g., legal services, housing, employment)?

What are your agency's plans to ensure that client input is used in the planning of services and their delivery (e.g., focus groups, interviews, consumer advisory boards, surveys)?

STEP 3: DESIGNING SERVICES

Designing services that are respectful, inclusive, and sensitive is the hallmark of quality service delivery. The questions below assist your agency with defining what quality service means to a particular community based on its characteristics, which were explored in Step 2.

Based on the data your agency has collected about this service population, its community, and trusted organizations (e.g., churches, social clubs, grassroots nonprofit social services):

How should outreach and marketing materials be improved or implemented to better serve this population?

Do marketing/outreach materials show pictures of individuals from the community ? Yes ☐ No ☐

Are marketing/outreach materials language-appropriate/bilingual? Yes ☐ No ☐

Other marketing/outreach strategies:

Do marketing/outreach materials discuss public accessibility of services (e.g., building accessibility and which bus line, subway stop, senior transportation companies provide access to the service area)?
Yes ☐ No ☐

If no, what steps does your agency plan to take to inform the service population of service accessibility?

How will marketing/outreach materials be pilot tested/reviewed, and by whom in the community (e.g., focus groups, interviews, surveys, consumer advisory board)?

Do marketing/outreach materials indicate the availability of bilingual staff, including sign language interpreter(s)? Yes ☐ No ☐

Which group in this population's community would benefit most from your agency's services (e.g., clients, caregivers, community organizations)?

Which services does your agency provide that would be the most valuable to this population?

How and where should services be delivered (e.g., with the assistance of family/life partners or caregivers, through a visible and trusted partnering agency in the community, in the home)?

Which legal requirements (e.g., anti-discrimination laws, population targeting requirements, translation requirements) **regarding service accessibility apply to services you provide to this population?**

Which steps does your agency plan to take to ensure that its policies, procedures, and services are aligned with legal requirements regarding service accessibility for this group (e.g., anti-discrimination laws, service population targeting requirements)?

What are the structural barriers* that limit services for this group (e.g., transportation, childcare for grandchildren, health literacy/education, income)?

Which steps does your agency plan to take to reduce or eliminate structural barriers for this population?

* Defined in Appendix B: Definitions

What are the cultural barriers* that limit services to this group (e.g., stigma of accepting help, values concerning gender/family roles, religious/spiritual beliefs)?

Which steps does your agency plan to take to reduce or eliminate cultural barriers* for this population?

STEP 4: PROGRAM EVALUATION

Program evaluation helps your agency make the case that it is being true to its commitment and mission to provide quality service to *all* older adults. The questions to follow allow your agency to consider how program evaluation can help it improve its services.

Is a program evaluation approach established for the services this community needs and values the most?

Yes ☐ No ☐

If yes, which resources has your agency identified that can help with evaluating services for this community?

If no, how does your agency plan to evaluate those services?

Which partners or potential partners can help your agency evaluate services for this community?

* Defined in Appendix B: Definitions

What is your agency's plan for verifying evaluation results with partner, client, and community perceptions of your agency's services (e.g., focus groups, interviews, surveys, questionnaires)?

Does your agency know the data collection barriers for this community (e.g., trust, confidentiality, previous negative experiences with research)?

What type of data collection methods align with the communication traditions of this community (oral tradition, written tradition, or both)? Should there be any special considerations made based on communication traditions?

Does your agency plan to collect quantitative (numeric) data, qualitative (descriptive) data, or both? Why or why not, and what does your agency think is best for this community?

Does your agency plan to use both output (counting the number of times or occurrences of an activity), as well as outcome (results) measures? Yes ☐ No ☐

If no, how does your agency plan to measure data? Which data measurement methods will it include?

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

The list of definitions presented in this appendix is intended as a starting point for users of this Toolkit. Agency staff and partners are encouraged to add to this list as needed.

Acculturation

The degree to which an individual adjusts, fits into, or adopts another culture as his/her own.

Assimilation

Adopting another cultural group's values, beliefs, behaviors, and attitudes.

Cross-Cultural Communication

Interaction between diverse individuals or groups.

Culture

A group with shared values, religion, language, and/or heritage. (Culture refers to more than just race and ethnicity; it also applies to groups, their members, and affiliations.)

Cultural Awareness

Being mindful, attentive, and conscious of similarities and differences between cultural groups.*

Cultural Barrier

A difference in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.

Cultural Brokering

Bridging, linking, or mediating between groups or persons from different cultures to reduce conflict and/or produce change.*

Cultural Competency

The capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs of consumers and their communities.**

Cultural Misalignment of Services

When services do not fit or are not valued in a community.

* Goode, Tawara, Suganya Sockalingam, Lisa L. Snyder, Claire Dunne, and Isabella Lorenzo Hubert. 2004. *The Essential Role of Cultural Broker Programs*. Washington DC: Georgetown University, National Center for Cultural Competence.

Cultural Proficiency

Policies and practices of an organization, or values and behaviors of an individual, that enable the agency or person to interact effectively in a culturally diverse environment. Cultural proficiency is reflected in the way an organization treats its employees, clients, and community.**

Cultural Sensitivity

Understanding the needs and emotions of one's own culture and the culture of others, and understanding how the two may differ.*

Diversity

Ethnic, socioeconomic, religious, and gender variety in a group, society, or institution.

Ethnic Group

Individuals who share values, traditions, and social norms.

Intercultural Differences

Differences within cultures; for example, differences between Vietnamese, Chinese, Korean, Japanese, Filipino populations within the Asian culture.

Linguistic Competency

The ability of an organization to communicate effectively and convey information in a manner that is easily understood by diverse audiences.*

Operational Knowledge of Serving Diverse Populations

A demonstration of how to serve diverse populations.

Race

A division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinctive human type.

Structural Barrier

Technical or logistical factors that limit a person's ability to access services.

Technical Knowledge of Serving Diverse Populations

Knowledge of how to serve diverse populations.

Worldview

The sum of a person's or group's perspectives including opinions, judgments, and beliefs based on culture, values, and life experiences.

** U.S. Department of Health and Human Services, Office of Minority Health, <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>

*** Lindsey, Randall B., Kikanza Nuri Robins, and Raymond D Terrell. 2009. *Cultural Proficiency: A Manual for School Leaders*. Thousand Oaks, CA: Corwin.

The list of concepts presented in this appendix is intended as a starting point for users of this Toolkit. Agency staff and partners are encouraged to add to these concepts.

ADDRESSING GENERALIZATIONS

When your agency begins to learn about serving diverse populations, it will quickly realize that there is a fine line between describing similar group behaviors and attitudes and generalizing about group behaviors and attitudes. So how can your agency truly understand diverse communities without generalizing?

Professionals who work with aging populations can authentically understand differences without falling into the trap of generalizing by evaluating how diverse communities respond to your agency's services.* Your agency can also understand differences by validating performance results with consumer advisory boards, focus groups, interviews, and survey data from clients and their communities.

Your agency will be serving diverse communities successfully when it offers services that are respectful,

inclusive, and sensitive to the population it serves. Then your agency can grasp the difference between authentic understanding and generalizing.

COLORBLIND TO RACE

Some aging agencies believe it is simply better to be "colorblind to race." The underlying assumption in this statement is that a person cannot possibly be prejudiced because he/she does not see race and, therefore, treats everyone the same. This position, although seemingly ideal, may not account for differences that may be at the core of defining what is respectful, inclusive, and sensitive service delivery for a particular community. While some people may not acknowledge racial differences, recognizing and addressing these differences may play a key role in understanding how to modify services to meet the needs of diverse communities successfully.

* To learn more about program evaluating, see Part I, Step 4: Program Evaluation, and Appendix G: List of Online Resources for Step 4.

MELTING POT VS. SALAD BOWL

The terms “melting pot” and “salad bowl” refer to different points of view of how people think about diversity in the United States.

The melting pot viewpoint asserts that diverse groups will “melt” into the majority culture, or assimilate into the mainstream community or group, by adopting the values, beliefs, behaviors, and attitudes of the majority culture.

The salad bowl viewpoint asserts that diverse groups never “melt” or disappear into the majority culture. Among salad bowl proponents, differences are both unique and valued, like each ingredient in a salad. Diverse groups experience degrees of assimilation, but cultural differences (including group affiliations, such as veterans) remain significant.



The scenarios presented in this appendix are starting points for users of this Toolkit. Agency staff and partners are encouraged to create their own scenarios to share with staff and partners.

CULTURAL BROKERING FOR AMERICAN INDIAN CLIENTS

Acculturation

The degree to which an individual adjusts, fits into, or adopts another culture as his/her own.

Ethnic Group

A group of individuals who share values, traditions, and social norms.

Cultural Brokering

Bridging, linking, or mediating between groups or persons from different cultures to reduce conflict and/or produce change.

Cultural Sensitivity

Understanding the needs and emotions of one's own culture and the culture of others.

An American Indian elder and his daughter come to the Area Agency on Aging (AAA) for assistance. When approached by a social worker and asked if they need help, the adult daughter states politely, "We are looking for Cynthia Ray." Cynthia Ray is the only American Indian social worker at the AAA. The social worker replies, "Cynthia is not here today, but I can help you." The elder states politely, "No thank you." Then he and his daughter leave the AAA. The next week, the same client and his daughter return to the AAA for services. Another social worker approaches the client and his daughter and asks them if they need assistance. The client states politely, "No thank you." After Cynthia Ray finishes with another client, the American Indian elder and his daughter approach Cynthia Ray for assistance. Social work staff see this occurrence and begin to notice that American Indian clients want to be served only by Cynthia Ray. While a few staff do not perceive this preference as a problem, most do and begin to call this preference "discrimination." At the next staff meeting, the AAA director knows she must address this issue to ensure that respectful, inclusive, and

sensitive services are provided by her staff for American Indian elders and their families.

1. Does the staff's reaction to the preferences of American Indian elders and their families demonstrate cultural sensitivity? Why or why not?
2. How do acculturation and ethnicity influence American Indian client preferences?
3. How can the AAA director use Cynthia Ray's knowledge and gained trust to support the AAA's services for American Indian elders and their families? (Think about roles for cultural brokering and staff education.)
4. Consider and discuss issues of trust regarding American Indian history and culture. Could a lack of trust be mistakenly interpreted as discrimination? Why or why not?

Supplemental Materials

To further explore the issue of acculturation, see:

Appendix E: Companion Presentations - John W. Berry's Model of Acculturation Presentation

ACCULTURATION: AN ASIAN FAMILY AND HOME HEALTH AID

Intercultural Differences

Differences within cultures; for example, differences between Vietnamese, Chinese, Korean, Japanese, and Filipino populations within the Asian culture.

Acculturation

The degree to which an individual adjusts, fits into, or adopts another culture as his/her own.

DEGREES OF ACCULTURATION *

Assimilation

While the client welcomes and fully socializes with individuals outside of his/her cultural group, to a lesser degree, the client stops embracing or valuing his/her own culture and begins to embrace another culture.

Integration

The client welcomes and fully socializes with people both inside and outside of his/her cultural group.

*Berry, J.W. 1997. Immigration, acculturation and adaptation. *Applied Psychology: An International Review*. 46:5-34.

Separation

The client's primary focus is maintaining values within his/her own culture rather than building relationships with people outside of his/her culture.

Marginalization

The client does not socialize with people outside of his/her cultural group; nor does he/she focus on maintaining relationships within his/her cultural group.

An Asian-American family calls the Area Agency on Aging (AAA) to complain about a “rude” home health care provider. The family describes the African-American home health aide as “loud” and “confrontational.” The staff of the home health agency and AAA debate whether or not it is a cultural issue because the family also made the same complaint about a Caucasian aide. In an attempt to resolve the issue, the AAA works with the home health agency staff to determine what they believe to be a culturally appropriate match for the client. They send a 25-year-old Asian-American aide to the client. The complaints continue.

1. Could acculturation be an issue? If so, how?
2. How would you define the client and her family's level of acculturation?
3. Could the African-American and Caucasian home health aides share the same level of acculturation?
4. Regarding the 25-year-old Asian-American health

home aide, could acculturation and intercultural differences be an issue as well?

Supplemental Materials

To further explore the issue of acculturation, see:

Appendix E: Companion Presentations - John W. Berry's Model of Acculturation Presentation

THE HEARING IMPAIRED OLDER ADULT: AN EXPECTATION OF SERVICE DELIVERY

Cultural Awareness

Being mindful, attentive, and conscious of similarities and differences between cultural groups.

Cultural Barrier

A difference in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.

Cultural Misalignment of Services


When services do not fit or are not valued in a community.

Structural Barrier

Technical or logistical factors that limit a person's ability to access services.

Worldview

The sum of a person's perspectives, including opinions, judgments, and beliefs based on culture, values, and life experiences.



An older adult who has been deaf all of his life, is fluent in sign language, and reads lips, seeks services at the local Area Agency on Aging (AAA). While completing the client's assessment, the service provider learns the client has been a long-time consumer of services for individuals with disabilities at the Center for Independent Living. After the assessment is completed, the service provider states loudly and slowly: "You should consider getting a hearing aid. I think I can identify some resources to cover that cost." The client shakes his head, indicating "no," while frowning at the aging professional. Using sign language he states, "Maybe I don't need a hearing aid. Maybe you need to learn sign language."

1. Do you think there is a cultural misalignment of services? Why or why not?
2. How do the worldview of the client and the worldview of the professional vary?
3. Are there any structural and/or cultural barriers to providing services for this client?
4. How does cultural awareness play into this situation?

Supplemental Materials

To further explore the topics of barriers to service and worldview, see:

Appendix E: Companion Presentations - Barriers to Serving Diverse Communities, Worldview Presentation

H O M E L E S S O L D E R A D U L T S : T H E V A L U E O F P A R T N E R S

Cultural Barrier

A difference in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.

Cultural Sensitivity

Understanding the needs and emotions of one's own culture and the culture of others.

Structural Barriers

Technical or logistical factors that limit a person's ability to access services.

In the last few years, Area Agency on Aging (AAA) staff in two regions of the state have noticed an increase in homeless older adults in their service areas. To address the needs of this population, a group of AAA staff writes a proposal with components for transitional housing, housing placement and assistance, job counseling, training and placement, energy assistance, and meals. The aging services professionals present the proposal to a community partner that serves homeless individuals. The partnering agency tells the aging services professionals they are missing very basic and critical components in the proposal. One problem is that the proposal starts with service provision at the AAAs, but the partner believes homeless older adults need a series of other services before they even walk into an AAA and ask for assistance.



1. What could those “basic” and “critical” services be?
2. Could there be cultural barriers, structural barriers, or both regarding those services?
3. How can the partnering agency help the AAAs serve this community better?

Supplemental Materials

To further explore this issue, see:

Appendix E: Companion Presentations - Barriers to Serving Diverse Communities Presentation
Appendix F: Companion Exercises - Structural or Cultural Barrier

PREVIOUSLY INCARCERATED OLDER ADULTS: BARRIERS TO SERVICE

Cultural Barrier

A difference in cultural values and perceptions about treatment, care, and services that limit a person’s ability to access services.

Structural Barrier

Technical or logistical factors that limit a person’s ability to access services.

Worldview

The sum of a person’s or group’s perspectives, including opinions, judgments, and beliefs based on culture, values, and life experiences.

Two Area Agency on Aging (AAA) directors have a routine phone conversation about a regional conference. At the end of the conversation, each mentions an increase in previously incarcerated older adult men seeking services at their AAAs. Both agree that “something” needs to be done to address this population because trends in data indicate increases in longer sentencing. Longer sentences lead to the release of older adults into the community who may need home- and community-based services in addition to transitional services tailored to meet their specific circumstances. Both directors feel a sense of urgency as they discuss how their staff shared resources with these clients, but knew that the AAA “fell short” of meeting these clients’ needs.

1. What could be some of the cultural barriers to providing services for this population?
2. What could be some of the structural barriers to providing services for this population?
3. With regard to opinions, judgments, and beliefs (worldviews) about serving this population, what could be some of the barriers these directors could encounter with AAA staff?

THE OLDER ADULT LESBIAN CLIENT: CULTURAL AWARENESS

Cultural Awareness

Being mindful, attentive, and conscious of similarities and differences between cultural groups.

Cultural Barrier

A difference in cultural values and perceptions about treatment, care, and services that limit a person’s ability to access services.

Cultural Sensitivity

Understanding the needs and emotions of one’s own culture and the culture of others.

Operational Knowledge of Serving Diverse Populations

A demonstration of how to serve diverse populations.

Technical Knowledge of Serving Diverse Populations

Knowledge of how to serve diverse populations.

An aging services professional enters a female client’s demographic information into a database to receive hospice care for cancer. The client tells the professional that her doctors have diagnosed her with terminal cancer. The professional asks the client, “Who would you like us to contact in case of an emergency?” The client responds while placing her hand over the hand of the woman beside her, “My partner Lynn is the person I trust. We’ve been together for 12 years now. She’s the person I want you to consult. We make decisions together.” Lynn then provides the professional with her full name. When the professional asks the client about Lynn’s relationship to her, the client states, “I just told you. She’s my partner. We live together.” The aging services professional says to the client, “I need the name of a family member.” The client states, “Lynn is my spouse.”

Did the aging services professional's cultural awareness meet the expectations of the client? Why or why not?

1. Based on the professional's response, could a cultural barrier to service occur?
2. Did the professional demonstrate technical knowledge or operational knowledge? Why or why not?
3. How can partnering with a trusted LGBT community organization assist this Area Agency on Aging?

Supplemental Materials

To further explore the issue of worldview and barriers to services, see:

Appendix E: Companion Presentations - Worldview Presentation

DIFFERENT WORLDVIEWS OF LEADERSHIP

Cross-Cultural Communication

Interaction between diverse individuals or groups.

Culture

A group with shared values, religion, language, and/or heritage. (Culture refers to more than just race and ethnicity; it also applies to groups, their members, and affiliations.)

Cultural Awareness

Being mindful, attentive, and conscious of similarities and differences between cultural groups.

Cultural Brokering

Bridging, linking, or mediating between groups or persons from different cultures to reduce conflict and/or produce change.

Cultural Sensitivity


Understanding the needs and emotions of one's own culture and the culture of others.

Worldview

The sum of a person's or group's perspectives, including opinions, judgments, and beliefs based on values and life experiences.

A group of professionals from the Aging Network attend a meeting with HIV/AIDS advocates to begin planning an older adult HIV/AIDS advocacy organization. Each group recognizes an increase in the rate of HIV/AIDS infection among community residents aged 55 and older. In anticipation of the need for social service resources and advocacy for older adults living with HIV/AIDS, each group recognizes the significance of creating such an organization. During the meeting, each group discovers the other has a different vision of leadership.

Both groups want an older adult to lead the advocacy organization. However, the HIV/AIDS advocates want an older adult who is living with HIV/AIDS to take a very visible and active leadership role in the organization.



They argue that this individual will bring a unique perspective to understanding what it means to live with HIV/AIDS. They state in the meeting: “Aging Network staff just don’t have that kind of knowledge.” The Aging Network staff respond, “An individual doesn’t have to have HIV/AIDS to represent those who are infected by the virus.” The aging services providers add that people with HIV/AIDS can be represented on the consumer advocacy board. “That’s what those boards are for,” they state. The HIV/AIDS advocates respond, “That simply isn’t good enough.” Both groups leave the meeting frustrated.

1. What may be some of the opinions, judgments, beliefs, and/or values each group has about leadership (worldview) that are stated or implied?
2. Which worldview of consumer advocacy is respected and by whom?
3. Is each group demonstrating cultural awareness? Why or why not?
4. Is each group demonstrating skills in cross-cultural communication? Why or why not?
5. Is each group demonstrating skills in cultural sensitivity? Why or why not?
6. How could a cultural broker assist these groups?

7. Could this example be applied to the Aging Network establishing relationships with the Disability Network? If so, what could be some of the worldview implications of starting a partnership with groups representing these older adult populations?

Supplemental Materials

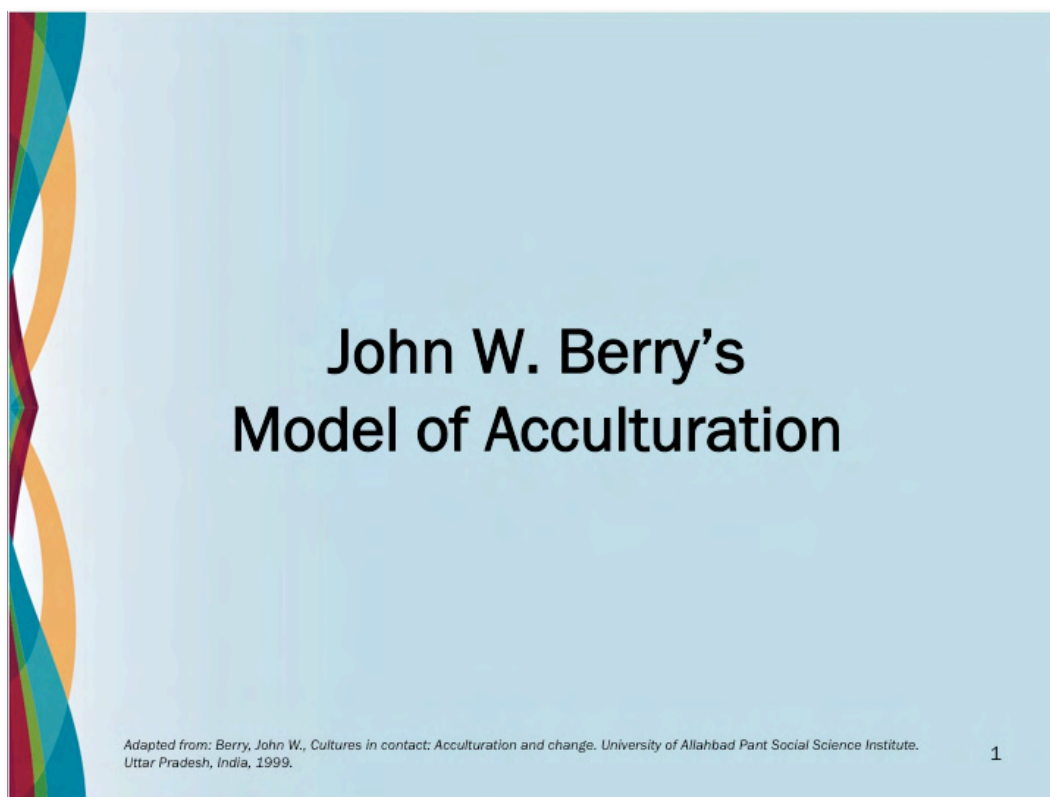
To further explore the issue of worldview, see:
Appendix E: Companion Presentations -
Worldview Presentation

COMPANION
PRESENTATIONS

APPENDIX E

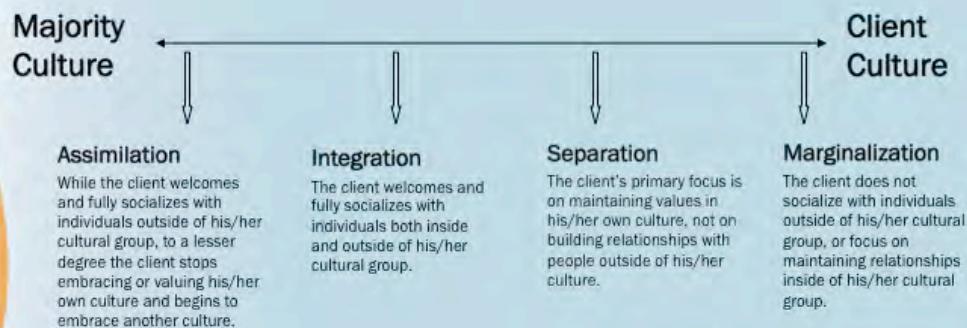


The presentations presented in this appendix represent a starting point for users of this Toolkit. Agency staff and partners are encouraged to create and share their own presentations.



What Is Acculturation?

The degree to which one culture interfaces with other culture(s), resulting in changes to one or both of the cultures.




2

Discussion Questions

- Has your agency ever considered the degree to which the diverse communities it serves are acculturated?
- Thinking about a specific population, how would your agency have to change its services to meet the needs of an older adult or community that is separated or marginalized from the majority culture?

3




Barriers to Serving Diverse Communities

1

Structural and Cultural Barriers to Service Delivery

- **Structural barriers** are technical or logistical factors that limit a person's ability to access services.
- **Cultural barriers** are differences in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.

2



Discussion Questions


- What are some examples of structural barriers your agency has experienced?
- What are some examples of cultural barriers your agency has experienced?
- How did or how can your agency overcome those barriers?

3

Technical vs. Operational Knowledge of Serving Diverse Communities

- **Technical knowledge** is understanding how to serve diverse communities, *"I can tell you."*
- **Operational knowledge** is demonstrating how to serve diverse communities, *"I can show you."*

4



True or False?

Technical knowledge can be a barrier to serving diverse communities.

5

True or False?

Technical knowledge can be a barrier to serving diverse communities.

True


Technical knowledge becomes a barrier when:

1. It is substituted for operational knowledge.

OR

2. An agency never moves beyond the technical understanding of serving diverse communities.

6



Discussion Questions

- What are some examples of technical knowledge?
- What are some examples of operational knowledge?
- How can your agency begin to support operational knowledge (i.e., effectively demonstrate service delivery to diverse communities of older adults)?

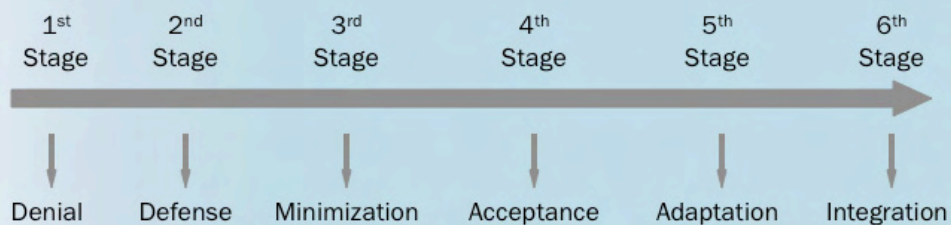
7

Milton J. Bennett's Model of Intercultural Sensitivity

Adapted from: Bennett, Milton J. "Towards a Developmental Model of Intercultural Sensitivity" in R. Michael Paige (ed.) *Education for the Intercultural Experience*. Intercultural Press, Yarmouth, Maine, 1993.

1

The Stages of Intercultural Sensitivity



2



1st Stage: Denial

The aging services professional denies that cultural differences exist.

“I’m colorblind to race. I treat all of the older adults I serve the same way.”


3

2nd Stage: Defense

The aging services professional acknowledges some cultural differences, but responds to those differences as if they are compromising his/her own reality.

“Why can’t they learn to speak English if they want to live here and access public services?”

4



3rd Stage: Minimization

The aging services professional acknowledges cultural differences, but minimizes their significance.

“I don’t think it’s necessary to discuss nutritional preferences. As long as our clients have nutritious meals, their preferences don’t really matter.”


5

4th Stage: Acceptance

The aging services professional recognizes and values cultural differences, but does not fully appreciate the context or consequences of those differences.

“Our outreach efforts to men have been successful in our elder abuse program, but we didn’t anticipate the need to tailor our services for gay and transgender clients.”

6



5th Stage: Adaptation

The aging services professional develops skills to communicate and interact with people outside of his/her own culture appropriately and respectfully.

“I’ve invited some partners from a local after-school program to help our agency plan an intergenerational summer program for older adults who come to the senior activity center.”

7

6th Stage: Integration

The aging services professional values other cultures and is constantly engaged in defining and redefining his/her perspectives and viewpoints of others. Learning from these challenges creates successful professional and client relationships outside of his/her own culture.

“With the help and support of hearing-impaired older adults at my agency, I personally celebrated Disability Month by learning sign language. Now I’d like to teach sign language to other staff members.”

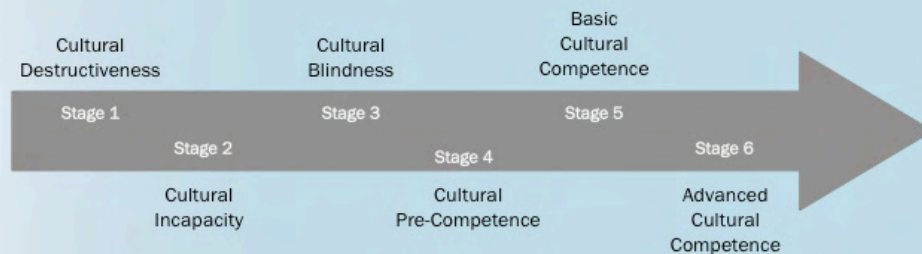
8

The Cross Model of the Cultural Competence Continuum

Adapted from: Cross, Terry L. "Cultural Competence Continuum" in *Focal Point*, the Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, Oregon, 1988.

1

The Six Stages of Cultural Competence



2



Stage 1: Cultural Destructiveness


- Culture and group differences are significant problems.
- Individuals should strive to fit in and “be like everyone else.”
- Individuals who maintain and value their culture are threats.
- Cultural superiority is a value belief.
- It’s OK for “superior cultures” to oppress, exploit, and harm “inferior cultures.”

3

Stage 2: Cultural Incapacity

- The value of diversity is never questioned or considered; it is assumed that everyone functions in the same cultural reality.
- Individuals fit into stereotypes; assumptions made based on perceptions about cultural group differences are often related to ignorance and fear.
- Individuals who maintain and value their culture are different, odd, or strange.
- Cultures that are perceived to be “inferior” do not have the ability to make decisions in their own best interests and need to be supervised by other cultures that “know better.”


4



Stage 3: Cultural Blindness

- Cultural similarities are seen while cultural differences are denied.
- Individuals are all the same and culture “just doesn’t matter.”
- Those who maintain and value their individual culture are only valued for their contributions.
- No culture is better than another. All cultures are the same.
- Cultural conflicts are not resolved. Cultural implications are never considered when trying to resolve issues.


5



Stage 4: Cultural Pre-Competence

- Cultural differences are acknowledged.
- Individuals are different and have the option of maintaining and valuing their culture.
- Others who maintain and value their culture are preserving their heritage, history, and identity.
- It is important to understand disparities and issues of inequality in relationship to other cultures.
- Technical knowledge (*understanding* cultural competency) is valued, but operational knowledge (*demonstrating* cultural competency) is weak.

6



Stage 5: Basic Cultural Competence


- Cultural differences are celebrated.
- Individuals are recognized for the unique cultural contributions they bring to the community.
- Individuals who maintain and value their individual culture are not judged but respected.
- All cultures have value and the potential to contribute to the greater good of the community.
- Learning from different cultures and how to interact and respond to differences is a valued goal.

7

Stage 6: Advanced Cultural Competence

- Cultural differences should be explored, taught, and shared, both formally and informally.
- Individuals should seek knowledge and information about diverse communities to become more comfortable in multicultural environments.
- Those who maintain and value their individual culture can make significant contributions to and inform others about issues that impact their group as well as the larger community.


8



Stage 6: Advanced Cultural Competence Continued

- Formal ways for diverse groups to engage in self-advocacy are supported and used as vehicles for observation and learning as well as opportunities for partnership and coalition building.
- A formalized technical and operational knowledge of interacting with diverse groups is valued, acquired, and sustained.

9




Factors that Influence Culture

1

True or False?

The concept of diversity refers *only* to racial and ethnic factors.

2



True or False?

The concept of diversity refers *only* to racial and ethnic factors.

False

The concept of diversity transcends racial and ethnic factors to include groups, their members, and affiliations.

For example: veterans, sororities, geographical communities, corporate organizations, advocacy groups.


3

Diversity

The concept of diversity *also* refers to differences in lifestyles, beliefs, economic status, etc.

Diversity encompasses just about any characteristic that distinguishes one group or person from another.

4



Some Factors that Influence Culture

Personal History/Experience	Health Status/Condition
Religion/Spirituality	Communication Styles
Values and Attitudes	Literacy
Language	Education
Socioeconomic Status	Physical Environment
Sexual Orientation	Geographic Location
Race	Formal/Informal Knowledge

5

Discussion Question

Based on your agency's experiences, what other factors influence culture?

6

The Steps of Planning Services for Diverse Communities



1

STEP 1: Assessments


- Organizational assessment: policies, procedures, bylaws, and community perceptions
- Staff assessment: knowledge, skills, and practices
- Self-assessment: personal attitudes, beliefs, and behaviors

STEP 2: Identifying Resources About the Community

STEP 3: Designing Services

STEP 4: Program Evaluation

2



Step 1: Assessments

Organizational Assessment:

What?

- The agency

Why?

- Provides a process to assess the policies, procedures, mission statements, and community perceptions of an agency

Value?

- Helps design a formal plan to assess, review, and revise policies and procedures to make them culturally responsive for the agency's service population; it also helps align policy with practice

3

Step 1: Assessments

Staff Assessment:

Who?

- All staff, managers, board members, committee members, consumer boards, volunteers; anyone who influences policy and provides services

Why?

- Provides a process to assess the knowledge, skills, and practices of staff and helps identify gaps in knowledge and practice

Value?

- Helps design a formal plan to establish goals and set milestones for staff education. Provides an opportunity for open dialog regarding staff attitudes about serving diverse communities

4

Step 1: Assessments

Self Assessment:

Who?

- All staff, managers, board members, committee members, consumer boards, volunteers; anyone who influences policy and provides services

Why?

- Provides a confidential process for an individual to assess personal attitudes, behaviors, beliefs with serving diverse communities


Value?

- Helps establish personal milestones for gaining knowledge and acquiring a level of comfort with serving diverse communities

5



6



Step 2: Identifying Resources About the Community

Agency Knowledge of Service Community

Who?

- All staff, board and committee members, partnering agencies, and volunteers

Why?

- Ensures that an agency understands the community it is serving

Value?

- The agency's staff can find out the values of the community to tailor its services to meet the community's needs

7

Step 2: Identifying Resources About the Community

Partnerships and Coalitions with Representatives from Diverse Groups

Who?

- Trusted and valued representatives from diverse service areas


Why?

- Creates an opportunity to gain credibility through associations with individuals and groups the diverse community trusts

Value?

- Provides an authentic opportunity for learning: cross-training, consulting, and collaborative service provision

8



Step 2: Identifying Resources About the Community

Client Data

Who?

- Aging agencies, research partners, local colleges and universities, research firms; local, state and federal government agencies

Why?

- To determine the best types of services for a particular community

Value?

- Increases understanding of the types of services to administer that can save time and energy from making costly mistakes

9

Step 2: Identifying Resources About the Community

Client Input

Source?

- Older adults and their communities who will receive the services

Why?

- To find out how consumer expectations and values relate to service provision

Value?

- Understanding what types of services a diverse community values and delivering those services can enhance and improve an agency's reputation and trustworthiness within a community

10



Step 3: Designing Services

How should services be designed and delivered to this population?

- Colors, language, images, pictures; with the assistance of family and/or life partners, caregivers, community organizations; etc.

Who should receive your agency's services?

- Clients, caregivers, community organizations, etc.

What types of services should be delivered, and which services are most valued and appreciated?

- Caregiver support, meals at the end of the month, energy assistance during summer/winter

12

Step 3: Designing Services

Where should services be delivered?

- At trusted community providers, through churches and social groups, in the home, etc.

What are the structural and cultural barriers to services

- Family role: grandparent, caregiver, etc.
- Income
- Transportation
- Health status/condition
- Cultural/group values
- Health literacy/language
- Geography/rural environment
- Access for individuals with disabilities
- Environmental conditions/home setting

13

STEP 1: Assessments

STEP 2: Identifying Resources
About the Community

STEP 3: Designing Services

STEP 4: Program Evaluation

- Organization and client evaluation of services
- Lessons learned

14

Step 4: Program Evaluation

Organizational and Client Evaluation of Services

What (should be evaluated)?

- Services (provided by both the agency and its partners); client and community perception of the quality and effectiveness of services

Why?

- To evaluate the process of service delivery and the quality of services

15

Step 4: Program Evaluation

Organizational and Client Evaluation of Services Continued

How?

- Process Evaluation
- Outcome Evaluation

Value?

- To ensure that program process and outcomes align with the values and needs of the client and community

16

Step 4: Program Evaluation

Process Evaluation

What?

- Evaluates the way a program is implemented and how effectively it is being managed

Depends on . . .

- How well program components and activities are defined and identified

17

Step 4: Program Evaluation

Process Evaluation Continued

Asks . . .

- “How does an agency manage the program to get things done?” and “Are we managing the program in the most effective way?”

Value?

- Helps to identify:
 - If the program is operating in the most effective way
 - The program’s strengths and weakness
 - Program components that need to be added, changed, or eliminated

18

Step 4: Program Evaluation

Outcome Evaluation

What?

- Determines the program's effectiveness for its intended client, whether goals were met and desired outcomes were accomplished

Depends on . . .

- How well program goals and objectives are clearly defined

19

Step 4: Program Evaluation

Outcome Evaluation Continued

Asks . . .

- "What were the program's results?" and "Did we meet our goal?"

Value?

- Helps to identify:
 - If the program is meeting its intended goals and objectives
 - If services are meeting client expectations and reflect community values
 - Unanticipated outcomes and/or effects that can be positive or negative

20

Step 4: Program Evaluation

Data

What ?

- Data is information that comes in several forms:
 - Quantitative – in the form of numbers (statistical information)
 - Qualitative – in the form of words (descriptive information)

Data sources are all around us

- Case management database, records and files, existing statistics, clients, and partners

21


Step 4: Program Evaluation

Data Continued

How do I collect the data?

- Documenting and tracking activities
- Database queries
- Questionnaires and surveys
- Interviews
- Observation
- Focus Groups

22



Step 4: Program Evaluation

How Does Your Agency Start?


1. **Develop a model or description of your program**
 - Clarify program goals and objectives
 - Clearly identify program components and activities
2. **Determine what type of evaluation is needed (process and/or outcomes)**
3. **Choose the type of data collection method**
4. **Choose the data source(s)**

23

Step 4: Program Evaluation

5. **Select an evaluation team and define specific roles and tasks**
 - Identify partners and agencies that can leverage expertise
 - Don't forget to include client and community representation
6. **Make sure evaluation questions are aligned with**
 - The program goals, objectives, and/or outcomes you are measuring
 - The program's components and activities
 - The client's and community's identified needs, expectations and services

24



Step 4: Program Evaluation

7. Create data collection protocols and review data collection capacity

- Develop a guidance document so data collection efforts are consistent, i.e., everyone is collecting the same type of data and that data is clearly defined
- Check telephonic and case management systems' ability to capture the type and quality of data needed

25

Step 4: Program Evaluation

Lessons Learned

Who?

- Everyone who was involved in the process, including the community

Why?

- Helps an agency identify how to make programs better for a particular diverse community

Value?

- Demonstrates that an agency is invested not only in its programs, but the community it serves
- Strengthens the community's role as a stakeholder

26

Characteristics of Success in Serving Diverse Communities

1

How Does It Impact an Agency's Service Quality and Delivery When:

Individual staff members are more committed than the agency's management to meeting the needs of diverse communities?



The agency's management is more committed than individual staff members to meeting the needs of diverse communities?

2

Agency and Staff Responsibility

Serving diverse communities cannot be successfully accomplished unless both the *agency* and the *individual* staff members take responsibility for its implementation.

Everyone has a role to play.

3

Maintaining the Balance Between Organizational and Individual Responsibility

Organizational
Management

Value Diversity

Policies

Structure

Practices



Individual Staff
Members

Value Diversity

Behaviors


Attitudes

Practices

Adapted from: Cross T., Bazron, B., Dennis, K., and Isaacs, M. Towards a Culturally Competent System of Care, Volume I, Georgetown University Child Development Center, CASSP Technical Assistance Center, Washington, D.C., 1989.

A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, Georgetown University Center for Child and Human Development, National Center for Cultural Competence, Washington, D.C., 2006.

4



Characteristics of Success in Serving Diverse Communities

Being aware of:

- Your cultural values and biases
- How, why, where, and when you control those biases
- Clients' and their communities' cultures
- Structural and cultural barriers to service

Adapted from: Anand, Rohini. *Teaching Skills and Cultural Competency: A Guide for Trainers*, Fourth Edition. National Multicultural Institute (NMCI) Publications, Washington, D.C., 2000.

5

Characteristics of Success in Serving Diverse Communities

Being able to:

- Exhibit effective communication skills when serving different cultures
- Be at ease with differences
- Advocate for communities that have different values from your own
- Mediate in cross-cultural disagreements

Adapted from: Anand, Rohini. *Teaching Skills and Cultural Competency: A Guide for Trainers*, Fourth Edition. National Multicultural Institute (NMCI) Publications, Washington, D.C., 2000.

6



Worldview

1

Worldview

The sum of a person's or group's perspectives; it includes opinions, judgments, and beliefs based on culture, values, and life experiences

All factors that influence culture create and shape worldview

2

What Influences Worldview?

Gender	Race	Age	Ethnicity
Stories from Impressionable Family & Friends	Geographic Location	Health Status/Condition	Experiences & Knowledge
Religion/Spirituality	Sexual Orientation	Childhood Memories & Experiences	Socioeconomic Status/Income
Social & Physical Environment	Educational Attainment	Political, Social, & Personal Affiliations	
Professional, Social, & Personal Roles	Personal, Family, & Cultural History	Nuclear & Extended Family Values	

3

The Impact of Worldview on Providing Services for Diverse Communities

When serving diverse communities, it's important that:

- The older adult's world view is respected.
- The broadest service options are provided to maximize the older adult's ability to select services that don't conflict with his or her worldview of health, illness, treatment, and death.
- The provider organization's worldview does not hinder the services that are introduced or offered to the older adult.

4



How to Read Your Medicare Summary Notice



Your Medicare Summary Notice (MSN) explains services and supplies that were billed to Medicare for a 30-day period. You get a Medicare Summary Notice when you get health care services that Medicare Part A or Part B covers. It's important that you check your notice to be sure you got all of the services, medical supplies, or equipment that providers billed to Medicare.

The MSN isn't a bill. **DON'T** pay unless you get a bill from the provider.

- This official government booklet
- shows examples of what you may see on your Medicare Summary Notice, and
 - helps you understand how to read your notice.

The exercises presented in this appendix represent a starting point for users of this Toolkit. Agency staff and partners are encouraged to create their own exercises.

EXERCISE 1: DEFINITION MATCHING

Race	A group with shared values, religion, language, and/or heritage.
Ethnic Group	The capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs of consumers and their communities.
Culture	Policies and practices of an organization, or values and behaviors of an individual, that enable the agency or person to interact effectively in a culturally diverse environment.
Diversity	Ethnic, socioeconomic, religious, and gender variety in a group, society, or institution.
Cultural Competency	Individuals who share values, traditions, and social norms.
Cultural Proficiency	A division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinctive human type.

Answers to definitions are provided in Appendix B.

EXERCISE 2: CULTURAL BARRIER OR STRUCTURAL BARRIER

CULTURAL BARRIER

A difference in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.

STRUCTURAL BARRIER

Technical or logistical factors that limit a person's ability to access services.

Which of the issues below are examples of structural or cultural barriers? Why or why not?

Is it possible the issues could result in both structural and cultural barriers?

Regarding each of the situations, how do an agency's cultural (institutional) values influence barriers?

1. An agency that lacks wheelchair accessibility.

Cultural ☐ or Structural ☐

Influence:

2. A client delaying a decision to sign up for needed services because his/her partner is not available to participate in the decisionmaking process.

Cultural ☐ or Structural ☐

Influence:

3. A client living by a bus route that suspends services during non-rush hours.

Cultural ☐ or Structural ☐

Influence:

Influence:

4. A client requesting a sign-language interpreter.

Cultural ☐ or Structural ☐

Influence:

7. An agency serving communities that have no advisory or consumer board representation.

Cultural ☐ or Structural ☐

Influence:

5. An agency distributing the same outreach brochures to different diverse communities.

Cultural ☐ or Structural ☐

Influence:

8. An agency making the decision to collect only quantitative (statistical/numeric) client data.

Cultural ☐ or Structural ☐

Influence:

6. An agency unaware of community-based partners providing services to the same diverse community group for which it is also providing services.

Cultural ☐ or Structural ☐

Influence:

9. An agency creating a policy option for board members to complete self-assessments.

Cultural ☐ or Structural ☐

Influence:

EXERCISE 3: TECHNICAL OR OPERATIONAL KNOWLEDGE?

While the goal of this exercise is to identify each statement as an example of technical knowledge, operational knowledge, or both, the purpose of this exercise is to stimulate discussion among agency staff and partners about the differences between technical and operational knowledge. Therefore, no prescriptive answer is provided. Learning is encouraged through discussion based on knowledge, background, and experiences.

Technical knowledge is understanding how to serve diverse populations: “I can tell you.”

Operational knowledge is demonstrating how to serve diverse populations: “I can show you.”

Technical ☐
Operational ☐

1. **Staff acquire first-level training in cultural competency.**

Technical ☐
Operational ☐

2. **Staff utilize a nutritional assessment that asks elderly Jewish clients if their non-Jewish caretakers need experience with cooking Kosher foods and maintaining a Kosher kitchen.**

Technical ☐
Operational ☐

3. **An agency completes an organizational cultural competency assessment.**

Technical ☐
Operational ☐

4. **An agency completes an organizational cultural competency assessment and uses the results to implement and enhance policies.**

Technical ☐
Operational ☐

5. **A program manager changes the vision statement of a program targeted to an American Indian caregiving service to reflect the cultural values of that community.**

Technical ☐
Operational ☐

6. **An agency invites American Indian elders and their families to assist with creating the vision statement and its family caregiving service to reflect the cultural values of that community.**

Technical ☐
Operational ☐

7. **An agency provides staff with guidance for supporting immigrant families caring for family members with Alzheimer’s disease.**

Technical ☐
Operational ☐

8. **An agency creates an intergenerational veteran support program that includes older adult veterans that mentor younger, recently discharged veterans.**

Technical ☐
Operational ☐

9. **Staff pass out health care brochures from a partnering clinic advertising free health care services for migrant worker families.**

Technical ☐
Operational ☐

10. **A state’s Aging Network partners with local non-denominational religious organizations to address increasing numbers of older adults with HIV/AIDS.**

LIST OF ONLINE RESOURCES | APPENDIX G

The list of resources presented in this appendix represents a starting point for users of this Toolkit. Agency staff and partners are encouraged to add to this list of resources.

STEP 1: ASSESSMENT RESOURCES

Organizational and staff assessments

A Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/documents/ncccorgselfassess.pdf>

A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument
National Center for Cultural Competence, Georgetown University
http://www.clcpa.info/documents/CLCPA_guide.pdf

Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures: Rationale for Cultural Competence in Primary Health Care
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy%20Brief%201%20Checklist.pdf>

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations: Linguistic Competence in Primary Health Care Delivery Systems Implications for Policy Makers
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy%20Brief%202%20Checklist.pdf>


Cultural and Linguistic Competence Policy Assessment
National Center for Cultural Competence, Georgetown University
<http://www.clcpa.info/documents/CLCPA.pdf>

Cultural Competency Organizational Self-Assessment
AIDS Education Training Centers, National Resource Centers
<http://www.aidsetc.org/doc/workgroups/cc-question-bank.doc>

Diversity and The Aging Network: An Assessment Handbook
National Aging Resource Center: Long-Term Care, Brandeis University
http://www.alz.org/national/documents/GEN_ASSESS-LTCDiversityHandbook.pdf

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.



Assessment of Organizational Cultural Competence
Association of University Centers on Disabilities (AUCD) Multicultural Council
http://www.aucd.org/docs/councils/mcc/cultural_competency_assmt2004.pdf

Self-assessments

Self-Assessment of Cultural Competence
Association of University Centers on Disabilities (AUCD) Multicultural Council
http://www.acphd.org/AXBYCZ/Admin/Publications/ddc_self_assess_cultural_competence.doc

Cultural Competence Self-Assessment Questionnaire: A Manual for Users
Portland University
<http://www.rtc.pdx.edu/PDF/pbCultCompSelfAssessQuest.pdf>

Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist%20PHC.pdf>

Rationale for Self-Assessment Checklist
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/orgselfassess.html>

Assessment tools

The Cross Cultural Health Care Program
<http://www.xculture.org/assesstools.php>

STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

Agency knowledge of service community

Inclusiveness at Work: How to Build Inclusive Nonprofit Organizations
The Denver Foundation
Module 5: Information Gathering, Part 1: Available Facts

<http://www.nonprofitinclusiveness.org/files/Module%205.pdf>
Module 7: Information Gathering, Part 3: Compiling Results
<http://www.nonprofitinclusiveness.org/files/Module%207.pdf>
Module 14: Programs and Constituents
<http://www.nonprofitinclusiveness.org/files/Module%2014.pdf>

Stakeholder Management

Curtin University of Technology, School of Architecture Construction and Planning
<http://www.e-campus21.com/courseware/notes/CourseMaterials/CME/PM442/PM442/topic8.pdf>

Partnerships and coalition building

Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs
The National Center for Cultural Competence at the Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/resources/brokering.html>

Developing Effective Coalitions: An Eight Step Guide
The Prevention Institute
<http://www.preventioninstitute.org/pdf/eightstep.pdf>

Improving Stakeholder Collaboration: A Special Report on Community-Based Health Efforts
Group Health Community Foundation
<http://www.cche.org/pubs/ghcf-publication-stakeholder-collaboration.pdf>

Inclusiveness at Work: How to Build Inclusive Nonprofit Organizations
The Denver Foundation
<http://www.nonprofitinclusiveness.org/inclusiveness-work-how-build-inclusive-nonprofit-organizations>

Ten Myths that Prevent Collaboration Across Cultures
Awesome Library, Evaluation and Development Institute
<http://www.awesomelibrary.org/multiculturaltoolkit-myths.html>

Client and community data

Aging Statistics
U.S. Administration on Aging, U.S. Department of Health and Human Services
http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

Bureau of Labor Statistics
U.S. Department of Labor
www.bls.gov

Federal Interagency Forum on Aging Related Statistics
www.AgingStats.gov

Inclusiveness at Work: How to Build Inclusive Nonprofit Organizations
The Denver Foundation (See Partnerships and Coalition Building)
http://www.denverfoundation.org/File_Download.cfm?file=IAW_intro.pdf

Migration and Data Reports
U.S. Census Bureau
<http://www.census.gov/population/www/cen2000/migration.html>

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

Minority Health

National Institutes of Health, U.S. Department of Health and Human Services
<http://health.nih.gov/category/MinorityHealth>

National Healthcare Disparities Report

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
<http://www.ahrq.gov/qual/qdr08.htm>

Office of Minority Health, U.S. Department of Health and Human Services
<http://www.omhrc.gov/>

Office of Refugee Resettlement, Administration of Children and Families

U.S. Department of Health and Human Services
<http://www.acf.hhs.gov/programs/orr/data/05arc10appendixC.htm>

Racial and Ethnic Populations, Office of Minority Health and Health Disparities

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
<http://www.cdc.gov/omhd/Populations/populations.htm>

Rural and Diversity Briefing

Economic Research Service, U.S. Department of Agriculture
<http://www.ers.usda.gov/Briefing/Population/Diversity.htm>

Selected Long-Term Care Statistics

Family Caregiver Alliance
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440

Selected Caregiver Statistics

Family Caregiver Alliance
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=439

Trends in Vision and Hearing Among Older Americans

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
<http://www.cdc.gov/nchs/data/ahcd/agingtrends/02vision.pdf>

U.S. Census Bureau

<http://www.census.gov/>

Women and Caregiving: Facts and Figures

Family Caregiver Alliance
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=892

Client input

Basics of Conducting Focus Groups

Free Management Library
http://www.managementhelp.org/grp_skill/focusgrp/focusgrp.htm

Effective Questioning

Free Management Library
http://www.managementhelp.org/commskls/qustning/old_qust.htm

Inclusiveness at Work: How to Build Inclusive Non-Profit Organizations
The Denver Foundation
Module 6: Information Gathering, Part 2: Stakeholder Perspectives
<http://www.nonprofitinclusiveness.org/files/Module%206.pdf>

STEP 3: DESIGNING SERVICES

Outreach/Marketing

Getting the Word Out: Effective Health Outreach to Cultural Communities
The Medtronic Foundation
http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf

A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials
National Center for Cultural Competence, Georgetown University
http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials_Guide.pdf

Inclusiveness at Work: How to Build Inclusive Non-Profit Organizations
Module 15: Marketing and Community Relations
The Denver Foundation
<http://www.nonprofitinclusiveness.org/files/Module%2015.pdf>

Tried and True Methods for Reaching Under-Served Populations
National Long Term Care Ombudsman Resource Center
<http://www.ltombudsman.org/sites/default/files/norc/Tried-and-True-Methods.pdf>

Service design and delivery

Developing Culturally-Competent Individual Service Plans for Wellness, Recovery and Resilience
Neal Adams, M.D., California Department of Mental Health
<http://www.afteradoption.org/Wraparound/strengthbasedserviceplans.ppt#293>

How Well Does Your Agency Provide Client-centered Services?
Center for Health Training
http://www.centerforhealthtraining.org/documents/agency_assess.pdf

Making CLAS Happen: Six Areas for Action
A Guide to Providing Culturally and Linguistically Appropriate Services (CLAS) in a Variety of Public Health Settings
Massachusetts Department of Public Health, Office of Health Equity
http://www.mass.gov/Eeohhs2/docs/dph/health_equity/clas_intro.doc

Cultural Competency
Homestead Schools, Inc. – Social Work

Chapter 4 – Developing Cultural Competence
<http://www.homesteadschools.com/LCSW/courses/CulturalCompetence/Chapter04.html>
Chapter 8 – Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families
<http://www.homesteadschools.com/LCSW/courses/CulturalCompetence/Chapter08.html>

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

Serving diverse communities: challenges, barriers, and best practices

Strategy Brief: Ombudsman Program Responses to Diversity

National Association of State Units on Aging

<http://www.nasua.org/pdf/Diversity%20Dialogue.pdf>

Chronic Disease and Pain Management – Part I PowerPoint Presentation

Hee Yun Yee, Ph.D., Assistant Professor, School of Social Work, University of Minnesota

<http://www.cehd.umn.edu/SSW/ContinuingEd/Documents/Module%206/Chronic%20Disease%20-%20Part%20I.pdf>

Health Literacy and Cultural Competency

Chronic Disease and Pain Management Fact Sheet

School of Social Work, University of Minnesota

<http://www.cehd.umn.edu/ssw/ContinuingEd/Documents/Module%206/Reading%20guide%20-%20Module%206.pdf>

Promising Practices Issue Brief: Respecting Diversity

Reaching Out Through Local Elder Abuse Networks

National Center on Elder Abuse

http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/PromisingPracticesRespectingDiversity.pdf

Senior Nutrition Programs: Promising Practices for Diverse Populations

New Jersey Department of Health and Senior Services

<http://www.state.nj.us/health/senior/nutrition/documents/nutrition.pdf>

STEP 4: PROGRAM EVALUATION

Organization and client evaluation of services

Basic Guide to Program Evaluation

Carter McNamara, M.B.A., Ph.D.

http://208.42.83.77/evaluatn/fnl_eval.htm

An Evaluation Framework for Community Health Programs

The Center for Advancement of Community Based Public Health

<http://www.cdc.gov/eval/evalcbph.pdf>

Everything You Wanted to Know About Logic Models but Were Afraid to Ask

Connie C. Schmitz and Beverly A. Parsons, InSites

<http://www.insites.org/documents/logmod.htm>

Engaging New Families in Evaluation

Federation of Families for Children's Mental Health

<http://ffcmh.org/wp-content/uploads/2009/pdffiles/Engaging%20New%20Families%20in%20Evaluation%20-%20Eng.pdf>

Spanish version: <http://ffcmh.org/wp-content/uploads/2009/pdffiles/Engaging%20New%20Families%20in%20Evaluation%20-%20Spa.pdf>

A Framework for Program Evaluation: The Logic Model and Evaluation Framework

Center for Addiction and Mental Health, University of Toronto

<http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/AFrameworkforProgramEvaluation.aspx>

How Do Measures Measure Up?

Evangeline Danesco, Ph.D.

The Provincial Center of Excellence for Child and Youth Mental Health

http://onthePOINT.smartsimple.biz/files/237865/f93611/Measures_Webinar_Slides_EN.ppt

The Legality of Collecting and Disclosing Patient Race and Ethnicity Data

Robert Wood Johnson Foundation and The George Washington University Medical Center

<http://www.rwjf.org/files/publications/other/RaceEthnicDisparitiesData06222006.pdf>

Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process

Judi Aubel, Ph.D., M.P.H.,

Child Survival Technical Support Project and Catholic Relief Services

http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf

Tools for Measuring Health Conditions

Resource Centers for Minority Aging Research, National Institute on Aging

National Institutes of Health, U.S. Department of Health and Human Services

<http://www.musc.edu/dfm/RCMAR/RCMARTools.html>

Toward Culturally Competent Evaluation in Health and Mental Health

The California Endowment

http://www.calendow.org/uploadedFiles/Publications/Evaluation/toward_culturally_competent_evaluation.pdf

Types of Program Evaluation

Center for Addiction and Mental Health, University of Toronto

<http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/TypesofProgramEvaluation.aspx>

Lessons learned

Ensure Use of Evaluation Findings and Lessons Learned (tobacco cessation)

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/chapter6.pdf

Family Engagement in Evaluation: Lessons Learned

Federation of Families for Children's Mental Health

<http://ffcmh.org/researchandpublications/FamilyEngagementinEvaluation.pdf>

ONLINE RESOURCES ON DIVERSE POPULATIONS

A

African-American/Black

Adaptation of an HIV Prevention Curriculum for Use With Older African American Women

Journal of the Association of Nurses in AIDS Care

http://www.oneloveca.org/_files/_files/5245_california-CorneliusOlderAAfemHIVp08.pdf

African Americans and Alzheimer's Disease: The Silent Epidemic

Alzheimer's Association

http://www.alz.org/Resources/Diversity/downloads/AA_EDU-SilentEpidemic.pdf

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

African American Health Coalition
<http://www.aahc-portland.org/aboutUs.htm>

Healthy Minds. Healthy Lives.
African Americans
American Psychiatric Association
<http://healthyminds.org/More-Info-For/African-Americans.aspx>

Mental Health: A Report of the Surgeon General
Chapter 3: Mental Health Care for African-Americans
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<http://mentalhealth.samhsa.gov/cre/ch3.asp>

National Caucus and Center on Black Aged
<http://www.ncba-aged.org/>

African-American Programs
American Diabetes Association
<http://www.diabetes.org/community-events/programs/african-american-programs/>

Serving African American Families: Home and Community Based Services for People with Dementia and Their Caregivers
Alzheimer's Association
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/docs/Toolkit_4_Serving_African_Americans.pdf

American Indian and Alaskan Native

Centers for American Indian and Alaska Native Health
University of Colorado – Denver
http://aianp.uchsc.edu/nerc/nerc_index.htm

Changing Direction: Strengthening the Shield of Knowledge
Building Understanding that Leads to Cross-Cultural Competence
AIDS Education and Training Centers, National Resource Center
<http://www.aidsetc.org/aidsetc?page=et-04-01>

Diabetes Program Affiliates
Association of American Indian Physicians
<http://www.aaip.org/?page=DAFFILIATES>

CultureCard: A Guide to Build Cultural Awareness, American Indian and Alaska Native
U.S. Department of Health and Human Services
http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4354/CultureCard_AI-AN.pdf

Indian Health Service
U.S. Department of Health and Human Services
<http://www.ihs.gov/>

Indigenous People and the Social Work Profession: Defining Culturally Competent Services
Hillary N. Weaver, School of Social Work, State University of New York
National Association of Social Workers
<http://www.socialworkers.org/diversity/ethnic/weaver.pdf>

Mental Health: A Report of the Surgeon General
Chapter 4: Mental Health Care for American Indians and Alaska Natives
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<http://mentalhealth.samhsa.gov/cre/ch4.asp>

National Indian Council on Aging
<http://www.nicoa.org/>

National Indian Health Board
http://www.nihb.org/public_health/public_health.php

National Native American AIDS Prevention Center
<http://www.nnaapc.org/>

National Resource Center for American Indian, Alaska Native and Native Hawaiian Elders
University of Alaska Anchorage
<http://elders.uaa.alaska.edu/about.htm>

National Resource Center on Native American Aging
Center for Rural Health, University of North Dakota
<http://ruralhealth.und.edu/projects/nrcnaa/publications.php>

Diabetes and Native Americans
American Diabetes Association
<http://www.diabetes.org/community-events/programs/native-american-programs/>

Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide
National Council on Disability
http://www.ncd.gov/newsroom/publications/2003/native_toolkit.htm

Asian American and Pacific Islander

Healthy Minds. Healthy Lives.
Asian American/Pacific Islanders
American Psychiatric Association
<http://healthyminds.org/More-Info-For/Asian-AmericanPacific-Islanders.aspx>

Association of Asian Pacific Community Health Organizations
<http://www.aapcho.org/site/aapcho/>

Asian American Health
U.S. National Library of Medicine, National Institutes of Health
<http://asianamericanhealth.nlm.nih.gov/>

Mental Health: A Report of the Surgeon General
Chapter 5: Mental Health Care for Asian Americans and Pacific Islanders
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<http://mentalhealth.samhsa.gov/cre/ch5.asp>

National Resource Center for Native Hawaiian Elders
Myron B. Thompson School of Social Work, University of Hawaii
<http://manoa.hawaii.edu/hakupuna/publications.html>

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

National Asian Pacific Center on Aging
<http://www.napca.org/>

National Resource Center for American Indian, Alaska Native and Native Hawaiian Elders:
University of Alaska Anchorage
<http://elders.uaa.alaska.edu/about.htm>

Reducing Health Disparities in Asian Pacific Islander Populations
The Providers Guide to Quality Care
<http://erc.msh.org/aapi/index.html>

Serving Asian and Pacific Islander Families: Home and Community-Based Services for People with Dementia and Their Caregivers
Alzheimer's Association
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/docs/Toolkit_5_Serving_Asian_Pacific_Islanders.pdf

C

Caregiving

Cultural Diversity and Caregiving
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1880

Cultural Competence & Diversity Guidance, Resources, and Training Materials

Aging and Diversity: Module 2 – Diversity
AgeWorks
http://www.ageworks.com/course_demo/380/module2/module2.htm

America's Diversity Guide
National Association of State Units on Aging
http://www.nasua.org/issues/tech_assist_resources/national_aging_ir_support_ctr/diversity_guide/index.html

The Cross Cultural Health Care Program
<http://www.xculture.org/cultcompprograms.php>

Culture Clues
Patient and Family Education Services, University of Washington Medical Center <http://depts.washington.edu/pfes/CultureClues.htm>

Cultural Competency Learning Objectives
Homestead Schools, Inc. – Social Work
<http://www.homesteadschools.com/LCSW/courses/CulturalCompetence/toc.html>

Cultural Competency Toolkit for Broward County, Florida
The Coordinating Council of Broward Multicultural Board
<http://www.broward.org/celebratingdiversity/ccbculturalcomptoolkit.pdf>

Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements
Health Resources Services Administration, U.S. Department of Health and Human Services
<ftp://ftp.hrsa.gov/financeMC/cultural-competence.pdf>

Cultural Complementarity™ Model

Greater Twin Cities United Way

http://www.unitedwaytwincities.org/ourimpact/culturaldynamics_complementarity.cfm

Culture and Diversity Tip Sheet

Prevention by Design

http://socrates.berkeley.edu/~pbd/pdfs/Culture_Diversity.pdf

Cultural Competence Resources for Health Care Providers

Health Resources Services Administration, U.S. Department of Health and Human Services

<http://www.hrsa.gov/culturalcompetence/>

Curricula Enhancement Module Series

National Center for Cultural Competence, Georgetown University Center for Child and Human Development

<http://www.nccc-curricula.info/>

Diversity and Equity

National Association of Social Workers

<http://www.socialworkers.org/diversity/default.asp>

Inclusiveness at Work: How to Build Inclusive Nonprofit Organizations

The Denver Foundation

<http://www.nonprofitinclusiveness.org/inclusiveness-work-how-build-inclusive-nonprofit-organizations>

Multicultural Toolkit: Toolkit for Cross-Cultural Collaboration

Awesome Library, Evaluation and Development Institute

<http://www.awesomelibrary.org/multiculturaltoolkit.html>

National Center for Cultural Competence, Georgetown University

<http://www11.georgetown.edu/research/gucchd/nccc>

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The Office of Minority Health, U.S. Department of Health and Human Services

<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

Network of Multicultural Aging (NOMA)

An American Society on Aging Constituent Group

<http://www.asaging.org/networks/index.cfm?cg=NOMA>

New Ventures in Leadership: A Leadership Program for Professionals of Color in Aging

American Society on Aging

<http://www.asaging.org/nvl/index.cfm>

The Office of Minority Health, U.S. Department of Health and Human Services

<http://minorityhealth.hhs.gov/>

Opening the Door to the Inclusion of Transgender People: The Nine Keys to Making Lesbian, Gay, Bisexual and Transgender Organizations Fully Transgender-Inclusive

National Gay and Lesbian Task Force Policy Institute and National Center for Transgender Equality

http://www.thetaskforce.org/downloads/reports/reports/opening_the_door.pdf

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

The Provider's Guide to Quality & Culture
Management Sciences for Health
<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

Race, Ethnicity and Health Care
Kaiser Foundation
<http://www.kaiseredu.org/tutorials/REHealthcare/player.html>

Standards for Cultural Competence in Social Work Practice
National Association of Social Workers
<http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs
The Office of Minority Health, U.S. Department of Health and Human Services
<http://www.thinkculturalhealth.org/>

D

Dementia/Alzheimer's Disease

Alzheimer's and Dementia Caregiver Resource Guide
Center for Aging and Diversity, Institute on Aging
The University of North Carolina at Chapel Hill
<http://www.aging.unc.edu/cad/files/CaregiverResourceGuide2009.pdf>

10 Steps to Providing Culturally Sensitive Dementia Care
The Washington DC Area Geriatric Education Center Consortium
<http://wagecc.gwumc.edu/pdf/10Steps.pdf>

Disability

Aging and Vision Loss Fact Sheet
The American Federation for the Blind
<http://www.afb.org/seniorsite.asp?SectionID=68&TopicID=320&DocumentID=3374>

Aging with Developmental Disabilities: Position Statement
Texas Council for Developmental Disabilities
http://www.txddc.state.tx.us/public_policy/position/aging.asp

Critical Elements of an Effective Drop-In Center Serving People with Psychiatric Disabilities
Michigan Department of Community Health and Michigan State University
http://www.michigan.gov/documents/mdch/Critical_Elements_of_an_Effective_Dropin_Center_203778_7.pdf

Disability Etiquette
Easter Seals
http://www.easterseals.com/site/PageServer?pagename=ntl_etiquette

Disability Etiquette: Tips on Interacting with People with Disabilities
United Spinal Association
<http://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf>

Enhancing Your Interactions with People with Disabilities
Public Interest Directorate of the American Psychological Association
<http://www.apa.org/pi/disability/enhancehome.html>

Guidelines for Reporting and Writing about People with Disabilities
Research and Training Center on Independent Living
University of Kansas
<http://www.apastyle.org/manual/related/guidelines-reporting-and-writing.pdf>

National Council on Disability
<http://www.ncd.gov/>

The National Council on Independent Living
<http://www.ncil.org/>

Network on Environments, Services and Technologies for Maximizing Independence (NEST)
An American Society on Aging Constituent Group
<http://www.asaging.org/networks/index.cfm?cg=NEST>

Parallels in Time I & II: A History of Developmental Disabilities
Minnesota Governor's Council on Disabilities
<http://www.mncdd.org/parallels/index.html>
<http://www.mncdd.org/parallels2/index.htm>

State Resource Locator
Office on Disability, U.S. Department of Health and Human Services
<http://www.hhs.gov/od/topics/Resource%20Locator/resourcelocator.html>

Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide
National Council on Disability
http://www.ncd.gov/newsroom/publications/2003/native_toolkit.htm

Vision Loss
Family Caregiver Alliance, National Center of Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=2222

E _____

English as a Second Language (ESL)

Guiding Values and Principles for Language Access
National Center for Cultural Competence, Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#lcpinciples>

Health Materials in Languages Other than English
http://macmla.org/sdu/handouts/coughlan_non_eng.pdf

Limited English Proficiency
A Federal Interagency Website
<http://www.lep.gov/>

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

National Council on Interpreting in Health Care
www.ncihc.org

National Standards on Culturally and Linguistically Appropriate Services (CLAS)
The Office of Minority Health, U.S. Department of Health and Human Services
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

H

Health Disparities and Minority Health

Cultural Competence in Health Care
Chronic Diseases Issue Brief
Center on an Aging Society, Georgetown University
<http://ihcrp.georgetown.edu/agingsociety/pdfs/cultural.pdf>

Estimating the Cost of Racial and Ethnic Health Disparities
The Urban Institute
http://www.urban.org/uploadedpdf/411962_health_disparities.pdf

Information for Selected Audiences
National Heart Lung and Blood Institute,
National Institutes of Health, U.S. Department of Health and Human Services
http://www.nhlbi.nih.gov/health/pubs/pub_slctpro.htm#afam

Daily Health Policy Report
Kaiser Health News
<http://www.kaiserhealthnews.org/Daily-Report.aspx>

Making the Grade on Women's Health: A National and State-by-State Report Card
National Women's Law Center
<http://www.nwlc.org/details.cfm?id=1861§ion=health>

Office of Minority and Women's Health
National Center for Preparedness, Detection and Control of Infectious Diseases, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
<http://www.cdc.gov/ncidod/omwh/>

Racial and Ethnic Disparities in U.S. Health Care: A Chartbook
The Commonwealth Fund
<http://www.commonwealthfund.org/Content/Publications/Chartbooks/2008/Mar/Racial-and-Ethnic-Disparities-in-U-S--Health-Care--A-Chartbook.aspx>

Rural Health Disparities
Rural Assistance Center, School of Medicine and Health Science, University of North Dakota
http://www.raconline.org/info_guides/disparities/

Regional and State Activities
National Partnership for Action to End Health Disparities, Office of Minority Health, U.S. Department of Health and Human Services
<http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=2&lvlid=5>

State Offices of Minority and Multicultural Health Liaison Map
Office of Minority Health, U.S. Department of Health and Human Services
<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=187>

U.S. Department of Health and Human Services
<http://www.ahrq.gov/research/minorix.htm>

Health Literacy

Quick Guide to Health Literacy and Older Adults
Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services
<http://www.health.gov/communication/literacy/olderadults/literacy.htm>

Hispanic/Latino American

Healthy Minds. Healthy Lives.
Latinos and Mental Health
American Psychiatric Association
<http://healthyminds.org/More-Info-For/HispanicsLatinos.aspx>

Latino Programs
American Diabetes Association
<http://www.diabetes.org/community-events/programs/latino-programs/>

Mental Health: A Report of the Surgeon General
Chapter 6: Mental Health Care for Hispanic Americans
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<http://mentalhealth.samhsa.gov/cre/ch6.asp>

A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics
The National Alliance for Hispanic Health
<http://www.hispanichealth.arizona.edu/Primer%20for%20Cultural%20Proficiency%20NAHH.pdf>

National Hispanic Council on Aging
<http://www.nhcoa.org/>

Serving Hispanic Families: Home and Community-Based Services for People with Dementia and Their Caregivers
Alzheimer's Association
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/docs/Toolkit_6_Serving_Hispanic_Families.pdf

HIV/AIDS

The Aging of HIV
National Association of Social Workers
http://www.socialworkers.org/practice/hiv_aids/AgingOfHIVFactSheet.pdf

Elderly and HIV
National Prevention Information Network, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
<http://cdcnpin.org/scripts/population/elderly.asp>

HIV-Associated Dementia
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1107

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

Research on Older Adults with HIV

AIDS Community Research Initiative of America
http://acria.org/clinical/roah_05_05_08_final.pdf

Persons Aged 50 and Older: Prevention Challenges

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
<http://www.cdc.gov/hiv/topics/over50/print/challenges.htm>

What Are HIV Prevention Needs of Adults Over 50?

Center for AIDS Prevention Studies, University of California, San Francisco
<http://www.caps.ucsf.edu/pubs/FS/over50.php>

Homeless

Homeless and Elderly: Understanding the Special Health Care Needs of Elderly Persons Who Are Homeless

Health Resources and Services Administration, U.S. Department of Health and Human Services
<http://bphc.hrsa.gov/policy/pal0303.htm>

Homeless Policy Academies: Improving Access to Mainstream Services for People Experiencing Homelessness

Health Resources and Services Administration, U.S. Department of Health and Human Services
<http://www.hrsa.gov/homeless/state/index.htm>

Homelessness Among Elderly Persons

National Coalition for the Homeless
<http://www.nationalhomeless.org/factsheets/elderly.html>

Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers

Health Resources and Services Administration, U.S. Department of Health and Human Services
<http://www.nhchc.org/Curriculum/module2/module2D/module2d.htm>

I

Immigrant

A Guide for Providers: Engaging Immigrant Seniors in Community Service and Employment Programs

Senior Service America and the Center for Applied Linguistics
http://www.seniorserviceamerica.org/news/cal_guide.html

U.S. Committee for Refugees and Immigrants

<http://www.refugees.org/article.aspx?id=2080&subm=178&area=Participate&>

L

Legal

Americans' Diversity Guide

Chapter 4: Laws, Executive Orders, and Standards

National Association of State Units on Aging

http://www.nasua.org/issues/tech_assist_resources/national_aging_ir_support_ctr/diversity_guide/diversitychapter4.html

Cultural Competency Legislation

Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs

The Office of Minority Health, U.S. Department of Health and Human Services

https://www.thinkculturalhealth.org/cc_legislation.asp

Durable Powers of Attorney and Revocable Living Trusts

Family Caregiver Alliance, National Center on Caregiving

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=434

Legal Information & Resources

National Center for Lesbian Rights

http://www.nclrights.org/site/PageServer?pagename=legal_getHelp

Legal Issues for LGBT Caregivers

Family Caregiver Alliance, National Center on Caregiving

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=436

Legal Issues in Planning for Incapacity

Family Caregiver Alliance, National Center on Caregiving

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=437

LGBT Elder Law: Toward Equity In Aging

Harvard Journal of Law and Gender

<http://www.law.harvard.edu/students/orgs/jlg/vol321/1-58.pdf>

Protective Proceedings: Guardianships and Conservatorships

Family Caregiver Alliance, National Center on Caregiving

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=431

Lesbian, Gay, Bisexual and Transgender (LGBT)

Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients

Gay, Lesbian, Bisexual and Transgender Health Access Project

<http://www.glbthealth.org/CommunityStandardsofPractice.htm>

Do We Intend to Keep this Closeted?

Edward H. Thompson, Jr., The Gerontologists

<http://gerontologist.gerontologyjournals.org/cgi/content/full/48/1/130>

Is Your Area Agency on Aging LGBT Friendly?

SageConnect

http://sageconnect.net/intranet/pops/pop_print.cfm?pop=61

Is Your "T" Written in Disappearing Ink? A Checklist for Transgender Inclusion

FORGE & Transgender Aging Network

<http://www.forge-forward.org/handouts/InclusionChecklist.pdf>

Lesbian, Bisexual and Transgender Female Elders

National Gay and Lesbian Task Force

<http://www.thetaskforce.org/downloads/misc/LBTFemaleEldersFactSheet.pdf>

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.

Lesbian, Gay, Bisexual and Transgender Elders

Aging Times, National Center for Gerontological Social Work Education
http://depts.washington.edu/geroctr/AT/2_3/lgbt.html

Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues

FORGE and Transgender Aging Network
<http://www.forge-forward.org/handouts/tgelderabuse-neglect.html>

LGBT Aging Issues Network (LAIN)

An American Society on Aging Constituent Group
www.asaging.org/lgain

LGBT Caregiving: Frequently Asked Questions

Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=409

Make Room for All: Diversity, Cultural Competency and Discrimination in an Aging America

National Gay and Lesbian Task Force
http://www.thetaskforce.org/reports_and_research/make_room_for_all

Module for Human Behavior and Social Environment Sequence

Diversity and Older Adults: Gay Men and Lesbians
Council on Social Work Education, California State University, Long Beach
http://depts.washington.edu/geroctr/Curriculum3/TeachingModule/HBSE_DiversityModule.doc

National Gay and Lesbian Task Force

<http://thetaskforce.org/>

Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual and Transgender Elders

National Gay and Lesbian Task Force
http://www.thetaskforce.org/reports_and_research/outing_age

Raising Issues: Lesbian, Gay, Bisexual, & Transgender People Receiving Services in the Public Mental Health System

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
http://www.nami.org/Template.cfm?Section=Multicultural_Support1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=28246

Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders

<http://www.sageusa.org/index.cfm>

State and Local Directory of LGBT Advocacy and Service Organizations

National Gay and Lesbian Task Force
http://www.thetaskforce.org/activist_center/act_locally

Transforming Mental Health Services for Older People: Lesbian, Gay, Bisexual and Transgender (LGBT) Challenges and Opportunities

FORGE & Transgender Aging Network
http://www.forge-forward.org/handouts/AARP_tranformingMH.pdf

Transgender Elders and SOFFAs: A Primer for Service Providers and Advocates
FORGE & Transgender Aging Network
<http://www.forge-forward.org/handouts/TransEldersSOFFAs-web.pdf>

Transgender Elder Health Issues
FORGE & Transgender Aging Network
<http://www.forge-forward.org/handouts/transelderhealth.pdf>

27 Practical Suggestions to Make Your Organization More GLBT Friendly
Benchmark Institute
<http://www.benchmarkinstitute.org/GLBT/27.htm>

M

Mental Health

Culture, Race, and Ethnicity
Mental Health: A Report of the Surgeon General
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<http://mentalhealth.samhsa.gov/cre/toc.asp>

Elderly Suicide Fact Sheet
American Association of Suicidology
http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-158.pdf

Depression and Suicide in Older Adults Resource Guide
Office on Aging, American Psychological Association
<http://www.apa.org/pi/aging/depression.html>

Mental Health and Aging Network (MHAN)
An American Society on Aging Constituent Group
<http://www.asaging.org/networks/index.cfm?cg=MHAN>

Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<https://www.ncoa.org/Downloads/PromotingOlderAdultHealth.pdf>

P

Previously Incarcerated Persons (PIPS)

One in 100: Behind Bars in America 2008
The Pew Center on the States
http://www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf

Note: Disclaimer from the U.S. Administration on Aging (AoA)

Information presented in this document does not constitute an endorsement or recommendation by the U.S. Administration on Aging or any of its employees. The AoA is not responsible for the contents of any referenced Web page(s) and does not endorse any specific product or service provided by public or private organizations. The user takes full responsibility for accessing any of the referenced links.



R

Religion and Spirituality

Body/Mind/Spirit: Toward a Biopsychosocial-Spiritual Model of Health

National Center for Cultural Competence, Georgetown University

http://www11.georgetown.edu/research/gucchd/nccc/body_mind_spirit/index.html

Forum on Religion, Spirituality and Aging

An American Society on Aging Constituent Group

<http://www.asaging.org/networks/index.cfm?cg=FORSA>

Integrating Spirituality into Social Work Practice: The Reflections on Spirituality and Aging (ROSA) Model

Council on Social Work Education, School of Social Service, Saint Louis University

http://depts.washington.edu/geroctr/Curriculum3/TeachingModule/Spirituality_ROSAModule.doc

Rural

National Rural Health Association

<http://www.ruralhealthweb.org/>

Rural Assistance Center

Center for Rural Health, School of Medicine and Health Science, University of North Dakota

Rural Policy and Research Institute

<http://www.raconline.org/>

P

Substance Abuse

Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems

Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services

<https://www.ncoa.org/Downloads/PromotingOlderAdultHealth.pdf>

Substance Abuse and Mental Health Among Older Americans: The State of the Knowledge and Future Directions

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

http://www.samhsa.gov/OlderAdultsTAC/SA_MH_%20AmongOlderAdultsfinal102105.pdf

V

Veterans

Center for Minority Veterans

U.S. Department of Veterans Affairs

<http://www1.va.gov/centerforminorityveterans/>

The list of training tips presented in this appendix represents a starting point for users of this Toolkit. Agency staff and partners are encouraged to add to these training tips.

These tips will assist your agency with training your staff in serving diverse seniors, using the materials in this toolkit.

Establish Training Policies Up Front

Ideally, the facilitator should take at least five minutes to ask participants what type of guidelines the group should establish for creating both a productive and respectful learning environment. The goal is not to create a list of rules, but to establish a few guidelines that foster learning. After the facilitator and participants create the list of guidelines, they should post the list in a visible place where everyone can periodically review the guidelines during the training session.

Neutralize the Discussion

It is important that a facilitator remain neutral about issues, so the participant group does not perceive any bias in the training. If the participant group perceives that a facilitator is biased or has strong preferences for certain groups or ideas (whether political, social, religious, or cultural), the facilitator risks losing credibility with the participant group.

Asking open-ended questions allows the facilitator to appear neutral and without judgment toward participants. Often, closed questions “couch” or imply a position on or attitude about a topic. Asking open-ended questions helps to neutralize the discussion and creates an environment in which the participants model the behavior of the facilitator.

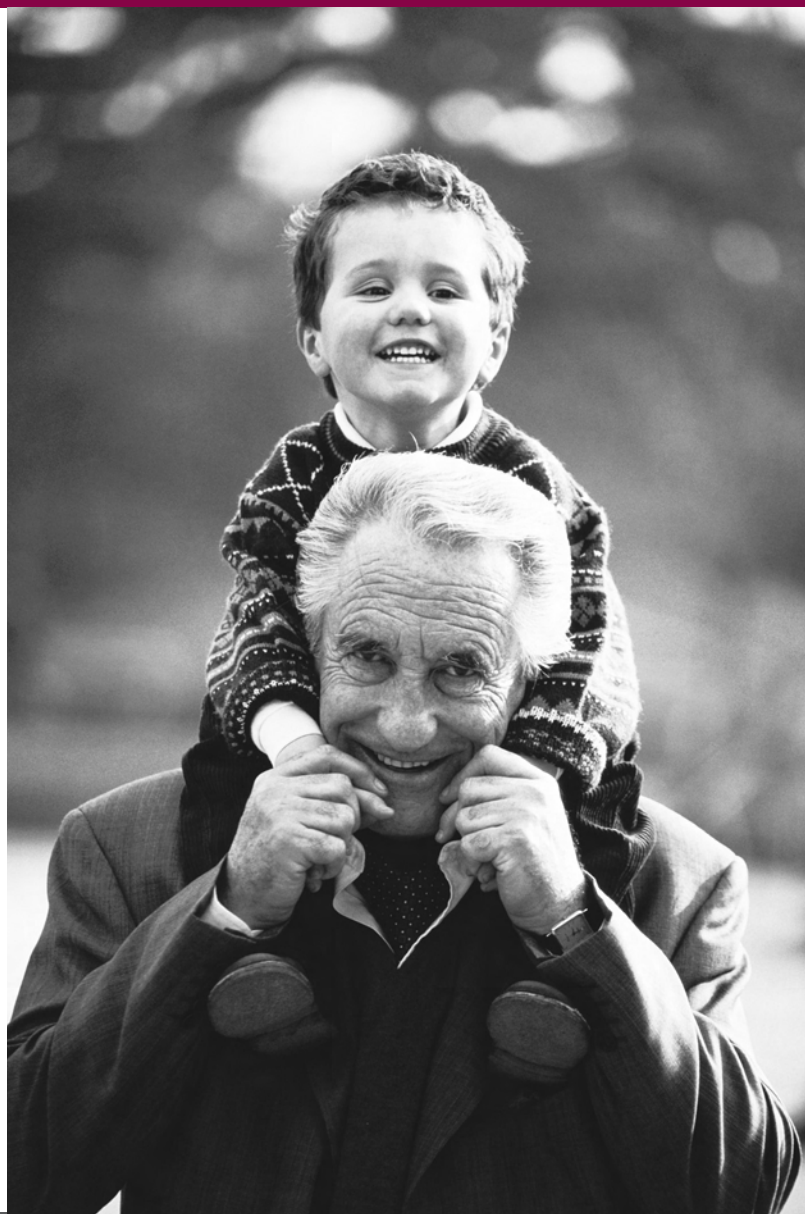
It is important to understand that the act of judging can be both a covert and an overt behavior. A facilitator should be careful about facial expressions and eye contact when participants respond. The facilitator should maintain an open, pleasant disposition when the participants voice opinions. Both verbal and non-verbal behavior should be neutral.


Avoid “Touchy Feely” Statements

Participants may assume that diversity training sessions include some level of “touchy feely” activity. Sometimes indicating up front that this will not be a touchy feely training session can immediately put some at ease. Let the participants know that sharing experiences is a very valuable learning tool and that it is okay to share. But for those who do not want to, that is okay too.

Acknowledge “Ouch Moments”

Not all topics about diversity are easy to discuss. A participant might express that he/she believes some viewpoints are insensitive and even offensive. This is an “ouch moment.” When a participant shares with the group that he/she perceives a particular viewpoint to be insensitive, the facilitator should simply acknowledge and thank the participant for his/her contribution without validating the participant’s position. There are two reasons for doing this: (1) it demonstrates that the facilitator is not apprehensive or uncomfortable about addressing issues that may be controversial, and (2) because the facilitator is not apprehensive, his/her credibility can be enhanced with the participant group. Do not dwell on the ouch moment; that could sidetrack





the training. Simply thank and acknowledge the participant for sharing his or her viewpoint and make the participant group aware of varying perspectives without minimizing the statement that was shared.

Ask Both Open-Ended and Leading Questions

One of the indicators of participant learning is the learner's ability to question and engage in self-reflection. A facilitator can initiate this self-reflective process by asking both open-ended and closed questions. Open-ended questions are less confrontational and are designed to encourage a learner to think about different perspectives. For example: "What are your general feelings about differences?" This question permits the participant to provide a broad range of responses. Therefore, it may not be perceived as confrontational.

Leading questions may be perceived as confrontational because they are direct. For example: "How did you feel when your outreach efforts to a particular community weren't successful?" Because this question leads the respondent to a specific answer, it may be perceived as being controversial. Both open-ended and closed questions have their learning benefits and disadvantages. It's up to the facilitator to choose carefully which to use in a given situation.

Checking-In

Checking-in provides a way to monitor both the group's and each individual's attitudes and feelings, and can offer the opportunity for the facilitator to adjust the training strategy. It can also indicate when a break in the training is needed to accommodate the mood or tempo of the class.

A facilitator may check-in by asking the participant group, "Does everyone feel okay?" If the facilitator chooses to use the check-in strategy, guidelines should be established for its use up front. If the facilitator does not set guidelines, the check-in could provide an opportunity for participants to openly vent disagreement or frustration and jeopardize the momentum of the participant group's learning. Be sure to gently express that checking-in does not require disclosure regarding why a participant is or is not feeling comfortable.

Schedule Breaks


Breaks provide excellent opportunities for the participants to talk casually about what they have learned, or to take time to self-reflect or journal. Providing breaks often helps individual participants to self-manage their emotions and attitudes during the training.

Encourage Journaling

Journaling is the process of allowing quiet reflection time for individual participants to note feelings, attitudes, and viewpoints during the training session. Journaling also permits an individual to share feelings in a confidential and comfortable way. This strategy works particularly well for people who may feel uncomfortable sharing their thoughts with the other participants.

Establish a Learning Wall

A facilitator can preserve learning or "aha" moments by having the participants document their responses to activities on easel paper, and then posting some of



the most important responses in a visible area of the training room. The participants can review previous concepts and reflect on discussions and lessons learned more easily when these points are posted on the wall.

Icebreakers and Energizers

Icebreakers have traditionally been used at the beginning of training sessions to help participants get to know each other. This is important because it is difficult for people to share experiences with strangers. Facilitators soon learn that a well thought-out icebreaker will often enliven participants' interests and enhance learning.

Icebreakers in the middle of a training session are called energizers. Facilitators should consider using energizers to control and lighten the mood or tempo of a training session. Facilitators can also use energizers as transitional strategies to move the participant group back into a learning mode following lunch and breaks.

Ask for Reporting Out

Facilitators may ask a learner from each group to summarize what he/she has learned from the lesson. Reporting out can help clarify the findings of groups, build consensus, and reveal differing perceptions and conclusions.

Pass the Ball

Sometimes a facilitator will experience a participant group that is extremely talkative to the point that frequent interruptions occur in the discussion. One way to control a group's conversation is to pick a small object (a ball, a toy, or a small action figure) that represents a turn to talk. When an individual finishes talking, he/she passes the object to another member of the group. Everyone should make an effort to pass the object to a person who has not previously had the opportunity to share thoughts. This ensures that participants with quiet personalities get an opportunity to voice their thoughts too.

Collect Anonymous Lessons Learned

Some participants may want to share their insights anonymously. Such insights can sometimes help reveal difficult topics in a non-threatening way. Sharing anonymously also allows the participants to take responsibility for the "elephant in the room" and enable the group to acknowledge a difficult topic with respect and without controversy.

Thank Participants

Sometimes it takes a lot of courage for a participant to share what was learned. When anyone contributes to the conversation, particularly when a personal experience was shared, facilitators should thank the participant for contributing.