The Impact of Alzheimer's Disease in the African American Community

Heart-Brain Health Fair
FIBCO

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Disclosure

The presenter have documented that she has no financial relationships to disclose or Conflicts of Interest to resolve.

Addressing Cultural Competence

- Discuss the concept of Cultural Competence in relation to healthcare, research, and the community
- Identify cultural influences on one's own belief and values
- Describe the term Cultural Competemility and the impact on healthcare, research, and the community
- Evaluate the role culture plays in determining how different people perceive and shape their world

COVID 19 and Culture

COVID 19 has caused us to amplify the term Culture in our:

- Society
- Community
- Family
- Work
- Self

"How companies respond … is going to define their brand for decades. How you treat your clients today will have more impact on your brand in future years than any amount of advertising, any amount of anything you literally could do."

Mark Cuban

Culturally Safe Communities

- Vulnerable populations are at risk of experiencing inequalities in health experiences and health outcomes
- Vulnerable populations are exposed to research that is driven by socio-cultural lenses
- Dominant Culture: Race and ethnicity

Wilson & Neville (2009)

How do you define Culture?

How do “we” define culture?

Society

Community

Family

Individual

Purnell (2017)

Culture

The word Culture has over 1,460,000,000 results.

There is no single definition.

Yet, the classical definition by Fejos (1959, p. 43) of **Culture** is described as “the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey or hand down to the next; in other words, the nonphysical inherited traits we possess.”

Steps to Cultural Competency

1. Personal heritage: Who are ***you***? What is ***your*** heritage? What are ***your*** HEALTH beliefs?
2. Heritage of others-demographics: Who is the other? Family? Community?
3. HEALTH beliefs and ***practices:*** What the competing philosophies are.
4. ***Healthcare culture and system:*** What all the issues and problems are.
5. *T**raditional*** HEALTHCARE ***systems***: The way HEALTH was for most, and the way HEALTH still is for many.

Rachel E. Spector (2017)

The Process of Competemility

- Cultural Awareness
- Cultural Knowledge
- Cultural Skill
- Cultural Encounter
- Cultural Desired

Campinha-Bacote, 2015

Cultural Awareness

Cultural Awareness is the process in which one conducts a self-examination of one's biases towards other cultures and the in-depth exploration of one's cultural and professional background. Involves being aware of the existence of documented "isms" in healthcare and research

Campinha-Bacote, 2015

Cultural Knowledge

Cultural Knowledge is the process in which the healthcare professional seek and obtains a sound educational base about culturally diverse groups.

According to Purnell, healthcare professionals must focus on the integration of three specific issues:

- health-related beliefs
- health-related practices
- health-related values

Campinha-Bacote, 2015

Cultural Skill

Cultural Skill is the ability to gather culturally relevant data regarding the information requested, as well as, accurately performing a culturally-based physical, spiritual, psychological, and medication assessments in a culturally sensitive manner.

Campinha-Bacote, 2015

Cultural Encounter

Cultural Encounter is the process which encourages the healthcare professional to **directly engage in face-to-face** cultural interactions and other types of encounters with clients from **culturally diverse backgrounds** in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

Cultural encounters is the pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence.

Campinha-Bacote, 2015

Cultural Desire

Cultural Desire is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters; not the "have to."

Campinha-Bacote, 2015

“Have I ASKED myself the right questions?”

- **A**wareness: Am I aware of my prejudices and biases, as well as the presence of ‘isms?’
- **S**kill: Do I know how to conduct a culturally specific history, physical, mental health, medication and spiritual assessment in a culturally sensitive manner?
- **K**nowledge: Do I have knowledge regarding different cultures’ worldview, the field of biocultural ecology and the importance of addressing social determinants of health?
- **E**ncounters: Do I have sacred and unremitting encounters with people from cultures different from mine and am I committed to resolving cross-cultural conflicts?
- **D**esire: Do I really ‘want to’ engage in the process of competemility?

We must ask ourselves and allow others to ask themselves

Why is Cultural Competence Important?

This term culture includes many different **ethnicities**, religions and various other cultures. Like any other community these groups are dynamic and change over time and through generations.

The challenge for dementia care providers, educators, researchers and policy makers is

- Adapting their approach to best support a more inclusive structure
- Learn about diverse cultures and how to offer appropriate support
- Understand how to work with a range of diverse communities

Applying Cultural Competemility in Dementia Care: Case Study

Case Scenario

Mrs. W., is a 79-year-old AA female, was born in Georgia, where she completed 6th grade and later moved to California after marrying at a young age. She worked as a caregiver in a care home most of her adulthood until she and her husband decided to retire in Arizona. Her husband was a deacon and she, a deaconess in her church.

Subjects whose education levels are 7th grade or lower, a score on the MMSE of 22 (26) or below. Adjusting for grade.

MMSE score, not only do we take education in effect, we also look at culture.

Case Scenario

Mrs. W. has three children, two (sons) of whom live in California and the youngest (dtr.) in Atlanta, GA.

Mrs. W. lived with her spouse and was his primary caregiver until around the time of her referral to BAI.

Mrs. W. medical history is Alzheimer's disease (early stage), Diabetes, Hypertension, Coronary artery disease and Osteoarthritis.

Common conditions for African Americans included depression, hypertension, diabetes, stroke, and cardiovascular disease – all risk factors for dementia

Case Scenario

Mr. W., an 86-year - old, retired postal service worker (veteran) health declined further, and he was placed in a NH.

Mrs. W., PCP referred her to BAI-FCS programs, prior to her husbands decline.

Family Dynamics. After her husband's placement, the couple's dtr. P. flew in from Atlanta to visit her father. During her visit she discovers her mother's diagnosis of dementia (level of embarrassment). P. began to take on the role of primary caregiver (DPOA, finance…).

Reluctance to acknowledge a potential memory problem outside of the family for fear of embarrassment

Case Scenario

P is a schoolteacher, who lives in a predominately AA community (attended an HBCU, AA organizations…), she has three- children, one male son who recently had challenges with law-enforcement and her dtr. was dx. with COVID. P. siblings offer very little support.

Historically black colleges and universities (**HBCUs**) are institutions of higher education in the United States that were established before the Civil Rights Act of 1964 with the intention of primarily serving the African-American community.

Amplified by current social unrest and the pandemic

Case Scenario

As Mrs. W. health starts to decline, P. begins to take on more responsibilities. Taking care of her mother and visiting her father began to become her new priority.

Though accompanying her mother to BAI visits, she overlooked the FCS program . She was encouraged to attend support groups, classes and participate in **research**. But after a while, she stop the visits at BAI and began attending her parent's church (spiritual care). BAI staff was struck by the number of times P. declined support and considered her non-complaint.

The least reported social support need was for counseling from clergy (16.7%), which could indicate either high levels of support from clergy

“Have I ASKED myself the right questions?”

- **A**wareness:
- **S**kill:
- **K**nowledge:
- **E**ncounters:
- **D**esire:

Case Scenario

Turning point: ASKED

After attending the BAI Case Conference, a BAI staff member reflected on the Steps to Cultural Competence and the ASKED Model = Applied Competemility…
P began to open up and talk to the staff member about mistrust, issues with care, education and research, her family, community and society as well as how her son's recent incident that caused her not to trust "others" even when it came to her parent's care.

It was through P's interaction with the staff member, there was an incremental increase in trust and P became more open to interventions and utilized resources.
P also realized how the resources she received for her mother applied to her father and how easily accessible they were. She even hinted how she may get involved in research.

Recommendations:

- Build Trust
- Improve Access to Health Care
- Provide One Point of Contact
- Increase Cultural Competence

Recommendations:

- All research studies should **take steps to be as inclusive** as possible, including in how research is advertised – using diverse images and culturally specific information.
- **Public involvement** in research studies should include a range of diverse representatives.
- As a research funder, it's vital that research communities recognize that recruiting individuals from diverse communities takes **additional time and money** and this should be considered when awards are made.
- Researchers should ensure that there is a **diverse range of peer reviewers** assessing research applications, and that reviewers are knowledgeable about research into people with dementia from diverse communities.
- We know diverse communities are underrepresented as participants in research studies so **service managers who engage with and deliver services to ethnic minorities could be key to recruiting people to studies**.


Trust is built in drops and lost in buckets.
KEVIN A. PLANK

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