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How We Care: Provider Perspectives on Services for Vietnamese Elderly in Boston's Dorchester Neighborhood

Loan Thi Dao

An Occasional Paper

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How We Care: Provider Perspectives on Services for Vietnamese Elderly in Boston's Dorchester Neighborhood

Loan Thi Dao

Abstract

The need for culturally competent care for the elderly is of growing concern for Asian American and Pacific Islander (AAPI) communities and health providers. In 2012, a preliminary study was conducted to ascertain the perspectives of service providers about the cultural competency of services for elderly Vietnamese Americans in Boston, Massachusetts. The study includes interviews with key informants representing the five major community health centers (CHC) programs in Boston's Vietnamese enclave in the Dorchester neighborhood. Secondary data collection from field observations and informal communications with other staff and elderly clients also inform the findings. While the study recognizes the value of existing services, critical needs remain unmet in terms of resource allocation, client tracking, bicultural staff training and recruitment, targeted developmental activities for Vietnamese aging populations, and clear programmatic evaluation measurements. The study highlights the need for further research on cultural competency models and best practices for aging immigrant minority populations in Boston like the Vietnamese in Dorchester.

Introduction

On November 15, 2013, a local news outlet in Boston produced a story on a Vietnamese American woman's difficult choice about how to care for her elderly mother. The story focused on the emotional and cultural challenges of sending elderly parents to assisted living facilities, but it also addressed the broader questions of how Asian American adult children must navigate between the cultural generational obligations of elderly care, and the financial and logistical challenges in American urban society. At the Standish Village assisted living facility in Dorchester, Carol Doan is noticeably the only Asian elder in the common room. According to journalist Christina Quinn, "Carol isn't hard to find. As the only Vietnamese resident among a sea of mostly white faces at Standish Village, she stands out. 'I speak with accent, so they can't understand me,' Carol said" (Quinn, 2013).

The daughter, Quynh, feels compelled to explain her perspective: "My father had been taking care of my mom... She has diabetes and has trouble walking. So when my Dad died, my mom lived with me for a short time. I was leaving her at home, and she was falling and burning food. I didn't even know about assisted living. I just thought there's nursing homes. Assisted living was just something we didn't plan for..." (Ibid.). Quynh goes on to explain the emotional guilt she had to overcome: "Because I'm Vietnamese, and that is what we do... And so I grew up with all these stories about parents sacrificing taking care of their kids, and kids growing up and taking care of their parents.

And the idea of adulthood and independence is not growing older and moving away from your family. It's growing older and taking care of your family" (Ibid.).

The article then asks the local community organizational representative, Nam Pham, to further explain the challenges for immigrant families in the U.S.:

There is a lack of assisted living facilities in Massachusetts that cater specifically to the Asian community. Though most families in Asian communities typically assume the caretaking role of their parents, the cultural landscape is shifting, says Nam Pham, executive director of Viet-Aid, a community development corporation in the Fields Corner section of Dorchester. 'Life in America is very busy for everybody,' Pham said. 'Also, we no longer have such an extended family support as we do in Vietnam. Family is scattered in cities and the country. So it's almost impossible for one or two persons taking care of elder parents.' (Ibid.)

While this paper does not focus on the question of assisted living directly, a central concern that Quynh Doan and Nam Pham raise is critical to how this adult generation of Asian Americans attempts to fulfill its generational "promise" to its elderly. It demonstrates the challenges of finding culturally competent/sensitive services for elderly Vietnamese in many cities across the country, and it emphasizes the potential sense of isolation and onset depression that is understudied in the Vietnamese American elderly

population. The reproduction of a culturally appropriate, communal environment that is similar to how people age in their countries of origin is a priority for many of these families. The right of these elderly communities to have access to culturally competent care is a policy priority all stakeholders must consider.

Literature Review

There is a growing body of health-related literature that is ethnic-specific or addresses comparative ethnicities for Vietnamese elderly, but few studies explain the landscape or assess the services for Vietnamese elderly in the northeastern U.S. (Tran et al., 2013; Chappell & Funk, 2012; Sun, Ong & Burnette, 2012; Bei, Lombardo, & Chang, 2010; Yee, 2009; Liu et al., 2008; Wallace et al., 1998). Existing studies approach health behaviors of the community, or examine the services provided upon refugee resettlement for community development (Scott, 1989; Hein, 1995; Robinson, 1995). They have provided insightful sociological and quantitative evidence of the role of community-based institutions in creating non-cash security nets, advocacy, and political representation for the community (Igasaki & Niedzwiecki, 2004; Boat People S.O.S., 2010; UC Irvine, 2013).

Access to the services of community-based institutions is critical to the sustained health and well-being of community members. However, little is known about social support networks of Asian immigrant populations, specifically on Vietnamese American elderly, that connect them to these services.

The few studies conducted on Asian Pacific Islanders have focused on how social support networks impact cancer screening health behavioral choices (Levy-Storms & Wallace, 2003; Honda & Kagawa-Singer, 2006), but they have suggested compelling potential for further inquiry. First generation elderly immigrants may provide a new map of how social networks are structured and levied in the process of immigrant adaptation and acculturation (Gellis, 2003). Berkman and Glass (2000) stated that studies on “issues related to cultural, ethnic, and class-related variations in the structure and function of networks will help us to develop critically needed interventions to improve health” (165). The findings from this study focus on community health centers (CHCs): not-for-profit and for-profit centers that provide broad health services and social services for a geographically specific clientele. Because the Vietnamese American population is concentrated in Dorchester, and many elderly who no longer live there still return for services because of the social support networks they offer, these CHCs tend to have Vietnamese-specific programs where 100% of the clientele identify as Vietnamese. The focus of this exploratory study is on the cultural competency of these programs from the perspective of staff.

This study uses the concept of cultural competency set forth by the U.S. Department of Health and Human Services’ Office of Minority Health. Findings are organized by the factors of recruitment and retention; geographic accessibility; bilingual and bicultural staff; services rendered; culturally

appropriate meals, materials, and activities; social well-being and mental health; and measuring success. While each section provides specific suggestions, the article concludes with broader recommendations and areas for further research.

Cultural Competency

The American Psychiatric Association's Council on National Affairs minority committee has raised concern that, since they are not "within the cultural mainstream of service needs and delivery," minority elders "have not received adequate attention in either clinical studies or practice" (APA, 1994, 1). One major challenge to services for elderly immigrant populations is creating accessible and culturally sensitive environments and products that will make the population feel safe, validated, and communicative. The Department of Health and Human Services Office of Minority Health defines culturally competent care as follows:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

"Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

"Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989). (Office of Minority Health, 2012: <http://minorityhealth.hhs.gov>)

Cultural competency thus includes, but is not limited to, bilingual staff, translators, and materials for the client population. In contrast, the Federal Government defines linguistic competence as the "skills to communicate effectively in the native language, or dialect of the targeted population, taking into account general educational level, literacy and language preferences" (OCR-DHHS, 1999).

Culturally and linguistically competent models take into consideration the client's health and belief systems, how the client perceives illness, and their attitudes toward health care services and providers (OCR-DHHS, 1999). In doing so, providers communicate effectively with the client without the cultural limitations, or "blind-ers," that preclude them from creating the best possible health and wellness outcomes for the client (Ibid.). The overall issues regarding elderly care must be understood through the lens of family and community rather than individual services and education (Bei, Lombardo, & Chang, 2010; Chappell & Funk, 2012; Fei, Ong, & Burnette, 2012; Wallace et al., 1998). The findings offer a preliminary view of the extent to which Dorchester's service providers consider cul-

turally competent care in their locations, staffing, and holistic services.

Methods

After identifying CHCs that serve Vietnamese American elderly in Dorchester (see Table 1 on page 11), I conducted formal semi-structured interviews and follow-up interviews, for approximately two hours each, with five organizationally designated representatives from the programs over a span of four months in the fall of 2012. These program staff served as key informants to the circumstances and needs of both the elderly community and the service providers. The agencies chose these individuals as representatives to speak on behalf of the CHC because they held leadership positions within the programs that specifically serve Vietnamese elderly in Dorchester. Each person had been employed at or overseeing their programs for two to ten years. Pseudonyms have been used to protect the identity of the staff and their affiliate organizations.

In addition, I spent two days a week at each site over the course of four months to observe activities. During these visits, I observed the arrival, attendance, participation, interaction with peers and staff, health services, and departure of the clients from the centers. Over the course of the observations, ten additional general staff in the organizations, and occasionally elderly clients, spoke informally with me during my observations, though they were not authorized to represent the organizations. While they are not quoted directly, these conversations greatly informed the observations and

analyses. These interviews, informal conversations, and observations provide a foundation for research questions in future studies on cultural competency services for Vietnamese and other immigrant elderly communities.

Areas of inquiry included a) recruitment and retention methods, including estimated numbers of Vietnamese elderly they serve per month or year, estimated number of Vietnamese elderly they estimate return, and frequency of returning visits; b) the kinds of services provided; c) cultural competency of the services (translated materials, interpreters, cultural sensitivity, etc.); and d) measurements of success. Every section concludes with recommendations for improvement based on observations, informal conversations, and formal interviews that document staff perceptions of the main challenges facing service providers for this population.

History of Vietnamese Migration to the United States

The U.S. intervention in Viet Nam has been well documented, from its economic investment in the French-Indochinese War between 1945–1954, and its indirect participation through multi-lateral negotiations and special forces training between 1954–1964, to its direct military involvement between 1964–1975. This long history of U.S. involvement in Viet Nam and its ongoing relationship with the South Vietnamese government and military over those decades led to its critical role in refugee resettlement at the end of the war in 1975 into the next

two decades.

Generally, we can divide the mass migrations of refugees from Viet Nam into four major cohorts. 1975 marked the first and largest immigration to the United States. The majority of people in this cohort had some formal education, some knowledge of the English language, and lived in or near large cities. People who worked with the American embassy, businesses, or military, or in the pre-existing Southeast Asian government or military, had more access to escape routes. In total, over 120,000 Vietnamese fled in 1975 to the U.S. Between 1979 and 1986, the second cohort of refugees streamed into the camps and to third-country resettlement. The majority of people in this cohort from Viet Nam were individual migrants (not families), ethnic Chinese, and had relatively more women and unaccompanied minors than the first cohort. Not only had they experienced the trauma of protracted war and violence inside refugee camps, they witnessed their countries undergoing extremely drastic shifts in every fabric of social, cultural, political, and economic life. The transition into American life tended to be more challenging during this period as refugee assistance and government safety net programs were drastically reduced throughout the 1980s (Chan, 1991; Hein, 1995; Robinson, 1995).

In 1989, the United States enacted the Comprehensive Plan of Action after immense pressure from the international community. The plan called for three main categories of (mainly Vietnamese) refugees to be screened and prioritized for immigra-

tion to the U.S.: AmerAsian children (Vietnamese children born to one American citizen parent, usually military personnel), relatives of refugees currently residing in the U.S., and former Republic of Viet Nam soldiers and personnel, many of whom had been incarcerated in re-education camps post-1975 (Robinson, 1995). Since 1992, the migration processes have resembled normative immigration processes rather than refugee migration for earlier cohorts. Family reunification, marriage, employment, and education have been the major reasons for immigration from Viet Nam to the U.S. over the past twenty years. Most elderly Vietnamese who immigrated to the U.S. in the past twenty years have been admitted under family reunification provisions with sponsorship from their adult children.

2010 Data on Vietnamese in Massachusetts and Boston

According to the 2010 Census, there are 1,737,433 Vietnamese Americans in the United States. While Vietnamese Americans' median household (\$52,511) and family (\$56,958) incomes are generally reflective of the overall U.S. population (\$50,046 and \$60,609 respectively), Vietnamese per capita income is \$19,987 compared with \$26,059 overall. 66.7% of Vietnamese in the U.S. are foreign born. Vietnamese American seniors (ages 65 and over) constitute 12.5% of this population, and 51.5% of the seniors report they speak English "less than very well," compared to 8.7% of seniors in the general population. Of Vietnamese American seniors, 17.9% report living at the Federal

Poverty Level, almost twice that of all Americans 65 years and over (9.0%) (Boat People S.O.S., 2010; SEARAC, 2011).

In Massachusetts, there are 47,636 Vietnamese Americans, a 30% increase since 2000. 11,670 Vietnamese Americans live in Boston, with 70.4% foreign-born, and 27.6% of this percentage arrived after 2000. Consequently, a large majority (67.2%) reports that they speak English “less than very well.” The median income is \$32,969 for Vietnamese in Boston, and the per capita income is \$14,268. The income brackets translate into relatively high poverty rates at 32.8% for families and 36.3% for individuals (Lo & Tran, 2012). Dorchester’s population is 31,785, with 13.3% (4,231) identifying as Asian, and the majority of those being Vietnamese (BRA, 2012). Dorchester has the highest population of senior citizens over 65 years in the city, at 8.4% (2,656) of the general population (Ibid.). Maps 1 and 2 (pages 12 and 13) show the population of Vietnamese elderly in Dorchester within the 2010 census tracts.

Census data in Map 1 shows the most populated Census tracts for Vietnamese males and females ages 65 and over living in Dorchester (n=716) (U.S. Census Bureau, 2010). The most populated tracts are along the only subway line and major thoroughfare, Dorchester Avenue, where there are major bus lines. The most populated areas are between the JFK/UMass, Savin Hill, and Fields Corner subway stations. Map 2 identifies Vietnamese elderly who live alone and by gender (blue for male and red for female). According to these Census tracts, there are almost twice as many females (n=83) as

males (n=53) who report living alone, totaling 136 (Ibid.). The distribution of residents is concentrated in the north end of Dorchester, near the Andrew subway station, and further south, between the Shawmut and Ashmont stations, rather than in the epicenter of the Vietnamese business and social services, because these tracts tend to have more affordable housing opportunities.

Findings

Service Model

Recruitment

There were two main methods of recruitment for all programs in this study. The first and more formal in structure was through Massachusetts Health (the state health insurance plan) and insurance companies. In some instances, the insurance provider stipulated that the elderly client must join one of the CHCs in order to receive benefits. If a case manager from an insurance company identified the need for and financial eligibility for bilingual services, then they referred the client to the organization. Over 75% of clients for each CHC were introduced in this manner.

The second major channel for recruitment of clients was through word of mouth amongst community members. CHC representatives cited social networks of extended relatives, church communities, and friends and neighbors as creating a major incentive for elderly to enroll in programs. Once community members were satisfied with the services they were receiving, they actively recruited their social networks to enroll. The

use of social networks in elderly populations has proven effective not only in recruitment, but also in educational outreach, cultural brokerage, and creating support systems through community building.

Referrals

Many Vietnamese seniors were not aware of the discounts, special services, or rights available to them, and they often did not understand the forms and documents that they must complete to access or advocate for these services and entitlements. Once staff members identified the needs of their elderly clients, they would make referrals to specialized physicians, agencies, or businesses that could more specifically address each client's needs. For example, all the CHCs refer their mental health cases to a bilingual psychiatrist in the neighborhood. Referrals also were a critical point of advocacy for the client to receive special attention and care at businesses and other agencies that might otherwise overlook or misunderstand their needs without the introduction of a cultural broker. For instance, Devoted Healing specialized in having staff conduct in-home care visits to assess the status and address the needs of their clients.

The remaining CHCs provide educational workshops on topics such as domestic violence, housing access and rights, and mental and physical health care, in which they bring in speakers to introduce to the elders. These educational workshops function as a type of referral in that the elders have opportunities to learn, ask questions, and build relationships with the speakers.

The staff reported that having the partners come to the CHC legitimizes the partners, and the elderly will feel more comfortable accessing their services and asking for help in the future.

Subcontracts

Given the large percentage of elderly Vietnamese who live under or near the federal poverty level, as well as who live independently, proper nutrition and home-cooked meals were very important to maintain. FlexCaring did not provide home-cooked meals for seniors, and AbsolutelyHealthy and BygoneBetter outsourced their meals to a local catering business. This catering business lost its operating license, and these centers could only provide internally cooked meals, which are distributed to all affiliate sites and thus not culturally specific to clients at any particular site. LiveLights was the only organization where the staff prepared Vietnamese meals in the center's kitchen. Devoted Healing also subcontracted meals to be delivered to the homes of their clients as requested by clients, and again, these meals were not culturally specific. They also subcontracted various in-home services, such as cleaning companies to clean the residences of their clients, but as one representative observed:

You see there is a lot of dust or dirt and you feel like it needs to be cleaned every once in a while but they like the way it is, "Don't touch my stuff." You know old people, they like to keep things the way it is. I would recommend them to clean

once a month, but some of them just don't trust homemakers to come into the house and clean. There are situations where some of them would be like, "Oh I lost some some stuff" or "Somebody stole this and that." The trust thing is really hard for the elders. (Huong)

This service exemplified the challenges of subcontracting. While the services are greatly needed, clients are reluctant to accept those services by non-Vietnamese speaking staff of businesses that are not culturally sensitive and familiar to the elderly clients. This predicament often precludes the elderly from asking for help or accepting services available to them.

Partnerships

The five programs provided health and nutrition services for clients in varying forms. FlexCaring hired physicians, social workers, and two psychiatrists at full and half time to work at their center and offer direct services to patients in addition to offering referrals to private practices. To ensure culturally competent care for non-proficient English speakers, they hired translators in Vietnamese and other languages to accompany patients on the appointments at the patient's request. If no translator was available, the center had access to a national phone-in translation service. For LiveLights, AbsolutelyHealthy, and BygoneBetter, there were one to two nurse practitioners, none of whom were Vietnamese speakers, on site to administer medication, check vital signs, conduct rou-

tine assessments of client health, and recommend external medical care as needed. Devoted Healing depended on their partnerships with FlexCaring and local hospitals to provide medical care for their clients.

The agencies did not cross-reference clientele with the other CHCs in the area, so it is beyond the capacity of this study to determine the extent to which the clients were receiving duplicate services and the agencies were simply serving a small population that was being referred between agencies. Conversely, the agencies also could not confirm the extent to which the community at large was being served by all the CHCs based on their client lists unless the lists were cross-referenced against other organizations.

Recommendation

A wraparound model of services might work well for this relatively concentrated set of providers. The wraparound model allows for continual coordination between providers, individuals, and families, with the expressed goals of keeping the individual in their community and providing individualized holistic services for every part of their lives in ways that no one organization can (Walter & Petr, 2011, 74). In addition, the model reinforces a sense of family and community for the individual by flexibly and creatively using both formal services and "natural support" (one's social networks) in collaboration. It provides outcome-based services that can document and maintain accountability: "outcomes must be determined and mea-

sured for the system, for the program, and for the individual child and family” (Ibid.).

Geographic Accessibility and Facilities

Community Health Center Locations

A critical component of the programs is the physical accessibility of the organizations for elderly Vietnamese clients, the majority of whom do not drive or have access to personal transportation. The most common methods of transportation for this population were walking and getting rides from adult children or relatives. Most Vietnamese businesses and services, such as grocery stores, restaurants, coffee shops, clothing stores, and insurance offices, as well as the elderly care programs in this study, were strategically located along Dorchester Avenue, shown in Map 3 (page 14). The elderly had to still walk significant distances from the subway lines to some service agencies, and this was a major obstacle in inclement New England weather with extreme cold in the winter and high temperatures in the summer.

All the elderly service organizations provided transportation options within certain geographical perimeters. Their contracted passenger vans picked up elderly clients from their homes early in the morning, took them to the CHC, and drove them back to their homes at the end of the day. While this was an indispensable service that helped sustain attendance and retain membership, for some elderly, the dependency and restrictions of time for pick-up and drop-off felt constraining. Others could not

access the shuttle because they lived too far from the CHCs due to the fact that their adult children had moved the family into more economically stable neighborhoods. Devoted Healing did not provide any of these services, as they only offered case managers that performed home visits. Elderly who lived with their adult children were homebound until the children were available to take them out, usually in the evening or Sundays. All interviewees stated that elderly clients felt isolated and confined to their homes except perhaps once or twice a week when they could accompany their family members on errands and other collective family activities. They rarely had the freedom of movement, especially in the winter months, to travel locally for social and other reasons that prioritized their own desires and needs.

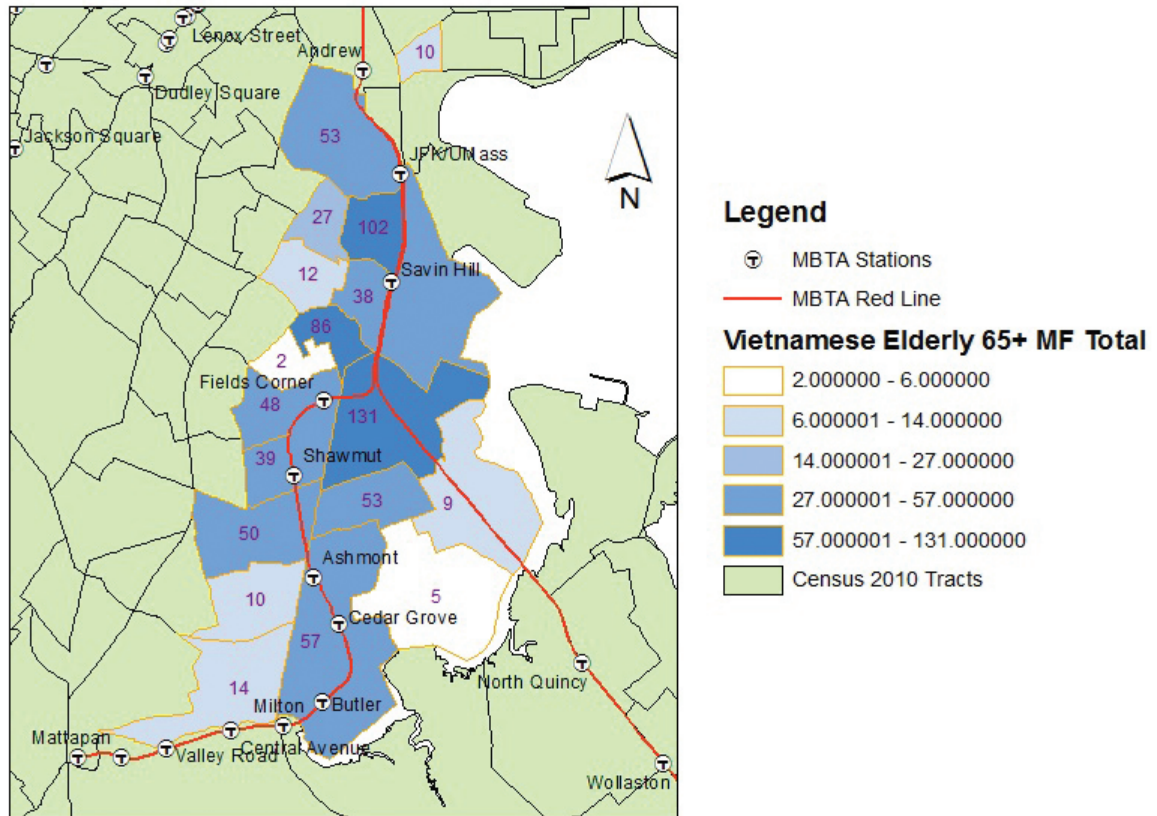
Facilities

The facilities for the programs were located in one large room, ranging from 2000–3,500 square feet, where multiple activities occurred throughout the day. There were no walls between most of the rooms to separate activities, with the exceptions of separate small rooms where the nurses met clients to secure privacy for medical meetings, and administrative offices for staff. While the staff believed the large rooms allowed them to watch the elderly more easily, they admitted that it could become a distraction for individuals who were more introverted or trying to concentrate on certain enriching exercises, such as memory-building. Informal conversations with clients also

Table 1. Community Health Center Program Profiles

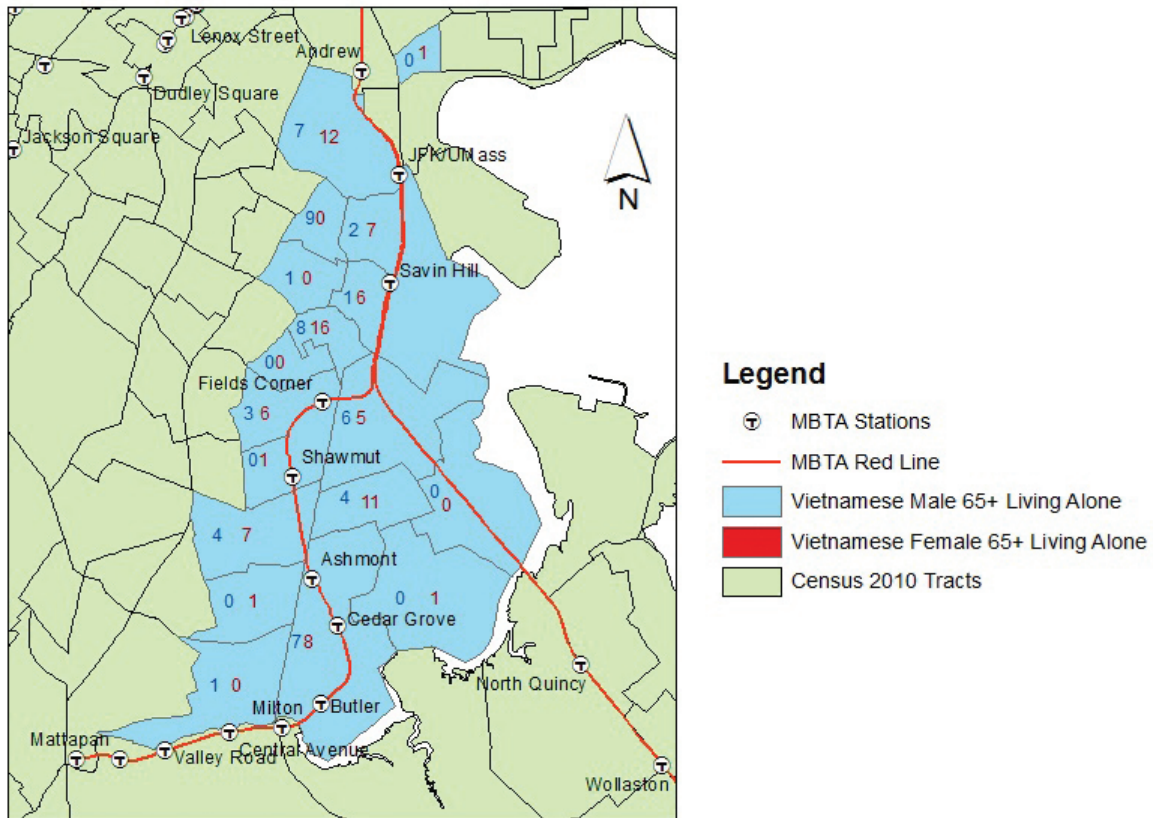
Pseudonym	Years of Service	Number of Elderly Served	Transportation	Physical Health Services	Mental Health Services	Social Services	Bicultural Programs & Activities	Bilingual Staff
FlexCaring	40+	4,000/yr	Buses, shuttle	On-site	Referral	Referral & Translation	Translation only	Yes
LiveLights	20+	30-40/day (5-day)	Buses, shuttle	Nurse on-site only	Referral	Translation	Yes	Yes
Absolutely Healthy	40+	15-20/day (5-day)	MBTA, buses	Nurse on-site only	Referral	Referral & Translation	Yes	Yes
Bygone Better	40+	35-40/day (5-day)	MBTA, buses	None	None	Ad hoc translation	Yes	Yes
Devoted Healing	40+	60/case manager (1 for Dorchester)	N/A—home visits by case managers	Referral	Referral	Referral & Translation	N/A	Yes

Map 1: Vietnamese Aged 65+ in Dorchester, MA by 2010 Census Tract



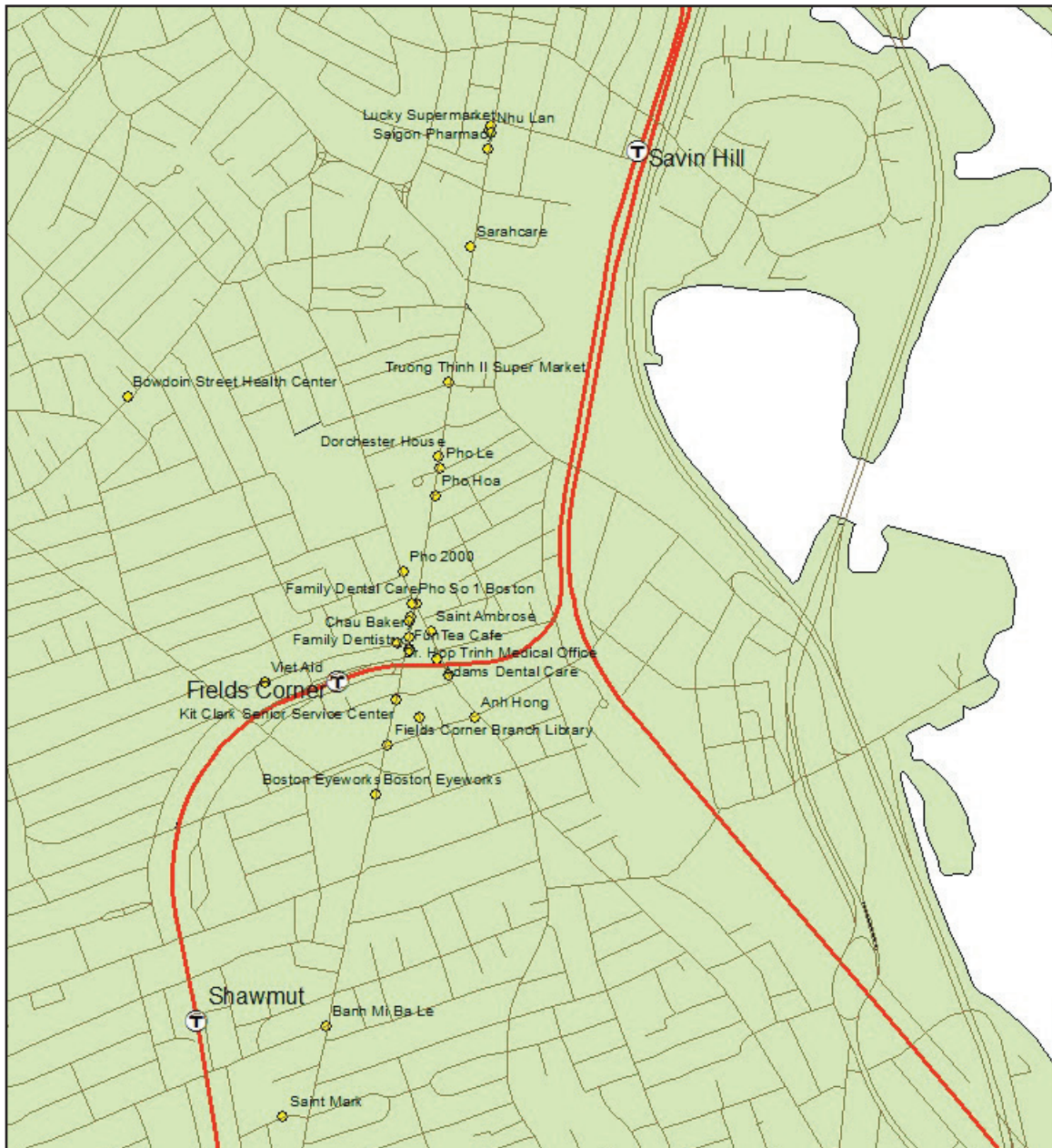
United States Census Bureau. (2010). American Factfinder.

Map 2: Vietnamese Aged 65+ Living Alone in Dorchester, MA by 2010 Census Tract



United States Census Bureau. (2010). American Factfinder.

Map 3: Sample of Vietnamese Services and Businesses, and Public Transportation in Dorchester, MA, 2012



Data compiled from Vietnamese Business Directory 2012 by Vincent Huynh.

suggested that they wanted a change in their physical environment rather than sitting in the same room for 6–8 hours a day. These rooms were either free-standing facilities or in separate locations from other programs at a CHC facility. FlexCaring was the only place with integrated programming that offered elderly different activities throughout its expansive building. As such, the clients moved throughout the building, interacted with different people throughout the day, and were aware of other events and services the center provided for the general population.

Recommendation

The CHCs could improve their transportation services for their elderly clientele in two ways. First, the elderly who are farther away from the Vietnamese center of Dorchester are more likely to need transportation services to participate in these programs. Expanding the geographic limits of shuttle services for current and potential clients could target the more isolated and underserved individuals of this population. Secondly, offering transportation in multiple shifts throughout the day would increase the clients' desire to go to the centers more regularly without feeling confined there all day. It would also address the responsibilities that some elderly have to come home early to care for grandchildren, which some said was a constraint to their participation.

Space is often overlooked in evaluations of elderly care. The CHCs need more physical space for multiple and diverse activities, and any physical space for elderly care ser-

vices need not be isolated from other kinds of community centers and programming. The increased facility space potentially offers more opportunities to have a greater variety of activities on a daily basis for elderly, and to help them feel less confined. Being located in a larger physical space with multi-use community functions would increase the potential for inter-generational interactions, improving the mental health of seniors (Zhan, 2004) and providing an essential connection to ethnic heritage for youth if programming encourages such an explicit dialogical relationship.

Bilingual & Bicultural Staff

Four of five staff members interviewed identified as 1.5 generation Vietnamese American, arriving in the U.S. at or before adolescence, and one identified as Euro-American. The four were bilingual and could easily linguistically as well as culturally transition between Vietnamese and English. They also spoke in regional accents and used vocabulary that is familiar to the majority of Vietnamese elderly from the pre-1975 period. Informal conversations with six other staff at the four site-based agencies showed that they had very similar backgrounds to the interviewees. Two staff at one agency were older women, newly immigrated within the past five years. There were no second generation Vietnamese Americans working at these organizations.

None of the Vietnamese Americans had formal training working with elderly populations. The bilingual/bicultural staff hired at the sites seemed to be hired for their lan-

guage and cultural skills, rather than their educational background or professional training in working with elderly populations. In fact, most of the health professionals and the staff who did have professional training in elderly care were not bilingual in Vietnamese or bicultural. The lack of training that is culturally competent within immigrant communities potentially leads to problematic experiences and lower quality of service for monolingual elderly groups (Davis & Smith, 2013; Gany et al., 2013; Lau et al., 2013; Morrison et al., 2012).

One challenge was the recruitment of Vietnamese Americans who have both the linguistic and cultural aptitude and the professional training:

We don't have a lot of social workers who are interested in doing this kind of work because, first thing is the salary is not very high, secondly the younger Vietnamese adults growing up from this country, they don't have the communication with the seniors. Especially the Vietnamese seniors, young adults must understand at least the culture, understand about what the senior needs, even at home young adults and their parents they still have a conflict. So if we have more Vietnamese social workers, then that will be very helpful and convenient for Vietnamese seniors who need help. (Huong)

While much training exists for non-native English speakers to become caregivers to English-speaking clientele, there is still a gap

in training for clients who are non-native English speakers and/or hold different cultural value sets. Davis and Smith (2013) have noted that "It is reasonable to surmise that cultural orientation to aging and dementia plays some part in ways that direct caregivers may objectify residents" (26). The social stereotypes that assume Asian Americans do not access elderly care services, as well as the real practices of filial obligation, have played a role in the oversight of training modules addressing cultural competency for this population. The growing need for elderly care in populations like Vietnamese Americans call for increased culturally competent multilingual professional development for staff at all levels (Boughtwood et al., 2011).

The staff also expressed a desire for continued professional development and training. For each of the organizations, the mixture of Vietnamese-speaking and non-Vietnamese-proficient staff meant that there was a great deal of dependency on the Vietnamese-speaking staff to be the cultural brokers within the organizations. Though CHCs did not provide added compensation to the staff for their bilingual and bicultural skills, they performed additional duties on behalf of other staff on a daily basis. Examples they gave included written and oral translation, interpretation of behaviors, communication with families, and accompanying clients to doctors' visits. The Vietnamese-speaking staff perceived lack of acknowledgement for their specific cultural and linguistic skills. To them, this communicated the centers' poor understanding of the

importance of culturally competent services to their clientele.

Recommendation

The specific skills needed for particular kinds of services, such as mental health, legal or court document interpretations, or home care and home visits, need more than literal translation. In difficult circumstances, such as interventions on domestic violence, they also require clarity on cultural nuances of services to communicate relevant information with sensitivity to the clients and their families (Boughtwood et al., 2011). Merely hiring bilingual staff is not enough. Staff must be continually trained, and given education on various topics that concern the target population. Culturally sensitive and knowledgeable staff must be hired and developed to address the various issues that might arise with their clients. While sending staff to in-person, group trainings would seem most effective, there are basic tools that staff may be trained with in-house, such as the American Psychiatric Association's Ethnic Minority Curriculum. These findings suggest that a leadership pipeline in this field of work needs to be institutionalized. Once in place, the stakeholders who provide monetary backing for these programs need to be responsive to the needs and the issues that staff observe in their daily interactions with Vietnamese elderly.

Services

The CHCs in this study offered three main categories of services: legal, social, and men-

tal health and well-being. The social services that these groups offered included interpretation, translation, and assistance completing forms for entities such as insurance companies, utilities, and government housing. As detailed in subsequent sections, health care concerns included preventative care, hospital and specialist referrals, transportation, and translation. The organizations advertised holistic well-being, including encouraging healthy diet, and supporting positive physical and mental health for Vietnamese American elderly as priorities in their programming.

Legal

Three of the programs provided referrals or assistance with legal matters, particularly immigration and citizenship applications. Interviewees reported that access to comprehensive care is directly linked to legal status for many Vietnamese elderly. Census data reports that over 50% of Vietnamese elderly in Massachusetts are noncitizens (BRA, 2012). Without citizenship, they do not have access to full health care benefits from the government. Many elderly have to travel back to Viet Nam to live up to six months out of a year in order to survive within the meager financial assistance provided for them as non-citizens. These individuals tend to have their healthcare needs met in Viet Nam. Because the extensive time they live abroad disqualifies them from the criterion of living in the U.S. for five consecutive years or more, even those who can pass the citizenship test may not be eligible. While the services provided to assist

clients with visa and citizenship applications are tremendously important to their access to more government assistance, this fundamental problem remains unresolved.

Social: Meals, Materials, Activities

The programs made concerted efforts to create comfortable environments and activities for the elderly at the sites. Devoted Healing did not offer activities or sites where one could make this assessment. Three of the four remaining programs had bilingual Vietnamese information and cultural references on their walls. One program used the room of another organization, which is a multi-use space, and could not post anything on the walls. All agencies with on-site programming had generic activities like Bingo, board games, arts and crafts, and field trips to museums.

FlexCaring, whose larger facility allowed for more diversity of physical activities than the others, also had a Vietnamese elderly person teaching yoga, meditation, and swimming to elderly peers, and provided staff who conducted workshops on health and nutrition once a month in English. Four programs provided culturally specific activities, such as karaoke in Vietnamese, visits to Asian grocery stores, and discussions about current events led by a Vietnamese-speaking staff person. However, the staff reported a lack of materials for Vietnamese elderly with dementia, such as Vietnamese language software for memory activities on the computer, and observations noted a similar lack of activities that targeted specific needs of Vietnamese aging populations. Even more

crucial, specialized Vietnamese meals were lacking at two agencies, and staff reported that some clients would refuse to eat lunch as a result. Overall, staff felt the leadership of the CHCs did not comprehend the full impact that the removal of such services, like meals or field trips, had on the elderly.

Mental Health and Well-being

Mental health care was the most underserved need for Vietnamese elderly that all interviewees expressed. Vietnamese Americans generally believe that only severely mentally unstable and non-functioning individuals should access mental health care. Interviewees and other staff believed that this becomes even more pronounced in regard to their elderly clientele. Interviewees stated that depression was the most obvious mental health issue among this population. While the social activities and attendance of clients at the sites help alleviate a sense of isolation and increase feelings of belonging in the United States, providers reported that the elderly Vietnamese suffer from symptoms of depression due to migration to the U.S., lack of acculturation to American lifestyle, unhealthy relationships with adult children and other relatives, loss of spouses and friends, and fear of death. Staff identified signs of depression such as social and/or linguistic isolation, unusual sleep patterns, lacking companionship, longing to return to Vietnam, and problems acculturating to the U.S. Unfortunately, the cultural stigma about mental health assistance and therapy was the leading cause for a lack of initiative and willingness by clients to visit

mental health professionals, according to staff. The lack of bilingual and culturally competent mental health professionals only exacerbates the problem.

Senior citizens living alone are especially vulnerable, particularly the ones who have very little social interaction with others throughout the day. Vietnamese elderly tend to feel more isolated due to a lack of transportation and linguistic isolation. Just the physical space to congregate, see their peers, and have a sense of belonging to a communal, culturally familiar environment can be immensely therapeutic to this vulnerable population. Phuong shared:

I think because of the language and culture barrier, in order to acculturate, to blend in, I can see an increase of depression among the elderly because of that. They feel frustrated that they can't speak their language. They have to depend on their children or someone to take them to doctor's appointment or just to places. So it's very frustrating, for them.

So that's why some of them say that it's more ideal for them to move back to Vietnam because they speak the language and they can go to places, do their own thing, but here because of the language issue, they feel like they can't do anything. They feel frustrated.

On top of that, because of their pride, they don't want people to know that they are depressed or that they really need help. (Phuong)

Phuong is expressing the lack of control and the powerlessness that her elderly clients feel as a result of immigration. Restrictions on movement, communicating one's needs, and finding social outlets lead to a sense of dependency on others, particularly one's children. The role reversal between children or grandchildren and the elderly can have a profound impact on their mental and emotional well-being.

The inability of elderly Vietnamese to name and address their symptoms resulted in a failure to seek help. Interviewees stated that, while the social activities and attendance of clients at the sites helped alleviate a sense of isolation and increase feelings of belonging in the United States, many elderly continued to show symptoms of chronic depression that might be triggered by reminders of past war or other traumatic experiences. Huong stated:

When I ask them, "Oh are you sad, is there something bothering you?" they say, "No, I'm OK. I'm fine." But then once I go back and look at the medications, a lot of them are taking antidepressants and sleeping pills to help them sleep...

There are some consumers that will tell you, "I am stressed every day, I think about this I think about that." And due to post-traumatic stress disorder, they tell me about traumatic memories they think about from the war or their refugee migration and they can't stop thinking about... (Huong)

All organizations identified social interaction as a cornerstone of their services in elderly care, and centralized the coordination of culturally competent activities for their clients. FlexCaring provided elderly physical exercise courses for the clients that were taught by one of the seniors. This peer-to-peer education allowed elderly people to see someone of the same age group as vibrant, active, and in leadership—a role model who represented an alternative narrative to common stereotypes of senior citizens.

LiveLights, AbsolutelyHealthy, and BygoneBetter did not have separate programs or courses for physical activity or social interaction. Instead, there were designated time slots set aside for different types of activities in their one large room. For example, they read the news—local, domestic, and international from Viet Nam—to the clients to stimulate discussion, and they provided activities such as karaoke in Vietnamese, cards, board games, and arts and crafts. They also provided field trips to Vietnamese grocery stores, shopping, museums, and other sites. The elderly signed up for field trips voluntarily, and the centers provided transportation for the trips.

Another major issue that providers observed amongst their clientele was domestic violence. Elderly Vietnamese may be targets of domestic violence from their spouses, family members such as adult children, or hired in-home care-givers. Staff recommended that elderly Vietnamese be educated on how to identify abusive behavior towards them, what their rights are, what

their options are for getting help, and what the process and potential consequences are. One informant expressed concerns about the need for advocacy concerning domestic violence:

I would say more resources could be provided to the elderly so they can protect themselves. A lot of the elders are being abused and they don't know how to protect their own rights and that's the one thing we don't cover. We do go, we look at their living styles and we are not connected, we are only there for half an hour to an hour with the consumer and a lot of them are not going to come out and tell you straight ahead I was abused, or domestic violence, and the Vietnamese community, I would know they deal with that...physical abuse... they don't deal with it right well enough, because they don't know how to protect their rights. (Thanh)

As with most domestic violence situations, this vulnerable population needs safe spaces and processes that proactively address physical, economic, legal, and emotional consequences of reporting abuse.

Both issues of depression and domestic violence exemplified the overwhelming need for providers to engage with their clients not just as individuals but as entire family units when appropriate (when they live in multi-generational homes, for example). All interviewees stated that many Vietnamese families have little knowledge of the aging process and gerontological dis-

eases, much less how to constructively support an elderly family member in such cases. This can lead to expecting the elderly person to behave beyond their current capacity and result in verbal or physical abuse by members of the family.

Recommendation

More public health education and training that debunks cultural beliefs about depression and domestic violence needs to be shared with these programs. Particular attention needs to be given to how to identify signs of depression in others, how to name and understand the roots of abuse, how to address the topic with the family member in need of assistance, and where to access culturally competent services within one's health plan. For the Vietnamese American community, education on the aging process, the needs of elderly, and inter-generational relationship building is critical to the mental health and sustainability of the community as a whole (Hernandez & Gonzalez, 2008).

Measuring Success

Of particular importance to many funders and government agencies is for providers to document and prove successful outcomes in their programming. Funders did not provide the programs with the tools to adequately measure or define success. Instead, they asked the staff to provide quantitative data produced from attendance records and patient tracking, as four of the five representatives attested. None of the staff were asked to give input on what measurements would

be most useful to them or were given any tools of measurement by funders to define "successful" programming, such as the satisfaction of the elderly with services, recommended improvements from staff, and measuring the cultural competency of these programs. Devoted Healing staff must visit their entire caseload (about sixty elderly per staff person) within a three-month cycle, and then revisit the list. The completion of this process was the measurement of staff success, but there was no clear indication of how they measure the program's success beyond vocalized gratitude from the clients to the staff on their visits. Since the agencies also referred their clients to one another, depending on the services needed, the ability to gauge the success of the centers' recruitment of the total population can be obscured by the possibility that the same pool of clients are accessing multiple centers while others do not participate in any programs.

Typifying the responses of other agency staff, one interviewee explained her program's attempt to perform qualitative assessment:

Usually every year we give them a survey so we try to make it similar because with the seniors we have here, more than 70% they don't have education, so they cannot even read or write, but they can speak... When we give them the survey we translate into Vietnamese, or either we can assist them with the questions so they can give us the answer by speaking... or they can bring home so their

children can assist them to answer the questions we have in the survey... If they answered the question here, they may try to be nice to us so they always say good things, so usually we ask them to take the survey so they have children read the questions so they can provide the answer, that's going to be more private. Because on a survey they don't tell this staff is not doing good job, but when they do it here, it's not very private for them to answer. (Ly)

Staff at other agencies also reported measuring success through anecdotal observations of client satisfaction. They considered factors such as "staff reporting of retention," whether "[clients] seem happy," and informal conversations with clients. Only one organization cited an external assessor from an insurance company who visited the site once a year to confirm the organization was in compliance with safety standards and government regulations.

The absence of clear and valid documentation, and of evaluation procedures, was the most critical area needing improvement reported by staff. The stakeholders invested in these CHCs lacked independent and trained evaluators with the cultural competency to appropriately assess the quality of services provided. The CHCs did not have quantitative and qualitative measurements of success, nor clarity on how to define programmatic success beyond counting attendance and membership numbers (Levy-Storms, Schnelle, & Simmons, 2002).

Recommendation

Current methods of assessment by the programs lack consideration for client anonymity, rendering the responses of the clients invalid. The responsibility for quality evaluation falls upon funders and organizational management, and these evaluative measures need to prioritize the quality of care rather than quantity of representation. The measurements and measurement tools (or lack thereof) need to be considered with more thoughtfulness about the goals of achieving the best care possible for immigrant and refugee populations, in addition to the ways in which these populations tend to express their needs and concerns.

Future Directions and Research

This preliminary study has offered insights into the strengths of cultural competency and community services for a vulnerable sub-population within the Vietnamese American community. As emphasized by the Office of Minority Health, "Cultural competency is one of the main ingredients in closing the disparities gap in health care." The most obvious gaps in cultural competency at the CHCs include a lack of professionally trained bilingual/bicultural staff, absence of healthy and culturally accessible meals that are critical to preventive health, and a lack of Vietnamese language and culturally sensitive activities that improve the physical health and mental well-being of the clients.

The emotional, cultural, and ethnic-specific verbal and nonverbal comprehension of elderly Vietnamese needs is invaluable for

interpreting the nuances and silences in communication styles of this community. In understanding what is unsaid as much as what is said—of filling in the gaps between language and lived experience—these service providers play a crucial role in the continued health and well-being of a physically and linguistically confined client population. Yet funding sources, insurance companies, and government agencies still undervalue the role of these cultural brokers. Advocates for culturally competent care must still create a narrative of the value and qualitative importance of bilingual and bicultural services for immigrant and refugee populations.

A common argument against providing culturally competent care is the lack of monetary resources. One response would be to create an inventory or database of bilingual products and templates that would be accessible nationally for agencies and organizations to use. This would provide a cost-effective way to offer at minimum a means for bilingual written communication without the time and costs of using staff or hiring a third party to translate complicated information.

This preliminary study offers pathways for future research to improve care for Vietnamese and other immigrant elderly populations. The most immediate intervention would be to gather best practices and materials to be shared on a national database. Future studies could include mixed-method data collection of the perceptions of care by the clients themselves. The use of surveys, interviews, and focus

groups would best capture the perspectives of elderly Vietnamese Americans, their decision-making processes, and accessibility to services. Using longitudinal and controlled studies of the agencies, the families, or just the elderly would also shed light on the depth of impact of current services.

Social networks analysis and mapping would be useful for studying the accessibility, social influences, and behavior choices and patterns of those who choose to receive services and those who do not. The use of maps to document Vietnamese American communities is a new and emerging site of study that has been used in studies of New Orleans post-Hurricane Katrina and in testing environmental health hazards to nail salon workers (Patterson, Weil, & Patel, 2010; Reynolds et al., 2010). Such methods would be beneficial in furthering the analysis of accessibility of services for the elderly beyond walking distance of Dorchester's Vietnamese enclave. We need more accurate data collection to advocate for more accessibility to culturally appropriate forms of care. With future research in the areas outlined, we can create models to best serve our most vulnerable population.

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