# A Toolkit for Serving Diverse Communities

U.S. Administration on Aging

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# PREFACE

## GOLDEN RULE.
Treat others the way you want to be treated.

## PLATINUM RULE*.
Treat others the way they want to be treated.

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

Although it might not seem obvious that we should treat people the way they want to be treated and not the way individuals, institutions, or systems want to treat them, we can change how we view people of different cultures. Helping to facilitate this change is the purpose of this Toolkit.

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

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

# Foreword

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

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

**Kathy Greenlee**
Assistant Secretary for Aging

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# Part One

# INTRODUCTION

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

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

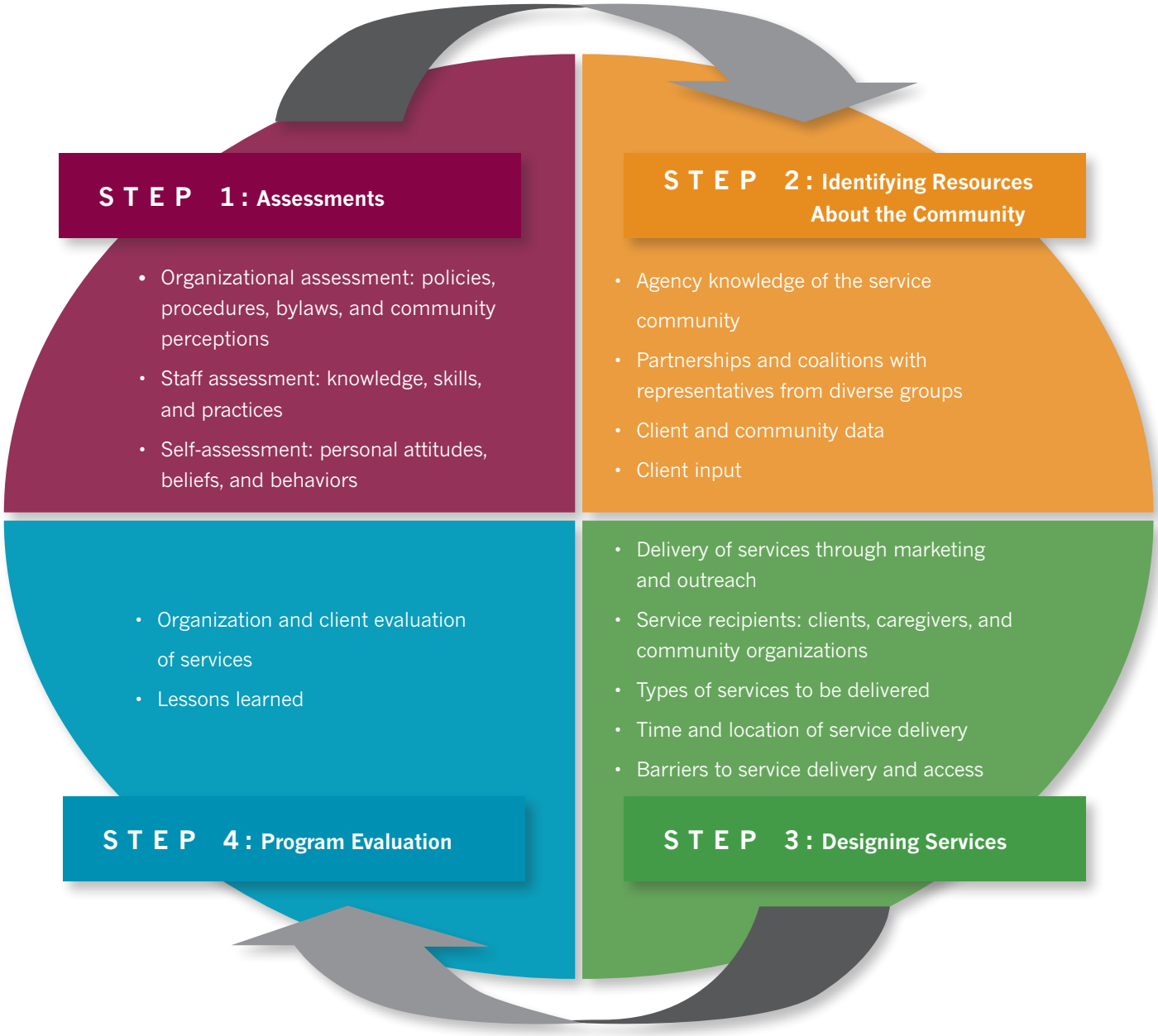
**Who should use this Toolkit?**
This Toolkit should be used by the Aging Network and its partners. This includes professionals who serve in a broad range of roles while assisting older adults and their families. Besides directors and managers of State Units on Aging (SUAs) and Area Agencies on Aging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

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

**What are the principles of the Toolkit?**

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

# THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES



STEP 1: ASSESSMENTS

# INTRODUCTION

**Purpose**

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

**Summary**

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

**Core Learning Question**

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

**Supplemental Toolkit Resources for Step 1**

*To learn more about assessments, see:*

Appendix G: List of Online Resources for Step 1

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

# PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES


*Assessments should be provided at every agency level.*

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

*Assessments can answer questions such as:*

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

## ORGANIZATIONAL ASSESSMENT

**Who?**
The agency.

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

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

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

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

## STAFF ASSESSMENT

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

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

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

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

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

## SELF-ASSESSMENT

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

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

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

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

STEP 1: ASSESSMENTS

# Diverse Community Questionnaire

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

**Target Population:**

_____

_____

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

_____

_____

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

**Has your agency provided services to this community?**
Yes ☐ No ☐

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

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

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

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

**How can your agency improve or enhance this perspective?**

**Are any of your agency's staff, board members, committee members, and/or consumer advisory-board members from this community?**
Yes ☐ No ☐

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

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

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

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

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

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

**Additional Notes:**

STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

# INTRODUCTION

**Purpose**

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

**Summary**

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

**Core Learning Question**

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

**Supplemental Toolkit Resources for Step 2**

*To learn more about identifying resources, see:*

Appendix E: Companion Presentations

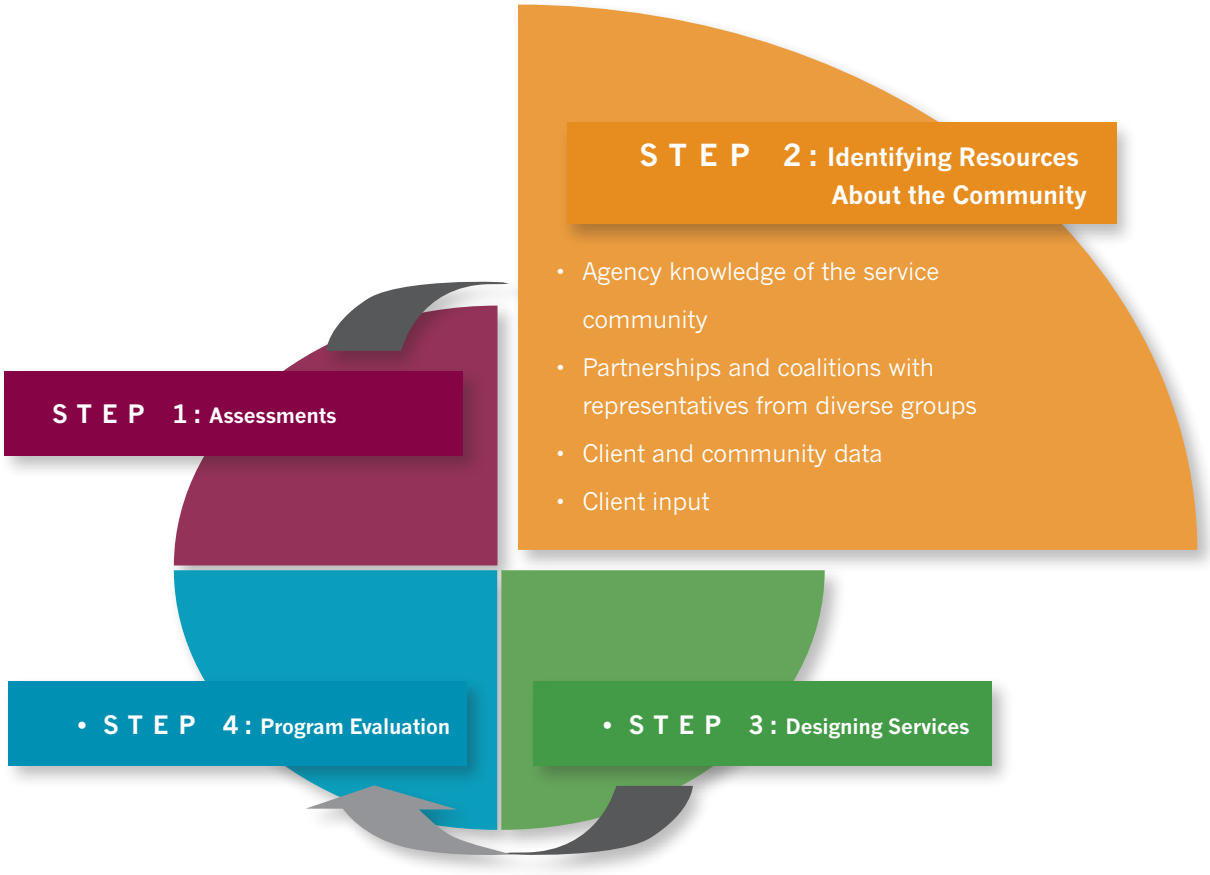
- Factors that Influence Culture
- World View

Appendix G: List of Online Resources for Step 2

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

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

# PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES




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

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

## AGENCY KNOWLEDGE OF THE SERVICE COMMUNITY

**Who?**
All staff, board members, committee members, partnering agencies, and volunteers.

**Why?**
Ensures that an agency understands the community it is serving.

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

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

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

## PARTNERSHIPS AND COALITIONS WITH REPRESENTATIVES FROM DIVERSE GROUPS

**Who?**
Trusted and valued representatives from diverse service areas.

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

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

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

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

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

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

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

## CLIENT DATA

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

**Why?**
Determines the best types of services for a particular community.

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

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

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

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

## CLIENT INPUT

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

**Why?**
Reveals how consumer expectations and values relate to service provision.

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

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

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

STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

# DIVERSE COMMUNITY QUESTIONNAIRE

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

**Target Population:**

_____

_____

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

_____

_____

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

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

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

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

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

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

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

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

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

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

**AoA statistics:** www.aoa.gov/AoARoot/Aging_Statistics/index.aspx
**AHRQ National Healthcare Quality & Disparities Reports:** www.ahrq.gov/qual/qrdr08.htm
**CDC National Health Statistics home page:** www.cdc.gov/nchs

_____

_____

_____

_____

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

**a. Community-based supports**
(e.g., family, church, grassroots organizations)
Good ☐ Fair ☐ Poor ☐

**b. Social service resources**
Good ☐ Fair ☐ Poor ☐

**c. Environmental conditions**
(e.g., pollution/air quality)
Good ☐ Fair ☐ Poor ☐

**d. Public transportation**
Good ☐ Fair ☐ Poor ☐

**e. Economic stability**
Good ☐ Fair ☐ Poor ☐

**f. Opportunities for community involvement**
(e.g., socialization, volunteerism, clubs)
Good ☐ Fair ☐ Poor ☐

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

_____

_____

_____

_____

_____

_____

**Community's most common family structure:**
Nuclear ☐ Extended ☐ Other:

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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

**Check all that apply:**

_____ Decisions are made by the client.

_____ Decisions are made by the client and family member(s) (adult children/spouse/partner).

_____ Decisions are made by the group consensus of various loved ones.

_____ Decisions are made by another (in the case of homelessness, mental health issues, guardianship).

_____ Females are the primary caretakers in this community.

_____ Males are the primary caretakers in this community.

_____ Adult children are the primary caretakers in this community.

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

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

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

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

_____

_____

_____

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

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

_____

_____

_____

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

_____

_____

_____

STEP 3: DESIGNING SERVICES

# INTRODUCTION

**Purpose**

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

**Summary**

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

**Core Learning Question**

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

**Supplemental Toolkit Resources for Step 3**

*For more information on designing services, see:*

Appendix D: Discussion Scenarios

Appendix E: Companion Presentations

- Acculturation
- Barriers to Serving Diverse Communities

Appendix F: Companion Exercises

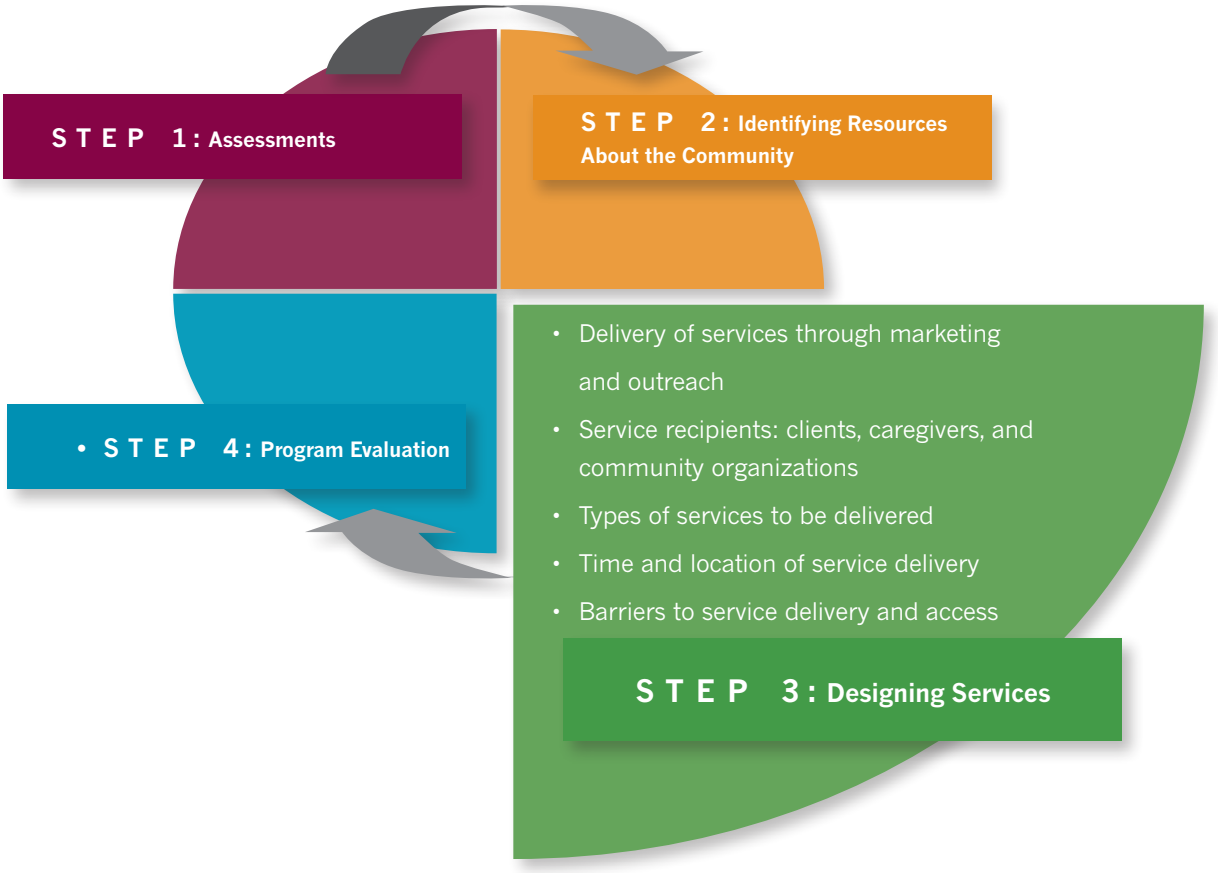
- Technical or Operational Knowledge
- Structural or Cultural Barriers to Accessing Services

Appendix G: List of Online Resources for Step 3

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

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

# PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES




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

## DESIGNING SERVICES

**How should services be designed and delivered to this population?**
Colors, language, images, pictures; with the assistance of family and/or life partners, caregivers, community organizations, etc.

**Who should receive your agency's services?**
Clients, caregivers, community organizations, etc.

**What types of services should be delivered, and which services are most valued and appreciated?**
Caregiver support, meals, older adult activity centers, transportation, medication management, health education, etc.

**When is service delivery the most valued?**
Social activities during holidays, meals at the end of the month, energy assistance during summer/winter months, etc.

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

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

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

## DESIGNING SERVICES (CONTINUED)

**Where should services be delivered?**
At trusted community providers, through churches and social groups, in the home, etc.

**What are the structural and cultural barriers to services?**

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

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

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

STEP 3: DESIGNING SERVICES

# Diverse Community Questionnaire

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

**Target Population:**

_____

_____

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

_____

_____

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

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

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

_____

_____

_____

_____

_____

_____

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

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

**Other marketing/outreach strategies:**

_____

_____

_____

_____

_____

_____

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

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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

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

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

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

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

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

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

*** Defined in Appendix B: Definitions**

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

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

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

**Additional Notes:**

*** Defined in Appendix B: Definitions**

STEP 4: PROGRAM EVALUATION

# INTRODUCTION

**Purpose**

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

**Summary**

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

**Core Learning Question**

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

**Supplemental Toolkit Resources for Step 1**

*For resources and guidance on program evaluation, see:*

Appendix G: List of Online Resources for Step 4

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

# PRESENTATION: THE STEPS OF PLANNING SERVICES FOR DIVERSE COMMUNITIES


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

## ORGANIZATIONAL AND CLIENT EVALUATION OF SERVICES

**What should be evaluated?**
Services (provided by both the agency and its partners); client and community perceptions of the quality and effectiveness of services.

**Why?**
Evaluates the process of service delivery and the quality of services.

**How?**
Process evaluation.

Outcome evaluation.

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

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

## PROCESS EVALUATION

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

**Depends on . . .**
How well program components and activities are defined and identified.

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

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

*(continued from last page)*

**Value?**

Helps to identify:

If the program is operating in the most effective way.

The program's strengths and weakness.

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

## OUTCOME EVALUATION

**What?**

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

**Depends on . . .**

How clearly program goals and objectives are defined.

**Asks . . .**

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

**Value?**

Helps to identify:

If the program is meeting its intended goals and objectives.

If services are meeting client expectations and reflect community values.

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

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

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

## DATA

**What?**
Data is information that comes in two forms:

Quantitative – in the form of numbers (statistical information)

Qualitative – in the form of words (descriptive information)

**Data sources are all around us**
Case management database, records and files, existing statistics, and input from clients and partners.

**How do I collect the data?**

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

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

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

## HOW DOES YOUR AGENCY START?

1. **Develop a model or description of your program.**
   Clarify program goals and objectives.

   Clearly identify program components and activities.

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

3. **Choose the type of data collection method.**

4. **Choose the data source(s).**

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

*Your agency should think about cost and capacity:*

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

Identify partners and agencies whose expertise your agency can leverage.

Don't forget to include client and community representation.

**6. Make sure evaluation questions are aligned with:**

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

The program's components and activities.

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

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

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

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

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

*A good evaluation process is characterized by support.*

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

## LESSONS LEARNED

**Who?**

Everyone involved in the process, including the community.

**Why?**

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

**Value?**

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

Strengthens the community's role as a stakeholder.

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

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

STEP 4: PROGRAM EVALUATION

# Diverse Community Questionnaire

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

**Target Population:**

_____

_____

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

_____

_____

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

**Is a program evaluation approach established for the services this community needs and values the most?**
Yes ☐ No ☐

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

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

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

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

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

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

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

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

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

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

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

# A Toolkit for Serving Diverse Communities

## Appendices

## Part Two

# DIVERSE COMMUNITY QUESTIONNAIRE | APPENDIX A

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

**Target Population:**

_____

_____

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

_____

_____

## STEP 1: ASSESSMENTS

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

**Has your agency provided services to this community?**
Yes ☐ No ☐

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

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

**How can your agency improve or enhance this perspective?**

**Are any of your agency's staff, board members, committee members, and/or consumer advisory-board members from this community?**
Yes ☐ No ☐

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

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

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

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

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

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

## STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

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

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

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

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

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

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

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

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

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

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

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

**AHRQ National Healthcare Quality & Disparities Reports:** www.ahrq.gov/qual/qrdr08.htm

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

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

**a. Community-based supports**
(e.g., family, church, grassroots organizations)

Good ☐ Fair ☐ Poor ☐

**b. Social service resources**

Good ☐ Fair ☐ Poor ☐

**c. Environmental conditions**
(e.g., pollution/air quality)

Good ☐ Fair ☐ Poor ☐

**d. Public transportation**

Good ☐ Fair ☐ Poor ☐

**e. Economic stability**

Good ☐ Fair ☐ Poor ☐

**f. Opportunities for community involvement**

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

Good ☐ Fair ☐ Poor ☐

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

_____

_____

_____

_____

_____

_____

**Community's most common family structure:**

Nuclear ☐ Extended ☐ Other:

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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

**Check all that apply:**

_____ Decisions are made by the client.

_____ Decisions are made by the client and family member(s) (adult children/spouse/partner).

_____ Decisions are made by the group consensus of various loved ones.

_____ Decisions are made by another (in the case of homelessness, mental health issues, guardianship).

_____ Females are the primary caretakers in this community.

_____ Males are the primary caretakers in this community.

_____ Adult children are the primary caretakers in this community.

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

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

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

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

_____

_____

_____

_____

_____

_____

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

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

## STEP 3: DESIGNING SERVICES

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

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

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

_____

_____

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

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

**Other marketing/outreach strategies:**

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

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

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

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

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

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

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

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

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

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

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

* Defined in Appendix B: Definitions

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

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

## STEP 4: PROGRAM EVALUATION

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

**Is a program evaluation approach established for the services this community needs and values the most?**
Yes ☐ No ☐

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

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

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

* Defined in Appendix B: Definitions

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

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

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

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

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

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

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

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

**Additional Notes:**

# DEFINITIONS | APPENDIX B

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

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

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

**Cross-Cultural Communication**
Interaction between diverse individuals or groups.

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

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

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

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

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

**Cultural Misalignment of Services**
When services do not fit or are not valued in a community.

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

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

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

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

**Ethnic Group**
Individuals who share values, traditions, and social norms.

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

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

**Operational Knowledge of Serving Diverse Populations**
A demonstration of how to serve diverse populations.

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

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

**Technical Knowledge of Serving Diverse Populations**
Knowledge of how to serve diverse populations.

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

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

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

# DIVERSITY CONCEPTS | APPENDIX C

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

## ADDRESSING GENERALIZATIONS

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

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

Your agency will be serving diverse communities successfully when it offers services that are respectful, inclusive, and sensitive to the population it serves. Then your agency can grasp the difference between authentic understanding and generalizing.

## COLORBLIND TO RACE

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

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

## MELTING POT VS. SALAD BOWL

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

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

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

# DISCUSSION SCENARIOS | APPENDIX D

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

## CULTURAL BROKERING FOR AMERICAN INDIAN CLIENTS

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

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

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

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

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

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

1. Does the staff's reaction to the preferences of American Indian elders and their families demonstrate cultural sensitivity? Why or why not?

2. How do acculturation and ethnicity influence American Indian client preferences?

3. How can the AAA director use Cynthia Ray's knowledge and gained trust to support the AAA's services for American Indian elders and their families? (Think about roles for cultural brokering and staff education.)

4. Consider and discuss issues of trust regarding American Indian history and culture. Could a lack of trust be mistakenly interpreted as discrimination? Why or why not?

**Supplemental Materials**

*To further explore the issue of acculturation, see:*

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

## ACCULTURATION: AN ASIAN FAMILY AND HOME HEALTH AID

**Intercultural Differences**

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

**Acculturation**

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

## DEGREES OF ACCULTURATION*

**Assimilation**

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

**Integration**

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

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

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

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

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

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

**Supplemental Materials**
*To further explore the issue of acculturation, see:*
Appendix E: Companion Presentations - John W. Berry's Model of Acculturation Presentation

## THE HEARING IMPAIRED OLDER ADULT: AN EXPECTATION OF SERVICE DELIVERY

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

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

**Cultural Misalignment of Services**
When services do not fit or are not valued in a community.

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

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

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

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

**Supplemental Materials**

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

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

## HOMELESS OLDER ADULTS: THE VALUE OF PARTNERS

**Cultural Barrier**

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

**Cultural Sensitivity**

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

**Structural Barriers**

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

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

1. What could those “basic” and “critical” services be?

2. Could there be cultural barriers, structural barriers, or both regarding those services?

3. How can the partnering agency help the AAAs serve this community better?

**Supplemental Materials**

*To further explore this issue, see:*

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

## PREVIOUSLY INCARCERATED OLDER ADULTS: BARRIERS TO SERVICE

**Cultural Barrier**

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

**Structural Barrier**

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

**Worldview**

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

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

1. What could be some of the cultural barriers to providing services for this population?

2. What could be some of the structural barriers to providing services for this population?

3. With regard to opinions, judgments, and beliefs (worldviews) about serving this population, what could be some of the barriers these directors could encounter with AAA staff?

## THE OLDER ADULT LESBIAN CLIENT: CULTURAL AWARENESS

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

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

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

**Operational Knowledge of Serving Diverse Populations**
A demonstration of how to serve diverse populations.

**Technical Knowledge of Serving Diverse Populations**
Knowledge of how to serve diverse populations.

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

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

1. Based on the professional's response, could a cultural barrier to service occur?

2. Did the professional demonstrate technical knowledge or operational knowledge? Why or why not?

3. How can partnering with a trusted LGBT community organization assist this Area Agency on Aging?

**Supplemental Materials**

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

Appendix E: Companion Presentations - Worldview Presentation

## DIFFERENT WORLDVIEWS OF LEADERSHIP

**Cross-Cultural Communication**

Interaction between diverse individuals or groups.

**Culture**

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

**Cultural Awareness**

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

**Cultural Brokering**

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

**Cultural Sensitivity**

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

**Worldview**

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

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

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

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

1. What may be some of the opinions, judgments, beliefs, and/or values each group has about leadership (worldview) that are stated or implied?

2. Which worldview of consumer advocacy is respected and by whom?

3. Is each group demonstrating cultural awareness? Why or why not?

4. Is each group demonstrating skills in cross-cultural communication? Why or why not?

5. Is each group demonstrating skills in cultural sensitivity? Why or why not?

6. How could a cultural broker assist these groups?

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

**Supplemental Materials**

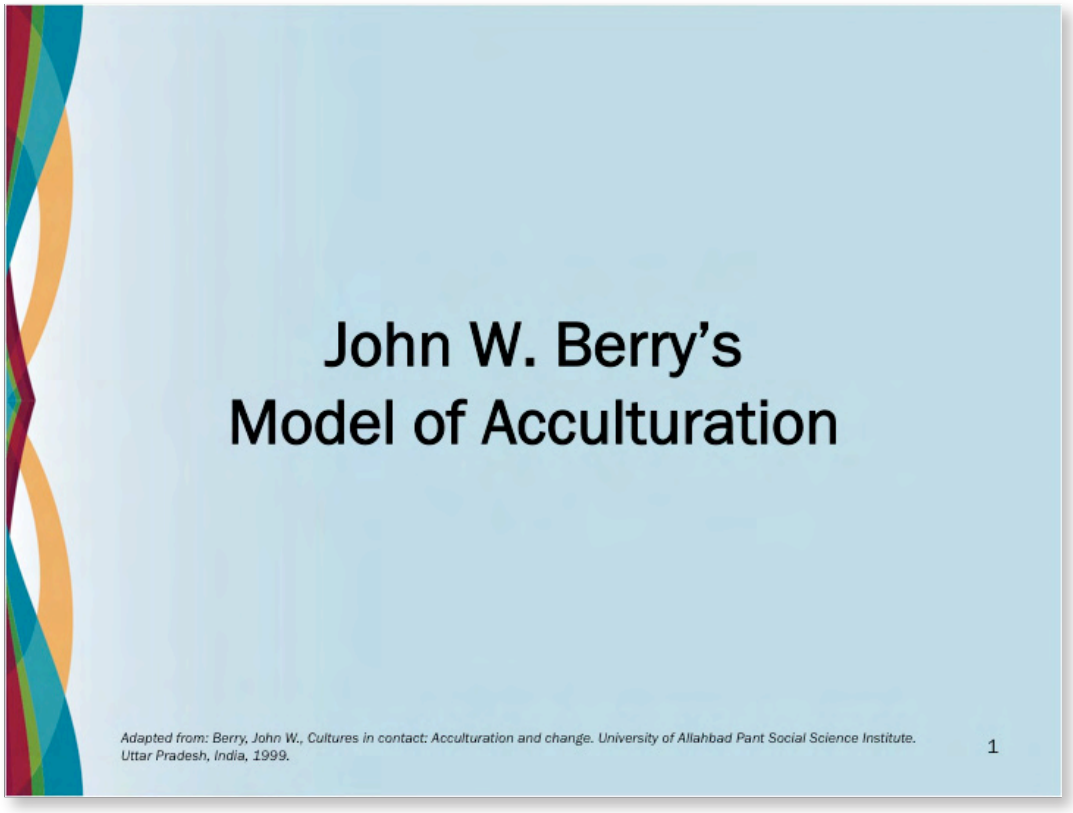
To further explore the issue of worldview, see:

Appendix E: Companion Presentations - Worldview Presentation

COMPANION PRESENTATIONS

# APPENDIX E

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



## What Is Acculturation?

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


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

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

**Separation**
The client's primary focus is on maintaining values in his/her own culture, not on building relationships with people outside of his/her culture.

**Marginalization**
The client does not socialize with individuals outside of his/her cultural group, or focus on maintaining relationships inside of his/her cultural group.

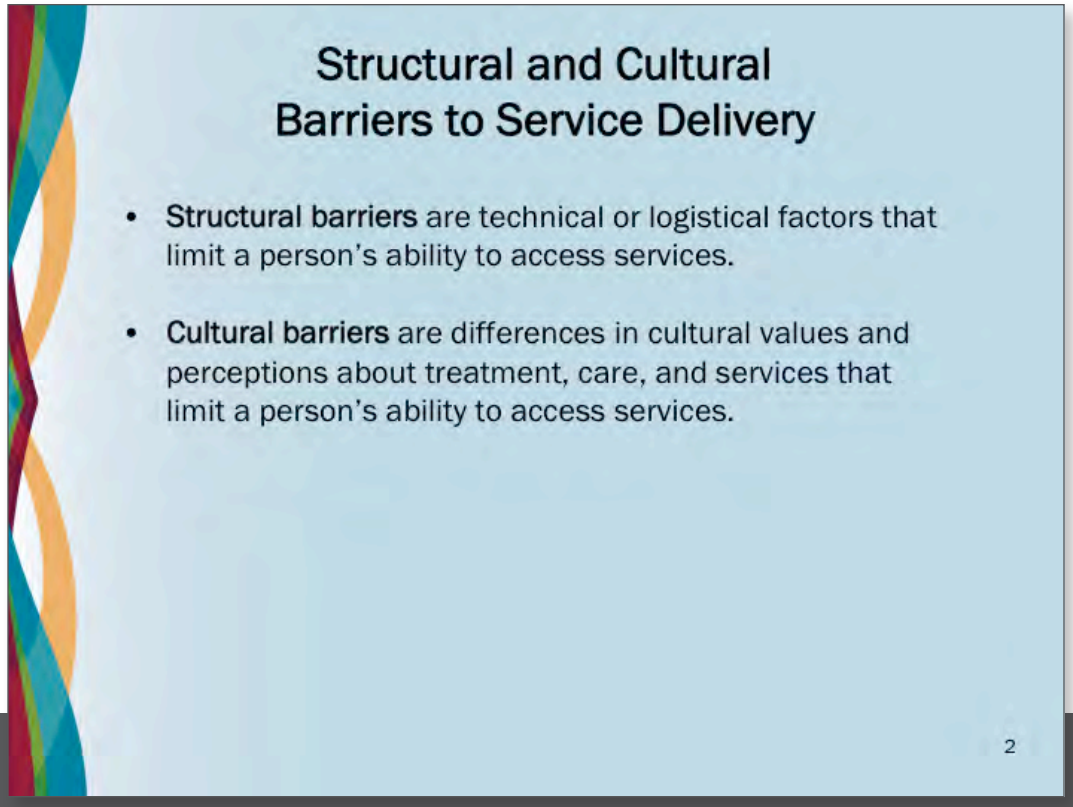
2

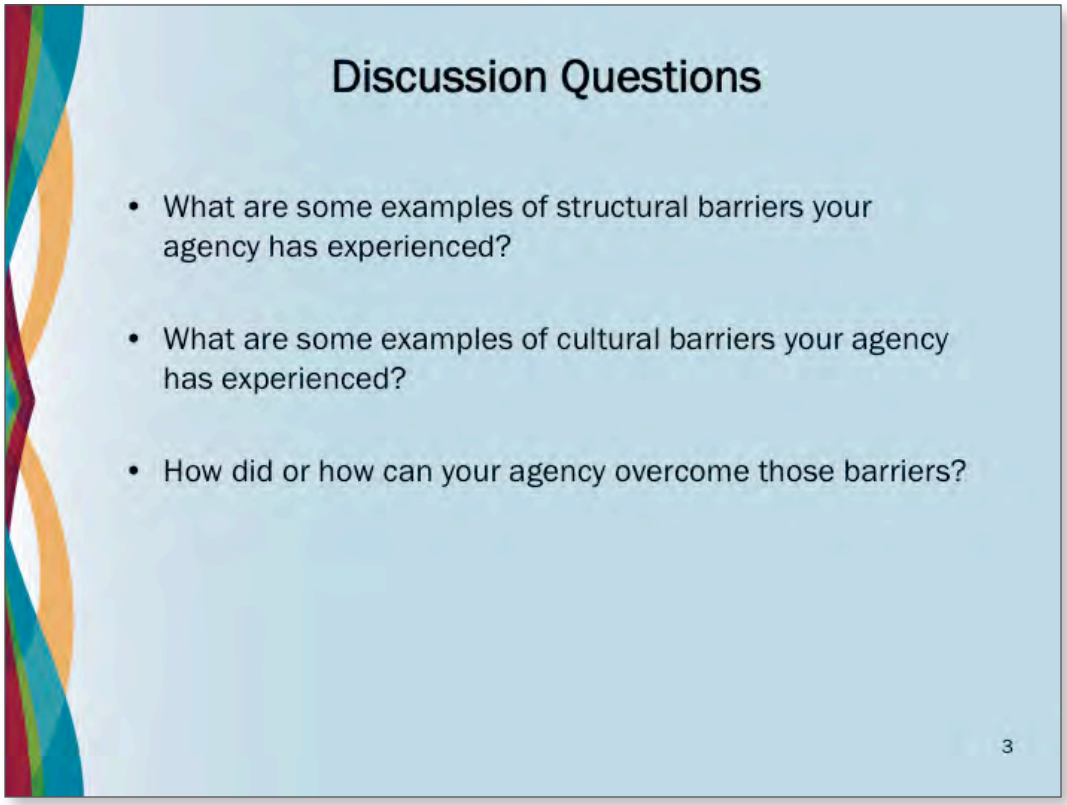
## Discussion Questions

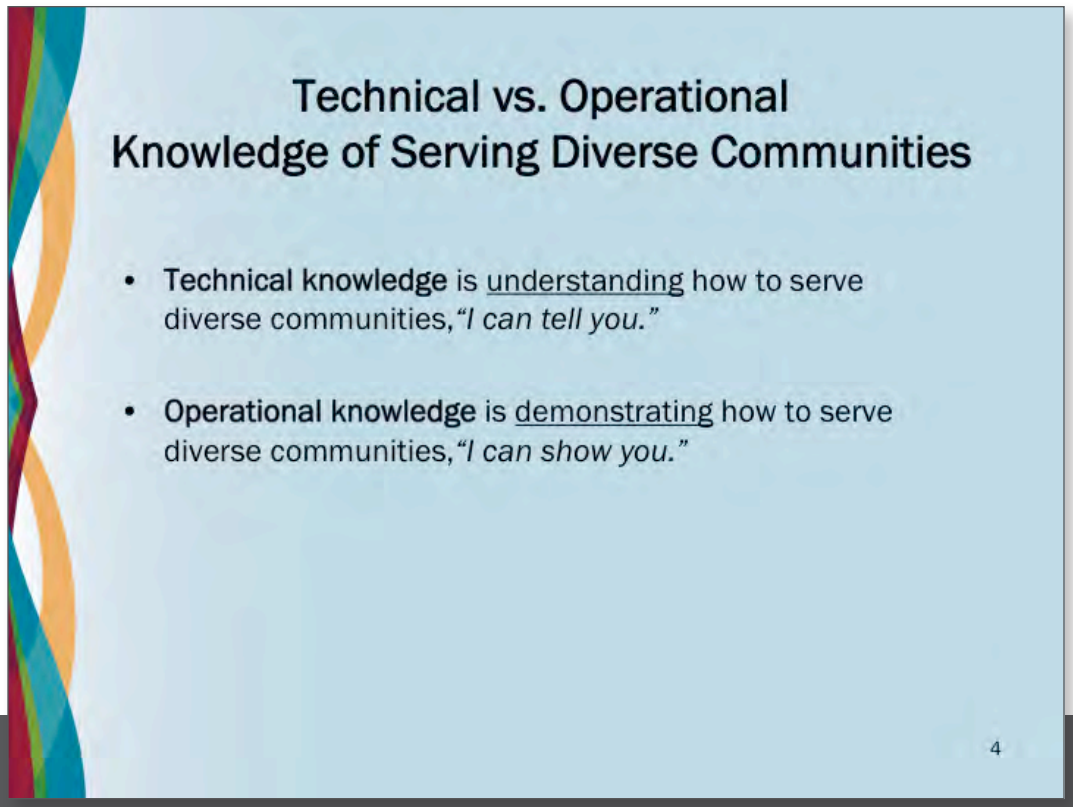
- Has your agency ever considered the degree to which the diverse communities it serves are acculturated?
- Thinking about a specific population, how would your agency have to change its services to meet the needs of an older adult or community that is separated or marginalized from the majority culture?

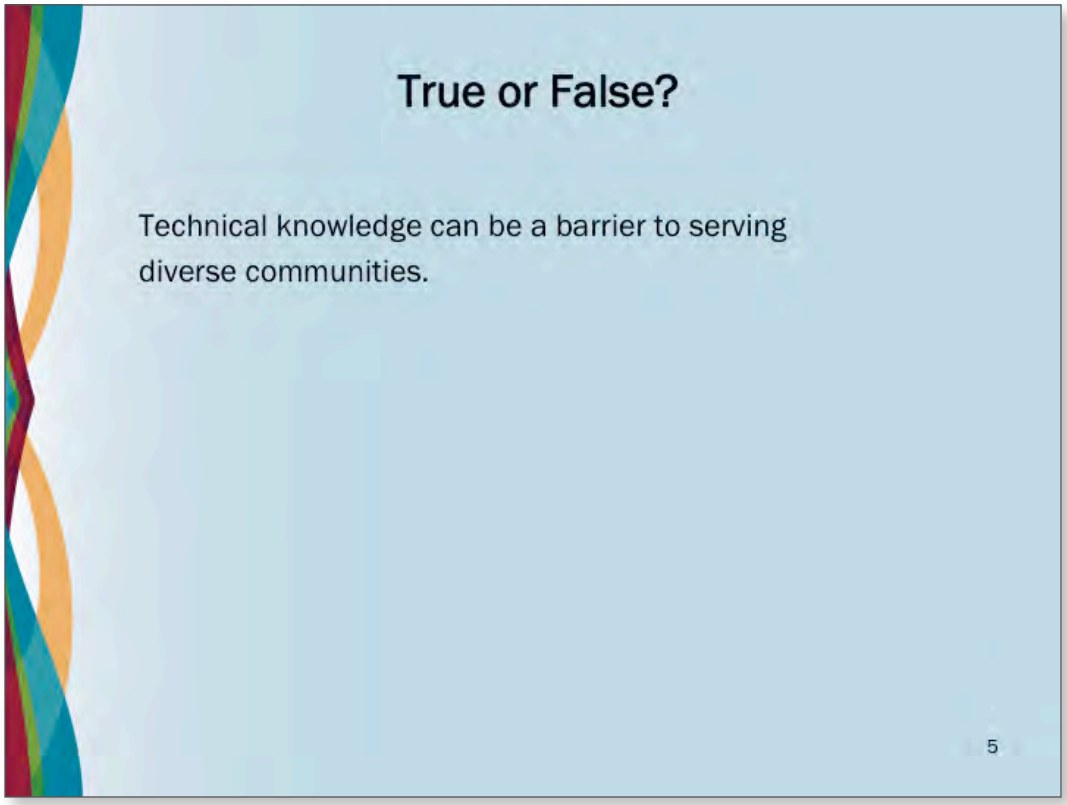
3

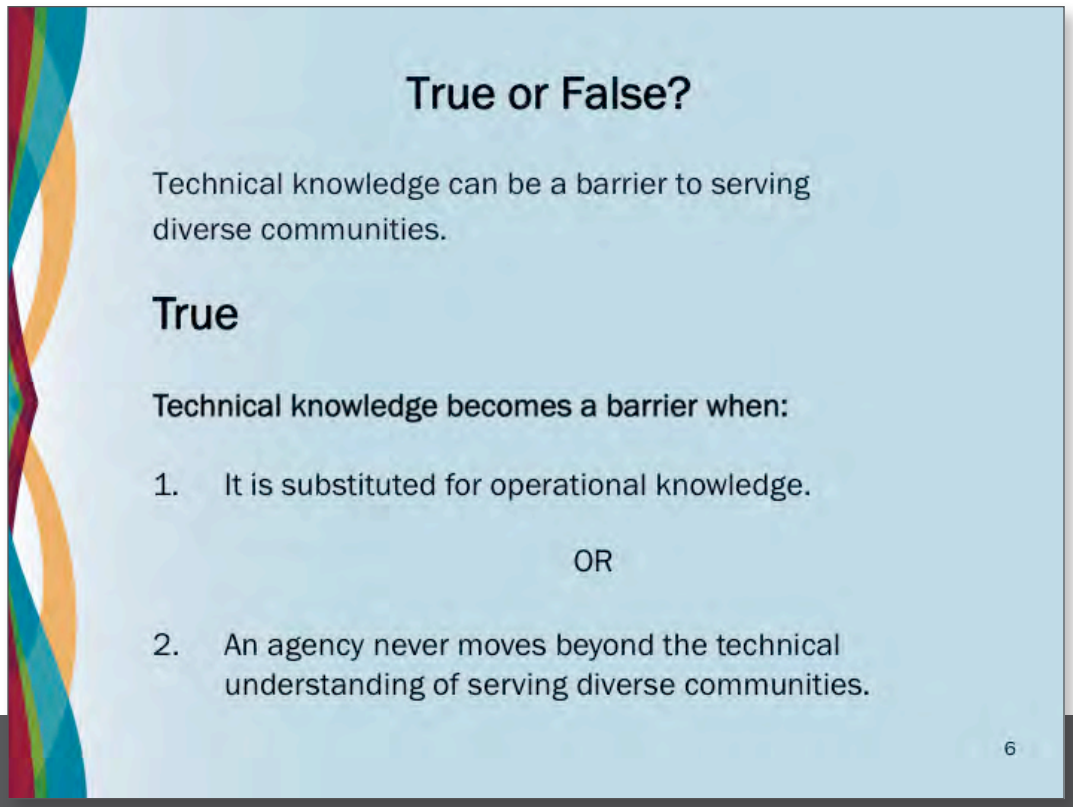

Barriers to Serving
Diverse Communities
1

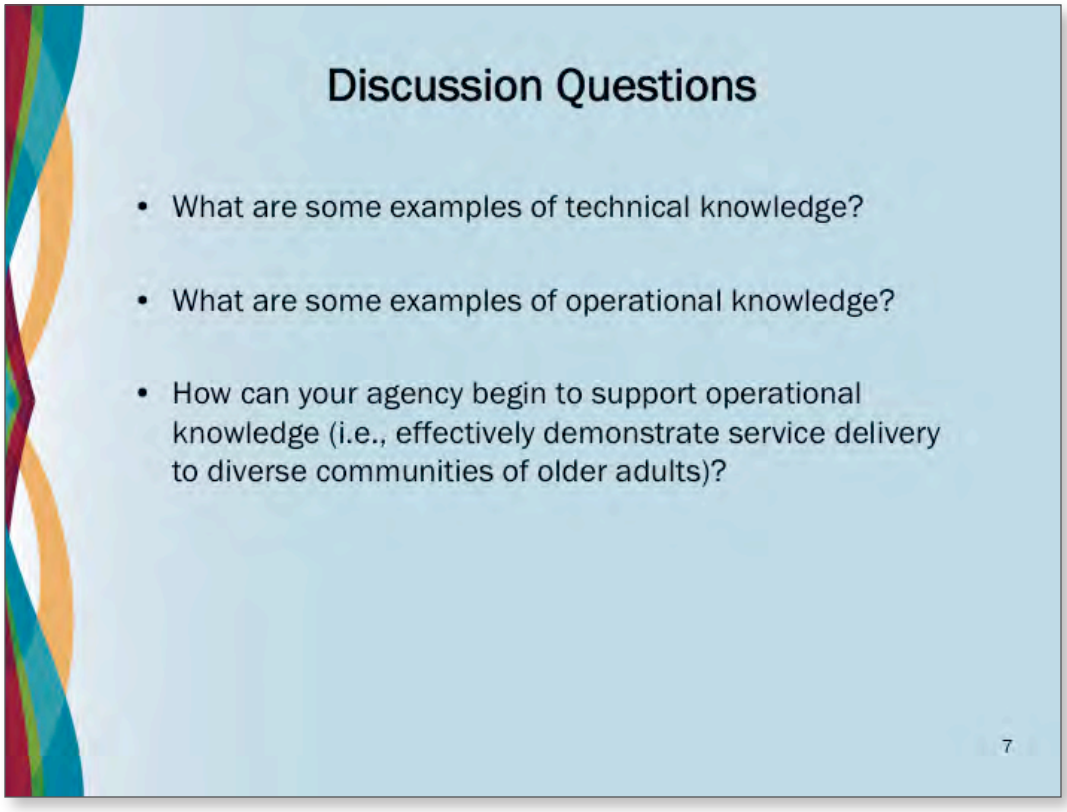

Structural and Cultural
Barriers to Service Delivery
• Structural barriers are technical or logistical factors that limit a person's ability to access services.
• Cultural barriers are differences in cultural values and perceptions about treatment, care, and services that limit a person's ability to access services.
2


Discussion Questions
• What are some examples of structural barriers your agency has experienced?
• What are some examples of cultural barriers your agency has experienced?
• How did or how can your agency overcome those barriers?
3


Technical vs. Operational Knowledge of Serving Diverse Communities
• Technical knowledge is understanding how to serve diverse communities, "I can tell you."
• Operational knowledge is demonstrating how to serve diverse communities, "I can show you."
4


True or False?
Technical knowledge can be a barrier to serving diverse communities.
5


True or False?
Technical knowledge can be a barrier to serving diverse communities.
True
Technical knowledge becomes a barrier when:
1. It is substituted for operational knowledge.
OR
2. An agency never moves beyond the technical understanding of serving diverse communities.
6


Discussion Questions
• What are some examples of technical knowledge?
• What are some examples of operational knowledge?
• How can your agency begin to support operational knowledge (i.e., effectively demonstrate service delivery to diverse communities of older adults)?
7

# Milton J. Bennett's Model of Intercultural Sensitivity

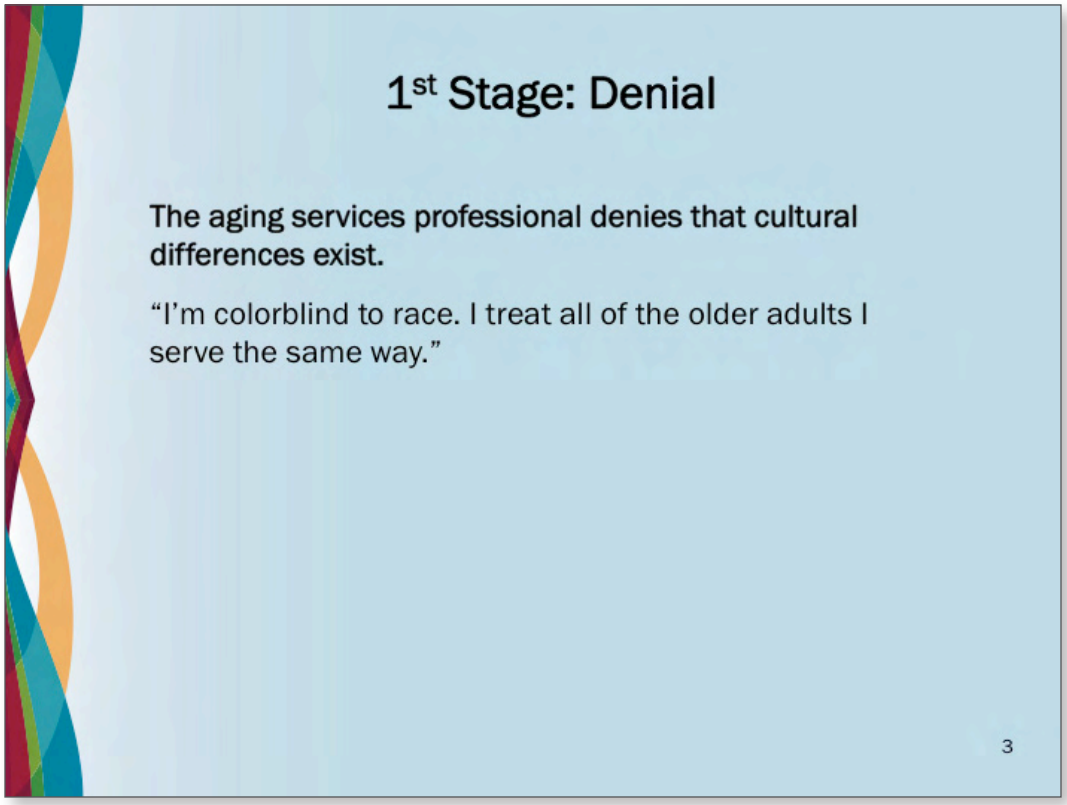
*Adapted from: Bennett, Milton J. "Towards a Developmental Model of Intercultural Sensitivity" in R. Michael Paige (ed.) Education for the Intercultural Experience. Intercultural Press, Yarmouth, Maine, 1993.*

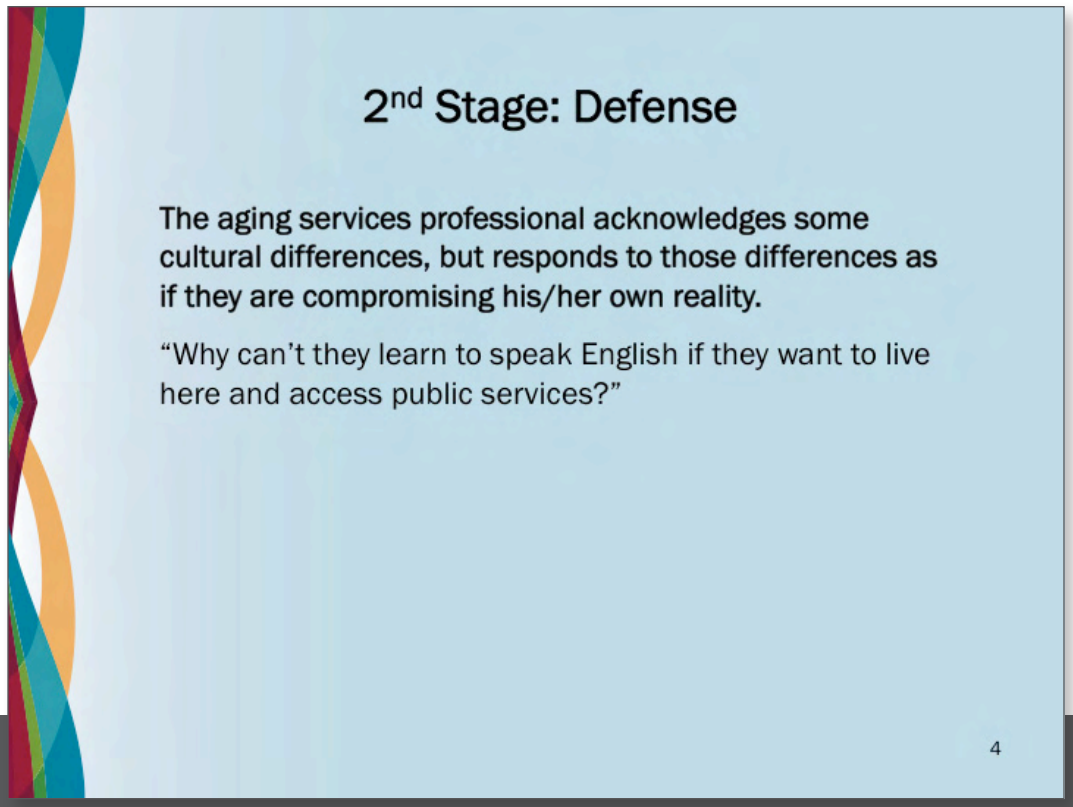
1

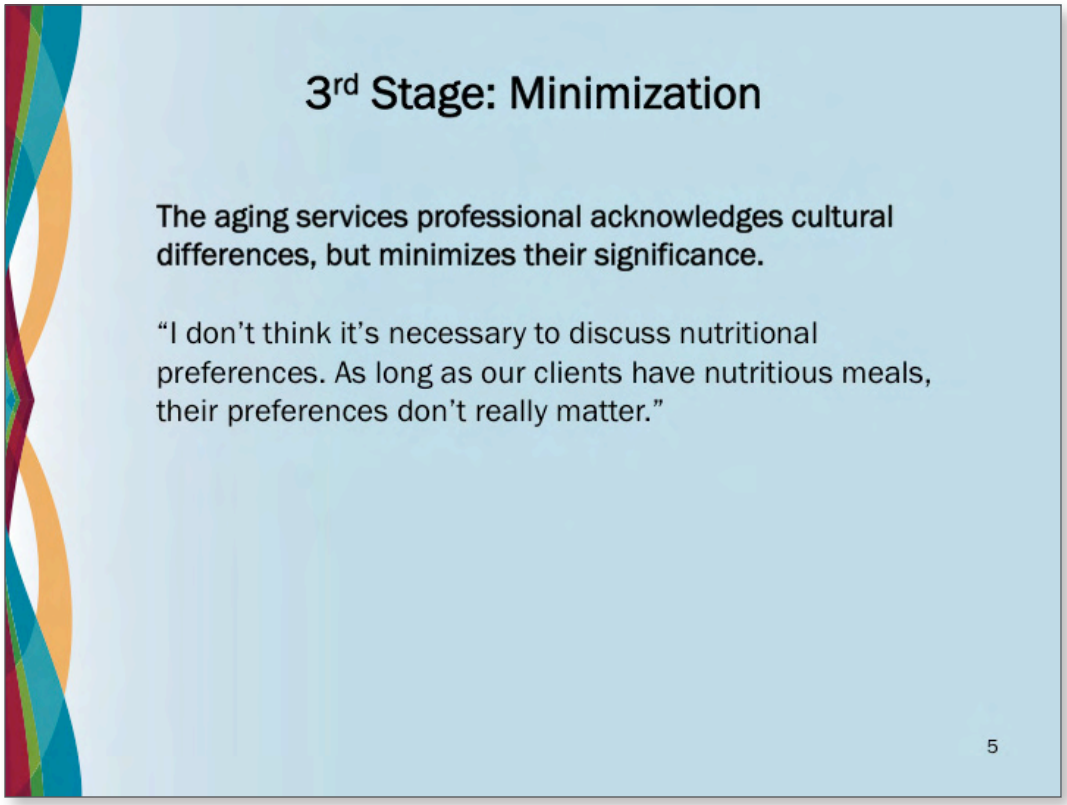
## The Stages of Intercultural Sensitivity

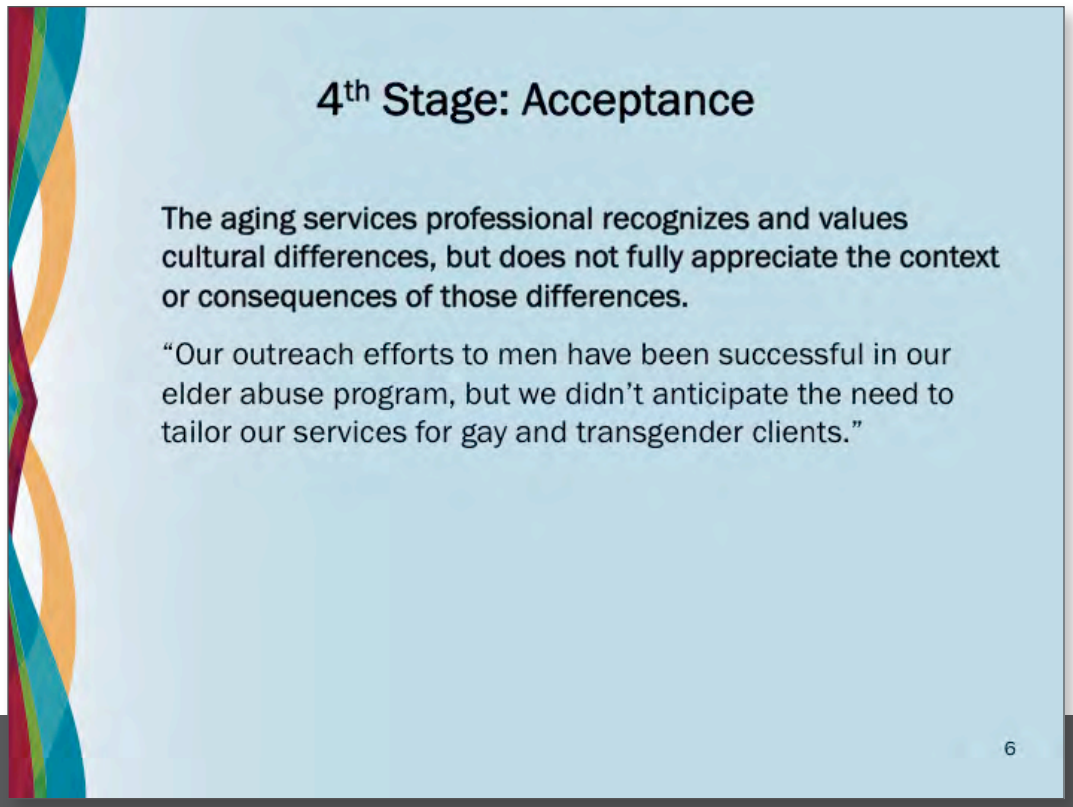
| 1st Stage | 2nd Stage | 3rd Stage | 4th Stage | 5th Stage | 6th Stage |
|---|---|---|---|---|---|
| Denial | Defense | Minimization | Acceptance | Adaptation | Integration |

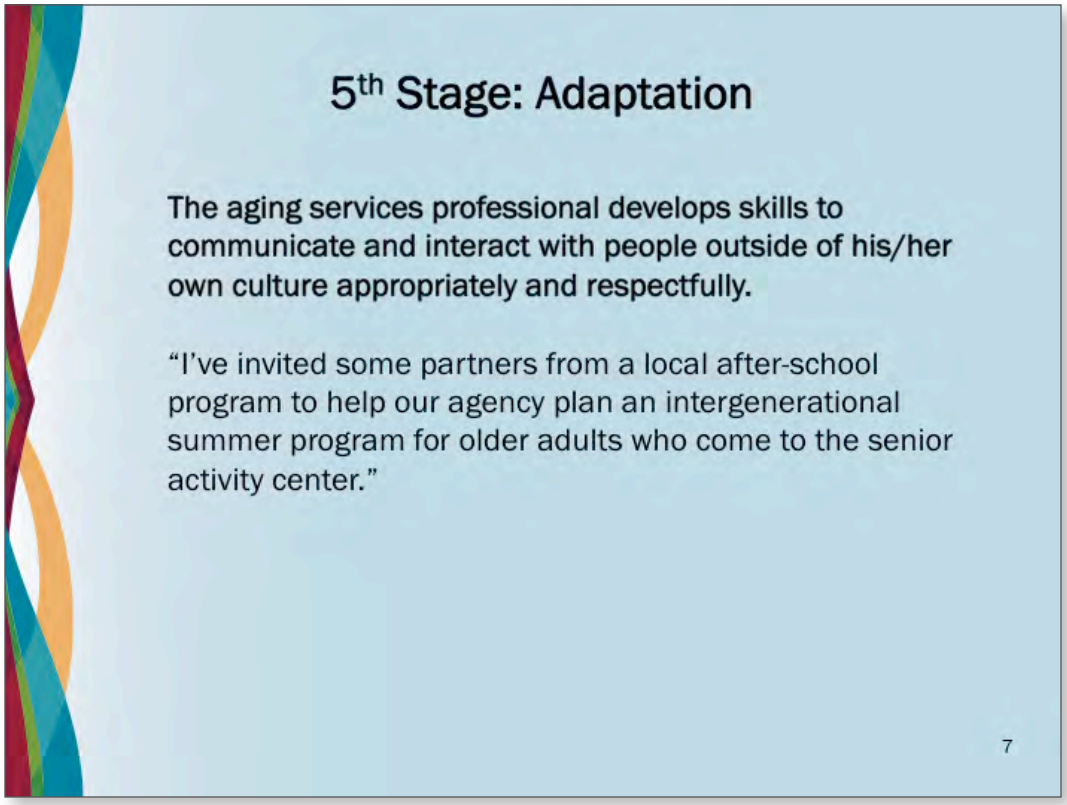
2

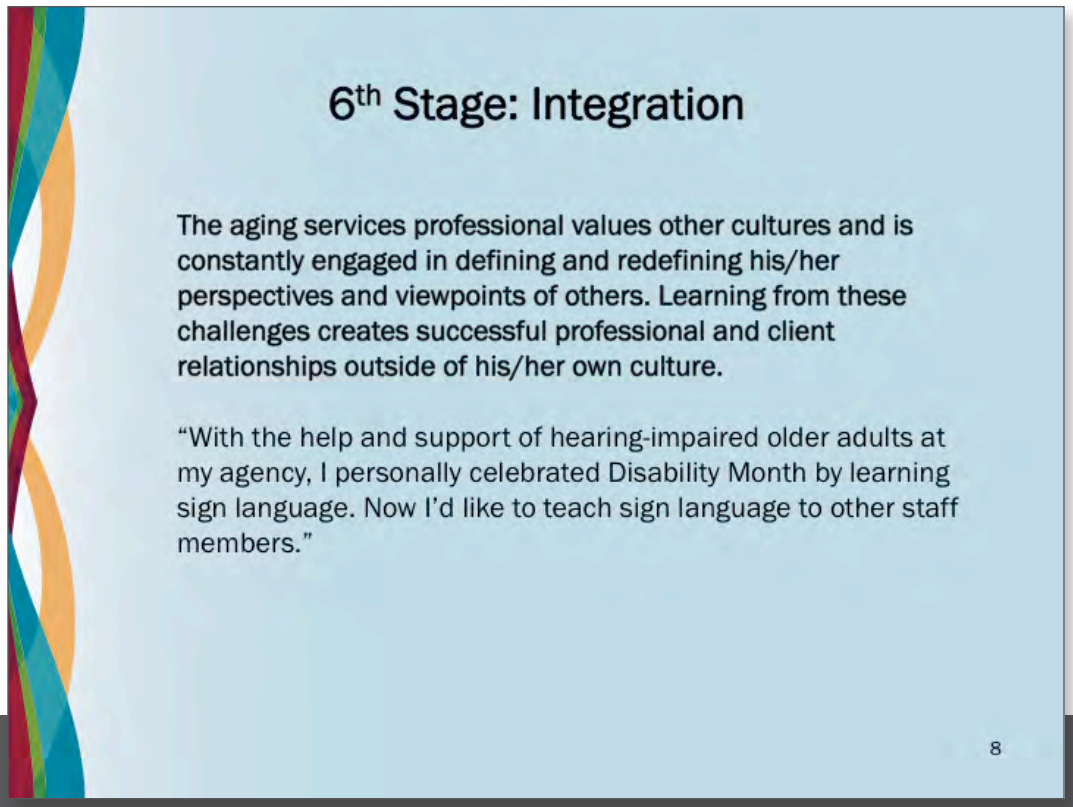

1st Stage: Denial
The aging services professional denies that cultural differences exist.
"I'm colorblind to race. I treat all of the older adults I serve the same way."
3


2nd Stage: Defense
The aging services professional acknowledges some cultural differences, but responds to those differences as if they are compromising his/her own reality.
"Why can't they learn to speak English if they want to live here and access public services?"
4


3rd Stage: Minimization
The aging services professional acknowledges cultural differences, but minimizes their significance.
"I don't think it's necessary to discuss nutritional preferences. As long as our clients have nutritious meals, their preferences don't really matter."
5


4th Stage: Acceptance
The aging services professional recognizes and values cultural differences, but does not fully appreciate the context or consequences of those differences.
"Our outreach efforts to men have been successful in our elder abuse program, but we didn't anticipate the need to tailor our services for gay and transgender clients."
6


5th Stage: Adaptation
The aging services professional develops skills to communicate and interact with people outside of his/her own culture appropriately and respectfully.
"I've invited some partners from a local after-school program to help our agency plan an intergenerational summer program for older adults who come to the senior activity center."
7

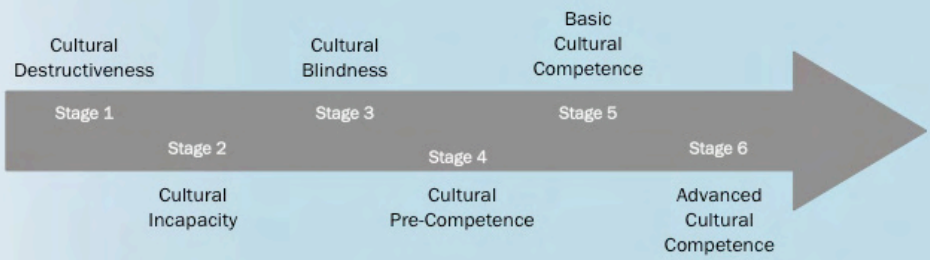

6th Stage: Integration
The aging services professional values other cultures and is constantly engaged in defining and redefining his/her perspectives and viewpoints of others. Learning from these challenges creates successful professional and client relationships outside of his/her own culture.
"With the help and support of hearing-impaired older adults at my agency, I personally celebrated Disability Month by learning sign language. Now I'd like to teach sign language to other staff members."
8

# The Cross Model of the Cultural Competence Continuum

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

1

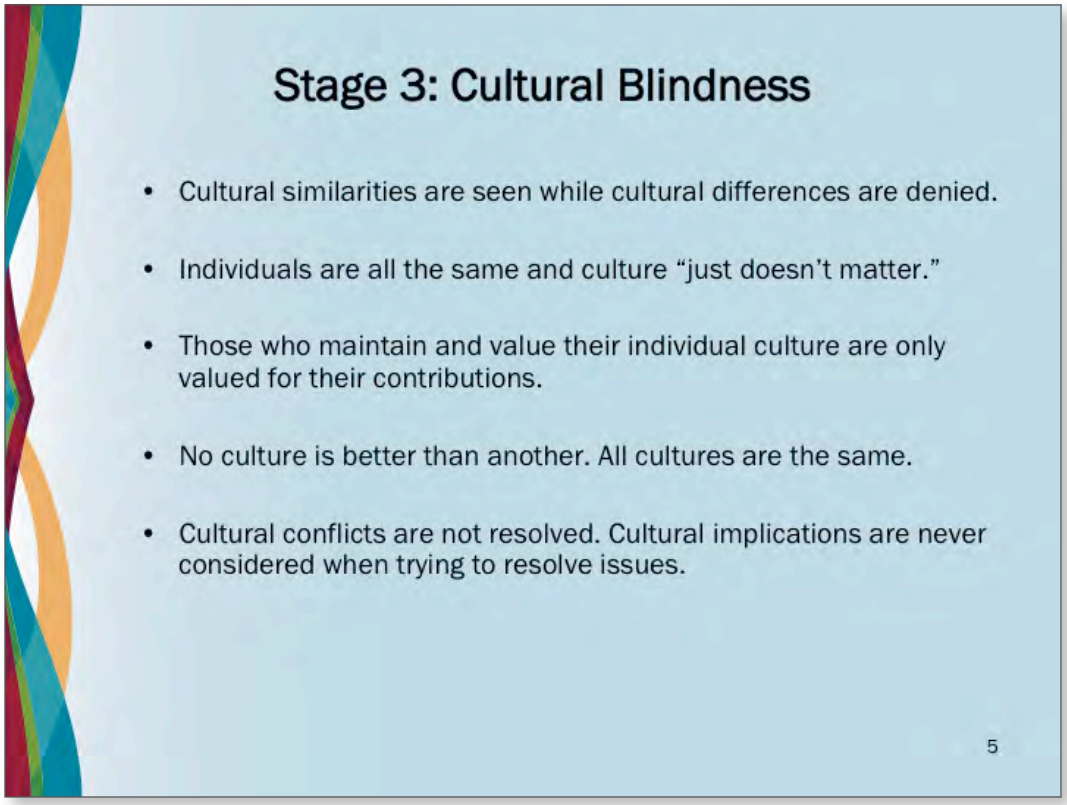
# The Six Stages of Cultural Competence

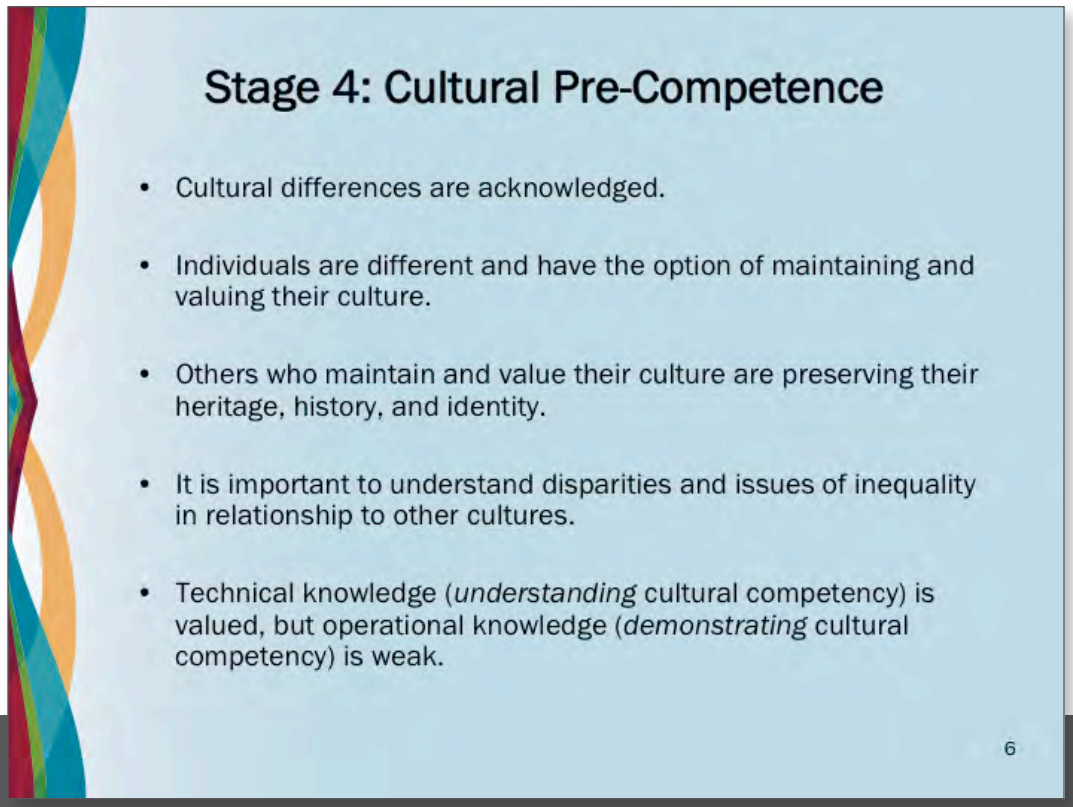



2

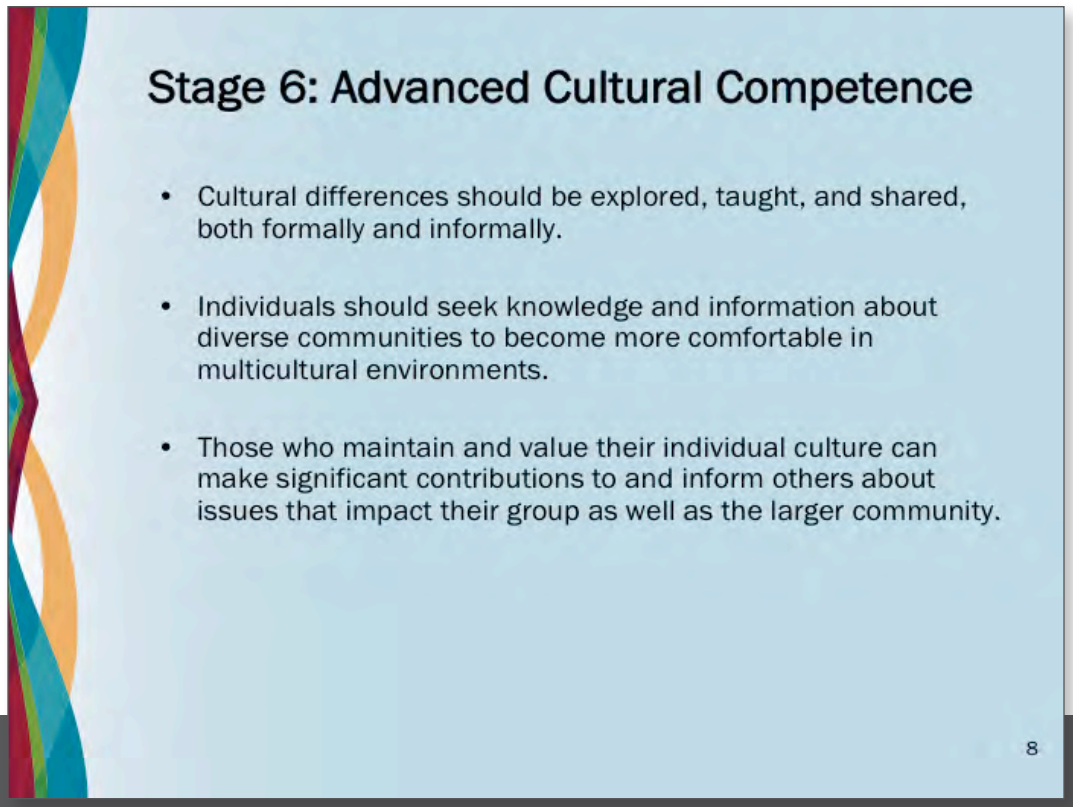

Stage 1: Cultural Destructiveness
• Culture and group differences are significant problems.
• Individuals should strive to fit in and "be like everyone else."
• Individuals who maintain and value their culture are threats.
• Cultural superiority is a value belief.
• It's OK for "superior cultures" to oppress, exploit, and harm "inferior cultures."
3


Stage 2: Cultural Incapacity
• The value of diversity is never questioned or considered; it is assumed that everyone functions in the same cultural reality.
• Individuals fit into stereotypes; assumptions made based on perceptions about cultural group differences are often related to ignorance and fear.
• Individuals who maintain and value their culture are different, odd, or strange.
• Cultures that are perceived to be "inferior" do not have the ability to make decisions in their own best interests and need to be supervised by other cultures that "know better."
4

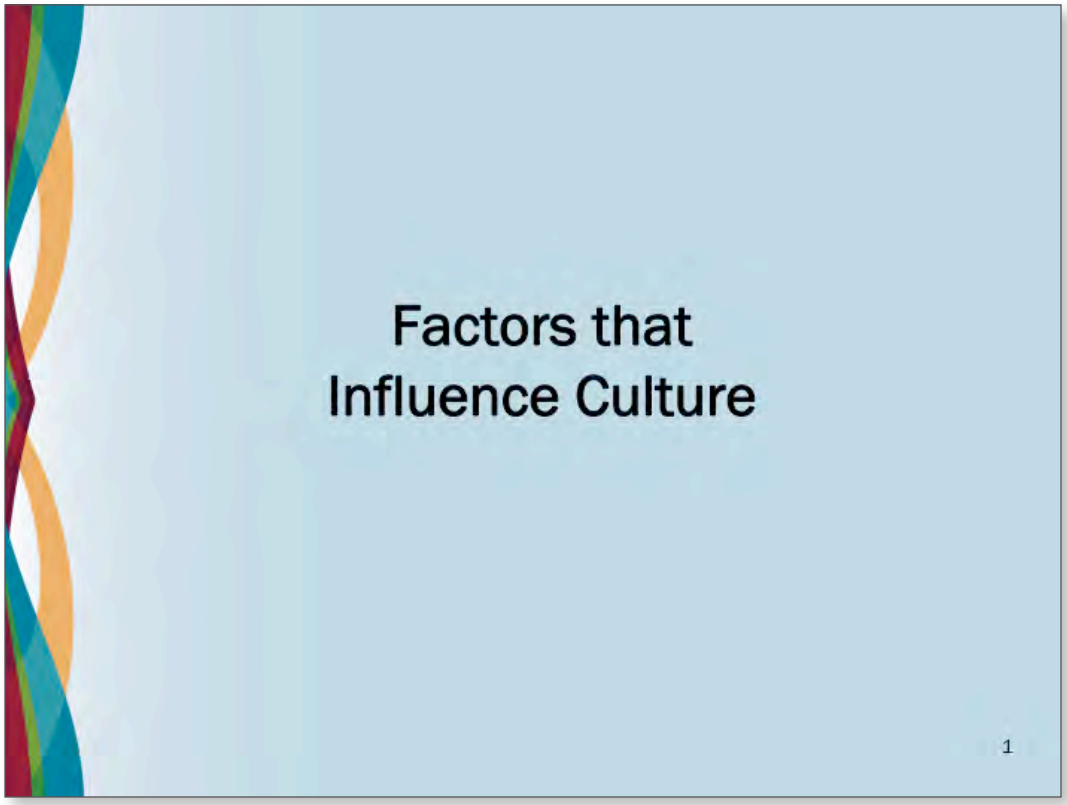

Stage 3: Cultural Blindness
• Cultural similarities are seen while cultural differences are denied.
• Individuals are all the same and culture "just doesn't matter."
• Those who maintain and value their individual culture are only valued for their contributions.
• No culture is better than another. All cultures are the same.
• Cultural conflicts are not resolved. Cultural implications are never considered when trying to resolve issues.
5

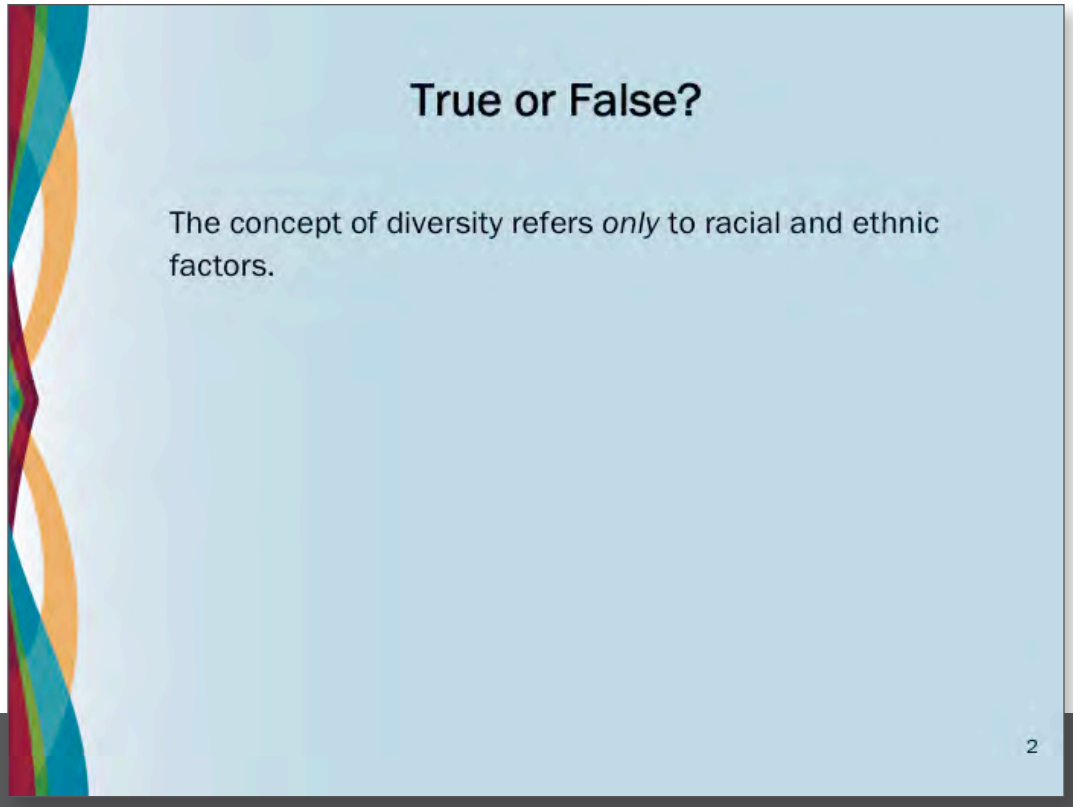

Stage 4: Cultural Pre-Competence
• Cultural differences are acknowledged.
• Individuals are different and have the option of maintaining and valuing their culture.
• Others who maintain and value their culture are preserving their heritage, history, and identity.
• It is important to understand disparities and issues of inequality in relationship to other cultures.
• Technical knowledge (*understanding* cultural competency) is valued, but operational knowledge (*demonstrating* cultural competency) is weak.
6


Stage 5: Basic Cultural Competence
• Cultural differences are celebrated.
• Individuals are recognized for the unique cultural contributions they bring to the community.
• Individuals who maintain and value their individual culture are not judged but respected.
• All cultures have value and the potential to contribute to the greater good of the community.
• Learning from different cultures and how to interact and respond to differences is a valued goal.
7

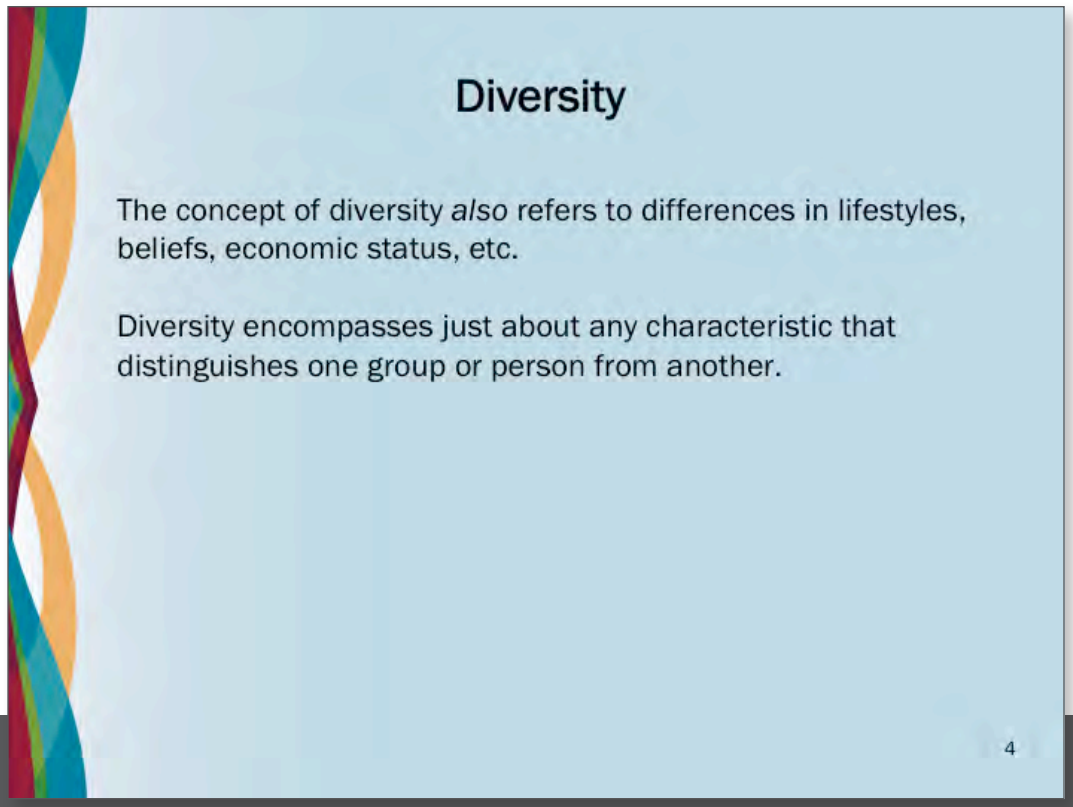

Stage 6: Advanced Cultural Competence
• Cultural differences should be explored, taught, and shared, both formally and informally.
• Individuals should seek knowledge and information about diverse communities to become more comfortable in multicultural environments.
• Those who maintain and value their individual culture can make significant contributions to and inform others about issues that impact their group as well as the larger community.
8


Stage 6: Advanced Cultural Competence Continued
• Formal ways for diverse groups to engage in self-advocacy are supported and used as vehicles for observation and learning as well as opportunities for partnership and coalition building.
• A formalized technical and operational knowledge of interacting with diverse groups is valued, acquired, and sustained.
9


Factors that
Influence Culture
1


True or False?
The concept of diversity refers *only* to racial and ethnic factors.
2


True or False?
The concept of diversity refers *only* to racial and ethnic factors.
False
The concept of diversity transcends racial and ethnic factors to include groups, their members, and affiliations.
For example: veterans, sororities, geographical communities, corporate organizations, advocacy groups.
3

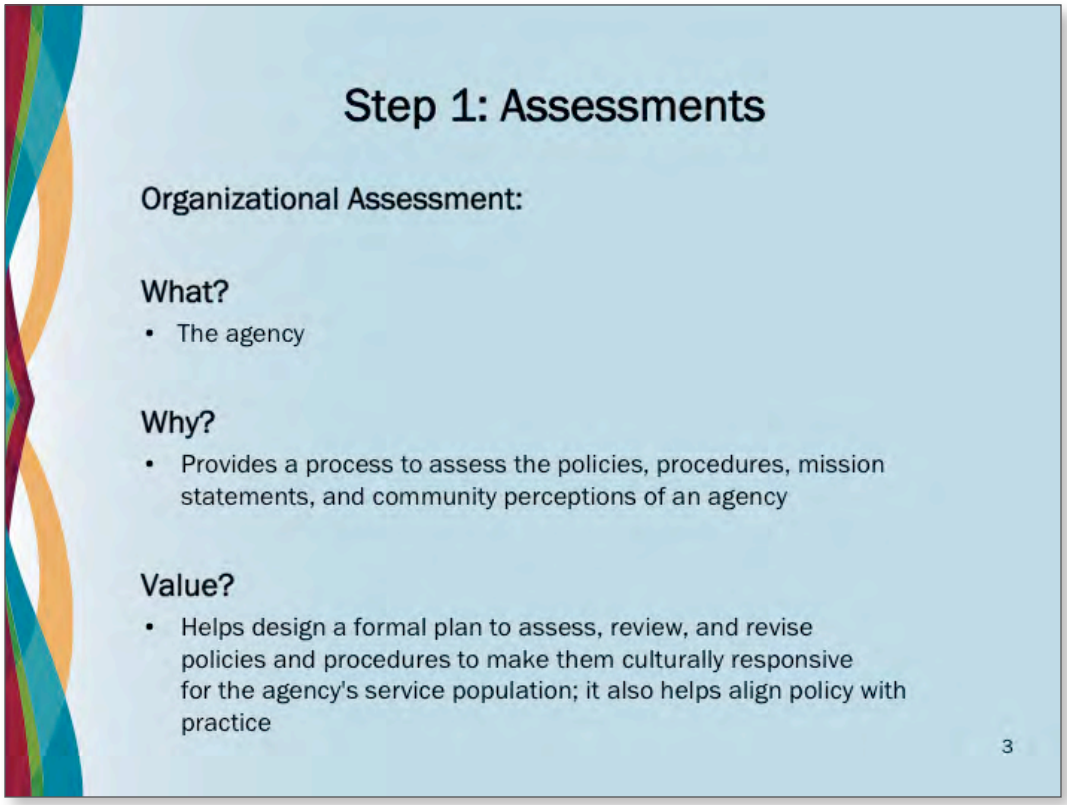

Diversity
The concept of diversity *also* refers to differences in lifestyles, beliefs, economic status, etc.
Diversity encompasses just about any characteristic that distinguishes one group or person from another.
4

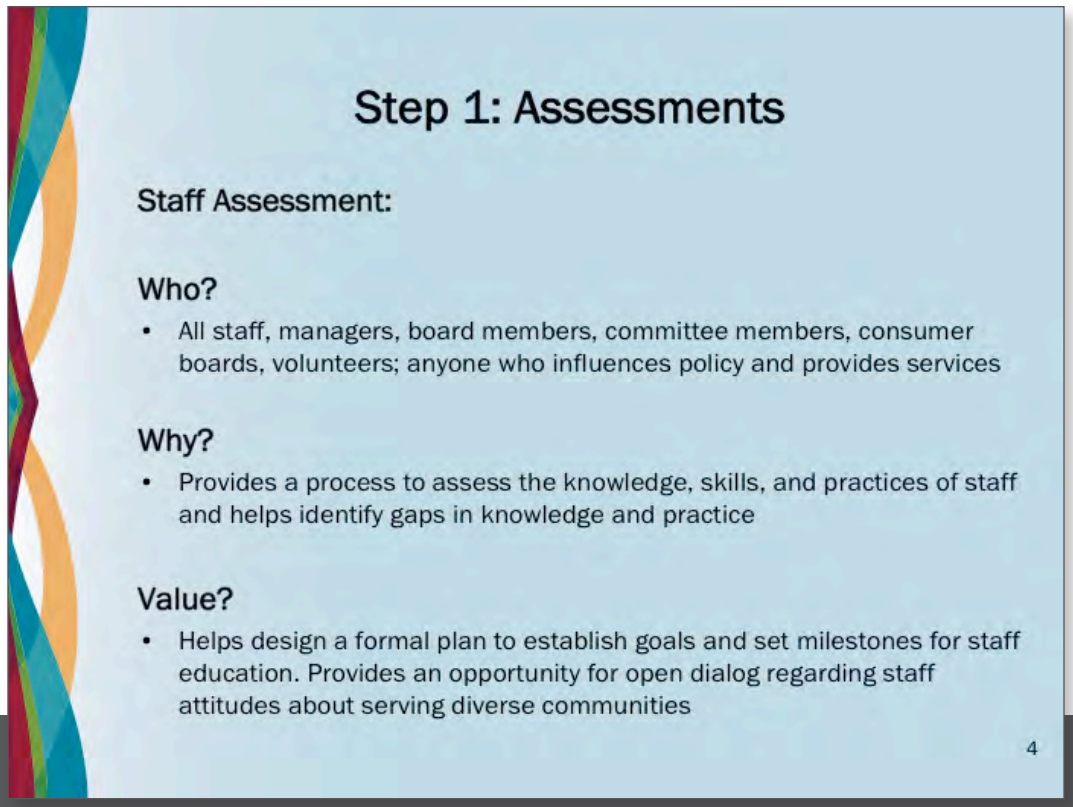

Some Factors that Influence Culture
Personal History/Experience
Religion/Spirituality
Values and Attitudes
Language
Socioeconomic Status
Sexual Orientation
Race
Health Status/Condition
Communication Styles
Literacy
Education
Physical Environment
Geographic Location
Formal/Informal Knowledge
5

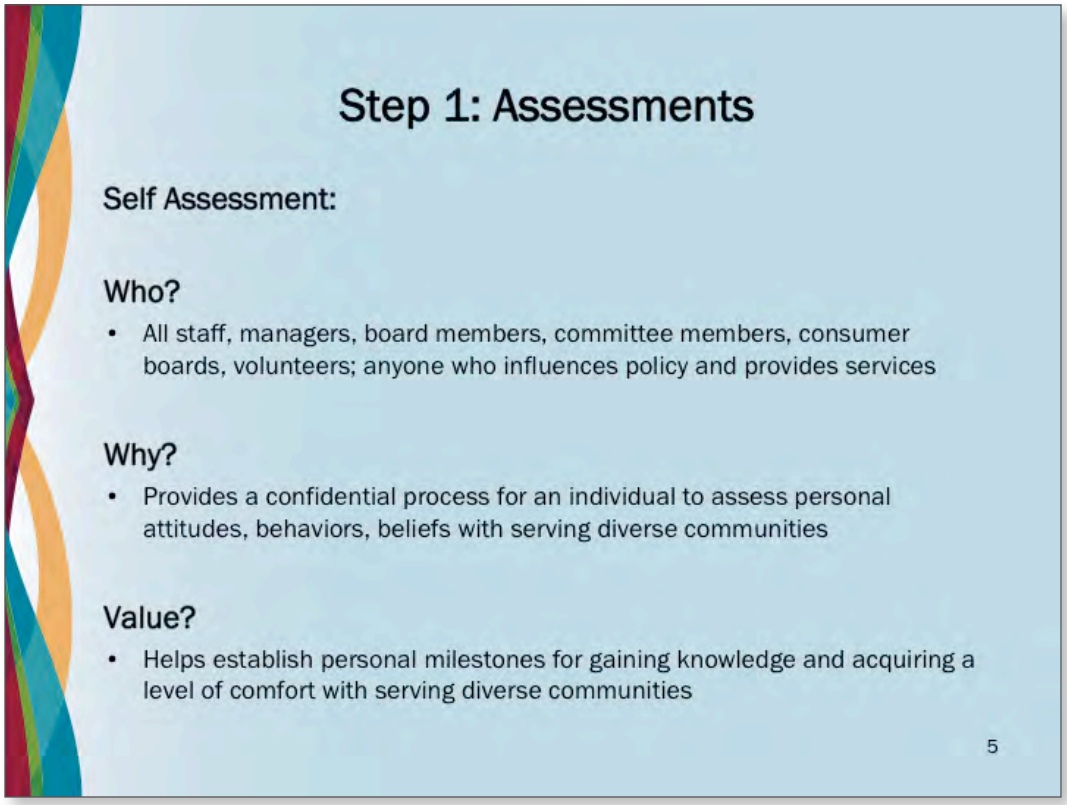

Discussion Question
Based on your agency's experiences, what other factors influence culture?
6


The Steps of Planning Services for Diverse Communities
STEP 1: Assessments
• Organizational assessment: policies, procedures, bylaws, and community perceptions
• Staff assessment: knowledge, skills, and practices
• Self-assessment: personal attitudes, beliefs, and behaviors
STEP 2: Identifying Resources About the Community
• Agency knowledge of the service community
• Partnerships and coalitions with representatives from diverse groups
• Client and community data
• Client input
• Organization and client evaluation of services
• Lessons learned
STEP 4: Program Evaluation
• Delivery of services through marketing and outreach
• Service recipients: clients, caregivers, and community organizations
• Types of services to be delivered
• Time and location of service delivery
• Barriers to service delivery and access
STEP 3: Designing Services
1

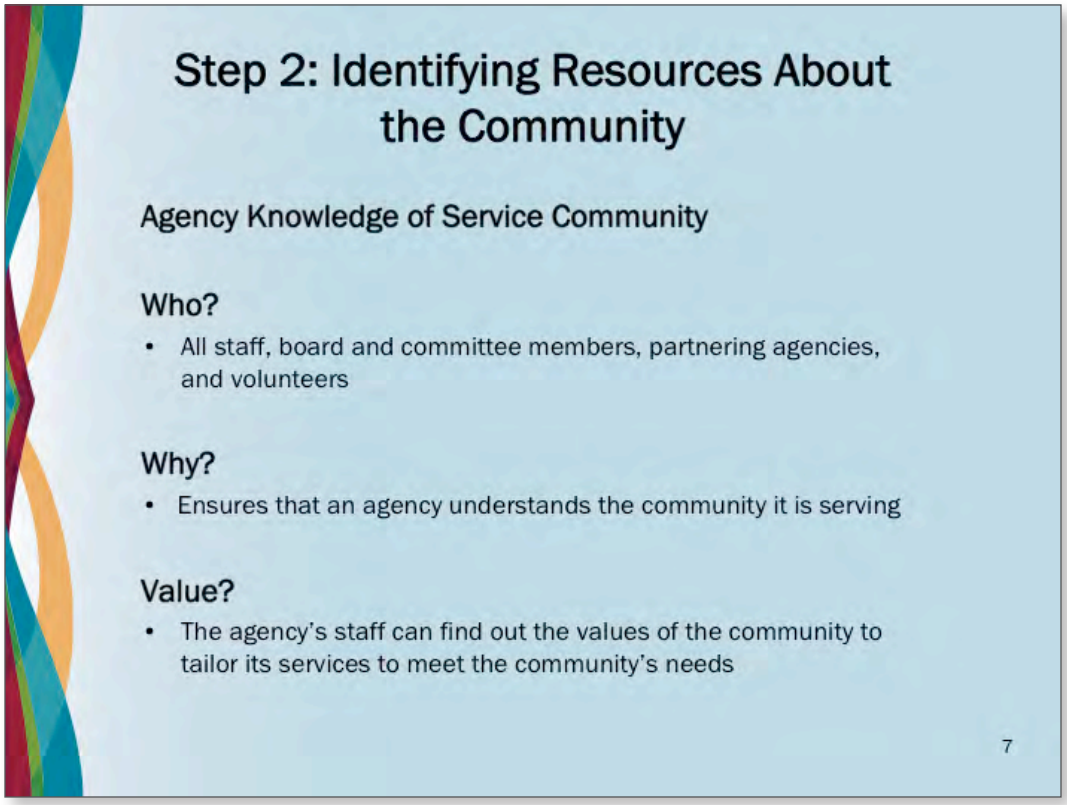

STEP 1: Assessments
• Organizational assessment: policies, procedures, bylaws, and community perceptions
• Staff assessment: knowledge, skills, and practices
• Self-assessment: personal attitudes, beliefs, and behaviors
STEP 2: Identifying Resources About the Community
STEP 4: Program Evaluation
STEP 3: Designing Services
2


Step 1: Assessments
Organizational Assessment:
What?
• The agency
Why?
• Provides a process to assess the policies, procedures, mission statements, and community perceptions of an agency
Value?
• Helps design a formal plan to assess, review, and revise policies and procedures to make them culturally responsive for the agency's service population; it also helps align policy with practice
3

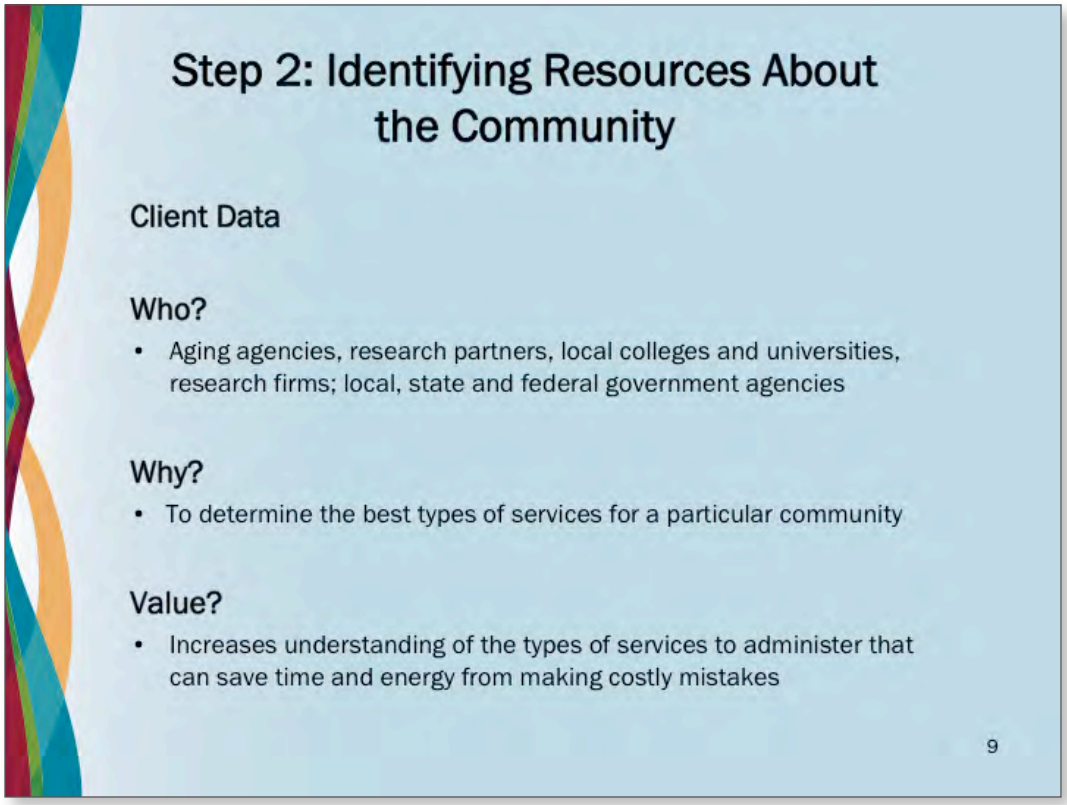

Step 1: Assessments
Staff Assessment:
Who?
• All staff, managers, board members, committee members, consumer boards, volunteers; anyone who influences policy and provides services
Why?
• Provides a process to assess the knowledge, skills, and practices of staff and helps identify gaps in knowledge and practice
Value?
• Helps design a formal plan to establish goals and set milestones for staff education. Provides an opportunity for open dialog regarding staff attitudes about serving diverse communities
4

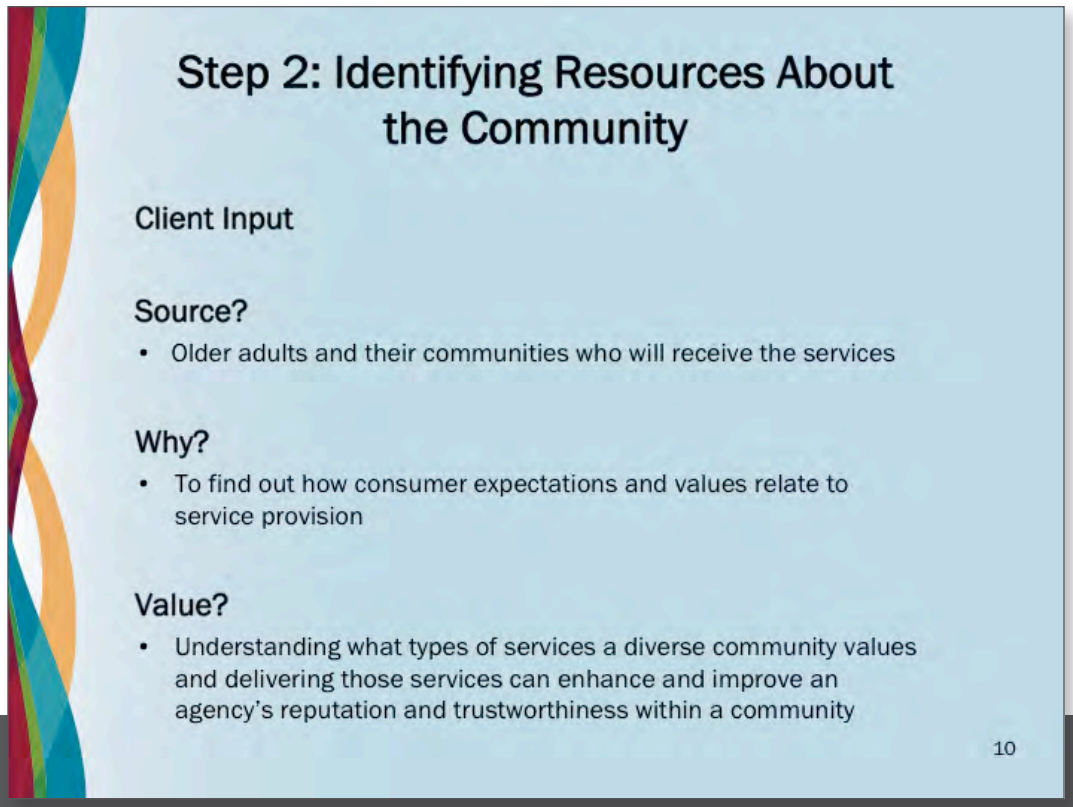

Step 1: Assessments
Self Assessment:
Who?
• All staff, managers, board members, committee members, consumer boards, volunteers; anyone who influences policy and provides services
Why?
• Provides a confidential process for an individual to assess personal attitudes, behaviors, beliefs with serving diverse communities
Value?
• Helps establish personal milestones for gaining knowledge and acquiring a level of comfort with serving diverse communities
5


STEP 2: Identifying Resources About the Community
• Agency knowledge of the service community
• Partnerships and coalitions with representatives from diverse groups
• Client and community data
• Client input
STEP 1: Assessments
STEP 4: Program Evaluation
STEP 3: Designing Services
6

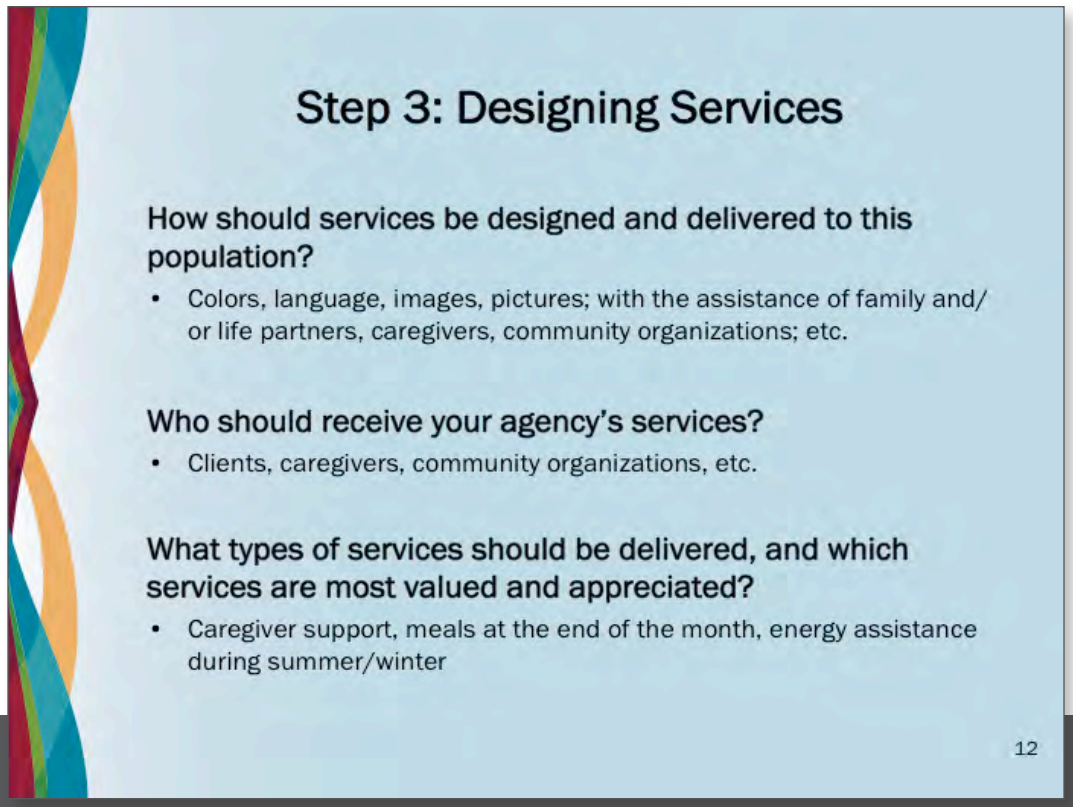

Step 2: Identifying Resources About the Community
Agency Knowledge of Service Community
Who?
• All staff, board and committee members, partnering agencies, and volunteers
Why?
• Ensures that an agency understands the community it is serving
Value?
• The agency's staff can find out the values of the community to tailor its services to meet the community's needs
7


Step 2: Identifying Resources About the Community
Partnerships and Coalitions with Representatives from Diverse Groups
Who?
• Trusted and valued representatives from diverse service areas
Why?
• Creates an opportunity to gain credibility through associations with individuals and groups the diverse community trusts
Value?
• Provides an authentic opportunity for learning: cross-training, consulting, and collaborative service provision
8


Step 2: Identifying Resources About the Community
Client Data
Who?
• Aging agencies, research partners, local colleges and universities, research firms; local, state and federal government agencies
Why?
• To determine the best types of services for a particular community
Value?
• Increases understanding of the types of services to administer that can save time and energy from making costly mistakes
9


Step 2: Identifying Resources About the Community
Client Input
Source?
• Older adults and their communities who will receive the services
Why?
• To find out how consumer expectations and values relate to service provision
Value?
• Understanding what types of services a diverse community values and delivering those services can enhance and improve an agency's reputation and trustworthiness within a community
10


STEP 1: Assessments
STEP 2: Identifying Resources About the Community
STEP 4: Program Evaluation
• Delivery of services through marketing and outreach
• Service recipients: clients, caregivers, and community organizations
• Types of services to be delivered
• Time and location of service delivery
• Barriers to service delivery and access
STEP 3: Designing Services
11


Step 3: Designing Services
How should services be designed and delivered to this population?
• Colors, language, images, pictures; with the assistance of family and/or life partners, caregivers, community organizations; etc.
Who should receive your agency's services?
• Clients, caregivers, community organizations, etc.
What types of services should be delivered, and which services are most valued and appreciated?
• Caregiver support, meals at the end of the month, energy assistance during summer/winter
12

## Step 3: Designing Services

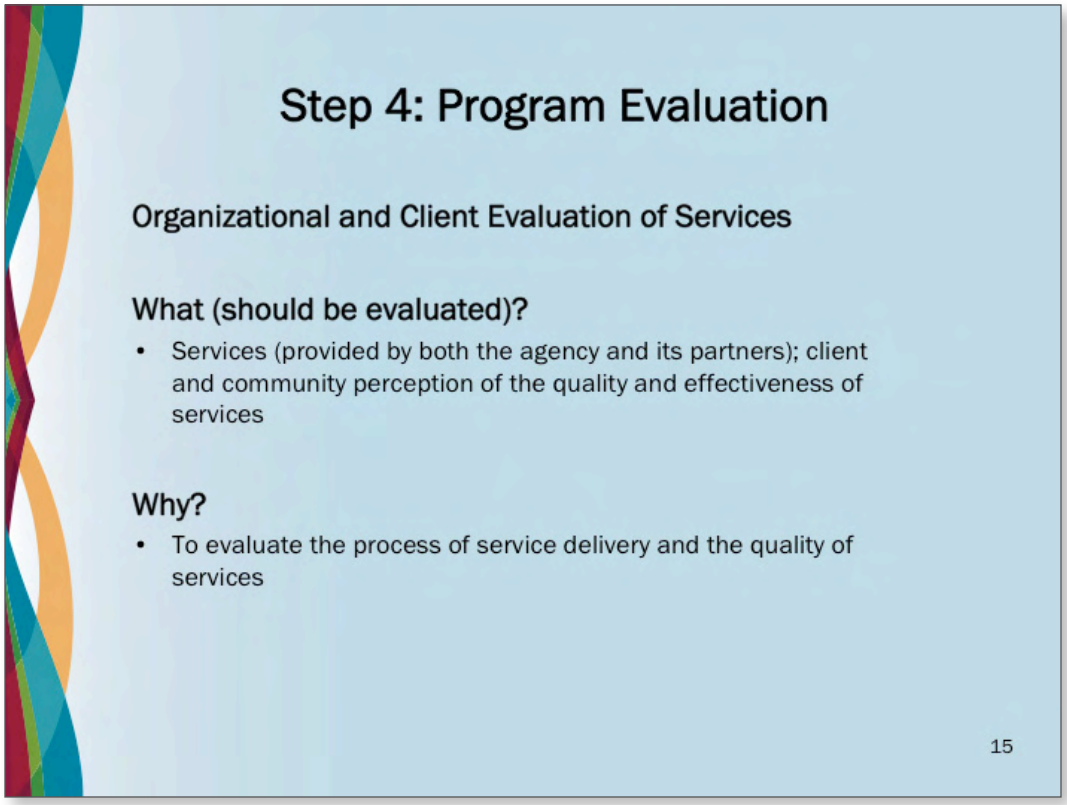
**Where should services be delivered?**

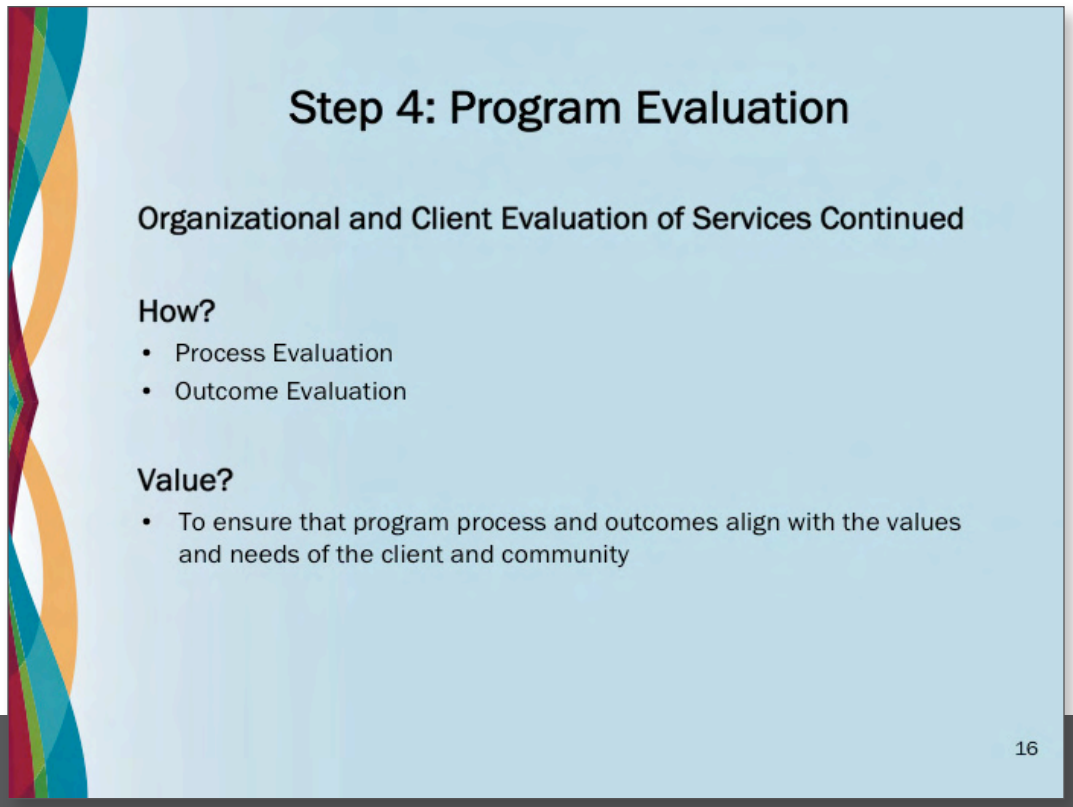
- At trusted community providers, through churches and social groups, in the home, etc.

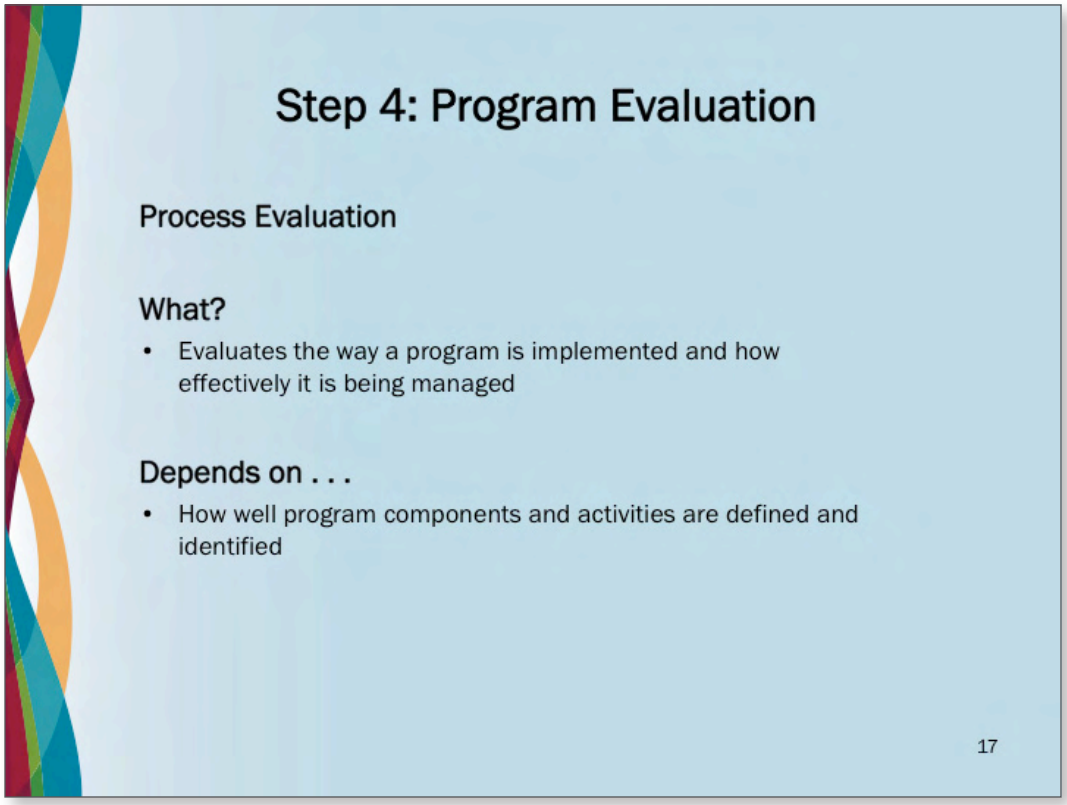
**What are the structural and cultural barriers to services**

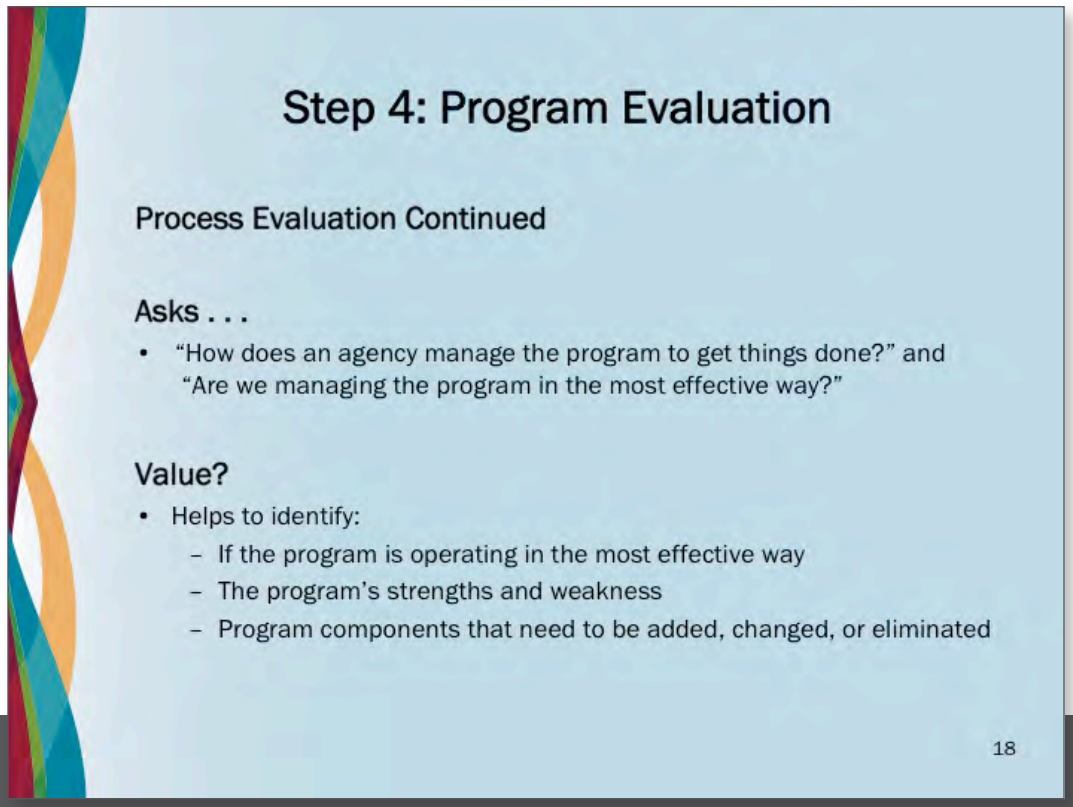
- Family role: grandparent, caregiver, etc.
- Income
- Transportation
- Health status/condition
- Cultural/group values
- Health literacy/language
- Geography/rural environment
- Access for individuals with disabilities
- Environmental conditions/home setting

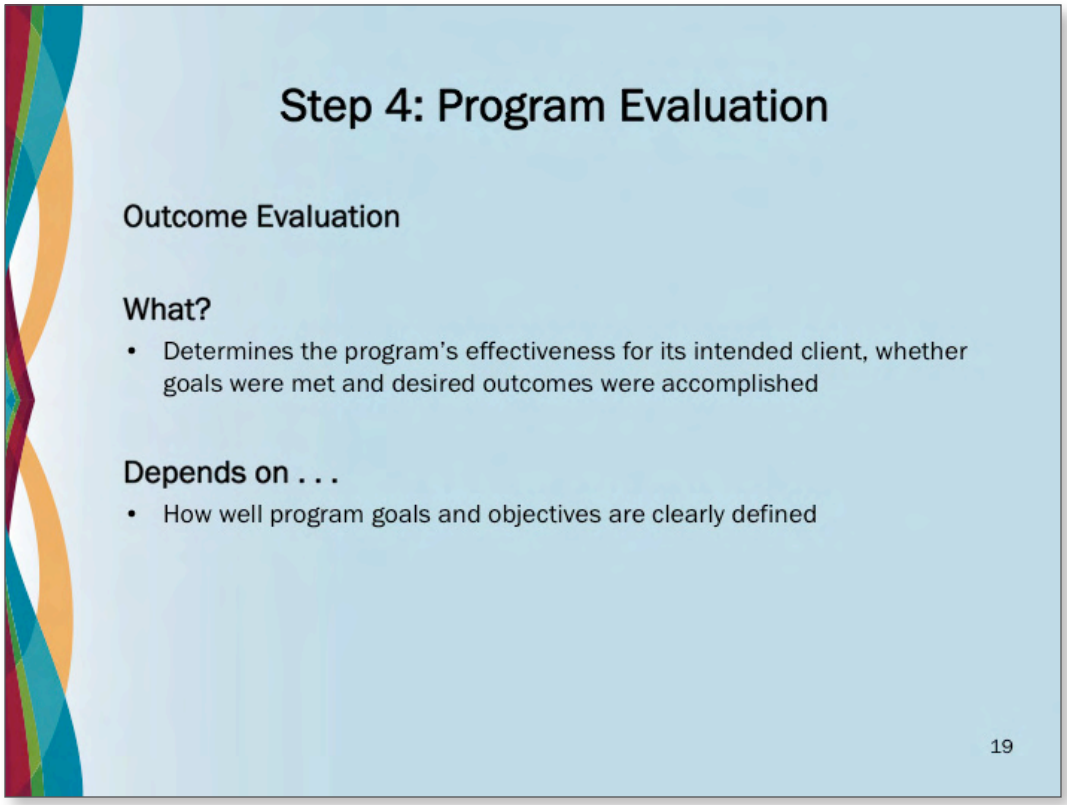
13

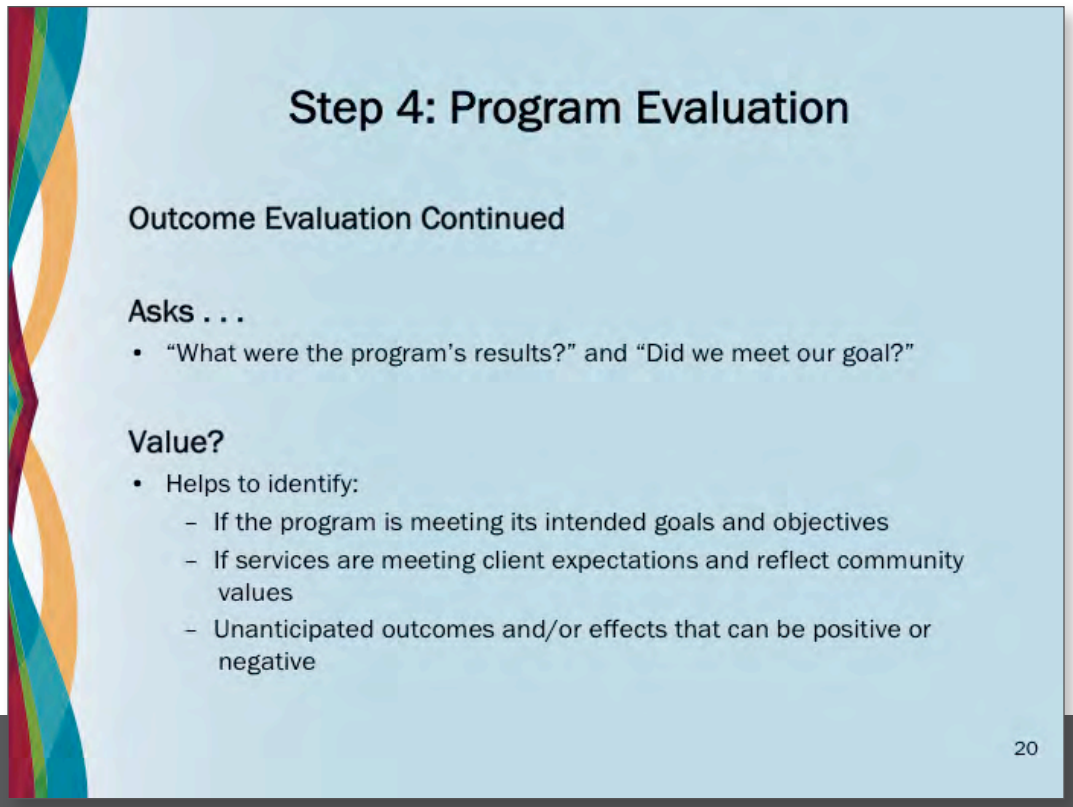

Step 4: Program Evaluation
Organizational and Client Evaluation of Services
What (should be evaluated)?
• Services (provided by both the agency and its partners); client and community perception of the quality and effectiveness of services
Why?
• To evaluate the process of service delivery and the quality of services
15

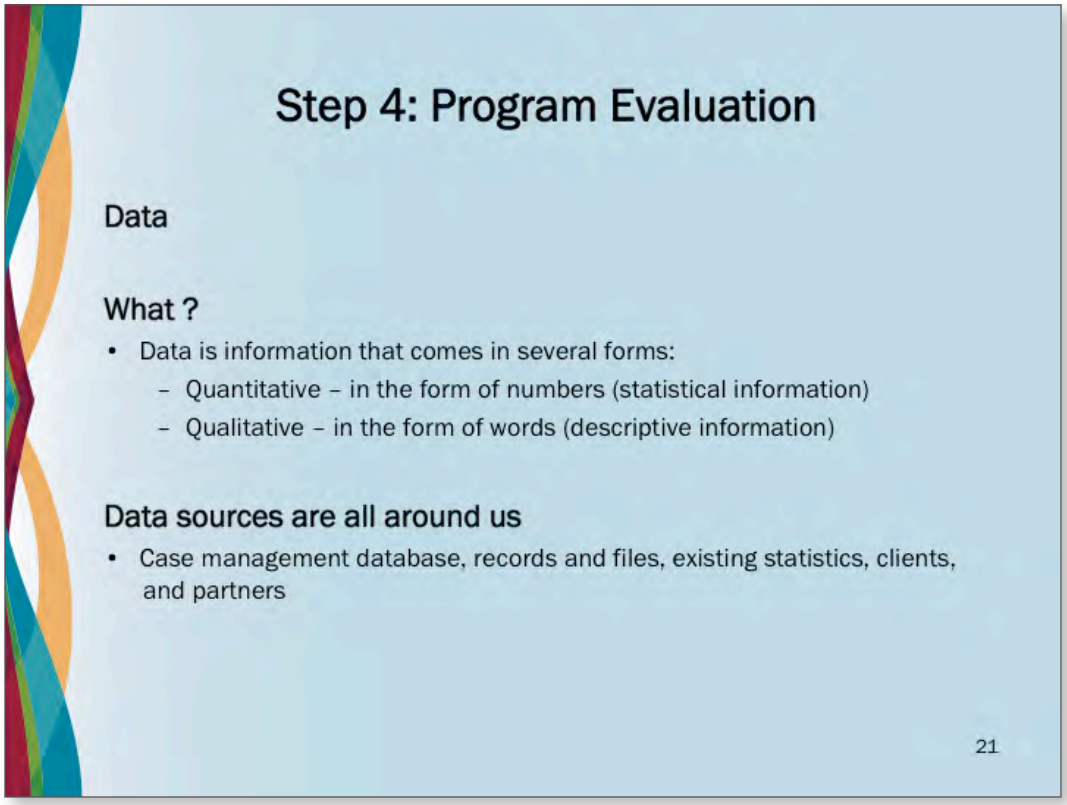

Step 4: Program Evaluation
Organizational and Client Evaluation of Services Continued
How?
• Process Evaluation
• Outcome Evaluation
Value?
• To ensure that program process and outcomes align with the values and needs of the client and community
16

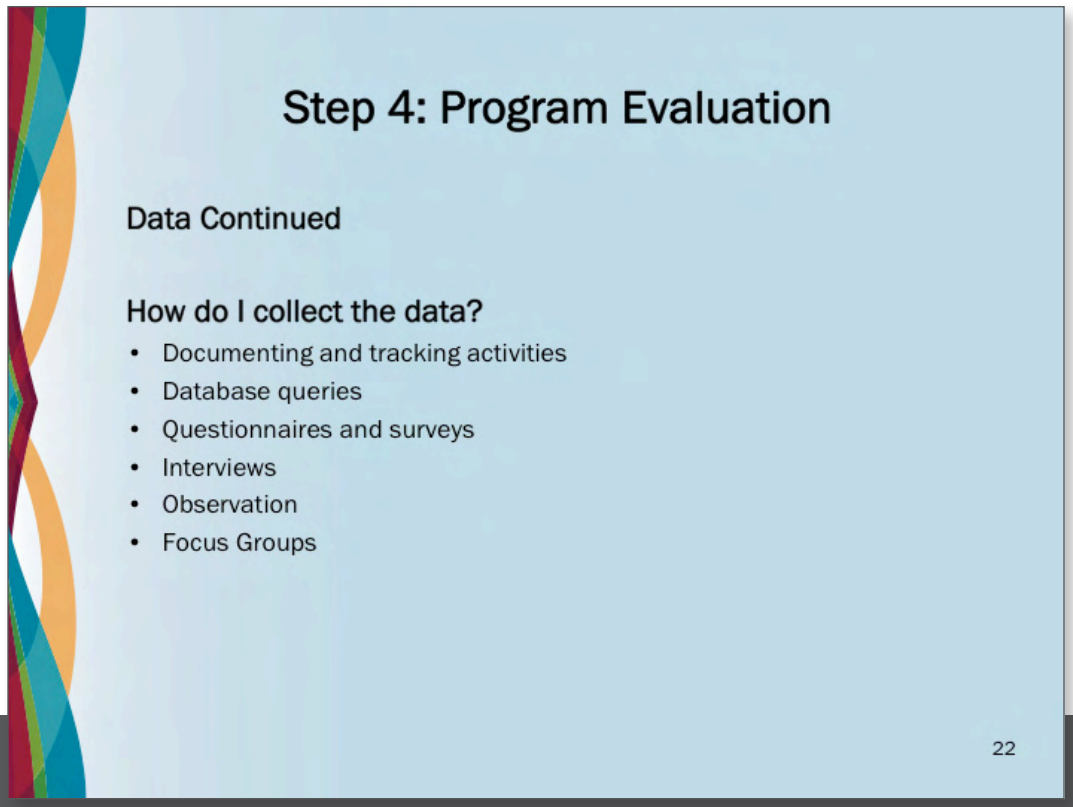

Step 4: Program Evaluation
Process Evaluation
What?
• Evaluates the way a program is implemented and how effectively it is being managed
Depends on . . .
• How well program components and activities are defined and identified
17

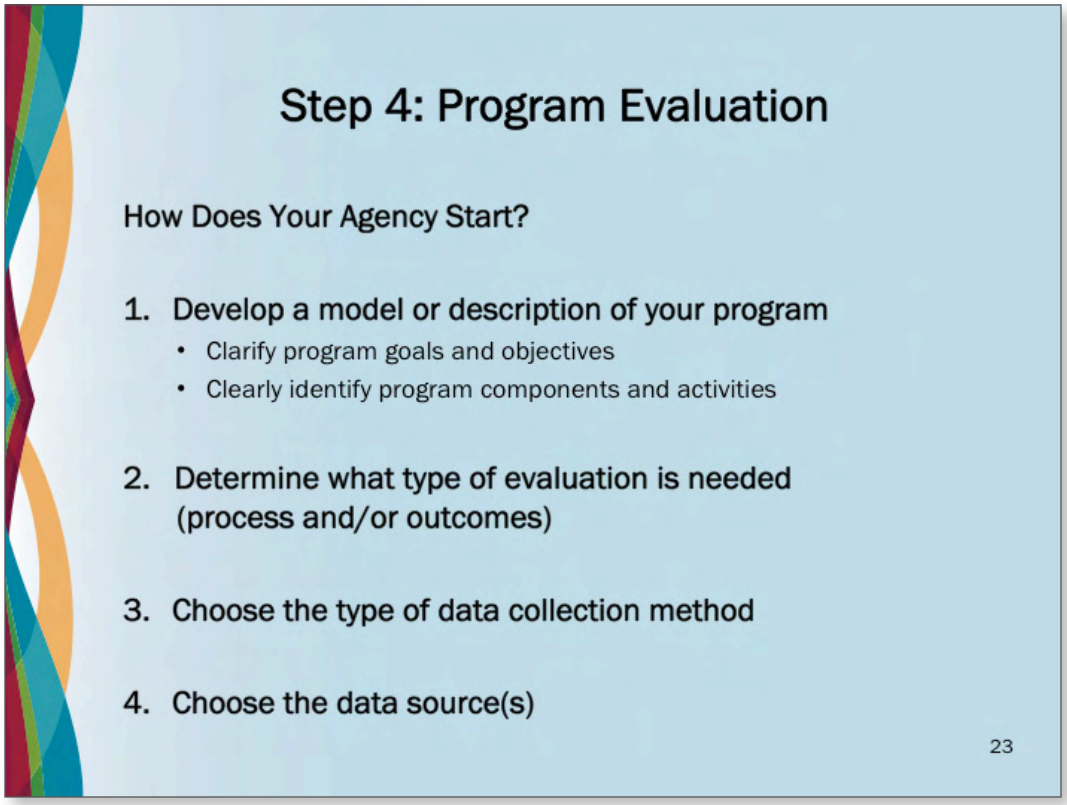

Step 4: Program Evaluation
Process Evaluation Continued
Asks . . .
• "How does an agency manage the program to get things done?" and "Are we managing the program in the most effective way?"
Value?
• Helps to identify:
– If the program is operating in the most effective way
– The program's strengths and weakness
– Program components that need to be added, changed, or eliminated
18

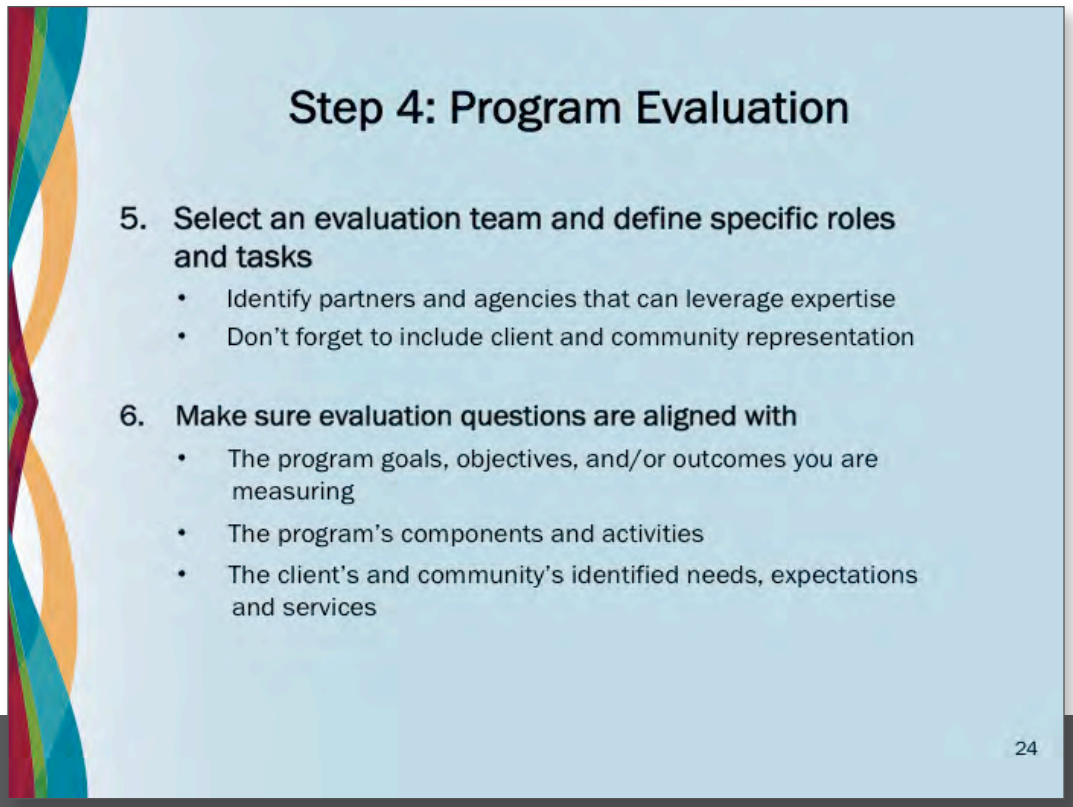

Step 4: Program Evaluation
Outcome Evaluation
What?
• Determines the program's effectiveness for its intended client, whether goals were met and desired outcomes were accomplished
Depends on . . .
• How well program goals and objectives are clearly defined
19

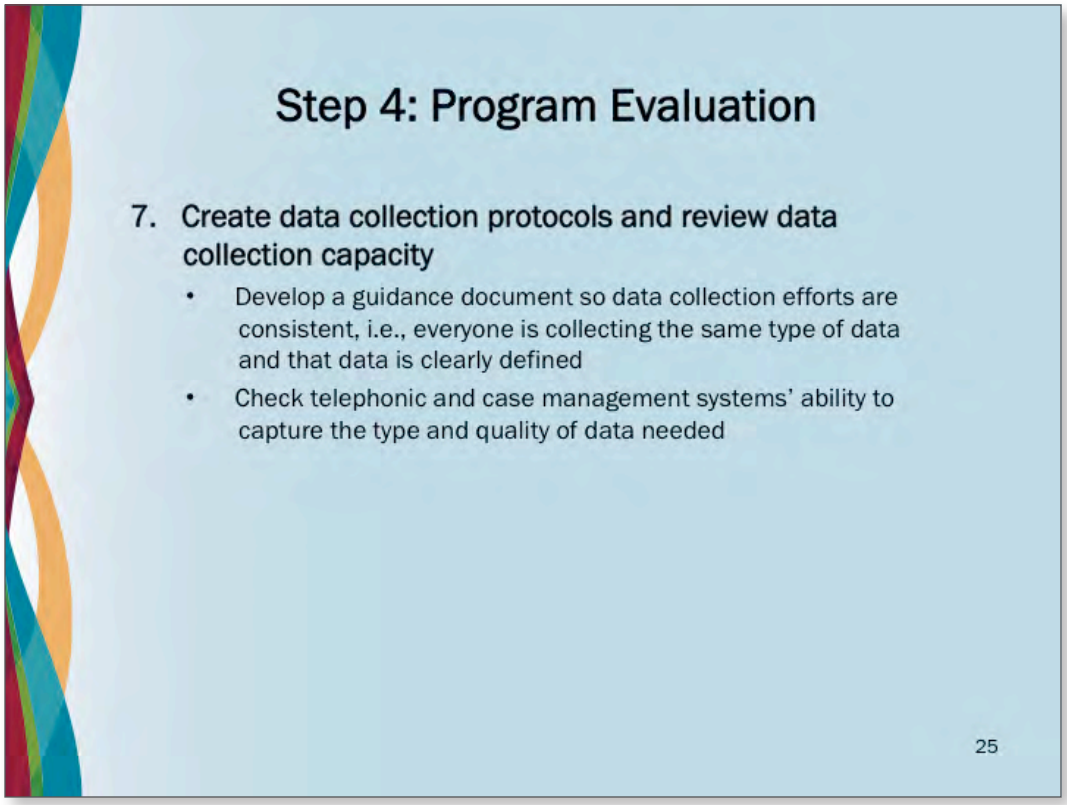

Step 4: Program Evaluation
Outcome Evaluation Continued
Asks . . .
• "What were the program's results?" and "Did we meet our goal?"
Value?
• Helps to identify:
– If the program is meeting its intended goals and objectives
– If services are meeting client expectations and reflect community values
– Unanticipated outcomes and/or effects that can be positive or negative
20

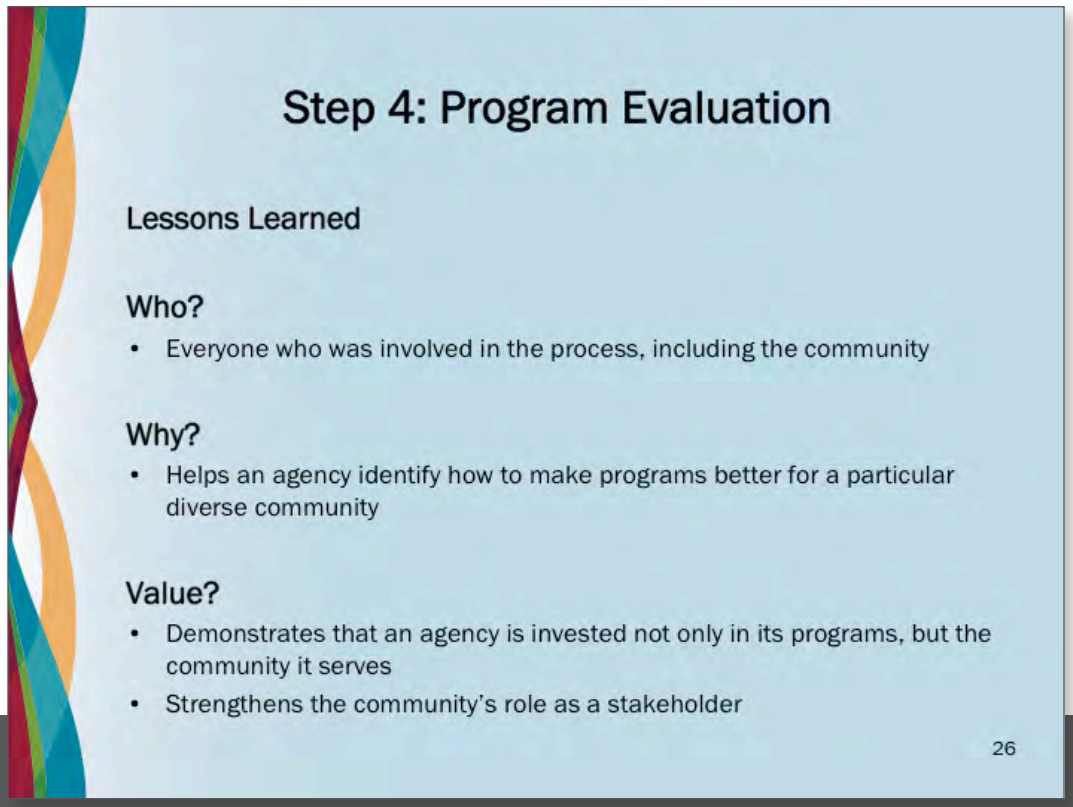

Step 4: Program Evaluation
Data
What ?
• Data is information that comes in several forms:
– Quantitative – in the form of numbers (statistical information)
– Qualitative – in the form of words (descriptive information)
Data sources are all around us
• Case management database, records and files, existing statistics, clients, and partners
21


Step 4: Program Evaluation
Data Continued
How do I collect the data?
• Documenting and tracking activities
• Database queries
• Questionnaires and surveys
• Interviews
• Observation
• Focus Groups
22


Step 4: Program Evaluation
How Does Your Agency Start?
1. Develop a model or description of your program
• Clarify program goals and objectives
• Clearly identify program components and activities
2. Determine what type of evaluation is needed (process and/or outcomes)
3. Choose the type of data collection method
4. Choose the data source(s)
23


Step 4: Program Evaluation
5. Select an evaluation team and define specific roles and tasks
• Identify partners and agencies that can leverage expertise
• Don't forget to include client and community representation
6. Make sure evaluation questions are aligned with
• The program goals, objectives, and/or outcomes you are measuring
• The program's components and activities
• The client's and community's identified needs, expectations and services
24


Step 4: Program Evaluation
7. Create data collection protocols and review data collection capacity
• Develop a guidance document so data collection efforts are consistent, i.e., everyone is collecting the same type of data and that data is clearly defined
• Check telephonic and case management systems' ability to capture the type and quality of data needed
25


Step 4: Program Evaluation
Lessons Learned
Who?
• Everyone who was involved in the process, including the community
Why?
• Helps an agency identify how to make programs better for a particular diverse community
Value?
• Demonstrates that an agency is invested not only in its programs, but the community it serves
• Strengthens the community's role as a stakeholder
26

# Characteristics of Success in Serving Diverse Communities

1

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

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

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

2

## Agency and Staff Responsibility

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

*Everyone has a role to play.*

3

## Maintaining the Balance Between Organizational and Individual Responsibility

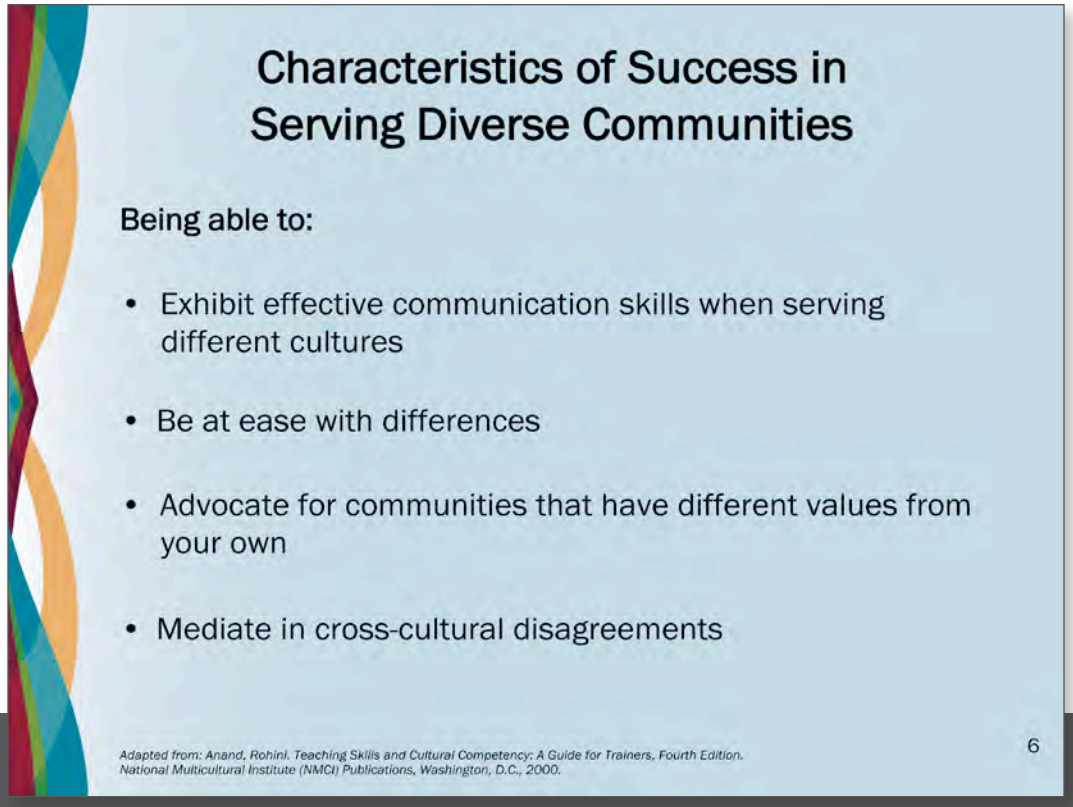
| Organizational Management | | Individual Staff Members |
|---|---|---|
| Value Diversity | | Value Diversity |
| Policies | | Behaviors |
| Structure | | Attitudes |
| Practices | | Practices |

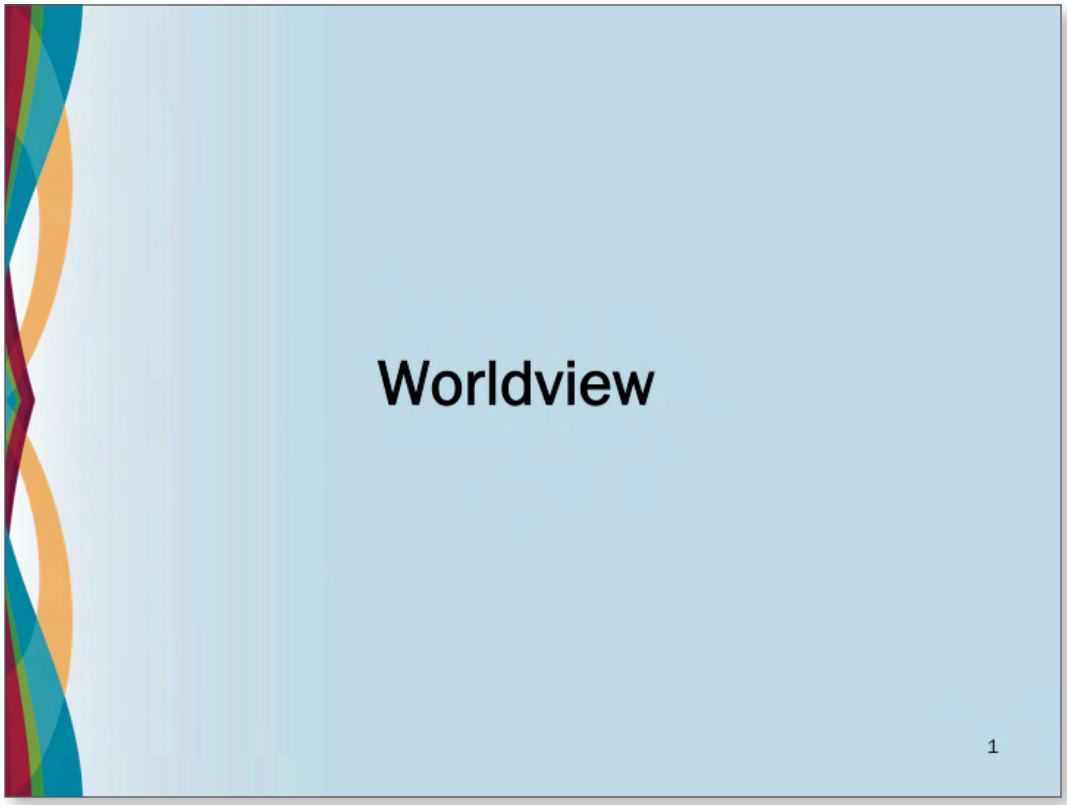
*Adapted from: Cross T., Bazron, B., Dennis, K., and Isaacs, M. Towards a Culturally Competent System of Care, Volume I, Georgetown University Child Development Center, CASSP Technical Assistance Center, Washington, D.C., 1989.*

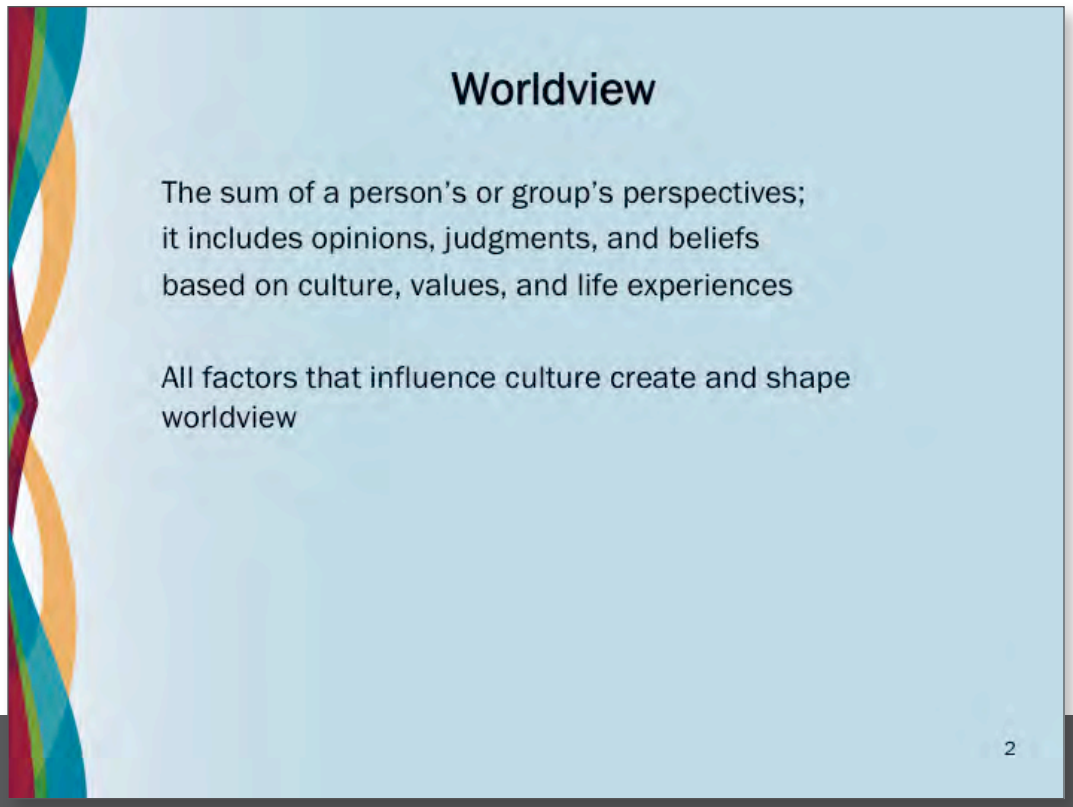
*A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, Georgetown University Center for Child and Human Development, National Center for Cultural Competence, Washington, D.C., 2006.*

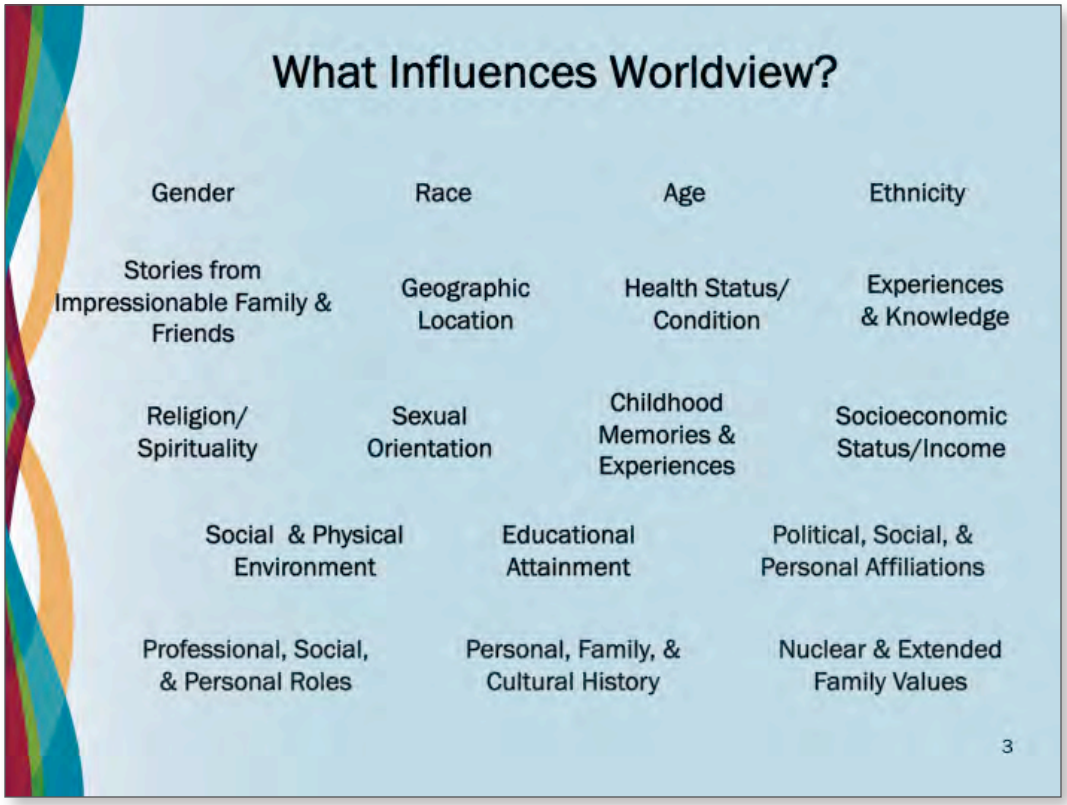
4

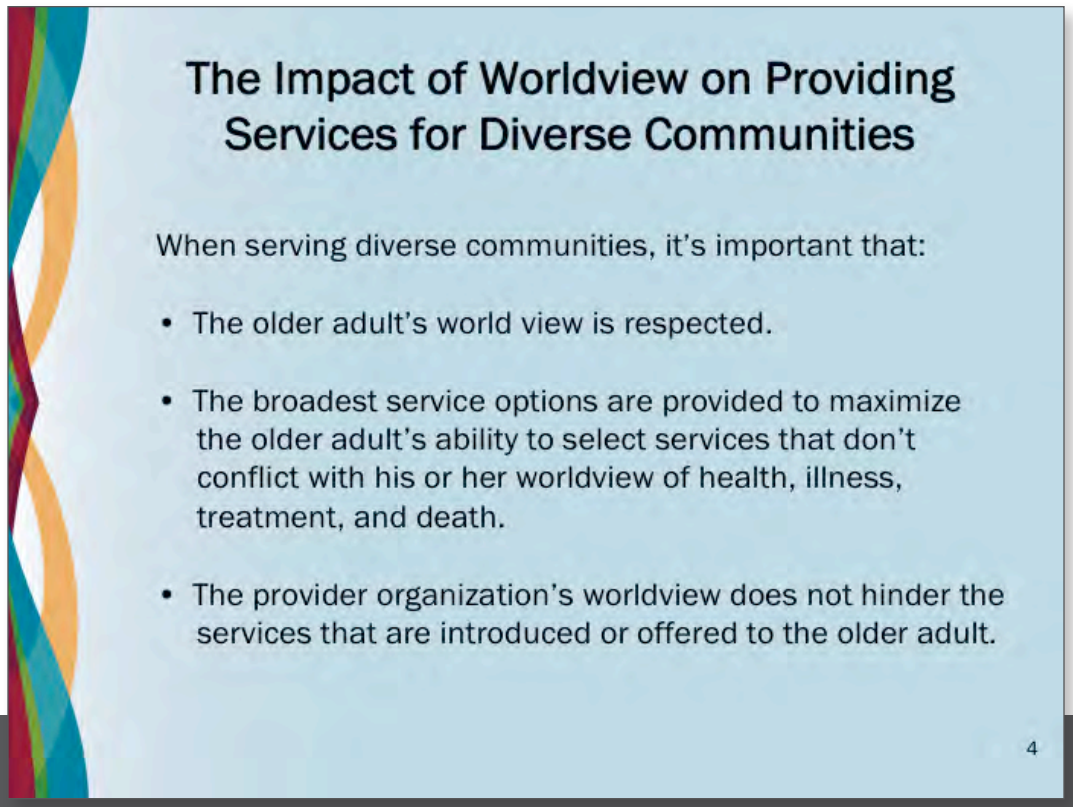

Characteristics of Success in Serving Diverse Communities
Being aware of:
• Your cultural values and biases
• How, why, where, and when you control those biases
• Clients' and their communities' cultures
• Structural and cultural barriers to service
Adapted from: Anand, Rohini. Teaching Skills and Cultural Competency: A Guide for Trainers, Fourth Edition. National Multicultural Institute (NMCI) Publications, Washington, D.C., 2000.
5


Characteristics of Success in Serving Diverse Communities
Being able to:
• Exhibit effective communication skills when serving different cultures
• Be at ease with differences
• Advocate for communities that have different values from your own
• Mediate in cross-cultural disagreements
Adapted from: Anand, Rohini. Teaching Skills and Cultural Competency: A Guide for Trainers, Fourth Edition. National Multicultural Institute (NMCI) Publications, Washington, D.C., 2000.
6


Worldview
1


Worldview
The sum of a person's or group's perspectives; it includes opinions, judgments, and beliefs based on culture, values, and life experiences
All factors that influence culture create and shape worldview
2


What Influences Worldview?
Gender
Race
Age
Ethnicity
Stories from Impressionable Family & Friends
Geographic Location
Health Status/ Condition
Experiences & Knowledge
Religion/ Spirituality
Sexual Orientation
Childhood Memories & Experiences
Socioeconomic Status/Income
Social & Physical Environment
Educational Attainment
Political, Social, & Personal Affiliations
Professional, Social, & Personal Roles
Personal, Family, & Cultural History
Nuclear & Extended Family Values
3


The Impact of Worldview on Providing Services for Diverse Communities
When serving diverse communities, it's important that:
• The older adult's world view is respected.
• The broadest service options are provided to maximize the older adult's ability to select services that don't conflict with his or her worldview of health, illness, treatment, and death.
• The provider organization's worldview does not hinder the services that are introduced or offered to the older adult.
4


How to Read Your
Medicare Summary Notice

# COMPANION EXERCISES | APPENDIX F

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

## EXERCISE 1: DEFINITION MATCHING

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

Answers to definitions are provided in Appendix B.

## EXERCISE 2: CULTURAL BARRIER OR STRUCTURAL BARRIER

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

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

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

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

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

1. **An agency that lacks wheelchair accessibility.**

   Cultural ☐ or Structural ☐

   **Influence:**

   _____

   _____

   _____

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

   Cultural ☐ or Structural ☐

   **Influence:**

   _____

   _____

   _____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

4. **A client requesting a sign-language interpreter.**

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

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

Cultural ☐ or Structural ☐

**Influence:**

_____

_____

_____

## EXERCISE 3: TECHNICAL OR OPERATIONAL KNOWLEDGE?

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

**Technical knowledge is understanding how to serve diverse populations:** "I can tell you."

**Operational knowledge is demonstrating how to serve diverse populations:** "I can show you."

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

Technical ☐
Operational ☐

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

# LIST OF ONLINE RESOURCES | APPENDIX G

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

## STEP 1: ASSESSMENT RESOURCES

### Organizational and staff assessments

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

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

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

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

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

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

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

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

### Self-assessments

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

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

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

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

### Assessment tools

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

## STEP 2: IDENTIFYING RESOURCES ABOUT THE COMMUNITY

### Agency knowledge of service community

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

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

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

## Partnerships and coalition building

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

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

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

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

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

## Client and community data

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

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

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

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

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

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

*National Healthcare Disparities Report*
Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
http://www.ahrq.gov/qual/qrdr08.htm

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

*Office of Refugee Resettlement, Administration of Children and Families*
U.S. Department of Health and Human Services
http://www.acf.hhs.gov/programs/orr/data/05arc10appendixC.htm

*Racial and Ethnic Populations, Office of Minority Health and Health Disparities*
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
http://www.cdc.gov/omhd/Populations/populations.htm

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

*Selected Long-Term Care Statistics*
Family Caregiver Alliance
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440

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

*Trends in Vision and Hearing Among Older Americans*
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
http://www.cdc.gov/nchs/data/ahcd/agingtrends/02vision.pdf

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

*Women and Caregiving: Facts and Figures*
Family Caregiver Alliance
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=892

## Client input

*Basics of Conducting Focus Groups*
Free Management Library
http://www.managementhelp.org/grp_skll/focusgrp/focusgrp.htm

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

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

## STEP 3: DESIGNING SERVICES

### Outreach/Marketing

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

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

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

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

### Service design and delivery

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

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

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

*Cultural Competency*
Homestead Schools, Inc. – Social Work

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

### Serving diverse communities: challenges, barriers, and best practices

*Strategy Brief: Ombudsman Program Responses to Diversity*
National Association of State Units on Aging
http://www.nasua.org/pdf/Diversity%20Dialogue.pdf

*Chronic Disease and Pain Management – Part I PowerPoint Presentation*
Hee Yun Yee, Ph.D., Assistant Professor, School of Social Work, University of Minnesota
http://www.cehd.umn.edu/SSW/ContinuingEd/Documents/Module%206/Chronic%20Disease%20-%20Part%20I.pdf

*Health Literacy and Cultural Competency*
*Chronic Disease and Pain Management Fact Sheet*
School of Social Work, University of Minnesota
http://www.cehd.umn.edu/ssw/ContinuingEd/Documents/Module%206/Reading%20guide%20-%20Module%206.pdf

*Promising Practices Issue Brief: Respecting Diversity*
*Reaching Out Through Local Elder Abuse Networks*
National Center on Elder Abuse
http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/PromisingPracticesRespectingDiversity.pdf

*Senior Nutrition Programs: Promising Practices for Diverse Populations*
New Jersey Department of Health and Senior Services
http://www.state.nj.us/health/senior/nutrition/documents/nutrition.pdf

## STEP 4: PROGRAM EVALUATION

### Organization and client evaluation of services

*Basic Guide to Program Evaluation*
Carter McNamara, M.B.A., Ph.D.
http://208.42.83.77/evaluatn/fnl_eval.htm

*An Evaluation Framework for Community Health Programs*
The Center for Advancement of Community Based Public Health
http://www.cdc.gov/eval/evalcbph.pdf

*Everything You Wanted to Know About Logic Models but Were Afraid to Ask*
Connie C. Schmitz and Beverly A. Parsons, InSites
http://www.insites.org/documents/logmod.htm

*Engaging New Families in Evaluation*
Federation of Families for Children's Mental Health
http://ffcmh.org/wp-content/uploads/2009/pdffiles/Engaging%20New%20Families%20in%20Evaluation%20-%20Eng.pdf
Spanish version: http://ffcmh.org/wp-content/uploads/2009/pdffiles/Engaging%20New%20Families%20in%20Evaluation%20-%20Spa.pdf

*A Framework for Program Evaluation: The Logic Model and Evaluation Framework*
Center for Addiction and Mental Health, University of Toronto
http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/AFrameworkforProgramEvaluation.aspx

*How Do Measures Measure Up?*
Evangeline Danesco, Ph.D.
The Provincial Center of Excellence for Child and Youth Mental Health
http://onthepoint.smartsimple.biz/files/237865/f93611/Measures_Webinar_Slides_EN.ppt

*The Legality of Collecting and Disclosing Patient Race and Ethnicity Data*
Robert Wood Johnson Foundation and The George Washington University Medical Center
http://www.rwjf.org/files/publications/other/RaceEthnicDisparitiesData06222006.pdf

*Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process*
Judi Aubel, Ph.D., M.P.H.,
Child Survival Technical Support Project and Catholic Relief Services
http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf

*Tools for Measuring Health Conditions*
Resource Centers for Minority Aging Research, National Institute on Aging
National Institutes of Health, U.S. Department of Health and Human Services
http://www.musc.edu/dfm/RCMAR/RCMARTools.html

*Toward Culturally Competent Evaluation in Health and Mental Health*
The California Endowment
http://www.calendow.org/uploadedFiles/Publications/Evaluation/toward_culturally_competent_evaluation.pdf

*Types of Program Evaluation*
Center for Addiction and Mental Health, University of Toronto
http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/TypesofProgramEvaluation.aspx

### Lessons learned

*Ensure Use of Evaluation Findings and Lessons Learned (tobacco cessation)*
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/chapter6.pdf

*Family Engagement in Evaluation: Lessons Learned*
Federation of Families for Children's Mental Health
http://ffcmh.org/researchandpublications/FamilyEngagementinEvaluation.pdf

## ONLINE RESOURCES ON DIVERSE POPULATIONS

A

### African-American/Black

*Adaptation of an HIV Prevention Curriculum for Use With Older African American Women*
Journal of the Association of Nurses in AIDS Care
http://www.oneloveca.org/_files/_files/5245_california-CorneliusOlderAAfemHIVp08.pdf

*African Americans and Alzheimer's Disease: The Silent Epidemic*
Alzheimer's Association
http://www.alz.org/Resources/Diversity/downloads/AA_EDU-SilentEpidemic.pdf

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

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

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

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

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

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

## American Indian and Alaskan Native

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Asian American and Pacific Islander

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

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

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

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

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

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

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

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

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

C

## Caregiving

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

## Cultural Competence & Diversity Guidance, Resources, and Training Materials

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

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

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

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

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

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

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

*Cultural Complementarity™ Model*
Greater Twin Cities United Way
http://www.unitedwaytwincities.org/ourimpact/culturaldynamics_complementarity.cfm

*Culture and Diversity Tip Sheet*
Prevention by Design
http://socrates.berkeley.edu/~pbd/pdfs/Culture_Diversity.pdf

*Cultural Competence Resources for Health Care Providers*
Health Resources Services Administration, U.S. Department of Health and Human Services
http://www.hrsa.gov/culturalcompetence/

*Curriculula Enhancement Module Series*
National Center for Cultural Competence, Georgetown University Center for Child and Human Development
http://www.nccccurricula.info/

*Diversity and Equity*
National Association of Social Workers
http://www.socialworkers.org/diversity/default.asp

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

*Multicultural Toolkit: Toolkit for Cross-Cultural Collaboration*
Awesome Library, Evaluation and Development Institute
http://www.awesomelibrary.org/multiculturaltoolkit.html

National Center for Cultural Competence, Georgetown University
http://www11.georgetown.edu/research/gucchd/nccc

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

Network of Multicultural Aging (NOMA)
An American Society on Aging Constituent Group
http://www.asaging.org/networks/index.cfm?cg=NOMA

*New Ventures in Leadership: A Leadership Program for Professionals of Color in Aging*
American Society on Aging
http://www.asaging.org/nvl/index.cfm

The Office of Minority Health, U.S. Department of Health and Human Services
http://minorityhealth.hhs.gov/

*Opening the Door to the Inclusion of Transgender People: The Nine Keys to Making Lesbian, Gay, Bisexual and Transgender Organizations Fully Transgender-Inclusive*
National Gay and Lesbian Task Force Policy Institute and National Center for Transgender Equality
http://www.thetaskforce.org/downloads/reports/reports/opening_the_door.pdf

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

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

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

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

D

## Dementia/Alzheimer's Disease

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

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

## Disability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E

## English as a Second Language (ESL)

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

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

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

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

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

H

## Health Disparities and Minority Health

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

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

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

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

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

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

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

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

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

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

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

## Health Literacy

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

## Hispanic/Latino American

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

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

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

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

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

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

## HIV/AIDS

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

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

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

*Research on Older Adults with HIV*
AIDS Community Research Initiative of America
http://acria.org/clinical/roah_05_05_08_final.pdf

*Persons Aged 50 and Older: Prevention Challenges*
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
http://www.cdc.gov/hiv/topics/over50/print/challenges.htm

*What Are HIV Prevention Needs of Adults Over 50?*
Center for AIDS Prevention Studies, University of California, San Francisco
http://www.caps.ucsf.edu/pubs/FS/over50.php

## Homeless

*Homeless and Elderly: Understanding the Special Health Care Needs of Elderly Persons Who Are Homeless*
Health Resources and Services Administration, U.S. Department of Health and Human Services
http://bphc.hrsa.gov/policy/pal0303.htm

*Homeless Policy Academies: Improving Access to Mainstream Services for People Experiencing Homelessness*
Health Resources and Services Administration, U.S. Department of Health and Human Services
http://www.hrsa.gov/homeless/state/index.htm

*Homelessness Among Elderly Persons*
National Coalition for the Homeless
http://www.nationalhomeless.org/factsheets/elderly.html

*Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*
Health Resources and Services Administration, U.S. Department of Health and Human Services
http://www.nhchc.org/Curriculum/module2/module2D/module2d.htm

I

## Immigrant

*A Guide for Providers: Engaging Immigrant Seniors in Community Service and Employment Programs*
Senior Service America and the Center for Applied Linguistics
http://www.seniorserviceamerica.org/news/cal_guide.html

U.S. Committee for Refugees and Immigrants
http://www.refugees.org/article.aspx?id=2080&subm=178&area=Participate&

L

## Legal

*Americans' Diversity Guide*
*Chapter 4: Laws, Executive Orders, and Standards*
National Association of State Units on Aging
http://www.nasua.org/issues/tech_assist_resources/national_aging_ir_support_ctr/diversity_guide/diversitychapter4.html

*Cultural Competency Legislation*
*Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs*
The Office of Minority Health, U.S. Department of Health and Human Services
https://www.thinkculturalhealth.org/cc_legislation.asp

*Durable Powers of Attorney and Revocable Living Trusts*
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=434

*Legal Information & Resources*
National Center for Lesbian Rights
http://www.nclrights.org/site/PageServer?pagename=legal_getHelp

*Legal Issues for LGBT Caregivers*
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=436

*Legal Issues in Planning for Incapacity*
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=437

*LGBT Elder Law: Toward Equity In Aging*
Harvard Journal of Law and Gender
http://www.law.harvard.edu/students/orgs/jlg/vol321/1-58.pdf

*Protective Proceedings: Guardianships and Conservatorships*
Family Caregiver Alliance, National Center on Caregiving
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=431

## Lesbian, Gay, Bisexual and Transgender (LGBT)

*Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients*
Gay, Lesbian, Bisexual and Transgender Health Access Project
http://www.glbthealth.org/CommunityStandardsofPractice.htm

*Do We Intend to Keep this Closeted?*
Edward H. Thompson, Jr., The Gerontologists
http://gerontologist.gerontologyjournals.org/cgi/content/full/48/1/130

*Is Your Area Agency on Aging LGBT Friendly?*
SageConnect
http://sageconnect.net/intranet/pops/pop_print.cfm?pop=61

*Is Your "T" Written in Disappearing Ink? A Checklist for Transgender Inclusion*
FORGE & Transgender Aging Network
http://www.forge-forward.org/handouts/InclusionChecklist.pdf

*Lesbian, Bisexual and Transgender Female Elders*
National Gay and Lesbian Task Force
http://www.thetaskforce.org/downloads/misc/LBTFemaleEldersFactSheet.pdf

*Lesbian, Gay, Bisexual and Transgender Elders*
Aging Times, National Center for Gerontological Social Work Education
http://depts.washington.edu/geroctr/AT/2_3/lgbt.html

*Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues*
FORGE and Transgender Aging Network
http://www.forge-forward.org/handouts/tgelderabuse-neglect.html

*LGBT Aging Issues Network (LAIN)*
An American Society on Aging Constituent Group
www.asaging.org/lgain

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

*Make Room for All: Diversity, Cultural Competency and Discrimination in an Aging America*
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*Module for Human Behavior and Social Environment Sequence*
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Council on Social Work Education, California State University, Long Beach
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*State and Local Directory of LGBT Advocacy and Service Organizations*
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FORGE & Transgender Aging Network
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*Transgender Elders and SOFFAs: A Primer for Service Providers and Advocates*
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Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
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http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-158.pdf

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

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

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

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National Center for Cultural Competence, Georgetown University
http://www11.georgetown.edu/research/gucchd/nccc/body_mind_spirit/index.html

Forum on Religion, Spirituality and Aging
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*Integrating Spirituality into Social Work Practice: The Reflections on Spirituality and Aging (ROSA) Model*
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http://www.ruralhealthweb.org/

*Rural Assistance Center*
Center for Rural Health, School of Medicine and Health Science, University of North Dakota
Rural Policy and Research Institute
http://www.raconline.org/

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V

## Veterans

*Center for Minority Veterans*
U.S. Department of Veterans Affairs
http://www1.va.gov/centerforminorityveterans/

# DIVERSITY TRAINING TIPS | APPENDIX H

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

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

**Establish Training Policies Up Front**

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

**Neutralize the Discussion**

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

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

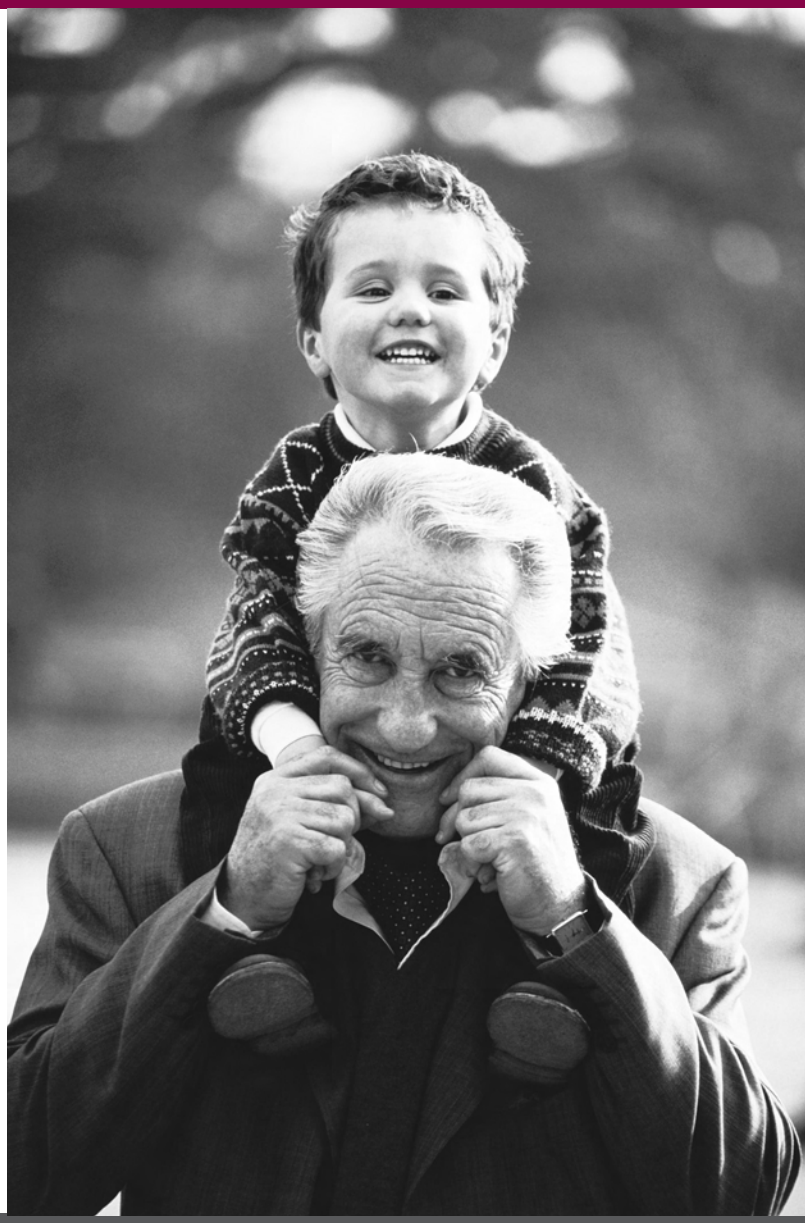
It is important to understand that the act of judging can be both a covert and an overt behavior. A facilitator should be careful about facial expressions and eye contact when participants respond. The facilitator should maintain an open, pleasant disposition when the participants voice opinions. Both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

**Avoid "Touchy Feely" Statements**

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

**Acknowledge "Ouch Moments"**

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



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

**Ask Both Open-Ended and Leading Questions**

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

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

**Checking-In**

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

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

**Schedule Breaks**

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

**Encourage Journaling**

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

**Establish a Learning Wall**

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

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

**Icebreakers and Energizers**

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

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

**Ask for Reporting Out**

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

**Pass the Ball**

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

**Collect Anonymous Lessons Learned**

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

**Thank Participants**

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