Patient Listening:

Health Communication Needs of Older Immigrants

TEMPLE UNIVERSITY®
Center for Intergenerational Learning

MetLife Foundation

The SHINE-MetLife Foundation Health Literacy Initiative

This report was produced as part of the SHINE-MetLife Foundation Health Literacy Initiative, which aims to do the following:

- Increase the ability of elder immigrants to communicate with healthcare providers and access healthcare
- Increase the cultural competence of current and future healthcare professionals
- Increase opportunities for college students from diverse backgrounds to learn about and address the health literacy needs of immigrant elders
- Develop educational materials that help immigrant elders communicate with healthcare providers and better understand the healthcare system
- Replicate a model of health literacy instruction and pilot health literacy ESL materials
- Build the capacity of ESL instructors, tutors, and adult education administrators serving immigrant elders to incorporate health literacy topics into their curriculum and educational programs

The focus groups and interviews discussed in this report were conducted by Project SHINE (Students Helping In Naturalization of Elders) based at Temple University's Center for Intergenerational Learning, in collaboration with San Jose State University's Gerontology Program and Temple University's Nursing Program.

SHINE is a national service-learning initiative that links college students with older immigrants and refugees who are seeking to learn English and obtain U.S. citizenship. Funded by the Corporation for National and Community Service, SHINE involves 18 institutions of higher education in eight states. For more information about Project SHINE and to access materials developed as part of the SHINE-MetLife Foundation Health Literacy Initiative, please go to www.projectshine.org.

This initiative was made possible by a generous grant from MetLife Foundation, with additional support provided by Temple University and San Jose State University.

Photo Credits: Janice Benech: front cover (second from top, center, bottom), back cover (center), page 9 (left and center), pages 11, 29, and 40. Heinz Kluetmeier: front cover (right), pages 7, 9 (right), 19, and 35. Patrick Snook: cover (top, third from top), back cover (left and right), pages 1, 12, 16, 23, and 30.

Patient Listening:

Health Communication Needs of Older Immigrants

Written by Daryl Gordon and Hitomi Yoshida,
with Nancy Hikoyeda and Debra David

Made possible by a grant
from MetLife Foundation

A publication of the Temple University
Center for Intergenerational Learning
1601 N. Broad Street, Room 206
Philadelphia, PA 19122

Biographical Sketches of Authors

Debra David, Ph.D., is the director of the Center for Service-Learning and a professor of Health Science at San Jose State University. Her innovative intergenerational work in health literacy was recognized by a Crystal Award from the Rosalynn Carter Institute for Caregiving. Dr. David has presented and published on topics ranging from intergenerational programs, ethnogerontology, and ethical issues in long-term care to faculty and program development in service-learning and civic engagement. She earned her doctorate in sociology from the University of California, Berkeley.

Daryl Gordon, Ph.D., is the assistant director of Project SHINE at Temple University's Center for Intergenerational Learning and an adjunct professor in Temple's TESOL program. She has taught ESL since 1988 in the Lao People's Democratic Republic, Mexico, and the United States. Dr. Gordon has presented and published on topics including identity shifts experienced by refugees and immigrants, second language acquisition among adult learners, and improving linguistic access for immigrant elders. Her doctoral dissertation, earned at the University of Pennsylvania, focused on second language acquisition among adult Lao refugees.

Nancy Hikoyeda, DrPH., is the director of the San Jose State University Gerontology Program. Her areas of expertise include ethnogerontology and ethnogeriatrics—studies of aging, ethnicity, and health. She has co-authored and edited numerous curriculum and training materials, as well as chapters on older Asian/Pacific Islanders in *Social Work Practice with the Asian American Elderly; the Encyclopedia of Aging*; *Minorities, Aging, and Health*; and *Cultural Issues in End-of-Life Decision Making*. Dr. Hikoyeda is a member of the Core Faculty of the Stanford Geriatric Education Center.

Hitomi Yoshida, M.S.Ed., is the project manager of the SHINE-MetLife Foundation Health Literacy Initiative at Temple University's Center for Intergenerational Learning. In her experience as a qualitative researcher at Research for Action, she has utilized a collaborative approach to investigate urban education policies and programs for immigrant elders. Her work has also involved advising ESL students and facilitating cross-cultural training at universities. Ms. Yoshida focused on intercultural communication and ethnography in her graduate studies at the University of Pennsylvania.

Acknowledgments

This project would not have been possible without the time and dedication of many people. First and foremost, we owe a debt of gratitude to the immigrant elders who participated in focus groups and interviews and shared their experiences interacting with the healthcare system. Special thanks to Nancy Hikoyeda and Hitomi Yoshida, who conducted the focus groups and interviews, and to the coordinators of the senior centers and community organizations who recruited elder immigrants to participate. Thanks to Liz Hayden in Philadelphia and Gabrielle Boles in San Jose for locating the community sites and arranging the focus groups. We are grateful to nursing professors Cathy Curley, Pat Dillon, Kim Olson, and Rita Lourie, and the students of Temple University's Community Health Clinical Experience. Appreciation is also extended to Jyoti Angal, research assistant at San Jose State University, and the students of Caroline Fee's class, Multidisciplinary Health Promotion in Later Life.

A variety of service providers in the areas of healthcare, adult education, and senior and immigrant services contributed to this document through their participation in information-gathering meetings or interviews. We appreciate their comments, which helped us to better understand the complex issues faced by immigrant elders.

We are deeply indebted to the members of the Working Group for offering direction on the scope and content of this report and for providing detailed feedback on various drafts. We appreciate their contributions, which have greatly enhanced this report. Thanks in particular to Tina Kluetmeier and Nancy Henkin for their careful reading and thoughtful comments.

External reviewers contributed their expertise in the disciplines of gerontology, healthcare, and ESL by reading and commenting on an earlier version of this report. Their observations helped us to clarify and streamline our work.

Many thanks to MetLife Foundation for their support of the SHINE-MetLife Foundation Health Literacy Initiative and their commitment to the needs of immigrant elders.

We appreciate the work of Rachel Mausner and August Tarrier, who edited versions of this document. Thanks also to photographers Janice Benech, Heinz Kluetmeier, and Patrick Snook, who took the photos included in this report. Research assistants at Project SHINE, including Erin Dwyer-Frazier, Amie Kerstetter, and Rachael Small, contributed to this project in many ways, including developing a database of community service providers, organizing community meetings, researching demographic information, and searching for bibliographic citations.

Working Group

Pat Dillon, Clinical Assistant Professor, Department of Nursing, College of Health Professions, Temple University

Nancy Henkin, Executive Director, Center for Intergenerational Learning, Temple University

Tina Kluetmeier, Director, Project SHINE, Center for Intergenerational Learning, Temple University

Rita Lourie, Clinical Assistant Professor, Department of Nursing, College of Health Professions, Temple University

Community Centers That Hosted Focus Groups

Philadelphia
The Philip Jaisohn Memorial Center
Cambodian-American Senior Association
Norris Square Senior Center
Asian Pacific Senior Resource Center at Coffee Cup
David Neuman Senior Center

San Jose
Indo-American Community Center
John XXIII Multi-Service Center
Korean American Community Services
Sacred Heart Community Services

External Reviewers

Marni Baker, Instructor, English Language Programs, University of Pennsylvania

Camilla Bixler, Instructor, English as a Second Language Department, City College of San Francisco

Jan Eyring, Professor, Modern Languages and Literature, California State University, Fullerton

Kin Lam, Program Manager, Chinese Health Information Center, Thomas Jefferson University Hospital

Martha Merson, Research Associate, TERC Science and Math Learning

Sookyung Oh, Program Coordinator, The Philip Jaisohn Memorial Center

Debra Sheets, Assistant Professor and Coordinator, Gerontology Program, California State University, Northridge

Table of Contents

Executive Summary

Older immigrants in the United States, particularly those who are not native speakers of English, confront many difficulties in obtaining healthcare. In order to learn about the nature of these difficulties and develop approaches to address the problem, it is important to hear from the elders themselves about the specific problems they have encountered and what they feel would be helpful for them.

To this end, staff of Project SHINE, a national service-learning initiative, which offers tutoring for older immigrants and refugees, conducted focus groups and individual interviews in Philadelphia, Pennsylvania, and San Jose, California, with 101 immigrant elders representing seven major ethnolinguistic groups. In addition, elders completed a checklist indicating the health issues and communication skills that were of greatest interest to them. Findings from these sessions were complemented by information-gathering meetings and interviews with service providers who work with elder immigrants.

The immigrants who participated in the focus groups and interviews told poignant stories illustrating their struggles related to health literacy and communication. For example, some elders delayed seeking medical care until health problems developed into emergencies because they were unable to read or understand their insurance information to ascertain if they had coverage. Others were unable to make a doctor's appointment because they could not understand the doctor's automated phone message. Many could not understand what a doctor said to them during an office visit, had no access to suitable interpreters, and were not able to ask for clarification.

The immigrants who participated in the focus groups and interviews told poignant stories illustrating their struggles related to health literacy and communication.

Breakdowns in communication were the source of many healthcare-related mishaps reported by the elders. In order to examine these communication difficulties and develop recommendations for addressing them, the authors describe components that are necessary for effective communication in healthcare settings. Effective communication involves more than l**anguage competence**, or knowing grammar and vocabulary.

Non-native speakers of English also require **cultural competence**, which is an understanding of cultural beliefs and practices that influence language use; **strategic competence**, the ability to ask for repetition or clarification if one does not understand spoken information; and **discourse competence**, an understanding of the "big picture" of healthcare systems and how to navigate these systems in order to obtain healthcare.

The challenges that elder immigrants experience with these aspects of communication are illustrated throughout the report by quotes and vignettes from elders themselves and the service providers who work with them. The report examines communication breakdowns that occur as elders schedule appointments, communicate with healthcare providers, and deal with medical bills and insurance coverage.

When asked how these communication gaps could be reduced, elders see responsibility for change on both sides—the elders themselves and the healthcare providers and systems that work with immigrant populations. While many elders are working hard to improve their command of English, they would like support from English as a Second Language (ESL) teachers to learn how to communicate more effectively with doctors and to understand how to navigate the U.S. healthcare

system. Many also felt that ESL classes provided an excellent opportunity for learners to share information about bilingual providers or interpreters in the community.

Elders were also acutely aware of the difficulty of mastering a second language and learning medical terminology at their age, and felt that healthcare providers needed to meet them halfway. They expressed the need for providers to offer health information in translation and quality bilingual interpretation services. Too often elders relied on friends or family members who were not familiar with medical terminology or who might not maintain the confidentiality of the patient-doctor encounter.

The report concludes with recommendations for those who work with the elderly immigrant population, including healthcare providers, senior and immigrant service providers, and ESL instructors. General suggestions are offered on working and communicating with immigrant elders, followed by specific suggestions for each group of professionals.

Mrs. Chin's Story

MRS. CHIN* is a 60-year-old Chinese woman who has lived in the United States for 20 years. Her husband passed away two years ago and she now lives alone, near her son and his family. She never attended English classes, due to long hours at a factory and years caring for her husband when he became ill, so she speaks limited English.

She used to see a doctor who spoke Mandarin, her native language. He told her that she needed to keep her high blood pressure under control. Sometimes she felt discomfort in her chest, but attributed it to the stress of dealing with her husband's death. She considered seeing her doctor, but was concerned about the cost and wasn't sure if she was covered by insurance. Her husband had always handled the insurance forms because she had difficulty reading them.

When the pressure in her chest got worse, Mrs. Chin used Chinese herbal medicines that reduce tension. This usually helped, but one night she felt a lot of pain and had trouble breathing. She called 911 and was taken to the emergency room. The ER doctor asked several questions in English, but he spoke quickly and she didn't understand. He smiled and told her slowly and calmly that he would find a translator.

A hospital administrator arrived who spoke some Cantonese but very little Mandarin. Because Mrs. Chin speaks only Mandarin, she didn't understand him. Mrs. Chin tried to communicate in writing, but the administrator couldn't read what she wrote. Mrs. Chin didn't understand what had happened to her or how long she would be in the hospital.

Finally her son arrived! He was fluent in English, but his knowledge of Mandarin was limited. He told his mother that she had been given medication to control her blood pressure and that she would be OK. After she was admitted to the hospital, a resident physician arrived to re-examine Mrs. Chin. She had more questions, but this doctor spoke to her son quickly and barely looked at her. She decided that she would wait to talk with that nice doctor who had seen her in the emergency room. The next morning, she was released from the hospital and told to contact a heart specialist.

> Mrs. Chin's story echoes the experience of many immigrant elders attempting to navigate the complex U.S. healthcare system.

When she called the cardiologist's office to make an appointment, she heard an automated message. It was too fast to understand, so she hung up. Speaking English over the phone was so difficult! Mrs. Chin was afraid the receptionist would not be able to understand her accented English. She decided to wait until her son had time to make the appointment for her. Mrs. Chin is frightened that the pain in her chest will return and is worried about paying for the hospital bills.

* Mrs. Chin's story is a fictional account, based on the experiences of many immigrant elders who participated in focus groups and interviews.

Introduction

Immigrant elders, especially those with limited English proficiency, face many obstacles in their efforts to access healthcare in the United States. This report describes findings from focus groups and interviews with elder immigrants who describe in their own words the many challenges they experience navigating the healthcare system. Elders from seven major ethnolinguistic groups living in Philadelphia, Pennsylvania and San Jose, California participated in the focus groups.

The stories and insights these elders shared have helped us to develop and pilot ESL health literacy materials designed for elder immigrants. Our findings can also guide healthcare providers in their efforts to more fully meet the needs of immigrant elders. This report is designed to offer practitioners who work with elder immigrants, including health-related professionals and paraprofessionals, senior service providers, and ESL instructors, a better appreciation of the health literacy needs and challenges faced by these elders, so that providers can offer more effective health information and services to this often overlooked group. Future healthcare professionals, such as nursing or other health professions students, and family members of older immigrants may also find this report useful.

Mrs. Chin's story echoes the experience of many immigrant elders attempting to navigate the complex U.S. healthcare system. As we conducted focus groups and individual interviews, we heard the stories of elders who, like Mrs. Chin, face many challenges in communicating with healthcare providers. Many have difficulty with understanding and speaking English in healthcare encounters and in reading prescriptions, insurance information, and consent forms. Some elders delayed necessary doctor visits due to confusion about insurance coverage or difficulty locating an interpreter. As in Mrs. Chin's case, these delays can have serious health consequences.

Immigrant elders spoke of the support they currently receive from healthcare providers and community networks and suggested ways that providers and other professionals could help them better understand and access healthcare services in the United States. We hope that the voices and experiences of the elders represented here will provide insight into the difficulties these elders may experience in accessing health services and communicating with healthcare providers.

Background

What Is Health Literacy?

The ability to play an active role in one's healthcare depends on a multi-faceted set of skills known as "health literacy." In this report, we adopt the definition of health literacy developed for the National Library of Medicine and used in *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). Health literacy is:

> *the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions* (Ratzan and Parker, 2000).

Broader than earlier definitions of health literacy, which involved only the ability to read and understand written health-related materials, this definition acknowledges that individuals may use oral communication skills as well as print literacy to obtain health information, access health services, and make health-related decisions. In Mrs. Chin's story, we can see how her limited health literacy affects her ability to obtain health services. Her limited print literacy in English makes it difficult for her to read and understand information about her insurance coverage. Her limited ability to communicate in English makes it difficult for her to understand the doctor she encounters in the emergency room and to make a follow-up appointment with a cardiologist after her release from the hospital. Communication skills of oral comprehension, pronunciation, and grammar are important for immigrant elders, as they have an impact on the elders' abilities to obtain medical care. This report offers many examples of the challenges immigrant elders experience in communicating with healthcare practitioners. In the "Communication Issues in Healthcare Settings" section, we discuss components of effective communication that are essential to prevent miscommunication. Awareness of these components is useful in understanding the reasons that miscommunication may occur in a healthcare encounter.

Cultural differences and understanding of the U.S. healthcare system also play an important role in healthcare communication and decision-making. Consider Mrs. Chin's interactions with the resident who saw her after her admission to the hospital. Even though her son was available to translate, she was reluctant to ask questions because she perceived the resident's attitude as brusque. She assumed that she would have another opportunity to see the emergency room doctor, whom she perceived as more understanding and approachable. If Mrs. Chin had had a better understanding of the process of hospital admissions, she would have known that a patient is generally assigned a new doctor after admission to the hospital and that it would be unusual to see the emergency room doctor again. Mrs. Chin's cultural background also influenced the way that she interpreted her physical symptoms as potentially stress-related, as well as her initial decision to treat her symptoms with herbal medications.

Cultural differences and understanding of the U.S. healthcare system also play an important role in healthcare communication and decision-making.

Further exploring this situation, we see that health communication is a two-way street. Having investigated how Mrs. Chin's limited health literacy and communication skills created challenges, let us now consider how healthcare providers experienced difficulty communicating with her. They had problems providing her with a competent bilingual interpreter. Although her healthcare provider sought to provide an interpreter, he lacked the cultural competence to know that Chinese people may speak different dialects and that speakers of one dialect often cannot understand speakers of another. Mrs. Chin, who is from mainland China, spoke Mandarin, but her interpreter, whose family is from Hong Kong, spoke Cantonese (UCLA Language Materials Project, n.d.a, n.d.b). While these dialects share a common writing system, the hospital administrator had not learned many Chinese characters and had difficulty

understanding what Mrs. Chin had written. Therefore, Mrs. Chin's son was entrusted with the responsibility of explaining medical procedures to her. However, like many immigrants who entered the United States as children, he had never learned medical terminology in Mandarin. Furthermore, Mrs. Chin also encountered a physician who lacked the cultural competence to know how to communicate effectively through an interpreter. Rather than interacting directly with Mrs. Chin, he spoke to her son, discouraging Mrs. Chin from asking any questions.

Challenges related to health literacy and communication began well before Mrs. Chin's hospitalization. If she had had a better understanding of her insurance policy and the types of treatment it covered, she might have obtained regular care from her doctor, obviating the need for an emergency room visit. If there had been a senior service provider or community organization that provided translation assistance and information about insurance and Medicare coverage, Mrs. Chin would have known that her visits to her bilingual provider were covered.

Why Is Health Literacy Important?

Research studies report that, like Mrs. Chin, many Americans experience challenges accessing healthcare due to limited health literacy skills. In 1999, *The Journal of the American Medical Association* reported that 46 percent of adults lack the literacy skills necessary to deal with the healthcare system (Gazmararian, Baker, et al., 1999). A large study conducted at two public hospitals found that many adults experienced difficulty with health-related literacy tasks. For example, 42 percent of patients who were native speakers of English could not understand the instruction to "take medication on an empty stomach" (Williams et al., 1998). Problems with limited health literacy are compounded by the fact that many health-related materials demand a higher literacy level than is realistic for their intended audience. Researchers have found that most of the

Balancing Traditional and Western Medicines

Cultural beliefs influence immigrants' understanding of health and wellness and of the type of treatments they seek to manage health problems.

MRS. TOUCH is a 68-year-old woman who grew up in a rural area in Cambodia. Forced to leave her homeland because of political turmoil, she lived in a series of refugee camps in Thailand and the Philippines before entering the United States in 1985. Speaking about the medical practices in her homeland, she says that patients depend on *khru khmer*, traditional healers who treat patients with herbal medicines and by appealing to healing spirits. Although Mrs. Touch grew up with a very different concept of medical treatment, she is comfortable using both traditional and Western medicine.

When she began to experience difficulty breathing three years ago, Mrs. Touch first tried "coining," a traditional practice in which a coin dipped in a mentholated ointment is rubbed on a patient's chest or back. According to Mrs. Touch, coining helps to increase blood flow and relieve stress, which may cause headaches or other ailments. However, when her condition worsened, her children called an ambulance, and she was admitted to the hospital for "the beginning of a heart attack." Although she uses both indigenous and Western medicine, Mrs. Touch does not discuss her indigenous treatments with her doctor. She says, "They didn't ask me, and I didn't tell the doctors about using herbal medicines."

materials they assessed exceeded the reading skills of the average high-school graduate (Rudd, Moeykens, and Colton, 2000; Singleton, 2002).

Elder immigrants face particular difficulties in health-related communication. In a study with public hospital patients, over 60 percent of non-native English-speaking patients lacked the literacy skills adequate to function in healthcare settings (Williams et al., 1998). A number of studies have reported that limited health literacy is a greater problem among older adults (Beers et al., 2003; Benson and Forman, 2002; Gazmararian, Baker, et al., 1999; Rudd, Moeykens, and Colton, 2000) and those with limited English proficiency (Schillinger et al., 2002; Weiss et al., 1994; Williams et al., 1995, 1998).

The ability to understand and act on health information directly affects a patient's ability to understand disease processes, engage in disease prevention and early detection interventions, and comply with therapeutic routines. In order to succeed in managing chronic diseases such as hypertension and diabetes, patients must be active participants in their care by making lifestyle modifications and taking medication consistently. Researchers studying patient compliance have found that patients with lower levels of health literacy may not fully understand their health problems and, therefore, are less likely to participate with their doctor in making decisions about a course of treatment (Gazmararian, Parker, et al., 1999; Kalichman et al., 2000; Schillinger et al., 2002). Additionally, patients with lower health literacy skills have more health problems and require longer hospitalization times than other patients (Baker et al., 1997; Bennett et al., 1998; Gordon et al., 2002; Guerra and Shea, 2003).

Few research studies, however, have specifically explored the challenges of health literacy and health communication that immigrant elders encounter. Those studies that have examined the problems experienced by non-native speakers of English have focused on native speakers of Spanish (Gazmararian, Baker, et al., 1999; Weiss et al., 1994; Williams et al., 1995, 1998). While these studies provide insight into challenges faced by Spanish speakers, they do not include individuals from other language backgrounds, who may face even greater difficulty locating bilingual/bicultural providers, competent interpreters, or translated materials. Also, these studies involved individuals of all ages, so they did not explore the potentially greater challenges faced by older immigrants, who often speak and understand less English and have less familiarity with U.S. culture than younger immigrants.

Furthermore, most health literacy studies have focused on print literacy, measuring an individual's ability to read a variety of health-oriented materials, such as health information brochures or prescription labels (Benson and Forman, 2002; Gazmararian, Parker, et al., 1999; Gordon et al., 2002). While these studies have yielded important insights into the difficulties individuals face in understanding health-related information, they do not capture how culture and communication affect the experiences of older immigrants in healthcare settings.

This report seeks to complement previous studies by sharing some of the stories "behind the numbers." The experiences of a diverse group of immigrant elders provide a rich description of how a low level of health literacy affects their ability to communicate in healthcare encounters, and how communication difficulties further impact their choices and access to healthcare services. The experiences elders related were instrumental in the development of ESL health literacy units designed to help elders communicate with healthcare providers and better understand the healthcare system.

Who Are Immigrant Elders?

The difficulties elder immigrants experience accessing healthcare are of urgent concern, given the recent steep increase in the foreign-born population. Between 1990 and 2000, the foreign-born population in the United States increased by 57 percent, from 19 million to 31 million. Of the current foreign-born population, 20 percent, or 6 million people, are over the age of 55. Because over 75 percent of immigrants are from Latin America and Asia, the majority of immigrant elders do not speak English as their first language (U.S. Census Bureau, 2002).

By 2050 the ethnic minority elder population is projected to double to more than 35 percent of the elderly population. While some of these elders may not be limited English speakers, these statistics indicate that elders of the mid-21st century will be

even more racially and ethnically diverse than today. Asian and Latino elders will be the fastest growing sectors of this population. The Latino elderly population is projected to grow from 2 million to 13 million, while the population of Asian elders will expand from 660,000 to 5.7 million during the same period. As the population of ethnic minority elders increases, their need for health and educational services becomes ever more pressing (Federal Interagency Forum on Aging, 2000; Fong, 2003).

A Diverse Population

Immigrant elders are an incredibly diverse group. While their diversity adds to the cultural mix of the United States and greatly enriches this country, it can also present a challenge to providers as they seek to learn about the needs, preferences, and expectations of immigrant elders. This section provides information about immigrant elders as a group, but it is important to remember that each elder is an individual, with a particular set of life experiences that influence his or her health beliefs, behaviors, traditions, and capacity for health communication.

Cultural heritage and language are elements of diversity. For example, Asian/Pacific Islander American (APIA) elders may come from Japan, Korea, China, Thailand, Tibet, Sri Lanka, Myanmar, India, or any one of the thousands of Pacific Islands. Each of the individuals from this group may speak one of over 100 different languages or language varieties. Adding further to the diversity within the APIA group, people who self-identify as Chinese may have immigrated from mainland China, Taiwan, Southeast Asia, Singapore, Hong Kong, or Malaysia (McBride, Morioka-Douglas, and Yeo, 1996). These elders may speak a dialect of Chinese (such as Mandarin or Cantonese) or the national language of their country. For example, an ethnic Chinese elder from Cambodia may speak a dialect of Chinese or Khmer, the language of Cambodia.

Even elders who share the same language may come from different cultural backgrounds and speak different dialects. For example, Latino elders, who speak Spanish, may come from any one of 19 separate countries or Puerto Rico, each with its own culture and traditions. Individuals from Spain, Mexico, Latin/South America, and other Spanish-speaking countries speak different varieties of Spanish. While these varieties are usually mutually comprehensible, they may have different pronunciation and vocabulary. Sometimes there are very different words for the same item in different Spanish dialects. For example, a computer is an *ordenador* in Spain but a *computadora* in Latin America (Erichsen, 2005).

> In addition to adapting to a radically different culture and language, older immigrants may also be adjusting to a different intergenerational role within the new environment.

Immigrant elders also vary in socioeconomic status. For example, within the large group of APIA elders in the United States, Japanese Americans have some of the highest incomes in the country, while Hmong elders have among the lowest incomes. Differences in socioeconomic status are often associated with differences in educational background and literacy skills (Tanjasiri, Wallace, and Shibata, 1995).

Familiarity with U.S. culture can vary immensely, depending on length of time in the United States and circumstances of entry. The families of some ethnic minority elders may have lived in this country for generations. For example, the first Japanese Americans arrived in the 1860s. Others, such as Bosnian or Somali refugees, are recent arrivals. Immigrants, who entered the United States voluntarily seeking a better life for themselves and their families, often adjust more quickly to U.S. culture than refugees, who were forced to leave their countries due to political turmoil, violence, and/or political repression.

What Challenges Do Immigrant Elders Face?

The challenges faced by immigrant elders are many. While those who immigrate as children or young adults often develop English proficiency and knowledge of the healthcare system by the time they reach old age, immigrants who enter the United States in middle age or later often experi-

MENTAL AND EMOTIONAL HEALTH

Immigrant elders may experience significant stress in their adjustment to a new cultural and linguistic landscape, which can compromise their mental health. Elders may worry about family members remaining in their native country. They may experience loneliness after a partner has died, which may be intensified by cultural and linguistic isolation. Elders interviewed for this report made the following comments about their stressful encounters:

I think a lot about the families in Cambodia … because their living conditions are not the same … I'm here in the United States, where everything is supported. But my main concern is … their well-being. But then … the more I think about that, it's only going to … affect my heart. So I try not to think too much about that.

~ Cambodian elder

Let me emphasize, for an immigrant, because the language barrier, if one, either the husband or wife, passed away, they become isolated. And it's worse if you cannot speak English; you are even more isolated.

~ Chinese elder

The elders demonstrated remarkable resilience as they faced the challenges of an unfamiliar land. Some elders emphasized the importance to their well-being of family members and involvement with social networks at immigrant community centers. A number of them found strength and support in spiritual traditions, as evidenced by the following comments:

I read a lot of spiritual books and also believe in God and spend a lot of time in prayers [to be healthy].

~ Asian Indian elder

Cambodians, in general, if they are very depressed, they are upset, very sad … they would go to the monk. They would go to the temple, speak to the monk, and try to get a fortune teller to tell their fortunes about what's going on in their life. You get the monks to do some praying for them to help them feel better. It's more of a clearing up their mind, spiritual in a way.

~ Cambodian elder

ence significant challenges in learning English and acculturating to American life. In addition to adapting to a radically different culture and language, they may also be adjusting to a different intergenerational role within the new environment. Erosion of traditional roles for elders is well-documented among immigrant groups in the United States. Younger family members often perceive that the wisdom and experience that elders have spent their lives accumulating are no longer relevant in the new country. In addition, as younger family members shift toward English they may lose the ability to speak the first language, creating a situation in which grandparents, parents, and children no longer have a shared language for communication. This situation can easily result in elders feeling isolated in the larger English-speaking society and within their own families (McKay and Weinstein-Shr, 1993; Weinstein-Shr, 1993).

Many elders encounter difficulty learning to speak, read, write, and understand in the English language. Some, like Mrs. Chin, may have lived in the United States for many years, but the necessities for survival in a new country may have taken precedence over formal language study. Many immigrants work long hours, care for young children, and may also be caregivers for older members of their extended family. Furthermore, older immigrants and refugees who lack literacy skills in

Adapting to a New Culture Can Be Stressful

Immigrant elders in the United States undergo cultural changes in their traditional family roles. Language barriers may intensify the stress they experience as they adjust to these new roles.

DR. XIN, a 62-year-old man, was a surgeon in his native country of China. He came to the United States eight years ago seeking better educational opportunities for his children. Dr. Xin spoke of the sense of loss and isolation that Chinese elders feel as traditional family roles shift. Chinese elders expect their children to care for them and support them financially in their old age. However, these patterns may change in the United States. He explains:

> *Sometimes, even though a son or daughter may promise to take care of you, once you are here … they may not be able to afford to do that. And the pressure is on seniors to … resolve that kind of problem. The money [was supposed to] come from the son or daughter. [Now] they cannot take care of that. Where can you resolve your daily expenses?*

their native language may be embarrassed by their limitations and reluctant to attend classes. If they do muster the time and courage to enroll in an ESL class, the class may focus on literacy-based teaching methods, which can present additional obstacles to learning English.

Immigrant elders may lack the confidence to learn a second language at their age, and their children may reinforce this doubt. Unfortunately, ageism, the belief that "you can't teach an old dog new tricks," exists in many societies, even those that hold older adults in high esteem.

Particularly troubling to elders is the fear of not being able to remember new information. While both young and old alike may forget new information, a younger person's memory lapse is considered normal, while a similar lapse in an older person may be labeled as "senility" (Becker, 2000).

A growing body of research on second language acquisition contradicts this myth and demonstrates that healthy older people retain their ability to learn (Oxford, 1985). In fact, some researchers report that adults have developed learning strategies that can help them learn languages more quickly in early stages than children (Krashen, Long, and Scarcella, 1979).

It is essential to acknowledge the strength and resilience of immigrant elders, many of whom faced hardship and sometimes great danger prior to arriving in the United States. Their survival in the new homeland is a testament to their courage, endurance, and ability to marshal external resources to overcome numerous obstacles (Weinstein-Shr, 1993).

What Are Barriers to Obtaining Healthcare?

Barriers to obtaining healthcare services may be structural, those that are built into the healthcare system, or sociocultural, those that are based on individual perceptions of health, illness, and treatment preferences. Both types of barriers create the potential for misunderstanding and miscommunication in medical situations. Both may delay or prevent access to needed healthcare services.

Some of the structural barriers immigrant elders might face include facilities that are not accessible to persons with disabilities, the high cost of healthcare, lack of affordable health insurance coverage, the absence of services in ethnic communities, inconvenient hours of operation, and the daunting paperwork frequently required. The lack of bilingual/bicultural healthcare providers or staff members can also create a structural barrier to medical services and treatment (Kagawa-Singer, Hikoyeda, and Tanjasiri, 1997). Sociocultural barriers may arise from a healthcare provider's lack of knowledge about immigrant groups, which may result in disregard for a patient's cultural beliefs and preferences.

Healthcare providers who have frequent contact with a particular immigrant group will find it useful to learn about those clients' cultural backgrounds and migration experiences. For example, immigrant elders may have encountered negative past experiences, such as discrimination, or hold different attitudes and beliefs about various diseases and their causes and the use of complementary and alternative medicine (Kagawa-Singer, Hikoyeda, and Tanjasiri, 1997).

Approach

In order to guide the development of ESL health education materials to help immigrant elders communicate with healthcare providers, a needs assessment was conducted in Philadelphia, Pennsylvania, and San Jose, California. These two cities are quite different in the size and composition of their foreign-born populations. San Jose is one of the most diverse communities in the United States; more than 35 percent of its residents are foreign-born, and nearly half of these individuals (44 percent) arrived in the previous decade. The largest immigrant groups are from Mexico, China, the Philippines, Vietnam, and India. Philadelphia's foreign-born residents comprise approximately 9 percent of its total population, with the largest immigrant groups from Russia and the Ukraine, Vietnam, China, India, and Jamaica (U.S. Census Bureau, 2000).

Three methods were used to collect information: focus groups and personal interviews with elder immigrants; completion of a checklist of health-related topics of interest; and discussions with professionals about their perceptions of elders' needs in the areas of healthcare, senior services, immigrant services, and education.

The immigrant elders who participated in the focus groups and interviews were recruited from ethnic senior centers, senior housing, community health centers, and other community-based organizations. These elders represented ethnic groups that have been in the United States long enough to develop established social networks. These elders were relatively active and sufficiently knowledgeable about community resources to attend a community center.

Focus group participants represented seven major ethnolinguistic groups, selected to reflect the diversity of immigrant elders in the United States.

Focus Groups

Ten focus groups of elderly immigrants were conducted in Philadelphia and San Jose from October 2003 through March 2004. A total of 84 participants represented seven major ethnolinguistic groups: Cambodian, Chinese (Mandarin), Asian Indian (Hindi, Gujarati, and Marathi), Korean, Russian/Eastern European, Latino, and Viet-namese. These groups were selected to reflect the diversity of immigrant elders in the United States and a range of socioeconomic and educational backgrounds.

The focus groups were held in ethnic-specific senior centers, senior housing facilities, community clinics, and community-based organizations. Participants were recruited by the site staff based on their age (60 or above) and their interest and availability. Focus groups were conducted in English, with interpretation in the languages of the participants. Focus groups were audiotaped and transcribed by a professional transcription service. See the Focus Group Participants table on the inside back cover for more detailed information on the number and ethnicities of focus group participants.

The Health Topics Checklist

After the focus group discussion, participants were asked to identify health topics of interest. A checklist was used, which listed a range of topics related to health problems and communication in healthcare settings. The checklist was translated into the native languages of the focus group participants, either in written form or orally, with the assistance of the interpreter.

Personal Interviews

In addition to the focus groups, 17 interviews were conducted to probe the concerns expressed in the focus groups and to capture perspectives and experiences of individual immigrants in greater detail. The interviews were conducted with the assistance of an interpreter. The majority of the interviews were audiotaped and transcribed by a professional transcriber; however, when it was not feasible to audiotape, detailed field notes were recorded by the interviewer.

Contributions from Service Providers

To better understand the complex issues faced by this population of elders, additional insights were gathered from service providers who work with the elders in a variety of capacities. These professionals were from healthcare, senior services, immigrant services, and adult education. Two information-gathering meetings were organized in Philadelphia, which were attended by a total of 36 professionals. In San Jose, individual interviews were conducted with five community-based service providers.

Communication Issues in Healthcare Settings

Elders who participated in focus groups emphasized the difficulty of communicating in healthcare encounters that required the use of English. A Korean elder commented that when he sees an English-speaking doctor, he can only explain his symptoms "20 percent of the time." His lack of English proficiency and knowledge of medical terminology in English hinders his ability to communicate with his doctor.

Not being able to understand a doctor in an emergency situation is especially frightening. An Eastern European elder from Philadelphia related the experience of a friend who needed urgent surgery. Unable to comprehend the doctors' explanation and without an interpreter available, the patient had to contact his English teacher, who was bilingual, to translate.

In another instance, a Chinese elder called attention to the impact of miscommunication in health settings:

> *I went to see a … specialist. I could not understand the words that the doctor was using. My daughter also could not understand. So I didn't go to see the doctor. The doctor asked me to have surgery or an operation. And since I don't understand what the doctor said, I don't want to go there anymore.*
>
> ~ Chinese elder

In this situation, the inability to understand the doctor resulted in the elder's failure to follow up in order to receive treatment for a medical problem.

Another elder underscored how lack of understanding in a healthcare situation may lead to longer recovery times, perhaps due to a patient's inability to follow a doctor's aftercare instructions:

> *The doctor said I am going to recover very soon, but actually it took extra time for me. For the explanation of that accident, the doctor didn't make any explanation. [There was] no translator. I only understand a little bit of what the doctor said. Not the whole thing.*
>
> ~ Chinese elder

Components of Effective Communication

As we saw in the example of Mrs. Chin, there were a variety of factors that led to miscommunication and failure to obtain needed care. One important factor was her lack of English language skills needed to understand the doctor, ask questions, and complete forms. Cultural differences are also an important factor that may influence a patient's perception of a doctor's communication style. For example, Mrs. Chin perceived the doctor she saw after her admission to the hospital as abrupt and impersonal, which inhibited her from asking questions about her condition. Mrs. Chin also lacked knowledge of the functioning of the healthcare and healthcare insurance system in the United States, which resulted in her confusion about whether visits to her doctor would be covered by her insurance.

In order to understand more fully how potentially hazardous communication breakdowns occur and what can be done to avoid them, we have made use of a framework for analyzing effective communication developed by Canale and Swain (1980) through their work with non-native speakers of English. We use this framework to examine elder immigrants' difficulties in accessing healthcare resources in English. Below is an adapted version of their framework, which includes four elements necessary to achieve effective communication in healthcare settings.

Each of these four competencies—language, cultural, strategic, and discourse—provides one piece of the communication puzzle. When any of these four components is missing, miscommunication, or even communication breakdown, can occur. We will explore how each component contributes to effective communication.

Language competence involves knowledge of vocabulary, grammar, and pronunciation and the ability to use this knowledge for both speaking and listening comprehension. This is the competence perhaps most commonly associated with being able to communicate effectively. Communication, however, involves much more than simply knowing vocabulary or grammar rules.

COMPONENTS OF EFFECTIVE COMMUNICATION

Language Competence
Ability to understand and use vocabulary, grammar, and pronunciation clearly and accurately

Cultural Competence
Cultural knowledge and ability to communicate appropriately depending on setting (e.g., formal or casual)

Strategic Competence
Ability to clarify or correct a misunderstanding by restating information or asking for repetition

Discourse Competence
Understanding the structure of healthcare encounters and the healthcare system and knowing how to navigate the system

(Adapted from Canale & Swain, 1980)

Another component of effective communication is **cultural competence,** or the ability to use language that is appropriate to both the person being addressed and the setting. Cultural beliefs regarding status and doctor-patient relationships influence what a patient considers appropriate within a healthcare encounter. A Philadelphia healthcare provider who works closely with Chinese elders commented that in traditional Chinese culture, "the doctor is a god never to be questioned." This stance differs markedly from the prevalent attitude within U.S. healthcare that patients should be informed health consumers who take an active role in their care by asking questions and obtaining second opinions. Insufficient cultural competence, in combination with insufficient language competence, may result in immigrant elders' inability to ask direct questions, express their opinions, or insist on a second opinion. With this in mind, it is no wonder that many immigrant elders said they were more comfortable with healthcare providers who spoke their native languages, precisely because they were more comfortable with the cultural norms that define such encounters in their native language and culture.

Cultural competence is also relevant for healthcare providers and healthcare systems. Doctors and other healthcare personnel working with individuals from other cultures need to be familiar with and respectful of their patients' beliefs, family relationships, and ways of interacting.

Strategic competence involves the ability to ask for repetition or clarification if one does not understand what has been said. Often, very simple strategies can enable non-native speakers to manage conversations more effectively and can help them avoid the risk of miscommunication with their healthcare providers. Using simple phrases such as "I don't understand. Can you repeat that?", "Can you write that down?", or "Please speak slower" allows the non-native speaker to clarify topics that he or she had difficulty understanding. Paraphrasing a healthcare provider's instructions is another effective strategy that patients may use to check their understanding in healthcare encounters. These strategies can signal to the healthcare provider that the patient is having difficulty understanding and may require additional explanation or bilingual interpretation.

However, the use of such strategies entails interrupting the healthcare provider. For elders from cultures that emphasize deference toward high-status individuals such as doctors, questioning or interrupting such an individual would be perceived as inappropriate. This overlap between

strategic and cultural competencies reflects the interplay among the components of communication and demonstrates the necessity of competence in all areas in order to communicate effectively.

The final component of clear communication is **discourse competence,** which refers to a speaker's ability to understand and interpret the context that frames an interaction. Discourse competence helps us know what to expect about the structure of a conversation or event—how it will begin, develop, and end—and what discussion topics to expect at each step. In the context of a visit to the doctor's office, discourse competence assists the patient in knowing what to expect at each stage of the visit. For example, an office visit usually begins at the receptionist's desk, where the patient provides information about insurance coverage and is asked to complete a medical history. This is usually followed by a visit with a medical assistant who takes the patient's weight and blood pressure. Only after interacting with a number of individuals, who might include the receptionist, billing technician, nurse, and medical technician, does the patient see the doctor for a consultation, which may be as short as 5–10 minutes. If a patient lacks the discourse competence to understand the general structure of an office visit, the patient may not know to whom he or she should address specific questions. Mrs. Chin had this difficulty when she wished to ask questions of the emergency room doctor after she had been admitted to the hospital. However, she lacked the discourse competence to know that she would have a new doctor after being admitted and would no longer have an opportunity to see the emergency room physician.

> Insufficient cultural competence, in combination with insufficient language competence, may result in immigrant elders' inability to ask direct questions or express their opinions.

In discussing health communication, we also use discourse competence more broadly to refer to understanding healthcare systems. Discourse competence involves understanding the "big picture" of healthcare and how to navigate the system in order to access care. Lack of discourse competence can have important consequences for an individual's health. In Mrs. Chin's case, her lack of knowledge about her insurance coverage contributed to her not seeing her doctor on a regular basis.

This report examines a variety of situations in which gaps in the components of effective communication compromised the elders' health literacy, or their ability "to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Ratzan and Parker, 2000). The first instance we examine is one in which miscommunication severely compromised an elder's ability to obtain information necessary to her health, resulting in serious consequences.

The Consequences of Communication Breakdowns

The following story of an Asian Indian woman's medical emergency illustrates how miscommunication about a medication dosage can have life-threatening consequences:

I had to go to the emergency [room] because of severe headache … It was due to an overdose of medicine that I was taking for [my] heart problem. About a week [earlier] they told me, through the blood test, if the [level of] medicine goes higher, they would inform me. But they had not informed me … so I wasn't sure whether I was taking the right dose of medicine. When I went there [the emergency room], they discovered that it was an overdose of the medicine. And they had to admit me for surgery. But I didn't have insurance because I hadn't heard back from the insurance people yet. So I had to undergo the surgery without the insurance and had to spend a lot of money for that … It is by the will of God that I really survived. I was almost on the deathbed.

~ Asian Indian elder

This anecdote illustrates how gaps in several of the components of clear communication can lead to serious consequences. Too high a dosage of medication led to this woman's severe headache and serious complications, but the error was not discovered until she required emergency surgery.

She had not been informed about the dosage problem and did not follow up proactively to find out the results of her blood test. There are many potential reasons for this communication breakdown. For example, she may have lacked the cultural competence to know that, under the current healthcare system, patients must often take responsibility to seek information about their treatment to avoid potentially life-threatening consequences. Whether it is in fact a patient's responsibility to seek information proactively from a healthcare provider is a culturally influenced notion. This woman may have considered this to be the responsibility of the medical establishment, rather than her own. In addition, it is common for immigrant elders to be unable to take on this responsibility because of a lack of language or strategic competence.

Additionally, the patient was unable to clarify whether her insurance would cover the surgery and, therefore, incurred the full cost of the surgery and hospitalization. She did not receive a prompt answer from the insurance company regarding her coverage and was unable to follow up to obtain the information she needed. There are many possible reasons for this. She may not have had the cultural competence to communicate assertively with the insurance company and get the answers she needed. Discourse competence may also have played a part here, as she may not have understood the appropriate steps to go through if a claim is denied. Knowing about available resources, such as social workers or an ombudsman within the hospital or external aging or legal aid services, might have helped this woman to navigate the complex health insurance system.

Difficulties Accessing Healthcare in English

The tasks associated with obtaining healthcare are complex and varied. Anyone who has had the perplexing experience of trying to find a doctor's office in the maze of a busy, large hospital can attest to even the physical complexity of modern healthcare environments. Even a fairly simple healthcare encounter, such as a visit to the doctor's office, requires a variety of interactions, each requiring health communication skills. Visiting the doctor first necessitates understanding health information and symptoms in order to recognize that one's symptoms necessitate a doctor's visit. While we commonly associate health literacy or health communication with the ability to commu-

nicate with a healthcare provider, many tasks must be accomplished before even seeing a healthcare provider. One may need to enroll in an insurance program through Medicare, Medicaid, or a private provider. Some non-native speakers of English may need to locate and make an appointment with a bilingual provider or find a qualified interpreter who can accompany the person to an office visit. After the visit, one must obtain prescription medications and understand instructions for taking them correctly, follow after-care instructions to manage a health condition, and understand billing reports and procedures. Each of these interactions requires the use of communication skills and involves possibilities for miscommunication, as we see in the example above.

As a result of an office visit, a patient may be referred to a specialist or another health professional, such as a physical or occupational therapist, meaning that this complex series of steps would need to be repeated in order to obtain the necessary services. An elderly patient may also require home care services, such as a nursing assistant, meal delivery, or housekeeping. Accessing these resources would require yet another set of complex interactions to locate organizations that offer these services, investigate insurance coverage, and communicate with individuals providing care.

I tried to call but it is all automated. Nobody is there. "If you want … press 1 … press 2." I do not understand and get frustrated.

~ Chinese elder

It is also important to mention that communication skill is only one of many factors that affect elders' ability to access healthcare. While the focus here is on how improved communication skills can help elders to access healthcare services, other important factors include a patient's socioeconomic level, education, and gender, as well as the affordability and accessibility of services.

We will now explore three types of typical healthcare encounters in which the elder immigrants who participated in focus groups experienced difficulty communicating in English. Each of these healthcare encounters is accompanied by a table with a sample of some of the health communication skills necessary for an immigrant elder to manage the encounter successfully. The first encounter is the deceptively simple process of making an appointment to visit a healthcare provider. Communicating with healthcare providers and negotiating billing and insurance coverage are other situations that involved difficulties for elder immigrants.

Making an Appointment

The first challenge elders encountered was the process of making an appointment with a healthcare provider. For some elders the process of arranging a scheduled time to see the doctor was unfamiliar, because in their native countries no appointment was necessary to see the doctor. Another challenging aspect is the fact that making an appointment usually requires a telephone conversation, which is particularly difficult for non-native speakers. During a face-to-face conversation speakers can provide visual cues, such as pointing to a calendar to indicate an appointment date or writing out a medication dosage. However, these visual cues are unavailable in a telephone conversation. Also absent are body language and facial gestures, which help to build a relationship between the speakers and can also help provide necessary visual information (e.g., a puzzled look may communicate lack of comprehension). Table 1 presents a sample of the health communication skills an immigrant elder needs to succeed in making an appointment with a healthcare provider.

Communication becomes even more challenging for elder immigrants faced with the new technology of an automated message. The following quotation from a Chinese elder clearly articulates the aggravation and sense of defeat she experienced in simply trying to make an appointment with her doctor:

TABLE 1: SKILLS REQUIRED TO MAKE AN APPOINTMENT

- Find a local bilingual healthcare provider or a qualified individual to provide bilingual interpretation.
- Understand the need for regular doctor's visits.
- Understand the procedures for making a medical appointment.
- Understand the receptionist and speak clearly over the telephone to provide necessary information.
- Understand the message on the automated voicemail system used by many healthcare providers; respond appropriately to various options in order to be connected to the appropriate office and leave a clear message.
- Negotiate scheduling with the receptionist, depending on the urgency of the problem.

I tried to call but it is all automated. Nobody is there. "If you want … press 1 … press 2." I do not understand and get frustrated. I don't understand. I'm sorry; I should go back to my country. It is very difficult to live here even with the amount of English I understand. What about those who do not understand at all?

~ Chinese elder

Most of us have had a similar experience when calling a hospital or medical office and can sympathize with this woman's frustration. However, this situation holds special difficulties for non-native speakers of English. Most voicemail recordings present multiple options using conditional statements, which are complex grammatical structures that are often difficult for beginning learners of English to understand. A fairly typical recorded message one might hear when calling the doctor's office would be:

> *Welcome to the Center for Primary Care. Please listen carefully to the following list of options. If this is a physician's office or a true medical emergency, press 1. If you are calling to schedule a routine appointment or to obtain test results, press 2. If you are calling for a prescription refill or if you are sick, press 3. If you need a referral or medical records, press 4.*

Even a fairly simple healthcare encounter, such as a visit to the doctor's office, requires a variety of interactions, each requiring health communication skills.

In addition to complex grammar, these instructions use specific vocabulary particular to healthcare appointments, which require a fairly sophisticated command of English. Even if the listener understands the vocabulary and options presented, the recorded message may be too quick for the listener to understand and respond to the instructions. Also, a recorded message provides no opportunity for the listener to ask for clarification if he or she does not understand or to ask the speaker to slow down.

A community service provider who works with Korean Americans echoed the comments of the Chinese elder, emphasizing that the technology-oriented culture of current medical services has increased the communication gap between older immigrants and the healthcare system:

Digitization and technological "breakthroughs" that are designed to improve the bottom line of healthcare providers and insurance companies are creating even more problems for senior citizens, as it is difficult to really navigate oneself through the maze of "Press 1" and "Press 2" or of rapidly fired instructions over the phone.

~ Korean American community service provider

TABLE 2: SKILLS REQUIRED TO COMMUNICATE WITH A HEALTHCARE PROVIDER

Interacting with Office Personnel

- Understand the processes involved in a doctor's visit and the responsibilities of various medical professionals, including medical assistant, lab technician, nurse, and doctor
- Comprehend and fill out medical history, consent forms, and insurance information
- Understand patients' rights and responsibilities, including the right to bilingual interpretation and translated documents
- Make an appointment for a follow-up visit if necessary
- Obtain a referral for a specialist, allied health provider, or further testing
- Handle co-payment and billing

Communicating with Providers

- Understand the cultural norms for doctor-patient interactions in the U.S. healthcare system
- Describe symptoms
- Describe personal and family health history
- Understand doctor's diagnosis and instructions
- Ask doctor to clarify or rephrase a statement
- Ask questions about how to take prescription medication
- Provide information regarding medication allergies or side effects
- Understand the need for further testing or referral to a specialist

In this era of cost-cutting by hospitals and insurance companies, there is a greater emphasis on efficiency and the speed of healthcare encounters, which threatens to make it even more difficult for immigrant elders to interact with healthcare providers.

Communicating with Healthcare Providers

Elders with greater English proficiency experienced little difficulty in making an appointment and were able to accomplish routine, predictable health literacy tasks, such as reading medication instructions. However, tasks that required more specific knowledge of medical terminology or more advanced English proficiency continued to be challenging. For example, one elder said he could fill out basic contact information on the medical forms, but "when it [comes] to my medical history in English, I can't do it." Many elders experienced difficulty communicating effectively with healthcare providers.

Elders participating in the focus groups commented on the fast pace of medical appointments. While praising the quality of advanced medical treatment available in the United States, elders often experienced U.S. doctors as impatient or hurried. A Vietnamese elder compared medical care in the United States and in Vietnam, commenting that in the United States.

> *Doctor does not spend time … The doctor just tells … very quickly. Doctor say, why this is caused. How it's caused … In Vietnam, the doctor has a lot of patience … the doctor [here] doesn't have time to go into detail.*
>
> ~Vietnamese elder

Elders sometimes perceived a doctor's haste as reflective of a lack of caring or concern for their well-being. However, even more problematic than the elders' perception is that many elders had difficulty understanding their healthcare providers simply because they spoke too quickly.

Immigrant elders who were able to communicate in English with their provider often required slower speech or repetition to understand. When asked what providers should do to help them understand, immigrant elders listed a variety of

TABLE 3: SKILLS REQUIRED TO UNDERSTAND BILLING AND INSURANCE COVERAGE

- Understand eligibility for Medicare, Medicaid, and private insurance programs
- Read and understand policies, including services and medications covered, insurance deductible, need for pre-authorization of services, and referral procedures
- Select a program based on needs, preference, and eligibility
- Complete enrollment forms
- Comprehend co-pay bills from provider
- Ask questions regarding complex and conflicting information about insurance coverage and billing
- Understand the appeals process if a claim is denied
- Locate resources, such as aging or legal aid service agencies, which can assist with the appeals process

supportive strategies including "spend time [talking with the patient]," "speak slower," "repeat what is said," and "write down what is said."

Healthcare providers should be aware that immigrant elders may not speak up in healthcare encounters if they do not understand. Consider the comment of this Chinese elder:

If the doctor speaks English and keeps repeating himself, I will not understand but will not ask either. It is better to keep quiet.

~ Chinese elder

If the doctor speaks English and keeps repeating himself, I will not understand but will not ask either. It is better to keep quiet.

~ Chinese elder

In this situation, the doctor's efforts at repetition are not helpful in clarifying the information. Perhaps if the doctor paraphrased or restated his instructions using different words, the elder might be able to comprehend. The doctor could also check the patient's comprehension by asking her to restate the information in her own words.

In addition to difficulties with comprehension, there may be other reasons for this elder's reticence. There may be issues of cultural competence; for example, she may not understand that Americans often take an active role in conversations with their doctor and that it is permissible and even encouraged to ask for clarification. She may perceive it as rude or inappropriate to interrupt her doctor to ask a question. There may also be an issue of strategic competence, as the elder may not have the language strategies to request repetition or signal that she needs the doctor to clarify a statement. Table 2 lists some of the health communications skills involved in visiting a doctor's office.

Understanding Billing and Insurance Coverage

The healthcare-related task of dealing with billing and payment procedures is of utmost importance to immigrant elders, most of whom are on a limited income. Like all older adults in the United States, immigrant elders acutely feel the high cost of healthcare. The following comments are representative of their concerns about healthcare costs and insurance coverage:

Another thing I want to point out is the medical insurance I have, including Medicare. They don't cover every type of medicine, drugs. If they don't cover it, we have to pay our own way … Our income's now low enough that it becomes a big burden for us to get our own medicine. It's very important.

~ Chinese elder

Dental problems [are] not covered by Medi-Cal and Medicare … Many people [are] without teeth, only dentures. Easily $700–$1,000 a visit, which they cannot afford.

~ Korean elder

Insurance coverage is of particular concern to immigrant elders, as foreign-born residents are nearly three times more likely than native-born residents to be uninsured. Previous studies with immigrant populations have indicated that cost is the major barrier to accessing healthcare for immigrants (Ku and Freilich, 2001). Most of the immigrant elders who participated in the focus groups did have some form of insurance, and those who were covered by government insurance programs such as Medicare often reported that their access to basic healthcare is better than in their native countries. However, some Mexican elders who participated in San Jose focus groups lacked coverage. This often resulted in a lack of medical care or delayed care, as reflected in the comments of community service providers:

Because some of the people don't have health insurance, they have no choice but to just not see a doctor.

~ Community service provider

Most of them don't have health insurance, so when they don't feel well, they wait to the last moment to see a healthcare provider.

~ Community service provider

Elders who were covered by insurance often expressed confusion about how insurance coverage works in the United States. The following summary of an interview illustrates an elder's lack of knowledge about healthcare insurance that led to a communication breakdown regarding whether a medical appointment was free:

When [she] first [arrived] in the U.S., she tried to make a medical appointment. A social worker at [a social services agency] told her that she could get a free check-up. Soon after the appointment, bills came, and then a collection notice. She was very afraid since she did not understand what it meant. So she had to borrow money from her son. Now she will not go back to the doctor … Social worker had said it would be free. Had she known ahead of time, she would not have gone [to the doctor].

~ Chinese elder

There are a number of factors that may have led to this elder's confusion about how she could receive free medical care. First, the elder's limited listening proficiency in English or her lack of understanding of the institutional structure of insurance benefits may have led the elder to believe that the appointment would be free at any doctor and without the use of insurance benefits. Had she received more detailed information about the insurance system or assistance registering for Medicare or Medicaid, this elder might have been able to obtain affordable healthcare. With a better understanding of available healthcare options, she might have known that there were public health clinics at which she could receive a free check-up. Later, when she began to receive bills for her visit, she lacked the English proficiency to read and understand the bills and was unable to communicate with her provider or with the collections agency to set up a payment plan. This misunderstanding regarding a billing issue has had not only financial repercussions but serious health implications, as this elder now avoids seeing a doctor.

Elders may lack insurance coverage not because they are ineligible, but because they are not in-formed about the healthcare system in general and insurance programs in particular. Lack of the health communication skills needed to obtain accurate information contributes to this problem. Immigrant elders may not have the negotiation skills to clarify complex or conflicting information about coverage, nor do they know whom to call or where to seek assistance to dispute a bill or to appeal if an insurance company denies their claim. The more confused elders are about the healthcare benefits that are available to them, the more reluctant they are to seek medical attention. Table 3 lists the variety of complex health communication skills required to understand insurance coverage and handle medical bills.

The following excerpt from a discussion by a group of South Asian women illustrates their confusion about whether Medi-Cal, California's version of Medicaid, provides coverage for emergency care:

SPEAKER 1: "Because without Medi-Cal and Medicare, the only [way to] get access to healthcare is through the emergency room."

SPEAKER 2: "If you call 911, it costs us $900 … If there is no one there to help … then it's really difficult to call 911."

SPEAKER 3: "How can we afford? It costs here. How can we afford? … Suppose something happens here. And—911, they charge."

SPEAKER 4: "Medi-Cal doesn't cover the costs for 911."

SPEAKER 2: "A portion … Before, I pay everything. We are over 65.We are getting Medi-Cal. If we call 911 for emergency, we have to pay."

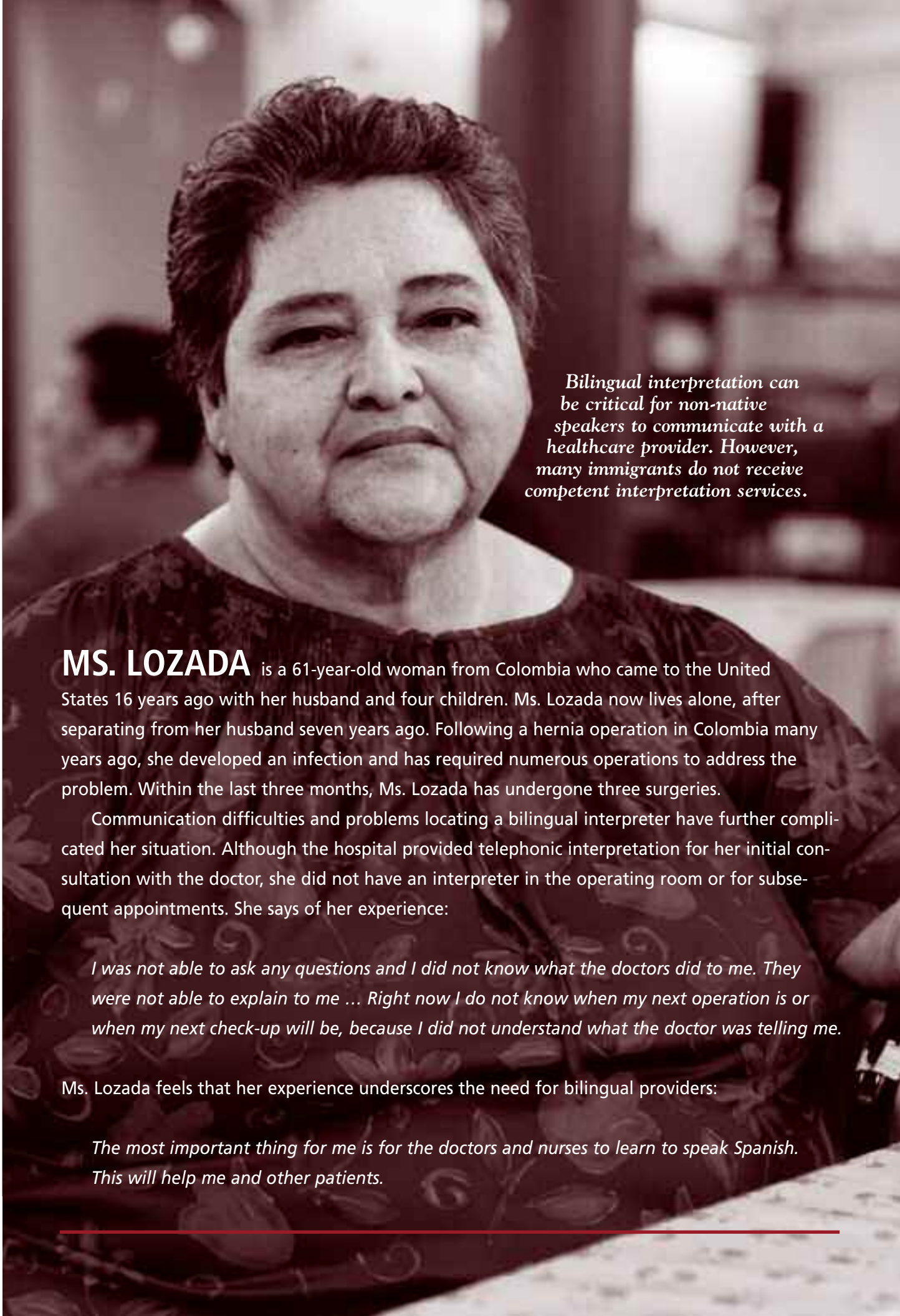
SPEAKER 3: "They no charge you anything. If you find out, let us know. Otherwise it's impossible for us to pay so much money."

~Asian Indian elders

In this conversation, the first speaker comments that without access to public benefits through Medi-Cal, emergency treatment is the only option for healthcare. Speaker 2 disagrees, stating that payment is required when 911 is called for emergency treatment or ambulance transportation to the hospital. A number of different opinions are exchanged regarding whether Medi-Cal will pay for emergency transport. One speaker says that it will not be covered; another suggests that they will pay a part. The last speaker comments to the focus group facilitator that she hopes the facilitator will let them know what the coverage is, adding that it is impossible for them to pay the full charge for an emergency visit. The women's lack of understanding regarding the payment structure for emergency services makes them reluctant to seek needed healthcare, even in an emergency situation.

Effort on the part of elders alone is not sufficient to resolve such difficulties. As we discuss further in the following section, healthcare providers also need to take measures to eliminate barriers to effective communication. More support, including insurance information available in the elders' first languages, should be provided for the growing immigrant population.

Challenges Communicating with Providers



Bilingual interpretation can be critical for non-native speakers to communicate with a healthcare provider. However, many immigrants do not receive competent interpretation services.

MS. LOZADA is a 61-year-old woman from Colombia who came to the United States 16 years ago with her husband and four children. Ms. Lozada now lives alone, after separating from her husband seven years ago. Following a hernia operation in Colombia many years ago, she developed an infection and has required numerous operations to address the problem. Within the last three months, Ms. Lozada has undergone three surgeries.

Communication difficulties and problems locating a bilingual interpreter have further complicated her situation. Although the hospital provided telephonic interpretation for her initial consultation with the doctor, she did not have an interpreter in the operating room or for subsequent appointments. She says of her experience:

> *I was not able to ask any questions and I did not know what the doctors did to me. They were not able to explain to me … Right now I do not know when my next operation is or when my next check-up will be, because I did not understand what the doctor was telling me.*

Ms. Lozada feels that her experience underscores the need for bilingual providers:

> *The most important thing for me is for the doctors and nurses to learn to speak Spanish. This will help me and other patients.*

Communication Is a Two-Way Street

Because of the great difficulty elders experienced communicating with healthcare providers in English, they often preferred to see doctors and other providers who spoke their native languages and who shared their cultural backgrounds. For example, a Chinese elder commented that when she saw an English-speaking doctor, she was unable to understand him. She contrasted this experience with seeing a doctor who spoke her native language. In that situation, she was able to understand the doctor's questions and the recommended treatment plan, and could ask questions when she required further explanation.

When elders could speak their native language with healthcare practitioners, they were able to participate more actively in their own care and felt greater trust and comfort. Although many of the elders participating in the focus groups were able to locate primary care doctors who spoke their native languages, they found greater difficulty locating specialists from the same ethnic background. When they were hospitalized or sought emergency care, it was necessary to use English. For immigrant or refugee populations who have immigrated to the United States more recently, as well as for those from less developed countries, it may be impossible to locate a primary care provider who speaks their native languages.

Because of the difficulty elders experienced communicating with healthcare providers in English, they often preferred to see doctors who spoke their native languages and who shared their cultural backgrounds.

As they discussed the challenge of communicating in English with healthcare providers, elders emphasized the importance of improving their English. However, many felt overwhelmed at the prospect of acquiring a new language at their age and felt they could not learn English well enough to understand complex medical terminology. The following comment from a bilingual interpreter who works closely with the Cambodian community describes the experiences of many elders regarding learning English:

They do understand the point of learning English. One reason is that when they go to a hospital … [they] need English to communicate with other people. That's the important thing. They understand. [But] because of their age, it's just difficult to keep what was studied in their head … so they do try, but it's a very slow process of remembering … it's like in one ear and out the next ear.

~ Focus group interpreter

For older adults who are not literate in their own language, acquiring English language and literacy may seem an almost impossible task. One Cambodian woman shared her doubts about learning English. Raised in rural Cambodia, she did not receive a formal education. After escaping from Cambodia and surviving in numerous refugee camps before coming to the United States, she worked long hours at low wages in her new country and raised her children, so she had limited opportunities to study English. Given her lack of first language literacy and her difficult life, she feels it would be almost impossible to learn a new language this late in life. Describing the challenges she has experienced trying to learn English, she says:

So it's not just English. Even in Cambodian language, I can't really read or write. I only go to school for a very short period of time, which is a long, long time ago. I don't remember anything any more. I tried to learn [English], I tried to study. But I don't … remember anything … It's very difficult for me, I pretty much [gave] up.

~ Cambodian elder

While not all elders articulated such hopelessness about their ability to learn English, many expressed similar feelings that language learning and retention was difficult at their age. Many feared the prospect of relying on their limited English in a medical setting, where errors could have serious consequences.

Many elders felt that communication in healthcare settings should be a responsibility shared between patient and healthcare provider. In particular, their comments called attention to the need for bilingual assistance from healthcare providers and assistance from social service agencies and community organizations.

Bilingual Support from Healthcare Providers

One Latino elder echoed the sentiments of many of the elders regarding both the importance of learning English and the need for bilingual interpretation in healthcare settings:

I would like to know some English. The healthcare providers [also need] to know some Spanish to be able to communicate with us.

~ Latino elder

Access to bilingual providers or interpretation is essential for elders to use healthcare services safely and successfully. When immigrant elders require interpretation, they typically depend on their family members. A Latino elder from San Jose commented that each of the three times she required surgery, her children acted as her interpreters. Sometimes a bilingual community member is able to offer bilingual interpretation when needed:

He was brought to the hospital in an ambulance and he needed an urgent surgery, but when the doctors got together, they couldn't understand [him], so the man had to call his English teacher and ask her to come to explain what was happening.

~ Eastern European elder

A family member or community member who is not trained in medical interpretation may provide inaccurate translations because of lack of familiarity with medical terms. Translating effectively in medical situations requires a trained interpreter who is familiar with medical terminology in both languages and is knowledgeable about cultural differences. Inaccurate translation in a medical setting can be disastrous. Morse (2003) writes of an inexperienced interpreter assisting a Hmong patient who had been diagnosed with cancer. The interpreter attempted to explain the concept of radiation by saying, "We're going to put a fire inside you." As a result, this patient refused what might have been a life-saving treatment.

One elder expressed concerns about the quality of the interpretation he receives when talking with the doctor:

I have problems with the interpreter sometimes. Sometimes the interpreter will miss some information. I want to communicate with the doctor. So I … ask the interpreter to fully translate what I said, otherwise there will be misunderstanding … The translator or interpreter may not be qualified enough.

~ Chinese elder

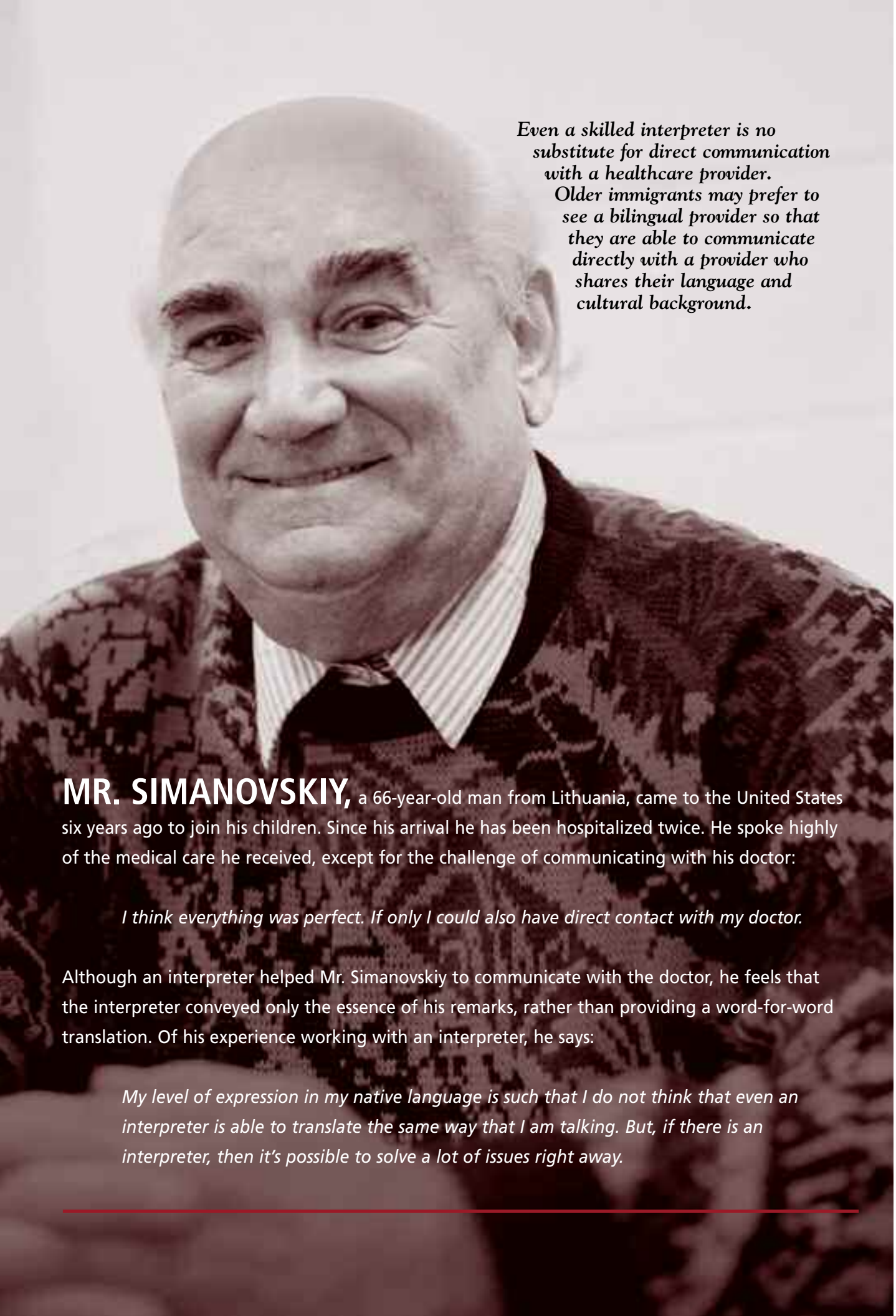
An interpreter must also be familiar with cultural traditions in order to translate accurately. For example, a senior service provider who works with Russian/Eastern European seniors noted that depression is often referred to as a somatic condition, namely "heart pain."

In addition, translation by a family member or a friend may be inappropriate or embarrassing for the elder and may infringe on the patient's privacy. A Spanish-speaking elder commented:

Sometimes it's very embarrassing to be talking to someone else and have a person translating for you to talk to the doctor. We wish we could have the English skills to tell them what we felt.

~ Spanish-speaking elder

The Limitations of Interpretation Services



Even a skilled interpreter is no substitute for direct communication with a healthcare provider. Older immigrants may prefer to see a bilingual provider so that they are able to communicate directly with a provider who shares their language and cultural background.

MR. SIMANOVSKIY, a 66-year-old man from Lithuania, came to the United States six years ago to join his children. Since his arrival he has been hospitalized twice. He spoke highly of the medical care he received, except for the challenge of communicating with his doctor:

> *I think everything was perfect. If only I could also have direct contact with my doctor.*

Although an interpreter helped Mr. Simanovskiy to communicate with the doctor, he feels that the interpreter conveyed only the essence of his remarks, rather than providing a word-for-word translation. Of his experience working with an interpreter, he says:

> *My level of expression in my native language is such that I do not think that even an interpreter is able to translate the same way that I am talking. But, if there is an interpreter, then it's possible to solve a lot of issues right away.*

Elders may be uncomfortable discussing private health issues or past experiences with a family member interpreting. An interpreter who is a family or community member may be reluctant to share social problems, such as alcoholism or domestic violence, which could be perceived as reflecting badly on the ethnic community.

The Right to Bilingual Interpretation in Healthcare Encounters

Service providers working in immigrant communities emphasized the importance of informing non-native speakers of English about their rights to interpretation and translation under Title VI of the Civil Rights Act of 1964. Title VI requires that hospitals, physicians' offices, and social service agencies that receive federal funds, such as Medicare or Medicaid, must provide interpretation and translated documents to limited English proficient (LEP) patients in order to help them access healthcare services (U.S. Department of Health and Human Services, 2003). While many of the elders participating in focus groups and interviews emphasized their need for interpretation in medical settings, only one person articulated that she had a right to interpretation.

Hospitals, physicians' offices, and social service agencies that receive federal funds must provide interpretation and translated documents to limited English proficient patients.

A number of healthcare organizations have made significant efforts to promote more culturally and linguistically appropriate care in order to ensure equal access and equal quality of care to all patients. However, interpretation and translation services have not been universally implemented. LEP patients and their advocates may still encounter a lack of awareness or even resistance when seeking bilingual services. LEP patients should be informed that it is appropriate to request an interpreter or translation of vital documents when those services are not offered by their healthcare providers and that they have a legal right to the provision of those services.

Healthcare providers may use a continuum of services, including bilingual providers, staff interpreters, contracted vendors who can provide interpretation either in person or over the telephone, and student volunteers, to ensure equal access to LEP patients. Resources for healthcare providers seeking professional interpretation and translation assistance are included in Recommendations on page 37.

Support from Community and Social Services

Professionals in the areas of aging services, social services, and community organizations within immigrant neighborhoods can play an important part in enhancing the health literacy of immigrant elders. A community service provider who works with Vietnamese elders speaks to the need for providers to reach out to immigrant elders:

Senior clients need outreach. Neighborhood clinic services are the key to reaching those who can't travel far from home due to language and cultural barriers … Many seniors are alone, isolated, and afraid to ask for help. The healthcare community needs to reach out to the seniors, not wait for the seniors to come to them for help.

~ Community service provider

Elders who participated in the focus groups and interviews spoke of many ways in which they utilized resources offered at senior or community centers in their neighborhoods to learn about health resources or improve their own health and wellness. Many elders spoke of taking advantage of fitness classes, health seminars, and preventive health measures, such as blood pressure screenings and flu shots, offered by local community and senior centers. Immigrant elders may not seek these services outside of their neighborhoods for a variety of reasons, including fear of leaving their immigrant communities where they can communicate easily, lack of knowledge about how to access services, or physical disabilities. However, elders are more likely to access services if they are offered at a familiar center where they can communicate in their own languages.

An ESL class is often the first place that elder immigrants interface with the English language and U.S. culture, and immigrants often view their ESL instructors as cultural informants. ESL teachers can help immigrant elders learn medical terminology, provide information about resources, and introduce the cultural and strategic competencies elders need to take a more proactive role in their own healthcare. One elder talked about her ESL class as a venue to build social networks that provide both support and information about healthcare:

I learned [about Medicare] from friends in my ESL class at the Jaisohn Center [a community clinic]. I exchange information with friends. Jaisohn Center also offered a workshop on Medicare and explained about eligibility, application, etc.

~ Korean elder

For this woman, the ESL class not only helped her to learn English, but also provided a venue in which she was able to obtain information that was essential to her ability to receive regular healthcare. Elders suggested a variety of ways in which community-based organizations and the healthcare community could collaborate to provide better services for elder immigrants. The following section offers recommendations about how professionals who interact with immigrant elders can assist them to better understand and access healthcare in the United States.

The Role of Community Support

Community organizations in immigrant communities are essential in helping elders locate bilingual medical and social services. Without these resources, many elders would find it difficult to continue living independently.

MRS. CHO is a 75-year-old Korean woman. She and her husband entered the United States 12 years ago, accompanying her son who came to attend graduate school. After receiving his doctorate, her son returned to South Korea, but Mrs. Cho and her husband decided to stay. Since her husband's death two years ago, Mrs. Cho has lived alone in a neighborhood with many Korean residents.

The support she receives from the Korean community makes an important contribution to her ability to live independently. Mrs. Cho is a member of a Korean church and has many Korean friends nearby. She sees her primary doctor at the Jaisohn Center, a community health clinic that provides bilingual healthcare services and offers social and educational programs, including ESL classes. In contrast, when Mrs. Cho needed to see a medical specialist outside of her community, she had great difficulty communicating in English and arranging for interpretation services.

Recommendations

This report has illustrated the many challenges elder immigrants experience in obtaining healthcare. Addressing these challenges adequately will require the assistance and support of professionals who interact with older immigrants.

While it is reasonable and appropriate to impress upon elders the importance of improving their English ability, many elders will continue to require assistance in using medical services. Healthcare providers, ESL instructors, and senior service providers, as well as staff of community-based organizations, can play important roles in helping elder immigrants better access the care they need. This section offers some observations about the elderly immigrant population that can be useful for anyone working with this population, followed by more specific recommendations for each professional group. We would like to stress the importance of collaboration among providers in order to address the multi-faceted issues faced by elder immigrants navigating the healthcare system.

Effective Strategies for Communicating with Immigrant Elders

The following strategies can improve communication with immigrant elders:

- Keep important points and instructions short and focused.
- Present information in a clear and well-organized way.
- Repeat key points in different contexts.
- Use content that elders can relate to from their own experiences. Encourage them to give examples and to draw on their own expertise.
- Speak slowly and clearly. If they have impaired hearing, make necessary adjustments. Speak to them on their "good side" and be sure to look at them when you speak. It is not necessary to shout.
- Use a variety of strategies (gestures, writing, pictures, etc.) to clarify meaning and assist memory.

When working with elder immigrants, be aware of age-related factors and stereotypes about the elderly that might affect their learning and self-perception, for example:

- Less efficient short-term memory and a tendency to tire more easily.
- Sensory deficits, such as hearing or vision impairments.
- Health problems, particularly those that cause depression, fatigue, or confusion, which can interfere with learning (Becker, 2000).
- The erroneous belief that older adults can't learn. Even if *you* know that elders can learn, *they* may accept the popular notion that "you can't teach an old dog new tricks."
- Fear that making a mistake would make them appear foolish or even senile (fear of dementia).

Recommendations for Healthcare Providers

Elder immigrants want what all of us want from healthcare professionals: knowledgeable, professional, and compassionate care. Perhaps more than most of us, elder immigrants experience difficulty accessing healthcare because of communication difficulties, limited knowledge of the U.S. healthcare system, lack of insurance, and concerns about immigration status. Based on the concerns expressed by immigrant elders and the professionals who advocated for them, we provide the following recommendations for healthcare providers:

- Provide interpretation for elder immigrants so that they can receive appropriate care; include language preference as an initial screening question for new patients and discus availability of interpretation.
- Ensure that interpreters are qualified to interpret in a medical context, which requires a high degree of language proficiency, as well as comprehensive medical knowledge, cultural knowledge, sensitivity, and intercultural communication skills. Interpreters must also understand patients' privacy rights, and patients need to be

assured that their privacy will be protected. To locate qualified interpreters, contact the National Council on Interpreting in Healthcare (www.ncihc.org), the American Translators Association (www.atanet.org), or Language Line, a service that provides telephonic interpretation (www.languageline.com).

- Obtain or develop translated documents for health education purposes for patients whose first language is not English. Online Resources on page 43 provides websites containing health education materials in a variety of languages.
- Be aware that elder immigrants with limited formal education may not be literate in their native language, and therefore will not be able to understand written health information, even if it is translated into their native language. These elders will require an interpreter to review this information orally with them.
- Consider alternative modes of teaching health information, such as videos, role plays, and comic books.
- Be sensitive to a patient's historical background and immigration status. While non-citizens of any immigration status, including those who are undocumented, have a right to healthcare and emergency medical assistance in the United States, such information is not common knowledge in immigrant communities. Those who are undocumented may not seek medical attention because they fear that their immigration status will be discovered.
- Recruit bilingual/bicultural youth to pursue careers in the health professions in order to develop a more linguistically and culturally diverse workforce.
- Provide training for healthcare providers and students who will be entering the health professions in such topics as intercultural communication and how to work effectively with an interpreter.

Recommendations for Senior Service Providers and Staff of Community-based Organizations

Senior service providers and staff of community organizations serving immigrant elders play an important role in helping these elders seek high-quality healthcare. Providers can educate elders about their right to translation and interpretation services, offer information about health maintenance and disease prevention, and provide opportunities for elders to share information about bilingual healthcare providers. Recommendations for social service providers seeking to better meet the needs of elder immigrants include the following:

- Publicize information about Medicare and Medicaid benefits in immigrants' native languages through ethnic newspapers and television channels.
- Develop collaborations with programs, such as legal clinics, that can help elders to understand their eligibility for public benefits, obtain emergency medical assistance, and navigate complex governmental systems.
- Inform undocumented immigrants and temporary workers that they may be eligible for emergency medical assistance to treat conditions that require urgent medical care. More information regarding immigrant eligibility for medical assistance is available from the Kaiser Commission on Medicaid and the Uninsured at www.kff.org/medicaid/2241-index.cfm.
- Offer educational workshops for elders and their family members about their right to interpretation and translation services. Advocate for patients' rights to interpretation during healthcare encounters.
- Collaborate with organizations that provide accessible and culturally sensitive fitness and health education programs for immigrant elders. Good institutions for collaboration include hospitals, many of which have community outreach programs, and colleges of health professions. For example, Temple University's Department of Nursing has developed a program in which nursing students conduct research into the health

INTEREST IN HEALTH-RELATED TOPICS

Focus group participants were asked to identify topics of greatest interest, based on a health topics checklist provided to them. The lists below show their preferences for health topics and health-related communication needs. These topics may be useful in organizing educational workshops, although interests may vary according to the concerns of the specific population.

Health Topics

- Heart disease
- Memory loss
- Vision loss
- Depression
- Stress reduction
- Diabetes
- Dental care
- High cholesterol
- Fall prevention
- Stroke

Communication Needs

- Understand medical instructions
- Discuss traditional health practices with doctor
- Call 911 in emergency
- Complete medical history and consent forms
- Learn body parts and internal organs in English
- Make a doctor's appointment
- Understand insurance forms
- Read prescription labels
- Obtain care for ill family member

needs of immigrant elders and then develop health education and fitness workshops to meet those needs. This type of program meets the needs of immigrant elders while also educating future healthcare professionals about how best to provide care for this population.

➤ Use bilingual outreach workers or health professions' students to conduct health education workshops.

Recommendations for ESL Instructors

Because immigrant elders often view ESL teachers as cultural informants, the ESL classroom can be an effective site for health literacy education. However, ESL teachers should explain their role and the limits of their expertise and let students know that while the teachers cannot give medical advice, they can help older learners communicate more effectively with healthcare providers. The main role of the ESL instructor should be to help students acquire the components of effective communication, so that they are able to communicate in healthcare settings.

Elders who participated in focus groups and interviews voiced the challenge of acquiring a new language at a later stage of life and emphasized that the health literacy lessons and materials should be "simple." They also expressed the hope that instructors will understand their challenges and remain patient with their pace of learning. An elder Chinese learner suggested that health literacy lessons should be "as simple as possible. Because of old age, cannot remember too much."

Incorporating Health Topics into an ESL Class

➤ Locate classes in a venue that is easily accessible for elders. Senior housing developments, senior centers, or religious institutions may be settings that are already familiar to and frequented by elders.

➤ Offer a referral to a community health provider, social worker, or other professional if a student needs information that is outside the ESL instructor's area of expertise.

➤ Collaborate with healthcare professionals to combine ESL classes with health education and fitness programs. Most hospitals have community outreach programs that provide health education and screening programs for

the community. Such programs may be an ideal community resource for health literacy collaboration. Make contact with the outreach program and invite staff to do an in-class health screening in conjunction with a lesson on health literacy. Instructors might want to follow up with a field trip to a hospital or other healthcare organization to familiarize elders with available resources.

- Help beginning ESL learners make a card with emergency information, including family and friends' contact information, insurance, allergies, and medical conditions.
- Offer students opportunities to present their healthcare-related experiences. Use stories or students' experiences to discus health issues, but avoid putting students on the spot; students should never feel forced to share health information.
- Make use of bilingual/multilingual materials, including videos and audiotapes. Interactive lessons and books with clear pictures were favored by the elders who participated in focus groups.
- Encourage students to follow their doctors' advice and to notify their healthcare providers if they have a problem, such as a medication side effect.
- Encourage students to make a written list of questions before a medical visit and, if possible, arrange for a bilingual person to accompany them.
- Inform students of their right to interpretation and translated documents in healthcare settings.
- Organize a classroom activity in which immigrant elders collaborate to create a resource list of bilingual providers or interpreters in their area.
- Assist ESL learners in understanding insurance and billing information by simplifying complicated language.

References

Arnold, C.L., Davis, T.C., Berkel, H.J., Jackson, R.H., Nandy, I., and London, S. (2001). Smoking status, reading level, and knowledge of tobacco effects among low-income pregnant women. *Preventative Medicine, 32*(4), 313–320.

Baker, D.W., Parker, R.M., Williams, M.V., et al. (1997). The relationship of patient reading ability to self-reported health and use of health services. *American Journal of Public Health*, *87*(6), 1027–1030.

Becker, A. (2000). *Citizenship for refugee elders: Issues and options in test preparation*. Washington, D.C.: Catholic Legal Immigration Network, Inc.

Beers, B.B., McDonald, V.J., Quistberg, D.A., et al. (2003). Disparities in health literacy between African American and non-African American primary care patients. *Journal of General Internal Medicine, 18* (Supplement), 169–179.

Bennett, C.L., Ferreira, M.R., Davis, T.C., et al. (1998). Relation between literacy, race, and stage of presentation among low-income patients with prostate cancer. *Journal of Clinical Oncology, 16*(9), 3101–3104.

Benson, J.G., and Forman, W.B. (2002). Comprehension of written healthcare information in an affluent geriatric retirement community: Use of the test of functional health literacy. *Gerontology, 48*(2), 93–97.

Canale, M., and Swain, M. (1980). Theoretical bases of communicative approaches to second-language teaching and testing. *Applied Linguistics, 1*(1), 1–47.

Erichsen, G. (2005). *Your guide to Spanish language*. Retrieved July 10, 2005, from http://spanish.about.com/cs/historyofspanish/f/varieties.htm.

Federal Interagency Forum on Aging. (2000). Federal interagency forum on aging related statistics. *Older Americans 2000: Key indicators of well-being*. Retrieved July 8, 2005, from http://www. agingstats.gov/chartbook2000/default.htm.

Fong, C. (2003). The changing face of aging. *Asian Pacific Affairs*. Seattle, Wash.: National Asian Pacific Center on Aging.

Gazmararian, J.A., Baker, D.W., Williams, M.V., et al. (1999). Health literacy among Medicare enrollees in a managed care organization. *The Journal of the American Medical Association, 281(6)*, 545–551.

Gazmararian, J.A., Parker, R., and Baker, D. (1999). Reading skills and family planning knowledge and practices in a low-income managed-care population. *Obstetrics and Gynecology, 93*(2), 239–244.

Gordon, M.M., Hampson, R., Capell, H.A., et al. (2002). Illiteracy in rheumatoid arthritis patients as determined by the Rapid Estimate of Adult Literacy in Medicine (REALM) score. *Rheumatology, 41*(7), 750–754.

Guerra, C.E., and Shea, J.A. (2003). Functional health literacy, comorbidity and health status [abstract]. *Journal of General Internal Medicine, 18*(Supplement 1), 174.

Kagawa-Singer, M., Hikoyeda, N., and Tanjasiri, S.P. (1997). Health issues for elderly Asian Pacific Islanders. In K. Markides and M. Miranda (Eds.), *Minorities, aging and health* (pp. 149–180). Thousand Oaks, Calif.: Sage.

Kalichman, S.C., Benotsch, E., Suarez, T., et al. (2000). Health literacy and health-related knowledge among persons living with HIV/AIDS. *American Journal of Preventative Medicine, 18*(4), 325–331.

Krashen, S.M., Long, M., and Scarcella, R. (1979). Age, rate and eventual attainment in second language acquisition. *TESOL Quarterly, 13*(1), 573–582.

Ku, L., and Freilich, A. (2001). *Caring for immigrants: Healthcare safety nets in Los Angeles, New York, Miami and Houston*. Retrieved August 18, 2005, from http://aspe.hhs.gov/hsp/immigration/caring01/report.pdf.

McBride, M., Morioka-Douglas, N., and Yeo, G. (1996). Aging and health: Asian and Pacific Islander American elders (2nd ed.). SGEC Working Paper Series #3, *Ethnogeriatric Reviews*. Stanford, Calif.: Stanford Geriatric Education Center.

McKay, S., and Weinstein-Shr, G. (1993). English literacy in the United States: National policies, personal consequences. *TESOL Quarterly, 27*(3), 399–420.

Morse, A. (2003). *Language access: Helping non-English speakers navigate health and human services*. National Conference of State Legislature's Children's Policy Initiative.

Oxford, R.L. (1985). Second language learning strategies: What the research has to say. *ERIC/CLL News Bulletin, 9*(1), 1, 3–5.

Ratzan, S.C., and Parker, R.M. (2000). Introduction. In C.R. Selden, M. Zorn, S.C. Ratzan, and R.M. Parker (Eds.), *Natural Library of Medicine current bibliographies in medicine: Health literacy*. NLM Pub. No. CBM 2000-1. Bethesda, Md.: National Institutes of Health.

Rudd, R., Moeykens, B.A., and Colton, T.C. (2000). Health and literacy: A review of medical and public health literature. In J. Comings, B. Garners, and C. Smith (Eds.), *Annual review of adult learning and literacy*. New York: Jossey-Bass.

Schillinger, D., Grumbach, K., Piette, J., et al. (2002). Association of health literacy with diabetes outcomes. *Journal of the American Medical Association, 288*(4), 475–482.

Singleton, K. (2002). ESOL teachers: Helpers in healthcare. *Focus on Basics: Connecting Research Practice, 5*(C), 26–39.

Tanjasiri, S., Wallace, S., and Shibata, K. (1995). Picture imperfect: Hidden problems among Asian Pacific Islander elderly. *The Gerontologist, 35*(6), 753–760.

UCLA Language Materials Project. (n.d.a). *Language profiles: Cantonese*. Retrieved July 10, 2005, from www.lmp.ucla.edu/Profile.aspx?LangID=73&menu=004.

UCLA Language Materials Project. (n.d.b). *Language profiles: Mandarin*. Retrieved July 10, 2005, from www.lmp.ucla.edu/Profile.aspx?LangID=78&menu=004.

U.S. Census Bureau. (2000). *Fact sheet: Philadelphia County, Pa*. Retrieved August 18, 2005, from www.Census.gov/main/www/cen2000.html.

U.S. Census Bureau. (2002). The older foreign-born population in the United States: 2000. *Current Population Reports: Special Studies*. Washington, D.C.: U.S. Census Bureau.

U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health*. Washington, D.C.: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services. (2003). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons*. Washington, D.C.: U.S. Department of Health and Human Services.

Weinstein-Shr, G. (1993). *Growing old in America: Learning English literacy in the later years*. Washington, D.C.: National Clearinghouse on Literacy Education.

Weiss, B.D., Blanchard, J.S., McGee, D.L., et al. (1994). Illiteracy among Medicaid recipients and its relationship to healthcare costs. *Journal of Healthcare for the Poor and Underserved, 5*(2), 99–111.

Williams, M.V., Parker, R.M., Baker, D.W., et al. (1995). Inadequate functional health literacy among patients at two public hospitals. *Journal of the American Medical Association, 274*(21), 1677–1682.

Williams, M.V., Parker, R.M., Baker, D.W., et al. (1998). Inadequate literacy is a barrier to asthma knowledge and self-care. *Chest, 114*(4), 1008–1015.

Online Resources

The Cross Cultural Health Program
The Cross Cultural Health Program addresses broad cultural issues that impact the health of individuals and families in ethnic minority communities and serves as a bridge between multicultural communities and healthcare institutions. This website provides information on cross-cultural healthcare and training programs for medical interpreters.
www.xculture.org/index.cfm

Culture Clues
Culture Clues are tip sheets, designed for clinicians, to raise awareness about the health concepts and patient preferences of 11 cultural groups. The sheets include information for each culture about traditions in dealing with illness, how medical decisions are made, norms about touch, reducing communication barriers, and additional information sources. There are also information sheets on handling end-of-life care for Latino, Russian, and Vietnamese immigrants.
http://depts.washington.edu/pfes/cultureclues.html

Diversity Rx
Diversity Rx is an organization that promotes language and cultural competence to improve the quality of healthcare for minority, immigrant, and ethnically diverse communities. This website provides information on the organization's national conferences, a healthcare news e-mail list, and research on best practices in multicultural healthcare.
www.diversityrx.org/

EthnoMed
The EthnoMed site presents information about the cultural beliefs and medical issues of newly arrived immigrant and refugee groups in the Seattle area, much of which can be generalized to other geographic regions. The site contains culture profiles for healthcare providers and patient education materials translated into a variety of languages. Currently the ethnolinguistic groups included are Amharic, Cambodian, Chinese, Eritrean, Hispanic, Oromo, Somali, Tigrean, and Vietnamese. Other ethnic groups will be included as materials are prepared.
www.ethnomed.org/

A Guide to Health Education Materials for Adults with Limited English Literacy Skills
Developed by World Education, this guide identifies a variety of resources that ESL teachers and health practitioners can use to help adult English language learners access health information and appropriate healthcare.
www.worlded.org/U.S./health/docs/culture/

Harvard School of Public Health: Health Literacy Studies
This website offers materials concerning health literacy and health issues for adult learners, including curriculum ideas relating to doctor visits, disease prevention, and healthy aging. The site also provides innovative health literacy materials and links to related sites.
www.hsph.harvard.edu/healthliteracy/talk_drvisit.html

The Health Literacy Resource Center
This webpage, developed by the California Health Literacy Initiative, is a central resource for health literacy information and training. The site is designed for literacy practitioners, healthcare professionals, adult literacy and ESL students, and the general public. It offers multicultural and multilingual health resources; information on health literacy research, education, and policy; and a directory of people involved in health literacy initiatives.
www.cahealthliteracy.org/healthliteracyresourcecenter.html

National Institute for Literacy: Health and Literacy Special Collection
Supported by the National Institute for Literacy, this website is a resource for teachers, students, and health educators, including those who teach people with limited literacy skills. This website offers health curricula for ESL classes, resources in languages other than English, information about relationships between literacy and health status, and links to organizations dedicated to health and literacy education.
www.worlded.org/U.S./health/lincs/index.htm

National Libraries of Medicine Current Bibliographies 2000–01: Health Literacy
This site presents a bibliography of literature related to health literacy. Topics include strategies for improving health literacy, improving provider-client communication, cultural/cross-cultural competence for providers, assessing the readability level of health information material, and disease-specific information.
www.nlm.nih.gov/pubs/cbm/hliteracy.html

National Standards for Culturally and Linguistically Appropriate Services in Healthcare: Executive Summary
This website presents 14 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare developed by the U.S. Department of Health and Human Services, Office of Minority Health. The standards fall into three categories: culturally competent care, language access services, and organizational supports for cultural competence. The report also offers recommendations on implementation of the standards.
www.n4a.org/datoolkit/CLAS_Exec_Summary.pdf

Non-English Language and Health Literacy Resources
This website, developed by the Consumer Health Reference Center at Treadwell Library, Massachusetts General Hospital, contains a list of resources for health education materials in languages other than English.
www.mgh.harvard.edu/library/chrc/noneng.html

Partnership for Clear Health Communication: Ask Me 3
The Partnership for Clear Health Communication is a coalition of national organizations that are working together to address the problem of low health literacy. The website provides downloadable information sheets for patients and providers about health literacy concerns, improving patient-provider communication, advocating for improved health literacy policy and increased funding, and research on health literacy issues.
www.askme3.org/PFCHC/

Project SHINE-MetLife Foundation Health Literacy Initiative
The Project SHINE-MetLife Foundation Health Literacy Initiative builds partnerships among universities and community based-organizations nationally to address the health literacy needs of elderly immigrants and refugees. Funded by MetLife Foundation, the initiative has developed health literacy curricula based on the needs identified by elderly immigrants. The units, which address a wide range of communication skills, health topics, and cultural issues, can be downloaded from the initiative's website.
www.projectshine.org/healthliteracy/

The Stanford Geriatric Education Center
The center is a federally funded consortium whose mission is to promote the cultural competence of healthcare professionals who provide care to ethnic minority elders in the U.S. The website provides information on curricula in ethnogeriatrics, online training modules for healthcare providers, and information about research and policy analysis.
http://sgec.stanford.edu/

System of Adult Basic Education Support
This website is designed to serve as a resource for adult educators who are interested in incorporating health topics into adult basic education and ESL classes. The site offers curriculum materials and training resources for teachers and program directors, as well as links to other sites and programs.
www.sabes.org/health/index.htm

Focus Group Participants

	Site Name	# of Participants Male	Female	Country of Origin	Native Language	Length of Stay in the United States	Site Characteristics
Philadelphia	Jaisohn Center	3	7	Korea	Korean	15–20 years	Medical center offering primary care services and senior program
	Norris Square Senior Center	2	9	Puerto Rico Colombia	Spanish	5 mos–41 yrs	Senior center with many social and educational programs
	David Neuman Senior Center	2	8	Israel Russia Ukraine Lithuania	Russian	2 mos–5 years	Senior center with social and educational programs
	Cambodian-American Senior Association	4	5	Cambodia	Cambodian	2–23 years	Very small senior center with lunch program and individual help
	Asian Pacific Senior Resource Center at Coffee Cup	6	5	China (including Hong Kong)	Chinese	8–18 years	Senior center with programs including SHINE tutoring and social activities
San Jose	Sacred Heart Community Services	2	5	El Salvador Mexico Peru	Spanish	3–23 years	Faith-based nonprofit organization that provides free food and clothing
	Indo-American Community Center	0	5	India	Hindi, Gujarati, Marathi	5–25 years	Senior center
	John XXIII Multi-Service Center	3	4	Hong Kong Taiwan Indonesia China	Mandarin	5–40 years	Multi-service center run by the Catholic Charities
	Korean American Community Center	4	4	Korea	Korean	3–23 years	Nonprofit organization that conducts programs for seniors and youth
	John XXIII Multi-Service Center	3	3	Vietnam	Vietnamese	8-25 years	Multi-service center run by the Catholic Charities
Subtotal		29	55				
Total: 84							

TEMPLE UNIVERSITY®
Center for Intergenerational Learning

Project SHINE
206 University Services Building
1601 North Broad Street
Philadelphia, PA 19122

phone 215-204-6160
fax 215-204-3195
web www.temple.edu/CIL

280-05 RF