SPECIAL SECTION

DIVERSITY AMONG SENIORS

A Toledo, OH, Hospital Assesses the Healthcare Needs of Elderly African Americans And Hispanics

BY EDWARD MORGAN, PhD, & DEBORAH D. SAMPSEL, MSN

The goal of outreach programs at Mercy Hospital, Toledo, OH, is to provide useful health information to help persons maintain or improve their health status. However, in 1992, Mercy's leaders realized its outreach programs (e.g., health fairs, screenings, and discussions on health topics) were not reaching as many elderly African-American and Hispanic residents from the surrounding neighborhood as they would have liked.

It became apparent that a disparity existed between what the healthcare providers thought their audiences needed and what residents really want to learn about. To rectify this, Mercy's leaders decided that the hospital could offer cultural-specific programs that better meet the healthcare needs of these populations. To secure elderly residents' perspective, an assessment process was launched.

To conduct the assessment, the Regional Gerontology staff of Mercy Hospital and St. Charles Hospital, Oregon, OH, proposed the research project. Three faculty members from Bowling Green State University, Bowling Green, OH, were invited to become involved in the research project for several reasons. The faculty was known for its expertise in cultural diversity issues and had previously conducted a similar research project. In addition, gerontology students from Bowling Green State University would be able to help with the research.

Institutional in-kind donations and a $4,350 grant award from the Mercy Health System, Cincinnati, OH, funded this $11,550 research project.

THE NEEDS ASSESSMENT

The first step in carrying out the assessment was to form a committee made up of representatives

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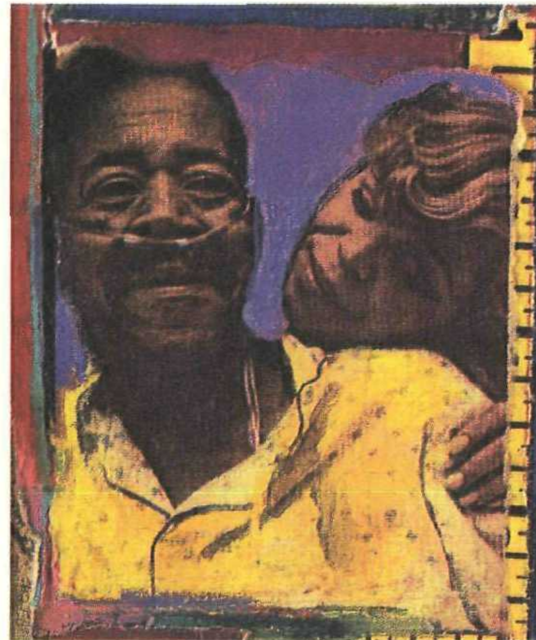
Summary In 1992, leaders at Mercy Hospital, Toledo, OH, realized the facility's outreach programs were not reaching as many elderly African-American and Hispanic residents from the surrounding neighborhood as they would have liked. Mercy's leaders therefore decided that the hospital could offer cultural-specific programs that better meet the healthcare needs of these populations. To secure residents' perspective, an assessment process was launched.

The data gathered from participants in face-to-face interviews revealed that some had problems with access to healthcare. A lack of money and other resources seemed to be the major barriers to care.

The key concern of the elderly persons interviewed is securing personalized care or services that help them maintain their independence. A number of participants wanted free transportation (other than to and from the hospital). They need help getting to their physician's office, the pharmacy, the grocery store, and the bank. Public agencies may offer such transportation services. In addition, the Hispanic elderly interviewed would like to see Spanish-speaking personnel in admissions and the emergency department.

from the three institutions who were knowledgeable about minority health issues. The committee included healthcare professionals, university faculty familiar with aging and ethnicity, university students studying aging, and representatives of the community-parish outreach program. Two committee members were fluent in Spanish.

The committee could not find a suitable needs assessment tool, so it developed its own needs assessment survey—an English version and a Spanish version. The survey was tested in four focus groups—two in the African-American community and two in the Hispanic community (at which a translator was present).



After the focus groups, the committee decided to use an interview format to gather data face to face, rather than a mailed survey, because interviews would be quicker, would be more effective in getting detailed responses to open-ended questions, would avoid the problem of creating a mailing list, and would allow interviewers to reach those who cannot read.

The questionnaire, refined on the basis of the focus group findings, assessed individual health needs and service usage, along with expectations for future usage and needs. Two committee members with experience in data-gathering techniques trained the interviewers, including nursing and gerontology staff from the two hospitals, Bowling Green State University students, and community volunteers.

Selection of participants was a major hurdle in completing the assessment. The greatest challenge was identifying elderly persons living in the inner city and convincing them to participate in the study, since they do not readily open their homes to strangers and are unwilling to give demographic information over the phone. The committee therefore asked representatives from churches, housing projects, and senior centers to provide names of potential participants. This worked well for recruiting Hispanic residents but was not successful for attracting African Americans to the study. The committee included no African Americans, so it lacked sensitivity to that group's cultural-specific behavior. This problem was solved when the president of the local chapter of the Black Nurses Association became involved. She explained that African Americans placed their trust in friends and neighborhood leaders. As a result, committee members worked with apartment building managers where African American elderly persons live, workers at clinics where the black elderly seek care, and church and senior center leaders whom the African-American elderly trust.

The committee decided to use an interview format to gather data face to face.

Participants were asked some demographic questions in the interviews and were required to sign a form indicating they consented to the interview. Personal interviews with 65 women and 33 men took place within a three-mile radius of Mercy Hospital at sites such as housing projects, clinics, and senior centers. We interviewed 47 Hispanics, 42 African Americans, 1 Native American, 1 white person and 7 persons who said they belonged to an ethnic group that was not listed on the questionnaire. Participants ranged in age from 55 to 90 years; 72 percent were aged 60 or older. A majority of participants (58) lived alone, 17 lived with a spouse, 6 lived with children, and 5 lived with someone other than family. (Twelve responses were not usable.)

Assessment Findings

The data gathered from participants revealed that they had a number of needs. Most participants had received medical care from a physician in the past six months. However, approximately 25 percent of those interviewed said they needed to see a physician more often than they do. A large percentage of participants do not seek medical advice from anyone other than a medical doctor.

Most of the elderly said that when their physician gives them a prescription, they have it filled. Those participants who did not have prescriptions filled said they did not have enough money to do so.

Approximately 45 percent of participants claimed their monthly income was less than $500. Thirty percent said they did not have vision and dental care problems taken care of because they did not have enough money to do so. This is significant because more than 90 percent of respondents wear glasses.

When ill or disabled, most of the elderly inter-

viewed rely on a family member (other than a spouse) or a friend to help with activities of daily living. Most participants could do almost everything they needed with no assistance and had no need for home nursing care.

About 10 percent of participants claimed they did not eat enough to maintain their strength—not because they did not have the money to purchase food or lacked transportation to get to a grocery store, but because they had no appetite. Most of those who felt weak said they had no desire to eat.

Most of the elderly interviewed claimed that they exercise either twice a week or every day. The most common form of exercise is walking.

Their key concern is securing personalized care or services that help them maintain their independence. A number of participants wanted free transportation (other than to and from the hospital). They need help getting to their physician's office, the pharmacy, the grocery store, and the bank. In addition, the Hispanic elderly interviewed would like to see Spanish-speaking personnel in admissions and the emergency department.

Findings' Implications

Meeting the healthcare needs of elderly, minority inner-city residents is an important social and health policy issue. When developing programs for elderly minority residents, healthcare facilities must consider various factors such as the target population's income level, its perception of what needs the system can meet, and its cultural acceptance of services offered.

Services are often developed from a Caucasian perspective. Each ethnic group has its own approach to securing services to fulfill its needs. Providers need to develop services based on various groups' customs, rituals, and cultural behaviors. For example, when developing nutritional counseling classes, the sponsor needs to consider the target group's usual diet and modify it accordingly, rather than recommending foods they are unaccustomed to.

Access Issues Four dimensions of healthcare access, identified by M. K. Petchers and S. E. Milligan (see "Access to Health Care in a Black Urban Elderly Population," *Gerontologist*, vol. 28, no. 2, 1988, pp. 213-217), can be useful in analyzing the data gathered in this assessment survey:

- Availability—the presence of medical services in an area
- Affordability—the presence of financial resources (e.g., income; insurance; and entitlements from federal, state, and local programs)
- Accessibility—logistical barriers (e.g., transportation) to the delivery of healthcare services
- Acceptability—the fragmentation and depersonalization that are frequent barriers to utilization

Participants' key concern was securing personalized care or services that help them maintain their independence.

Emergency care clinics, private physician offices, and three hospitals are within a two-mile radius of where the target minority populations live. It is safe to assume that availability is not a factor in service utilization.

Participants said that a lack of money was a major reason for not seeking medical care and obtaining prescription medication. This is not surprising, since 78 percent of participants reported incomes of less than $1,000 a month.

All participants indicated that transportation to obtain medical services was available when needed. A majority drove themselves or walked or had a spouse or other family member drive them to a healthcare facility.

The survey did not include direct questions about acceptability. However, in response to, "Why haven't you gotten what you need?" participants said they were afraid of the dentist or of contracting AIDS, did not know which physician to see, or could not fill out applications.

Thus the findings of the needs assessment show that some participants had problems with access to healthcare. A lack of money and other resources seemed to be the major barriers to care. Respondents expressed some dissatisfaction with the healthcare delivery system, but most said that their healthcare needs were being met.

Services Needed When asked what services they would like to see Mercy and St. Charles hospitals provide, participants suggested the following: a Spanish-speaking person in admissions and in the emergency department; programs in Spanish; and access to primary care physicians on a regular basis, rather than just access to emergency room services.

Other suggestions included a diet program, health education, dental care information, exercise program, help getting glasses and dentures, a foot program, free diabetic classes, hearing and vision tests, information on energy conservation techniques, mammograms, communications programs, self-help classes, services for cataracts, blood-sugar screenings, and programs on arthritis. Since the hospitals were already offering many of these programs, these responses indicated that

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VALUING OUR DIFFERENCES

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same region. And in the long run the new immigrants may help create as many jobs as they fill, bringing skills and initiative to the U.S."[16] □

NOTES

1. "Managing Diversity," *Working Age*, AARP Newsletter Special Issue, 1990, p. 1.
2. Lennie Copeland, "Making the Most of Cultural Differences at the Workplace," *Personnel Journal*, June 1988, p. 52.
3. Lisa Harrington, "Why Managing Diversity Is So Important," *Distribution*, November 1993, p. 90.
4. "Managing Diversity," p. 3.
5. Aaron Epstein, "Blacks Still Subject to Discrimination in Hiring, Study Says," *St. Paul Pioneer Press*, May 15, 1991, p. 3b.
6. Lennie Copeland, "Valuing Diversity, Part 2: Pioneers and Champions of Change," *Personnel Journal*, July 1988, pp. 45-46.
7. Norma Jean Schmieding, "A Novel Approach to Recruitment, Retention and Advancement of Minority Nurses in a Health Care Organization," *Nursing Administration Quarterly*, vol. 15, no. 4, 1991, p. 71.
8. Schmieding, p. 72.
9. Copeland, "Valuing Diversity, Part 2," p. 3.
10. Nancy J. Adler, *International Dimension of Organizational Behavior*, Kent Publishing, Northridge, CA, 1986, pp. 77-83.
11. Audrey Edwards "The Enlightened Manager: How to Treat Your Employees Fairly," *Working Woman*, January 1991, p. 47.

    A number of games can bring cultural diversity training programs to life. Among them are "The Diversity Game," created by New York City–based Quality Educational Development, Inc., and "Diversity Bingo Advancement Strategies," Bloomington, IN. For further information, see "Games Augment Diversity Training," *Personnel Journal*, June 1993, pp. 78-82.
12. Copeland, "Valuing Diversity, Part 2," p. 3.
13. Daniel Coleman, "Individualism vs. Collectivism Is Key to Unlock Cultural Contrasts," *Minneapolis Star Tribune*, January 3, 1991, p. 8E.
14. Coleman, p. 1E.
15. Abby Livingston, "The Enlightened Manager: How to Treat All Your Employees Fairly," *Working Woman*, January 1991, p. 47.
16. "Managing Diversity," p. 7.

"DOING" DIVERSITY

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Each institution submits an annual plan of its objectives.

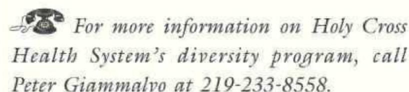
diversity, the employees of Holy Cross Hospital in Silver Spring, MD, staged an educational fashion show in which participants wore costumes from their place of national origin. "The show was very popular among the employees," says Giammalvo, "not only because of the costumes' styles and colors but also because the narrator of the show provided various bits of information about each country and its culture." More recently, Holy Cross Hospital held a management retreat that focused on diversity.

MEASURING THE RESULTS

Giammalvo says it is too soon to evaluate the system's diversity program.

HCHS's leaders have coached local chief executive officers (CEOs) to work toward diversity on their boards of trustees and leadership teams, he says. Beyond that, each member institution submits an annual plan of its objectives. "Beginning this year," says Giammalvo, "each CEO has been asked to identify the specifics of his or her facility's diversity plan and decide how it will be measured. Next year, when our CEOs are evaluated, one of the criteria will be: What specifics were you able to initiate and measure in diversity?"

In addition, as part of its systemwide mission assessment and development process, HCHS will be taking a comprehensive look at diversity in the overall context of mission fulfillment. —*Gordon Burnside*



For more information on Holy Cross Health System's diversity program, call Peter Giammalvo at 219-233-8558.

SENIORS

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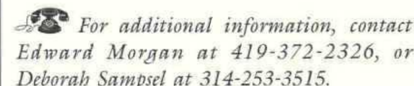
Future research should focus on the homebound.

Mercy and St. Charles needed to take a different communication approach with residents. The hospitals have explored ways to further incorporate the findings into their delivery systems, and the local community's cultural needs continue to influence emerging services. The hospitals have taken programs into the community. For example, they are now presenting educational programs at apartment complexes where elderly African Americans and Hispanics live.

MORE RESEARCH NEEDED

Because the sample size of this needs assessment was so small, future research on minority elderly health issues is needed. In addition, we recognize that the survey had its limitations. Namely, it did not allow for in-depth probing to learn exactly what participants meant by their responses. For example, many participants said they exercised often. But to them the term "exercise" meant going to visit a neighbor one door away.

Participants in this study were ambulatory, reported they were in good health, and sought medical care when needed. They were not representative of homebound elderly in poor health. Additional research could focus on identifying the status and needs of the homebound, inner-city, minority elderly. Healthcare institutions could use additional data to help them increasingly respond to elderly persons' needs, especially those from minority ethnic groups. □



For additional information, contact Edward Morgan at 419-372-2326, or Deborah Sampsel at 314-253-3515.