BEST PRACTICES IN PROVIDING PRIMARY HEALTHCARE TO
ELDERLY ASIAN ADULTS

by

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STATEMENT BY AUTHOR

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Associate Professor of Nursing
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To my parents who have always told me to “Try your best”. Through my trials and tribulations, my parents have always been supportive and loving. The completion of this degree is for both my parents since they were unable to get a college education after immigrating over here. This Master’s project is for both of you because all of your sacrifices have been worth it. I can not ask for anything more from both of you. By passing on our cultural traditions, I have tried to incorporate them into my daily life, especially within the healthcare perspective.

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ABSTRACT

The purpose of this project was to present recommendations for best practices among advanced practice nurses caring for elderly Asian immigrants. The number of Asian immigrants residing in the United States has increased significantly throughout the years. Immigrants from China, India, the Philippines, Korea and Vietnam have surpassed the one million population mark in the United States. Many of these immigrants are elderly and have increased healthcare needs compared to younger individuals. However, due to limited English proficiency and cultural differences, communication problems with healthcare providers are high. Leininger’s Theory of Culture Care Diversity and Universality provided an organizing framework for recommendations for best practices; addressing culturally competent care, understanding and comparing folk and Western medicine, and practical aspects of care (i.e. use of interpreters). Proposed cultural competency strategies and guidelines are described; moreover, the healthcare providers will be able to assess their understanding and knowledge of culture through a check list with possible solutions to help increase Asian immigrant quality health care. Overall, further research is needed to develop improved standard healthcare practices for Asian elderly immigrants with limited English proficiencies.
CHAPTER ONE - PROBLEM IDENTIFICATION

Introduction

The purpose of this project was to present recommendations for best practices among advanced practice nurses caring for elderly Asian immigrants. The United States (US) Asian population has increased drastically due to immigration and procreation. In fact, the US Chinese, Indian, Filipino, Korean and Vietnamese populations now number more than one million. For a majority of these individuals, English is a second language; moreover, the elderly Asian population has a limited English proficiency. Therefore, when elderly Asian individuals seek care, they may encounter difficulties with healthcare providers due to language and cultural barriers. The significance of this problem will be shown through data provided on the US Asian population, immigration from Asia to the US, and the increasing US elderly population.

Significance of Project

United States Asian Population

According to the United States (US) Census of 2000, the Asian population increased faster than the total population between the years of 1990 and 2000. The range of increase is 48 to 72 percent; moreover, the total population only increased approximately 13 percent (Asian Population, 2002). Five Asian groups have a total over one million people: Indian, Chinese, Filipinos, Korean and Vietnamese (Figure 1).
At the age of 55 or over, Asian men composed 9% and women 12% of the total US population in 2000; therefore, there are more elderly Asian women than elderly Asian men. However, the Asian population aged 65 and over only accounted for 8% out of 12% of the total US population (We the People, 2004).

**Asian Elderly Immigrant Demographics**

The largest group of immigrants who became legal permanent US residents are from the continent of Asia. (Yearbook, 2006). From the years 2000 to 2005 there has been a surge in immigration from Asian countries to the US. Table 1 shows how many immigrants to the US were from each Asian country during those six years (Yearbook).
A total of 1,122,373 people obtained legal residency in the United States (US) in 2005 (Yearbook, 2006). Approximately 15% of those people are 60 years of age and older; moreover, an estimated 41,000 of the prior total are elderly Asian immigrants. Table 2 breaks down the population by age and gender (Yearbook).

TABLE 1: Persons Obtaining Legal Permanent Resident Status by Region and Selected Country of Last Residence: Fiscal Years 2000 to 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>58442</td>
<td>73416</td>
<td>73771</td>
<td>49525</td>
<td>65015</td>
<td>79314</td>
</tr>
<tr>
<td>India</td>
<td>38938</td>
<td>65673</td>
<td>66644</td>
<td>47032</td>
<td>65507</td>
<td>79140</td>
</tr>
<tr>
<td>Korea</td>
<td>15107</td>
<td>19728</td>
<td>19917</td>
<td>12076</td>
<td>19441</td>
<td>26002</td>
</tr>
<tr>
<td>Philippines</td>
<td>40465</td>
<td>50644</td>
<td>48493</td>
<td>43133</td>
<td>54651</td>
<td>57656</td>
</tr>
<tr>
<td>Vietnam</td>
<td>25159</td>
<td>34537</td>
<td>32372</td>
<td>21227</td>
<td>30074</td>
<td>30832</td>
</tr>
</tbody>
</table>

Table 2 breaks down the population by age and gender (Yearbook).

TABLE 2: Persons Obtaining Legal Permanent Resident Status by Gender and Age Fiscal Year 2005

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total</th>
<th>Gender</th>
<th>Gender</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>60-64 years</td>
<td>26807</td>
<td>10885</td>
<td>15922</td>
<td>–</td>
</tr>
<tr>
<td>65-74 years</td>
<td>36684</td>
<td>15479</td>
<td>21203</td>
<td>2</td>
</tr>
<tr>
<td>75 years +</td>
<td>13105</td>
<td>5266</td>
<td>7837</td>
<td>2</td>
</tr>
</tbody>
</table>
Increasing Age and Healthcare

Predictions have shown by the year 2030, the population of older adults will increase up to 71 million, and will comprise approximately 20% of the US population (State of Aging, 2007). Due to improved medical and health prevention care, the life expectancy of older adults has increased. However, approximately 80% of the elderly population has at least one chronic health condition and 50% have two chronic health conditions. The leading causes of death are no longer infectious diseases or acute illnesses; they are due to chronic diseases and degenerative illnesses.

The increased longevity does not come without extra costs. The cost of healthcare for an elderly person is three to five times greater than an individual younger than the age of 65 (State of Aging, 2007). More than two-thirds of the healthcare costs are for treating chronic illnesses. Because older adults have chronic diseases and degenerative illnesses, they require frequent contacts and more visits with their primary care providers than younger individuals (State of Aging, 2007). This may be true for elderly Asian adults as well, for they have chronic illnesses that require more contact with the healthcare system. For the elderly, approximately 95% of healthcare expenditures are for chronic disease conditions.

Barriers in Primary Healthcare for Elderly Asian Adults

Elderly Asian adults tend to encounter problems during visits with their primary care provider due to language and cultural barriers. Approximately 37 million adults speak another language other than English at home; furthermore, 18 million, or 48%, report that they know English less than “very well” (Cultural Competence, 2004). In the
Asian population, 40% spoke English less than “very well” (We the People, 2004). This percentage may be higher in first generation immigrants because it is difficult to learn another language when there are no opportunities provided. Because of language barriers, communication between elderly Asian patient and healthcare provider may be problematic. This may lead to patient dissatisfaction, poor comprehension and adherence, and lower quality of care. Green et al. (2005) state patients with limited English proficiency (LEP) report higher rates of medication complications and less satisfaction with overall healthcare services (p. 1050). In fact, Asian American immigrants who speak little to no English have more complications with health care than any other Asian American immigrants (Ngo-Metzger et al., 2003).

Older Asian immigrants are at disadvantage for English proficiency because many immigrated as adults, and they had limited opportunities to learn English after arriving. Some lived with family members and did not need to work; therefore, they had no need to learn English (personal experience). Even if there is an opportunity to learn English, these elderly immigrants have difficulty. When these Asian immigrants attempt to get healthcare from providers who do not share their language, barriers do occur (Enslein et al., 2002). For example, when provided with antibiotics for bacterial illnesses, an Asian immigrant may believe that he/she does not need to take the full course once his/her symptoms are better (personal experience). They will save the rest of the antibiotics for later use or to give to others when they are ill. Elderly Asian individuals also experience difficulties with healthcare providers with limited cultural competencies.
Most Asians report that their primary care providers seem unfamiliar with Asian background and cultural values; in addition, they feel as though providers are disrespectful and condescending (Cultural Competence, 2004). If healthcare providers are unfamiliar with Asian cultures, then it can interfere with their communication with clients and lead to culturally inappropriate care. Uba (1992) stated Asian adults often had difficulty accessing healthcare because providers lack understanding of their cultures. Healthcare providers may also be unaware of their insensitive behaviors and so may unintentionally insult or frighten an elderly Asian client. In fact, healthcare providers tend to offend clients when they disregard Asian folk medicines for treatment of ailments (Cultural Competence).

Summary

The United States (US) Asian population grows day by day through immigration and procreation. Many Chinese, Indian, Filipino, Korean and Vietnamese immigrants come to the US. It has also been projected that the US elderly population will grow to approximately 71 million. Chronic illnesses tend to be part of aging, and most elderly individuals have at least one chronic illness. Therefore, elderly Asian immigrants also have chronic conditions that need to be managed. However, due to their limited English skills, they may find it difficult to get quality healthcare from their providers. Language and cultural barriers are the main obstacles and challenges that both the healthcare provider and elderly Asian patient face. Cultural competency and practices to reduce these barriers are needed to help increase elderly Asians overall health. Chapter two will
discuss Leininger’s Theory of Culture Care Diversity and Universality along with each culture’s values and lifeways in comparison to the Western professional medical system.
CHAPTER TWO - CONCEPTUAL FRAMEWORK AND REVIEW OF HEALTH CARE SYSTEMS

Introduction

Leininger’s Theory of Culture Care Diversity and Universality provided the conceptual framework for this project. In the beginning of this chapter, an overview of Leininger’s theory and her Sunrise model will be provided. Afterwards, a summary will be provided on the cultural values, beliefs and lifeways of the five Asian cultures: Chinese, Filipino, Indian, Korean and Vietnamese cultures. For each culture, there are influences with cultural values and religion that affect health in some manner. Common effects to health are spiritual or imbalances in one’s body, yet each culture has different dietary methods or herbal remedies to help treat these ailments. An overview of the professional care system of Western medicine will be given to supply an understanding of the dissonance between Asian and Western medical cultures.

Leininger’s Theory of Culture Care Diversity and Universality

The major concepts in Leininger’s theory include culture, culture care, and culture care differences and similarities (McEwen, 2002). Culture is defined as the learned, shared and transmitted values and beliefs of a group that guide their thinking, decisions and actions. Culture care is learned and transmitted values and beliefs in which maintain the group’s health and helps them in dealing with illness or death. Culture care differences, or diversity, are the variations in meanings, patterns, or symbols of care. Culture care similarities, or universality, are when the meanings, patterns, or symbols of care are the same (Luggen & Kish, 2001).
Other major concepts of Leininger’s Culture Care Diversity and Universality theory are care and caring, emic view, etic view, generic health care system, professional health care system and culturally congruent nursing care (McEwen, 2002). Care is to assist, support, or enable others with needs to improve their human condition. Caring is the actions and activities completed to assist, support or enable others to improve their health or to deal with death. The emic view consists of language expressions, perceptions, beliefs, and practice of cultural groups in relation to certain events. The etic view consists of universal language expression, beliefs and practices in relation to certain occurrences. The generic health care system refers to folk medicine that was passed on and used to improve one’s health or to help in dealing with a person’s death. The professional health care system is Western medicine in which health and illness are taught formally. Culturally congruent nursing care is the nurse providing culturally competent care and interventions that are meaningful and beneficial to one’s culture (Luggen & Kish, 2001).

Along with the Culture Care Diversity and Universality theory, Leininger developed a tool (Figure 2) to help in visualizing the different dimensions of the theory. The rising sun symbolizes care. The top of the model focuses on the worldview and social structure that may affect health and care. The bottom of the model relates to the professional health care and generic health care systems. One can begin at the top and work his/her way down the model or vice versa; however, he/she can begin at any point within the model (Luggen & Kish, 2001). At the midpoint, is nursing in which the health care professional can use the generic care system with the professional care system. Each arrow shows influences that are not casual or linear relationships. The dotted lines
indicate open systems. The model joins the human race with its culture and no separation is made possible. The model was created to aide the health care professional in his/her assessment, to provide culturally congruent care and to have scientific inquiry (Leininger, 1991).

Leininger purposefully left nursing intervention and nursing problems off from her theory and model. She states that those terms cannot be used because they are in association with Western professional nursing ideologies (Leininger, 1991).
Leininger’s Sunrise Enabler to Discover Culture Care

FIGURE 2. Leininger’s Culture Care Diversity and Universality Sunrise Enabler from http://www.madeleine-leininger.com/eng/student-resources.shtml
Asian Cultures: Overview of Folk Health Systems in Relation to Religion and Cultural Lifeways

Introduction

Each Asian culture has similarities and differences within its religion and cultural lifeways. In this section, each Asian culture has a summary of cultural values, beliefs and lifeways. In each of the cultures reviewed, health is affected by various aspects such as spiritual or imbalances within one’s body. However, treatments for these ailments differ within each culture.

Asian Indian: Religious and Cultural Lifeways

India is a country located in the southern part of Asia. The largest religious group is the Hindus; however, many other religions originated from India: Buddhism, Jainish and Sikhism (Prathikanti, 1997). Islam, Christianity and Judaism have many followers as well. Hinduism and Buddhism is discussed in further detail.

Hinduism is one of the most ancient religions of India, dating back to approximately 2500 BC (Coward & Sidhu, 2000). Traditional teachings about duties of individuals and families are passed down from generation to generation in order to maintain a beneficial lifestyle in relation to physical and mental health. Coward and Sidhu (2000) state “The fundamental idea is that each person is repeatedly reborn so that his or her soul may be purified and ultimately join the divine cosmic consciousness” (p. 1168). A person’s good or bad actions will influence the circumstances and predispositions experienced in future lives.
The religion of Buddhism originated approximately 2,500 years ago. A prince, Buddha, traveled throughout his life to find enlightenment when he saw the suffering of his people (Smith-Stoner, 2006). It is believed that human suffering is universal and that life is a cycle of reincarnation. Illness, disability and death are a part of the Noble Truths of Buddhism; in fact, it is believed that illness results from one’s past actions and helps one to develop a deeper insight of his/her mind (Smith-Stoner).

In the Asian Indian population, a person “exists as a physical body, a reincarnating soul, and a social being invested with a particular dharma” (Prathikanti, 1997). Illness results when one of these three realms is disturbed. Praying, purification rituals, soothing ointments, changes in diet and behavior are some remedies used to restore harmony between the three realms. Ayurvedic physicians, various gurus and mystics help to balance and restore overall well-being to the ailing individual. Furthermore, palmists, herbalists, and diviners are also called forth, and they combine elements from Indian astrology with folk beliefs and magic to help the person in distress (Prathikanti). The sacred role is outstanding in all the healing traditions of India; for example, the guru concentrates on the abandonment of dharma, and the palmist with the scheme of karma. Western medication does not consider the role of the sacred in healing; therefore, some Asian Indians may develop attitudes of distrust toward Western healthcare providers.

Chinese: Religious and Cultural Lifeways.

China is a large country that has a land mass about 9.6 million square kilometers; it is more than 300,000 square miles larger than the United States. It is one of the world’s
countries with the oldest history and culture (Lee, 1997a). China’s traditional system is influenced through the philosophical teachings and religious beliefs of Confucianism, Taoism, and Buddhism. Confucianism incorporates the teachings of Confucius. There are five important concepts of Confucianism: “Jen” (benevolence), “Yi” (righteousness), “Chung” (loyalty), “Hsia” (filial piety) and “Te” (virtue). These concepts greatly influence Chinese behavior (Chen, 1996). Taoism has a main concept of Way, or “Tao”, in which the religion teaches conformity or harmony with nature (Chen).

The Chinese population believes in the concept of yin and yang. Yin is associated with the cold, darkness, being stationary, passiveness, receptivity, tranquility and quiescence; yang is associated with heat, light stimulation, excess, assertiveness, dominance, movement, arousal and dynamic potential (Kaptchuk, 2002). Two vital life energies, qi (energy) and jing (sexual energy) are kept in balance by yin and yang (Lee, 1997a). If there is an imbalance of yin and yang, then a person is more susceptible to illness. Usually, the use of herbal medicines is thought to correct this disequilibrium. However, if the ailment is supernatural, then religious healers are sought for treatment (Uba, 1992). Herbal medicine, acupuncture and therapeutic massage are some of the various healing practices still used today. Eating certain foods will also be helpful in restoring one’s health. The Chinese have categorized foods into five groups: hot, cold, allergic, moderate and nutrient (Lee, 1997a).

The five elements is another important concept in which the Chinese believe. These five elements have laws that the universe and humans are subjected to. Table 3 shows how these five elements compare to other aspects of life (Lee, 1997a).
TABLE 3: Key Concepts of Five Elements

<table>
<thead>
<tr>
<th>Five Phases</th>
<th>Direction</th>
<th>Season</th>
<th>Organs</th>
<th>Orifices</th>
<th>Emotion</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wood</td>
<td>East</td>
<td>Spring</td>
<td>Liver</td>
<td>Eyes</td>
<td>Anger</td>
<td>Green</td>
</tr>
<tr>
<td>Fire</td>
<td>South</td>
<td>Late Summer</td>
<td>Heart</td>
<td>Ears</td>
<td>Joy</td>
<td>Red</td>
</tr>
<tr>
<td>Earth</td>
<td>Middle</td>
<td>Summer</td>
<td>Spleens</td>
<td>Nose</td>
<td>Compassion</td>
<td>Yellow</td>
</tr>
<tr>
<td>Metal</td>
<td>West</td>
<td>Autumn</td>
<td>Lungs</td>
<td>Mouth</td>
<td>Sorrow</td>
<td>White</td>
</tr>
<tr>
<td>Water</td>
<td>North</td>
<td>Winter</td>
<td>Kidney</td>
<td>Genitals</td>
<td>Fear</td>
<td>Black</td>
</tr>
</tbody>
</table>

Using the table above, an example is provided. The first example is about the only son from a wealthy family. He was born sick and remains weak throughout his childhood. He is of the fire phase. In order for him to live a longer and healthier life, his family betroths him to a girl born of the wood phase. Wood fuels fire, so it is believed that the girl he marries will make him healthier (personal experience).

Elderly Chinese immigrants may use a number of home remedies that are quite diverse. Zhan and Chen (2004) have identified these to include “Zhong Yao” (traditional Chinese medicine), “Pian Fang” (folk remedies) and “Bu Yao” (dietary supplement). Compliance to Western medication is based on symptoms, degree of congruence of their culture with their physician, being able to pay for the prescriptions, communication with their provider and knowledge about prescriptions. Zhan and Chen (2004) found elderly Chinese individuals who reported having cultural barriers in healthcare were more likely to use both prescriptions and herbal remedies.
Filipinos: Religious and Cultural Lifeways

The Philippines consists of habitable islands in the Pacific Ocean. There are many different dialects. This country is the only known Asian country that is primarily Catholic due to its history of Spanish influence and domination (Sustento-Seneriches, 1997).

Sustento-Seneriches (1997) states “…illness is an interweaving of different physical, mental and spiritual, and psychological components” (p. 108). Due to the influences of other cultures in Filipino history, the causes of illness are viewed differently by every person. For example, approximately 73% of the people believe that illness is caused by bacteria and viruses; 66% due to inadequate nutrition; 57% due to natural elements such as rain, cold, and heat; 15% due to God’s will; 5% due to evil spirits; and 3% due to witchcraft (Sustento-Seneriches). A traditional healer may be consulted for herbs, rituals and incantations. The physician is held in high regard and may prescribe medications and give direct advice on lifestyle or attitude changes.

Korean: Religious and Cultural Lifeways

Korea is located in northeastern Asia between China and Japan. Although there is a strong cultural influence from China and other Asian neighbors, Korea was able to maintain its own culture. Confucian ethics influence Korean culture, and Christianity is popular because it provides social and psychological support with religious functions (Kim, 1997). Confucianism is the official religion of Korea since the 14th century (Purnell & Kim, 2003). Although the country is separated due to politics, the Koreans of both regions have the same beliefs regarding health and illness.
Koreans believe the causes of illness are supernatural, afflicted by evil or vengeful spirits, or a result of hereditary weakness, character weakness, physical and emotional strain, or from the imbalance of yin and yang (Kim, 1997). Isolation, rest, prayer and repentance are some of the therapies used. Koreans also use folk healing methods that are a combination of elements from diverse healing traditions (Kim). Folk therapies may include rare organic food, herbs, ceremonial purification of ancestral spirits, chanting, hymning and prayer. Koreans also use faith healing, religious counseling and fasting to help treat their ailments. Some of these therapies resemble what the Chinese utilize for treatment.

Vietnamese: Religious and Cultural Lifeways

Vietnam is a country located in Southeast Asia. This country has been highly influenced by China and French domination. Confucianism, Taoism and Buddhism, Christianity and animism are the main religions of Vietnam, but there is no official religion (Calhoun, 1986).

The Vietnamese also view health as a balance between yin and yang; however, they express these elements as am (yin) and duong (yang). Am also designates the element of “cold” and duong is “hot” (Calhoun, 1986). Disequilibrium of these elements causes an individual to become prone to illness. Supernatural entities such as gods and spirits are also believed to cause poor health. During illness, the imbalance of “hot” and “cold” may cause the individual to change his/her diet. If the ailment is believed to be from too much “hot”, then more “cold” foods are consumed to balance out one’s health (personal experience). Folk medicine and traditional practices use herbs, tiger balm and
coining. Coining, or cao gio, is forceful rubbing with a silver coin dipped in tiger balm to particular areas of the forehead, base of nose, neck, chest and back. This technique tends to leave long lines of continuous dark bruises on the skin (personal experience). Local healers provide acupuncture and cupping. If the ailment is believed to be caused by supernatural entities, then prayer and offerings made at the temple or church are done to appease the evil spirit or god. Ahn et al. (2006) report Vietnamese Americans commonly use complementary and alternative therapies, and they commonly use coining, massage and cupping (p. 651).

Professional Care Systems

According to Leininger, professional care systems are formally taught, learned and transmitted professional care, health, illness, wellness and related knowledge and practice skills (Andrews, 2003). In professional care, one must have specialized education and knowledge of the responsibilities for care, such as nurses, advanced practice nurses, physicians, physical therapists and other licensed health care providers. However, this system has Western ethics that some non-Western societies do not share (Purnell & Paulanka, 2003a). The Western ethic principles are patient autonomy, self-determination, justice, do no harm, truth telling and promise keeping. For example, when obtaining informed consent for a surgical procedure, a physician would simply acquire approval from the patient. However, in Asian cultures, it is best to have the whole family involved in the decision before attaining informed consent from the patient (personal experience).
Western medicine compared to traditional/folk medicine is more research and scientifically based. Moreover, integration of both medical practices is limited due to attitudes of physicians and other healthcare providers, medical education and the integration of the service (Wong et al., 2006). For each area, there is a mutual misunderstanding of the other. However, Western medicine must not neglect the significance of traditional/folk medicine because far more people use these therapies for acute and chronic illnesses than utilizing Western medicines. Research has shown that patients rarely tell their primary care physicians about traditional medicine use.

Summary

Leninger developed the Theory of Culture Care Diversity and Universality and included a model for transcultural healthcare. The religious and cultural lifeways of the five chosen Asian cultures was provided; furthermore, illness in each culture is attributed to many factors, with spiritual being the common theme. Treatments for health ailments vary greatly through each culture from diet to use of traditional medicines. The professional health care system is also discussed in comparison to traditional/folk medicine. In professional health, scientific and research bases the treatments of ailments; furthermore, traditional/folk medicine is an unknown and fairly unused practice because it is believed to be reflective in nature and unproven. Whichever medicine is practiced, the healthcare provider must accept and learn to understand the different treatment modalities of Asian elderly patients. By integrating the religious and cultural lifeways of the elderly Asian patient along with the professional health system, providers may be able to develop a good rapport with their patients in order to provide culturally competent
care. Therefore, it is suggested that healthcare providers have a positive attitude about complementary medicine so that a better patient-provider relationship develops (Wong et al.)
CHAPTER THREE - PRACTICE INNOVATION: CULTUALLY COMPETENT CARE FOR ELDERLY ASIANS

Introduction

This chapter will present the proposed best practices for culturally competent care for elderly Asian immigrants. In order to provide culturally competent care, it is recommended that the healthcare provider must 1) learn about the Asian culture of the elderly patient; 2) use interpreters whenever possible; 3) provide health education materials in the elderly patient’s preferred language; and 4) ask the patient about his/her specific cultural understandings and needs (Purnell & Paulanka, 2003b). By following these suggestions, the healthcare provider may become more cultural aware and may develop a positive patient-provider relationship.

Cultural Competency

In order to provide culturally competent care, the advanced nurse practitioner (ANP) must learn about different Asian cultures through previous knowledge and experience. One can not learn to be culturally competent overnight or from taking a few training courses. Training courses may vary in content, teaching method and have intracultural variations (Cultural Competence, 2004). The American Medical Association does provide health care professionals with information and resources on the policies, publications, curriculum and training materials to promote cultural competent practices. Basic attitudes such as curiosity, empathy, respect and humility will help to strengthen the clinical relationship and aid the ANP to learn and understand his/her client’s beliefs.
and health practices. Table 4 lists some common strategies and changes for improving patient-provider interaction in the healthcare system (Cultural Competence).

### TABLE 4: Common Strategies for Cultural Competence in Health Care

<table>
<thead>
<tr>
<th>Common Strategies</th>
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<tr>
<td>1. Provide interpreter services.</td>
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<td>2. Recruit and retain minority staff.</td>
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<td>3. Provide training to increase cultural awareness, knowledge and skills.</td>
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<td>4. Coordinate with traditional healers.</td>
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<td>5. Use community health workers.</td>
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<td>6. Incorporate culture-specific attitudes and values into health promotion tools.</td>
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<tr>
<td>7. Include family and community members in health care decision making.</td>
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<td>8. Locate clinics in geographic areas that are easily accessible for certain populations.</td>
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<tr>
<td>9. Expand hours of operation.</td>
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<tr>
<td>10. Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing and other written materials.</td>
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</table>

There are also resources online that are set up for healthcare providers. These websites will help healthcare providers such as ANPs to understand different cultural backgrounds. The appendix provides a list of resources that healthcare providers can use to attain information helpful in their practice with elderly Asian patients.
Use of Interpreters

Many healthcare providers do not provide interpretation services to their elderly Asian patients due to the cost; however, they do not consider the consequences of care without interpretation services and the cost benefits of improving communication with their patients (Jacobs, Shepard, Suaya & Stone, 2004). Using interpreters will increase the delivery of healthcare to the older Asian adult. Therefore, healthcare providers should use interpreters whenever possible to provide quality care. However, an interpreter cannot be just any person who speaks the foreign language. Trained language interpreters have formal education and must follow the professional code of ethics that includes confidentiality, impartiality, accuracy and completeness (Herndon & Joyce, 2004). The interpreter also needs to understand the cultural background and health beliefs of the patient. Using an interpreter who is the same gender as the patient would be preferable because using an interpreter of the opposite gender may create difficulties due to male/female health differences (Poss & Rangel, 1995). For example, an elderly Vietnamese female would not like to report her vaginal dryness to a male interpreter. Table 5 lists some useful guidelines for adult nurse practitioners when using interpretation services (Poss & Rangel; Lee, 1997b).
TABLE 5: Guidelines for Working with Interpreters

<table>
<thead>
<tr>
<th>Guidelines</th>
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<tbody>
<tr>
<td>1. Have preinterview meeting with the interpreter.</td>
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<tr>
<td>2. Allow plenty of time during the patient visit when using interpreters.</td>
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<tr>
<td>3. Do not use the patient’s children as interpreters.</td>
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<tr>
<td>4. Conduct interview in comfortable environment.</td>
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<tr>
<td>5. Talk directly to the patient and not the interpreter.</td>
</tr>
<tr>
<td>6. Watch the patient’s face for understanding of the translation and information provided.</td>
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<tr>
<td>7. Speak slowly and clearly; use short, simple statements.</td>
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<tr>
<td>8. Be aware of verbal and nonverbal (body language) communication style.</td>
</tr>
<tr>
<td>9. Be aware of the age difference between the patient and the interpreter.</td>
</tr>
<tr>
<td>10. Do not interrupt the interpreter during translation; allow enough time for translation to occur.</td>
</tr>
<tr>
<td>11. Allow time for patients to ask questions and seek understanding of health concerns.</td>
</tr>
<tr>
<td>12. Have the patient repeat instructions so that one is certain that the patient understands what to do.</td>
</tr>
<tr>
<td>13. Be a good listener and do not take excessive notes during the interview process.</td>
</tr>
<tr>
<td>14. Document the name of the interpreter who translated for the patient.</td>
</tr>
<tr>
<td>15. Be aware of translation errors; tell the interpreter that he/she can tell the practitioner when he/she is having difficulty translating.</td>
</tr>
</tbody>
</table>

Health Education Materials

Some Asian elderly are able to read in their language. Therefore, health education materials in their language may be useful. Williamson, Stecchi, Allen and Coppens (1997) found that video presentations were very effective in providing health education in
different oral languages. Moreover, the University of California in San Francisco College of Medicine developed a website on health for the Vietnamese community. Health education materials in different languages can be found online with web searches. The Center for Disease Control and Prevention provides immunization information in many different languages and is provided in portable document format for easy printing purposes. As mentioned earlier, Appendix A provides resources that are available on the web.

**Summary**

In order to provide culturally competent care, the healthcare provider must be able to understand and communicate with the elderly Asian patient. Due to language and cultural barriers, a strained relationship between patient and provider may arise. Communication problems may cause the patient to disregard the healthcare system itself. The nurse practitioner needs to become more culturally competent and understanding of Asian medicine practices. Using interpreters and language appropriate health education materials will provide the nurse practitioner with the power to build a better relationship with his/her elderly Asian patient. Resources on the internet are available and free for use; however, the nurse practitioner must be sure that these sites provide well accredited health information.
CHAPTER FOUR - EVALUATING THE ADVANCE PRACTICE SETTING FOR CULTURALLY COMPETENT CARE FOR ELDERLY ASIAN PATIENTS

Introduction

Culturally competent care may be difficult to develop and provide within a busy healthcare setting. Therefore, this chapter will present a proposed checklist that healthcare providers in primary care can use to evaluate whether the care provided is culturally competent for elderly Asian immigrants. The checklist will also provide a list of resources that may be used to increase culturally competent healthcare for primary care healthcare setting.

Proposed Checklist

The following checklist will provide healthcare providers with a convenient and time-efficient way to ensure that culturally competent care is being provided. If not, resources are also given so that changes can be made. This checklist is simple and may be transmitted through the internet or printed and copied repeatedly for use. Further changes and reviews will be necessary as the years pass and there are changes within the healthcare system. Healthcare providers can also make personal changes to the checklist. By doing so, they may add on more questions for consideration or take out certain areas that they do not provide. For example, the healthcare provider may have adequate finances to print off health materials in several different languages, but he/she may not be able to have an interpreter available during all elderly Asian patients’ appointments. The overall goal of the checklist is to supply healthcare providers with information that will help guide their care to elderly Asian immigrants. A pilot study may be useful in
determining whether or not the checklist is effective in changing healthcare providers’
care to elderly Asian immigrants. Another component to the study is to see what changes
may be needed to improve the checklist for later utilization. Table 3 is the proposed
checklist.
<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Yes or No</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do I understand my elderly Asian patient’s culture?</td>
<td></td>
<td>✤ Take transcultural healthcare courses.</td>
</tr>
<tr>
<td>2. Do I know what his/her healthcare beliefs are?</td>
<td></td>
<td>✤ Research Asian culture before patient appt.</td>
</tr>
<tr>
<td>3. Do I value and respect traditional/folk medicine?</td>
<td></td>
<td>✤ Ask patient about his/her culture.</td>
</tr>
<tr>
<td>4. Do I provide culturally competent care?</td>
<td></td>
<td>✤ Research on his/her health beliefs.</td>
</tr>
<tr>
<td>5. Is there any other way to improve care to my elderly Asian patient?</td>
<td></td>
<td>✤ Reflect and see if there are any biases.</td>
</tr>
<tr>
<td>6. Is there any communication barriers between my elderly Asian patient and me?</td>
<td></td>
<td>✤ Research about alternative therapies.</td>
</tr>
<tr>
<td>7. Is an interpreter necessary?</td>
<td></td>
<td>✤ Reflect to see what changes are needed in primary care setting.</td>
</tr>
<tr>
<td>8. Is the interpreter effective?</td>
<td></td>
<td>✤ Research and ask other providers about more resources for culturally competent care.</td>
</tr>
<tr>
<td>9. Do the costs outweigh the benefits of using an interpreter?</td>
<td></td>
<td>✤ Consider using a professional interpreter.</td>
</tr>
<tr>
<td>10. Are there health education materials in Asian languages?</td>
<td></td>
<td>✤ Listen attentively and speak slowly.</td>
</tr>
<tr>
<td>11. Do I know where to get health education materials in other languages?</td>
<td></td>
<td>✤ Observe patient’s body language during appt.</td>
</tr>
<tr>
<td>12. Are the health education materials informative?</td>
<td></td>
<td>✤ Research to see what resources are available for interpretation services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Evaluate to see if there is adequate funding for interpretation services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Reflect and see if materials will be useful for elderly Asian patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Ask other healthcare providers for their resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Research online for translation services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Have elderly Asian patients fill out surveys to provide their input.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Have elderly Asian patients or interpreters scrutinize material for any translation errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Evaluate elderly patient’s health for improvement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✤ Survey patient’s response to materials.</td>
</tr>
</tbody>
</table>
Summary

Providers have difficulty finding the time to develop ways to provide cultural competent care. A checklist was developed to aid the healthcare provider in determining what changes are needed within their primary care setting. The checklist includes elements drawn from cultural competency, interpretation services and health education materials in different Asian languages. A section gives providers questions to ponder and another gives solutions to those questions. The checklist is simple and easy to use, and it may be changed for personal preferences. However, further research needs to be conducted in order to revise the checklist for nationwide and possible worldwide utilization. Also, it is often difficult to predict or generalize one’s needs; in fact, providers need to develop skills. Providers may respectfully ask the Asian elderly patient about his/her culturally-based health needs.

Conclusion

As the Asian population increases steadily with immigration and aging, the United States must have a solution in providing healthcare to elderly Asian immigrants. Culturally competent care is a must among all healthcare providers because most elderly Asian patients have chronic health conditions and seek more medical care than younger adults. Challenges such as miscommunication, cultural barriers and decreased cultural awareness need to be addressed. Healthcare providers must find resources they can use to help them provide culturally competent care. They must also understand the differences between Western and traditional/folk medicine because most elderly Asian immigrants may use both at the same time. In order to develop a trusting and good rapport with the
elderly Asian immigrant, the healthcare provider must become culturally competent, use interpreters when necessary and provide language appropriate health materials.

In conclusion, language and cultural barriers will always be a problem in the healthcare setting. However, with minimal effort, the healthcare provider may become culturally competent and accepted by using the common strategies and guidelines provided. The checklist is a tool that providers may use to make changes within their healthcare setting so that they and others may give culturally competent care to all elderly Asian immigrants.
APPENDIX A

AVAILABLE RESOURCES ONLINE
## Available Resources Online

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language Line Service</td>
<td><a href="http://www.languageline.com">http://www.languageline.com</a></td>
</tr>
<tr>
<td>1-800-Translate</td>
<td><a href="http://www.1-800-translate.com/medical.html">http://www.1-800-translate.com/medical.html</a></td>
</tr>
<tr>
<td>DiversityRx</td>
<td><a href="http://www.diversityrx.org">http://www.diversityrx.org</a></td>
</tr>
<tr>
<td>Cross Cultural Health Care Program</td>
<td><a href="http://www.xculture.org">http://www.xculture.org</a></td>
</tr>
<tr>
<td>Caring for Patients with Limited English Proficiency</td>
<td><a href="http://www.lep.gov">http://www.lep.gov</a></td>
</tr>
<tr>
<td>American Cancer Society</td>
<td><a href="http://www.cancer.org/acmmain/(nxtxyq550t4jz2r2lfndxfak)/DefaultACS.aspx">http://www.cancer.org/acmmain/(nxtxyq550t4jz2r2lfndxfak)/DefaultACS.aspx</a></td>
</tr>
<tr>
<td>Asian American Network for Cancer Awareness, Research and Training (AANCART)</td>
<td><a href="http://www.aancart.org/index.htm">http://www.aancart.org/index.htm</a></td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
<td><a href="http://www.immunize.org/vis/index.htm#index">http://www.immunize.org/vis/index.htm#index</a></td>
</tr>
</tbody>
</table>

Compiled by: Huong Trinh (2/20/2007)
REFERENCES


Herndon, E. & Joyce, L. (2004). Getting the most from language interpreters: Communicating with patients who have limited English proficiency requires more than simply “finding someone who speaks their language”. Family Practice Management, 37-40.


