MINNESOTA DIVERSE ELDERS COALITION

PRESENTS

THRIVING DIVERSE ELDERS:
EFFECTIVE COMMUNICATION STRATEGIES

Facilitation Guide

These case studies are designed to be used as part of a facilitated discussion, following the viewing of a panel conversation of experts from Minnesota's indigenous, LGBTQ and East Indian communities at our virtual workshop, Thriving Diverse Elders: Effective Communication Strategies, held May 27, 2021.

1. **Read each scenario out loud.**

2. **Encourage general exploration of comments such as:**

    - What thoughts, feelings, and associations come to mind first when you think about the communication styles or methods in this scenario?
    - Based on what you have learned, what would you change and why?
    - Has anyone had a similar experience? What did you do? Would you do anything differently now?

3. **Prompt for discussion as needed:**

    - What did you mean when you said _____?
    - Can you say more about _____?

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African American Community Case Study

Developed by
Robbin Frazier, University of Minnesota Center for Healthy Aging & Innovation

Claretta Ross is a 79-year-old, who lives alone in her split-level home. She has lived in her home for almost 30 years and wants to remain in her home and community. She can pay her mortgage and all expenses with the social security she receives and a small pension from her deceased husband, but she has limited funding to make upgrades to the home.

Claretta is a devoted mother, grandmother, and great-grandmother. She raised her four children and was highly active in the lives of the seven grandchildren often keeping them on weekends and during the summer. Her home is the cherished place where family has gathered over the years to celebrate birthdays and holidays. Since her children and grandchildren are working adults with full-time jobs and some hold part-time positions while parenting young children the frequency of family visits to Nana is less and usually on the weekend.

Claretta has long suffered from high blood pressure, which she controls with medication. She also has type-2 diabetes. She tries to take her medication whenever she can remember and but has difficulty with getting the right dosage of insulin to inject due to vision and shaky hands. After two car accidents and a lower spinal fusion she experiences back pain periodically but holds her head high, keep commitments, and rarely complains. She believes God is my source and will not give me more than I handle.

Recent test results from an ER visit due to a severe headache and blurred vision show her blood pressure is significantly elevated, her diabetes is no longer under control, and there has been a recent decline in her kidney function. Today here oldest daughter, Rhoda, and dear sister-friend of 30-years, Ms. Beverly, a member of her church want to discuss concerns about her health decline and share concerns about memory loss and changes in her ability to take medication as prescribed and safely cook with her primary care doctor.

The doctor greets the group with a slightly annoyed welcome saying, “I see you have a crew with you today, Claretta.” He asks why Claretta why she is there, and she says, “I feels fine and I’m doing good at home, I just had a little rise in my sugar and pressure, so I went to the ER due to a headache, but now I fine and there is nothing to worry about.” **Her daughter and sister-friend attempt to object saying they are worried about her memory and changes they have seen providing the following examples:**

1) The stove burner and oven being accidently left on after she has finished cooking. And food once delicious is occasionally discarded due to poor taste – likely missed ingredients or over cooking.
2) The medication container with 2-3 skipped days indicating pills and extra syringes that should have been used for insulin injections were not taken.
3) Repeating the same stories and questions during a single conversation

The doctor says ok, I have heard enough as he turns his back to her family. He compliments Claretta on the beauty colors in her pants suit and matching silver sandals. He says his Mom is younger, only 65, and her whole wardrobe is black, grey and brown. He says “Claretta you live in color and embrace life.” He gently holds Claretta hands and says he would like to ask her a few questions. **He proceeds to cover the following questions:**

1) What is you date of birth?
2) What is your address?
3) What is your phone number?
4) Where were you born?
5) What is your maiden name?
6) Who is the governor?
7) Who is the president?
8) What medications does she take for her blood pressure and diabetes?

After Claretta answers all the questions correctly he turns to the family and says “Claretta’s memory is fine and she looks 65 not going on 80, not a single wrinkle. I guess that is why I hear people comment black doesn’t crack.” He tells the family do not overreact to a one-time episode and suggest check-in six months. In the meantime, Claretta can her blood pressure and A1c every two months during a nursing visit.

A month later Claretta is admitted to the hospital with second and third degree burns on her upper body after forgetting food in the stove-top and attempting to extinguish the flames herself to hide the memory lapse. A neighbor saw the smoke, called the fire department, and recused her just in time to save her life. The house is condemned, cannot be rebuilt (under-insured home policy was not updated to reflect current costs) and all the treasured physical memories are in ashes. Claretta faces a long, painful road to recovery. Her beautiful mocha brown face is now covered in burns and she cannot bear to look in the mirror when they change her dressings.

Potential Discussion Questions

1) How did gender impact this case? Do you think the results would have been different if a male son or friend attended the primary care visit?
2) What beliefs do you believe the doctor has about age? Did his beliefs or biases impact care?
3) How do you believe race, ethnicity, and culture impacted the care the patient received?
4) How did the patients' values, beliefs, desires, and faith impact her interaction with others?
5) What could have been done differently?
6) Please described the missed opportunities for a more productive and insightful visit.
7) What changes can your organization you make to ensure patient and family concerns are properly addressed?
8) Can you share an example of a negative health outcome you have experienced or heard about that was influenced by discrimination based on the race, ethnicity, gender identity, sexual orientation, or immigrant or refugee status?
9) What can be done to dismantle the processes, systems, and organizational cultures that brings discrimination, harm and at times death to BIPOC and LGBTQ, and underserved communities?
10) How will you share and apply this information in your personal and professional life?

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Asian Immigrant Community Case Study

Developed by
Sneha Singh, Eden Pathways, LLC and Sipra Jha, Asian, Women United of Minnesota

An Iraqi Muslim woman in her late 60's Samira came to the U.S as a second wife. Soon after she became a victim of severe physical, verbal, emotional and financial abuse. She suffered the abuse silently and stayed in the marriage for 2years because divorce has a huge stigma in the community that she came from. A divorced or separated woman according to Samira was not seen with respect and faces discrimination back in Iraq and in her community in the US. Moreover, she said that she would get a cultural divorce first if at all. Over time the abuse became worse, and Samira's physical health deteriorated. She was experiencing intense abdominal pain. She asked her husband to take her to the doctor, but he refused to do so. One evening the pain was so terrible that she called one of her husband's friends and he dropped her off on the steps of one of the metro Hospitals. The hospital contacted various shelters about this situation, but no one knew how to help. Samira was not comfortable with the interpreters the hospital provided. She had no insurance, had a dicey immigration status, no family, or friends, did not speak English and had no money and according to the hospital they could not keep her beyond a certain time Samira had no idea where she was and continued trauma and disturbances led to a nervous breakdown No shelter had the capacity to help an aging woman with severe health and immigration issues,

Potential Discussion Questions

1. What approach can a provider take when working with an immigrant/refugee with multiple needs?
2. How do we work with aging immigrant refugee populations with respect, inclusion, and sensitivity?
3. Currently what systems are in place for a situation like this? How can we do better to help women in crisis?

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East Indian Community Case Study

Developed by
Sneha Singh, Eden Pathways, LLC and Sipra Jha, Asian Women United of Minnesota

An East Indian woman, Rani (name changed) in her 50's migrated to the US. She was living with her daughter, son-in-law, and their kids in Minnesota. She was in her early 80's when we met with her. She had quite a large sum of money in her name in her account and yet a cultural dilemma around spending money for her own care. It was not easy to explain to her why she would not qualify for any assistance from the state. She felt she was neglected, isolated, and felt left out by her own family.

Her husband had abandoned her when she was pregnant with their daughter. Later she migrated to the US which was extremely hard for her, and she developed mental health issues that became apparent by her behavior. Her daughter and son-in-law both had good jobs and both her grandkids had moved out of the home. Most of the time Rani was at home which was not modified to suit her need. All the bedrooms and bathrooms were on the upper level. Her past trauma -the feeling of forced migration to the US kept coming back. Rani had worked extremely hard in India and was a very socially active person in her younger days but in the US. She was homebound and dependent on others as she could not drive or work, and more importantly had a language barrier.

With age and loneliness Rani developed health issues, both physical and mental and now needed care and support however she was not ready to spend money for her own care... We had a couple of meetings with Hennepin County social workers, who took the time to fill out the form and explain to her why she was not eligible. The worker informed her and tried to educate her to use the money she had in her account to get a PCA or do the home modifications and told her that maybe then she may be eligible for other services. Rani was not willing to make the change as she wanted to keep that money for her grandkids and did not want to use it on herself. She expected her daughter to take care of all her expense.

In one of our conversations, we involved her daughter as well and explained the cultural dilemma her mom had but she was clear that whatever funds her mom had in her account should be used for her care and she did not need her mother's money. However, the daughter did not want to have further communication about this issue, and it was not easy to continue to help Rani anymore.

Most of the older adults from East Asian communities, who migrated in the 80's and 90's, and have not worked here face this cultural dilemma, since their expectations from their kids is that they should care for them -physically and financially. Self-care is not a widely known notion as personal health is not a priority, lack of financial understanding and almost no understanding of how the system works are huge issues for most East Asian aging adults.

Potential Discussion Questions

1. The social worker compassionately and patiently tried to explain the assistance program eligibility to the patient. Do you think she had the right approach? If you were a social-worker, how would you have effective communication with the patient? What should be our communication style?
2. How did the patients' values, beliefs, desires, and faith impact the care she received?
3. How can we help aging adults in such a situation where they are not willing to accept the change?
4. Can you share an example of a negative health outcome you have experienced or heard about that was influenced by discrimination based on cultural dilemmas?
5. How will you share and apply this information in your personal and professional life?

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Indigenous Community Case Studies

Developed by
Joy Rivera, Division of Indian Works

Scenario 1:
A Native American Elderly man went to the emergency room for a laceration on his head from falling. A young European American ER nurse who was doing his intake asked him the routine series of questions to find out about him and how the accident happen. One of the questions she asked him was, “were you drinking again?” He said no, “I don’t drink.” She asked a second time the same question. He responded the same. She then said, “are you sure.” He said yes. She then moved on to other intake questions.

Scenario 2:
An elder woman and her husband - both Indigenous people - were notified during a visit to the doctors that it was time for her to begin arrangements for a transitional care facility due to her drastic change in health condition. She lives with her husband, and he works full time. The elderly couple is being told she needs full time care and cannot be left alone to care for herself during the day. The doctor told the couple, “I am going to have you speak to our social services representative before you leave today.” Then asked what type of facilities and location would be best for her?

Scenario 3:
An American Indian man was, for the first time, on MNsure after losing his job. He was given a prescription to an orthopedic clinic to get a knee brace. On his first appointment the receptionist looked at her paperwork and said, “you know you can only get one brace every three years on this kind of insurance, Medical Assistance, right? I will have to look up and find out how many you have received.” Other people were listening in the waiting area.

Scenario 4:
An 84-year-old Native Alaskan women was told by her clinic located in a low-income neighborhood and her pharmacy that her insurance would not cover her diabetes medicine. She was using free samples given to her clinic from the pharmaceutical company and discovered that this medicine worked best for her. She noticed how she felt so much better on it and asked her doctor could she stay on it. When she asked why she was denied, she was told the medicine cost too much. She cried saying she did not understand and that she felt like she was not worth expensive medicine.

Scenario 5:
A clearly Indigenous looking male patient of 67 years was waiting to be transported from one part of a hospital to another. When the male transporter arrived to transport him, he said, “Are you ready to go, Chief?” The patient responded, “I am not a Chief.” To which the responder said, “my bad.” The patient never exchanged any more words again with the transporter.

Potential Discussion Questions

1) What beliefs may the providers had about age or ethnicity? Did beliefs or biases impact care?
2) How do you believe race, ethnicity, and culture impact the care the people received?
3) How do people’s bias, values, beliefs, desires, and faith impact their interaction with others?
4) What could have been done differently?
5) Please described the missed opportunities for a more productive and insightful exchanges.
6) What changes can your organization do proactively ensure situations like these are properly addressed?
7) Can you share an example of a negative health outcome you have experienced or heard about that was influenced by discrimination based on the race, ethnicity, gender identity, sexual orientation, or immigrant or refugee status?
8) What can be done to dismantle the processes, systems, and organizational cultures that brings discrimination, harm and at times death to BIPOC and LGBT, and underserved communities?
9) How will you share and apply this information in your personal and professional life?

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Latine Community Case Study

Developed by
Roxana Linares and Yoli Chambers, Centro Tyrone Guzman

Don* Leonardo Candelario Gomez** lived in Mexico with his son Luis. Don Leonardo speaks Spanish at home. His son, Rodrigo, lives in Minnesota and speaks English. Rodrigo is married to Eliana. They have a ten-year old daughter and an eight-year-old son who are very close to Don Leonardo. He helped raise them.

Luis and Rodrigo were worried about Don Leonardo's behavior and memory loss. They talked with Don Leonardo and convinced him to travel to stay with Rodrigo in Minnesota and visit a doctor. Don Leonardo came to Minnesota, but he said he only trusted his doctor in Mexico. It took many conversations for him to agree to see a doctor in Minnesota. When Don Leonardo agreed, Rodrigo made the appointment for the consultation.

A few days later, Don Leonardo answered a phone call at home from the clinic. The message was, "*Usted tiene una cita: Wednesday at ten a.m... Su cita es en: One thousand Parkway Minneapolis*" Don Leonardo told Eliana about the phone call the next day, Tuesday. He did not understand what the machine was saying so he could not tell Eliana. Eliana thought at first the appointment was for her children. She called the clinic, but it was not for them. The next day, Wednesday, Eliana figured out it was the appointment for Don Leonardo, so she called the clinic. After 30 minutes of calling several phone numbers, and being put on hold, she finally talked to a nurse. The nurse told her the appointment was that morning. The nurse told Eliana she should check her online chart and should not be late.

Eliana called Rodrigo and told him about the appointment. Rodrigo would meet them at the clinic. Both kids were at home and Eliana did not have anyone to care for them. Moreover, they wanted to go with grandpa, so Eliana took the children and Don Leonardo to the appointment.

Upon arriving to the clinic, the nurse told Eliana Don Leonardo needed to go in alone. The nurse said it was not appropriate for children to be at the consult for privacy reasons. Eliana explained Don Leonardo did not speak English. She also explained her children were very concerned about grandpa. The nurse

said there was a translator. Eliana felt the nurse was upset with her because she had brought her children, but she could not live them alone at home.

Around 10:30 a.m., the nurse said, "*Gomez*". Eliana tried to understand what the nurse was saying, but she never called her father-in-law by his mother's last name. The nurse came to Don Leonardo and said, "are you Gomez Candelario?" Eliana realized the nurses' mistake and said, "*Yes."* The nurse told them the interpreter was there. The interpreter introduced herself and explained Don Leonardo needed to go in alone. At that point, Rodrigo arrived. He went in with his dad. Eliana waited with the children.

The doctor greeted them, "*Hola Leonardo, buenos días*". At 80 years old, Don Leonardo was surprised by this greeting. He looked at Rodrigo. During the whole visit, Don Leonardo felt very uncomfortable. Don Leonardo felt the interpreter was translating only half of what the doctor said. The doctor was busy with his computer and did not look at him. Don Leonardo also felt they were talking about him as if he were not in the room. He did not feel part of the conversation. Don Leonardo tried to explain he did remember things. It just took him a bit longer. But he could not share this with the doctor.

At the end of the visit, the doctor said: "*Hasta luego, Leonardo*". Don Leonardo told Rodrigo they were never coming back. He felt the doctor did not listen to him. Don Leonardo just wanted to keep on helping at home and being independent. Nothing he heard from the translator made sense to him. Rodrigo tried to talk with his father, but Eliana also said they will manage somehow, but she did not want to go back to the clinic either. She told Rodrigo, "*Other families had taken children and went into the rooms. Why was our family different?"*

It was so difficult for Eliana to see the changes in Don Leonardo, and it took so long to convince him to go to the doctor to get help. Instead, the family felt they were doing everything wrong.
Because of this experience Don Leonardo's diagnosis and treatment was delayed several months.

* *Don – Sir – Used to denote respect.*

** *Candelario Gomez – Candelario is Don Leonardo's father last name and Gomez is Don Leonardo's mother's last name.*

Potential Discussion Questions:

1. How can providers be better at using correct names and family names?
2. How can providers make sure they are being respectful when addressing a person?
3. How can reminder calls be improved? Who should receive the call?
4. As technology becomes more prevalent, how can the use of tools like answering machines and My Chart be made accessible and friendly for all?
5. Should we work on the assumption that every family has access to Internet and is able /willing to use tools like My Chart?
6. How can clinic policies and procedures be made explicit, so staff and families understand what expectations for a visit are?
7. What could the doctor have done differently? The nurse?
8. Individuals with memory loss many times are scared. They feel frustrated with themselves and do not want to accept their memory is failing them. They might deny anything is happening. How can providers listen to both the individual with memory loss and the family member who notices the changes in a respectful way?

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LGBT Community Case Studies

Scenario #1:

Developed by
Phil Duran, Rainbow Health

Melanie is a new resident in the building, and the care coordinator came for a visit.

"Hi, Mel!" the coordinator says cheerfully as she breezes into the room. Melanie winces but says nothing. "You sure have your make-up looking great, but that button-down shirt… I don't know about that! Is that your husband's?"

"Well, no, it's mine," Melanie replies. "Whatever works, I guess," the coordinator says. "We have a great salon day here on Wednesdays… do you need someone to give you a manicure? Let me see those hands!" The coordinator takes Melanie's hand in hers, and her eyes grow wide as she realizes Melanie's hand seems large for a woman.

"Oh, my god! Are you a man??" she cries, loud enough for people in the hallway to hear. She quickly drops Melanie's hand. "No, I'm a woman," sighs Melanie. "Well, I mean, yeah, you have the hair, and the make-up, but… those hands! You're really a man, though, right?"

"I'm a woman," Melanie repeats. "Well, if you have a… well, you know, if you have… *man parts*, we have to make sure we don't assign that bed over there to a real woman, because there's all sorts of policies about that. So do you?"

"I really don't want to answer that," says Melanie, as another woman enters the room. "Hi, Melanie," the visitor says, "Getting all settled in?" The care coordinator pipes up, "Why hello – we were just getting acquainted! And who are you? His sister?"

"No, I'm Susan, *her* wife," came the reply. The coordinator takes a deep breath. "I just don't know about any of this. We have standards here, you know! I'm going to go speak to the director!"

Potential Discussion Questions

1) How did personal biases or beliefs impact care?
2) How do you believe gender, race, ethnicity, and culture impact the care the people receive?
3) How do people's bias, values, beliefs, desires, and faith impact their interaction with others?
4) What could have been done differently?
5) Please described the missed opportunities for a more productive and insightful exchanges.
6) What changes can your organization make to proactively ensure these situations are addressed?
7) Can you share an example of a negative health outcome you have experienced or heard about that was influenced by discrimination based on gender identity or sexual orientation?
8) What can be done to dismantle the processes, systems, and organizational cultures that brings discrimination, harm and at times death to LGBT, and other underserved communities?
9) How will you share and apply this information in your personal and professional life?

Scenario #2:

Taken from
Training to Serve (now Rainbow Health) LGBT Older Adults Education Curriculum

Merilee Weathers is a short-term resident at the nursing home you manage. She is a male-to-female transgender person who has not had gender confirmation surgery (also known as sex reassignment surgery). She will be sharing a room with another resident.

Potential Discussion Questions:

1. Will you place her with a male or female roommate?
2. What, if anything, do you tell her roommate?
3. What do you tell the staff members who will be assisting her with baths and other personal hygiene activities?

Scenario #3:

Taken from
Training to Serve (now Rainbow Health) LGBT Older Adults Education Curriculum

You are a male home health aide taking care of Joe, a frail 86-year-old male client who was never married. You provide personal cares to Joe for several hours and bathe him three times a week. Joe is pleasant but gets confused due to memory loss. You often have to remind him to do things and often have to help him out. One day, while drying him off after a bath, he puts his arms around you and plants a somewhat passionate kiss on your lips. This takes you by surprise.

Potential Discussion Question:

1. How do you handle the situation?