ACHIEVING CULTURAL COMPETENCE: A CASE STUDY OF ETHNIC CHINESE ELDERS IN VANCOUVER LONG-TERM RESIDENTIAL CARE

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Abstract

The increasing ethnic diversity in Vancouver's aging population brings challenges to the long-term care (LTC) system to create and deliver culturally appropriate quality services to ethnic minority elders. Several American jurisdictions have introduced a cultural competence framework that assists health care organizations to improve health outcomes and eliminate racial and ethnic health disparities.

The study has two components: a standard questionnaire to interview 40 Chinese-Canadian elders and identify their particular needs; and a survey, adapted from a cultural competence check-list, mailed to 35 care facility administrators in Vancouver. The study demonstrates that Vancouver facilities meet 4 of the 17 cultural competence standards. Specific shortcomings of current policy and practice were described in the elders' interviews. This study analyzes three policy alternatives using four feasibility tests. The recommended strategies propose that Vancouver Coastal Health LTC system implement specified culturally competent health services to reduce administrative and linguistic barriers to patient care.

Executive Summary

This paper examines the problems faced by the growing number of ethnic Chinese elders in the Vancouver area in finding long-term health care facilities that provide culturally appropriate services. Over the next two decades the population of minority elders in urban Canada will grow significantly with the influence of ethnic and cultural differences on the adaptation and psycho-social well-being of the elderly in North America.

The Vancouver aspect of this national problem is demonstrated by the steadily increasing number of ethnic elders on the transfer waiting list for local facilities designed to meet the needs of the Chinese community. In 2002, a new admission system was introduced which assigns priority status to clients according to urgency of need for placement, as opposed to the length of time someone has been on a waitlist for a facility of his or her choice. When the priority access system was first introduced, the policy seemed efficient and equitable. However, unexpected issues of uneven cultural competence in various facilities have emerged that are becoming increasingly severe. They have stimulated the research undertaken in this paper.

The paper researched the problem from two different perspectives, that of facility administrators and of ethnic clients. The principal research methods used were the following:

1) Specially designed questionnaires mailed to all long-term care administrators in Vancouver area evaluating the cultural competence level at each facility. Four elite interviews were conducted to understand specific challenges and barriers. The survey results were used to rank each facility on a cultural competence continuum derived from standards currently employed in several US jurisdictions. The research findings demonstrated that the majority of the Vancouver facilities are not practising adequate cultural competence interventions.

2) Structured face-to-face interviews conducted with ethnic Chinese elders to identify their unique cultural needs and how culturally insensitive practices in an integrative facility affect their adaptation process and choice of facilities. The data demonstrate that ethnic Chinese elders residing in Vancouver long-term care (LTC) facilities have a set of culturally specific needs which are not being addressed these unmet needs are causing psycho-social stresses.

What are the possible solutions to the problem of cultural insensitivity faced by ethnic elders seeking culturally competent long-term health care facilities in the Vancouver area? The paper suggests three policy alternatives: 1) status quo; 2) implementation of culturally and linguistically appropriate services (CLAS) practice standards; and 3) incremental implementation of a cultural competence framework. In order to analyze the efficacy of the three alternatives in the Vancouver area, four feasibility criteria are applied: budgetary; administrative; political feasibility, and responsiveness to client needs.

The paper recommends individual facilities choose one of the three alternatives depending on their cultural competence level. For facilities that belong to the "culturally insensitive" category, policy option three "incremental implementation of cultural competence framework" is recommended. A set of nine implementation alternatives were identified during elite interviews and are ranked and recommended for individual facility administrators who have the authority to develop long-term care programs and service in Vancouver.

Dedication

To my parents and my best friend who have sustained me

Acknowledgements

I offer my enduring gratitude to the faculty, staff and my fellow students at the SFU Public Policy Program, who have combined to stimulate my research in our field. I owe particular thanks to Dr. Nancy Olewiler, Dr. John Richards and Dr. Kennedy Stewart for enlarging my vision on social policy and providing guidance and support in the preparation of this project.

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1 Introduction

The demographic profile of Canada's older population is projected to change dramatically in the coming century. In 2001 Statistics Canada projected that the senior population (age 65+) will reach 9.2 million in 2041 – that is, nearly one in four Canadians (Statistics Canada, 2001). Within the same time frame, the population of minority elders in urban Canada is also expected to grow significantly (Public Health Agency Canada, 2005). As part of the increasing recognition of diversity, researchers have become concerned with the influence of ethnic and cultural differences on social life, adaptation and psycho-social well-being of the elderly in North America. Social scientists realize that our multicultural society has not homogenized ethnic elders from diverse origins and that ethnicity continues to serve as a powerful influence in shaping lifestyles and defining the service needs of older Canadians (Geene & Monahan, 1984).

It is conventional wisdom that ethnic families take care of their own. However, this view has been challenged by some. Cuellar and Weeks (1980) conclude that family-provided care-providing is no longer universal among ethic families and the conventional wisdom has led to a lower concern about developing and implementing appropriate services for ethnic elders. Some of the possible reasons that restrict ethnic minority use of elderly health services are cultural isolation (due to language barriers), physical isolation (such as long distances needed to travel to get to health care facilities), and the general lack of services available that are specifically oriented toward and operated by members of respective ethnic groups. It has been found that lack of congruence between culturally defined personal needs and the environmental characteristic of the institution may be a major source of stress for the elderly in long-term care facilities (Espino, 1992).

Ever since the B.C. Ministry of Health introduced a priority access admission system for long-term care in 2002, there has been a drastic increase in the number of ethnic Chinese elders placed on the waiting list requesting to transfer from their integrative long-term care (LTC) facility to a Chinese-specific facility in Vancouver. Why are so many ethnic Chinese minority elderly requesting to transfer? To what extent do language barriers and cultural factors raise challenges for ethnic elderly to access quality long-term care services? In spite of the fact that cultural issues are frequently recognized as important in the management of chronic illness, very

little is known about the unique issues that ethnic elders face in adjusting to a culturally non-congruent long-term care facility (Clark, 1983; Harwood, 1981). This paper examines ethnic Chinese elders as a case study to investigate whether cultural factors are indeed the driving determinants that affect ethnic Chinese elders' choices of facility. There are three additional policy research questions: 1) whether Vancouver LTC facilities do practice and provide culturally competent policies and services ; 2) whether individual facilities have achieved cultural competence levels when assessed against a widely used American cultural competence practice benchmark; and 3) for ethnic elders residing in culturally non-congruent facilities with unmet cultural needs, what are policy alternatives that can address the challenges and barriers faced by these ethnic minority clients.

2 Policy Problem Context

2.1 Background

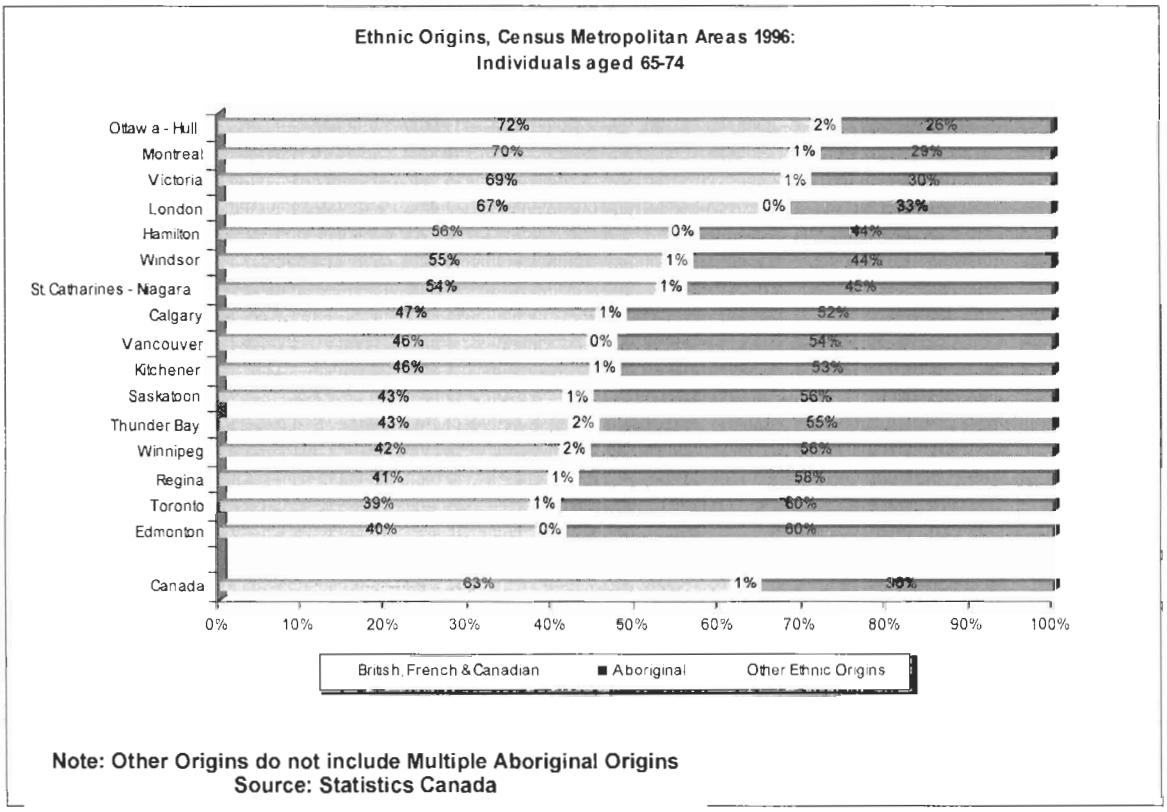
2.1.1 Demographic Profile of Canada's Aging Population

Seniors constitute the fastest growing population group in Canada. In 2001, an estimated 3.92 million Canadians were 65 years of age or older, a figure that is two thirds larger than in 1981. In fact, the growth of the seniors' population will account for close to half of the growth of the overall Canadian population in the next four decades. Major concentrations of this population are in Metropolitan Toronto (13percent), Montreal (11percent) and Vancouver (6percent) (Public Health Agency Canada, 2005).

The fastest growth in the seniors' population is occurring among the oldest Canadians. In 2001, over 430,000 Canadians were 85 years of age or older, more than twice as many as in 1981, and more than twenty times as many as in 1921. The population of Canadians aged 85 or more is expected to grow to 1.6 million in 2041, that is, four percent of the overall population (Statistics Canada, 2001).

Canada's demographic profile in the last two decades is also becoming increasingly diverse. Department of Canadian Heritage's report on the ethnic profiles of Canada's senior age cohorts states that seniors of visible minority or Aboriginal backgrounds accounted for approximately seven percent of the total population sixty-five years or older in 1996 (Canadian Heritage, 2003). The following figure indicates that approximately 54 percent and 60 percent of the population between 65-74 years of age in Vancouver and Toronto respectively were ethnic minorities (non-Aboriginal, non-British and non-French) in 1996.

Figure 1: Ethnic Origins, Census Metropolitan Areas (CMAs) 1996: Individuals aged 65-74.



Each metropolitan area in Canada represents a different mix of ethnic groups. Italian, German and Jewish seniors predominate in Toronto, while Chinese, German and South Asian seniors constitute the dominant groups in Vancouver as shown in Table 1 below (Canadian Heritage, 2003).

Table 1: Top 10 Senior Ethnic Groups, Ranked by 65+ for Canada and Vancouver CMAs

Rank	Ethnic Groups	65+	65-74	75+
Canada				
1	German	257,030	163,445	93,585
2	Italian	120,575	94,170	26,405
3	Ukrainian	114,140	68,520	45,620
4	Dutch	66,355	57,215	29,140
5	Chinese	77,495	51,945	28,290
6	Polish	74,305	46,015	28,290
7	Jewish	56,875	46,015	27,290
8	South Asian	38,230	29,585	10,755
9	Aboriginal	34,760	27,475	11,050
10	Norwegian	28,260	16,360	11,900
Vancouver				
1	Chinese	25,750	17,305	8,445
2	German	16,505	10,270	6,235
3	South Asian	8,070	5,640	2,430
4	Ukrainian	6,240	3,435	2,805
5	Dutch	5,535	3,615	1,920
6	Italian	5,365	3,620	1,745
7	Polish	4,005	2,400	1,605
8	Norwegian	3,330	1,925	1,405
9	Swedish	3,160	1,790	1,370
10	Jewish	1,765	460	1,305

Data Source: Department of Canadian Heritage, 2003

Among the 25,750 elders of Chinese heritage residing in Greater Vancouver, approximately 8,400 individuals are estimated to have a disability and likely require formal and informal long-term health care support (Lai, 2003). This increasing number of ethnic Chinese elders with chronic illnesses means that more elderly are likely to seek publicly funded facility care instead of being cared by family members at home. However, studies have reported that due to language barriers and cultural related issues, ethnic elders in long-term care facilities are facing increasing levels of distress and difficulties coping with institutional life (Talyor, 1988). A study done in 2003 on the health and well being of older Chinese in Canada has revealed that 41.1 percent of Chinese elders (age 65 and older) do not understand any English and 35.7 percent understand a "little bit" of English (Lai, 2003).

2.1.2 Long-Term Care System in British Columbia

As a result of the changing demographics, and changing health and functional status of the elderly population, health care providers in Canada and in British Columbia are facing increased challenges in addressing the needs of patients with varying cultural and ethnic backgrounds. Despite concerns over increased health services utilization by an aging population, very few studies describe long term health service utilization by ethnic minority residents. This study investigates ethnic differences by examining potential interactions between ethnicity and organizational characteristics. Because ethnic Chinese elders represent the largest visible minority group in Greater Vancouver, the research project selects this ethnic group as a case study.

This research project examines the current long-term care admission policy in Vancouver and its impact on ethnic minority client groups. It attempts to identify whether there are any health and well-being disparities experienced by Chinese-Canadian elderly in LTC facilities as a result of cultural variations. It also examines whether the current policies and practices within the facilities are consistent with a cultural competence framework that is employed in many North American jurisdictions.

Definition

Long-term care is a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity (Kahana, 1982). Long-term residential care is provided for individuals whose care requirement cannot be adequately met in their own home or another setting, such as supported housing, assisted living, a family care home or group home. Long-term residential care facilities are licensed, approved or funded by provincial departments of health and/or social services and provide 24-hour professional nursing care, along with room, board and recreational programs in a home-like environment (Branch & Jette, 1992))[1].

[1] Long-term care encompasses a broad range of help with daily activities that chronically disabled individuals need for a prolonged period of time. These primarily low-tech services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning. The services include hands-on and stand-by or supervisory human assistance. For example, the services include assistance with basic activities of daily living, such as bathing, dressing, eating or other personal care. Services may also help with instrumental activities of daily living, including household chores like meal preparation and cleaning; life management such as shopping, money management, and medication management; and transportation (McCaslin, 1988).

B.C. Long-Term Care System

The long term care system in British Columbia is a province-wide, single-point-entry system. That means that the same program exists across the province and the five health regions. Under the provincial long-term care program, residential facilities are provided for individuals who can no longer live independently because of health-related problems. Those who need nursing home care can call the continuing care office and ask for an intake worker or case manager or assessor. A client is assessed and identified to require one of the three services: 1) personal care, 2) intermediate care (IC) at levels 1, 2, or 3; or 3) extended care (EC). The increase in levels indicates an increase in need for assistance. The basic difference between intermediate care and extended care is the ability to walk or transfer independently using a walker, wheelchair, or other device. If the client is able to be independent, he or she is classified IC. Up until May 2002, people who are IC2 or IC3 or EC were eligible for placement (Silin, 2005). In this project, we are identifying ethnic Chinese clients who require intermediate level care and are cognitively intact as participants in the survey study.

Residential Priority Access Admission Policy

Admission to all residential facilities in the region is coordinated centrally through the Vancouver Coastal Health Authority. As of April 1, 2002, a priority access system was introduced by the Ministry of Health Services. The aim of the "priority access system" is to provide efficient long term care services to clients. Clients are assigned priority status according to urgency of need for placement. The central committee bases admission to care on need and acuity, as opposed to the length of time someone has been on a waitlist. Thus, clients are admitted to facilities on a "first available bed" basis; that is, clients who are given priority are admitted to an available bed regardless of whether it is in a facility of choice. Health authorities manage access to residential care beds centrally and clients have access to a bed anywhere in the province. Clients must be willing to go to any place where a bed is offered within three months. If a bed is offered and it is refused, the client's name is taken out of the committee's pool of names of people needing placement. The client will not be placed in a publicly funded care facility. If a place is offered in a facility which is not the preferred choice, the person will be placed on a "transfer waiting list" and be transferred to the preferred facility when a bed becomes available. Depending on the number of people waiting for that facility, the number of people from the community being placed, and the number of people awaiting placement from hospital, the waiting period can be very long (Silin, 2005).

Transfer Waiting List

Although health authorities would like to admit clients to their preferred facility, there may not be vacancies at the preferred facility when the client needs care. Clients can request a move to a preferred facility once they are in residential care. If the first available bed is turned down, the health authority will assume a client's need is not urgent and move his or her name off the priority access list.

This admission system has several deficiencies from the perspective of both administrators and health care workers. For example, several administrators expressed difficulties in making appropriate individualized arrangements for incoming clients who are assigned to them often on a very short notice by a centralized computer system. Moreover, this priority access system does not adequately convey the complexity of the human needs of each individual. Some administrators recalled that, before 2002, they had adequate communication between the incoming clients and the facilities before individuals arrived. This allowed ample time for the facility to arrange and design services that would match new clients' preferences and needs. This is no longer possible with the current priority access system as the administrators do not know whom they will receive in the week when a bed is available.

In the following section, the paper illustrates the impact of the impersonal feature of the current priority access system on minority elders by looking at the situation in Simon K.Y. Lee senior care home, a facility that serves the Chinese community.

2.2 Policy Issue

Simon K.Y. Lee Senior Care Home

Simon K.Y. Lee multi-level care facility project was first initiated by S.U.C.C.E.S.S. (United Chinese Community Enrichment Services Society) in 1989 in response to the demand for a linguistically and culturally appropriate care facility. After 12 years of preparation and development, Simon K.Y. Lee Senior Care home was built and began admitting residents in 2001. Since its operation, the number of people on the transfer waiting list for this facility has increased drastically. Currently, there are over 100 people on the transfer waiting list for this home that has only 103 beds. This waiting list is 10 times longer than that of many other facilities, and most people wait for over three years before they can move into the care home of their choice.

The question arises, how do ethnic Chinese elders adapt in culturally non-congruent facilities in the meantime? The literature has reported that ethnic elders, in a culturally non-congruent facility facing new demands and restrictions, experience traumatic isolation from the

familiar cultural milieu which had sustained their sense of self. Their vulnerability may be associated with their limited personal and social resources, difficulties in seeking and accepting formal assistance due to language barriers or in some cases stigma associated with membership in a cultural or ethnic minority (Cubillos & Paz, 1988). Research indicates that such stressful situations adversely affect the quality of life and life expectancy (Cruz-Lopez & Pearson, 1985). This problem may be exacerbated by the current Vancouver priority access system which aims to reduce cost by moving patients out of primary acute care as quickly as possible into long-term care facilities. However, many of these LTC facilities may not have capacity, resources or ethnically appropriate programs to receive clients with diverse cultural backgrounds.

During informal preliminary interviews conducted with social workers and LTC staff, many articulated their frustration at being unable to understand and service clients with cultural backgrounds of which they have insufficient knowledge. The key problem and the solution therefore may not lie with the priority access system per se, rather attention should focus on how to increase the cultural competence level of each facility and equip health care providers with skill sets and practice standards which can be employed when receiving culturally diverse clients. As a consequence, a facility with enhanced infrastructure would provide ethnically appropriate services and improve the quality of life for ethnic elders.

In recent years, the cultural competence concept has received increasing attention from various health care organizations in the U.S. A cultural competence health practice framework has recently been extensively studied, developed and tested in several U.S. jurisdictions. This service model is widely followed by mental health, pediatric and geriatric hospitals in a number of American states.

In the following section, the paper introduces this framework in detail and elaborates on its importance in shaping Vancouver long-term care facilities to become more effective in meeting the needs of its diverse clientele.

2.3 Analytical Framework

2.3.1 Cultural Competence and Health Care

Cultural Competence Definition and Framework

In recent years, many American organizations are supporting the idea of cultural competence, both as an end in itself and a means for reducing disparities. This framework has

come to encompass both interpersonal and organizational interventions and strategies that seek to facilitate the achievement of clinical and public health goals when those differences come into play. Some reports have stated that establishing cultural competence standards, values, and policy requirements for long-term care may enhance treatment outcomes for patients (NCCC, 2003). Other studies are claiming that the provision of long-term care services in a culturally competent manner is fundamental to ensure high quality and cost-effective mental health services (CCHCP, 1999). Many have concluded that the investment to reach cultural competence goals must be made at all levels of the system with an identified strategic plan defining the process of making the needed changes to improve treatment outcomes and overall care. Reflecting this enhanced public support for the concept, a growing body of American federal and state laws, as well as quasi-governmental actions, seeks to guarantee cultural competence as a legal entitlement (OMH, 2000).

The literature review has yielded various working definitions for cultural competence, with nearly all touching upon the need for health systems and providers to be aware of and responsive to patients' cultural perspectives. The most widely accepted cultural and linguistic competence definition was proposed by Cross in 1989. He defined cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in a cross-cultural situations." (Cross, 1989). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health services, thereby producing better health outcomes. Cultural competence is an important vehicle to increasing access to quality care for all patient populations, by tailoring delivery to meet patients' social, cultural, and linguistic needs (CCHCP's Cultural Competency Curriculum, 1999).

A culturally competent organization accepts and respects differences among and within different groups. It continually assesses its policies and practices regarding culture, expands cultural knowledge and resources and adapts service models in order to better meet the needs of different racial and/or ethnic groups. It is required that these organizations hire staff who are unbiased, represent the racial and ethnic communities being served and seek advice and counsel from their clients. A culturally competent organization is committed to policies that enhance services to a diverse clientele. Moving a health care system towards cultural competence needs to be viewed as a developmental process. (Cross et. al. 1989).

Extensive literature supports cultural competence concepts and practice. Many studies state that good provider-patient relationships form the core of high quality medical practice. The foundation of this relationship is based on trust, which is developed over time and predicated on an appreciation of patients' individual characteristics (Taylor et al, 1989). The goal of developing cultural competency is neither to overemphasize nor underestimate the effects of culture in the healthcare encounter, but to understand the influence of cultural factors on healthcare and health outcomes and to work with these factors in optimizing the services provided (Gonwa, 1992)). Although it is important to be aware of various cultures and customs, cultural competence does not require organizations to be familiar with every culturally specific belief and behaviour. Rather, it requires that clinicians respect the diversity of cultural perspectives that influence the health of individuals and communities (Cuellar, 2000).

Rationale for Cultural Competence Framework

This paper attempts to identify which elements of the American Cultural Competence Framework are applicable in Canada and how they might be used to reduce disparities in the Vancouver long-term health care system. However in doing so, it is necessary to examine the original American rationale for the introduction of this system.

The framework and practice of cultural competence was developed in a variety of separate jurisdictions. A National Centre for Cultural Competence was established by Georgetown University where it conducts studies to facilitate the exchange of information and research on how this framework could be applied to health care systems. The centre has pioneered the elaboration of this framework and developed various rationales related to the American context. The reasons for incorporating cultural competence into organizational policy are numerous. In this study, we have identified and adapted the following five of seven reasons produced by the National Centre for Cultural Competence as being salient for Canada.

A. To respond to current and projected demographic changes in Canada

As recognized by many researchers, cultural competency in health care is an old concept but it is receiving new attention in recent years fuelled by the changing demographics and assimilation patterns of patients. Practitioners in long-term care facilities face situations in which their clients' cultural backgrounds are clearly different from their own.

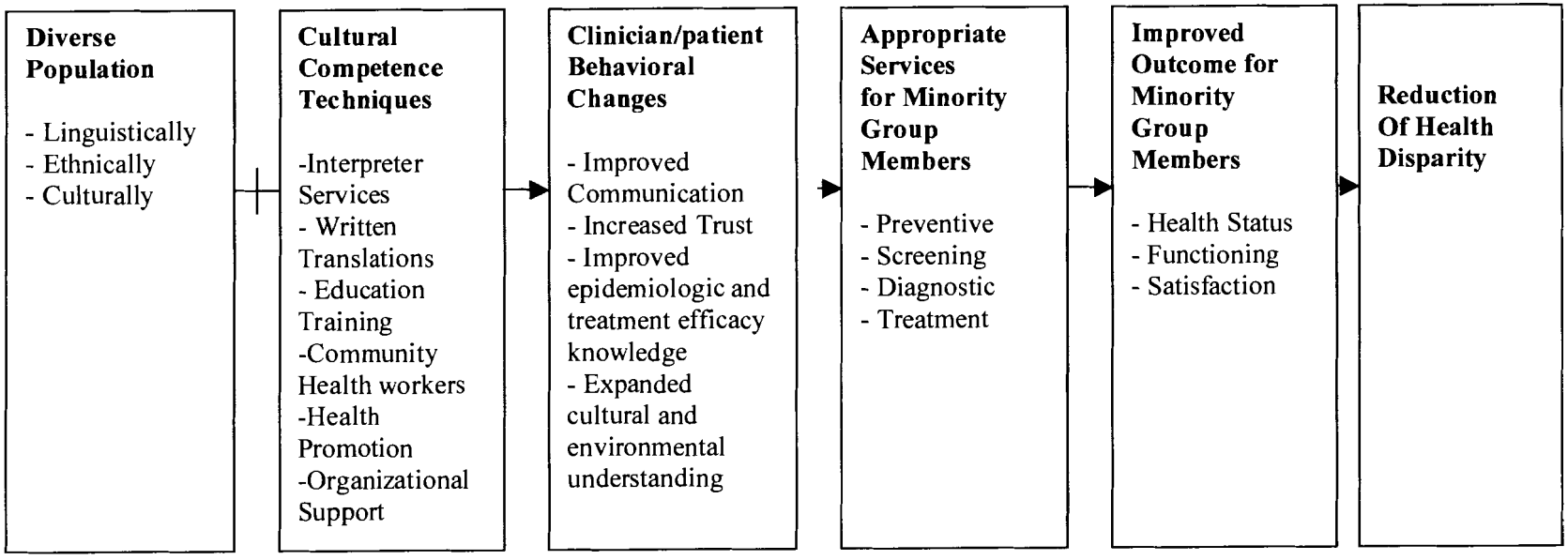
B. To eliminate health care disparities among people of diverse racial, ethnic and cultural backgrounds.

Many studies and recent analysis have proven that a cultural competence model can provide health care organizations with techniques to reduce racial and ethnic disparities (Kramer,

1998). Studies have revealed that despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among visible minorities and First Nations as compared with the Canadian population as a whole (Health Canada, 2001).

Cultural disparities have severe implications for the healthcare industry. Whether real or perceived, communication barriers and prejudice within the healthcare system have the potential to escalate into more significant problems. Patients who do not have a clear understanding of treatment guidelines are likely to be noncompliant, which ultimately leads to the need for further health system encounters that require more expensive and invasive treatments (Aponte, 2000). As summarized in figure 2 below, cultural competence interventions are aimed at reducing health disparity among ethnic minorities.

Figure 2: Reducing Health Disparity through Cultural Competence



Data Source: Brach and Fraser, Medical Care Research and Review (57 Supplement 1) pp. 181-217

C. To improve the quality of services and health outcomes.

Despite similarities, fundamental differences among people arise from nationality, ethnicity and culture, as well as from family background and individual experience. These differences affect the health beliefs and behaviours of both patients and providers. The delivery of high-quality primary health care that is accessible, effective and cost-efficient requires health care practitioners to have an understanding of the socio-cultural background of patients, their families and the environments in which they live. Culturally competent health services facilitate clinical encounters with more favourable outcomes, enhance the potential for a more rewarding interpersonal experience and increase the satisfaction the individual receiving health care services (NCCC, 2002).

Those who design evaluation methodologies for continual program improvement must address hard questions about the relevance of health care interventions. Cultural competence will have to be inextricably linked to the definition of specific health outcomes and to an ongoing system of accountability that is committed to reducing the current health disparities among racial, ethnic and cultural populations (Castillo, 1997).

Cultural competence techniques introduced singly or in combination could change clinician and patient behaviour by improving communication, increasing trust, improving racially or ethnically specific knowledge of epidemiology and treatment efficacy, and expanding understanding of patients' cultural behaviour and environment. Appropriate services in turn result in improved outcomes, such as better health status, functioning, and satisfaction. The final result is a decrease in disparities in health care access and quality and health outcomes (U.S. Department of Health and Human Services, 2001).

D. To improve communication between providers and patients and decrease the likelihood of liability/malpractice claims.

Lack of awareness about cultural differences may result in legal liability in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand health beliefs, practices and behaviour on the part of providers or patients breaches professional standards of care. Failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider (NCCC, 2002).

The ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. A 1994 study appearing in the journal of the American

Medical Association indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. When physicians treat patients with respect, listen to them, give them information and keep communication lines open, therapeutic relationships are enhanced and medical personnel reduce their risk of being sued for malpractice (Vogel, 1999). Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. With the growing diversity among patients, differences between patients and providers will lead to diagnostic errors; missed opportunities for screening; failure to take into account differing responses to medication; harmful drug interactions resulting from simultaneous use of conventional and traditional folk medications; and inadequate patient adherence to clinician recommendations on prescriptions, self-care, and follow-up visits. Health care organizations and programs must address linguistic competence – assuring accurate communication of information in languages other than English (NASW, 2003).

Increasing linguistic and cultural competence provides one potential way to address flaws in the delivery system. According to an American study, communication with physicians presents a problem for one in five patients receiving health care, and the percentage rises to 27 percent among Asian Americans and 33 percent among Hispanics (Brach, Cindy; Fraser, Irene, 2002). These barriers have a negative impact on utilization, satisfaction, and possibly adherence to prescribed treatments. People with language barriers or limited English proficiency (LEP) have fewer physician visits and receive fewer preventive services, even after controlling for such factors as literacy, health status, access to health insurance, regular source of care, and economic indicators (CCCH, 2003).

E. Cost Effectiveness

The fifth incentive for these organizations to become culturally competent is improved cost-effectiveness in caring for patients. Cultural competence has the potential to change both clinician and patient behavior in ways that result in the provision of more appropriate services, which can be cost-effective in both the short and long run. For example, researchers have noted an association between language barriers and higher rates of diagnostic tests. Apparently, physicians and health care providers compensate for difficulties in communication by ordering additional tests. Hiring bilingual staff or interpreters could be a cost-effective intervention, permitting more accurate medical histories to be taken and eliminating unnecessary testing. To the extent that cultural competence in health care results in prevention, earlier detection, and more

appropriate treatment of illness, enrollees presumably will use fewer services. Fewer services yield greater cost savings for health care organization (CCHD 2002).

With the exception of a small set of studies on techniques related to overcoming language barriers, there has been little rigorous research evaluating the impact of particular cultural competence techniques. The American Office of Minority Health and Agency for Healthcare Research and Quality recently put together an ambitious cultural competence research agenda that could fill many of these gaps. However, it will be several years before a comprehensive set of findings will be available. In the interim, there is a need to conduct cost-effectiveness study on a cultural competence framework (OMH, 2003).

2.3.2 Literature Review on Current Cultural Competence Interventions

The literature review revealed a considerable descriptive literature on each of the cultural competence interventions. Although limited in scope and depth, the body of existing empirical studies does suggest that several of the proposed interventions have the potential to affect health care delivery, health outcomes and increase in knowledge. However, subsequent impacts on provider or patient behaviour and/or health outcomes were not explored.

Practices such as cultural competence training and racial and ethnic concordance have shown improvements in subjective, self-assessed measures of provider knowledge and patient satisfaction. Health promotion and education programs that utilize interpreters, community health workers, translated materials and other culturally sensitive approaches reported increases in intake, program completion, and knowledge (NCCC, 2003). Studies examining the impact of linguistic and communication interventions on outcomes were found to have different degrees of effectiveness on patient satisfaction and health services utilization (Cuellar, 2000). No literature was identified that specifically examined both the processes and outcomes of organizational accommodations for cultural and linguistic competence.

In summary, the literature reveals promising trends in outcomes-related research that should be further explored. Some studies that measured outcomes for specific interventions revealed inconclusive results, due to significant variations in definitions, study design or approach (Ewalt, 1997). Their findings cannot be easily generalized; additional research studies are needed. The aim of this capstone project is threefold: 1) to investigate whether cultural factors are indeed the driving determinants that affect ethnic Chinese elders' choices of facility; 2) to evaluate whether current Vancouver LTC facility policies and practices are meeting a widely used American cultural competence standards; 3) to propose policy alternatives on how to improve

culturally sensitive services based on the identified clients' needs. In doing so, the project hopes to identify the most appropriate and effective interventions that can be later linked to potential improvements within the facility.

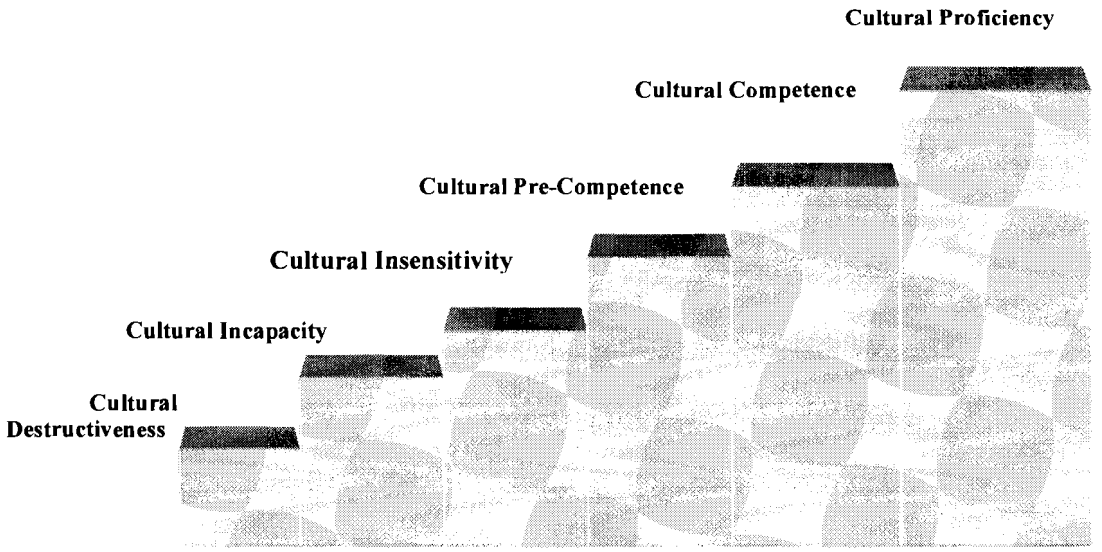
In the following section, the paper introduces the cultural competence continuum concept which is used as the basis for ranking where Vancouver facilities stand in comparison to the benchmarks proposed by the National Centre for Cultural Competence and the U.S. Department of Health and Human Services Office of Minority Health.

2.3.3 The Cultural Competence Continuum

Cultural competence is not a matter of being politically correct or of assigning one person to handle diversity issues, nor does it mean simply translating materials into other languages. Rather, it is an ongoing process of organizational and individual development that includes learning more about our own and other cultures, altering our thinking about culture on the basis of what we learn, and changing the ways in which we interact with others to reflect an awareness and sensitivity to diverse cultures (NCCC, 2002).

The Cultural Competence Continuum depicted in Figure 3 below was developed by Cross et al. (1989) for mental health professionals. Today, many other public health practitioners and community-based service providers also find it a useful tool. The continuum assumes that cultural competence is a dynamic process with multiple levels of achievement. It can be used to assess an organization's or individual's level of cultural competence, to establish benchmarks, and to measure progress (Issac, 1989).

Figure 3: Cultural Competence Continuum



Based on: Cross, T (1988). Services to Minority Populations. Focal Point, Vol. 3 No. 1, pp.1-4.
Lynch E. & Hanson, M. (1998). Developing Cross-Cultural Competence. Baltimore: Paul H.Brookes

This continuum includes six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency (Cross et al., 1989).

Cultural Destructiveness

The negative end of the continuum is characterized by cultural destructiveness. Organizations or individuals in this stage view cultural differences as a problem and participate in activities that purposely attempt to destroy a culture. Examples of destructive actions include denying people of color access to their natural helpers or healers, removing children of colour from their families on the basis of race, and risking the well-being of minority individuals by involving them in social or medical experiments without their knowledge or consent. Organizations and individuals at this extreme operate on the assumption that one race is superior and that it should eradicate "lesser" cultures (Cross, 1989).

Cultural Incapacity

Organizations and individuals in the cultural incapacity stage lack the ability to help cultures from diverse communities. Although they do not intentionally seek to cause harm, they believe in the superiority of their own racial or ethnic group and assume a paternalistic posture toward "lesser" groups. They may act as agents of oppression by enforcing racist policies and

maintaining stereotypes. Employment practices of organizations in this stage of the continuum are discriminatory (Cross, 1989).

Cultural Insensitivity[2]

Cultural insensitivity is the midpoint of the continuum. Organizations and individuals at this stage believe that culture makes no difference and that all people are the same. Individuals at this stage may view themselves as unbiased and believe that they address cultural needs. In fact, people who are culturally insensitive do not perceive, and therefore cannot benefit from, the valuable differences among diverse groups. Services or programs created by organizations at this stage are virtually useless to address the needs of diverse groups (Cross, 1989).

Cultural Pre-competence

Culturally pre-competent organizations and individuals begin to move toward the positive end of the continuum. They realize weaknesses in their attempts to serve various cultures and make some efforts to improve the services offered to diverse populations. Pre-competent organizations hire staff from the cultures they serve, involve people of different cultures on their boards of directors or advisory committees, and provide at least rudimentary training in cultural differences. However, organizations at this stage run the risk of becoming complacent, especially when members believe that the accomplishment of one goal or activity fulfills the obligation to the community. Tokenism is another danger. Organizations sometimes hire one or more workers from a racial or ethnic group and feel that they have done all that is necessary (Cross, 1989).

Cultural Competence

Culturally competent organizations and individuals accept and respect differences, and they participate in continuing self-assessment regarding culture. Such organizations continuously expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations. In addition, they strive to hire unbiased employees, and seek advice and consultation from representatives of the cultures served. They also support their staff members' comfort levels when working in cross-cultural situations and in understanding the interplay between policy and practice (Cross, 1989).

Cultural Proficiency

Culturally proficient organizations hold diversity of culture in high esteem. They seek to add to the knowledge base of culturally competent practice by conducting research, developing

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[2] The term "Cultural Insensitivity" is used in this paper instead of the term "cultural blindness" which was originally proposed by Cross in 1989.

new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient organizations hire staff members who are specialists in culturally competent practice. Achieving cultural competence and progressing along the continuum do not happen by chance. Policies and procedures, hiring practices, service delivery, and community outreach must all include the principles of cultural competence. For these reasons, a commitment to cultural competence must permeate an organization before a disaster strikes. If the concepts of cultural competence and proficiency have been integrated into the philosophy, policies, and day-to-day practices of the mental health provider agency, they will be much easier to incorporate into disaster recovery efforts (Cross, 1989).

In this capstone project, each stage of the cultural continuum is carefully examined. The objective is to evaluate whether current Vancouver facilities are providing culturally competent long-term care services. If this is not the case, where does each facility stand in comparison to the cultural competence practice benchmarks proposed by the U.S. Department of Health and Human Services Office of Minority Health (OMH, 2005)?

The following methodology section of this paper will describe in detail the continuum and benchmarks which are used to assess the cultural competence level of each Vancouver long-term care facility.

3 Methodology

3.1 Research Design Overview

We examine Vancouver publicly funded long-term care facilities and ethnic residents in Vancouver by conducting a) literature review and b) empirical research. In order to obtain a realistic assessment of the current long-term care services provided for ethnic clients, this project investigates the issue from both the facility and ethnic clients' perspectives. Hence, the empirical research component consists of two mini-studies: 1) Vancouver long-term care facility administrators are surveyed with a cultural competence assessment questionnaire and 2) ethnic Chinese clients' needs assessment is performed via structured face-to-face interviews.

Most study results are based on either i) studies conducted with physicians and administrators evaluating practitioners' responses to specific instances of cultural differences or ii) research results generated from quality of life or well-being studies with ethnic clients (Kleinman et al, 2001). There has not been sufficient evidence-based study of linkages between cultural competent practice/policies, and how they are relevant to the clients' perceptions of the quality of care received. Attempting to bridge this research gap, this project explores the issues by conducting two pilot studies with both LTC facility administrators and the clients.

Secondly, the policy recommendations developed for this project depend on empirical results that are derived from both studies. In the survey conducted with the facility administrators, services of individual facility are evaluated against a cultural competence best practice benchmark. This check list of culturally competent interventions has been developed in the U.S. and is widely used by various health care organizations when conducting organizational self-assessment. The objective of this study is to analyze Vancouver facilities against this practice benchmark and identify service deficiencies in response to external standards. However, to avoid applying standards derived from other jurisdictions blindly, a client-based study is included from which specific needs of the ethnic minority clients in Vancouver long-term care facilities are identified. The purpose of conducting the two studies is not only to evaluate Vancouver LTC facilities against cultural competence practice standards, but also to provide recommendations that are tailored to the ethnic minority residents and the long-term care facilities in Vancouver.

In the following methodology section, the paper examines and discusses the two studies separately to ensure clarity. The study results for the first study can be found in section 3.2.2. and for the second study in section 3.3.2.

3.2 Part I - Cultural Competence Survey with LTC administrators

3.2.1 Research Design and Procedures

With 43 publicly funded Vancouver long-term care facilities distributed throughout the six community health regions, the researcher identified 35 facilities that provide intermediate level care to diverse populations. The objective of this study is to survey the 35 facilities with a cultural competence practice checklist and assess the cultural competence level of each. The study intends to explore three research questions: 1) whether Vancouver long-term facilities meet the cultural competence standards when evaluated against the best practice benchmark; 2) for facilities that do not meet the cultural competence level and its standards, to which category does each facility belong on the "cultural competence continuum" and 3) from the survey, what culturally competent service deficiencies can be identified, if any?

Study Sample

The 35 long-term care facilities identified consist of three different types: 1) those with an ethnically diverse client population base; 2) facilities having mostly English-speaking residents and 3) facilities that are designed to serve specific minority groups such as Jews, Germans, Chinese and Finnish. During the two month period of research data gathering, out of 35 facilities surveyed, 18 facility administrators (response rate of 51.4 percent) responded and mailed back the completed questionnaire.

After conducting the survey, four elite interviews were conducted with case managers, social workers and facility administrators to pinpoint specific barriers and constraints that prevent the development of cultural competent interventions in Vancouver.

Research Survey

The U.S. Department of Health and Human Services Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) have invested resources in developing research to examine how cultural competence affects health care delivery and health outcomes. In December 2000, a cultural competence best practice benchmark was established and has been used by institutions such as the National Centre for Cultural Competence at Georgetown University in their research. In designing the survey for this project, the researcher consulted

various cultural competence assessment checklists used by different health care organizations in the U.S. and elsewhere. The following is a list of four principal sources from which this survey is adopted.

1. Georgetown University Child Development centre
2. The U.S. Office of Minority Health of the Department of Health and Human Services emphasized cultural competence by publishing national standards for culturally and linguistically appropriate services (CLAS) in health care3.
3. A standard developed by National Centre for Cultural Competence at Georgetown University.
4. Cultural Competence checklist for Agencies, Multicultural Disability Advocacy Association of New South Wales.

This study survey with 22 questions is broken down into three categories and designed to examine 17 cultural competence practice components. These service components characterize a culturally competent health care organization. The survey examines individual facilities' cultural competence at organizational, administrative/service and community levels.

The LTC administrators were given the cultural competence definition and were asked to rank their answers to each question numerically as follows:

1 = we always do this; 2= we often do this; 3 = we occasionally do this; 4 = we rarely or never do this; and 5 = we don't know

The facility that ranks "1" to all questions will be considered "culturally competent" and the facility that ranks "4" to all questions will be considered "culturally insensitive" on the cultural competence continuum. From a preliminary informal interview conducted with social workers and Vancouver administrators, none of the facilities belong to either the "culturally destructive" or "culturally incapacitated" categories (the two lowest levels). When analyzing the "cultural competence level" of each facility, the paper assumes that the surveyed 35 Vancouver long-term care facilities fall within the three categories (Cultural Insensitivity, Cultural Pre-Competence and Cultural Competence levels) of the continuum.

[3] CLAS standards span the delivery of culturally competent care, language access services, and organizational supports for cultural competence. The promulgation of these standards, taken with other activities by the U.S. federal government, combine to create a federal climate that promote cultural competence in the U.S.

In addition to the questionnaires, the survey includes an open-ended question which invites administrators to describe barriers which prevent them from developing culturally competent interventions. Among the 18 respondents, 11 individuals answered this question.

3.2.2 Data Findings

Facility Survey

As described in the previous section, among the 35 surveys mailed to Vancouver long-term care facilities that provide intermediate level care, 18 facilities responded representing a response rate of 51.4 percent. Table 2 below summarizes the responses received from the 18 facility administrators and presents the findings in terms of how they responded to each of the 22 questions. The results enable us to identify how responsive Vancouver facilities are in terms of cultural competence on a question-by-question basis. For instance, on only two questions ("background documentation" and "intake assessment") do all 18 Vancouver facilities report themselves as culturally competent. For the remaining 20 questions, facilities showed a high degree of cultural competence on only two tasks; namely, i) "recruitment" with 45 percent and 55 percent of facilities indicating that they either always or often recruit culturally diverse staff; and ii) "ethnic representation within the facility's councils and committees." In the latter category, 61 percent of respondents stated that they always include ethnic minority members in their facility councils. This table illustrates that measuring against a check list of 22 cultural competence practices, Vancouver facilities overall have met the cultural competence level on only 4 tasks. Among the 18 responding facilities, 23 percent reported that they "always" performance the 17 cultural competence component and 28 percent reported that they "occasionally or rarely" have these culturally appropriate practices in place.

Table 2: Distribution of cultural competence components with research findings from Vancouver LTC organizational self-assessment study

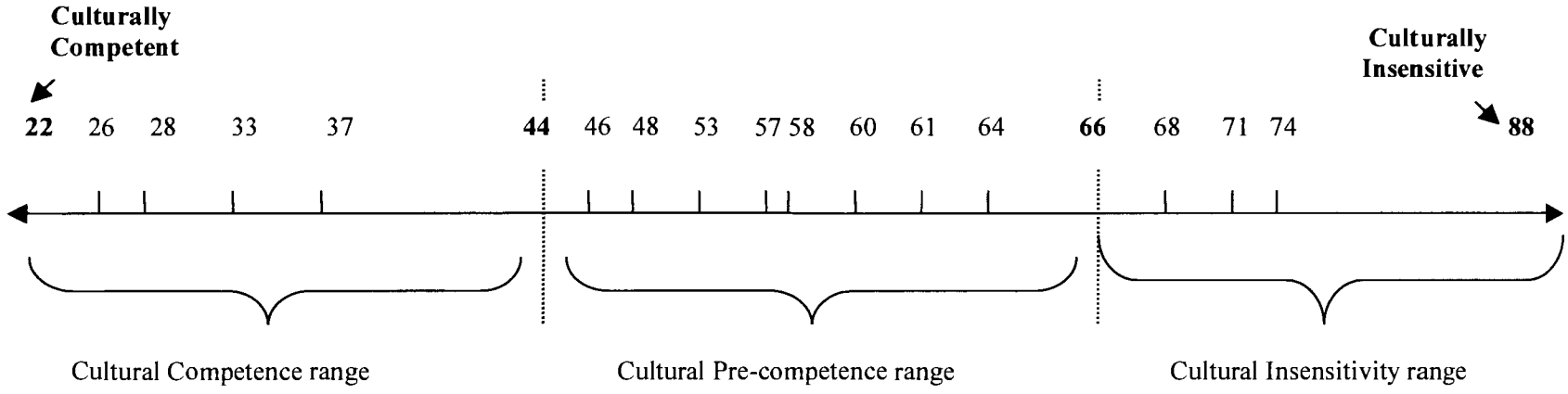
Categories	Cultural competence components	Always	Often	Occasional	Rarely/Never	Don't Know	Total
Organizational	1. Mission statement promotes cultural competence	4 (22%)	6 (33%)	4 (22%)	4 (22%)		18
	2.Boards and committees are cultural diverse	7 (39%)	6 (33%)	5 (28%)			18
	3. Cultural competence planning process	4 (22%)		3 (17%)	11 (61%)		18
Administrative	4. Recruits, hires and retains culturally-sensitive staff	8 (45%)	10 (55%)				18
	5. Regular cultural competence training for staff.		4 (22%)	6 (33%)	7 (39%)	1(6%)	18
	6a. Internal course			3 (17%)	14 (78%)	1 (6%)	18
	6b. Staff cultural knowledge awareness		3 (17%)	12 (67%)	3 (17%)		18
	7.Fiscal resources for translations and interpretation services				17 (94%)	1 (6%)	18
	8.Policy for interpretation and translation services			4 (22%)	14 (78%)		18
	9a. Provides interpretation/translation services on request	2 (11%)	4 (22%)	12 (67%)			18
	9b. Staff speaking the language	2 (11%)	2 (11%)	6 (33%)	8 (48%)		18
	10a. Culturally sensitive decorations	2 (11%)	4 (22%)	7 (39%)	5 (28%)		18
	10b. Available diversity information		2 (11%)	10 (56%)	6 (33%)		18
	10c. Pamphlets Language		2 (11%)	2 (11%)	13 (72%)	1 (6%)	18
	11.Any ethnic representation within the facility's committees	11 (61%)	7 (39%)				18
	12a. Collects and documents clients' cultural needs	18 (100%)					18
	12b. Intake Assessment	18 (100%)					18
	13. Policy against culturally inappropriate language.	6 (33%)	7 (39%)	3 (17%)	2 (11%)		18

Categories	Cultural competence components	Always	Often	Occasional	Rarely/Never	Don't Know	Total
Community Outreach	14. Ethnic foods provided	3 (17%)	4 (22%)	11 (61%)			18
	15. Working relation with local ethnic community agencies	2 (11%)	7 (39%)	9 (50%)			18
	16. Consult with non-English speaking clients in service area	2 (11%)	2 (11%)	10 (56%)	4 (22%)		18
	17.Links developed with volunteers the ethnic communities	1 (6%)	10 (56%)	4 (22%)	3 (17%)		18
TOTAL		**90 (23%)**	**80 (20%)**	**111 (28%)**	**111 (28%)**	**4 (15%)**	**396 (100%)**

For the purposes of analyzing on a facility-by-facility basis, this paper has organized the results differently in Figure 4 below. In this case, we have assigned numerical values to each reply to indicate the cultural competence responsiveness to each of the 22 questions. (The values for the answer to questions on how frequently the facility follows each cultural competence practice are as follows: "always" =1; "often" = 2; "occasional" = 3; and "rarely or never" = 4.) A score is calculated for each facility by adding all the values reported for each question. In figure 4, on the axis, a number of 22 (cultural competence level) represents the highest conformity to cultural competence and the number 88 (cultural insensitivity level) represents the least conformity. Using the terminology defined by Cross, we have assigned the range from 22-44 to represent the category "cultural competence"; the range from 44-66 to represent the category "pre-competence" and the range 66-88 to represent "cultural insensitivity". From the data results, we observe that all 18 responding Vancouver LTC facilities fit into these three stages of the continuum.

i) **Culturally competence category** - the data reveals that 4 of the facilities fall into this category; namely 26, 28, 33, 37
ii) **Cultural pre-competence category** - 11 Vancouver LTC facilities belong to this category with the following scores: 46, 48, 53, 53, 57, 58, 58, 60, 61, 61, 64
iii) **Culturally insensitive category** - 3 facilities fall into this category. The scores are: 68, 71, 74

Figure 4: Cultural competence Spectrum - reported study results from Vancouver LTC organizational self-assessment



The results from the above two analyses present a clear picture of where the 18 Vancouver LTC facilities rank in terms of the cultural competence continuum and pinpoint. the specific service areas where facilities require the greatest expenditure of time, money and attention in order to reach a higher standard.

Responses from Health care Providers

After identifying where culturally competent service deficiencies are, the paper turns to challenges and barriers in providing culturally appropriate care through interviews and the open-ended question on the survey. Of the 18 respondents, 11 individuals answered the open-ended question. Additionally, 4 health care providers (one case manager, 2 social workers and 1 recreational manger) were interviewed. Each interview was one- to one and one half hour in length. The following table provides an overview of the responses (open-ended question and interviews) from the long-term care health providers.

Table 3: Research Results from health care provider

Themes (main challenges)	Sub-issues	Number of people who commented on the issue
1. Budgetary and Human Resources Constraint *"Facilities do not have the staff or the money to meet the diverse cultural needs of clients"*	i) **Food** - it is difficult to provide enough variety of ethnic foods to meet the requests of all clients due to budget constraints	N = 5
	ii) **Interpreters/Translators** - there are no professional translators or interpreters due to budget concerns	N=7
	iii) **Staff** - facilities rely on culturally diverse staff to provide necessary health care to ethnic minority clients	N=2
	iv) **Training** – there is no budget for training. People are expected to learn and increase culturally related on the job. Staff have little cultural awareness (cultural values, belief etc.)	N=3

Themes (main challenges)	Sub-issues	Number of people who commented on the issue
2. Lack of available culturally diverse information, pamphlets and decorations *"There is no available access to pamphlets and printed materials in Chinese or other languages"*	i) No information and pamphlets in other language besides English. iv) It is difficult to decorate the facility environment (e.g. posters, decorations) for any one ethnic group when we have a diverse resident population.	N=7 N=2
3. Lack of community partnership *"Need to improve working relations with ethnic community agencies"*	Need to work with ethnic community more closely and recruit volunteers with diverse ethnic cultural backgrounds.	N = 4
4. Constraints with Union Agreement	i) "The union agreement means that the facility cannot assign specific staff to all the Chinese floors and staff can choose their work rotations". ii) "We have 2 Chinese registered nurses. But they work the night shifts and are not available when we need a lot of help in the day time. With union regulations, staff choose work hours based on seniority. With low seniority, the Chinese nurses only work the night shifts and we have no help in the day."	N=1 N=1
5. Recruiting staff with specific language skills	i) "There are not enough Chinese nurses working in the long-term care."** ii) "We have a lot of Pilipino nurses, but do not have staff who speak Chinese."	N=4 N=2

** *For detail discussion on this issue, please refer to the following "Discussion" section.*

3.2.3 Data Analysis

After assessing Vancouver long-term care facilities against the cultural competence best practice benchmark, it is evident that the majority of facilities do not have culturally competent or

appropriate services in place. Among the 18 respondents, only 4 achieved the cultural competence standard, whereas 11 facilities fell in the cultural pre-competence category and 3 facilities are classified as culturally insensitive.

The high variation can be explained in part by the introduction of the priority access system in 2002. In the case of most facilities that have predominately English-speaking residents, culturally competence services or policy did not seem necessary to the administrators before 2002.

The results from the ranking process completed in the previous section have now enabled us to conclude that among the 18 respondents, 14 facilities did not meet the cultural competence practice standard. The next question of interest is the service areas in which these facilities showed significant deficiencies. This paper now examines the research results for each functional level individually.

1) Organizational Cultural Competence Level

Table 3 shows that 55 percent of responding facilities occasionally or rarely have mission statements, procedures and policies that promote cultural competence in their facilities and 78 percent of the facilities do not have a cultural competence planning process in place. Half of the responding facilities are not aware of the cultural competence framework and 61 percent of the facilities do not have any cultural competence planning policies in their mandate.

2) Administrative Cultural Competence Level

The survey results reveal that among the 17 cultural competence interventions tested, the responding facilities have done well on only two categories: "recruiting culturally diverse staff" and "ensuring ethnic representation within the facility's councils and committees." Facilities do not meet the cultural competence standards on the following items.

Training

The results indicate that 72 percent and 95 percent of the responding facilities have regular training programs or internal courses for staff on cultural competence either occasionally or rarely. This issue was further articulated when interviews were conducted. There are no training budgets available at the facilities, and staff are expected to learn and increase their cultural awareness on the job. However, we observe that 84 percent of respondents stated that their staff occasional or rarely possess adequate cultural knowledge. During the interviews, social workers emphasized that most of the nurses and care aides at the facilities do not have much understanding of the cultural values and beliefs of importance to ethnic minorities. The

interviewees stated that, if they understood ethnic elders' cultural perception of their illness, they would be able to provide better care.

Interpreter Service & Financial Resources

All of the facilities reported that they have no financial resources for translations and interpretation services. In addition, they occasionally or rarely have policy and procedure for the use of interpretation and translation services. When asked whether they "provide any interpretation/translation services on request", 67 percent indicated "occasionally"; however, all of the respondents indicated that they rely on culturally appropriate staff or unpaid volunteers for the job. This study found that when bilingual staff are pressed into serving as translators, there may be job conflicts, frustration, and misinterpretation. A Chinese-speaking care aide said to the researcher "I am feeling overburdened sometimes. Everyone comes to me for the issues related to the Chinese residents because no one understands what they say besides me".

Recruitment

Table 2 indicates that facilities are doing well at recruiting culturally diverse staff. However, 81 percent of the respondents showed that they occasionally or rarely have staff that speak or understand the language used by their ethnic minority residents. Respondents during the interview said that they do not have Chinese nurses and have a hard time recruiting them. To illustrate this issue, one facility reported that there is only one ethnic Chinese staff who works part time and another facility has two full-time Chinese speaking staff who work the evening shifts. Both facilities have more than twenty ethnic Chinese elders.

Food

Out of the 18 responding facilities, 61 percent indicated that they occasionally provide ethnic meals. We must note however, that 17 facilities did not reply to this survey. The researcher speculates that those facilities that have residents who are mainly Caucasians did not answer the questionnaire and it is reasonable to deduce that these facilities do not provide ethnic meals as there is not a demand from their resident population. However, the question of interest is "how will the facility cope when receiving a new resident who is an ethnic minority and cannot take any Western meals?"

Culturally Diverse Information and Living Environment

Administrator responses indicate that almost all of the facilities have done poorly in this category. 89 percent of respondents reported only occasionally or rarely having culturally diverse

information or reading materials at the facility; 83 percent of facilities do not have pamphlets in a language other than English; and 67 percent of the replies stated that they only occasionally or rarely have culturally sensitive posters and decorations. What is the implication of this finding? From the interviews conducted, we learned that to some social workers, being able to provide a culturally sensitive living environment that makes an ethnic minority elder feel welcomed and at ease is the most important factor. Based on their experience, achieving cultural competence on these practices is ranked with higher importance than providing ethnically diverse meals. For detail discussion on the importance, please refer to the following "recommendation" section.

3) Culturally Competent Community Outreach/Partnership

The results show that a majority of the responding facilities achieved the "culturally pre-competence" level in term of forming partnerships with ethnic communities. For instance, 56 percent of the facilities occasionally have procedures available to facilitate consultations with non-English speaking clients and ethnic communities in the service area; 89 percent of the respondents reported they often or occasionally have working relation with ethnic community agencies in the service area; and over half of the replies indicated they have developed links with volunteers in the ethnic communities who provide cultural consultation services.

3.2.4 Discussion

The purpose of this study is to investigate whether Vancouver long-term care facilities are culturally competent at the organizational, administrative and community levels. By evaluating their current services against a cultural competence practice benchmark, this paper has identified specific areas that are deficient. From the research findings, the paper concludes that only 4 out of 18 responding facilities have achieved the cultural competence level. Among the 17 examined cultural competence interventions, facilities have done poorly on 13 items. In the data analysis section, the paper presented and analyzed the results of each deficient organizational, administrative and service area. During the interviews conducted subsequently, health care providers provided important insights into the challenges and barriers preventing individual facilities from developing culturally appropriate or competent services. These will be analyzed in the "Policy Alternative and Recommendation" section of the paper where the implication and significance of the data results from the two studies will be further analyzed together.

3.3 Part II – Ethnic Chinese Elder Needs Assessment

3.3.1 Research Design and Procedures

The objective for the ethnic elder needs assessment pilot study is to explore cultural competence from the patients' perspective. With extensive literature review, it became evident that most cultural competence measures and interventions described to date come from the medical establishment and are focused on evaluating physicians' responses to specific instances of cultural difference. The results of this literature search demonstrate a need to build an evidence base linking cultural competent interventions to specific impacts on patient care outcomes. In this study, the face-to-face structured interviews conducted gave voice to the ethnic Chinese elders who identified their specific care needs. The client-based research findings serve as one basis for policy recommendations. In addition, the research results gathered can help future studies to develop links and measure the impact/ effectiveness of a particular cultural competence practice on patient outcome.

From the preliminary data gathering, a sharp increase in the number of ethnic Chinese elders on a transfer waiting list into a facility designed to meet the needs of the Chinese community was identified. To investigate the causes behind this phenomenon, part II of this project took a cross-sectional approach and interviewed two groups of participants with a structured questionnaire that contains 29 questions examining 7 independent variables. This exploratory study investigates two research questions: 1) whether ethnic Chinese are transferring (or have transferred) out of an integrative care homes due to cultural factors; and 2) If the answer to the first question is true, then which cultural variables are identified by the elders.

Data Sample

In this study, the researcher selected Chinese-Canadian elders for two reasons.

1) Since the largest ethnic minority group in Vancouver is Chinese, the elders in this ethnic group are taken as a case study for the purpose of analysis. It is important to note that, although each ethnic group and subgroup has different cultural preferences and variations, the issues explored in this study with ethnic Chinese elders illustrate the common challenges that ethnic residents encounter.

2) In this project, ethnic Chinese elders are selected as a case study because the researcher can speak, understand and write Chinese without an interpreter; hence minimizing systematic human error.

Taking the cross-sectional research approach, a "snapshot" of the characteristics of ethnic Chinese elders in Vancouver long-term care facilities is provided. Two groups of ethnic Chinese are interviewed in this study as listed below:

> **1) Experimental Group (Group A)** – Thirty ethnic Chinese elders who have either moved or intended to move out of an integrative care facility[4] were interviewed.
>
> **2) Control Group (Group B)** – ethnic Chinese elders who are currently residing in an integrative care facility and have no intention to transfer. Due to the time and resource constraint, 10 randomly selected ethnic Chinese elders were interviewed.

All forty ethnic Chinese elders who participated in this study are cognitively intact and require intermediate level care at the facility where they were interviewed. Each interview lasted 15 to 20 minutes and was conducted face-to-face with the researcher.

Hypothesis

Whether ethnic Chinese elders are transferring their facilities as a result of cultural factors?

Variables

*i) **Dependent Variable*** - Ethnic Chinese elders' decision on whether to transfer or not transfer.

*v) **Independent Variables***

With an extensive literature review, seven cultural factors are identified as having the most significance for ethnic minority clients requiring health care services. These variables are chosen (list in Table 4 below) as independent variables in this study.

[4] Integrative long-term care facility: facility with residents who have diverse cultural backgrounds
Segregated long-term care facility: facility that provide care services to a particular ethnic group

Table 4: Description of the independent variables

Independent Variables	Description
Family Members' Geographic Location	To test whether the geographic location of the residents' family members is a factor that influences elder's decision in staying or leaving the integrative facility.
Information Received	To investigate whether the elder's receipt of adequate information from the facility in a language which he/she understands is a determining factor in his or her decision making.
Communication	To examine whether the elder understands the language spoken by the health care providers at the facility. If not, are there interpretation assistance/services?
Food and Drink	To determine whether ethnic Chinese elder's food preference is a key factor affecting the dependent variable
Friends and Facility Environment	To examine whether friends and social network within the facility are key factors affecting the individual's decision.
Activities and Social Events	To test whether activity and social events are important to the individual's perceived quality of care.
Community Support	To investigate whether community support and involvement is viewed as important to the client when deciding on his or her choice of facility.

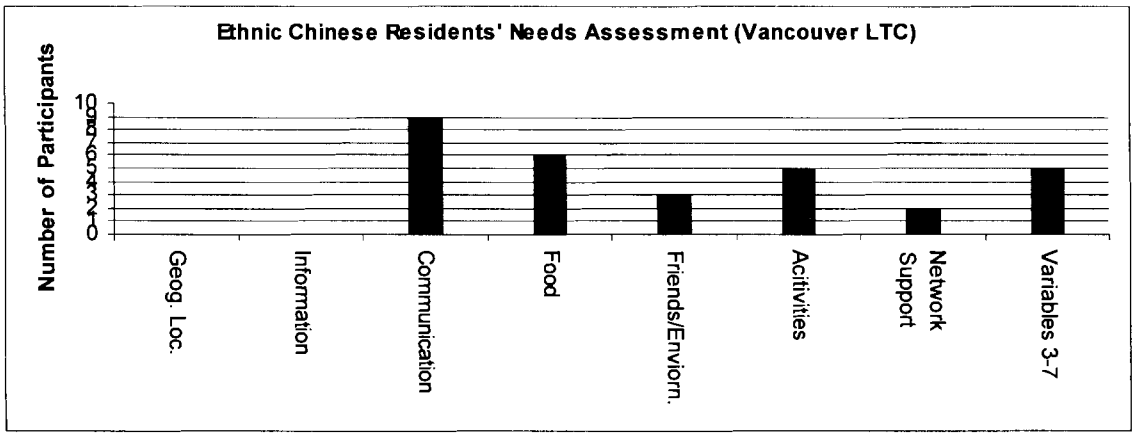
3.3.2 Research Findings and Analysis

Group A (experimental group) - Data Analysis

The standardized interview questionnaire with 31 questions is designed to investigate the relationship between the dependent variable (the respondents' decision to stay or transfer out of an integrative facility) and the 7 independent variables (the challenges experienced by the respondents while interacting with long-term health care providers). As illustrated in Figure 5 and Table 5 below, among 30 ethnic Chinese elders interviewed, 9 individuals (30 percent) identified that being able to communicate to health care providers is the most important variable to them; 6 elders (20 percent) have transferred or want to transfer because they require Chinese meals; 5 interviewees indicated that culturally appropriate games and activities are essential to their daily living (17 percent); 3 individuals (10 percent) identified that having friends with whom they can communicate in an understandable language and living in an environment that is

culturally sensitive are the key determinants in making their decision; 2 elders emphasized the importance of ethnic ties and wished more people would visit them from Chinese communities and that they could be involved in activities organized by Chinese communities; lastly, five interviewees (17 percent) indicated that in their perception, having good quality long-term residential care means that all 5 components are important in a facility, namely, i) staff with whom they can communicate (e.g. interpreters or culturally diverse staff); ii) traditional Chinese meals; iii) a culturally sensitive and welcoming living environment (e.g. posters and decorations); iv) culturally appropriate activities and social events (e.g. mah-jong); and v) involvement with Chinese community and ethnic ties (e.g. organized Chinese volunteers visits).

Figure 5: Most Important reasons for ethnic Chinese LTC residents wanting to move



The study results show no causal relationships between the dependent and two independent variables: "geographic location of the residents' family members" and "Information received in an understandable language upon entering the facility." Most of the elders said that when they arrived at the facilities, they were either feeling too sick and did not care to learn much information or they rely mostly on their family members to provide them with necessary information. Hence, based on the data collected from the 30 research participants, receiving adequate information in language that ethnic Chinese elders can understand is not a critical element that affects their decision making.

It is interesting to learn that "geographic location of residents' family members" has no impact on ethnic residents' decision on changing facilities. The limitation of the geographic scope of this study may be the explanation. Due to time and resource constraints, this project examines the issues only within Vancouver. If the study surveyed a larger population sample in a health

region like the Fraser Health Authority that includes several separated cities like Mission and Hope, the "geographic location" variable would probably be more important.

Table 5: Hypothesis testing - Results summary on reasons for wanting to transfer

Independent Variables	**Results of Hypothesis Testing**	**Importance Ranking** ***(by 30 participants in the Experiment Group)***
Communication	Increase language barriers increase the likelihood that an ethnic Chinese elder will transfer	1st (N=9)
Food	Increase ethnic food services leads to decreased ethnic Chinese's decision to transfer	2nd (N=6)
Culturally Appropriate Social Activities and Special Events	Increase the number of culturally appropriate activities provided lead to decreased chances of transferring facility	3rd (N=5)
Variables 3-7 *(comm., food, activities, environ., network supp.)*	Study participants stated that all 5 variables are equally important when making their transfer decisions.	3rd (N=5)
Friends/Environment	Increase cultural sensitivity of the living environment decreased the likelihood of transfer	4th (N=3)
Network support	Increase community support and involvement decreased the likelihood of transferring	5th (N=2)
Information Received in an Understandable Language upon resident's admission to the facility	No predictability	N=0
Family Members' Geographic Location	No Predictability	N=0

During the interviews, some elders expanded on their individual concerns after providing answers to the 31 interview questions. Four general themes emerged. The most frequently encountered are related to language barriers. The inability to communicate with staff members

resulted in a variety of negative impacts on the psychological and physical health of the residents: clinical depression, isolation, ill temper, withdrawal, and lost of self-worth. This point is illustrated by the following comments:

> I am frustrated. I cry all the time. They don't understand me...I know they give me the wrong thing, but I can't explain it to them. There are no interpreters here. We have to pay to get one...It takes a long time for them to find a staff member who understands me. By the time someone comes, it is often too late...it's the little things everyday. I gave up already.

> I just talk to them [nurses] in Chinese and the nurse told me to speak English, shouting...My daughter has no time to take care of me at home and that is why I end up here.

The next most frequently addressed theme was frustration with the facility because either it does not provide culturally appropriate activities. This issue is most evident when it comes to food and special activities. The following two quotes highlight this shortcoming.

> I don't care to go to the Chinese festivals/activities (organized here)...these are not special events - just some food and we have the same thing every time like some fried rice, noodle and turkey. They are not real traditional festival food...and we have to pay extra for special dim sum... Besides eating, we don't do anything else when we are there....

> There are a few Chinese meals in a week, but the Chinese menu is the same everyday...the changes are between stir fried noodles and rice done in the western style...not real Chinese food... we are not asked on what Chinese food we want to see on the menu.

Some care homes provide culturally appropriate services that are tokenism. Culturally trained staff are not available in the facilities and special recreational activities show little real understanding of cultural events. Facilities that are ranked "culturally pre-competent" on the continuum often provide services that are ineffective.

Lastly, random comments were raised by individuals on issues such as i) the lack of reading/entertaining material in a language they understand; and ii) the separation from Chinese communities. The following comments were made by Mr. J and Mr. A:

> I need Chinese reading material/newspapers...these are as important as food.

> I wish more Chinese folks would visit me... I wish to watch some shows, Chinese movies or have some Chinese games. I feel very lonely here.

It is evident that the lack of appropriate responses from long-term care facilities to clients' cultural needs is an indication that there is a demand for systemic change within the facilities' infrastructure. These data findings will be further analyzed in the "policy alternative and recommendation" section of the paper.

Group B (Control Group) – Data Analysis

To further examine whether there is a disparity in perceived patient care outcome among ethnic Chinese elders due to cultural factors, a control group of 10 Chinese residents who do not want to transfer is examined. The 10 individuals were interviewed with the same questionnaire as that given to the elders in Group A. The table below is a report on the data result.

Table 6: Research findings from the control group

Research Results	Independent Variables Tested	Number of Respondents
- A 54 year old resident educated in Hong Kong who speaks fluent English does not mind staying in an integrative facility because she can understand everyone and she does not mind Western foods - One elderly man speaks good English and is very active. He attends every activity organized by the facility regardless of what they are. - Three elders are born in Canada and are comfortable with western food and can communicate with staff in fluent English.	Reducing language barriers (and high level of acculturation) increase ethnic minority residents' ability to adapt to the integrative facility	N=5
- A resident's daughter brings Chinese dinner to her from home everyday because the daughter lives 5 minutes away from the facility	Ethnic foods	N=1
Three ethnic Chinese elders enjoy staying in their facilities which have a big Chinese resident population. One stated "half of the residents here are Chinese. I can always find a staff who can understand me and there are Chinese meals a few times a week."	Various culturally appropriate services are available in facilities with large ethnic Chinese residents	N=3

Research Results	Independent Variables Tested	Number of Respondents
One resident is not happy in the care home. He cannot get used to the food and feels very lonely. However he said "I am not going to move because everywhere is going to be the same. It's a hassle (to move)...the food, the nurses, the milieu, it's all the same."	Culturally insensitive living environment	N=1

The results presented above reveal that cultural factors are indeed important elements that affect ethnic Chinese elders' ability to adapt to an integrative facility. It is evident that the individuals would stay in an integrative long-term care facility if the following conditions were satisfied:

1. The ethnic Chinese individuals have high English language proficiency.
2. Their family is living close to the facility and can bring in home-made meals.
3. The individual is born in Canada and fully integrated into western society.
4. The facility has a growing Chinese resident population and the facility is providing some culturally appropriate services to meet the clients' needs

In conclusion, at the current stage, most Vancouver LTC facilities have inadequate financial and administrative resources to provide appropriate services for the growing number and diversity of their ethnic clients.

3.3.3 Discussion

From the research findings, we concluded that a) cultural factors do determine ethnic Chinese elders' decision on their preferred long-term care facility; and b) at the current stage, most Vancouver LTC facilities have inadequate financial and administrative resources to provide culturally appropriate services for the growing number and diversity of their ethnic clients. Results from the hypothesis testing have shown that, among the 7 independent variable examined, five cultural factors (communication, food, activities, environment and network support) are significant in predicting the dependent variable. However, two independent variables (information received and family geographic location) seem not to affect ethnic Chinese elders' decision on transferring. In addition, study results from the LTC organizational cultural competence assessment have revealed only 4 out of 18 responding facilities have achieved the

cultural competence level. Among the 17 examined cultural competence interventions, facilities have done poorly on 13 tasks.

4 Policy Alternatives

It is evident from the data garnered that ethnic Chinese elders residing in Vancouver long-term care (LTC) facilities have culturally specific needs which are not being addressed. In the following section of this paper we will first suggest three policy alternatives to address these issues. Subsequently, four criteria are applied to analyze the efficacy of the three policy options: 1) Budgetary; 2) Administrative; 3) Responsiveness to Client Needs; and 4) Political Acceptability in the Vancouver area.

4.1 Alternative 1 - Status Quo

4.1.1 Current Issues

The main objective of the priority access admission system is to maximize efficiency in moving elderly patients out of acute care units into long-term care facilities, to provide health services to clients who have the most urgent need for placement on a fair, efficient and equitable basis. This admission policy has served the community well on those three grounds since its implementation. However, since 2002, several unexpected issues have emerged and become increasingly severe.

1) Residents, particularly ethnic minority clients, claim that priority access system is efficient in addressing their short-term health needs, but overlooks their long term human needs.

2) During interviews conducted in this project, administrators/social workers indicated that facilities without prior experience or basic cultural knowledge in providing services for ethnic clients are experiencing difficulties in coping with an increasing number of new ethnic minority residents.

3) Several interviewees expressed difficulties in trying to arrange for appropriate individualized services for new clients who are assigned to their facility on a very short notice by the centralized computer system.

4.2 Alternative 2 - A Comprehensive Standard for Cultural Competence Intervention

4.2.1 Culturally Competent Health Care Practice Standards

In the last two years, a remarkable surge in awareness and responsiveness to the needs of diverse populations has been observed (OMH, 2002). In addition to the initiatives studied by various universities and institutions, at the U.S. Federal level alone, more than five major governmental policy initiatives have been launched to directly address cultural competence in a range of rules that cover nearly every health care provider in the country (NCCC, 2003). A few states and institutions have also begun implementing culturally competent health care delivery systems (for example, the Mayo Foundation in Minnesota, California's state hospitals and Washington state mental institutions).

In 1998, U.S. Department of Health and Human Services Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) sponsored a Cultural Competence Research Agenda project to examine how cultural competence affects health care delivery and health outcomes. It completed a process with the OMH-sponsored development of national standards for culturally and linguistically appropriate services (CLAS) in health care. These were subsequently published in the Federal Register in December 2000 (U.S. Department of Health and Human Services Office of the Secretary, 2000). They have become the basis for government and private sector activities to define, implement, and evaluate cultural competence activities among health care providers.

The CLAS standards shown in appendix I provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care. They are intended to offer a broad and practical framework for the implementation of services and organizational structures that can help health care providers be responsive to the cultural and linguistic issues presented by diverse populations. The standards are intended to be inclusive of all cultures and not limited to any particular population group. However, they are especially designed to address the needs of racial, ethnic, and linguistic populations that may experience unequal access to health services.

For this research project, we use CLAS as the basis for a modified comprehensive list of interventions for Vancouver LTC facilities. Since achieving cultural competence is an ongoing process, CLAS should be viewed as a long term target for moving towards cultural competence.

Ultimately, cultural competence requires working with many audiences and stakeholders, as illustrated in Table 7.

Table 7: Policy audiences and stakeholders

Policy Audiences & Stakeholders Involved	Description
Policymakers	Federal, Provincial and local facility administrators and program managers.
Accreditation and credentialing agencies	To assess and compare organizations and to assure quality for diverse populations
Clients	To be able to understand their right to receive accessible and appropriate health care services, and to evaluate whether health care organizations and providers can offer such services.
Advocates	To promote quality health care for diverse populations, and to assess and monitor care being delivered by health care organizations and providers. The potential audience include: local and national ethnic, immigrant and other community-focused organizations; and local and national non-profit organizations that address health care issues.
Educators	To incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. The audience include health care educators and training institutions, as well as educators for legal and social services professions.
The health care community	To debate and assess the applicability and suitability of cultural competence initiatives to be adopted into standard health care practice in the local community

To achieve cultural competence, Table 8 provides a guideline on what programs and series of actions need to be undertaken and at what level.

Table 8: Cultural competence interventions

Implementation Levels	Standard Cultural Competence Interventions
Policymaking Level	1. Appoint board members from the community so that voices from all groups of people within the community participate in decisions 2. Actively recruit multiethnic and multiracial staff 3. Provide ongoing staff training and support developing cultural competence; 4. Develop, mandate, and promote standards for culturally competent services; 5. Insist on evidence of cultural competence when contracting for services; 6. Nurture and support new community-based multicultural programs and engage in or support research on cultural competence; 7. Support the inclusion of cultural competence on provider licensure and certification examinations; and support the development of culturally appropriate assessment instruments, for psychological tests, and interview guides.
Administrative Level	8. Include cultural competency requirements in staff job descriptions and discuss the importance of cultural awareness and competency with potential employees; ensure that all staff participate in regular, in service cultural competency training; 9. Promote programs that respect and incorporate cultural differences; and consider whether the facility's location, hours, and staffing are accessible and whether its physical appearance is respectful of different cultural groups.
Service Level	10. Learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences; 11. Include neighbourhood and community outreach efforts and involve community cultural leaders if possible; 12. Work within each person's family structure, which may include grandparents, other relatives, and friends; 13. Recognize, accept, and, when appropriate, incorporate the role of natural helpers (such as shamans);

Implementation Levels	Standard Cultural Competence Interventions
	14. Understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact with a person; or access to a family may be gained only through an elder); 15. Know that, for many people, additional tangible services--such as assistance in obtaining housing, clothing, and transportation or resolving a problem with a child's school--are expected, and work with other community agencies to make sure these services are provided;

Source: U.S. Office of Minority Health, 2003

Organizations will achieve cultural competence when the following criteria are met (NCCC, 2004):

1) Policies consistently address cultural diversity and related issues.

2) Recruitment methods and interviews address cultural knowledge and training.

3) Cultural training and education are commonplace.

4) Language access and interpretation are readily available.

5) Treatment teams consistently include information in assessments, conferences, progress notes, discharge plans, and court reports about the patient's ethnicity and cultural beliefs and the role they play in positive treatment outcomes.

6) Patients and family members participate in treatment decisions.

7) Treatment modalities include alternative culturally specific interventions.

8) Strategic plans include cultural competence in the mission, vision and value statements as well as annual goals and objectives.

9) Research and treatment outcome measures address ethnic, language and cultural differences in treatment provision and response.

10) Staff, patient satisfaction surveys address the role culture has in positive outcomes.

11) Treatment environments display culturally diverse art work and provide literature of a cultural nature.

12) Special events celebrate a wide range of cultures.

4.3 Alternative 3 - Incremental Implementation of Cultural Competence Framework

Alternative Two requires a fully operationalized culturally competent system of care needs to integrate an extensive set of culturally appropriate interventions into all levels of the organization. However, with current budget limitations, a great deal of political and administrative resistance may be experienced from the facilities if they are required to undertake drastic organizational changes to achieve full cultural competence. Hence, this paper proposes a third alternative.

In the following section, the paper closely examines the cultural competence deficiencies identified in the Vancouver LTC facility self-assessment findings and studies them in accordance with three functional levels: 1) organizational cultural competence; 2) administrative cultural competence; and 3) culturally competent outreach programs and community partnership. This third alternative allows policy makers and administrators to select certain cultural competence health care services subject to their budgetary and administrative capacity.

1) Organizational Cultural Competence

The research data revealed that most of the Vancouver facilities are at the cultural pre-competence and cultural insensitive stages. To improve organizational cultural competence, facilities may select interventions such as the following:

1. Include cultural diversity or competence into the facility mission statement and policy procedures.
2. Maximize diversity within health care leadership and workforce. Establish programs for minority health care leadership development and strengthen existing programs. The desired result is to create a core of professionals who may assume influential positions in health care delivery system.
3. Hire and promote minorities in the health care workforce.
4. Involve community representatives in the health care organization's planning and quality improvement meetings.
5. Establish budget or fiscal resources for cultural competence development.

2. Administrative Cultural Competence

To achieve administrative cultural competence, it is essential to develop mechanisms for community and patient feedback, to implement systems for patient racial/ethnic and language

preference data collection, to develop quality measures for diverse patient populations, and to ensure culturally and linguistically appropriate health education materials are provided. Based on the research findings and literature review, a list of culturally competent interventions is highlighted below:

1) Provide on-site interpreter services in health care settings when facility is consisted of a significant population of limited-English-proficiency (LEP) patients. Employ other kinds of interpreter services in settings with smaller LEP populations, limited financial or human resources.
2) Offer cross-cultural training as a required, integrated component of the professional development of health care providers. Thus, build capacity to design and organize cultural events that are authentic and avoid tokenism.
3) Design meal plans that are appropriate to the clientele of each facility.
4) Provide culturally sensitive decorations, reading material and directories to create a culturally familiar environment.
5) Engage in quality improvement efforts that include culturally and linguistically appropriate patient survey methods and the development of process and outcome measures that reflect the needs of multicultural and minority populations.
6) Offer programs to educate patients on how to navigate the health care system and become an active participant in their care.
7) Develop health information for patients that is written at the appropriate literacy level and is targeted to the language and cultural norms of specific populations.
8) Incorporate standards for measuring systemic cultural competence
9) Seek inputs and feedbacks from ethnic families and clients when designing ethnically appropriate programs and activities.

3) Culturally Competent Outreach Network

The results of the open-ended questions on the cultural competence survey revealed that the lack of links with the Chinese ethnic community is one of the major shortcomings. Table 2 (in the Methodology section) illustrates that most of the facilities occasionally consult with the ethnic communities, but do not have a regular and sustained system to take advantage of all the resources and knowledge that these community agencies can provide. The majority of the Vancouver LTC facilities currently do not have the knowledge network to allow them to start designing or implementing active cultural competence programs. At this stage, it would be most practical to reach out to the local ethnic community experts and to encourage them to become

partners in implementing cultural initiatives in the health care system. This would be a low cost solution since facilities will utilize the existing resource provided by ethnic community organizations. To create a culturally competent outreach network, a facility can take the following actions.

1) Establish a working relationship or liaison with ethnic community agencies in the service area
2) Develop procedures in place to facilitate consultations with ethnic community experts
3) Form links with community agencies and use workers as cultural consultants when needed.

The above cultural competence interventions proposed for alternative 3 are derived from the two mini studies that are conducted in this project. In the following section, we will evaluate and analysis the three policy alternatives using a set of four feasibility criteria.

4.4 Feasibility Assessment

4.4.1 Definition of the Feasibility Criteria

Budgetary Feasibility

This term refers to the annual financial limits set by the BC government for the long-term health care program. We will try to evaluate the policy options recommended on the basis of whether they require significant expenditures. The provincial government has been consistently trying to reduce expenditures in order to lessen the tax load on citizens, thereby stimulating the economy. This has resulted in a reduced rate of growth in health budgets since the current BC government came into office.

Administrative Feasibility

This criterion refers to the physical and human resource capability of each facility to carry out duties and responsibilities under each policy alternative.

Responsiveness to Client Needs

The client needs assessment conducted in this study has identified 5 significant cultural factors that affect the perceived LTC quality for ethnic Chinese elders. Each policy option is evaluated in terms of its ability to meet the client needs in Vancouver LTC.

Political Acceptance

The paper examines the political feasibility of the three policy alternative from two aspects: 1) from the viewpoint of the cost saving philosophy of the current provincial government and 2) from the standpoint of political pressures from ethnic minority communities.

In the following sections, we will give a detailed evaluation of each of the three alternatives. Results are summarized in Table 9 below.

Table 9: Feasibility assessment of the policy alternatives

Policy Alternatives	Budgetary Feasibility	Administrative Feasibility	Responsiveness to Client Needs	Political Acceptance
Alt. 1 - Status Quo	High	High	Very Low	Medium
	This alternative would involve no new expenditure	This option would not involve the acquisition of any new physical or human resources	It does not meet any of the identified cultural needs of the ethnic clients	**A. Government Acceptance** 1) Most favoured by current administrators as it provides efficient and equitable LTC delivery 2) By allocating clients efficiently into LTCs, it reduced pressure on primary acute care units **B. Public Acceptance** Ethnic community acceptability is low due to lack of cultural sensitivity
Alt. 2 - Comprehensive Cultural Competence Standards	Low	Low	Very High	Medium
	Introduction of comprehensive standards would greatly exceed budgetary limitations	Radical change in infrastructure and personnel priorities would overwhelm facility and human resources.	Meet all of the Vancouver clients' needs articulated in the interviews conducted by this capstone study.	**A. Government Acceptance** Politicians need to be convinced that, in setting priorities within a limited budget framework, the needs of visible minority elders rank higher than other demands. **B. Public Acceptance** Ethnic community acceptability is high due to enhanced awareness and sensitivity of ethnic communities

Policy Alternatives	Budgetary Feasibility	Administrative Feasibility	Responsiveness to Client Needs	Political Acceptance
	High	High	High	High
Alt. 3 - Incremental Changes (at the organizational, administrative and community levels)	Because of flexibility, both the government and individual facilities can set their program development priorities to conform to budget levels	Each facility has the autonomy to provide culturally competent services in accordance with its administrative capacity	Depending on the interventions selected, some or all of the identified client needs will be met	**A. Government Acceptance** 1) It is attractive because each individual facility is given the authority to develop programs that are tailored to facility's capacity and priority needs 2) Ministry of Health will support low cost programs that demonstrate cultural sensitivity. **B. Public Acceptance** This is highly acceptance to clients, administrators, health care workers and ethnic communities.

4.4.2 Assessment of Status Quo

As indicated in the matrix above, the status quo rates high on the budgetary and administrative feasibility criteria, medium on the political acceptability and low on responsiveness to ethnic client needs.

Administrative and Budgetary Feasibility

With Vancouver Coastal Health Authority managing the centralized computer admission system, less time has been required to place clients throughout the region. Without the supporting mechanisms available in the long-term care facility to provide quality services to all clients, the priority access system will simply off-load the burden onto long-term care facilities without providing a solution to the frustrations in coping with diverse clientele. Therefore, although the priority access system is efficient in providing available beds to clients, it may result in human resource and administrative inefficiencies in the long-term for LTC facilities that do not know how to deliver culturally sensitive services to ethnic minority clients.

Responsiveness to Client Needs

The priority access system has been very effective from a short-term perspective. Immediate client health needs are indeed addressed by being placed in a facility that can provide adequate health treatments. However, in the long-term, for elderly resides who depend on life-time facility care, it becomes more important to have therapeutic and social services provided from a home-like residence rather than simply receive impersonal medical treatments.

The short term effectiveness of the priority access system cannot be sustained and will be overtaken in the long run by the frustrations expressed by the growing number of ethnic elders in Vancouver area. The empirical findings garnered from ethnic Chinese elder interviews provide a glimpse of the magnitude of the problem in the future. With the changing demographic profile, this issue is likely to become more acute throughout the province. The priority access system has now shifted the responsibility of providing ethnic service from the traditional community agencies and other specialized facilities to all publicly supported facilities in the province.

Political Feasibility

The current provincial government is very supportive of the status quo: it takes credit for allocating beds in a way that reduces budget cost and appears to be fair and efficient. In addition, by allocating clients efficiently into LTCs, it reduced pressure on the primary acute care units.

However, this satisfaction with the system has to be tempered by the need to accommodate political pressure from ethnic communities.

In summary, the status quo has been cost-effective, efficient and fair in the short term placement of long-term care clients. The research findings in this capstone project have demonstrated that in the long term, Vancouver facilities have to raise their cultural competence level significantly in order to accommodate deficiencies in meeting and providing appropriate service to the increasingly diverse ethnic client population. Hence, though the status quo is acceptable to the health authorities in budgetary, political and administrative terms, it has shortcomings and is most unresponsive to the needs of its diverse client base.

4.4.3 Assessment of Alternative Two

Budgetary Feasibility

This criterion is critical when we consider the budget restraints imposed by the BC government. Since the release of CLAS standards, some evaluation has been conducted in the U.S. Health care practitioners have expressed concerns about the "unreasonable burden in costs and resources associated with the draft standards," and noted that "if applied literally, they would likely overwhelm most hospitals' and physicians' resources — both time and money." (OMH, 2003)

Administrative Feasibility

For an organization to achieve full cultural competence, specific interventions have been identified at three administrative levels: 1) policy makers 2) administrators, and 3) practitioners. In order to reach cultural competence, an organization needs to incorporate the standards such as CLAS at these three levels. Full implementation of all of the practices would take significantly more administrative resources than LTCs currently have available. If one examines the standards in detail, they require radical change in infrastructure and personnel priorities

Responsiveness to Clients' Needs

A fully integrated cultural competence program ultimately embraces diversity in ethnicity and culture as a common practice throughout the agency. It is clear that if all of the CLAS standards were implemented, this would more than meet the Vancouver clients' needs articulated in the interviews conducted by this capstone study.

Political Feasibility

This alternative would be attractive to ethnic minorities since this initiative will enhance awareness and sensitivity for their communities. However, any political party has to balance the various expectations of the voting public. Thus, many politicians will need to be convinced that, in setting priorities within a limited budget framework, the needs of ethnic minority elders rank higher than other demands. Although B.C. politicians have recently shown increasing sensitivity to minority leaders, there is no evidence of a clear demand in this province for a comprehensive and expensive cultural competence health care delivery system. In conclusion, The CLAS standard developed by OMH is very thoroughly researched and provides practical instruction on how to reach cultural competence in health care organizations. It represents an ideal framework against which to measure whether an organization is moving in the desirable direction in a culturally diverse society. However, a great deal of research and evaluation still needs to be done on the cost-effectiveness of its various components.

4.4.4 Assessment of Alternative Three

Budgetary and Administrative Feasibility

Alternative Three is appealing because it allows each facility to evaluate its own progress and to make a choice on which element needs most improvement. Hence, each administrator can prioritize his or her institutional interventions. This flexibility will assist facility planners in making rational budgetary decisions and administrative arrangements.

Responsiveness to Clients' Needs

Alternative Three permits each facility to move forward incrementally by selecting one or two aspects of each functional level at a time. Though this does not meet all of the clients' needs, facilities are hopefully able to achieve a higher cultural competence level along the continuum, while acting within their budget and administrative limitations.

Political Feasibility

This policy option is the most politically attractive of the three alternatives for the provincial government. It can be presented to the voting public as a new policy initiative designed to respond to the articulated needs of the growing community of ethnic elders in B.C. It will also appeal to many members of the public because it maximizes the cooperation with the existing organizations at the neighbourhood level. The community-based involvement is consistent with the prevailing mandate of this government to download responsibility wherever

possible to the local level. And lastly, it can be justified as having a minimum impact on the budget because it can be implemented gradually in accordance with available financial resources.

In conclusion, alternative three is the most practical and cost saving policy option among the three considered. It is superior in terms of budgetary, administrative and political feasibilities. In addition, it is unique in being the most responsive to clients' needs since the policy recommendations are derived from both external practices and empirical studies of the Vancouver situation.

5 Recommendations and Implementation

In the previous policy alternative section, this paper presented and analyzed three policy options with a set of four feasibility criteria. Table 9 clearly indicates that Alternative Three is the best of the three proposed options.

The conventional approach in making recommendations in a policy research paper is to choose one policy alternative that demonstrates the highest potential for its effectiveness at addressing the policy issue. However, in the case of this project, because Vancouver situation is complex and variegated with facilities achieving different levels of cultural competence along the continuum, it is not optimal to choose one alternative to fit all facilities.

The paper recommends that each individual facility select one of the three alternatives depending on its cultural competence ranking as described below.

1) "**Status Quo**" is recommended for facilities that are currently "culturally competent".

For the four facilities that are culturally competent, the status quo and current priority access system is an efficient policy that can be sustained in the long run.

2) "**Comprehensive Cultural Competence Standards**" is proposed for both "culturally competent" and "culturally pre-competent" facilities to use as a systematic standard and concise guideline on what cultural competence interventions to make and how to do them effectively. By conducting organizational cultural competence self-assessment on a regular basis, individual facilities can identify their unique service deficiencies and make appropriate adjustments as they compare their performance level with the comprehensive cultural competence standards.

3) **"Incremental Implementation of Cultural Competence Framework"** is appropriate for facilities that are "culturally insensitive.". By selecting different combinations of interventions at different cultural competence levels , current "culturally insensitive" facilities will be able to move forward on the continuum while still taking their facility-specific limitations into account.

Although only three facilities were found to fall under the "cultural insensitive" category in this study, I suspect that the number could be higher in Vancouver and those health authority regions that have many rural communities (e.g., Fraser Health Authority). Out of the 35 facilities

surveyed in Vancouver, 17 facilities did not reply. One possible explanation for the relatively low response rate is that some of the facilities may have little awareness of the cultural competence concept and currently do not have adequate culturally appropriate programs. Therefore, it is reasonable to postulate that these facilities are unlikely to show interest in participating in the study. However, with the priority access system as the admission policy, any facility can receive ethnic minority clients at any time. Since facilities at the "culturally insensitive" stage need the most guidance and help in making improvements, this paper provides them with a list of sub-alternatives as a pragmatic tool kit.

5.1 Facilities Belong to "Culturally Insensitive" Category

The interventions discussed in this section can easily be integrated into the existing infrastructure of Vancouver LTC facilities. These alternative are ranked based on three criteria: a) economic cost to implement; b) administrative cost to implement; and c) the degree of importance in terms of implementation.

1) Mission Statement and Facility Mandates

It is most important to have mission statements, procedures and policies that promote cultural diversity and competency. A health care organization is not likely to move upward on the cultural competence continuum if there is no cultural competence planning process in the organization. Several interviewees also stated the need to mandate interpreter services, since it is important to give clients a voice, reduce medical malpractice and client-staff misunderstandings.

2) Culturally Sensitive Facility Environment

In terms of cultural competence at the administrative level, interviewees identified that the most important thing is to provide a culturally sensitive living environment for all clients. Social workers have commented that most of the staff do not have enough knowledge on different cultural values, beliefs and the ethnic clients' perception on illnesses. It is difficult for the facility to provide appropriate services and better care when the care providers do not know ethnic clients' cultural needs. There is a need for short-term education programs in the facility that provide information on Chinese medication/treatment such as acupuncture, herbal drinks, Chinese tonic soup and Tai Chi etc. If staff attitudes and beliefs are in conflict with the values of the clients, there is a need to provide informal "Brown Bag" lunches for staff to explore their attitudes, beliefs and values. Facilities should also develop short-term specialized training for staff involved in the interpretation process. There is an assumption that if the health care provider

is bilingual then s/he can interpret. Training bilingual staff in interpreter skills will enhance their ability to effectively communicate in both directions.

Furthermore, when a facility provides a culturally sensitive atmosphere that makes the ethnic minority clients feel welcome, the clients are likely to make adequate adjustments and adapt to facility lifestyle even when the clients have limited English language proficiency. Culturally and linguistically friendly interior design, pictures, posters and artwork make the facilities more welcoming to the clients. It has also been proven that providing services in a comfortable setting enhances program participation (Manson, 2001).

3) On-Site Language Assistance

Currently, there are no formal interpreter services available in long-term care facilities. Language barriers can become a critical challenge in a crisis situation when neither the family members nor the client understand English.

Several alternatives on language assistance are identified by the interviewees:

1) A booklet that contains contact information on the volunteer interpreters who are willing to provide free interpreter services over the phone at anytime.

2) A booklet that contains pictures on one side and the English word on the other side (for the client)

2) A booklet that contains simple English phrases that are translated into different languages (for the family members)

3) Pictures on the wall to which clients can point when they need to communicate with staff (e.g., stomach ache)

4) Teach staff to speak a few key words in the language of their major ethnic client population.

4) Translated Document

Although research findings from client needs assessment conducted with ethnic Chinese elders indicate that the participants do not think obtaining medical information translated in a language they can understand is critical, several administrators reported on their facility survey that there is a need to have some pamphlets made available in languages other than English. From the health providers' perspective, it is critical to have some documents, such as the Client Intake Assessment Forms, translated into languages other than English.

For example, the Mini Mental Status Exam is conducted with all clients as they enter the facility. This is an essential process to assess the client's cognitive ability. The assessment will

be important for many reasons such as pairing appropriate roommates. When ethnic elders are received, their "Mini Mental Status Exam" is often marked as "not accessible due to language barriers."

The ideal solution for this problem is to have on-site professional interpreter assisting the client in answering the questions. This has been the standard practice at Vancouver hospitals. However, this initiative may be economically and administrative costly.

The alternative is to translate this short standardized questionnaire into other languages and have volunteers and family members help the staff to conduct the assessment. Since this mini exam consists of standard questions that are in use by all facilities, B.C. Ministry of Health could make a one-time translation of this form accessible from the internet for long-term care health providers.

5) Cultural Games and Programs

Developing Programs and activities that keep clients active physically and mentally is a big part of long-term care services. It is important to organize special events that include all ethnic groups. Our study results show that some ethnic Chinese clients do not attend any of the special activities designed for them. This demonstrates a need to conduct program assessments periodically and to gather feedbacks from both clients and staff on what types of programs to develop for clients with diverse cultural backgrounds.

With facilities that do not have any culturally appropriate program developed, clients suffer psychologically from isolation. In one reported case, an elder Chinese resident was found crying for a few days. When finally investigated, the staff found that her radio was broken. It has a Chinese channel that she listens to every day and that is the one activity she depends on because she stays in her room most of the day. There are no recreational programs in the facility that are culturally appropriate for her.

6) Ethnic Food

It is always nice to have ethnic meals. For some elders, ethnic food may be essential when they cannot get used to other type of food; for others, ethnic meals help to create a home-like environment which the ethnic clients are comfortable and familiar with. It is however, not always administratively possible for the facility to offer different ethnic meals to a diverse clientele. In addition to ethnic meals offered within facilities, several alternatives are available.

1) With the permission of the dietician, family members can bring food to the client

2) Clients can participate in the Meals-On-Wheels program. The cost is approximately $3/meal

7) Cultural Resources

Many reports have stated that it is important to translate health information and pamphlets into major languages of their clients (Wong, 1989; Benston, 1999). This initiative is important but costly. From the interviews conducted with Vancouver ethnic Chinese elders, it is evident that elders place higher emphasis on obtaining reading material (e.g., newspapers, magazines) in their own language over receiving understandable technical health information. Thus, to Vancouver LTC facility administrators, we recommend that facilities provide leisure reading, entertainment material and entertainment (e.g. ethnic movie and music CDs etc) for ethnic minority clients. Since elders rely on their families to provide them with health information, it is important for Vancouver Coastal Health Authority to develop standard language or templates for key documents used by many health care organizations (e.g., consent forms, health information, and medication information) in the long run. Alternatively, health care officials can translate important information into a range of languages, and make it available through the internet for downloading and customization by individual facility administrators.

8) Supportive Network

Several interviewees articulated the importance of working with ethnic communities. For facilities that are culturally insensitive and have limited human and financial resources, it is necessary to establish working relationships with ethnic community agencies that can provide information/knowledge and consultation services at very little cost.

This paper recommends Vancouver Coastal Health Authority to design a resource booklet that contains contact information of different ethnic community agencies that provide volunteering services and work with long-term care facilities.

9) Recruitment

During the interview, facility planners expressed concerns about a lack of Chinese nurses. One individual stated that with 20 ethnic Chinese elders in her facility, there are only two Chinese-speaking staff who work in the evening. It has always been difficult to recruit Chinese nurses. Most of the job applicants are either foreign-trained or have little experience. This interview finding explains one of the study results from the facility survey. When facility self-assessment data are analyzed, it is noted that all responding facilities are culturally competent in the sense they are striving to hire staff with diverse cultural backgrounds. However, when

administrators were asked whether they have staff speak the language of those of the clients, 33percent indicated "occasionally" and 48percent said "rarely or never".

The interviewee identified that there are not enough ethnic minority nursing students enrolled in LTC education programs. With no financial resources available for interpreter services in LTC facilities, administrators rely heavily on their culturally diverse staff to provide culturally appropriate services to clients with limited English language proficiency. If the university programs do not recruit and retain a sufficient number of nursing students with various ethnic backgrounds, we will see an increasing difficulty in hiring culturally diverse staff.

In summary, interviewees stated that language barriers are challenges that can be overcome; the most important thing is to provide a culturally sensitive home-like living environment to the diverse clientele. The following table ranks the proposed sub-alternatives via three criteria, namely budget cost, administrative cost and the degree of importance in terms of implementing these culturally competent interventions.

Table 10 Sub-alternatives Ranking

Alternatives (for "culturally insensitive facilities)	**Budgetary Cost**	**Administrative Cost**	**Degree of Importance to implement**
Mission Statement and Facility Mandates	Low	Low	Very High
Culturally Sensitive Facility Environment (e.g. staff training, education program)	Medium	Medium	Very High
On-Site Language Assistance.	Low	Low	High
Translated Document	Low (one-time cost)	Low	High
Cultural Games and Programs	Medium	Medium	High
Cultural Resources	Medium	Low	Medium
Ethnic Food	Medium to High	Medium to High	Medium to High
Supportive Network	Medium	Medium	Medium
Recruitment	High	High	Medium (Short-Run High (Long-Run)

In British Columbia, the Ministry of Health and individual authorities provide only a general practice guideline and it is left to the individual facility administrator's discretion as to what type of services need to be developed and provided. Therefore, this paper recommends that the B.C. Ministry of Health mandate all long-term care facilities to promote cultural diversity and culturally competent services. As for individual facilities, an organizational cultural competence self-assessment must be conducted periodically and performed on an on-going basis. Based on the individual facility's level of cultural competence, the administrator needs to develop and provide culturally competent interventions that are most suitable. Administrators, program and policy planners can choose one of the three alternatives as analyzed in the previous section.

To summarize, 1) "Status Quo" is recommended for facilities that are currently "culturally competent"; 2) "Comprehensive Cultural Competence Standards" is proposed for facilities that are either "culturally competent" or "culturally pre-competent"; and 3) "Incremental Implementation of Cultural Competence Framework" is appropriate for facilities that are currently "culturally insensitive." A set of sub-alternatives is available for this type of facility. By selecting different combinations of interventions at different cultural competence levels (e.g. organizational, administrative and community levels), current "culturally insensitive" facilities will be able to move forward on the continuum while still taking their facility specific limitations into account.

5.2 Study Limitation

It is important to keep in mind families and family contexts when developing long-term care policies and programs. Due to time constraint, we did not include family members as study participants. However, culturally competence interventions may affect not only the ethnic elders, but also the elders' families. For example, a new policy may affect the costs borne by the family and not just the elder. For future studies, researchers should take a larger view and conduct focus groups with family members. It is also important to recognize that this project is only a pilot study. The project has taken a cross-sectional approach and the sample population (ethnic Chinese elders interviewed) does not represent the entire ethnic population. The client needs assessment study conducted intends to explore the various cultural factors and issues faced by ethnic Chinese residents. For future research, more in-depth investigations understanding ethnic elder's well-being and adaptation process to institutional life are needed. It would be beneficial for future researchers to survey a larger population and conduct the studies in several cities or

health regions. It is important to examine the effect of the priority access system on ethnic clients in terms of geographic location of the facility.

6 Conclusion

Very little is known about the unique issues that ethnic elders face in adjusting to a culturally non-congruent long-term care facility. However, this is an important matter as illustrated by the ethnic elders' response to the priority access admission system for long-term care introduced in 2002. Since then, there has been a drastic increase in the number of ethnic Chinese elders placed on the transfer waiting list requesting to transfer from their integrative long-term care (LTC) facility to a Chinese-specific facility.,

This paper investigates these issues by conducting two mini-studies. The paper's methodology stressed empirical research on the problem from two different perspectives: facility administrators and ethnic clients. The principal research methods were: 1) client-based needs assessment conducted with ethnic Chinese elders and 2) organizational cultural competence self-assessment conducted with Vancouver LTC facilities. The principal findings were: 1) ethnic Chinese elders residing in the Vancouver long-term care facilities have culturally specific needs that are not being addressed and these unmet needs cause psychosocial stress; and 2) the majority (78 percent) of the responding Vancouver facilities are not "culturally competent" when evaluated against a widely used American cultural competence standard.

The research results demonstrate that most of the publicly funded Vancouver LTC facilities do not have a systematic plan, the capacity or resources to provide the appropriate care to a culturally diverse client population. In a cosmopolitan city like Vancouver, where over half the elders (age 65-74) are ethnic minorities, it is socially irresponsible for B.C. Health Care Authorities not to consider modification to the long-term care facilities services. Therefore, the policy goal is to raise the level of cultural competence among all facilities and the paper proposes three policy alternatives: 1) status quo; 2) implementation of CLAS Cultural Competence standards; and 3) incremental implementation of cultural competence framework. In order to analyze the efficacy of the three alternatives, four feasibility criteria are applied: budgetary; administrative; responsiveness to client needs; and political acceptability.

The paper recommends individual facilities choose one of the three alternatives depending on the facility's cultural competence level. For facilities in the "culturally insensitive"

category, "incremental implementation of cultural competence framework" is recommended. In British Columbia, Ministry of Health and individual authorities provide only a general practice guideline and it is left to the individual facility administrator's discretion as to what services need to be developed and provided. This paper recommends that the B.C. Ministry of Health mandate all long-term care facilities to promote cultural diversity and culturally competent services. As for individual facilities, an organizational cultural competence self-assessment must be conducted periodically and performed on an on-going basis. Based on the individual facility's level of cultural competence, administrators need to develop and provide culturally competent interventions that are most suitable for their individual situations. In conclusion, this issue of cultural competence needs more attention and should be placed on the top of the B.C. Ministry of Health policy agenda.

7 Appendices

7.1 Appendix I

Excerpts from: U.S. National Standards for Culturally and Linguistically Appropriate Services in Health Care

Federal Register: December 22, 2000 (Volume 65, Number 247) [Page 80865-80879]

Source: Office of Minority Health Resource Centre

1. Health Care Organizations Should Ensure That Patients/Consumers Receive From All Staff Members Effective, Understandable, and Respectful Care That Is Provided in a Manner Compatible With Their Cultural Health Beliefs and Practices and Preferred Language

2. Health Care Organizations Should Implement Strategies To Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area

3. Health Care Organizations Should Ensure That Staff at All Levels and Across All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery

4. Effects of cultural differences among patients/consumers and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

5. Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation

6. Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services

7. Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/ Consumer)

8. Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area

9. Health Care Organizations Should Develop, Implement, and Promote a Written Strategic Plan That Outlines Clear Goals, Policies, Operational Plans, and Management Accountability/Oversight Mechanisms To Provide Culturally and Linguistically Appropriate Services

10. Health Care Organizations Should Conduct Initial and Ongoing Organizational Self-Assessments of *CLAS*-Related Activities and Are Encouraged To Integrate Cultural and Linguistic Competence-Related Measures Into Their Internal Audits, Performance Improvement Programs, Patient Satisfaction Assessments, and Outcomes-Based Evaluations

11. Health Care Organizations Should Ensure That Data on the Individual Patient's/Consumer's Race, Ethnicity, and Spoken and Written Language Are Collected in Health Records, Integrated Into the Organization's Management Information Systems, and Periodically Updated

12. Health Care Organizations Should Maintain a Current Demographic, Cultural, and Epidemiological Profile of the Community as Well as a Needs Assessment to Accurately Plan for and Implement Services That Respond to the Cultural and Linguistic Characteristics of the Service Area

13. Health Care Organizations Should Develop Participatory, Collaborative Partnerships With Communities and Utilize a Variety of Formal and Informal Mechanisms to Facilitate Community and Patient/ Consumer Involvement in Designing and Implementing *CLAS*--Related Activities

14. Health Care Organizations Should Ensure That Conflict and Grievance Resolution Processes Are Culturally and Linguistically Sensitive and Capable of Identifying, Preventing, and Resolving Cross-Cultural Conflicts or Complaints by Patients/Consumers

15. Health Care Organizations Are Encouraged to Regularly Make Available to the Public Information About Their Progress and Successful Innovations in Implementing the *CLAS* Standards and To Provide Public Notice in Their Communities About the Availability of This Information

7.2 Appendix II

Interview Questions for the Chinese-Canadian Elders

Any information that is obtained during this study will be kept confidential to the full extent permitted by the law. Knowledge of your identity is not required. You will not be required to write your name or any other identifying information on research materials. Materials will be maintained in a secure location.

Your answers are very important to the study. You may choose to do this interview or not. You may withdraw from participation at any time. Your decision to do the interview will not affect any benefits you get. The questions should take about 15 minutes to answer.

Demographic Data

1. What is your age? Male or female?

2. Where were you born?

3. How many years have you been in Canada?

4. What language do you mainly speak at home?

5. Do you speak English? ( ) YES ( ) NO

If yes, how well?
( ) 1. WELL
( ) 2. ADEQUATE
( ) 3. VERY LITTLE
( ) 4. BARELY

6. Do you have family/relatives in the Lower Mainland? If yes, which city do they live in?

7. Did you transfer to the Simon K.Y. Lee care home from another facility?
( ) YES ( ) NO

If yes when did you transfer from another facility to the Chinese care home?
Date:
From what facility:
Why:

The amount of information received by the elder in a language that s/he understands

8. How much information were you given about the facility before you moved into the residence? In what language?
( ) 1. A LOT
( ) 2. MODERATE AMOUNTS
( ) 3. A LITTLE
( ) 4. NONE

9. Have your health care providers explained your conditions to you?
( ) 1. YES ( ) 2. NO

10. Do you understand the signs and directories at the residence?
( ) 1. YES ( ) 2. NO

Communication

11. Have you ever had a hard time speaking with or understanding a doctor or other health providers because you spoke different languages?

( ) 1. ALWAYS
- If so, over what time period?

( ) 2. SOMETIMES
( ) 3. SELDOM
( ) 4. NEVER

13. Have you needed an interpreter to help you speak with nurses/doctors or other health providers?
( ) 1. ALWAYS
- If so, how frequent (e.g. 5 times a day)?

( ) 2. SOMETIMES
- If so, how frequent (e.g. 5 times a week)?

( ) 3. SELDOM
- If so, how frequent (e.g. 2 times a month)?

( ) 4. NEVER

14. When you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?

( ) 1. ALWAYS
( ) 2. SOMETIMES
( ) 3. SELDOM
( ) 4. NEVER

Did this process take time? If so, how long?

15. If the health providers do not understand you, what do you do? (e.g. do you get other types of help)

Food and Drink

16. What type of food and drink do you like?
( ) 1. CHINESE
( ) 2. WESTERN FOOD
( ) 3. BOTH

17. What food and drink is served at your residential care facility?
( ) 1. CHINESE
( ) 2. WESTERN FOOD

( ) 3. BOTH

18. If Chinese food is serve at your residential care facility, how often per week?

( ) 1. ONCE
( ) 2. TWICE
( ) 3. THREE TIMES
( ) 4. MORE THAN THREE TIMES
( ) 5. EVERYDAY

19. Do you ever refuse to eat a meal served at your residential care facility?
( ) YES ( ) NO

If YES, how often?
( ) 1. FREQUENTLY REFUSE
- If this is the case, how frequent (e.g. 3 or more times per week)

( ) 2. SELDOM REFUSE

20. Does your family/relatives bring outside food to you?
( ) YES ( ) NO

If YES, how often?

Friends and Roommates

21. Do you have friends at the residential care home?
( ) YES ( ) NO
- If yes, how many? What are their cultural backgrounds? Do you speak the same language?

22. On an average day, how much time do you spend

( ) 1. IN YOUR ROOM
( ) 2. COMMUNAL AREAS OF THE RESIDENTIAL CARE HOME
( ) 3. OTHER RESIDENT'S ROOMS

Activities and Social Events

23. Do you participate in the games/activities at the senior care residence?
( ) YES ( ) NO

If YES, how often?
( ) 1. ONCE
( ) 2. TWICE
( ) 3. THREE TIMES
( ) 4. MORE THAN THREE TIMES
( ) 5. EVERYDAY

If NO, why not?

24. What types of games/activities are organized at your senior care residence?

26. Are there any newspaper/magazine, radio show, TV channels available in the language you understand?
( ) YES ( ) NO

27. Does your senior care home celebrate Chinese festivals or other cultural festivals?
( ) YES ( ) NO

28. Are you able to suggest different recreational activities to the staff/managers?
( ) YES ( ) NO

Network of Support

29. Do you maintain contacts with your community friends and organizations?
( ) YES ( ) NO

30. Are there any recreational activities organized by the senior care home with your community groups?
( ) YES ( ) NO

31. If we were to take one item away from the following list, which one you would not want to lose the most? Please rank 3 most important items to you.

1. ( ) Chinese Food. 2. ( ) Chinese activity/events/festivals
3. ( ) Chinese speaking staff 4. ( ) some information material written in Chinese
5. ( ) Chinese social events

7.3 Appendix III

Survey Form: Long Term Residential Care Facility - Administrators

This survey will take about 10-15 minutes to complete. Your responses will be held in strictest confidence and will be anonymous. Materials will be maintained in a secure location. Only people directly involved with this project will have access to the information. All information that is obtained during this study will be kept confidential. The results of this survey will be utilized in aggregate and summary form only.

Your answers are very important to the study. You may choose to do this survey or not. You may withdraw from participation at any time. Your decision to complete the survey will not affect any benefits you get.

If you have questions about the assessment of organizational cultural competence, please contact Catherine Cheng or my supervisors, Dr. Nancy Olewiler and Dr. Kennedy Stewart, Department of Public Policy, Simon Fraser University, 8888 University Way, Burnaby, British Columbia, V5A 1S6 Canada Phone: 604-291-5289.

Thank you again for taking the time to assist me in this research!

Please indicate your length of involvement with this organization:

Less than 1 year 1 to 5 years More than 5 years

Part A - Directions: Please read each statement and write in each box with a number from 1-3 which most closely reflects your facility's practices:

1 = We always do this
2 = We often do this
3 = We occationally do this
4 = We rarely or never do this
5 = Don't Know

Cultural Competence is defined as: set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable an organization to work effectively cross-culturally.

It is often defined as a "system" or a "model" that is demonstrated through a cluster of measured activities and is developed in a program as an intrinsic part of service delivery planning and implementation process.

Organization

1. ___ A revision of the facility's mission statement, procedures and policies are regularly reviewed to ensure they reflect and promote cultural diversity and cultural competence.

2. ___ Non-English speaking clients are encouraged to participate in the facility's committees and groups to make suggestions and recommendations on services, programs, etc.

3. ___ The facility documents their client's cultural, language and religious backgrounds and needs, and that of their family if applicable.

4. ___ The facility has processes in place to enhance cultural competence.

Administration

5. ___ The recruitment, hiring, training and retention processes of the facility are culturally sensitive and/or driven to a certain degree by the need to achieve cultural diversity in the facility

6. ___ Staff are trained on a regular basis on cultural competence.

7. ___ An internal course(s) in the cultural beliefs of the patient populations is required of all staff

8. ___ Staff members possess the knowledge and experience to work effectively with culturally diverse clients

9. ___ The facility's committee and councils contain members that can represent the facility's cultural service areas.

10. ___ The facility collects information on client's cultural, linguistic and religious backgrounds and needs during their initial assessments and/or during their intake.

11. ___ If a client or staff uses culturally inappropriate languges, do you have a policy or procedure to address this?

12. ___ The cultural background of the client is considered with respect to the food services of the facility.

13. ___ Fiscal resources are available for translation and interpretation services.

14. ___ The facility has interpretation services that are readily available upon request.

15. ___ Policies and procedures for the use of interpretation/translation services are in place and actively applied.

16. ___ The facility has enough staff/interpreters who are proficient in writing and speaking the languages of its clients.

If your answer to Question 16 is YES, please answer the questions in the box below. If your answer is NO, please skip the box, and continue with Question 17

The following statements refer to the on-site interpreters:

1) They are easily accessible to our patients. **Yes** **No**
2) The majority are professional medical intrepreters. **Yes** **No**
3) The majority are volunteer interpreters. **Yes** **No**
4) The volunteer interpreters are knowledgeable in medical terminology. **Yes** **No**
5) The volunteer interpreters receive an orientation/training in medical interpreting. **Yes** **No**
6) The volunteer interpreters receive compensation (i.e. extra vacation time, yearly bonus, awards, etc.) for performing these services. **Yes** **No**

17. ___ The facility makes available resources and information on cultural diversity issues.

18. ___ Pamphlets and other printed materials providing information about the facilities that are available in the language spoken by your clients.

19. ___ Posters, pictures and other decorative items are present in the facilities that reflect the cultures of the facility's clients.

Resources and Outreach

20. ___ The facility has a workng relationship and/or liaises with ethnic community agencies in its service area.

21. ___ The facility has procedures in place to facilitiate consultations with clients of non-English speaking backgorunds and ethnic communities in its service area.

22. ___ The facility develops links with ethnic communities and uses workers in those communities as cultural consultants when needed.

Part B - Please indicate any challenges that are faced in making institutions culturally competent

Thank you very much for your time and help in this research study!

Survey adapted in part from:

Cultural Competence Checklist for Agencies, Multicultural Disability Advocacy Associate of New Santa Wales

Promoting Cultural Diversity and Cultural Competence Self Assessment Checklist for Personnel Providing Services and Support to Children with Special Health Needs and Their Families by Tawara D. Goode, Georgetown University Child Development Center.

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