



Mather LifeWays Orange Papers are provided as a resource on topics related to the growing fields of aging, wellness, and workforce development. Their content reflects the expertise of

Mather LifeWays researchers, educators, and other professionals who are leaders in creating Ways to Age Well.SM

Diversity & Cultural Competency in Health Care Settings

A Mather LifeWays Orange Paper by Dawn Lehman, PhD; Paula Fenza, MA; and Linda Hollinger-Smith, PhD, RN, FAAN

Diversity & Cultural Competency in Health Care Settings

*Knowledge of cultural
customs enables health
care providers to offer
better care and help avoid
misunderstandings.*

CULTURAL COMPETENCY DEFINED

Cultural competency is at the core of high quality, patient-centered care, and it directly impacts how care is delivered and received. According to the Institute of Medicine's report, *Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare*, a consistent body of research indicates a lack of culturally competent care directly contributes to poor patient outcomes, reduced patient compliance, and increased health disparities, regardless of the quality of services and systems available. In addition to improving care quality and patient satisfaction, delivering culturally competent care increases job satisfaction and contributes to staff retention.

Multiple definitions of cultural competence abound in health care literature. Culture refers to "the learned patterns of behavior and range of beliefs attributed to a specific group that are passed on through generations. It includes ways of life, norms and values, social institutions, and a shared construction of the physical world." Competence is used to describe behaviors that reflect appropriate application of knowledge and attitudes. A health care professional who has learned cultural competence engages in assistive, supportive, facilitative, or enabling acts that are tailor-made to fit with individual, group, or institutional cultural values, beliefs, and lifeways in order to provide quality health care. In other words, they demonstrate attitudes and behaviors that enable them to effectively work with individuals with diverse backgrounds. Integrating skills in culturally competent care meets six aims for quality of health care: safe, effective, patient-centered, timely, efficient, and equitable. Most important, care that is patient-centered means that all care providers truly "know" the patient and take into account cultural differences, knowledge level, and preferences.

Theorist Dr. Josepha Campinha-Bacote developed the Culturally Competent Model of Care, which identifies five constructs of cultural competence: cultural awareness (a self-reflection of one's own biases), cultural knowledge (obtaining information about different cultures), cultural skill (conducting an assessment of cultural data of the patient), cultural encounters (personal experiences with patients of different backgrounds), and cultural desire (the process of wanting to be culturally competent). Campinha-Bacote referred to cultural competence as a process, meaning that the health care provider should continually strive to effectively work within the cultural context of each client.

Diversity & Cultural Competency in Health Care Settings

Researchers argue that, although the field of cultural competence is in its preliminary stages, there is much promise for continued success in the impact it can have on health outcomes and well-being.

WHY A CULTURALLY COMPETENT HEALTH CARE WORKFORCE IS NEEDED

Facing a rapidly aging nation, the U.S. government seeks to develop the cultural competence of health care providers in order to reduce health disparities. The growing older adult population represents a cultural entity unto itself. The proportion of older adults from ethnic and racial minority groups is projected to increase exponentially by 2050, with the largest growth rates being among Hispanics, followed by Asian-Pacific Islanders, American Indians, and African-Americans. In 2006, the U.S. Census Bureau indicated that 19% of the U.S. population age 65 years and older was minority. By 2050, 39% of the nation's older adults will be represented by minority groups.

In health care settings, cultural awareness, sensitivity, and competence behaviors are necessary because even such concepts as health, illness, suffering, and care mean different things to different people. Knowledge of cultural customs enables health care providers to provide better care and help avoid misunderstandings among staff, residents/patients, and families.

CULTURALLY COMPETENT HEALTH CARE: THE BENEFITS

Researchers posit that culturally competent health care has many benefits: more successful resident/patient education; increases in health care-seeking behavior; more appropriate testing and screening; fewer diagnostic errors; avoidance of drug complications; greater adherence to medical advice; and expanded choices and access to high-quality clinicians. Researchers conclude that although the field is in its preliminary stages, there is much promise for continued successes in the impact of cultural competence on health outcomes and well-being.

Health care providers trained in cultural competency:

- Demonstrate greater understanding of the central role of culture in health care
- Recognize common barriers to cultural understanding among providers, staff, and residents/patients
- Identify characteristics of cultural competence in health care settings
- Interpret and respond effectively to diverse older adults' verbal and nonverbal communication cues
- Assess and respond to differences in values, beliefs, and health behaviors among diverse populations and older adults
- Demonstrate commitment to culturally and linguistically appropriate services
- Work more effectively with diverse health care staff
- Act as leaders, mentors, and role models for other health care providers

CULTURALLY COMPETENT HEALTH CARE IN YOUR

Diversity & Cultural Competency in Health Care Settings

*Once you get past
interpreters and other
language services, you find
very little about cultural
competence training, and
what exists is mostly for
physicians.*

ORGANIZATION

The National Center for Cultural Competence at Georgetown University states that cultural competence requires that organizations:

- Have a defined set of values and principles and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally
- Have the capacity to 1) value diversity; 2) conduct self-assessment; 3) manage the dynamics of difference; 4) acquire and institutionalize cultural knowledge; 5) adapt to the diversity and cultural contexts of the communities they serve
- Incorporate the above into all aspects of policymaking, administration, practice, and service delivery and systematically involve consumers, key stakeholders, and communities

Use the following checklists to evaluate your organization's cultural competency. By checking the items that best describe your organization, you will gain a clearer picture of your current strengths and, most important, areas of opportunity. After the three checklists have been completed and reviewed, you will be in a better position to determine the course of action needed to achieve cultural competency in your workplace and workforce.

The three checklists included are:

- Areas of your organization's culture that can negatively impact quality of care (areas of opportunity)
- Barriers to cultural competency
- Recommendations for culturally competent care

Numerous sources were used to develop the checklists (see References). Primary sources were Spector and Christensen Community Consulting.

CHECKLIST: DIVERSITY & CULTURAL COMPETENCY IN HEALTH CARE SETTINGS

Aspects of the health care provider's culture that can negatively impact quality of care

Beliefs

- ___ Staff holds different beliefs about the nature of health and illness
- ___ Staff believes in the omnipotence of Western medicine
- ___ Staff believes in the omnipotence of technology
- ___ Staff stereotypes culture groups
- ___ Staff's misconceptions about the nature and quality of residents'/patients' health care practice
- ___ Staff's general interpretation of the cause of illness
- ___ Staff assumes health professional knows best

Diversity & Cultural Competency in Health Care Settings

*There is a lack of consensus
on which racial ethnic
groups should be studied by
nurses, a contributing factor
to inadequate cultural
competence education.*

Attitudes

- ___ Staff expects promptness
- ___ Staff expects compliance
- ___ Staff takes paternal approach
- ___ Staff disrespects non-traditional healing practices
- ___ Staff does not consider residents'/patients' conflict regarding familiar belief systems and current practices
- ___ Staff does not keep an open mind

Behaviors

- ___ Staff does not adjust approach to coincide with the needs of the resident/patient
- ___ Staff relies on technology/procedures to identify problem
- ___ Staff limits time with residents/patients
- ___ Staff uses jargon
- ___ Staff limits communications with family
- ___ Staff tries to force use of Western medicine
- ___ Staff does not agree on type and quality of care
- ___ Staff miscommunicates

Rituals

- ___ Staff does not consider residents'/patients' attitudes and beliefs regarding the physical examination
- ___ Staff does not greet residents/patients in a culturally appropriate way

Checklist: Diversity & Cultural Competency in Health Care Settings *Barriers to Cultural Competency in Organizations*

Residents

- ___ Many residents/patients lose their capacity to communicate in their secondary language and revert to their first language.
- ___ There is a move in immigrant communities toward professionalized care for frail seniors.
- ___ Seniors who have been living with their adult children often expect the same level of individualized and personalized service when they enter a long-term care home. Their high expectations frequently cannot be met both because of regulatory requirements (e.g., food service regulations) and available resources/funding.
- ___ Residents/patients who need assistance in completing their washing ritual before prayers may find that staff is not available to help them.
- ___ Residents/patients from different cultures are not used to the food they are served and find it difficult to adapt to a change in diet later in life.
- ___ The availability of physical care is linked to spiritual support and care. For

Diversity & Cultural Competency in Health Care Settings

Complete cultural awareness, sensitivity, and competence behaviors related to health care are necessary because even general ideas of health, illness, suffering, and care mean different things to different groups of older adult patients.

example, a resident/patient may not be able to pray if s/he has been incontinent and his/her continent briefs are wet or soiled and/or if s/he has been unable to wash.

Organization

- ___ Increasing levels of care put pressure on available staff and resources.
- ___ The diversity of linguistic, cultural, and spiritual groups makes it difficult for any single health care setting to recruit staff that reflects that diversity.
- ___ Operational logistics make it difficult to provide linguistically, culturally, and spiritually appropriate care.
- ___ There is a need to engage families and communities in a mutual learning process that informs program development and supports the organization's capacity to tailor services to residents'/patients' needs.
- ___ Stereotyping and misdiagnosis may lead to misinterpretation of behaviors as hostility or agitation.
- ___ If clinicians do not understand the appropriate linguistic descriptors, they may fail to elicit the correct information about symptoms or may misconstrue them.
- ___ Cultural differences between health care workers themselves and within organizations can cause potential conflict in the workplace and can create barriers to providing quality care.
- ___ If information is not available to residents and their families because of the language barrier, effective communication is impossible.
- ___ It is difficult to accommodate small groups speaking different languages that may also need translation.
- ___ Language barriers and ethno-specific issues cannot be addressed as long as the sector depends on personal support workers who have minimal training and possibly limited English language skills.
- ___ Poor communication can lead to a lack of respect for persons whose cultural values are different from one's own.
- ___ The extent of ethno-cultural diversity in some organizations complicates the process of developing programs and services suitable for everyone's specific needs.
- ___ Many long-term organizations assign residents to units within the home according to their health and social needs and/or type of accommodation (private, semi-private); thus, it may not be possible to place every resident from specific ethno-cultural communities in the same unit or even on the same floor.
- ___ Large ethnic, linguistic, and spiritual communities are not monolithic, which complicates programming and service delivery.
- ___ Staff may see residents/patients from the perspective of providing health care (the "medical model"), rather than from the perspective of providing holistic care within a comfortable home environment.
- ___ Food service regulations define how and when meals are served. For some

Diversity & Cultural Competency in Health Care Settings

*Many Black Americans
view receiving health care
as a degrading, demeaning,
or humiliating experience,
and have a feeling of
powerlessness and alienation
in the system.*

groups, the way in which food is served and meal times are not culturally sensitive or religiously appropriate.

- ___ The pressure to fill beds in long-term care organizations creates some difficulty in establishing and maintaining specific units for ethno-cultural and religious groups.
- ___ It is difficult to compare ethnic foods and spices with dietary guidelines.
- ___ Compliance requirements prohibit flexibility and adaptability in providing diets in accordance with dietary laws (e.g., kosher foods).

Family

- ___ Families may not know the right questions to ask regarding services offered within the organization, limits on what the organization can do for the residents/patients, resources that are available, or how to engage those resources.
- ___ Families do not or cannot—for cultural or linguistic reasons—discuss their expectations with the organization.
- ___ Families may find it hard to visit and participate in programs with residents, especially if they do not have access to transportation.
- ___ Volunteerism is not part of the value system in some ethno-cultural communities, and adult children may not be interested in participating in social and cultural activities with residents.

Community

- ___ Without the encouragement and support of community partners, organizations face challenges in meeting the needs of residents from recently arrived or smaller ethno-cultural or religious groups.
- ___ Regulatory requirements may restrict the degree to which organizations can adapt their current practices to accommodate ethnic groups with different perspectives and backgrounds.

RECOMMENDATIONS: CULTURAL COMPETENCY IN SENIOR LIVING COMMUNITIES

Cultural Awareness

- ___ Decrease ethnocentrism by being aware of one's own cultural values and biases.
- ___ Be aware of the various myths and stereotypes related to older people.
- ___ Recognize that ageism, like racism, affects all aspects of society, including health professions, and can adversely affect optimal care of residents.
- ___ Understand that there may be racist attitudes and beliefs among families and residents.
- ___ Learn how to communicate more effectively to decrease racist attitudes.
- ___ Identify ethnic groups, not just race.

Diversity & Cultural Competency in Health Care Settings

Many Chinese find some aspects of Western medicine (e.g., diagnostic tests) distasteful. Some are upset by the drawing of blood.

- ___ Identify immigration level (i.e., first generation or later).
- ___ Assess English competency.
- ___ Identify help-seeking behavior patterns through health education and open communication.
- ___ Understand mistrust of senior living communities and other health care organizations by some minority families.
- ___ Be aware of cultural differences in attitudes toward illness and acceptance of help.
- ___ Staff should let residents know that they understand their views toward illness and medical treatment.
- ___ Staff can encourage participation of other staff members of the same race/ethnicity/religion or a “local healer” (including clergy).
- ___ Involve family or key supports from the resident’s social network.
- ___ Ask community-based key informants who are knowledgeable about the ethnic minorities being served to act as “culture brokers.” This person, who ideally is also familiar with the operating and regulatory environment defining long-term care homes, could facilitate the design of culturally appropriate programs and services.
- ___ Employ bilingual staff, rather than a family member or paid translator, who may be more comfortable for the resident because they have more extended contact with them.
- ___ Use culturally specific phrasing and patterns of expression to gain resident compliance.
- ___ Be aware of cultural variants in the expression of psychological distress.
- ___ Encourage staff to see themselves working in each resident’s home rather than seeing them as people who happen to live in the staff’s work environment.
- ___ Involve everyone in the organization—staff, residents, family members, board members, community partners, and volunteers—in assessing their perceptions of cultural problems and conflicts, and plan how they should be fixed. This opens up issues for communication that may have been suppressed.

Leadership

- ___ The Department of Health and Human Services Culturally and Linguistically Appropriate Services (CLAS) standards recommend the recruitment, retention, and promotion of a diverse staff and leadership at all levels of the organization.
- ___ Leadership at the top, as opposed to good practices by individual staff members who may leave the organization, is critical to creating a consistent, sustainable environment characterized by good practices.
- ___ Making a business case for cultural competency is a critical element for change.
- ___ Share knowledge and lessons learned with other organizations.

Diversity & Cultural Competency in Health Care Settings

Some American Indian family members and communities minimize memory loss and dementia and may not consent to treatment unless physical function is impaired.

Workplace Practices

- ___ Show compassion for the families of the residents and the difficulties they face.
- ___ Observe religious holidays and provide a place of worship that is respectful of residents' spiritual beliefs. Refrain from installing permanent symbols that may be offensive to other faiths. Consider moveable adornments for worship.
- ___ Accommodate individual needs if possible (e.g., setting up a small Hindu shrine in the resident's room).
- ___ Offer culturally appropriate meal choices. Learn about these choices from the cultural community.
- ___ Allow cultural décor and signage to personalize rooms.
- ___ If the resident agrees, encourage groupings with others of similar cultural, linguistic, or religious backgrounds (e.g., at meals).
- ___ Provide television and radio programming that is culturally and linguistically appropriate.
- ___ Using a communication board (e.g., pictures plus words in the resident's language) to facilitate staff-resident communication.
- ___ Post activities and programs in different languages.
- ___ Offer greater flexibility in family and caregiver visiting hours.
- ___ Offer flexibility in scheduling dressing, bathing, and meal times.
- ___ Help staff develop flexibility in communicating with each other across cultural or language divides. Help them apply these skills in their work with residents who are different from them.
- ___ Wherever possible, arrange to have someone who speaks the language and/or is familiar with or part of the same culture to greet the new resident and ease the transition. The "greeter" could be another resident, a staff member, or a volunteer.
- ___ Explore the feasibility of English as a Second Language lessons for residents who are able to participate.
- ___ Translate brochures, signage, and key documents/information materials (consent forms, handbooks) into other languages. Have individuals from the group you are trying to reach review any materials you plan to use for outreach.
- ___ Avoid literal translations of existing material as they lose their meaning when syntax and vocabulary are not within cultural contexts.
- ___ Convene a family support group for those whose family members are residents of long-term care communities.
- ___ Provide internships for diverse health profession students to gain insight from their perspectives.
- ___ Measure and track cultural competence as part of the effort to deliver high-quality care.
- ___ In addition to cultural assessment tools, organizations can conduct focus groups with or administer satisfaction surveys to family members of residents.

Diversity & Cultural Competency in Health Care Settings

- ___ Have meaningful processes for community representation and feedback, including focus groups, advisory committees, and/or board representation.
- ___ Employ a patient advocate from the ethnic community who can serve as the bridge in bringing health care services to the residents.

Training & Education

- ___ Offer cultural sensitivity training on a regular basis to address issues associated with literacy, language barriers, family support, the need for respect, traditions, and alternative health and illness remedies.
- ___ Provide “Lunch ‘n’ Learn” opportunities for staff. Invite speakers from diverse communities to talk about their ethnic group, or invite representatives from organizations to talk about their best practices working with a diverse group of people.
- ___ Provide basic language classes for staff.
- ___ Encourage individual staff members to learn a few phrases in several languages spoken by residents.
- ___ Recruit staff who are open-minded and view training as a learning opportunity.
- ___ Exhibit information on cultural competence and provide opportunities for staff to attend professional meetings and conferences.
- ___ Obtain resources such as poetry, books, religious texts, and music from an ethnic community.
- ___ Administer a cultural competency assessment.

Community Outreach

- ___ Learn who are the most effective resource people in ethnic communities (e.g., local neighborhood government advisory group representatives, church committee chairs, local business owners, funeral planners, teachers) and enlist their support for your program.
- ___ Anticipate the need for partnerships so that when residents arrive, the organization is prepared to provide relevant services.
- ___ Reach out to ethno-cultural and religious communities to engage trainers (e.g., spiritual leaders) who understand the cultural background of residents and train staff in the nuances of working with residents to demonstrate respect.
- ___ Seek information from experts (e.g., professors, graduate students, cultural organizations/associations, and other organizations) with a history of serving diverse ethnic groups.
- ___ Recruit bilingual and minority volunteers from churches and established volunteer organizations such as AmeriCorps and Retired Seniors Volunteer Program (RSVP).
- ___ Encourage families to bring friends and community members as friendly visitors as often as possible.

Diversity & Cultural Competency in Health Care Settings

PROMOTING SAFETY & QUALITY OF CARE

CLAS, Office of Minority Health:

- CLAS is a tool that promotes cultural and linguistic competence.
- CLAS standards are primarily directed at health care organizations; however, individuals also are encouraged to use the standards to make their practices more culturally and linguistically accessible.
- The principles and activities of culturally and linguistically appropriate services are integrated throughout an organization and undertaken in partnership with the community served.

JCAHO now The Joint Commission (a nonprofit formed in 1951):

- Mission: to improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.
- Policy: views the delivery of services in a culturally and linguistically appropriate manner as an important health care safety and quality issue.
- For general information on standards related to cultural competency, contact hlc-info@jointcommission.org.

Dawn Lehman, PhD, Mather LifeWays' director of education; Paula Fenza, MA, grants manager; and Linda Hollinger-Smith, PhD, RN, FAAN, vice president, have developed programs, presented papers, and conducted workshops on cultural competency for health care providers serving older adults. Ms. Lehman can be reached at dlehman@matherlifeways.com.

Mather LifeWays is a unique nonprofit organization that enhances the lives of older adults by creating Ways to Age Well.SM For more information about our senior living residences, community initiatives, or award-winning research, please visit www.matherlifeways.com or call (847) 492.7500.

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

REFERENCES

- Adams, V.H., III, & Jackson, J.S. (2000). The contribution of hope to the quality of life among aging African Americans: 1980-1992. *International Journal of Aging and Human Development*, 50(4), 279-295.
- Adler, R. (2004). Introduction to cross-cultural health care for older adults. In R. Adler and H. Kamel (Eds.) *Doorway thoughts: Cross-cultural health care for older adults* (pp. 2-15). Boston: Jones and Bartlett Publishers.
- Administration on Aging. (2000). *Achieving cultural competence: A guidebook for providers of services to older Americans and their families*. U.S. Department of Health and Human Services. <http://aoa.dhhs.gov/minorityaccess/guidebook2001>
- Agency for Health Care Policy and Research. (1999). *Understanding and eliminating minority health disparities* (RFA: HS-00-003). Rockville, MD: Agency for Health Care Policy and Research.
- Agency for Healthcare Research and Quality. (2004). *National healthcare disparities report*. Rockville, MD: Agency for Healthcare Research and Quality.
- Ahmed, S.M., & Lemkau, J.P. (2000). Cultural Issues in the Primary Care of South Asians. *Journal of Immigrant Health*, 2(2), 89-96.
- Alexih, L. (2001). The impact of sociodemographic change on the future of long-term care. *Generations*, 1, 7-16.
- Aleman, S. (1999). *Therapeutic interventions with ethnic elders: Health and social issues*. New York: Haworth Press.
- American Academy of Nursing. (1992, November/December). Culturally competent health care. *Nursing Outlook*, 40(6), 277-283.
- American Geriatrics Society. (2004). *Doorway thoughts: Cross-cultural care for older adults*. Subury, MA: Jones and Bartlett.
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., & Normand, J. (2003). Culturally competent healthcare systems. A systematic review. *American Journal of Preventative Medicine*, 24(3 Suppl), 68-79.
- Andresen, J. (2001). Cultural competence and health care: Japanese, Korean, and Indian patients in the United States. *Journal of Cultural Diversity*, 8(4), 109-21.
- Andrews, M.M. Chapter on cultural assessment. In C. Jarvis. (2002). *Health assessment*. Philadelphia: W.B. Saunders Company.
- Andrews, M.M., & Applegate-Krouse, S. (2005). Health and well-being of urban Indian elders. *Journal of Native American Research*, 29(1), 65-77.
- Andrews, M.M., & Boyle, J.S. (2002). Transnational concepts in nursing care. *Journal of Transcultural Nursing*, 13(3), 178-180.
- Autotte, P. A. (1995, September). Folk medicine. *Archives of Pediatrics &*

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

Adolescent Medicine, 149(9), 949-950.

Axtell, R. E. (1991). *Gestures: The do's and taboos of body language around the world*. New York: Wiley.

Barr, D.A., & Wanat, S.F. (March 2005). Listening to patients: cultural and linguistic barriers to health care access. *Family Medicine*, 37(3), 199-204.

Baer, R. D., Clark, L., et al. (1998). Folk illnesses. In *Handbook of immigrant health* (pp. 183-202). New York: Plenum Press.

Barresi, C. M., & Stull, D. E. (Eds.). (1993). *Ethnic elderly and long-term care*. New York: Springer.

Bartol, G. M., & Richardson, L. (1998). Using literature to create cultural competence. *Image: Journal of Nursing Scholarship*, 30(1), 75-79.

Bates, M. S. (1996). *Biocultural dimensions of chronic pain: Implications for treatment of multi-ethnic populations*. Albany, NY: State University of New York Press.

Berkanovic, E., & Telesky, H. (1985). Mexican-American, Black-American, and White-American differences in reporting illness, disability, and physician visits for illnesses. *Social Science & Medicine* (20), 567-577.

Betancourt, J.R., Green, A.R., & Carrillo, J.E. (October 2002). Cultural competence in health care: Emerging frameworks and practical approaches. New York, NY: The Commonwealth Fund.

Blackhall, L. J., Michel, V., Murphy, S. T., et al. (1998). A discourse of relationships in bioethics: Patient autonomy and end-of-life decision making among elderly Korean Americans. *Medical Anthropology Quarterly*, 12, 403-423.

Boi, S. (2000, September-October). Nurses experiences in caring for patients from different cultural backgrounds...including commentary. *NT Research*, 5(5), 382-390.

Bonder, B., Martin, L., & Miracle, A. (2001). Achieving cultural competence: The challenge for clients and healthcare workers in a multicultural society. *Generations*, 25(1), 35-43.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57, 181-217.

Brach, C., & Fraser, I. (2002). Reducing disparities through culturally competent health care: An analysis of the business case. *Quality Management in Health Care*, 10(4), 15-28.

Brangman, S.A. (1995, February). African-American elders: Implications for health care providers. *Clinics of Geriatric Medicine*, 11(1), 15-23.

Bulatao, R.A. & Anderson, N.B. (Eds.). (2004). *Understanding racial and*

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

ethnic differences in health in late life: A research agenda. Washington, DC: National Academies Press.

Cagney, K.A., Browning, C.R., & Wen, M. (2005). Racial disparities in self-rated health at older ages: What difference does the neighborhood make? *Journal of Gerontology: Social Sciences*, 60B, S181-S190.

Cameron, C. (1996). Patient compliance: Recognition of factors involved and suggestions for promoting compliance with therapeutic regimens. *Journal of Advanced Nursing*, 24, 244-250.

Cameron, C. (1999). How does cultural competence affect patient safety? *Focus on Patient Safety*, 2(4), 3,6.

Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum*, 30(4), 19-25.

Campinha-Bacote, J. (1997). Understanding the influence of culture. In J. Haber, B. Krainovich-Miller, A.L. McMahon, & P. Price Hoskins, *Comprehensive psychiatric nursing* (5th ed., pp.75-90). St. Louis, MO: Mosby.

Campinha-Bacote, J. (1998). The process of cultural competence in health care: A culturally competent model of care. (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38(5), 204-207.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, 13(3), 181-184.

Caralis, P. V., Davis, B., et al. (1993). The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *Journal of Clinical Ethics*, 4(2), 155-165.

Carrillo, J., Green, A., & Betancourt, J. (1999). Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine*, 130;829-834.

Cassel, J. (1957). Social and cultural implications of food and food habits. *American Journal of Public Health*, 47, 732-740.

Cave A., Maharaj U., Gibson, N., & Jackson, E. (1995). Physicians and immigrant patients. *Cross-cultural communication. Canadian Family Physician*, 41, 1685-90.

Chang, P.H., & Fortier, J.P. (1998). Language barriers to health care: An overview. *Journal of Health Care for the Poor and Underserved*, 9, (Supplement), S5-19.

Chen, J.L., & Rankin, S.H. (2002). Using the resiliency model to deliver culturally sensitive care to Chinese families. *Journal of Pediatric Nursing*, 17(3), 157-66.

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

Chin, J. L. (2000, January/February). Culturally competent health care. *Public Health Reports*, 115(1), 25-33.

Clark, D.O., Maddox, G.L. (1992). Racial and social correlates of age-related health at older ages: What difference does the neighborhood make? *Journal of Gerontology: Social Sciences*, 47, S222-S232.

Cohen, R.A., Bloom, B., Simpson, G., & Parsons, P.E. (1997, July). Access to health care. Part 3: Older adults. *Vital and Health Statistics*, 10(198), 1-32.

Collins, S. D. (2006). Is cultural competency required in today's nursing care? *Imprint*, 53(2), 52-54.

Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2002). *Unequal treatment: Confronting racial and ethnic disparities in care*. Washington, DC: The National Academic Press.

Cotton, T. K. (1999, October 4). When it comes to cultural competency, never assume anything. *Nursing Spectrum*, 12(20), 38.

Coye, M., Alvarez, D. (1999). *Medicaid managed care and cultural diversity in California*. New York: Commonwealth Fund.

Crimmins, E.M., Hayward, M.D., & Seeman, T.E. (2004). Race/ethnicity, socioeconomic status and health. In N.B. Anderson, R.A. Bulatao, & B. Cohen (Eds.), *Critical perspectives on racial and ethnic differences in health in later life* (pp. 310-352). Washington, DC: National Academies Press.

Denboba, D.L., Bragdon, J.L., Epstein, L.G., Garthright, K., & Goldman, T.M. (1998). Reducing health disparities through cultural competence. *Journal of Health Education*, 29(5, suppl.), S47-S53.

Donini-Lenhoff, F. & Hedrick, H. (2000). Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health*, 29:241-245.

Espino, D.V., & Lewis, D. (1998). Dementia in older minority populations: Issues of prevalence, diagnosis, and treatment. *American Journal of Geriatric Psychiatry*, 6(2 Suppl 1), S19-S25.

Ehtisham, M., Guthrie, S., Hickling, J., et al. (1991). *Health needs of elderly people in the inner city*. Birmingham: West Birmingham Health Authority.

Evans, C. A., & Cunnigham, B. A. (1996). Caring for the ethnic elder: Even when language is not a barrier, patients may be reluctant to discuss their beliefs and practices for fear of criticism or ridicule. *Geriatric Nursing*, 17, 105-110.

Flemming, D. A. (2003, January-February). Cultural sensitivity in end-of-life discussions. *Missouri Medicine*, 100(1), 69-75.

Fahie, V.P. (1998, Spring). Utilization of folk/family remedies by community-residing African American elders. *Journal of Cultural Diversity*, 5(1), 19-22.

Ferraro, K.F. (1980). Self-rates of health among the old and the old-old. *Journal*

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

of Health and Social Behavior, 21, 377-383.

Fongwa, M.N. (2001, January). Exploring quality of care for African Americans. *Journal of Nursing Care Quality*, 15(2), 27-49; quiz 74-75.

Frederick Schneiders Research. (1999). Perceptions of how race and ethnic background affect medical care: Highlights from focus groups. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Fried, S.B., & Mehrota, C.M. (1998). *Aging and diversity: An active learning experience*. Washington, DC: Taylor & Francis.

Frye, B. A. (1990, May-June). The Cambodian refugee patient: Providing culturally sensitive rehabilitation nursing care. *Rehabilitation Nursing*, 15(3), 156-158.

Fung, L. W. (1994). Implementing the patient self-determination act (PSDA), how to effectively engage Chinese-American elderly persons in the decision of advance directives. *Journal of Gerontological Social Work*, 22(2), 161-174.

Gallagher-Thompson, D. (2000). Development and implementation of intervention strategies for culturally diverse caregiving populations in R. Schulz (Ed). *Handbook on dementia caregiving* (pp 151-183) New York. Springer.

Gaskin, D.J., & Hoffman, C. (2000). Racial and ethnic differences in preventable hospitalizations across 10 states. *Medical Care Research Review*, 57(Suppl.1), 85-107.

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

Goode, T.D., & Jones, W. A definition of cultural competence. National Center for Cultural Competence, Georgetown University.

Gollop, C.J. (1997, April). Health information-seeking behavior and older African American women. *Bulletin of the Medical Library Association*, 85(2), 141-146.

Gregg, J. (2004). The role of culture and cross-cultural miscommunication in the perpetuation of disparities. *Journal of General Internal Medicine*, 19(8), 900-902.

Groger, L., Mayberry, P., & Straker, L., (2001, November 15-18). A last resort: African American elders' use of nursing homes. Paper presented at the Annual Meeting of the Gerontological Society of America, Chicago, IL.

Haddad, A., & Brown, K. (1994, July). Ethics in action: What would you do? Cultural issues on end-of-life decisions. *RN*, 57(7), 19-21.

Hayes-Bautista, D., Hsu, P., Perez, A., & Gamboa, C. (2002). The 'browning' of the graying of America: Diversity in the elderly population and policy implications. *Generations*, 26, 15-24.

Health Resources and Services Administration. (2001). *Health resources and*

Diversity & Cultural Competency in Health Care Settings

It is important that cultural competence is viewed as nursing competence, meaning that nurses have the capacity to be equally therapeutic with older adult patients from any social context or cultural background.

services and administration study on measuring cultural competence in health care delivery settings: A review of the literature.

Health Resources and Services Administration, U.S. Department of Health and Human Services, Center for Managed Care, Cultural Competence Works. (2001). www.hrsa.gov/cmc

Hendrix, L. Health and healthcare of American Indian and Alaska elders. San Francisco: University of California.

Hopp, F.P. & Duffy, S. (2000). Racial variations in end-of-life care. *Journal of the American Geriatric Society*, 48, 658-663.

Jackson, V.H. (2002). Cultural competency. *Behavioral Health Management*, 22(2), 20.

Johnson, M., Noble, C., Matthews, C., & Aguilar, N. (1998). Towards culturally competent health care: language use of bilingual staff. *Australian Health Review*, 21(3), 49-66.

Johnson, R.A., & Tripp-Reimer, T. (2001). Aging, ethnicity, & social support: A review. *Journal of Gerontological Nursing*, 27(6), 15-21.

Kaiser Family Foundation. (1999). Race, ethnicity, and medical care: A survey of public perceptions and experiences. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Kavanagh, K., Absalom, K., Beil, J.W., & Schliessmann, L. (1999). Connecting and becoming culturally competent: A Lakota example. *Advances in Nursing Science*, 21(3), 9-31.

Kennedy, S., Stubblefield-Tave, B., & Smith, C. (1999). Report on recommendations for measures of cultural competence for the quality improvement system for managed care. Cambridge, MA: Abt Associates.

Kim, H. K., & McKenry, P. C. (1998). Social networks and support: A comparison of African Americans, Asian Americans, Caucasians and Hispanics. *Journal of Comparative Family Studies*, 29(2), 313+

Lavizzo-Mourey, R., & Mackenzie, E. R. (1996). Cultural competence: Essential measurements of quality for managed care organizations. *Annals of Internal Medicine*, 124(10), 919-921.

Levin, P. D., & Sprung, C. L. (2003, May). Cultural differences at the end of life. *Critical Care Medicine*, 31(Suppl. 5), S354-7.

Li, B., Caniano, R., et al. (1998). A cultural curriculum: Combining didactic, problem-solving, and simulated experiences. *Journal of the American Medical Women's Association*, (S), 53(3)127-129.

Lindesay, J., Jagger, C., Hibbett, M., et al. (1997). Knowledge, uptake and availability of health and social services among Asian Gujarati and white elderly persons. *Ethnicity and Health*, 2, 59-69.

Diversity & Cultural Competency in Health Care Settings

- Luquis, R. R., & Perez, M. A. (2003, May-June). Achieving cultural competence: The challenges for health educators. *American Journal of Health Education*, 34(3), 131-140.
- Ma, G.X. (1999). Between two worlds: The use of traditional and Western health services by Chinese immigrants. *Journal of Community Health*, 24(6), 421-437.
- Macklin, R. (1999). The doctor-patient relationship in different cultures. In *Against relativism, cultural diversity and the search for ethical universals in medicine* (pp. 86-107). New York: Oxford University Press.
- Marbella, A.M., Harris, M.C., Diehr, S., & Ignace, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine*, 7(2), 182-185.
- Mavundla, T.R. (1996, September). Factors leading to black elderly persons' decisions to seek institutional care in a home in the Eastern Cape. *Curationis*, 19(3), 47-50.
- McBride, M., & Lewis, I. (2004). African American and Asian American elders: An ethnogeriatric perspective. *Annual Review of Nursing Research*, 22, 161-214.
- McCann, J.J., Hebert, L.E., Beckett, L.A., Morris, M.C., Scherr, P.A., & Evans, D.A. (2000, December). Comparison of informal caregiving by black and white older adults in a community population. *Journal of the American Geriatric Society*, 48(12), 1612-1617.
- Mebane, E.W., Oman, R.F., Kroonen, L.T., & Goldstein, M.K. (1999). The influence of physician race, age, and gender on physician attitudes toward advance care directives and preferences for end-of-life decision making. *Journal of the American Geriatric Society*, 47, 579-591.
- The Medical Advantage Organization National QAPI Project for 2003. (2003). Centers for Medicare and Medicaid Services. Retrieved October 19, 2005, from <http://www.cms.hhs.gov/healthplans/quality/project03.asp>
- Merkelz, K. P. (2001). Hispanic and Latino elders. In B. J. Berkman, C. M. Callahan, T. T. Fulmer, E. L. Mitty, G. J. Paveza, E. L. Siegler, & N. E. Strumpf (Eds.); M. M. Bottrell (Managing Ed.). *The encyclopedia of elder care* (pp. 348-350). New York: Springer Publishing Company, Inc.
- Miles, T. (2001). Ethnogeriatrics comes of age. *Journal of the American Geriatric Society*, 49(7), 005.
- Moldm, F., Fitzpatrick, J., & Roberts, J. (2005). Minority ethnic elders in care homes: A review of the literature. *Age and Ageing*, 34(2), 107-113.
- Morales, L.S., Cunningham, W.E., Brown, J.A., Liu, H., Hays, R.D. (1999). Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine*, 14(7), 409-417.

Diversity & Cultural Competency in Health Care Settings

- Moulton, C.P. (1997, March). Special health considerations in African-American elders. *American Family Physician*, 55(4), 1243-1253.
- Nelson, J. (2006). Madeleine Leininger's culture care theory: The theory of culture care diversity and universality. *International Journal for Human Caring*, 10(4), 50-56.
- Noelker, L.S., (2001, Spring). The backbone of the long-term care workforce. *Generations*.
- Nokes, K.M., Nickitas, D.M., Keida, R., & Nevilile, S. (2005). Does service-learning increase cultural competency, critical thinking, and civic engagement? *The Journal of Nursing Education*, 44(2), 65-70.
- Noor Al-Deen, H.S. (1997). *Cross-cultural communication and aging in the United States*. Mahwah, New Jersey: Lawrence Erlbaum Associates.
- Office of minority health. National standards on culturally and linguistically appropriate services (CLAS) in health care. Executive summary. (2001). Washington, D.C.: U.S. Department of Health and Human Services.
- Office of Minority Health, Public Health Service, U.S. Department of Health and Human Services. www.omhrc.gov/clas/guideintro.htm
- Office of Minority Health, U.S. Department of Health and Human Services. (2002). *Teaching cultural competence in health care: A review of current concepts, policies, and practices*.
- Ohmans, P., Garrett, C., & Treichel, C. (1996). Cultural barriers to health care for refugees and immigrants. Providers' perceptions. *Minnesota Medicine*, 79(5), 26-30.
- Orque, B. B., & Monrroy, L. S. A. (1983). *Ethnic nursing care*. St. Louis: Mosby.
- Orque, M. S. (1983). Orque's ethnic/cultural system: A framework for ethnic nursing care. In M. S. Orque, B. Bloch & L. S. A. Monrroy (Eds.), *Ethnic nursing care: A multicultural approach* (pp. 5-48). St. Louis: Mosby.
- Palafox, N.A., Buenconsejo-Lum, L., Riklon, S., & Waitzfelder, B. (2002). Improving health outcomes in diverse populations: competency in cross-cultural research with indigenous Pacific Islander populations. *Ethnicity & Health*, 7(4), 279-85.
- Paniagua, F., O'Boyle M. et al. (2000). Self-evaluation and unintended biases and prejudices. *Psychological Reports*, 87, 823-829.
- Poor communications, cultural barriers impacting quality of health care for minorities. (2002). *Quality Letter for Health Care Leaders*, 14(4), 11-3, 1.
- Powe, B.D., (1995). Fatalism among elderly African Americans. Effects on colorectal cancer screening. *Cancer Nursing*, 18, 385-392.
- Purnell, L. (2002). The Purnell model for cultural competence. *Journal of*

Diversity & Cultural Competency in Health Care Settings

Transcultural Nursing, 13(3), 193-196.

Rawlings-Anderson, K. (2004). Continuing professional development. Assessing the cultural and religious needs of older people. *Nursing Older People*, 16, 29-33.

Recommendations for culturally sensitive nursing care. (2000). *International Journal of Nursing Practice*, 6(3), 146-152.

Richardson, J. Leisten, R., & Calviou, A. (1994). Lost for words. Health services are inaccessible to many people from ethnic minorities because of inappropriate health information. *Nursing Times*, 90, 31-33.

Rivadeneyra, R., Elderkin-Thompson, V., Silver, R.C., & Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. *American Journal of Medicine*, 108(6), 470-474.

Robert, S.A. & Lee, K.Y. (2002). Explaining race differences in health among older adults: The contribution of community socioeconomic context. *Research on Aging*, 24, 654-683.

Saha, S., Morse, E., & Jimison, J. (2005). Cultural competence among health professionals: A taxonomy. *Journal of General Internal Medicine*, 20(Suppl 1), 111.

Sakauye, K. (1992). The elderly Asian patient. *Journal of Geriatric Psychiatry*, 25, 169-171.

Sakauye, K. (1994). American Psychiatric Association Committee on Minority Elderly. In: *Ethnic minority elderly: A task force report of the American Psychiatric Association*. Washington, D.C.: American Psychiatric Association.

Sakauye, K.M. (2002). Cultural influences on pain management in the elderly. *Clinical Geriatrics*, 10(7), 20-25.

Shambley-Ebron, D., & Boyle, J. (2004). New paradigms for transcultural nursing: Frameworks for studying African American women. *Journal of Transcultural Nursing*, 15, 11-17.

Shaw-Taylor, Y. (2002). Culturally and linguistically appropriate health care for racial or ethnic minorities: analysis of the US Office of Minority Health's recommended standards. *Health Policy*, 62(2), 211-221.

Smedley, B.D., Stith, A.Y., Nelson, A.R., (Eds.). (2003). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington DC: National Academies Press.

Smith, D. (1990). Population ecology and the racial integration of hospitals and nursing homes in the United States. *Milbank Quarterly*, 68(4), 561-596.

St. Clair, A., & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education*, 38(5), 228-234.

Stewart, M., Meredith, L., Brown, J.B., & Galajda, J. (2000). The influence of

Diversity & Cultural Competency in Health Care Settings

- older patient-physician communication on health and health-related outcomes. *Clinical Geriatric Medicine*, 16(1), 25-36.
- Talamantes, M., Lindeman, R. and Mouton, C. (2000). *Ethnogeriatrics curriculum module: Health and health care of Hispanic/Latino American elders*. http://www.stanford.edu/group/ethnogeriatrics/ebooks/hispanic-latino_american.pdf
- Thiederman, S. B. (1986). Ethnocentrism: A barrier to effective health care. *Nurse Practitioner*, 11, 52-59.
- U.S. Census Bureau. (2000, January). Population projections of the United States by age, sex, race, Hispanic origin, and nativity: 1999-2100. <http://www.census.gov>
- U.S. Department of Health and Human Services. (2001). *Achieving cultural competence: A guidebook for providers of services to older Americans and their families*.
- U.S. National Center for Cultural Competence. <http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf>.
- Valle, R. (1998). *Caregiving across cultures: Working with dementing illness in diverse populations*. Washington, DC: Taylor & Francis.
- Weech-Maldonado R., Guwani J., Mor V. (2000, November 15). Impact of race and ethnicity on nursing home quality. Paper presented at the 128th Annual Meeting of the American Public Health Association (APHA), Boston, MA.
- Wu, A.M., Tang, C.S., Kwok, T.C. (2004). Self-efficacy, health focus of control, and psychological distress in elderly Chinese women with chronic illnesses. *Aging & Mental Health*, 8(1), 21-28.
- Xakellis, G., et al. (2004). Curricular framework: Core competencies in multicultural geriatric care. *Journal of the American Geriatrics Society*, 52(1), 137-142
- Yee, D., Tursi, C. (2000). Recognizing diversity and moving toward cultural competence: One organization's effort. *Generations*, 26:54-58.
- Yeo, G. (1996/1997, Winter). Ethnogeriatrics: Cross-cultural care of older adults. *Generations*, 20(4), 72-.
- Yeo, G. (Ed.). (2000). *Core curriculum in ethnogeriatrics* (2nd ed.). Stanford, CA: Stanford Geriatric Education Center. (Developed by the members of the Collaborative on Ethnogeriatric Education, supported by Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services.)

Publications cited from the Commonwealth Fund's Web site, www.cmcwf.org:

Diversity & Cultural Competency in Health Care Settings

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care (October 2006). Joseph R. Betancourt.

The Evidence Base for Cultural and Linguistic Competency in Health Care (October 2006). Tawara D. Goode, M. Clare Dunne, and Suzanne M. Bronheim.

Cultural Competency and Quality of Care: Obtaining the Patient's Perspective (October 2006). Quyen Ngo-Metzger, Joseph Telfair, Dara Sorkin, Beverly Weidmer, Robert Weech-Maldonado, Margarita Hurtado, and Ron D. Hays.

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care (October 2006). Joseph R. Betancourt.

Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions (August 2006). Romana Hasnain-Wynia and David W. Baker. Health Services Research, vol. 41, no. 4, pt. 1 (In the Literature summary).

Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race and Identity (October 2005). David W. Baker, Kenzie A. Cameron, Joseph Feinglass et al. Journal of General Internal Medicine, vol. 20, no. 10 (In the Literature summary).

Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals (August 2006). Matthew Wynia and Jennifer Matiassek.

Providing Language Services in Small Health Care Provider Settings: Examples from the Field (April 2005). Mara Youdelman and Jane Perkins.

Taking Cultural Competency from Theory to Action (October 2006). Ellen Wu and Martin Martinez.

Diversity & Cultural Competency in Health Care Settings

LINKS

Administration on Aging (AoA) fact sheets: Serving Our African American Elders; Serving Our Hispanic American Elders; American Indian, Alaska Native & Native Hawaiian Program, Serving Our Asian American & Pacific Islander Elders; Lesbian, Gay, Bisexual & Transgender Older Persons; Caregiver Diversity; Cultural Competency

www.aoa.gov/may2001/factsheets

African-American Elders

<http://www.stanford.edu/group/ethnoger/african.html>

American Geriatrics Society

Position paper on Ethnogeriatrics.

http://www.americangeriatrics.org/products/positionpapers/ethno_committee.shtml

Bibliography in Ethnogerontology

<http://www.sunyit.edu/library/html/culturedmed/bib/ethnogerontology/index.html>

Chinese-American Elders

<http://www.stanford.edu/group/ethnoger/japanese.html>

Cultural Competencies To Serve Older Americans

<http://www.apha.org/tnh/index.cfm?fa=Adetail&ID=739>

Curriculum in Ethnogeriatrics

Stanford University has developed ethnic Specific Modules (African Americans, American Indian, Alaskan Native, Hispanic/Latino, Asian Indian, Chinese, Pakistani, Southeast Asian, Korean, Filipino, Japanese, Native Hawaiian/ Pacific Islander)

<http://www.stanford.edu/group/ethnoger>

Ethnic Elders Care

<http://www.ethnicelderscare.net>

Diversity & Cultural Competency in Health Care Settings

Ethnogeriatrics

Florida State University Department of Geriatrics

<http://www.med.fsu.edu/geriatrics/ethnogeriatric/default.asp>

Filipino-American Elders

<http://www.stanford.edu/group/ethnoger/filipino.html>

Health Management For Older Adults III

Select Model #6: Ethnogeriatrics: Knowing the Difference

<http://medinfo.ufl.edu/~gec/hmoa3/mods.html>

Hispanic Elders

<http://www.stanford.edu/group/ethnoger/hispaniclatino.html>

Japanese-American Elders

<http://www.stanford.edu/group/ethnoger/japanese.html>

National Asian Pacific Center on Aging

www.napca.org

National Caucus and Center on Black Aged, Inc.

www.ncba-blackaged.org

National Hispanic Council on Aging, Inc.

www.nhcoa.org

National Indian Council on Aging

www.nicoa.org

Native American/Alaska Native Elders

<http://www.stanford.edu/group/ethnoger/americanindian.html>

Diversity & Cultural Competency in Health Care Settings

Native Hawaiian and Pacific Islander Elders

<http://www.stanford.edu/group/ethnoger/nativehawaiian.html>

Pioneer Network (Advocates for culture change in aging)

www.pioneernetwork.net

Working with Elderly Patients from Minority Groups

The University of Kansas School of Medicine – Wichita has a Web site on health care concerns for elders from such minority groups as African-Americans and Hispanics.

<http://wichita.kumc.edu/fcm/interp/elders.html>