Cultural Responsiveness Committee

Share out with Work Group

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Summary of cultural responsiveness committee process:

The Cultural Responsiveness (CR) committee met a total of four times between February and April 2018. The committee was comprised of medical providers, care persons, community advocates, non-profit staff, and local government staff, and state agency staff. Several participants identified themselves as being a part of a specific racial, ethnic, GLBT, rural, and/or Tribal community.

The CR committee worked to both define their scope and agree upon necessary definitions for their work together. The group desired to provide clear definitions and guidance for other committees and the Work Group related to health equity, cultural responsiveness and other terminology. A small subset of group members reviewed the National Alzheimer's Plan for examples of culturally specific work. Another set of group members developed a listing of key terms and definitions.

The CR committee developed that cultural responsiveness and health equity could be more effectively and consistently woven throughout the entire Legislative report.

Documents created via the committee process include:

- A document with guiding values, key terms, and reflection questions for use by other committees and the Work Group. This is intended to help embed health equity and cultural responsiveness across the Legislative report.

- An Inventory of culturally-specific information and Minnesota resources. This may be utilized by other committees who desire to know about different cultural norms and experiences related to Alzheimer's. This inventory can be considered a living document, with other committees both using it as a reference document and adding to it through their work.

- A review and summary of the National Alzheimer's Plan 2017 Update and other State Alzheimer's plans for recommendations or strategies related to cultural responsiveness or health equity.

- A glossary of terms related to the committee's work, which can be used as a reference as needed by other committees.

Presentations and discussions generated via the committee process include:

- Presentation and discussion from Bruce Thao, Center for Health Equity, Minnesota Department of Health

- Small group discussions with community based organizations and others doing cultural responsive work in Minnesota

- Key findings and next steps

Guiding Values, Equity Lens for Analysis, and Key Terms

"I was really pleased about how Dr. Kaplan talked about his diagnosis – he talked about how well he was treated after he was diagnosed. He talked about how the physician sat with him and went thru about the disease. Let me tell you how we were treated. The very first time Cedric was diagnosed, the neurologist came in and said, "Your husband has Alzheimer's – there's nothing I can do. Go join a study, maybe you can get some pills there." That's how I was treated." *Testimony Excerpt of Mrs. Venoreen Browne-Boatswain (who is an African-American Minnesotan) at a NIH dementia summit on October 17, 2017.* [National Research Summit on Care, Services and Supports for Persons with Dementia and Their Caregivers (Day 2). National Institutes of Health.](#)

The cultural responsiveness committee considered how they can support other committees to consider health equity and cultural responsiveness in their work. The committee developed the following key terms, guiding values, and definitions to share with other groups and include in their work.

Guiding values:

The cultural responsiveness group requests that other committees and the work group consider these values when conducting their work, and use the Equity lens questions below to ensure they are considering cultural responsiveness and health equity.

Authenticity:

- Accept people where they're at – individual, family, provider, etc. We're all responsible to play an active role in the work of health equity and cultural responsiveness.

- Providers and those in positions of power must be open to not only hear and learn about different needs but positively address concerns expressed showing that they have sought and fully heard the voice of the client/patient/caregiver.

Assets-based approach to equity and diversity:

- There are many variations of families and caregiving can look different. A patient isn't one person – it's whatever their family structure is. Consider the needs of families and caregivers who may have different cultural norms and values related to dementia/Alzheimer's, as well as families where the care structure isn't a husband/wife team.

- Communities have many different norms around how they view Elder's and Alzheimer's. An equitable solution may mean that different groups need different things, rather than a one-size fits all approach.

Openness in discussions and out of the box ideas:

- Acknowledge through constructive dialogue the role that race and racism has played, and continues to play, in creating the ADRD policies and procedures that provide services and support for some individuals while denying them for others. These ADRD programs and processes have been a product of the dominant culture's assumptions without input from those who are not of that culture but deserve "a seat at the table" of decision-making.

- Actively create opportunity for voices that have been hidden to participate in ideation and decision-making that may create meaningful outcomes for communities of color and Indigenous peoples.

Equity Lens Questions for Analysis

- What groups are most impacted or marginalized in relation to this policy/program/issue?
- Who is most effected by the policy/issue program? Who is included/excluded from this policy/program/issue?
  - What needs to change in the proposed model that takes into consideration the social, economic and political structures that impact the desired outcome?
- What are the biomedical and public health barriers for:
  - People and families accessing services?
  - Providers to providing culturally responsive care?
  - Creating a system/policy that leads to more equitable outcomes?
  - Participation of community groups?
- Who is at the table for decision making related to this topic? Who is missing?
  - How can decision making be shared with rather than just informed by the communities impacted?
  - Who is paid/not paid to be at the table? How do we create structures to compensate communities for their time and engagement in this work? Pay community members and cultural consultants to participate and share knowledge.
  - Who are the allies to help work with different communities on this policy/program/issue?

Key Terms

Structural Racism: Structural racism is the normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and Indigenous peoples. Reference: 2014 Advancing Health Equity in Minnesota.

Structural inequities: Structures or systems of society — such as finance, housing, transportation, education, social opportunities, etc. — that are structured in such a way that they benefit one population unfairly (whether intended or not). Reference: 2014 Advancing Health Equity in Minnesota.

Institutional racism: The systematic distribution of resources, power and opportunity in our society – such as through a specific bank, college, government agency - to the benefit, intentionally or not, of people who are white and the exclusion of people of color and Indigenous peoples.

Cultural competence: The ability to interact effectively with people of different cultures. ... to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. In practice, both individuals and organizations can be culturally competent. "Culture" is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. To produce positive change, prevention practitioners and other members of the healthcare workforces must understand the cultural context of their target community. They must also have the willingness and skills to work within this context. This means drawing on community-based values and customs and working with knowledgeable people from the community in all efforts. Practicing cultural competence throughout the program planning process ensures that all members of a community are represented and included. It can also prevent wasteful spending on programs and services that a community can't or won't use.   Reference: https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

Cultural responsiveness: Culturally responsive care considers and adjusts appropriately to the individual and family being served based on their education, class, race/ethnicity, immigration status, and geographic location.

Health disparities: A population-based difference in health outcomes (e.g., African-Americans incidence of Alzheimer's is twice that of Caucasian Americans). Reference: 2014 Advancing Health Equity in Minnesota.

Health inequity: A health disparity based in inequitable, socially-determined outcomes. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. Reference: 2014 Advancing Health Equity in Minnesota.

Health equity: When every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health. Reference: 2014 Advancing Health Equity in Minnesota.

Cultural humility: A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process. The concept of cultural humility was developed by medical doctors Melanie Tervalon and Jann Murray-Garcia in a 1998 academic article published in the Journal of Health Care for the Poor and Underserved.

Inventory of Cultural Information and Minnesota-Specific Resources

The resources below were provided by committee members as items that may be helpful to other committees. Some of these resources are general information regarding different cultural, First Nations, racial and/or ethnic groups, while others are

This is intended to be a living document and can be added to by other committees.

Dementia and General Disparities - National and International Information

1. **Deconstructing lifecourse mechanisms of Alzheimer's disease disparities -** clarifies the independent influences of language, acculturation, educational experiences, racial socialization, and socioeconomic status on cognitive test performance, with the ultimate goal of understanding more about the relationship between culture and cognition. Jennifer J. Manly. NIH Videocasting. October 18, 2017.

2. **The Role of Early-Life Educational Quality and Literacy in Explaining Racial Disparities in Cognition in Late Life -** Racial disparities in late-life cognition persist even after accounting for educational attainment. by Shannon Sisco, Alden L. Gross, Regina A. Shih, Bonnie C. Sachs, M. Maria Glymour, Katherine J. Bangen, Andreana Benitez, Jeannine Skinner, Brooke C. Schneider, Jennifer J. Manly. Published in: Journal of Gerontology Series B: Psychological Sciences, v. 70, no. 4, July 2015, p. 557-567

3. Racial Differences in Perceived Burden of Rural Dementia Caregivers (Faith, African American, Rural) – Abstract summary: "This study explores whether religiosity explains racial differences in caregiving burden for a rural sample of dementia family caregivers. Data are from a probability sample of 74 non-Hispanic White and 67 African American dementia caregivers in rural Alabama… Religious involvement in general, and church attendance in particular, seem to provide both spiritual and social psychological benefits to dementia caregivers. Thus, supplementing formal services with the services provided by religious organizations may be important in rural areas where formal resources are scarce." (Sun, F. et al. "Racial Differences in Perceived Burden of Rural Dementia Caregivers." *Journal of Applied Gerontology* 29.3 (2009): 290-307.)

4. **Montessori For Dementia (Australia)** - As an innovative method of working with older adults living with cognitive and/or physical impairments, Montessori has the potential to change the lives of people in residential care and enhance the lives of people in their own homes

   Quality Aging using Montessori (Australia) - The Montessori Method for Dementia is an evidence-based intervention that can enrich quality of life.

5. [Study on Alzheimer, hope for Africa. MARCH 27 2017](). (Kenya) It is estimated that about 2.1 million of those suffering from Alzheimer's disease live in sub-Saharan Africa. Scientists at Georgetown University in Washington DC, US, have managed to accurately predict the onset of Alzheimer's disease after years of study on a small sample involving 525 people aged over 70 years.

Cross-Cutting – Minnesota Specific

6. [MN2030 Looking Forward- Status Check: Developing Strategies in Cultural and Ethnic Communities]() - This September 2017 report provides a snapshot of the MBA's current status in a goal area identified in 2000. At that time, the Minnesota Board on Aging (MBA) in partnership with the Minnesota Department of Human Services assembled key stakeholders to develop a report called the [Long Term Task Force Report](). The report identified six broad goals and 15 strategies to prioritize action about long term care for older Minnesotans.

7. [Cultural Awareness in Dementia Care]() American Society on Aging presentation. January 17, 2017. The Minnesota Board on Aging's "Cultural Awareness in Dementia Care" initiative is designed to promote principles of health equity and enhance person-centered dementia care for diverse ethnic and cultural communities who have the highest health disparities. Shares the program's design and steps for implementation. First Nations and Somali cultural consultants share their experience in working with service providers to strengthen capacity to provide culturally enhanced services.

8. [ACT on Alzheimer's (actonalz.org) A Health Equity Call to Action]() - Alzheimer's disease touches every community, yet some groups are at greater risk of developing the disease. The lack of equity (social, health, environmental) impacts the health and well-being of all and creates health disparities. ACT on Alzheimer's seeks to eliminate or reduce health disparities and the impact of Alzheimer's disease and to practice inclusiveness and equity in engaging communities to build supportive, dementia-friendly environments. ACT on Alzheimer's formed a Health Equity Leadership Group to consider health disparities and inequities with dementia care. See a summary of the group's evolution within the larger ACT initiative. One way ACT on Alzheimer's is addressing health disparities in dementia care is by offering cultural competence and awareness resources for providers, tips for screening and diagnosing diverse populations and culturally responsive resources for patients and families.

9. [Act on Alzheimer's – Community Evaluation Reports]() - ACT on Alzheimer's provides a range of evaluation reports for efforts in communities around Minnesota.

10. [Act on Alzheimer's Dementia Friendly Communities]() – ACT on Alzheimer's website includes links to information about Dementia Friendly Communities around Minnesota.

11. [Montessori for Aging and Dementia Consultant]() - Brush Development Company believes that Montessori for Aging and Dementia is an approach to life that supports each individual in engaging in their community in a purposeful way. Live 2-day training teaches care provider how to establish a culture where participant(s) thrive.

12. [Caregiving for Older Adults – A Conversation on Caregiving in Minnesota]() – A series of videos from ECHO/TPT sharing different perspectives on caregiving in the Hmong, Khmer, Cambodian, Spanish, and Somali communities of Minnesota.

13. [MN2030 Looking Forward – Cultural Responsiveness Policy Brief](#) - The Minnesota Board on Aging policy briefs offer an opportunity for stakeholders to learn and engage in a planning effort to reform our system and to prepare communities and the state meet the challenges and opportunities associated with an aging population. (2017)

14. [Cultural Information Sheets](#) – TPT and ECHO Minnesota developed information sheets containing common cultural norms, values, and traits in the areas of familial structure, religion, communication styles, personal space, gender roles, and traditional beliefs on health and medicine. Not dementia specific. (Hispanic, Hmong, Somali, Vietnamese, Lao, Cambodian, Karen, Arab)

Faith Communities

15. [Faith-Related Programs in Dementia Care, Support, and Education](#) - Provides an overview literature and interviews with faith-related programs focused on serving people with dementia and their care persons. Includes examples of adult day centers, along with other examples of broader spiritual/religious programs that provide a range of supports.

Indigenous peoples and First Nation Tribes

16. [Adult caregiving Among American Indians: The Role of Cultural Factors](#) – Abstract: Using a sample of American Indian adults, study authors estimated the prevalence of adult caregiving, assessed the demographic and cultural profile of caregivers, and examined the association between cultural factors and being a caregiver. This is the first such study conducted with American Indians. (Goins, R. Turner et al. "Adult Caregiving Among American Indians: The Role of Cultural Factors." *The Gerontologist* 51.3 (2011): 310–320.)

17. [American Indian Family Caregivers' Experiences with Helping Elders](#) – Abstract: This mixed methods study explores the negative and positive aspects of providing elder care among 19 northern plains American Indian family members. These caregivers described low levels of burden and high levels of reward, attributable to cultural attitudes toward elders and caregiving, collective care provision, strong reciprocal relationships with elders, enjoyment of elders, and relatively low levels of care provision. Caregiving manifested as part of a complex exchange of assistance rather than a unidirectional provision of assistance from the family member to the elder. That caregiving emerged as such an overwhelmingly positive experience in a community faced with poverty, alcohol disorders, trauma, and cultural traumatization is testimony to the important roles that elders often continue to play in these communities. (Jervis, Lori L., Mathew E. Boland, and Alexandra Fickenscher. "American Indian Family Caregivers' Experiences with Helping Elders." Journal of cross-cultural gerontology 25.4 (2010): 355–369. PMC. Web. 17 Apr. 2018.)

African American

18. [National Research Summit on Care, Services and Supports for Persons with Dementia and Their Caregivers (Day 2). National Institutes of Health.](#) Testimony of Venoreen Browne-Boatswain at a NIH dementia summit on October 17, 2017. Mrs. Browne-Boatswain is a Minnesota African-American sharing her experiences as a caregiver navigating the medical and research systems – speaking to the structural and institutional racism that exists and the need for culturally competent services. Time Stamp 7:59:00 - 8:07:59.

19. [Education Is Key to Reducing Disparities in Alzheimer's](#) - the disparities in developing Alzheimer's disease across race are accounted for by indicators of school quality. by Dana Talesnik.

20. Study: Fewer healthy years for older black Minnesotans than whites – MPR news story on a 2013 U.S Centers for Disease Control and Prevention report concluding that "black Minnesotans can expect a little over half of their remaining years - or 57 percent -- to be healthy. On average Minnesotans 65 and older can expect 77.5 percent of their remaining years to be healthy. But while that is true for whites, black senior citizens will not see as many healthy years." (Author: Lorna Benson.)

21. [The Meanings African American Caregivers Ascribe to Dementia-Related Changes; The Paradox of Hanging on to Loss](#) – Abstract: This study used qualitative methods to explore the meaning African American caregivers ascribed to the dementia-related changes in their care recipients. Results from this study suggest that African American caregivers tend to focus on the aspects of the care-recipients' personalities that remain, rather than grieve the dementia-related losses. These findings have the potential to deepen gerontologists' understanding of the AA caregiver experience. This, in turn, can facilitate effective caregiver decision making and coping. (Lindauer, A. et al . "The Meanings African American Caregivers Ascribe to Dementia-Related Changes: The Paradox of Hanging on to Loss." *Gerontologist* 56.4 (2015):733-42.)

22. [Alzheimer's risk is higher in African Americans, but many fear clinical studies](#) - in minority communities there is distrust of clinical trials. by Frederick Kunkle, Nov 2014.

23. [The Clinical and Cultural Changes of Dementia in African-Americans and Hispanics](#) -Discussion of barriers in diagnosis of ADRD and principles of a dignified diagnosis. Vimeo Presentation by Jennifer J. Manly and Teresa Santo

24. [Caregiver Profile: The African American/Black Caregiver](#) - This profile summarizes data from the Caregiving in the U.S. 2015 research study, jointly conducted with the National Alliance for Caregiving and AARP. August 2015.

25. [Race, risk, and resilience: understanding racial differences in cognitive aging and brain pathology](#) Older African-Americans, a rapidly growing segment of the U.S. population, bear a disproportionate burden of Alzheimer's disease and cognitive impairment compared to non-Hispanic whites. Present data from several longitudinal cohort studies of older African-Americans on how risk factors and resilience markers impact cognitive aging. Lisa Barnes, Ph.D., Professor, Departments of Neurological Sciences and Behavioral Sciences, Rush University Medical Center. NIH Videocasting. February 28, 2018.

26. **Lill's Angel's African American Support Group**
    Volunteers of America
    Phone: (952) 945-4175
    Services/Programs: Support group for dementia caregivers, dementia education for caregivers

27. **People's Center Health Services**
    425-20th Ave. So., Minneapolis, MN 55454
    Phone: 612-332-4973
    Offer full range of primary care including geriatric specialties to a variety of cultural populations.

28. **Augustana Open Circle of Heritage Park**
    Part of the Heritage Park Senior Services campus. Provides respite for caregivers while helping people with changing physical, cognitive and/or social abilities to enjoy fulfilling lives. Members can attend one of the adult day centers two to five days a week and find an environment that helps them thrive.

LGBT

29. LGBT Older Adults in Long-Term Care Facilities – Stories from the Field (2015). A survey undertaken by six organizations seeking to better understand the experiences of LGBT older adults in long-term care settings. The survey also sought to capture personal comments that describe some of the varied experiences of LGBT older adults, their loved ones, and the providers who care for them.

30. LGB Fact Sheet – Survey of Older Minnesotans – "In 2015, the Minnesota Board on Aging (MBA), in partnership with the Minnesota Department of Human Services, conducted a statewide survey of persons age 50 and older in Minnesota. The MBA conducts this survey approximately every five to ten years to monitor the changing needs, assets and expectations of older persons in the state. This information is used to improve the design and targeting of public programs for older persons and to help researchers and policy makers better understand Minnesota's older population."

31. Training to Serve – LGBT Aging Resources List – A listing of resources related to LGBT aging. This includes surveys and assessments, reports on the experiences of LGBT older adults, LGBT caregiving, LGBT elder abuse articles, articles on LGBT older adults in Long-Term Care Facilities, and information on LGBT inclusion.

32. LGBT caregivers support group - Wilder

Hispanic/Latino

33. Caregiver Profile – The Hispanic/Latino Caregiver - This profile summarizes data from the Caregiving in the U.S. 2015 research study, jointly conducted with the National Alliance for Caregiving and AARP. August 2015.

34. Alzheimer's Risk: The Ethnicity and Race Connection (The Mary Hanson Show) - The question of why some ethnic groups have a higher risk for getting Alzheimer's is answered in this interview. Mary's guests are Robbin Frazier, Director of Diversity and Inclusion with the Alzheimer's Association, Minnesota-North Dakota, and Yoli Chambers, Administrator, Health and Wellness Department at Centro Tyrone Guzman in Mpls, MN. Learn more about this very common disease which still has a lot of attached stigma in many communities. The stigma can prevent people from seeking medical attention for symptoms and conditions which are not Alzheimer's and may be treatable. Aired: Oct 14, 2017.

35. National Hispanic Council on Aging. 2017 Status of Hispanic Older Adults: Insights from the field – Caregivers Edition. Washington, D.C.: National Hispanic Council on Aging: 2017.

36. **Centro MN**
    1915 Chicago Ave, Minneapolis, MN 55404
    Phone: (612) 874-1412
    Services/Programs: Adult Day program (in Spanish) for individuals with dementia, respite for caregivers

37. **Spanish Heartland Adult Day Center**
    4949 Olson Memorial Highway, Golden Valley, MN 55422
     (612) 825-4452
    Services/Programs: Adult Day program for individuals with dementia, respite for caregivers

38. **People's Center Health Services**
    425-20th Ave. So., Minneapolis, MN 55454
    Phone: 612-332-4973
    Offer full range of primary care including geriatric specialties to a variety of cultural populations.

East African (Somalian, Kenyan, etc)

39. Cultural Awareness in Dementia Care – "Hal Million oo dollar maaha baraka." The attitudes, beliefs and behavior concerning dementia in the Somali community are directly tied to their religious practices.
40. Somalis in Minnesota - Common medical issues and cultural concerns of Somali patients.
41. Cultural Awareness Assessment – Somalia - Test your familiarity with a particular society, including geographic facts, major religions, history, security situation, social customs, and basic survival phrases in the dominant language of the region.
42. A comparative study to screen dementia and APOE genotypes in an ageing East African population. Chen CH1, Mizuno T, Elston R, Kariuki MM, Hall K, et. Al. Previous studies have established cross-cultural methods to screen for ageing- related dementia and susceptibility genes, in particular Alzheimer's disease (AD) among the Canadian Cree, African Americans and Yoruba in Nigeria. We determined whether the Community Screening Interview for Dementia (CSID), translated into Kikuyu, a major language of Kenya, could be used to evaluate dementia of the Alzheimer type.

West African (Liberian, Nigerian, etc)

43. West African older people in the UK with dementia - explains how healthcare professionals can work together to help tailor provision to meet their needs and provide culturally-sensitive assessments by Roseline Ndoro Community psychiatric nurse, Camden and Islington Mental Health and Social Care NHS Trust.

Asian American/Pacific Islander

44. Caregiver Profile - The Asian American/Pacific Islander Caregiver - This profile summarizes data from the Caregiving in the U.S. 2015 research study, jointly conducted with the National Alliance for Caregiving and AARP. August 2015.

45. *The Treatment of Dementia in Hmong American Culture,Stanford University* – Stanford Geriatric Education Center
46. **CAPI (Center for Asian/Pacific Islanders)**
    3702 E Lake St, Ste 200, Minneapolis, MN 55406
    (612) 721-0122
    Services/Programs: Caregiver focused one-on-one counseling, resources, referrals, outings and field trips for caregivers

47. **Millennium Center for Performing Arts Adult Day Center**
    12325 Hwy 55, Plymouth, MN 55441
    (763) 544-1109
    Services/Programs: Adult Day program for individuals with dementia, rehabilitation for elders with or without a dementia diagnosis, respite for caregivers, support groups for caregivers
48. **Vietnamese Social Services of Minnesota's Elder Program**
    277 University Ave W, St. Paul, MN 55103
    (651) 641-8904
    Services/Programs: One-on-one counseling and care coordination for caregivers, Adult Day program for individuals with dementia
49. **People's Center Health Services**
    425-20th Ave. So., Minneapolis, MN 55454
    Phone: 612-332-4973
    Offer full range of primary care including geriatric specialties to a variety of cultural populations.
50. **Korean Service Center**
51. **Lao Advancement Organization**

Rural

52. [Act on Alzheimer's – Community Evaluation Reports](#) - ACT on Alzheimer's provides a range of evaluation reports for efforts in communities around Minnesota.

53. [Act on Alzheimer's Dementia Friendly Communities](#) – ACT on Alzheimer's website includes links to information about Dementia Friendly Communities around Minnesota.

54. (More information needed for rural communities)

National Resources for Individuals and Families

[Alzheimer's Association Diversity Portals (African-American, Hispanic, Asian websites)](#)
Includes resources in multiple languages on dementia-related topics for persons with dementia and family members.

[Inside the Brain: An Interactive Brain Tour](#)
Explains how the brain works and how Alzheimer's affects it (available in multiple languages).

[Alzheimer's Caregivers (NIH website for people with dementia and caregivers)](#)
Discusses caregiver issues and support in Chinese (traditional), Spanish, and English.

https://www.usagainstalzheimers.org/networks/african-americans/

https://www.usagainstalzheimers.org/networks/latinos

Cultural Responsiveness in other State Plans and the National Alzheimer's Plan

Cultural Responsiveness committee members reviewed the 2017 National Plan update and other State plans. They selected examples for other committees from these two documents that relate to cultural responsiveness and health equity.

Other committees may wish to refer to the relevant sections in this document to inform their work and understand how other states and the National plan have addressed cultural responsiveness in relation to their topic.

The following section is organized by committee, with relevant links and examples provided. The Cultural Responsiveness committee reflected on the following questions when gathering this information:
- What are innovating/promising practices in other states that Minnesota might consider?
- What recommendations from the 2017 National Plan Update might be relevant for committees?

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All state plans are located here: State Plans

Comparisons of State Plan Recommendations: For a comparison of the recommendations of published state plans, click on the specific category below, or download the complete comparison- Complete Comparison Document

Public Awareness and Risk Reduction

Public Awareness Increasing awareness of Alzheimer's disease among the public.

- **Massachusetts:** Work with the Alzheimer's Association to create multilingual, multicultural public service announcements and pursue resources for a public relations campaign to promote Alzheimer's awareness. The campaign may work in concert with a broad range of public and private partners to reach targeted demographics, particularly Latinos and African Americans.
- **Nevada:** Disseminate information about the many aspects of Alzheimer's in a variety of languages to meet the needs of every person and caregiver, regardless of age, gender, language, physical or mental disabilities, race/regional/national origin, religion, sexual orientation, and economic status.
  - Develop toolkits to assist with outreach to different cultural communities.
  - Foster the development of three awareness campaigns to provide information about the earliest signs of dementia and to rebuke the stigma of Alzheimer's disease and other dementias. The campaigns will include updates about current research and prevention trials that can delay progression, as well as information about how earlier diagnosis and intervention can lead to a more productive and valuable life. The three campaigns are to: (1) allied health professionals, bankers, emergency first responders, financial planners, lawyers, and other professionals who may have contact with persons with dementia; (2) the general public; and (3) caregivers and family members of persons with dementia, focused on ways to help alleviate the fear, stress, and stigma surrounding dementia and the sense of isolation that often accompanies the disease, including educating and informing caregivers about support group opportunities and other available supportive services that will help them care for themselves and their families.
- **Pennsylvania:** Identify and engage the support of non-traditional partners (such as utility companies, insurance providers, health plans, sports teams, billboard companies, banks, and agricultural extension offices) in disseminating educational materials and resources that foster public awareness of Alzheimer's and other dementias and available services.
- The **Northern California/Northern Nevada** Alzheimer's Chapter Home has a diversity page which highlights African American Resources, Latino Resourced, Asian Resources and LGBT resources.

National Plan Update 2017 - RECOMMENDATION 17 (correlates with MN 4. Prepare Our Communities and the Public)

Federal agencies, states, national health and aging organizations, and community partners must continue to expand public awareness and training, reduce stigma, and help connect people to information and available resources. Outreach should include children and youth, diverse racial/ethnic/socioeconomic groups, and people with IDD. Increase information developed for children and youth using video and social media, and provided through school curriculum and youth-serving organizations.

- Develop expanded partnerships to support outreach through groups such as unions, community colleges/adult education, community and faith organizations, and first responders.
- Increase engagement of national health-related organizations (e.g., Down syndrome, heart, and diabetes) in providing information and resources addressing dementia.
- NATIONAL PLAN TO ADDRESS ALZHEIMER'S DISEASE: 2017 UPDATE :

National Plan Update 2017 - 4A *Memory Sunday: Increasing Awareness of Alzheimer's Disease in Church Congregations*. CDC supported the Balm in Gilead to develop and implement Memory Sunday, the Second Sunday in June, as a designated Sunday, within congregations serving African Americans, that provides education on AD: prevention, treatment, research studies and caregiving. The purpose of Memory Sunday is to bring national and local attention to the tremendous burden that AD/ADRD are having on the African American community; to utilize the power and influence of the African American pulpit to bring awareness; to distribute the facts about AD; to encourage participation in research studies; and to support persons living with AD and their caregivers. For more information, see: http://brainhealthcenterforafricanamericans.org/memory-sunday

In 2015, the ROAR team continued to promote a toolkit of customizable materials for aging services & public health professionals to use in community settings & social media, & expanded the potential reach by translating materials into Spanish & Chinese. https://www.nia.nih.gov/health/publication/roar-toolkit

In June 2017, NIH hosted a workshop entitled Inclusion Across the Lifespan, to examine the science of inclusion of various populations in clinical trials & studies. https://www.nia.nih.gov/about/events/2017/inclusion-across-lifespan

Brain Health Promoting activities that would maintain and improve brain health.
- Oklahoma - • Create culturally competent public service announcements to raise the level of public education about brain health and the warning signs of Alzheimer's and other dementias, some of which should specifically target populations with disproportionately higher rates of these diseases.(Latino and African American)
- Washington - • Work with UW Healthy Brain Research Network (HBRN) and other partners to develop evidence-based public messages around promoting healthy aging and brain health, while ensuring messages are culturally/ethnically appropriate and designed to reach statewide populations including persons with limited English.

Safety Improving public safety and addressing the safety-related needs of those with Alzheimer's.
- Montana: Develop a community-based emergency crisis intervention/prevention program that institutes a "course of action" to mitigate Alzheimer's and other dementias issues for families of all cultures and economic means who find themselves at immediate risk. Situations requiring an immediate course of action from emergency personnel include such things as (1) a caregiver is admitted to the hospital and there is no one else to care for the individual with dementia; and (2) a caregiver passes away and there is no one readily available to care for the individual with Alzheimer's and other dementias.

Diagnosis, Treatment and Professional Education

Early Detection and Diagnosis Encouraging increased detection and diagnosis of Alzheimer's disease.

- **Maine:** Develop plans for multilingual, multicultural awareness campaign for consumers and professionals regarding the Medicare Annual Wellness Visit and the inclusion of the "detection of any cognitive impairment" requirement.
- **New York:** Request state agencies to post on their websites current, accurate, culturally-aware information for health care professionals, including physicians, nurse practitioners, psychologists and social workers, to detect and diagnose dementia in its earliest stages.

Care and Case Management Improving the individual health care that those with Alzheimer's disease receive.

- **California:** Strengthen primary care practices by dedicating staff support (or by providing access to a Dementia Care Manager) to coordinate care, manage individual cases, and develop formal mechanisms for referral to health care homes and community-based agencies that offer specialized expertise, social supports, and mental health services. (could add that the dedicated staff has cultural competence training related to dementia)
- **Massachusetts:** Work with private and public partners to produce and disseminate multi-lingual and multicultural information regarding availability and eligibility criteria for all dementia-related state supported and private services and educate the newly diagnosed and their families on next steps and services. (i.e. when does someone with dementia qualify for Medicare Hospice?)
  - Develop and disseminate culturally competent materials to assist families with end-of-life care and planning decisions.
- **Utah:** Encourage care providers to partner with multicultural coalitions as they develop "dementia-friendly services" for ethnically diverse clients and residents across the continuum of care, including adult day care, in-home respite, assisted living, long-term care, and specialized dementia care.

National Plan 2017 Update: RECOMMENDATION 1 (correlates with MN recommendation **2. Use "Health Care Home" for Alzheimer's Care**)

"The 2017 National Plan should continue to provide a robust, comprehensive, and transformative scientific Road Map for achieving the goal of preventing, effectively treating, and providing effective care and services for AD/ADRD by 2025."

- "Include and prioritize specific milestones for populations at high risk for AD/ADRD (e.g., people with Down syndrome, African Americans)."
  - o MI Example: The Alzheimer's Association Greater Michigan Chapter has a federal grant that focuses on the developmentally disabled population direct program outreach to residential care settings: group homes, adult foster homes.
- "Increased attention should be paid to person-centered and family-centered outcomes with respect to research planning and the delivery of care and services."

CMS Response- raising awareness of the benefits of Medicare's CCM service for beneficiaries with multiple chronic conditions including ADRD, and furnishing resources for implementation across all diverse populations. CMS is driving efforts to empower beneficiaries and their providers to make decisions, take ownership of their care, and make certain they have the information they need to make informed choices.

National Plan Update 2017 - RECOMMENDATION 14 (correlates with MN 3. Achieve Quality and Competence in Dementia Care)

Congress, federal agencies, and states must expand efforts to address the needs of family caregivers, including caregivers from diverse racial/ethnic/socioeconomic groups, caregivers of younger adults and people with IDD, and children and youth who provide care for older adults. Particular support is needed to expand and scale effective caregiver interventions for diverse racial/ethnic/socioeconomic groups; address reimbursement, training, and HIPAA policy and practice barriers to enable health care providers to provide care planning with family caregivers; increase support for respite care; and address the financial burden to family caregivers. To accomplish this: Identify the roles, prevalence, and impact of caregiving among young children, including children in immigrant, minority, and Tribal populations, who provide care for older adults with dementia.

Training Better equipping health care professionals and others to deal with individuals with Alzheimer's.
- **New York:** Increase the pool of culturally-appropriate social service and health care providers and home health aides using evidence-based training programs. • Encourage professional education programs in all health professions to include a course in cultural competency within the required curricula.
- **Rhode Island:** Develop partnerships across communities and with a diverse range of partners to integrate existing training and education programs with best practices for the delivery of culturally-competent care, including language skills where possible.

Workforce Development Increasing the number of health care professionals that will be necessary to treat the growing aging and Alzheimer's populations.
- **Pennsylvania:** Promote innovative practices to encourage recruitment of competent and ethical individuals to meet the needs of the diverse growing population of persons with Alzheimer's and dementia.

Quality of Care Improving the quality of the health care system in serving people with Alzheimer's.

None noted

Health Care System Capacity Expanding the capacity of the health care system to meet the growing number and needs of those with Alzheimer's.
- **Rhode Island:** Assess capacity within the network of existing long-term care providers for specialization in various languages and cultures; identify specific resources available to providers interested in and capable of moving toward such specialization and develop recommendations for the designation of any provider offering language and/or cultural specialty.

Residential Services

[Home- and Community-Based Services](#) Improving services provided in the home and community to delay and decrease the need for institutionalized care.

- **Arizona:** Ensure that services, supports, and approaches in a dementia-capable system are available, accessible, and acceptable regardless of ethnicity, geography, or culture. Encourage care providers to partner with multicultural coalitions as they develop dementia-capable services for ethnically diverse clients and residents across the continuum of care.
- **New Hampshire:** Work with private and public partners to produce and disseminate multilingual and multicultural information regarding availability and eligibility criteria for all dementia-related state supported and private services and educate the newly diagnosed and their families on next steps and services.

[Long-Term Care](#) Improving long-term care, including assisted living, for those with Alzheimer's disease.

RI -• Forge community partnerships to encourage integration of culturally competent elements appropriate to patient diversity within each long-term care setting, including: food and nutrition needs, skilled language needs, space and time for observation of religious or cultural practices, and other accommodations as the need or desire is expressed.

[Caregivers](#) Assisting unpaid Alzheimer's caregivers.

- **Maine:** Increase participation in educational programs among diverse caregivers through culturally and linguistically appropriate trainings and materials. Customize outreach tailored to immigrant and other diverse communities and where possible, recruit participation of native language speakers to deliver programs. Educate and enlist the faith community as community resources that can help reach out to and support family caregivers. Invite faith leaders to applicable trainings and also utilize them as a resource to disseminate information and materials.

[Research](#) Increasing research on Alzheimer's disease.

- **Arizona:** Identify and overcome challenges to engaging participants in Alzheimer's disease and other dementias research, including geographic, socio-economic, cultural, or other differences that may discourage participation.
- **Texas:** Ensure that volunteer recruiting activities and measures are published in multiple languages and formats with high degrees of cultural sensitivity.

Assessment of Trends and Disparities

[Data Collection](#) Creating a better system of data collection regarding Alzheimer's disease and its public health burden.

- Mississippi: Recommend use of the Behavioral Risk Factor Surveillance System (BRFSS) to collect health outcomes data for persons with impaired brain function and Alzheimer's disease and other dementias, including the impact of cultural variances.

No Committee Assigned: Adult Day/In-Home Supports/care person supports

(ADS = "Adult Day Services")

Adult Day Services: Strategy 2.D: Identify High-Quality Dementia Care Guidelines and Measures Across Care Settings

VA Models of Non-institutional Long-Term Care. VHA has implemented innovative programs to provide patient-centered alternatives to long-term institutional care. New models of care have included programs focusing on dementia care, care coordination, and/or caregiver support. A summary report on Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care was posted online. The report described a number of innovative programs developed and implemented at VA medical facilities, along with some initial results and lessons learned from the projects. VHA continues to offer a range of innovative dementia care programs in urban, suburban and rural areas that provide veteran and caregiver support through multi-media communication, education, in home services, outpatient services, and interaction with primary care teams. Examples of some of these sustained, successful innovative programs include the following:

- The VA Mobile Adult Day Health Care (ADHC) program, also known as the ADHC Mobile Veteran Program, is a therapeutically-oriented outpatient program that serves to enhance veterans' quality of life and alleviate isolation and depression by maximizing their physical, mental, and social abilities and well-being. The program provides support and respite care for families and other caregivers of veterans who are functionally impaired and/or socially isolated, enabling the veteran to maintain residence in a supportive home environment. VHA establishes U.S. Department of Health and Human Services 33 community partnerships, usually with Veteran Service Organizations, that donate the use of their site. VHA staff travel to the site during specified days, as agreed upon with the community partner. veterans must have a designated VA primary health care provider who provides orders while the veteran is enrolled in the program. The VA Mobile ADHC program treatment team recommendations are communicated to the primary health care provider based on the veteran's individual need.

Strategy 2.E: Explore the Effectiveness of New Models of Care for People with Alzheimer's Disease and Related Dementias

Translation of Care of Persons with Dementia in their Environments in a Publicly-Funded Home Care Program. This home-based intervention involves up to 12 home visits; a nurse provides education to caregivers as to common concerns (constipation, detection of pain, incontinence, hydration and importance of taking care of self), conducts a brown bag medication review, takes blood and urine from the person with dementia and does a visual inspection of skin integrity; an occupational therapist meets with families to assess abilities of person

with dementia and to work with caregiver to provide strategies for managing their care challenges and educate them as to the nature of the disease and ways to support daily functioning. Activities include:

- NIA-funded trial ongoing in Connecticut to translate this approach in Medicaid Waiver Program (Principal Investigator, Dr. Richard Fortinsky, Co-Investigator, Dr. Laura Gitlin).
- **ACL-funded project to Maine's Adult Day Serves to integrate Adult Day Plus and Care of Persons with Dementia in their Environments (COPE) Intervention.**
- ACL-funded project to Orange County, North Carolina to integrate COPE/Tailoring Activities for Persons with Dementia and Caregivers (TAP) into home care services.
- Australia-funded translational study of COPE in various settings (hospital to home, home care, social service agencies).
- COPE as part of the MIND model being tested under the CMS's (Innovation Center) Health Care Innovation Awards (HCIAs).
- COPE being integrated into a program for Managed Care to be delivered by Volunteers of America.

Strategy 2.F: Ensure that People with Alzheimer's Disease and Related Dementias Experience Safe and Effective Transitions between Care Settings and Systems

Improved Care Planning for Medicare Beneficiaries. In 2013, CMS began paying separately under the Medicare Physician Fee Schedule for transitional care management services for the transition of Medicare beneficiaries back into the community following discharges from certain settings. In 2015 CMS began paying separately under the Medicare Physician Fee Schedule for chronic care management (CCM) services for beneficiaries with multiple chronic conditions. In 2017, CMS began separate Medicare Physician Fee Schedule payment for additional care management services, including payment for: complex CCM for Medicare patients with multiple chronic conditions; behavioral health integration services including services furnished using the "psychiatric Collaborative Care Model"; and cognitive and functional assessment and care planning for beneficiaries with cognitive impairment (e.g., AD/ADRD). The latter, billed under code G0505 for 2017, must be furnished by a physician or other appropriate billing practitioner (e.g., nurse practitioner or physician assistant). The service includes a cognition-focused evaluation, including a pertinent history and examination; medical decision making of moderate or high complexity; functional assessment (for example, ADLs), including decision making capacity; use of standardized instruments to stage dementia; medication reconciliation and review for high-risk medications; evaluation for neuropsychiatric and behavioral symptoms (including depression), including use of standardized instruments; evaluation of safety (for example, home safety), including motor vehicle operation, if applicable; identification of caregivers, caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; **advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference; creation of a care plan, including initial plans to address any neuropsychiatric symptoms (NPS) and referral to community resources as needed (for example, adult day programs, or support groups)**; and care plan shared with the beneficiary or caregiver with initial education and support.

Strategy 3.B: Enable Family Caregivers to Continue to Provide Care while Maintaining Their Own Health and Well-Being

Adult Day Care and Residential Care State Policy Compendia. ASPE recently updated two policy compendia examining state approaches to regulation of long-term care settings. The first compendium examines state regulation around adult day services (ADS) -- a non-residential service that provides services outside of an individual's home for less than a full day to older adults and younger adults with physical disabilities. These services also meet unpaid caregivers' need for respite in order to work, fulfill other obligations, and recover from the demands of continuous caregiving. Many caregivers who use ADS are providing care to family members with dementia who need constant supervision to ensure their safety. The second compendium examines state approaches to residential care, including assisted living. Residential care provides 24-hour supervision, meals, and assistance with ADLs. States vary in their approaches to licensure for residential care facilities. For more information, see:

• https://aspe.hhs.gov/basic-report/regulatory-review-adult-day-services-final-report-2014-edition

•https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulationsand-policy-2015-edition

Translation and Evaluation of the Adult Day Service Plus Program. ADS Plus augments ADS with a systematic approach to supporting families. Staff of ADS (e.g., social worker, care manager, intake specialist, occupational therapist, nurse) can be trained to provide ADS Plus. Pilot data in three centers showed that ADS Plus increased the number of days using ADS, decreased nursing home placement, improved caregiver well-being including decreasing depressive symptoms, and enhanced sense of selfefficacy. Activities include: ▯ Through funding from ACL, ADS sites in Maine are using ADS Plus combined with elements from TAP and COPE. ▯ NIA-funded study to test ADS Plus in 30 sites across the country. ▯ Plan to add sites and also develop an online program to train ADS staff nationally.

No Committee Assigned: Policy Victories

- The Alzheimer's Accountability Act (AAA) passed 2014
- Research funding requests passed since creation of AAA ... FY16 $350M, FY17 $400, [request currently pending: FY18 $418] ...
- 2017 CMS implemented a billing code for care consultation with dementia diagnosis
  - **Supported the 21st Century Cures Act** to bolster medical research to accelerate the discovery, development and delivery of new treatments and cures for Alzheimer's and other diseases.
  - RAISE Family Caregivers Act passed 2018 to address the needs of our nation's family caregivers through the development and implementation of a coordinated national strategy.

No committee assigned: Caregivers and in-home services

Massachusetts Alzheimer's: http://coastlineelderly.org/wp-content/uploads/2014/07/Massachusetts-State-Plan-on-Aging-2018-2021.pdf

Targets under the ADSSP Project include plans to provide basic dementia training to a minimum of 200 options counselors, information and referral specialists and Medicaid Eligibility Specialists. The anticipated outcomes of the project include:

1. An increase of dementia-related skills, knowledge, and competency among professionals caring for individuals with dementia;

2. The development of a dementia-capable care transitions pilot with the potential for continued sustainability;

3. An increased rate of prevention or delay of nursing home placement among individuals with dementia who wish to remain in the community;

4. A reduction in caregiver stress and an increase in informal caregivers' capacity to provide care; and

5. The creation of dementia-specific care plans to promote appropriateness and consistency of services.

Massachusetts Alzheimer's places their Summary on their website. http://www.alzmassnh.org/ar/

Glossary of Terms

The committee included terms for issues related to race, ethnicity, GLBT as part of their work.

1. **Culture**: Culture is a way of life. Culture is passed on from generation to generation through institutions, groups, interpersonal, and individual behavior. Culture provides the glue which gives institutions their legitimacy from generation to generation. For individuals, culture provides a sense of identity, belonging, purpose, and worldview. In the U.S., our dominant "white" culture provides the basic values and worldview, assumptions, ways of thinking, styles of learning, and ways of relating to each other (Challenging White Supremacy Workshop, 2000).
2. **Racism**: Racism, both personal and institutional, involves prejudice and the power to enforce it (Allies for Change, 2009). It is revealed in attitudes, behavior and systems in which white people maintain supremacy over people of color. Human beings create and maintain the systems, which in turn, reinforce racism. Personal/individual racism is a result of the beliefs, attitudes, and actions of people that support or perpetuate racism. It happens at both an unconscious and conscious level, and can be both passive and active. Examples include telling a racist joke, using a racial epithet, or believing in the inherent superiority of white people. (Adams, Bell and Griffin, 1997 p 89)
3. **Structural Racism:** Structural racism is the normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and Indigenous peoples. Reference: 2014 Advancing Health Equity in Minnesota.
4. **Structural inequities:** Structures or systems of society — such as finance, housing, transportation, education, social opportunities, etc. — that are structured in such a way that they benefit one population unfairly (whether intended or not). Reference: 2014 Advancing Health Equity in Minnesota.
5. **White supremacy/institutional racism**: White supremacy is the institutionally enforced system of racism. It is historically based on: 1) the theft & military conquest of native lands of North America; and 2) the economic exploitation of North American land through slavery (Challenging White Supremacy Workshop, 2000). Institutional racism/white supremacy is the network of institutional structures, policies, and practices that create advantages and benefits for whites, and discrimination, oppression and disadvantage for people of color. Institutional racism or white supremacy is built in to many institutions in the U.S (Martinez, 2004). The advantages created for whites are often invisible to them, or are considered "rights" available to everyone as opposed to "privileges" awarded to only some individuals and groups (Wijeyesinghe et al, 1997).
6. An example of institutional racism is the crack versus powder cocaine laws. While it is well documented that there is no difference in the effect between the two, federal sentencing guidelines result in a 100:1 disparity between the sentences for crack and for powder cocaine. A five year sentence is the mandatory minimum for crack, whereas a five year sentence for powder cocaine requires possession of 500 grams. Crack is much more commonly used among blacks, whereas cocaine is primarily used among whites. According to Nolan, "The government has chosen to penalize the use of one form of a drug, favored by blacks, 100 times more harshly than another form of that same drug favored by whites" (Nolan, 1997, p. 416).
7. **White privilege**: "White privilege is a historically based, institutionally perpetuated system of: 1) preferential prejudice for and treatment of white people based solely on their skin color and/or ancestral

origin from Europe; and 2) exemption from racial/national oppression (that is, oppression based on skin color and/or ancestral origin from Africa, Asia, the Americas and the Arab world" (Challenging White Supremacy Workshop, 2000). Peggy McIntosh, in White Privilege, *Unpacking the Invisible Knapsack*, offers many clear examples of identifying white privilege. For example: "I can turn on the television or open to the front page of the paper and see people of my race widely represented, "or "I do not have to educate my children to be aware of systemic racism for their own daily physical protection," or "I can be pretty sure that if I ask to talk to the "person in charge", I will be facing a person of my race."

8. **Discrimination**: "Discrimination is the differential allocation of goods, resources, and services, and the limitation of access to full participation in society based on individual membership in a particular social group" (Racial Equity Tools, 2009).

9. **Oppression**: "Illegitimate institutionalized power, built and perpetuated throughout the course of history. Allows certain 'groups' to confer illegitimate dominance over other 'groups', and this dominance is maintained and perpetuated at an institutional level" (Colours of Resistance).

10. **Race**: Race is a concept invented by people to use characteristics such as skin tone, ancestral heritage, and ethnic classification to artificially divide people (Wijeyesinghe et al, 1997). Research has shown us that there is more difference within racial groups than across racial groups (O'Neil, 2009). Racial categories have changed over time. Just look at the U.S. Census; it is administered at ten year intervals. We can see that there are "new" races added to the race category (Staples, 2007).

11. **White**: The term white was created by colonial rulers such as Virginia slave holders in the 1600s. The purpose was to differentiate European plantation owners from African slaves, indigenous peoples and poor white people. After Bacon's Rebellion of 1674, 'white' was used to separate the servant class on the basis of skin color and continent of origin (Adair and Powell, 1988).

12. **People of color:** "People of color is a term used to refer to nonwhite people, used instead of the term "minority," which implies inferiority and disenfranchisement. The term emphasizes common experiences of racial discrimination or racism" (Colours of Resistance). The term 'minority' implies inferiority and disenfranchisement and is inaccurate since people of color are the majority of the world's population, as well as the majority in many communities in the United States. The term emphasizes common experiences of racial discrimination or racism (Colours of Resistance, 2008).

13. **Prejudice**: Prejudice is a set of negative personal beliefs about a social group that leads individuals to pre-judge people from that group or the group in general regardless of individual differences among members of that group (Goodman and Shapiro, 1997 p 118). We can all be prejudiced, regardless of our power status. For example, "all blondes are dumb," is a common prejudice often reinforced in Hollywood films. Another common prejudice on college campuses suggests that "all athletes are dumb." This becomes a racial prejudice when the majority of athletes on campus are students of color. Can Black people be prejudiced against Latino/as? Yes; they can make incorrect assumptions about their citizenship or their language use. We do not believe that African Americans can be racist toward Latinos. Racism involves prejudice plus the power to enforce that prejudice.

14. **Ethnicity:** Ethnicity is a social construct which divides people into social groups based on characteristics such as a shared sense of group membership, values, behavioral patterns, language, religion, political and economic interests, history and ancestral geographical base. Ethnicity shapes a group's culture. For example, the food, language, music, and customs often identify an ethnic group. Everyone has an ethnicity, though many white people today do not identify themselves ethnically. Whether you come from a German background, an Irish background, or a combination of many backgrounds, these ancestral ethnic identities

have most likely played a very important role in shaping how you view, interpret, and interact with the world. African American ethnicity is based on the African tribal identity of the person. Obviously, most African American people do not know their ancestral roots. Latino/as often identify ethnically based on their country of origin, e.g. Puerto Rican, Colombian, Mexican, etc. This is similar for Asian Americans, e.g. Vietnamese, Chinese, Japanese, Hmong (Navigating a Diverse World). American Indian ethnicity is based on tribal identification. White/Euro-American ethnicity is tied to ancestor origins, e.g. German American, Irish American, etc.

15. **Cultural competence:** the ability to interact effectively with people of different cultures. ... to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. In practice, both individuals and organizations can be culturally competent. "Culture" is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. To produce positive change, prevention practitioners and other members of the healthcare workforces must understand the cultural context of their target community. They must also have the willingness and skills to work within this context. This means drawing on community-based values and customs and working with knowledgeable people from the community in all efforts. Practicing cultural competence throughout the program planning process ensures that all members of a community are represented and included. It can also prevent wasteful spending on programs and services that a community can't or won't use.   Reference: https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

16. **Cultural humility:** is a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process. The concept of cultural humility was developed by medical doctors Melanie Tervalon and Jann Murray-Garcia in a 1998 academic article published in the Journal of Health Care for the Poor and Underserved. In this article, Tervalon and Murray-Garcia identified three facets to cultural humility.
    a. The first aspect is a lifelong commitment to self-evaluation and self-critique. Underlying this piece is the knowledge that we are never finished — we never arrive at a point where we are done learning. Therefore, we must be humble and flexible, bold enough to look at ourselves critically and desire to learn more.
    b. The second feature of cultural humility is a desire to fix power imbalances where none ought to exist. Recognizing that each person brings something different to the proverbial table of life helps us see the value of each person.
    c. Finally, cultural humility includes aspiring to develop partnerships with people and groups who advocate for others (Tervalon & Murray-Garcia, 1998). Cultural humility, by definition, is larger than our individual selves — we must advocate for it systemically.

17. **Cultural responsiveness:** Culturally responsive care considers and adjusts appropriately to the individual and family being served based on their education, class, race/ethnicity, immigration status, and geographic location.

18. **Equality:** Equality is about sameness--we all get the same treatment, and access to exactly the same resources.

19. **Equity**: Equity is about fairness. If certain groups are economically disadvantaged, they get more access to resources, not the same as everyone else.

20. **Health disparities:** A population-based difference in health outcomes (e.g., African-Americans incidence of Alzheimer's is twice that of Caucasian Americans). Reference: 2014 Advancing Health Equity in Minnesota.
21. **Health inequity:** A health disparity based in inequitable, socially-determined outcomes. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. Reference: 2014 Advancing Health Equity in Minnesota.
22. **LGBT+, LGBTQ, LGBTQA, TBLG**: These acronyms refer to Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Asexual or Ally. Although all of the different identities within "LGBT" are often lumped together (and share sexism as a common root of oppression), there are specific needs and concerns related to each individual identity.
23. **Asexual**: A person who generally does not feel sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.
24. Ally: Typically any non-LGBT person who supports and stands up for the rights of LGBT people, though LGBT people can be allies, such as a lesbian who is an ally to a transgender person.
25. **Bisexual:** A person who is attracted to both people of their own gender and another gender. Also called "bi".
26. **Cisgender:** Types of gender identity where an individual's experience of their own gender matches the sex they were assigned at birth.
27. **Coming Out**: The process of acknowledging one's sexual orientation and/or gender identity to other people. For most LGBT people this is a life-long process.
28. **Gay**: A person who is attracted primarily to members of the same sex. Although it can be used for any sex (e.g. gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women.
29. **Gender expression**: A term which refers to the ways in which we each manifest masculinity or femininity. It is usually an extension of our "gender identity," our innate sense of being male, female, etc. Each of us expresses a particular gender every day – by the way we style our hair, select our clothing, or even the way we stand. Our appearance, speech, behavior, movement, and other factors signal that we feel – and wish to be understood – as masculine or feminine, or as a man or a woman.
30. **Gender identity**: The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected social roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.
31. **Genderqueer**: A term which refers to individuals or groups who "queer" or problematize the hegemonic notions of sex, gender and desire in a given society. Genderqueer people possess identities which fall outside of the widely accepted sexual binary (i.e. "men" and "women"). Genderqueer may also refer to people who identify as both transgendered AND queer, i.e. individuals who challenge both gender and sexuality regimes and see gender identity and sexual orientation as overlapping and interconnected.
32. **Gender Roles**: Among many older GLBT people, more masculine looking women or men were called "butch," and more feminine looking women or men were called "femmes." Roles did not mean that butch lesbians wanted to be men or only behaved as traditional men, nor did it mean that femme men wanted to be women or behaved as traditional women.
33. **Heterosexual:** A person who is only attracted to members of the opposite sex. Also called "straight."

34. **Homophobia/heterosexism:** A range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual or transgender (LGBT). It can be expressed as antipathy, contempt, prejudice, aversion, or hatred, may be based on irrational fear, and is sometimes related to religious beliefs.

35. **Homosexual**: A clinical term for people who are attracted to members of the same sex. Some people find this term offensive.

36. **Intersex**: A person whose sexual anatomy or chromosomes do not fit with the traditional markers of "female" and "male." For example: people born with both "female" and "male" anatomy (penis, testicles, vagina, uterus); people born with XXY.

37. **In the closet:** Describes a person who keeps their sexual orientation or gender identity a secret from some or all people. In African American communities, this is also called "on the down low."

38. **Lesbian**: A woman who is primarily attracted to other women.

39. **Queer:** 1) An umbrella term sometimes used by LGBTQA people to refer to the entire LGBT community**.** 2) An alternative that some people use to "queer" the idea of the labels and categories such as lesbian, gay, bisexual, etc. Similar to the concept of genderqueer. It is important to note that the word queer is an in-group term, and a word that can be considered offensive to some people, depending on their generation, geographic location, and relationship with the word.

40. **Questioning**: For some, the process of exploring and discovering one's own sexual orientation, gender identity, or gender expression.

41. **Sexual orientation**: The type of sexual, romantic, and/or physical attraction someone feels toward others. Often labeled based on the gender identity/expression of the person and who they are attracted to. Common labels: lesbian, gay, bisexual, pansexual, etc.

42. T**ransgender**: This term has many definitions. It is frequently used as an umbrella term to refer to all people who do not identify with their assigned gender at birth or the binary gender system. This includes transsexuals, cross-dressers, genderqueer, drag kings, drag queens, two-spirit people (indigenous LGBT) and others. Some transgender people feel they exist not within one of the two standard gender categories, but rather somewhere between, beyond, or outside of those two genders.

43. **Transphobia**: The fear or hatred of transgender people or gender non-conforming behavior. Like biphobia, transphobia can also exist among lesbian, gay, and bisexual people as well as among heterosexual people.

44. **Transsexual:** A person whose gender identity is different from their biological sex, who may undergo medical treatments to change their biological sex, often times to align it with their gender identity, or they may live their lives as another sex.