Multiculturalism in Age-Friendly Health Systems

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Abstract

Age-Friendly Health Systems utilize evidence-based interventions to support the quality of life and care of older adults through four M's—What Matters, Medication, Mentation, and Mobility. A growing body of literature outlines that health disparities are perpetuated by structures and systems. To achieve true health equity for older adults, transformation must occur not just in individual practice, but also in systems. We propose the addition of "Multicultural"—the acknowledgment that an individual's identity includes belonging to a specific group or community which experiences phenomena (including health) through a unique lens, and consequently, prevention and intervention strategies must be considered within this context.

Introduction

A collaboration of stakeholders established the Age-Friendly Health System framework which leverages evidence-based practices in geriatrics.[1] The framework is also a social movement designed to leverage proven models of geriatric care to improve clinical outcomes. The model is based on reviewing evidence with geriatric experts and synthesizing common elements in care practices, exploring existing clinical practices in health care settings, and testing content with geriatric experts.[2] The process resulted in a four "M" framework: What Matters, Medication, Mentation, and Mobility. The framework is backed by evidence-based research shown to be effective in supporting both the quality of life of and quality of care for older adults.

Disparities in Geriatrics: The Need for a Fifth "M"

It is well documented that disparities exist among Black, Indigenous and people of color (BIPOC) and lesbian, gay, bisexual, transgender and queer (LGBTQ) older adults in comparison to their peers. Some of these disparities include emergency department utilization[3]; nursing home utilization[4]; advanced care planning[5]; and chronic disease rates (such as stroke,[6] diabetes,[7] dementia,[8] and depression,[9] to name a few.

The Minnesota Department of Health published a historic report[10] noting the perpetuation of disparities for older persons occurring primarily through structural racism and inequities in systems and practices. This included a declaration that racism is a public health issue. This report as well as subsequent research on public health and disparities make the compelling case that changes to systems and practices are necessary to mitigate and eliminate disparities and achieve true health equity.

Beyond clinical care is an awakening occurring across communities related to social, economic and health disparities experienced by minoritized* communities. The greater awareness of racism due to tragedies such as the murder of George Floyd is providing an opportunity for meaningful conversation and change in societal structures. Yet, we know racism is multi-faceted, and change must occur not just in individuals and communities, but must also transfer to sectors such as health systems if we are to address our own disparities and health inequities. To that end, we propose the addition of a fifth M to the framework—Multicultural.

Proposed Definition of "Multicultural"

Multiculturalism is the acknowledgment that an individual's identity includes belonging to a specific group or community which experiences phenomenon (including health) through a unique lens and consequently, prevention and intervention strategies must be considered within this context. Multiculturalism is not simply the acceptance of the existence of diverse cultural groups; it further acknowledges the proactive application of strategies related to "social justice, equal access, and opportunity for minorities and other oppressed groups."[11]

Multiculturalism often is recognized as being important but ultimately not purposefully incorporated. These sentiments are well articulated in the American Psychological Association's Multicultural Guidelines: An Ecological Approach to Context, Identity and Intersectionality.[12] It is also consistent with the National Institute on Aging (NIA) Health Disparities Framework[13] that provides a multilevel approach to capturing environmental, biological, sociocultural, and behavioral factors that lead to disparities across the life course, including the role of culture.

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*In this article we use various words to describe groups from diverse communities including "minoritized," "marginalized," and "diverse." These words were purposefully selected as each have different, but related meanings and recognize not only the cultural differences between groups, but also the existence of social constructs such as oppression and access to opportunity.

This work is based on the multitude of studies that point to the importance of social influencers of health, and the role in health equity of environments where we are born, grow up, work, and age over the life course. Our addition of Multicultural is based on this framework as a key domain impacting health equity and well-being.

Making the Case

The older population is becoming more racially, ethnically diverse,[14] yet disparities in health outcomes for this population persist, especially for older adults from historically minoritized groups. The care needs of older adults from marginalized communities are often left unmet compared to those of dominant groups. For example, older adults from marginalized communities are more likely to live in under-resourced care facilities and residents in under-resourced facilities are far more likely to report unmet care needs.[15-17]

Multicultural factors greatly influence our priorities including important care and end-of-life decisions. Cultural and lived experiences impact choices, preferences for care received, and the mechanisms through which care is delivered.[16] However, for minoritized groups, care settings and supports have not historically been suited to meet their needs. For instance, nursing homes are highly segregated and were not created with Black, Indigenous, and other adults from minoritized groups in mind.[16, 18-19] In fact, systemic racism and structural barriers to quality care and services have resulted in well documented disparities over the life course.[20-22] Black nursing home residents are more likely to have insufficient support with pain management,[23] Hispanic nursing home residents have a greater chance of having incontinence,[24] and LGBTQ older adults experience higher rates of chronic physical and mental health conditions compared to their non-LGBTQ counterparts.[9] These disparities have been exacerbated by the COVID-19 pandemic—for example, communities of color are vaccinated at significantly lower rates (9% Black, 15% Hispanic, 6% Asian, 1% Indigenous) than whites (61%).[25]

Diverse community members' thoughts regarding health care have been strongly shaped by historical and contemporary experiences. The Tuskegee Experiment in the African American community,[26] the diagnosis of homosexuality as a mental disorder,[27] and inadequate funding of the Indian Health Services (2015)[28] are just some of the many examples of inequity in health care. These negative historical experiences result in deep-seated mistrust of providers. For example, four out of five LGBTQ older adults are unsure or do not believe they would receive safe services from their health care provider if that provider knew they identified as LGBTQ (Croghan, et al., 2015).[29]

Care providers can value diversity and are invested in providing culturally sensitive and quality care.[30] Framing health care from an equity perspective, we must first name structural isms and acknowledge issues that they perpetuate.[31-32] For example, structural racism is a multi-domain construct and refers to the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[33] Examples of structural racism in health care and long-term care include well-established racial segregation that results in access to poorer quality of care and quality of life for BIPOC older adults.

Even data-based evidence that providers wield for interventions towards improving services can be problematic.[34-35]. Research typically explores inequities from a dominant culture perspective that centers the majority.[35] Research questions about race typically compare outcomes of minoritized groups to that of whites (or other dominant groups), where the outcomes of the dominant group is used as a standard.[35] To achieve social justice and health equity, it is important to refocus and "center at the margins"—empower disenfranchised groups, and shift the power dynamics to truly understand what matters to them.[36]

In addition, the diversity of decision makers who direct care programming and service delivery matters. There is a paucity of providers in decision-making roles and who have culturally similar lived experiences to the growing diverse population of older adults receiving long-term services and support across various settings.[37] An underrepresentation of decision makers from historically minoritized groups has implications for the types of strategies employed to improve care and understand the preferences of multicultural populations. Addressing care preferences with a lens that does not incorporate a multicultural perspective is less likely to achieve equitable outcomes. [35-36]

How providers consider these factors is key in providing equitable services and supports, and meeting the needs of those they serve from these multicultural backgrounds is key to achieving equity and health justice in aging-related care outcomes. Strategies to provide culturally appropriate care and support need to include recognizing and eliminating barriers to the care that minoritized and marginalized older populations experience.

Implications for Practice, Policy, and/or Research

We can achieve equitable, age-friendly health systems for all when health care providers act on the connection between historical and contemporary trauma and health equity. The concept of *ethnogeriatrics* incorporates the idea that fundamentally, our cultural identity impacts health care in old age. By recognizing limitations in knowledge and experience in serving diverse communities, and moving forward with action steps to expand understanding of the diversity of patients, providers will serve these communities better.

Further, there is a need to support the diffusion of Multiculturalism. In general, there is a lack of resources related specifically to equity in Age-Friendly Health Systems. Toolkits and case

examples of successful initiatives would further the work to mitigate and eliminate health disparities within diverse communities and work to achieve health equity. We encourage developers and adopters of the Age-Friendly Health System to make a strong statement by revising the framework to include Multicultural and invest in resources to support diffusion of evidence-based prevention and intervention strategies for diverse older individuals and communities.

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