

Pioneering Change

**Diversity
Education Module**



to

**Promote Excellent Alternatives in Kansas
Nursing Homes**

ABOUT THIS MODULE

This educational module is intended for use by nursing homes who wish to promote more social, non-traditional models of long-term care. The intent of this module is to assist organizations in implementing progressive, innovative approaches to care that should make a significant difference in the quality of care and the quality of life for those living and working in long-term care environments.

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Course Objectives

1. Understand what diversity means
2. Understand diversity in the context of the nursing home environment
3. Assist everyone living and working in nursing homes in learning to accept and embrace the diversity of one another through the development of cultural competence
4. Identify benefits of cultural competence for residents, staff, families and facility





Pre-Test

The pre- and post-tests included with this module are optional. The questions provide information about material to be covered and can be used for learning self-evaluation.

1. A stereotype is:
 - a. when one knows everything about other people
 - b. the same opinion is shared in one's community
 - c. no attempt is made to learn whether the individual fits the statement or generalization
 - d. common sense

2. What is the percentage of ethnic minorities living in Kansas?
 - a. 5%
 - b. 4.2%
 - c. 8.7%
 - d. 13.9%

3. Diversity is difference as it relates to:
 - a. nationality
 - b. race
 - c. sexual orientation
 - d. all of the above in addition to other elements

4. What is culture?
 - a. values, beliefs and preferences specific to a group
 - b. sharing the same holidays
 - c. watching the same movies
 - d. speaking the same language

5. One acquires a nationality through:
 - a. birth on a country's soil
 - b. parents' nationality
 - c. naturalization
 - d. all of the above

6. Cultural competence occurs when:
 - a. staff know residents' culture
 - b. staff teach residents about their own culture
 - c. staff have mastered skills to provide services appropriate to residents' culture
 - d. all of the above



7. Outdated racism is:
 - a. expressed by people who believe that their race is superior
 - b. expressed by older people who grew up when racism was an accepted part of their culture and are not aware of present social norms in this regard
 - c. non-verbal communication
 - d. something that occurred in the past

8. Culture influences things such as:
 - a. family structure and organizations
 - b. religious beliefs
 - c. how family members promote health and react to illness
 - d. all of the above

9. By 2030, the percentage of non-white population age 65 and older is estimated to reach:
 - a. 12.5%
 - b. 19.8%
 - c. 25.4%
 - d. 5.6%

10. Why do many nursing homes eagerly hire foreign-born nurses?
 - a. to increase cultural competence among staff
 - b. to answer a severe shortage of nurses
 - c. to increase diversity among nurses
 - d. none of the above

Answers can be found on page 30.



Introduction

“You never really understand a person until you consider things from his point of view.”

Harper Lee, *To Kill a Mockingbird*

Group Activity: Stereotypes

How has the media shaped stereotypical images about the following groups?

- Latinos
- Southerners
- Old people
- Politicians
- Asian Americans
- African American males
- People with gold teeth
- Germans
- Jewish people
- People who use wheelchairs, canes, or walkers
- Obese people
- Thin girls
- Native Americans
- White Anglo Saxons
- Jamaicans
- Africans

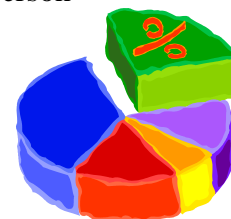


Can these stereotypes affect how we treat people who are dependent on our care?

Can you name any movies, TV ads or books that have stereotyped these groups?

When people fail to learn about other cultures their judgment is based on a **stereotype**, an ending point, where no attempt is made to learn whether the individual in question fits the statement or generalization. A stereotype occurs when an opinion is fixed, and unchanging characteristics are ascribed to all members of a particular culture. An example would be the statement: “All Arabs are Muslims.” Without further information the statement may be unsuitable to a particular person (Galanti, 1991).

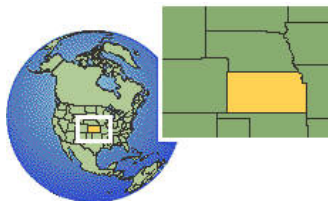
It is a widely known fact that the American population is aging. What is less known is the fact that in the near future the population of older adults will be more diverse. In 2004, the percentage of non-white people over the age of 65 was 16.4%. It is estimated that in 2030, the percentage of non-white elders will increase to 25.4%.





Consequently, the proportion of white older adults will decrease in comparison to people of color (Administration on Aging, 2002, as cited by Cummings & Galambos, 2004). By the year 2050, the number of elderly Whites will double, but the number of elderly African Americans will triple, and the number of elderly Asian Americans, Pacific Islanders, and Hispanic Americans will increase more than five-fold (Morgan, & Kungel, 1998).

In Kansas, this trend has been slower but nevertheless present. Minorities make up



13.9% of the population in Kansas. However, minority populations doubled between 1980 and 2000, from 223,637 to 454,421.

This segment of the population in the state grew an estimated 9% within 3 years, from 2000 to 2003, mostly in urban areas (Kansas Department of Health and Environment, 2005). Diversity in Kansas, as stated by the US Census Bureau 2001, is shown by the following statistics:

- White persons, 86.1%
- Black or African American persons, 5.7%
- American Indians, 0.9%
- Asians, 1.7%
- Hawaiian and Other Pacific Islanders, 0.1%
- Persons reporting some other race, 3.4%
- Persons reporting two or more races, 2.1%
- Persons of Hispanic or Latino origin, 7.0%
- Foreign born persons, 5.0%
- Language other than English spoken at home, 8.7%

The trend of continual growth of population diversity is even better illustrated when one analyzes statistics for public schools in Kansas. For example, in the 1999-2000 school year, the Emporia School District reported that 28.1% of its student body was of Hispanic origin. In that same year, the percentage of white students was 63.8%. Within six years (2007-2008), Hispanic student population increased to 41.6% of the student body while the white student population decreased to 46.8% (Emporia Public School report, 2007).

Some school districts, like USD 500 in Kansas City, Kansas, noted that 43% of their students were African American, 36% Hispanic, 17% White and 4% other. This data was reported in the Kansas School Building Report Card, School Year 2007-2008, so one can assume that the number of non-white students has increased by now. Some of these students may apply to work in nursing homes, and some of these students' parents or grandparents may need nursing home care in the near future.



Neglecting to understand diversity in resident and staff populations can contribute to conflicts, misunderstandings, and potential hostility that may indirectly affect residents' quality of life and care (Dennis & Small, 2003). The most important principle to remember is that *"there is a point of convergence where people enjoy sameness before differences cause divergence"* (Dennis & Small, 2003, p.18). All people have the same universal need to be treated with respect. The ability of caregivers to honor this need is based on their awareness of the interactions of three cultures: personal, health care delivery system, and



the culture of the person who is being taken care of.

These three elements should create harmony with each other. Some of the more important skills relative to culture and nursing care are worth remembering: “Improve interpersonal



effectiveness. Learn to listen. Resist judgmental reactions. Respect differences. Know yourself. Recognize your contributions to the interactions with clients

and others. Gain insight into your cultural heritage. When tensions arise, it is highly likely that your values are being challenged. Maintain openness to learning of other cultures. Read, observe, and ask questions. This will reduce ethnocentric tendencies. Dare to be uncomfortable. It usually means that you are learning and growing as a professional. Incorporate respect of person into all nursing care approaches” (Dennis & Small, 2003, p. 23).

Health care providers need to understand the importance of culture, how it relates to people, their families, and their communities, and how it affects health, wellbeing and attitudes towards elders (Dennis & Small, 2003). Being open to other persons who are culturally different sends a message that they can trust a caregiver because they show that they are concerned about a person’s well-being (Zoucha, 2000).



DIVERSITY

“The crucial differences which distinguish human societies and human beings are not biological. They are cultural.”

Ruth Benedict

Diversity is a difference in race, ethnicity, religion, age, sexual orientation, physical and mental ability and so on. But it also means differences in thinking style, lifestyle, political philosophy and education – to name a few. The following elements of diversity are addressed in this module:

- Ethnicity
- Race
- Nationality
- Geographic regions
- Spirituality (not related to religion; also addressed in the module “Nursing Home Residents’ Diverse Spiritual Needs. Do We Meet Them?”)
- Socio-economic class status (which encompasses education and income levels)

An additional aspect of diversity, sexual orientation, will be addressed in a separate module due to its sensitivity as well as importance in nursing home life.

This module will focus on three aspects of diversity: race, ethnicity and socio-economic status. Below you will find a quick review of the concepts related to diversity (World Book Encyclopedia, 1994). An ethnic group or **ethnicity** is a population of human beings whose members identify with each other, either on the basis of a presumed common genealogy or ancestry, or recognition by others as a distinct group, or by common cultural, linguistic or territorial traits (This is not a precise definition since



in China alone there are 56 ethnic groups; however, most people define a person from China of Chinese ethnicity). Members of an ethnic group, on the whole, have shared cultural norms. An example would be an American Jew.

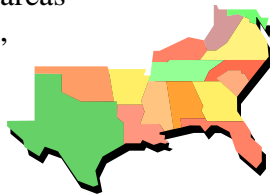


Ethnicity is used in contrast to **race**, which refers to a classification of physical and genetic traits perceived as common to certain groups. An example would be an African American.

Culture is most commonly defined as a referral to values and preferences that are specific to a group. Culture provides rules that govern life. It is a basis for attitudes, beliefs and behaviors. It also influences how people from the same culture judge and react to others within and outside of their group.

Nationality refers to people living in a certain country such as the French. Due to diversity in contemporary France, French could mean a Muslim whose parents emigrated from Morocco. Generally, nationality is established at birth by a child's place of birth and/or bloodline. Nationality may also be acquired later in life through naturalization.

Geographic regions may have formed cultures specific to a certain area (region). An example would be the Southern region of the U.S which, due to the areas' cultural and historic heritage, has developed its own customs, holidays, literature, musical style and unique dishes. Southerners are distinguished by their speech, both in terms of accent and idioms.



Ethnocentrism is the tendency to look at the world primarily from the perspective of one's own culture. It is defined as the viewpoint that "one's own group is the center of everything," against which all other groups are judged. Ethnocentrism often claims that one's own race or ethnic group is the most important and/or that some or all aspects of its culture are superior to those of other groups.

Socioeconomic status

People who are from the same race, same geographic region, and the same gender can share very different world views if they are from differing socio-economic backgrounds.

Ruby Payne writes about these differences in her book, *A Framework for*

Understanding Poverty. The book was written for teachers



so that they could understand differences in the families of the children that they teach but it is very appropriate for nursing home organizations.

She explains that nearly all organizations operate with middle class values. These values sometimes conflict with family or staff member values. Without judging a set of values as being superior to others, Payne lays out these differences and how they affect relationships and interactions. For instance, persons who live in poverty view time from the perspective that the present is important and that decisions should be made for the moment based on current feelings or the need for survival. Middle class members see the future as most important, basing their decisions upon possible ramifications. Wealthy persons think of the past and traditions as most important. Payne also demonstrates the differences in resources available to each group. This becomes apparent when a nurse aide fails to show up for work. While a middle-class person might



have a fall-back babysitter or a second car to drive, a person of lower socio-economic status may not be able to afford to find another caregiver for her child when grandma is sick. She may have no money to repair the tire on her beat-up car.

However, many people of poverty have other resources that they can rely upon.



Sometimes these resources help people to rise out of poverty. They can include faith, a sense of humor,

loyalty to friends, and resilience. A strong nursing home culture can nurture these strengths and help staff and family members grow in the environment. *Framework* is written in a workbook fashion with exercises that will assist staff members in learning how to do this.

It is important to remember that people should not feel as though they are better or worse off than someone else because of their monetary wealth. In a person-centered home a person's value is measured in many other ways.

Diversity in the Context of the Nursing Home Environment

Diversity is present among American nursing home staff. The national data



indicate that 93% of nursing home health care workers are women. Almost 55% of them are white, 35% are black, and 10% are Hispanic (Bureau

of Labor Statistics, 1999, as cited by Kolb, 2003). Fourteen percent of aides are foreign born (National Clearing House, 2006). Seventy five percent of non-white nurse's aides report experiencing racism on the job. This racism is expressed toward front-line

workers who represent different cultures. Berdes and Eckert (2001) noted in their studies that most racism came from residents (56%), some from their families (23%) and from their fellow staff (40%).



Many aides recognized that due to the residents' age, social background or lack of education, their racism was outdated. A resident would use language that is not acceptable today but it is not meant to be offensive. One Certified Nurse's Aide stated: "Well, it did not bother me that much because I knew she was old and senile. But she did not forget her prejudices" (Berdes and Eckert, 2001, p.118). They also understood that the residents with dementia could not be responsible for their behavior. However, they acknowledged that racism expressed by some residents was malignant.

Racism from the residents' families and other staff caused more stress among nurse's aides than racism inflicted by residents. Some staff members said that racist language by residents affected the care they provided to them. The aides felt that they developed coping skills, and while providing needed care they kept their distance from these residents (Berdes and Eckert, 2001).

Nursing home foreign-born workers are more likely to experience racism from co-workers in comparison to African American staff (Kolb, 2003). They attribute this attitude to the fear that American-born workers may have developed in competing for jobs with foreign-born employees (Berdes and Eckert, 2001). Very few nursing homes include questions regarding racism in their surveys. Consequently, the presence of racism, its degree, and how it affects staff attitudes and mutual relationships is not



known to most nursing home administrators. Racism is rarely addressed in training.

Diversity is not seen only among nursing home staff. Nursing homes in Kansas welcome more and more elders whose background is radically different from staff. The most recent 2007 data summary report for admissions in April shows the following numbers:

Racial/Ethnic Background	# admitted	% of total admissions
American Indian/Alaskan Native	59	0.35%
Asian/Pacific Islander	60	0.35%
Black, not of Hispanic origin	690	4.08%
Hispanic	234	1.38%
White, not of Hispanic origin	16, 882	93.84%

Mid America Convalescent Center in Chicago groups elders according to their ethnicity. Asians live on one floor, Hispanics are on another. Each floor has its traditional food, activities and a staff who speak their language (per a phone interview with the Mid-America Convalescent Center's Director of Nursing). This accommodation is less feasible in Kansas nursing homes due to a lesser concentration of ethnic and racial groups among residents. However, with proper training and education, staff can provide nursing care that is culturally appropriate to all residents.



Terrace Garden Care Center in Garden City, Kansas, employs many staff members who identify themselves as Latino. Management noticed that many family members of staff

would visit the nursing home in search of their relatives who worked there. The concept of a family is understood very broadly in a Hispanic community. The boundary between a family and a working place is not very clearly defined in that culture. Consequently, there were many visitors coming to see their relatives to discuss family matters during shift time. The management has provided training on when it is appropriate for a family member to pay a visit to another family member while he/she works. Now, all visitors report to the receptionist's desk if they want to see their family member. Management has also defined the appropriate time for a visitor to come to the nursing home at all.



Cross-cultural communication between residents and staff members is a key ingredient for provision of high quality of life and care to residents. Effective communication contributes to higher job satisfaction among staff whose experience is different from a more common Kansas lifestyle. Caregivers need to approach residents practically with enough flexibility to be open to multiple possibilities (Dennis & Small, 2003). An example would be Mrs. Hernandez, a Mexican resident, who may differ from her husband, even though they came from the same village. Their process and degree of adaptation to the American culture varies.

In order to be culturally competent, staff must start by re-examining their value system, so they can:

- Be aware of his/her own cultural and family values



- Be aware of his/her personal biases and assumptions about people with different values
- Be aware of and accept cultural differences among staff and individual residents
- Understand the dynamics of the differences
- Adapt to and respect diversity (Cummings & Galambos, 2004).

Each culture has its own expectations and behavior/styles of interaction. When these expectations are violated it may damage relationships between those receiving care and those giving care (Beyene, 1992 as cited by Barker, 1994). Using surveys, Kolb (2003) studied the effects of ethnicity and race among residents in a nursing home. The elders and their families included African-Americans, Afro-Caribbean, Jewish and Latino populations. They mentioned concerns about food, hair care, language, the need to show respect to older relatives and religious services. Without learning elders' preferences (in most cases



influenced by their culture) their lives in nursing homes may be far from satisfactory.

For the purpose of this module, the focus is on residents who are the center of care in nursing homes. However, one has to be aware that all principles included here apply to staff members and residents' families as well.

Cultural Competence

Why is cultural competence important?

- Fosters better relationships during daily life in a nursing

home because everyone knows the cultural values of others

- Some cultures are hesitant to share personal information with people outside of their cultural group, so understanding their culture can help them to open up
- Minimizes resident complaints because diversity is incorporated and understood, as the healthcare system is more responsive to resident needs
- Serious shortages of skilled staff in healthcare forces employment of a diverse work force (Sulman et al., 2007).



Cultural competence is seen as a never-ending process. It is an ongoing effort “in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context” of the resident (Campinha-Bacote, 2002, p.181). Five elements constitute cultural competence:

- Cultural awareness
 - Cultural knowledge
 - Cultural skill
 - Cultural encounters
 - Cultural desire
- (Campinha-Bacote, 2002)

Cultural Awareness

Cultural awareness is asking ourselves about our own cultural background. This question helps staff recognize their own biases, prejudices and assumptions about people who are different from themselves. The examination of residents' culture helps prevent staff from imposing their own cultural norms, beliefs, values and patterns of behavior on residents (Campinha-Bacote,



2002). All people have a culture, and most represent several subcultures. For example, if a person's heritage is Mexican American and his/her profession is that of a nurse, then he/she identifies with Mexican American culture and the registered nurse subculture.

Both have cultural behaviors, rules, values and traditions (Zoucha, 2002).

Group Activity: Self-reflection



This activity should be conducted privately to avoid any painful/uncomfortable confrontations. After participants complete the assignment, ask if anyone wants to discuss any aspect of the activity.

Can you identify your race, ethnicity, subculture, sexual orientation, and religion or other form of spirituality?

What does it mean to you to be identified with any of these groups?

Can you describe typical behaviors associated with these groups?

Have you experienced any prejudices associated with any of these groups? How has it affected you?

How do you deal with it?

How would you feel if you had to change those behaviors that you have learned from the culture circle you grew up with?

Have you met a person whose behavior is very different from yours due to their cultural, racial, regional, or sexual orientation background?

Have you felt resentment against this person for being different?

Has this person's behavior made you curious about his/her cultural background?

What stereotypes and prejudices are common in American society?

What stereotypes and prejudices do you have?



Case Study: Cultural Awareness: Should I care when other people's behavior is radically different from mine?



A resident living at the Prairie Moon Care Center complained to Cynthia, the administrator, that an aide had pointed and shook his finger at him and laughed. When Cynthia told the aide he didn't know why there was a problem, so she asked him to run through the exchange with her. He showed her his big smile that he always gave everyone, and extended his arm with his index finger in the air. He said, "In my country, this is a sign to say, 'I am at your service, I will do what you want.'" Cynthia could see how the resident misinterpreted the "sign and the smile" as being disrespectful. She spent some time with the resident and the aide on explaining differences in body language between the two cultures.

Have you ever been in a situation when you felt that your cultural norms were violated?

How did you react?

Why do most people have biases against people who are different?

How do your values relate to health care?

Cultural Knowledge

Cultural Knowledge is the process of learning about diverse cultural and ethnic groups. When staff learn about residents' worldviews they gain an invaluable tool for dealing with their needs. It is important to get to know residents' beliefs and cultural values relating to health and health care (Campinha-Bacote, 2002).

At Good Samaritan in Junction City, Kansas, a Korean elder is allowed to sleep on a low bed that is customary to her culture. Staff had to adjust the height of the bed and modify caring tasks to accommodate this resident's cultural need (per conversation with Nathan Pearson, Good Samaritan administrator).

II. Case Study: Why would an American nursing home comply with non-American cultural expectations?



Nav, an 87-year-old resident at the Hills, was dying. The Hills' administrator informed Nav's eldest son. She followed the instructions given to her during Nav's admission to the home. Nav's family came from Vietnam, where only the eldest son should be informed of the approaching death of a parent. This is a social norm strictly followed in the Vietnamese culture. Nav was not told that his life was near the end. The family took care of Nav and started spending all their time at his side. They developed a schedule to make sure that Nav always had a family member present so that he would not die alone. The staff was informed about Nav's culture and end-of-life decisions, and even though Nav was conscious till the end, he was never informed about his nearing death.



Why did the Hills' nursing home administrator follow Vietnamese cultural norms?

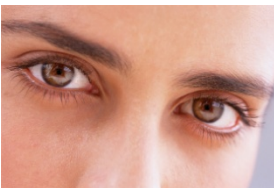
Do you agree with her decision?

What are your cultural norms associated with death?

Cultural Skill

Cultural skill is the ability to collect information that is related to residents' care and to provide care that is harmonious with a resident's cultural norms (Campinha-Bacote, 2002).

III. Case Study: Why do health care providers need to understand each others' cultural beliefs and behavioral norms?



Jennifer, a nurse at Crescent View, had a hard time connecting with a CNA who was of Chinese origin. Whenever they interacted, Ai would avoid

looking her in the face. Jennifer found it uncomfortable talking to Ai without any eye contact. She decided to ask Ai whether there was anything about her behavior that bothered her. Ai responded that she liked and respected her supervisor. Jennifer decided to be more direct with Ai and asked

her why she avoided looking her in the eye while talking to her. Ai explained that in her culture this is a sign of respect. Ai saw Jennifer as an authority figure, and by not looking Jennifer directly in the eye she was showing her respect for her higher position.

Jennifer decided to have a special meeting with Ai to find out other differences between the two cultures and eliminate any potential misunderstandings between Ai, residents and co-workers. She also decided to educate Ai on the importance of direct eye contact when interacting with residents and staff members. Jennifer wanted to learn more about Ai's culture to understand what other cultural norms may be conflicting with the western behavioral norms.



How did knowing why Ai avoided direct eye contact with her help Jennifer?

How would you handle the situation?

How might Ai's lack of direct eye contact affect residents?

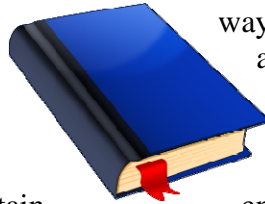
Is there anything about other people's behavior that bothers you that you suspect or know is part of their culture?



Cultural encounters

Cultural encounters are the direct, cross-cultural interactions of persons living and working in nursing homes who are from different cultural backgrounds. Direct interaction with each other will increase knowledge about specific cultures and modify stereotypes associated with these cultures.

However, one has to be aware that knowing a few individuals from a certain culture does not mean they will find that all people from that group will behave and react the same way. There is variation within each culture group due to people's different socio-economic backgrounds, education levels, religious beliefs, and life experiences (Campinha-Bacote, 2002).



should attend to Rebecca's spiritual needs, but that it would also be appropriate for Yolanda to continue taking care of Rebecca, reading and talking to her, and spending as much time with her as possible. Yolanda decided to ask the rabbi for directions on ways to improve her care that would be appropriate to Rebecca's culture and faith.

Do you think that Yolanda has done enough to find out about Rebecca's cultural background?

Was it her place to find out Rebecca's cultural background?

Have you cared for someone from a different cultural background from your own?

How did you go about learning how to appropriately provide care for that person?

Do you think you could have provided culturally appropriate care to Rebecca another way?

IV. Case Study: Collecting information about resident's cultural background.

Yolanda is one of three CNAs working in the High Meadow Neighborhood. Her parents came to the U.S. from Mexico when Yolanda was three years old. She grew up in a predominantly Mexican community, and Yolanda strongly identifies with that culture. She was assigned to take care of Rebecca, who was dying. Rebecca did not have any family, and Yolanda felt compelled to be Rebecca's surrogate family during this trying time. Had Rebecca been a Mexican, Yolanda might have placed spiritual amulets, religious medallions, and rosary beads near her. Yolanda decided to talk to

the social worker to help her identify Rebecca's cultural background and the customs she grew up with. The social worker checked Rebecca's file and identified her as a Polish Jew. They both concluded that a minister of the Jewish faith





Cultural desire

“Compassion is the basis of all morality.”

Arthur Schopenhauer

German philosopher

1788 - 1860

Cultural desire is the motivation of health care providers to *want* to know residents’ culture and not simply to *have* to. It involves the concept of caring and a genuine passion to be open and flexible with people, to accept differences, to deal with stereotypes in constructive ways by learning from differences, and to strive to be non-judgmental (Campinha-Bacote, 2002).



Nearly 75% of African Americans express a concern about finding providers who will understand and respect their cultural beliefs and values. Only 30% of

white Americans identified the same concern (Older American Report, 2006).

V. Case Study: Compassionate caring.

Mabel was one of a few African-American residents at the Blue Sky nursing home. She came from Louisiana to be closer to her daughter who lived in Kansas. Mabel seemed to adapt to her new environment rather quickly and enjoyed visiting with residents and staff. The neighborhood leader, Stephanie, noticed that Mabel never asked for food items during their weekly neighborhood learning circle, even though team members noted that other residents were very vocal in identifying what they

wanted to see on the menu. The team members reported that Mabel hardly ate the meals offered at the Blue Sky. Mabel’s daughter was bringing home-made dishes for her mother during her weekly visits. Stephanie decided to be proactive and explore Mabel’s food preferences. She visited Mabel and asked what kind of dishes she was cooking at home. Mabel face lit up when she talked about gumbo soups, shrimps, pecan pies and other dishes she grew up with and learned to cook for her family. Stephanie continued to visit Mabel and acquired more information about the importance of beignets, crawfish and jambalaya in Mabel’s life. Mabel thought no one in Kansas could cook the Louisiana dishes, so she never asked for any.

Stephanie assured her that the cook would give a serious try and involve Mabel in consulting. This resulted in the cooking of many Creole dishes in the Blue Sky kitchen. Mabel, and sometimes her daughter, presented each dish to the residents and staff and talked about its ingredients and preparation techniques. It triggered a competition with a few other residents who wanted to present the dishes important to them. The team and the elders decided that each person would introduce one main dish a month and a snack or dessert on a weekly basis. Some staff members started using the residents’ recipes at their homes.



All new recipes were compiled into a cook book that was sold to staff, residents’ families, and in the community.

Why was it important for Stephanie to find out Mabel’s food preferences?



Was Stephanie projecting a cultural desire when she initiated talking with Mabel about her favorite food?

What are other culture-related things that she should ask Mabel about?

Would accommodating Mabel’s food culture be feasible at the nursing home you work in?

How do you accommodate your residents’ food preferences?

What kind of dishes come to your mind that you would not like to live without?

Village Shalom: Diversity

Most residents at Village Shalom in Kansas City, KS, are Jews (77%). Most staff employed at the home are non-Jewish. This discrepancy has created a need for additional education for staff to help them learn about

Jewish culture, holidays, traditional foods and their meanings, traditions and other particulars that are meaningful to this ethnic population. The rabbi is instrumental in teaching



staff about Judaism, holidays, their meanings and traditions associated with each one. Staff watch documentary movies on the Holocaust, as some residents are Holocaust survivors and need special consideration and care.

Food preparation, cooking and serving meals at Village Shalom reflect kosher principles that most residents observe either due to religious laws and/or traditions that are a thousand years old. Staff working at Rachel Café, which strictly adheres to kosher guidelines, are trained in food preparation. The kitchen is painted in two distinctive colors to separate meats from dairy products and to help staff prevent errors in this area. The rabbi blesses food on Sabbath days.



Regardless of staff’s own religious principles and traditions, all staff members work very hard to assure their Jewish residents continue to live according to their cultural values and norms.

Living the Heart of Diversity: A Diversity Program in Seattle

Brenda Jennings, RN, MM, and a neighborhood coordinator at Providence Mt. St. Vincent in Seattle, Washington, works with 17 different nationalities on her team. Most of the team members represent various African and Asian countries, and the only American is a woman from a nearby American Indian tribe. She identifies the following challenges when caregivers are from a different culture than residents:

- Resident frustration and fear
- Staff misunderstanding/conflicts



- Staff comprehension
- Names that are difficult to pronounce

In order to decrease and/or eliminate the problems, staff formed a Diversity Committee, whose motto is taken from the Pioneer Network: “*Know each person on staff.*” Each staff member is encouraged to talk about their culture with residents and staff. Staff members’ cultures are presented during culture festival days. Each culture is the focus of one festival day. During this time, traditional food representing that culture is served. Staff talk about their customs, holidays, information related to the area they came from, etc. They also wear their national costumes, bring music from their culture, and sometimes even demonstrate dances. Brenda believes that this is a worthwhile process because it creates an opportunity to break down



prejudices, and may enhance personal growth for everyone involved in the process. Spontaneous activities are a big part of Mt. St. Vincent’s life.

These activities provide an opportunity for staff to share their culture with residents at an appropriate time.

Many new staff members have also struggled with English proficiency. To help them become more proficient, the home provides English classes on site and during shift times to these staff members. These classes create an opportunity for elders to tutor staff members who need help with English. Brenda has seen relationships between staff and residents flourish. However, she cautions that some residents will never be receptive to people from different cultures and/or races. In cases such as these, she assigns staff members that are

culturally similar to the residents’ backgrounds (Pioneer Network Conference, 2007).



Wheatridge Park Care Center in Liberal, Kansas and Terrace Garden Care Center in Garden City, Kansas offer free phone counseling to staff who experience racism from residents. This helps them deal with emotional wounds caused by racial comments/name calling (per a phone conversation with its administrator).

Core Values for Cultural Competence

- “Cultural competence is about *all* of us, not just *some* of us.”
- “Cultural competence is growth-oriented, not deficiency-oriented.”
- “Cultural competence is a life-long process, not an event.”
- “We’re in a marathon, not a sprint.”
- “Everyone is both a teacher and a learner.”
- “Engagement is more important than agreement.”
- “Humor heals and keeps us human.”

(Howard, 2006; used by permission of Gary Howard and the REACH center. For more information contact Gary Howard at garyhoward@earthlink.net or the REACH center at reach@nwlink.com).



Principle Elements Related to Diversity

Communication

According to the 2000 U.S Census, over 70 million people living in the United States, or 19.7% of the total population, identify their first language as something other than English. The 2006 American Community Survey shows that 10.3% of Kansans speak languages other than English at home. Forty six percent of the population that is 65 or older estimates their ability to speak English as “less than very well.” Since only two options were available for self-assessment of one’s English proficiency, one can assume that some people who marked the “less than very well” category speak no English or very little. Language is a significant issue in health care delivery.

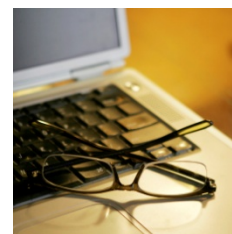
Health care providers recommend an experienced translator if an individual cannot express him/herself in English (Kirkwood, 1993). Community volunteers and relatives should be discouraged from serving as translators, as residents may be uncomfortable discussing personal problems with people they know (Hall, 2001).



If communication is possible:

- Speak slowly and distinctly. Do not use slang. Use simple vocabulary. However, do not speak to a resident as you might speak to a child.
- Pause from time to time. This gives a listener more time to understand and process the information.
- Avoid raising your voice.
- Never judge intelligence by a person’s accent (Cepero, 2004).

Almost 50% of the staff at the Wheatridge Park Care Center in Liberal, Kansas are Hispanic. Presently, two of the residents who are Hispanic do not speak English. Management is very conscious of the communication needs of these residents. At least one Spanish speaking staff member is assigned on each shift to be available to the Hispanic residents. When it is not possible, staff use a picture book that has both Spanish and English descriptions under each picture to communicate with these residents. Often they use computer software that translates two languages in order to keep communication with residents going (per a phone conversation with the Wheatridge Park Care Center social worker).



Spirituality

The diversity of people also means that they have various religious and/or spiritual values. It is an important challenge for health care providers to accommodate individuals’ needs in this area. Different religious beliefs can lead to misunderstandings between staff and people in their care. Each religion has very specific rituals and preferences. The particular persuasion or preference of the residents may be obtained either from him/her or their family.

For more information see the PEAK module titled, *Diverse Residents Spirituality: Are We Meeting Their Needs?*



End-of-Life

Cultural norms become even more pronounced at the end-of-life. It is important to examine each resident's beliefs regarding end of life in order to accommodate their norms and customs. This will ease the person's experience of dying and enhance the comfort and peace of mind of their family. Staff need to work on being sensitive which requires self-evaluation of individual attitudes, values, and practices concerning end-of- life within their own culture.

Communication is the core of sensitivity. It involves acute listening skills, nonverbal communication, the use of touch and silence, and observing language patterns of

the resident and his/her family (Dorrenbos & Myers Schim, 2004).



End-of-life wishes vary among racial and

ethnic groups and between genders. Many African Americans accept the notion of living in nursing homes until they die. Hispanic women are more interested in extensive medical interventions than Hispanic men (Gazella, 2006). In predominantly Catholic countries "hospice" is associated with extreme poverty or orphanage (Jones, 2005). Lack of attendance to residents' cultural needs is one of the elements that may negatively influence the experience of dying.

For more information see the PEAK *End-of-Life* module.

Benefits

More and more health care practitioners are beginning to realize the need to address diversity. Assessing how an organization is

dealing with racial and cultural diversity creates a model for other elements of quality assurance.

Administration and staff members start seeing opportunities for positive changes. Not only do the regulators and particular staff and residents benefit, but all staff and all residents will gain a higher quality of life (Capitman, Hernandez-Gallegos, Yee, 1991).



For assessment, care planning, coordination with other providers and direct care, multiculturally aware organizations use professional and paraprofessional staff who are familiar with cultural factors in any caregiver-consumer interaction. Staff pay attention to such matters as

- Cultural differences in both food preferences and meanings associated with food preparation and serving (Capitman, Hernandez-Gallegos & Yee, 1991). Having an ethnically appropriate diet can enhance a resident's quality of life (Beauliev, 2007).
 - Example: A religious Jew never eats pork or pork products.
- Racial differences in both personal care routines and status attributed to nursing personnel
 - Example: Staff ask residents what they prefer to be called or what kind of care they wish to receive and are aware of gender and privacy issues in provision of care.

When staff are encouraged to focus on how cultural differences may influence



interactions with elders, these organizations start defining quality of care as “treating each ‘resident’ as the product of a unique and valid personal and cultural heritage” (Capitman, Hernandez-Gallegos & Yee, 1991, p. 75). Training should help staff appreciate their own culture as well as the cultures of other people, and at the same time help them discover how much people are alike.

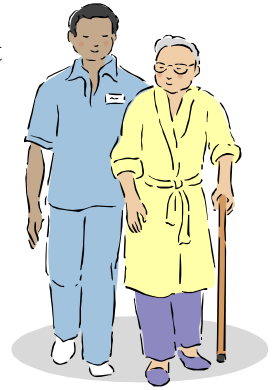
Studies show that multicultural teams contribute to negotiating and problem-solving ideas when one group does not dominate or exclude others. Many organizations see the benefits of staff diversity in group decision making. Diverse staff provide more creative solutions and more ideas to critique them. Members may



have knowledge about relating to residents and their family if they share the same culture. It increases the success of communication between a caregiver and a care receiver. The key to the team’s success is good communication that leads to recognition of potential for a greater creativity of the team. However, diversity can also lead to the malfunctioning or even failure of a team when its members are either not aware of, or not sensitive to the importance of multicultural issues (Waite, Harker, Messerman, 1994).

When staff and residents are educated about their cultural values, better relationships are formed during daily life in a nursing home. Incorporating and understanding diversity can increase resident’s life satisfaction. “Service providers from all disciplines engaged in working in nursing homes need a well-informed understanding of the cultural traditions and expectations of each individual as shaped by his or her

socialization” (Kolb, 2003, p. 2). Cultural sensitivity in recruitment and appropriate training of staff and assignment of residents to staff members who work with them are very important elements of addressing diversity. The nursing shortage is already partially solved by recruitment of foreign nurses who add ethnic and racial diversity among staff (Kolb, 2003). The anticipation is that the reliance on foreign nurses and nurse aides will be even stronger in the future.



In 2000, St. Anthony Regional Hospital and Nursing home in Carroll, Iowa, experienced a severe shortage of front-line workers. The facility and its local religious organizations initiated and sponsored eight Catholic nuns from Africa and India to come to the United States as missionaries. In a missionary role, nuns are committed to help others. The nuns were trained to be Certified Nurse’s Aides to work with the 79 residents. They were also assisted with learning English and transitioning into the new culture. In return for the nuns’ work, paychecks provided financial support to the sisters left behind in their African and Indian communities. The program was so successful that the facility invited four more African nuns and four more sisters from India. The organizers attribute the success to the commitment of both the organization and of the community (American Hospital Association, 2003).

Hall (2001) identified the following benefits of a culturally competent approach to care:

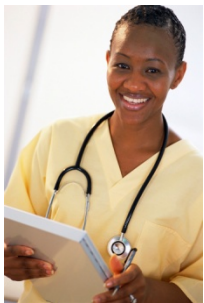
- development of more appropriate care plans
- improvement of quality of resident care and outcomes



- reduction of resident non-compliance
- improvement of resident satisfaction
- provision of enhanced individual and family care
- development of sensitivity to resident and staff needs
- increased effectiveness of work with diverse residents and staff
- Increased compliance with federal and state requirements.

Conclusion

The reality is that American society is becoming more diverse, and this trend continues to get stronger. Diversity impacts all people working and living in nursing homes. The serious shortage of registered nurses has resulted in many employers recruiting foreign nurses. This trend is likely



to continue in the future. The majority of foreign nurses come from the Philippines, India, and Nigeria. As long as the government continues to rely on foreign-educated nurses, this solution is a long-term answer addressing a severe shortage of nurses in the country (Davis & Nichols, 2002). This trend, in combination with the 14% foreign-born nurse's aides recorded in nursing home industry and a growing number of the non-white older population, has increased diversity among persons living and working in nursing homes.

Acquiring new skills and attitudes on how to think, act, lead, and work effectively with people from different cultures, styles, abilities, classes, nationalities, races, sexual orientation, and gender is only the first step

in attaining cultural competence. It also requires giving up familiar thinking, expectations, roles, and styles of interaction (Salmond, 2000). The key to understanding residents is clear and meaningful communication between staff members and elders. The impact of culture on communication is very significant. For that reason, the knowledge of one's culture is the basis of good long-term care.

It is important to know residents' culture but at the same time, staff need to remember that each resident is an individual and may not follow all the attitudes and beliefs from that culture. A useful question may be, "I have heard that many people from your country feel that medical issues should be discussed with the family rather than the patient. Is that true in your case?" Learning all facts and nuances about different cultures is less realistic than being open to the culture's influence on communication and relationships with elders. It is crucial to expect the uniqueness that relationships with residents from a different culture may bring (Brechtelsbauer, 2007).



Beauliev (2007) analyzed social workers' survey results in Massachusetts. They revealed that almost 50% of facilities do not recognize individual residents' dietary preferences. Almost 50% of social workers are never engaged in providing formal, regular in-services for staff to educate them on cultural competence. Nursing homes can not only strengthen staff in dealing with diversity, but can advocate for the recruitment of diverse staff and volunteers as well. Engaging volunteers from a community of the same cultures as residents can be meaningful. Volunteers from ethnically diverse communities can provide



assistance through activities, special religious ceremonies, or dietary contributions.



Cultural issues are present in nursing homes today and will remain an important part of nursing home life, both enriching it and creating challenges. “How nursing homes

will meet these challenges has profound implications for both quality of care where residents and families are concerned and job satisfaction for nursing home staff” (Chichin, 199, p. 10). The western view of health care effectively practiced in the 20th century must be expanded to accommodate the unprecedented cultural shifts happening in the American population (Habel, 2001). Unless administration intervenes, prejudice and discrimination will be transferred from the broader community and “replicate themselves in organizational structure and staff intervention” (Sulman et al, 2007, p. 146). Team communication improves when leadership is skilled in diversity management (Shea-Lewis, 2002). In order for a diversity program to be successful, organizations need to make a long-term commitment to diversity (Sulman et al, 2007).

Diversity, respect and understanding of cultural differences are the prominent values of person-centered care with its focus of individual’s unique needs and preferences that for some parts come from their cultural backgrounds. Only when all people living and working in nursing homes understand each other, will development of strong relationships between them, the hallmark of culture change, flourish.

HOLIDAYS

Holidays play an important role in each culture. Traditions associated with holidays are passed from one generation to another and are present in one’s life from early childhood. Because of the emotional connection with childhood memories including spending time with family members, enjoyment of food cooked by grandmas, and cherished rituals reflecting each holiday’s principles, most people have an emotional attachment to holidays. When holidays are not acknowledged people’s identities are devalued and their lives empty. Celebrating holidays with residents acknowledges the importance of their culture and who they are.

Christmas

Christmas as we know it today is a Victorian invention of the 1860s. Probably the most celebrated holiday in the world, modern Christmas is a product of hundreds of years of both secular and religious traditions from around the globe. It is the holiday that is most likely the easiest for staff to put into practice, as it is the holiday that most members celebrate themselves. It gives a good opportunity for asking residents how they have celebrated this holiday, what traditions they have observed, what type of foods their families have prepared and what memories they associate with it.



Hanukkah

On each night of Hanukkah, the menorah is lit to commemorate the miracle that occurred after the Jews proclaimed victory over the Syrian armies in 165 B.C.E. When Jews came to rededicate the Temple, which had been defiled by the Syrians, they found



only one small flask of oil with which to light the menorah. This flask contained only enough oil for one day, yet the lamp burned for eight days (by which time a fresh supply of oil was obtained). The most popular theme throughout Hanukkah cooking is the use of oil. The oil is a reminder of the oil that burned eight days instead of one. Latkes are potato pancakes made



from grated potatoes mixed with eggs, onions, and flour, and fried in vegetable oil. The texture is crispy on the outside and tender within. They're served hot and often dipped in apple sauce or sour cream.

Cinco de Mayo

Cinco de Mayo literally means the fifth of May. The date is observed in the United States as a celebration of Mexican heritage and pride. The holiday commemorates the initial victory of Mexican forces led by General Ignacio Zaragoza Seguin over French forces in the Battle of Puebla on May 5, 1862. The holiday celebrates the culture and experiences of Americans of Mexican ancestry.

Although it is not an official holiday, many cities with large populations of Mexican ancestry honor the day as a symbolic representation of Mexican pride, and as a representation of a culture that blends both Mexican and American roots.



Kwanzaa

Kwanzaa is a seven day festival celebrating the African American people, their culture and their history. It is a time of celebration, community gathering, and reflection: a time of endings and beginnings. Kwanzaa begins on December 26th and continues until New Years Day, January 1st. The Kwanzaa table is covered with a black or green tablecloth. The Mkeka (mat) is placed in the center of the table. A candleholder containing seven candles is in the center of the table. The colors of the candles are red, green and black, representing the colors of the Benera or African Flag. The black candle is placed in the center of the candleholder, which is called a Kinara. The 3 red candles are placed on the left side of the Kinara and the 3 green candles on the right.

Passover

Passover is the eight day observance commemorating the freedom and exodus of the Israelites from Egypt during the reign of Pharaoh Ramses II. A time of family gatherings and lavish meals called Seders, the story of Passover is retold through the reading of the Haggadah. With its special foods, songs and customs, the Seder is the focal point of the Passover celebration. Passover is celebrated on the 15th night of the Jewish month of Hebrew Calendar, usually in April.

There are many resources for receiving information and facts related to all holidays. A very informative source is <http://www.holidays.net/index2.htm>.

"If we cannot now end our differences, at least we can help make the world safe for diversity."

John F. Kennedy



GAMES

Say "Hello" in Many Languages

Hello in Different Languages: Description of a Cross-Cultural Activity by James Neill

The goal of this activity is to heighten cross-cultural awareness, celebrate cross-cultural knowledge, and to say "hello" in many different languages. This can be used as a fun, warm-up, get-to-know-you activity with a cross-cultural theme. Within a group, you may be surprised how much knowledge there is of different languages for basic phrases.

Optional: Ask participants to see if they can guess how many people there are in the world and how many different languages are spoken. (There are ~2800 languages and ~6 billion people. If an equal number of people spoke each language, that would be ~2 million people per language. You might relate this to local city/town size).

Challenge the group to come up with as many different languages for "hello" as possible. When somebody volunteers (e.g., Bonjour!), make sure they say it or repeat it clearly for the rest of the group who then repeat. Optional: Before people start making suggestions, ask the group to have a guess how many collective languages the group will be able to come up with. Don't allow discussion - just do a quick whip around each person's guess and take a rough average - that's the group's estimate. The group leader keeps count on his/her fingers.

Was the final number of "hellos in different languages" close to the group's guess? If the group underestimated, they may not realize the knowledge within the group that might be used to their advantage. If the group's guess was an overestimate, why did they overestimate their knowledge resources? Discuss.

- Optional - to make more difficult or to add variation, try asking for these basic phrases:
 - Hello...Goodbye
 - Hello, my name is...?
 - Hello, how are you?
 - Yes...No
 - Please...Thank you
 - Do you speak English?
 - Numbers 1-5 or 1-10
- Optional, but recommended - have a list of hello in lots of different languages from which you can read (see Jennifer's Language Page under links below). This is especially useful for groups who don't know many different languages, as well as to learn, have fun, and illustrate the range of different languages.
- Variation: Can be run as a competition between groups.



Links:

- Jennifer's Language Page: Lists basic phrases in many different languages.
www.elite.net/~runner/jennifers/
- "Say Hello to the World": Provides pronunciation sound files for "hello" in many different languages.
www.ipl.org/div/kidspace/hello/

Have You Ever?

Description of an Icebreaker & Get-to-know-you Activity

Equipment: None. Can be done indoors or outdoors. Time: 10 to 15 minutes.

- This is an active, fun way to explore and celebrate the rich diversity of experiences that different people bring to any group. Works best with larger groups.
- The instructor explains that he/she will call out different things that may or may not apply to each person. If the item does apply to you, then run into the middle, jump in the air, and do a high 5 with anyone else who runs in.
- A list of about 20 items should be tailored to the particular group, setting, and program goals, but some suggestions are below. Usually the items are of a "Have you ever....?" form, but also feel free to ad lib, e.g., "Does anyone have....?"
- Items should be carefully considered in order to prevent embarrassment, ridicule, etc.
- The motivation of participants to participate often needs some encouragement. Try to do some other warm-ups first. The rest is up to the leader's skill in demonstrating and encouraging participation.
- List of Possible "Have You Ever?" Items:
 1. Have you ever climbed to the highest point in your country of birth?
 2. Have you ever lived overseas for more than 1 year?
 3. Have you ever sung karaoke?
 4. Have you ever been without a shower for more than 2 weeks?
 5. Do you have both a brother and a sister?
 6. Have you ever ridden a horse?
 7. Have you ever eaten frogs' legs?
 8. Can you speak 3 or more languages?
 9. Have you ever been in love with someone who was vegetarian?



10. Have you swum in 3 or more different oceans?
11. Have you ever flown an airplane?
12. Have you broken 3 or more bones in your body?
13. Have you done volunteer work sometime in the last month?
14. Have you ever free-climbed a tree or rockface more than 10 meters vertically?
15. Have you ever had a close relative who lived to over 100?
16. Have you ever cooked a meal by yourself for more than 20 people?
17. Have you ever kept a budgerigar as a pet?
18. Have you ever been parachuting or done a bungee jump?
19. Can you click your fingers on your non-dominant hand?
20. Have you ever seen a polar bear?

Variations

Adapted from Dave Hall (n.d.), www.nirsa.org/naturalhigh/pdf/icebreak.pdf

- Participants can generate their own questions. Here's one way. People are sitting in a circle. Everyone has a chair (or rope ring or hula hoop) except the person who is IT, standing in the center.
- The person in the middle asks a "Have You Ever" question that is true for him/her self e.g., "have you ever climbed a mountain over 10,000 feet?"
- Anyone whose answer is "yes" gets up and moves to an empty seat. So, if four people get up they try to exchange seats as quickly as possible. The person who asked the question tries to quickly gain a seat, leaving one other person without a seat and they become the new IT.
- In choosing a question, participants can try for questions which reveal something e.g., "Have you ever trekked the Great Wall of China?" or ask simple questions like "Have you ever fallen off a bicycle?" for which everyone would get up.

Pileup variation: Anyone can ask a question and if you can answer yes to the question you move one space to your right and sit in that chair. If you cannot answer yes to the question, you stay seated in the chair where you are. This means somebody may be coming to sit on your lap from the seat to your left. Sometimes you get three or four people sitting on top of you. When the next question is asked and individuals can move one seat to the right by answering yes, participants peel off one at a time, sit down, and you end up on top. It creates some very interesting combinations. Physical touch reveals something about people and it breaks the ice so that people can then begin to feel more comfortable talking about and doing other novel things.



Post-test

The pre- and post-tests included with this module are optional. The questions provide information about material to be covered and can be used for learning self-evaluation.

1. A stereotype is:
 - a. when one knows everything about other people
 - b. the same opinion is shared in one's community
 - c. no attempt is made to learn whether the individual fits the statement or generalization
 - d. common sense

2. What is the percentage of ethnic minorities living in Kansas?
 - a. 5%
 - b. 4.2%
 - c. 8.7%
 - d. 13.9%

3. Diversity is difference as it relates to:
 - a. nationality
 - b. race
 - c. sexual orientation
 - d. all of the above in addition to other elements

4. What is culture?
 - a. values, beliefs and preferences specific to a group
 - b. sharing the same holidays
 - c. watching the same movies
 - d. speaking the same language

5. One acquires a nationality through:
 - a. birth on a country's soil
 - b. parents' nationality
 - c. naturalization
 - d. all of the above

6. Cultural competence occurs when:
 - a. staff know residents' culture
 - b. staff teach residents about their own culture
 - c. staff have mastered skills to provide services appropriate to residents' culture
 - d. all of the above

7. Outdated racism is:
 - a. expressed by people who believe that their race is superior



- b. expressed by older people who grew up when racism was an accepted part of their culture and are not aware of present social norms in this regard
 - c. non-verbal communication
 - d. something that occurred in the past
8. Culture influences things such as:
- a. family structure and organizations
 - b. religious beliefs
 - c. how family members promote health and react to illness
 - d. all of the above
9. By 2030, the percentage of non-white population age 65 and older is estimated to reach:
- a. 12.5%
 - b. 19.8%
 - c. 25.4%
 - d. 5.6%
10. Why do many nursing homes eagerly hire foreign-born nurses?
- a. to increase cultural competence among staff
 - b. to answer a severe shortage of nurses
 - c. to increase diversity among nurses
 - d. none of the above

Answers can be found on page 30.



Pre- and Post-test answers

1. C
2. D
3. D
4. A
5. D
6. D
7. B
8. D
9. C
10. B



SELF-ASSESSMENTS

(1) Assessing Your Privilege

Please read the following statements carefully. Circle your response as A=Agree, D=Disagree or NS=Not Sure.

1. I can walk or drive in most neighborhoods at night without being stopped by the police.
A D NS
2. Most people have no difficulty pronouncing my name.
A D NS
3. I can enter most buildings that have security stations and typically undergo only brief scrutiny.
A D NS
4. I can eat in most restaurants without sensing that I am being stared at by the other patrons.
A D NS
5. I have not had to overcome a physical, mental or learning disability to achieve my current success.
A D NS
6. My sexual orientation would not be considered if I were applying for a teaching position.
A D NS
7. I do not feel my age is a detriment to my career.
A D NS
8. I have not experienced any difficulty being comfortable on airplanes due to my height or weight.
A D NS
9. I do not fear publicly holding hands with a person I love.
A D NS
10. My religious beliefs, while differing in details, are fairly typical of the religious beliefs of the majority.
A D NS



11. My high school and college teachers and counselors encouraged me to pursue academic and professional goals.
A D NS
12. Dressing casually does not reflect negatively on how others perceive my competency.
A D NS
13. When hired or promoted, I feel assured that my coworkers will assume my appointment was based on merit, rather than on gender, disability, or race.
A D NS
14. I have no reservations about placing a picture of my spouse or significant other in my work space.
A D NS
15. When I arrive in a parking lot I am not concerned about whether the blues spaces, reserved for individuals with disabilities, are already filled.
A D NS
16. My native language is English.
A D NS
17. I am seldom asked about my accent.
A D NS
18. I have/had a trust or inheritance.
A D NS
19. When growing up, I did not have to share my room with one or more other children or adults.
A D NS
20. I received effective coaching on how to secure my initial jobs.
A D NS
21. I had a mentor at work who showed me the ropes.
A D NS
22. Cashiers almost always put my change in my hand instead on the counter.
A D NS



23. At work, I am never the only person of my race, gender, or sexual orientation at staff or project group meetings.
A D NS
24. I grew up in a home owned by my family.
A D NS
25. My co-workers and I would feel comfortable in each other's homes.
A D NS
26. I have received financial assistance from my family to make a down payment on a house, a new car/or to pay for college expenses.
A D NS
27. When growing up, I heard grammatically correct English spoken at home.
A D NS
28. I do not recall ever being followed by security personnel when shopping in a mall as an adult.
A D NS
29. I do not feel that because of my race, gender, or physical ability I have to work harder than others to prove myself.
A D NS
30. I think it is unlikely that I will be the victim of sexual or racial harassment in the work place.
A D NS
31. If I were ever a victim of sexual or racial harassment in the workplace, I would not hesitate to report the incident due to the fear of retaliation or being viewed as a malcontent.
A D NS
32. I am not smaller or larger than most of my coworkers.
A D NS
33. At least one of my parents or caretakers had a college degree.
A D NS
34. When asked "Do you have children?" or, "Are you married?" I do not feel at risk of personal exposure.
A D NS



35. I do not feel I might be pre-judged as incompetent because of my race, gender, sexual orientation, or disability.

A D NS

36. Most of the time I do not feel my personal safety is at risk while walking alone at night.

A D NS

Number of Agree Responses = _____

Number of Disagree Responses = _____

Number of Not Sure Responses = _____

(2) Are you a Diversity Change Agent/Ally?

How often do I, as an individual...

(1=Never, 2=Sometimes, 3=Usually, 4=Always)

1. Challenge others *privately* when they make racially, ethnically, or sexually offensive comments?

1 2 3 4

2. Challenge others *publicly* when they are making fun of others because of their race, gender, ethnic background, religion, appearance, disability, sexual orientation?

1 2 3 4

3. Think about the impact of my comments and actions before I speak or act?

1 2 3 4

4. Refuse to tell jokes that are derogatory to any group, culture, or sex?

1 2 3 4

5. Refrain from repeating statements or rumors that reinforce prejudice or bias?

1 2 3 4

6. Avoid generalizing the behaviors or attitudes of one individual to an entire group (e.g. "all blacks are...", "all disabled people are...", "all men are...")?

1 2 3 4



-
7. Accept that I am biased person and understand that there will be times when my biases will come out in my actions or words?
1 2 3 4

 8. Avoid using language that reinforces negative stereotypes (e.g. “You are acting like a pack of wild Indians”, “jew them down”, “White of you”, “I’ll get my girl to do it”)?
1 2 3 4

 9. Learn about people different from myself (read, attend voluntary seminars, watch television specials, listen to speakers)?
1 2 3 4

 10. Get to know people from different races and groups as individuals (make the first efforts to talk to them, invite them to socialize)?
1 2 3 4

 11. Support and take responsibility for helping my organization meet EEO/AA guidelines?
1 2 3 4

 12. Value people who are different from me as resources because of their unique skills, abilities, perspectives, and approaches?
1 2 3 4

 13. Work to change policies that disregard different cultural beliefs or religious holidays?
1 2 3 4

 14. Challenge the notion that individuals need to act or look a certain way to be successful or valuable to the organization?
1 2 3 4

 15. Forgive people who make biased statements about me or others and allow them to regain trust and respect?
1 2 3 4

 16. Include and invite people different from myself into the decision-making process?
1 2 3 4

 17. Provide timely and honest feedback to others, including those different from myself, even if it feels risky?
1 2 3 4

 18. Share the formal and informal rules of my group with those different from myself?
1 2 3 4



19. Disregard physical characteristics (disability, attractiveness, height, weight, dress, etc.) when interacting with others and making decisions about their ability?

1 2 3 4

20. Support organizational policies regarding equal treatment, by confronting people who violate those policies and reporting them if necessary?

1 2 3 4

Total Score _____

Awareness Spectrum:

Naïve: 20-25

Perpetuator: 26-40

Avoider: 41-59

Diversity Change Agent/Ally: 60-74

Fighter: 75-80

(MacIntosh, 1988. Used with the author's permission.)

Internet Resources

African Community Health and Social League (ph. # 510-839-7764)

<http://www.progway.org/achss.html>

Association of Asian Pacific Community Health Organizations (ph. # 510-272-9536)

<http://www.aapcho.org>

AMA Cultural Competence Initiative

<http://www.ama-assn.org/eth/diversity>

DiversityRX

<http://www.diversityrx.org>

Promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities is the mission of this site.

Office of Minority Health Resource Center

<http://www.omhrc.gov/omhhome.htm>

Under the direction of the Deputy Assistant Secretary for Minority Health, OMH advises the Secretary and the Office of Public Health and Science (OPHS) on public health issues affecting



American Indians and Alaska Natives, Asian Americans, Native Hawaiians and Other Pacific Islanders, Blacks/African Americans, and Hispanics/Latinos. The mission of OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health.

Cross Cultural Healthcare Program

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

The mission of the Cross Cultural Health Care Program is to serve as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. This site provides training for health care and other management professionals in the skills of cultural competency.

National Alliance for Hispanic Health

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

A culturally relevant/competent website of the National Alliance for Hispanic Health, the oldest and largest network of health and human service providers servicing over 10 million Hispanic consumers throughout the U.S.

National Center for Cultural Healing

<http://www.culturalhealing.com>

Cultural healing can reveal how a group can repair, re-new, and continually "make whole" its "mental map," identify and support "best practices," and reach planned results. The Center provides the tools and resources necessary to develop and sustain culturally competent organizations. Bibliographic references are included by topic.

Center for the Study of Latino Health and Culture

<http://www.cesla.med.ucla.edu/home.html>

A resource since 1992, the Center promotes Latinos in the healthcare industry and educates the public on Latino healthcare providers and recipients. The core research activities include: Latino Health Data Archive and Latino Medical Classics (translating colonial era documents on medicine).

U.S. Department of Health and Human Services: The initiative to eliminate racial and ethnic disparities in health

<http://www.raceandhealth.hhs.gov/>

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



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