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A MATTER OF EQUITY: PROVIDING LINGUISTICALLY APPROPRIATE CARE TO IMMIGRANT OLDER ADULTS

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Abstract

Immigrant older adults who do not speak either official language fluently are at increased risk for poor health outcomes. In this review, we examine the current literature on providing linguistically appropriate care to older adults with a focus on: 1) cognition, 2) medication review, 3) access to community supports and 4) interpretation services. We describe some of the challenges and opportunities that arise when there is language discordance between patient and clinician. We conclude with recommendations to help clinicians provide comprehensive, high-quality care to all older adults regardless of linguistic background.

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immigrant older adults, limited English proficiency, advocacy, systems-level change

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Key Recommendations

1. We recommend that patients be screened for cognitive impairment in their preferred language with the help of a professional interpreter.
2. We recommend that in-person professional interpreters be scheduled for appointments in settings where they are available, and that additional time be allocated for these visits.
3. We recommend that clinicians familiarize themselves with the community-based resources for immigrant older adults available in their area.
4. We recommend that translated materials be offered to patients and caregivers when possible.
5. We recommend that geriatric medicine training programs across Canada include education on providing linguistically appropriate care and partnering with interpreters.

Background

The population of older adults in Canada is becoming increasingly linguistically diverse.[1] Among immigrant older adults who arrived in Canada between 2011-2016, 63% reported being unable to speak either official language.[2] Most of these older adults have settled in urban centres like Toronto, where nearly two-thirds of seniors are immigrants and 46% report a mother tongue that is not English or French.[3] A greater number of immigrant older adults are now settling in suburban and rural areas.[4] Therefore, clinicians across Canada are likely to care for older adults who are not proficient in either official language.

Studies differ on how language "proficiency" is defined.[5] The US literature commonly refers to individuals who report speaking English less than "very well" as having limited English proficiency (LEP). More recently, studies have examined the importance of "language concordance" between patient and clinician when describing the impact of language on quality of care.[6-8] For the purpose of this article, we will preferentially use the term "language concordance," as the term highlights the relational nature of language in clinical interactions. We will use "LEP" if the literature cited used this term.

Patients with LEP experience a greater risk of adverse events, poorer outcomes in chronic disease management,[9-11] longer lengths of stay,[12] and increased hospital readmissions.[13] Immigrant older adults who are not proficient in either official language are also more likely to live in poverty,[14] be socially isolated,[2,15] and face barriers to accessing health care services.[16] Racialized* older adults from linguistic minority groups are more likely to have low income and poorer self-reported health than non-racialized older adults.[3] As a result, providing linguistically appropriate care to immigrant older adults requires careful consideration of the intersection of language discordance and other forms of disadvantage.

Our review summarizes the current knowledge on providing linguistically appropriate care to older adults. We will focus on Anglophone settings as we reviewed only the English-language literature. Where possible, we provide recommendations that we hope will be helpful in the Canadian context.

*The Ontario Human Rights Commission defines racialization as "the process by which societies construct races as real, different, and unequal in ways that matter to economic, political, and social life" and recommends that the term "racialized person" be used in place of terms like "racial minority" or "visible minority." www.ohrc.on.ca/en/racial-discrimination-race-and-racism-fact-sheet

Methods

We searched PubMed to identify articles using the keywords: cognitive impairment, communication, confusion assessment method, dementia, elderly, interpreter, language, language barrier, language concordance, language discordance, limited English proficiency, medication, MMSE (Mini Mental Status Exam), MOCA (Montreal Cognitive Assessment), multilingual, older adult, prescription, RUDAS (Rowland Universal Dementia Assessment Scale). We reviewed the title and abstracts of all articles published between January 1, 2000 and September 1, 2019.

Our search yielded 194 results. We analyzed the full text of English-language articles that: 1) included adults 65 years of age and older, 2) discussed linguistic diversity, language discordance, or limited English proficiency, and 3) presented original research. After screening, 48 articles remained. We then conducted a targeted search of the grey literature. The two authors discussed and agreed upon four themes across studies: 1) cognitive assessment, 2) medication review, 3) access to linguistically appropriate services, and 4) interpretation and translation.

Cognitive Assessment

Given the linguistic diversity of older adults in Canada, clinicians must be aware of limitations of the tools used to diagnose and screen for cognitive disorders such as dementia and delirium.

Formal language-based screens for cognitive assessment such as the MMSE and the MOCA have limitations when there is language discordance between the patient and assessor.[17,18] Both the MMSE and MOCA have been translated in several languages and validated in some using native language speakers to administer the test.[19,20] Neither test has been validated for use with an interpreter. In contrast, the RUDAS (please click here to view) is designed to minimize the effects of education and language on assessment of cognition.[21] It was developed and validated in Australia and has high specificity (91.4%) in patients who are not fluent in English.[22] A novel screening test called the Visual Cognitive Assessment Test (VCAT) has been developed for use in multilingual populations.[23] The 30-point test is comparable to the MOCA in sensitivity (85.6%) and specificity (81.1%)[24] when studied in a multilingual Southeast Asian population in Singapore. The VCAT shows promise, but needs further validation (please click here to view).

Language discordance may also pose unique challenges in delirium screening. The original validation studies for the Confusion Assessment Method (CAM)[25] excluded patients with LEP. The CAM has since been translated into more than 13 languages and is validated in four (Thai, German, French, Portuguese),[26-29] but these studies used professional interpreters or researchers fluent in the test language.

The 4AT (Rapid Clinical Test for Delirium – please click here to view) has been validated to screen for delirium in a culturally diverse geriatric inpatient population with professional interpreters used for non-English speaking patients.[30]

Where possible, efforts should be made to use language-concordant clinicians to screen for delirium. When caregivers are available, one may consider a screening tool based on collateral history, such as the Family Confusion Assessment Method[31] Please click here to use.

Importantly, many of these tools were validated with professional interpreters or native language speakers. This limits their generalizability to real-world clinical settings, where language discordance exists and professional interpretation is not always available or used.[32] Irrespective of the tool, we recommend that patients be screened for cognitive impairment in their preferred language with the help of a professional interpreter.[33] If an interpreter is not used, it should be documented and clinicians should be cautious in interpreting a low score as evidence of mild cognitive impairment or dementia.

Medication Review

Patients with LEP have an increased risk of adverse drug events,[34] lower comprehension of prescription labels,[35] and are less likely to know which medications to take after discharge from hospital.[36] When LEP and cognitive impairment exist together, there may be an even greater risk of adverse drug events.[37] Individuals from linguistic minority groups are less likely to receive a medication review from their pharmacists.[38] Clinicians must therefore be especially diligent to intervene and counsel on high-risk medications that may otherwise go unnoticed in this population.

Professional interpretation improves patient comprehension of new prescriptions[39] and is the preferred method for medication counselling when language discordance exists. If family caregivers who speak the same language are present, it may be appropriate to engage them to help improve comprehension of prescriptions. Clinicians should also make use of linguistically concordant pharmacies if they are available. In larger cities, independent pharmacies may serve specific linguistic communities and provide language-concordant medication counselling and prescription labels. Access to drug labels and written information in the patient's preferred language improves patient trust,[40] comprehension, and medication adherence.[41]

Access to Linguistically Appropriate Services

Immigrant older adults in Canada may experience systemic and institutional barriers to accessing linguistically appropriate community health services, home care, and long-term care.[42] Day hospitals and falls prevention programs that are delivered exclusively in English or French may not meet the language needs of some older adults. Local ethnocultural community agencies may provide linguistically accessible programs, and we suggest that clinicians be aware of the resources in their community. Access to linguistically concordant programs may be challenging outside of an urban centre or for older adults who are from linguistic communities that are not well-represented in Canada.

Home care services are integral to reducing hospitalizations and enabling older adults to age in place for as long as possible. Inequities may exist in access to home care for older adults who are not fluent in either official language. In a study of immigrant seniors in Toronto, those whose mother tongue was not English were more likely to receive home care from family and less likely to receive government-funded professional home care when compared to those whose mother tongue was English.[43] In addition, patients typically prefer to receive care from language-concordant personal support workers (PSWs). We found no Canadian data on the frequency of language concordance in home care, but a large study from New York City found that just 20% of home care visits to patients were language concordant.[44] We recommend that clinicians caring for older adults highlight a patient's preferred language in home care referrals and advocate that home care coordinators match clients to language-concordant PSWs, nurses, and other clinicians where possible.

Long-term care homes may not always meet the ethnocultural and linguistic needs of immigrant older adults. As a result, homes that do meet these needs often have very long waitlists. In addition, older adults who do not speak either official language disproportionately come from lower income groups and may have limited means to access private retirement residences or private home care.[45] Clinicians should encourage patients who may wish to access specific long-term care homes in the future to apply early as part of advanced care planning.

Interpretation and Translation Services

Language proficiency is contextual. A patient may be able to independently engage in conversation about simple aspects of their care, but find it difficult to discuss complex issues without interpretation. Professional interpreters improve patient satisfaction, adherence to treatment,[46] and may reduce hospital length of stay and readmissions.[47] However, clinicians often rely on family members or other staff for interpretation. These "ad-hoc" interpreters are more likely to omit important content and make clinically significant errors when compared with professional interpreters.[48]

In addition, a patient's proficiency in their non-primary language is vulnerable to cognitive decline (i.e. in some dementias such as Alzheimer's dementia patients lose their most recently acquired languages first and revert to their primary language). Therefore, clinicians caring for older adults should have a low threshold to partner with interpreters. A patient's preferences around interpretation should also be elicited, as some may prefer that family members act as interpreters.[49] While some family members may wish to interpret, others may find it stressful.[50] These situations can be difficult to navigate. Consequently, we encourage clinicians to explore if the patient and family might agree to the presence of a professional interpreter, even if the interpreter simply provides support to the family member who is interpreting.

We recommend that in-person interpreters be scheduled for appointments in settings where they are available, and that additional time be allocated for these visits. There should be a section for preferred language on referral forms to facilitate this. If in-person interpretation is not available, some jurisdictions including British Columbia, Winnipeg, and institutions in Toronto offer telephone interpretation services.[51-53] Electronic translation platforms like Google Translate hold promise, but are not yet sufficiently accurate for translation of important medical information.[54] Table 1 provides a list of translated online resources for dementia from reputable organizations.

We suggest that clinicians who speak other languages seek objective testing of their language proficiency and consider partnering with interpreters for complex assessments or discussions. We feel it is important to prioritize partnering with interpreters for outpatient scenarios known to be high-risk of error, such as establishing diagnoses, medication counselling, and informed consent.[55] It is vital to use in-person interpretation for goals of care discussions (please click here to view), assessments of capacity, and for medical assistance in dying.

Conclusion

All older adults should receive comprehensive, high-quality care regardless of their linguistic background. We have highlighted some challenges and practical recommendations related to language to help clinicians provide linguistically appropriate care to immigrant older adults. Improving health inequities in the care of these patients requires attention to linguistic needs at the bedside and a targeted research, education, and policy agenda.

For general information on communication in health care the following resource is suggested:
http://canadiangeriatrics.ca/wp-content/uploads/2016/11/3_Health-Literacy_Judy-Peng.pdf

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Table 1. Translated dementia resources available online*

Organization	Resources	Languages	Website
Alzheimer's Association (US)	Webpage with translated material about Alzheimer's and tips for caregivers	Spanish, Chinese, Japanese, Korean, Vietnamese	www.alz.org/?lang=es-mx (Spanish) www.alz.org/asian/ (Chinese, Japanese, Korean, Vietnamese)
Alzheimer's Society of BC	Most frequently used brochures	Chinese, Japanese, Korean, Farsi, Punjabi	https://alzheimer.ca/en/bc/We-can-help/Resources/Non-English-resources
Alzheimer's Disease International	Provides links to Alzheimer's Societies across the world and sites with information in many languages	51 languages	www.alz.co.uk/other-languages
Dementia Australia	Publishes dementia-related information	44 languages	www.dementia.org.au/languages
Finding Your Way Ontario	Tips for caregivers on how to prevent people from going missing and what to do if it happens	Italian, Spanish, Portuguese, English, French, Cantonese, Mandarin, Punjabi, Tagalog, Arabic, Urdu, Tamil	www.findingyourwayontario.ca

* The recommended resources are examples identified by the authors and the accuracy of the content and translations have not been verified.

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