UNDERSTANDING IMMIGRANT SENIORS' NEEDS AND PRIORITIES FOR HEALTH CARE

A community engagement research project in the Champlain Local Health Integration Network (LHIN) region of Ontario

Authored by Vivian Runnels, August 2017

South-East Ottawa Community Health Centre
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Views and opinions expressed in this document are those of the author and study participants, and do not necessarily reflect those of OLIP or the Champlain LHIN.

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Alejandro Gomez helped design and administer the organizational survey. Terri Scott facilitated the focus groups. Vivien Runnels was the note-taker/researcher for the focus groups. Vivien Runnels & Verbatim Ottawa Services Inc. (Jeanie Zeiter) transcribed the focus groups and interviews. Aurélie Lacassagne translated documents into French. April Carrière conducted an interview in French. Zahia Lahoua conducted a French language focus group and Laurence Lenoir was the note-taker.

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We hope that the voices of all participants in this study and the knowledge that they shared, are considered carefully and action taken to address their concerns.

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UNDERSTANDING IMMIGRANT SENIORS' NEEDS AND PRIORITIES FOR HEALTH CARE

Ontario's population is aging. Its health systems are preparing to meet the health needs and health equity of increasing numbers of seniors. Immigrants form part of the general population of seniors in Ontario: being foreign-born has been shown to impact access and utilization of health care.

Immigrant seniors in the Champlain LHIN region took part in a study in which they described the things that they liked about health care, their experiences of barriers and challenges that constrained their access and use, what they thought might happen in their future, and what they thought were important priorities to address.

Many immigrant seniors who participated in the study spoke little English or French: they described how effective communications and understanding between organizations, health care staff and immigrant seniors were hindered because of language and cultural differences. This complicated health care encounters and impeded the delivery of quality home and health care.

The ability of many immigrant seniors to pay out-of-pocket costs for items and services that they needed for their health and daily living was limited by low income. Public transportation to get to health care appointments could be costly. Some lacked social support and were socially isolated. Some were not literate in their own languages of origin. Despite their need for age-appropriate housing, private sector accommodation designed for seniors was not affordable for low income immigrant seniors, nor was it culturally appropriate. Informal caregivers help immigrant seniors with their health and health care, but can find their own health, employment and family responsibilities challenged as a result of caring for the immigrant seniors.

Immigrant seniors in all of their diversity, need specific support in order to make optimal use of health promotion, disease prevention and health care, and reduce their burden of illness and disease. Health care planning can help to create a level playing-field upon which all seniors participate equitably, and access the health care that they need. Health planners can also ensure that immigrant seniors' living arrangements are supportive of their health, and prevent or postpone their involvement with costly residential health care. Demographic data identifying the immigrant senior population can enable planners and health organizations to target and tailor resources to where they are most needed. Prioritizing plans to address language and cultural barriers will enable enhanced access to multiple components of health care and help immigrant seniors reach their full health potential.

While some services and programs for immigrant seniors are already in place in the Champlain LHIN, linking organizations and working across sectors can assist. Health care models which operate at the local level, such as community health centres, are well-placed to work with health care and other sectors to mediate the effects of social isolation, poverty, poor housing conditions and basic health illiteracy on immigrant seniors' health.

EXECUTIVE SUMMARY
UNDERSTANDING IMMIGRANT SENIORS' NEEDS AND PRIORITIES FOR HEALTH CARE

Canada's population is aging. Population pyramids show increasing numbers and proportions of the over-65s relative to the rest of the society. But while health systems are planning for caring for increased numbers of seniors, age is not the only determinant of the health and health needs of seniors. Canada's population of seniors is not all the same in terms of individual and group characteristics. While there are similar conditions and diseases associated with processes of aging, what seniors bring to their encounters with the health care system and experience in accessing health care, differs. Ensuring every Canadian, including seniors, has equitable access to care to meet health needs, is a fundamental goal of Canada's and Ontario's health care system.

Immigration has been a constant factor in the formation and shaping of Canadian society. As a result of immigration, Canada's population is highly diverse. In 2011, close to 3 in 10 people in Ontario (28.5%) were foreign-born (the average for Canada is 20.6%). Of these foreign-born people, many are Canadian citizens and have lived in Canada for many years. Others are fast approaching the age of retirement and yet others are recent newcomers to Canada, having landed as family members or as refugees from conflict zones and failed states.

A community-based and engaged research project on immigrant seniors' health was commissioned by the Champlain Local Health Integration Network (LHIN) located in Eastern Ontario. The project was carried out by the Ottawa Local Immigration Partnership (OLIP) and the South-East Ottawa Community Health Centre (SEOCHC).[1] The goal of the project was to gather data about the immigrant senior population and their experiences and knowledge of health and health care in the Champlain LHIN region that could be used to inform the planning of equitable, appropriate, accessible, affordable and properly utilized health care services.

One hundred immigrant seniors shared their knowledge and experiences of health and health care in the Champlain LHIN region. Ninety-five immigrant seniors in Ottawa participated in focus groups organized by language (English, French, Chinese, Arabic, Somali, Russian, and Vietnamese). Some immigrant seniors who have few social contacts with others (defined as socially isolated senior citizens) were interviewed individually. Informal caregivers (defined as family, friends and other unpaid caregivers) who support immigrant seniors living in the community, also took part in focus groups to give their particular perspectives of immigrant seniors' health. Sixty-five health organizations across the Champlain LHIN region including rural areas, also gave their perspectives and views on the health care of immigrant seniors through an on-line survey.

The project's research components were reviewed by a Research Ethics Board to ensure that all participants understood the benefits and risks of participating in the research, and ensuring their informed consent. All data from the different components of the project were collated and analyzed. The analysis showed that immigrant senior participants had experiences in common. These were also confirmed in the informal caregivers' focus groups and organizational survey responses.

Immigrant seniors' health experiences

While many focus group participants described existing physical, mental and dental health problems and some had unmet or unresolved health needs, immigrant seniors were satisfied in general with the health care that they received. However, they reported that their health care was affected by factors that limited access and use of health care.

Access - language, communication and culture

Many immigrant seniors are not able to communicate in English or French: for some this can lead to social isolation. Though some immigrant seniors are accompanied to health care appointments with informal caregivers who assist with interpretation, lack of shared language and culture impedes effective communication and understanding

1 See Also Appendix B Decision Making Model Immigrant Seniors' Health & Wellbeing Project

between health care staff and patient. Language and cultural factors can also serve to complicate the health care encounter. For example, some cultures do not inform people they are dying because this knowledge will lead the individual to "*give up and they will not fight the disease they are having (informal caregiver).*" When health care professionals are not aware of or are not sensitive to this type of cultural difference, they can bring about significant distress for the patient and family members.

Immigrant seniors and informal caregivers also cited difficulties in negotiating the health care system, and expressed a need for coordinated information on health and health care services, and efficient ways of managing patients' own information.

Access – wait-times and affordability

Immigrant seniors' experiences of getting health care were described as accompanied by delays, waiting lists or perceived inaction. As one person reported, "*The system is good, but the waiting time is so long* (immigrant senior)". Stalled access to care caused worry and stress for immigrant seniors.

Immigrant seniors reported inability to pay for health-related items out of pocket. This was the case for certain medications, eye care, hearing, teeth and physiotherapy. "*Ihe drug plan doesn't seem to cover the basic medications ... People on low income can't afford that* (immigrant senior)".

Access – transportation

For many participants, accessing health care was closely dependent on organized public transportation including Para Transpo in the Ottawa area. Paying for transportation was difficult for seniors who "*have zero income and were dependent on their children…and had to ask their children for bus money."(*immigrant senior focus group participant). Seniors and informal caregivers' experiences of making arrangements on the telephone for Para Transpo were time-consuming and they were often unsuccessful in their attempts to secure a ride. Organization survey respondents identified lack of access to transportation to health and mental health services as a barrier to meeting the health needs of immigrant seniors in the Champlain LHIN region.[2]

Future needs and living arrangements

Immigrant seniors anticipated changes in personal health status as they aged, which they associated with increased need for health care, increased likelihood of social isolation and potential changes in living arrangements. All focus groups and interview participants preferred living arrangements that supported immigrant seniors to remain living in their own homes as independently as possible for as long as possible. As seniors get older and less able to manage, living at home with supports in place (including help with housekeeping, cooking and washing, and home adaptations) was seen as critical for maintaining health and preventing relocation to a nursing home or long-term care. Ability to pay for private retirement residences was severely constrained for immigrant seniors, many of whom were low income.

Age, sex and ethno-cultural backgrounds of immigrant seniors

Age, sex and ethno-cultural backgrounds are important determinants of individual and population health. Most respondents suggested little to no personal knowledge, evidence or information that would support a finding of different or lower quality care because of their age, sex, or ethno-cultural background. However, many survey respondents' comments spoke to lack of awareness of cultural needs or lack of ethnic/cultural sensitivity, implying that many providers lacked resources or knowledge with regard to cultural competence. Immigrant seniors also reported experiences but did not identify them as problematic per se, but experiences they accepted. For example, one immigrant senior said: "*I feel everyone in the health care system judges me because of my colour…I have been living with that ethno-cultural thing my whole life, so that I accept that I have been treated in a different way* (immigrant senior)."

Responses to the survey of health care organizations in the Champlain LHIN suggested that health care organizations could benefit from increased support and capacity with regard to data collection and health equity assessments. Disaggregated (sorted) data is an important adjunct in informing the prioritization and planning of services.

2 The Champlain LHIN has a funded transportation service operated by community agencies, the Non-Urgent Transportation Service – Health Care http://www.champlainhealthline.ca/listServices.aspx?id=10109. None of the respondents specifically named this service.

Priorities

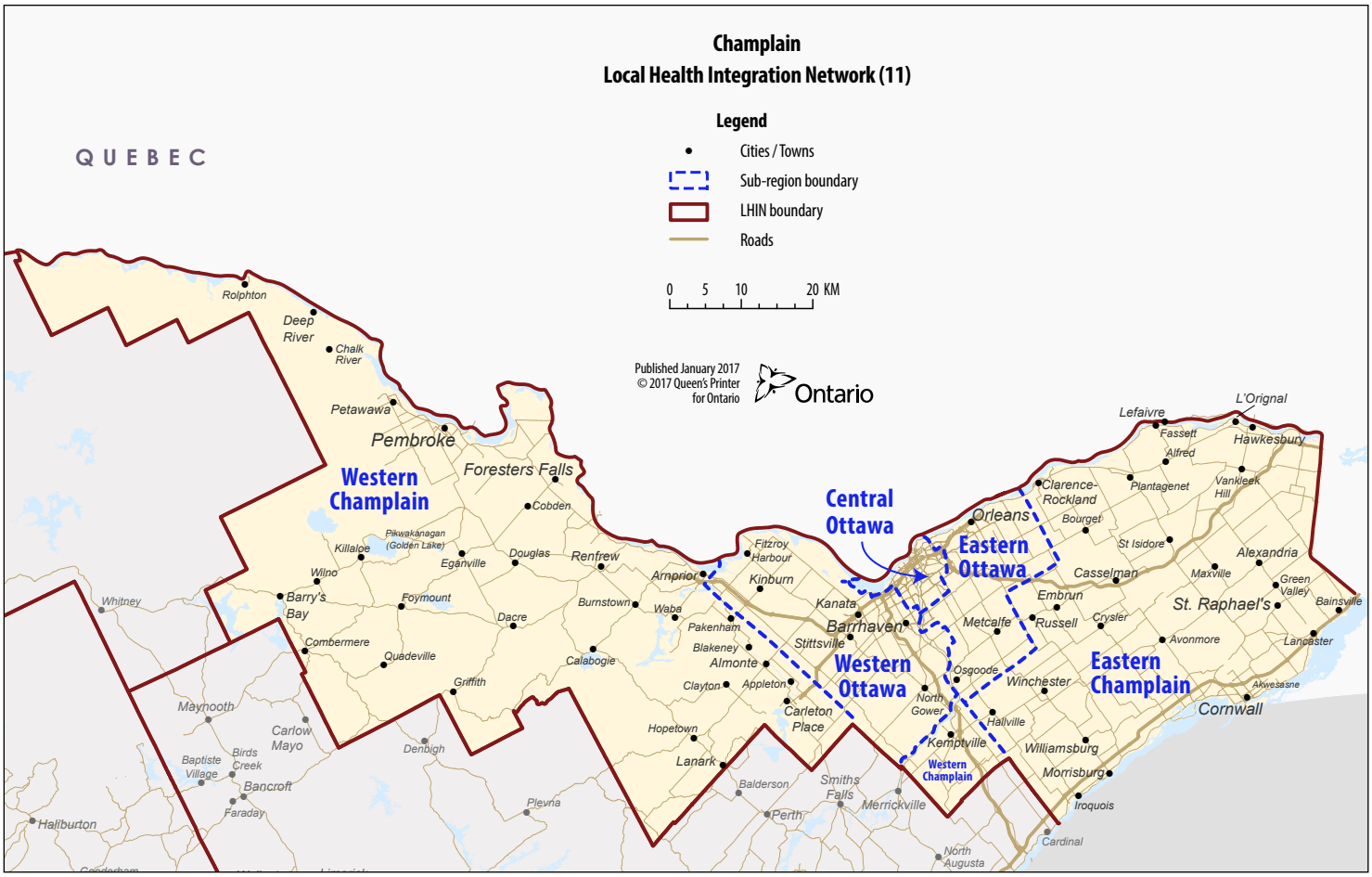
As communications were seen as a central challenge to health care access, providing language interpretation (translation) with cultural understanding was identified as the major priority. Other important priorities for immigrant seniors' health care included addressing wait-times and delays; addressing affordability and out-of-pocket costs including accessible and available transportation; improving resources/knowledge of the health care system; and providing appropriate homes and programs for immigrant seniors. Health system priorities included increased mental health and health care by age-specialized staff. If given a choice, surveyed organizations were more likely to select making investments in operational funding to assist them in integrating and coordinating services, and investing in outreach and communication to improve immigrant seniors' health.

Executive summary conclusion

There are many culturally and linguistically diverse immigrant seniors in the Champlain LHIN region and this population is forecast to increase in the future. While some services are already in place, planning for equitable health care for immigrant seniors will take into consideration that different populations from different contexts have different trajectories in accessing and receiving health care. Acknowledging that the social determinants of immigrant seniors' health are closely entwined with health care can also assist in priority planning for health care and programs that maintain immigrant seniors' health and mental health, whilst preventing or postponing their involvement with residential health care. The priorities generated through this research recommend certain directions for planning and decision-making. An immigrant senior urged the decision-makers to: "*… take care of seniors, give seniors good health care and don't think that now they can't do anything for this country, because they used to be very useful for the country, so now please give them very good health care.*"

Source: http://www.champlainlhin.on.ca/GoalsandAchievements/OurStratPlan/SubRegions.aspx. Accessed on March 25, 2017.

Figure 1: Sub-regions of the Champlain LHIN



INTRODUCTION
UNDERSTANDING IMMIGRANT SENIORS' NEEDS AND PRIORITIES FOR HEALTH CARE

This document reports on a community-based and engaged research project on immigrant seniors and health. Commissioned by the Champlain Local Health Integration Network (LHIN), the research was carried out by the Ottawa Local Immigration Partnership - a multi-sectoral partnership involving over 60 local organizations and the South-East Ottawa Community Health Centre (SEOCHC). The project was designed to find out about immigrant seniors' experiences with their health and health care, and what health care needs they identify as important now and in the future. Information acquired from the community and organizations that deliver health care and programming could then be used to inform the planning of equitable, appropriate, accessible and utilized health care services for immigrant seniors. The focus of this report is the experience and knowledge of immigrant seniors, with supplemental findings from the other components of the study .[3] The final sections of this report, outline the priorities from the evidence and recommendations that arose from discussions of the findings.

Background for this study – Diversity and an aging population in Canada

Canada's population composition is diverse as a result of permanent migration from all parts of the world for many years. In 1981, two-thirds of all foreign-born persons living in Canada—including immigrants who had arrived several decades earlier—were born in Europe. Since 2006, the largest group of newcomers to Canada has been from Asia. The African-born proportion of newcomers was 12.5% from 2006-2011, and African-born newcomers form about 7.3% of the population. In 2011, close to 3 in 10 people in Ontario (28.5%) were foreign-born (the average for the whole of Canada is 20.6 %). (Demography Division, 2016). Just over 4% of *new* immigrants were aged 65 and over in 2012 compared to approximately 15% for the Canadian population as a whole (Demography Division, 2016, p. 30). In Ottawa, Canada's national capital, there is a population of immigrants of diverse origins (Table 1 below).

Table 1: Top 3 regions of origin for immigrants aged 65+ in Ottawa

Origin	Population
Europe (Northern Europe)	20,740
Asia (Eastern Asia)	10,580
Americas (Caribbean & Bermuda)	4,970

Source: Census data - immigrants 65 and over (July 2016)[3]

While migration has set the context for diversity, Canada's population structure is also marked by the aging of the population, with greater numbers and proportions of senior members relative to other age groups. In Ottawa, there is a sizeable population of seniors (109,280) of which approximately 35% (38,155) was foreign-born. In the Champlain LHIN region as a whole, including Ottawa, the percentage drops slightly to 28% (43,985). Less than 5,000 immigrant seniors live outside the Ottawa area, approximately 3.7% of the total population of all seniors in the Champlain region.

Table 2: Population aged 65+ for the Champlain LHIN region and Ottawa area by immigrant and non-immigrant status

Population	Champlain	Ottawa
Total population 65+	159,405	109,280
# immigrants (65+)	43,985	38,155
# non-immigrants (65+)	115,420	71,125
% immigrants	28%	35%

Source: Census data - immigrants 65 plus (July 2016)[4]

3 The third component was focus groups with informal caregivers who were asked to describe their experiences of caring for their immigrant seniors. These focus groups used similar questions focusing on the health care of immigrant seniors but bringing in the voice of informal caregivers. The final component was a survey of LHIN-funded organizations. Questions were divided into three sections: questions on organizations' delivery of health care and overall governance; organizations' experience of immigrant seniors and their health care; and organization priorities and planning for the future including what would assist organizations to enhance their services.

4 With thanks to the Champlain LHIN for providing these data.

Health status of seniors and immigrant populations

In Canada, "seniors are proportionately higher users of hospital and physician services, home and continuing care, and prescription drugs" compared with non-senior adults (Canadian Institute for Health Information, 2011). The increasing number of chronic conditions (also called non-communicable diseases - NCDs), drive their need for health care. As well as NCDs, there are other health problems and declines in capacity ((World Health Organization, 2015, 2016). Social problems such as poverty and elder abuse are also of concern for seniors and immigrant seniors' health (Conference Board of Canada, n.d.; Registered Nurses' Association of Ontario, 2014).

The health of immigrant and refugee populations in Canada has received some specific attention in the last decade (Pottie et al., 2011). However, the health of immigrant (foreign-born) senior Canadians and their access to health care has raised concerns. Some senior populations consistently experience differentially poorer outcomes because membership in certain population groups locates them to experience disadvantage or marginalization in aspects of life (also referred to as social determinants of health). These social determinants of health include health care. Following from this, questions which concerns immigrant seniors' access, receipt and utilization of the health care they need, including whether they receive the right service in the right place and at the right time, have also been raised (Gulliford et al., 2002; Levesque, Harris, & Russell, 2013).

Box 1: Immigrant seniors and health care in the Champlain LHIN region - A Community-engaged research project

- Engaged 100 immigrant seniors in the Champlain LHIN region in eight focus groups to understand their health and well-being experiences and challenges
- Engaged immigrant seniors living in the community who have few social contacts with others - socially isolated senior citizens
- Gained knowledge and insights from informal caregivers (family, friends and other unpaid caregivers) in two focus groups. Informal caregivers have a very important role in supporting immigrant seniors living in the community
- Integrated the perspective of health organizations across the Champlain LHIN on the health and health care concerns of immigrant seniors through a survey (The survey was sent out to all LHIN funded organizations - 65 organizations provided data)
- Received input from immigrant-serving organizations and staff
- Benefited from the knowledge and recommendations of the Project Advisory Committee convened by OLIP (See Appendix A)

HOW THE INFORMATION (DATA) WAS COLLECTED

We designed a 'community-engaged' project to ensure that the perspectives of immigrant seniors of their health and health care experiences would be central to the collection and presentation of evidence.

We started the project by looking at the 'knowledge' (the literature) that had already been collected, and used this to inform the project's research questions. The main question directed at the literature asked: What is already known about senior immigrants' views, perspectives and experiences of their own health, health needs and health care? Searches of the literature were conducted from the year 2000 to the present.

The questions we asked immigrant seniors in the focus groups and interviews were designed to solicit the experience and knowledge of all the research participants, building on the literature. We asked: What are immigrant seniors' experiences, views and perspectives on their aging and health and on getting health care? What helps or prevents immigrant seniors from getting the right help at the right time in the right place? What health care needs do immigrant seniors see as currently important and in the future? Included were questions about living arrangements and health. We also asked immigrant seniors if and how their age, sex and ethno-cultural background impacted their health care, and asked them to think of what important things decision-makers should be doing now for immigrant seniors' health.

Ethics

The research project plans underwent a rigorous assessment and review by the Research Ethics Board (REB) of the South-East Ottawa Community Health Centre (SEOCHC).[5] Participation in the research project was through free and informed consent. Consent documents were available in English and French.

Recruitment to the focus groups and the interviews was carried out through close liaison and coordination with community-based immigrant-serving organizations, who also organized interpretation. Immigrant-serving organizations worked with the research team members to ensure sensitivity to divergent values, traditions and privacy issues of the diverse ethno-cultural participants.

Research activities were carried out from November 2016 to February 16, 2017. We conducted eight focus groups with immigrant seniors. Two immigrant seniors' focus groups were conducted in English with translation assistance available, and one was conducted in French. All remaining focus groups were conducted in English with translation done into the participants' mother tongue. We conducted five interviews with socially isolated seniors, (two in English without translation, two with translation in two of the interviews, and one in French). All focus groups and interviews were transcribed and transcriptions reviewed and checked for accuracy by the researcher against the digital sound recordings.

How the data were analyzed

Data from the immigrant seniors' and informal caregiver focus groups, and the interviews with socially isolated seniors were first organized according to the questions asked. Qualitative data from the survey responses were also ordered in the same way. The next stage of analysis involved looking for themes and any links between themes. The researcher used a qualitative data analysis software package to assist in organizing and coding the data. All data were re-analyzed later using the lens of sex, age and ethno-cultural background.[6] Much of the evidence is presented using direct quotes of the study participants (in italics).

Who were the immigrant seniors who provided the evidence for this study?

- 95 participants total (85 of them between 65 and 84 years of age)
- 71 (75%) female. 24 (25%) male
- 76% Canadian citizens; 17% permanent residents (Refugees 5% and Other 2%)
- 27 countries of birth

5 The job of an REB is to oversee the ethical conduct of research involving humans, and to ensure that research is conducted with respect and protection of participants by identifying risks and mitigating them where appropriate –(concern for their welfare); and to treat people fairly and equitably (Canadian Institutes for Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014).

6 There is a separate section in this report which looks specifically at these analyses.

- Arrived in Canada from the mid- 1960s – 2016
- Lived in Canada between 0.3 – 56 years (mean years in Canada = 20.1)
- Lived in Ottawa between 0.3 – 54 years (mean years in Canada = 19.3)
- Major religions represented: Christian (35%); Muslim (34%) Buddhist (10%); Jewish (5%); Hindu & Sikh (2%); none/atheist 12%; other 2%.
- 15 languages spoken (other than English or French): South Asian (27%); European 18%); Chinese (12%); African languages excluding Arabic (25%); Arabic (18%)
- 91 % reported speaking another language at home. 58 spoke English away from home, 24 spoke French away from home.
- Family members in Canada - 94%; without family members - 6%
- Living arrangements – 43% live alone; 32% live with a spouse: 22% live with a non-spousal family member
- Annual household income – 30/89 had annual income of less than $10K; 37/89 had annual income of $10K to $20K. 85/89 below$ 50K (not all participants reported income)
- 95% did not have paid work; 43% reported volunteering with an organization

Many seniors who arrived in Canada have had difficult experiences. Informal caregivers' and staff[7] accounts of the health status of the immigrant seniors they looked after acknowledged the stress and trauma some seniors had experienced in their lifetimes, sometimes many years ago, but with ongoing effects.

> *"She came from a war zone and because her husband passed away, she really missed him. When she came here, it was a big change, a different nature."*
>
> *(*informal caregiver*).*

Immigrant seniors participating in interviews: count and characteristics

The population of focus in interviews was socially isolated immigrant seniors.

- Five participants - three females and two males – all with characteristics of social contact which fit definitions of social isolation
- Four between 65-74 years and one between 55-64 years of age
- All Canadian citizens or permanent residents – arrived in Canada between 1975 and 2011
- All five have family members in Canada
- Years lived in Ottawa (Canada) between 5-40, average = 20.2 (21)
- Regions of birth: South and South-East Asia, Middle-East, Africa, Latin-America and Caribbean Region (five different countries)
- Four religions represented
- All spoke languages from their country of origin (not English or French)
- All had income under $15K, one reported less than $5K

7 Staff who were present in the immigrant seniors' focus groups also made observations from their experience of working with immigrant seniors. Informal caregivers' focus group participants also encouraged immigration policy that prioritizes seniors, particularly for those seniors abroad who only have children in Canada, in order that the children can care for them in their old age.

THE PROJECT'S FINDINGS

How immigrant seniors' understood their health and future health

Health was consistently understood by immigrant seniors in this study as more than physical health, and included spiritual, emotional and mental health. Good health meant freedom from loneliness and being free from illness. Immigrant seniors described a number of activities that they did to take care of their health. In addition to eating well, having some physical exercise and sleeping well, these activities included: maintaining social contacts and social interaction; observing spiritual health and having positive attitudes; gardening (and sharing produce with neighbours); reading; helping others and volunteering; not smoking, drinking or using drugs; and using traditional medicine and alternative therapies. Participants emphasized social engagement, keeping occupied, and avoiding stress for good health.

While many of the participants described current health problems that were being treated, which included cancer, heart disease and other serious conditions, they also described unmet or unresolved health issues for which they needed care. They also anticipated changes in personal health as they aged which were strongly linked to increased worry about health and what is going to happen to them. Some focus group participants referred to mental health and thought that loss of memory and conditions such as dementia and Alzheimer's were associated with their aging. They envisaged increased need for assistance with daily living (e.g. meal preparation, housework and shopping) and health care. They were concerned about an increased likelihood for social isolation, sometimes expressing fear of being on their own, and indicating that they might need to live in a long-term care or nursing home. Some focus group participants observed that they (immigrant seniors) were more likely to speak their first language and want to eat cultural food as cognitive challenges became worse.[8]

> *"For me it's scary at night if you get sick and live alone. … That is one of the scariest things in life. When you live alone and you are too sick and you can't help yourself. Suppose you fell out of the bed and can't reach the phone you and can't call for emergency help"*
> (immigrant senior focus group participant)

8 One reviewer of this report also pointed out that this is not unusual with aging, that is to say, these preferences do not solely emerge as a result of cognitive difficulties.

IMMIGRANT SENIORS' EXPERIENCES OF HEALTH CARE

Immigrant seniors reported satisfaction in general with their experience of health care in the Ottawa area. As one participant said, for example:

> *I have had a very good experience with health care and my family doctor. I ask the receptionist for the doctor, she says come and I will fit you in. They are so good. … I find everything excellent (immigrant senior focus group participant).*

Box 2: Social isolation and immigrant seniors' health and safety

"I'm worried that I cannot get a doctor to see me at home. I live alone. I could die without access to medical care because there is no one at home. If my daughter cannot take me, I have no one else. I...even have fractured my bones, but sometimes... for example, with pneumonia, I'm completely helpless and I'm stuck at home without anyone to care" (female study participant).

As well as using family physicians, community health centres, walk-in clinics, emergency departments and hospitals, the health care system helped some immigrant seniors to stay in their own home and out of institutional care. Items included help with housework and food; help with transfers and transportation, and social support programs.

Access to health care

Immigrant seniors' experiences of health care were marked by different types of barriers in accessing health care they needed.

A need for language-enabled and culturally sensitive health care

A pronounced and constant theme throughout the study was that immigrant seniors' were impacted by lack of access to language-enabled and culturally sensitive health care. A story exemplifying this was shared with a focus group by an immigrant senior and her helper:

> *A woman said, "I visited the hospital emergency department three times. So the third time they said that your health is not good. I was very sick and they operated on me. I was admitted in a room with a man. They said if you want to be in another room without the man - you have to pay. Otherwise you have to stay with that. When the helper came to the hospital, I was crying."*
>
> *The helper spoke to the nurse and the nurse said, "She (the patient) is not cooperative. She's not taking the food or drink that we give her. Since last night she is not eating."*
>
> *The helper said, "Let's ask her" and spoke to her in her own language.*
>
> *The woman said, "First they took my clothes.... I am naked and a man is lying here and they are telling me to get up and go to the bathroom. How can I just get up naked and go to the bathroom? Yes, I put my hand like that (showed covering herself). I sometimes crawl to the bathroom and I have urine. But I can't get up and they want me to get around or walk."*
>
> *The helper gave her another gown and put her hijab on and she walked.*
>
> *The helper said to the nurse, "The reason that she didn't eat is because she doesn't want to visit the bathroom frequently and she said "because I am naked, I can't go."*

The woman was unable to effectively communicate to health care staff her cultural values and feelings about appearing exposed in front of a man. Although there were indications of cultural differences, staff were not culturally sensitive and assumed that the woman was being non-compliant with care.

Access to and communicating with health practitioners and other staff in the health system is constrained by those speaking little English or French. Not being able to find a family doctor that spoke the same language as the immigrant senior was a major issue.

> *"My friend found me another doctor (with a different ethno-cultural background) but the doctor won't see me. She's in panic because she doesn't understand me. … She doesn't understand my language and she asks all the time, "Oh, what is it? What did you say?"*
> *(immigrant senior interviewee).*

Informal caregivers also realized the lack of language also had implications for other parts of immigrant seniors' lives including limiting their engagement with social activities.

Although the Community Care Access Centres (CCACs) organized help for some seniors, assigned workers who did not speak the same language as the immigrant senior, did not allow for effective communication.

> *"They send somebody who doesn't speak her language...she fears she is foreign, She doesn't understand what she's saying to her. She doesn't understand what my mom wants …"*
> *(informal caregiver).*

This resulted in diminishing the effectiveness of the worker and increasing stress in the individual.

Informal caregivers also identified a relationship of not speaking English or French with social isolation of immigrant seniors. As they spoke the same language as the immigrant seniors they looked after, they often felt personally responsible for filling the language gaps.

The responses of surveyed organization with regard to organizational priorities suggested a common theme of immigrant seniors' not understanding the language of health care providers (and vice versa), as a barrier to access and an impediment to health care. *"The concern we see most is access and language" (survey organization respondent).* Addressing language deficits through translation/interpretation was the highest (first) priority for many surveyed organizations, because all other aspects of health care services then fall into place.

"Interpretation and health care navigation are equally important. It is difficult for the client and provider to make informed decisions together if there are language barriers, and interpretation is severely underfunded "
(survey organization respondent).

Language enables understanding of culture, and language serves to mediate aspects of culture: solutions to language and communication problems are closely related to understanding culture. Ensuring therapeutic communication is developed between health care staff and immigrant senior patients by providing translation services, can help. Cultural competence and sensitivity to cultural beliefs, as survey respondents and staff pointed out, are essential for developing respect, trust, and effective communication of health issues and needs, and informed resident/patient care plans. Although as one survey respondent noted, "*Culture and age are very important determinants of health that are taken into consideration in the delivery of safe and quality services in our organization*", this was not experienced consistently by all.

Timely access

"The system is good but the waiting time is so long"

Wait-times for accessing and receiving health care are of concern to immigrant seniors. They described their experiences of getting health care as fraught with delays, waiting lists or perceived inaction. Many expressed that seeing the family doctor seemed to take a long time, but seeing a specialist took a lot longer. Those who had used emergency departments reported long waits which did not always result in receiving care. One example shared with a focus group was that of a person who could not see and was waiting for an appointment for eye surgery, but the person feared having been abandoned as a patient after many months of not hearing anything from the system.

Informal caregivers' noted that waiting was hard for immigrant seniors because they were used to the experience of accessing health care in a timely fashion. "For them to wait for six months to see the specialist, it's hard for them to understand the culture."

Affordability of health care

Low-income immigrant seniors were impacted by their inability to pay for health-related items. This was the case for certain medications, eye care, hearing, teeth and physiotherapy mobility aids and the need for home adaptation.

I feel helpless. I don't get anything. Sometimes I cry. When I have this infection, I'm not taking anything. I cannot go anywhere, it's the money. (immigrant senior focus group participant).

The drug plan doesn't seem to cover the basic medications…People on low income can't afford that
(immigrant senior focus group participant).

Lack of oral health care and the high costs of dental health were discussed. [9]

I can't eat as most of my teeth are not in good shape. I don't go to a dental clinic because it's too expensive - $3,000 to put in a denture. It's too much.
(immigrant senior focus group participant)

Access to information

Some immigrant seniors found that there was not enough information in the community. They expressed their need for better information and someone to help them understand health and health care.

There is the CCAC and something some people don't know about it … lots of people don't know that they are there. They don't know that they can access them for care or if they need a wheelchair or if they need someone to come in for one day. … Those services are the ones that really do help seniors. Those services need to be promoted more, so people know that they are there and if they need help so they can access them and get whatever help they need (immigrant senior focus group participant).

Doctors do not know or pass on information about who or what can help them. Ideally information would be in the immigrant seniors' language (informal caregiver).

9 See Appendix for some notes from the literature on dental care and senior populations in Canada.

Transportation

Immigrant seniors' understanding of health was closely associated with health care and the ability to access it. Lack of accessible and affordable transportation to get to health care appointments is a barrier to many immigrant seniors' access. Physically accessing health care was closely dependent on their access to organized transportation (including Para Transpo in the Ottawa area).

For example, organized transportation enabled this one interviewee to go to the doctor, but it was only used for that purpose:

> *I'm not crippled. I could walk but I can't walk by myself … Yeah, Para Transpo, I use it if I go to the doctor. I don't go to the mall or something else. I go to the doctor only, for now (Interview participant)*

In the Ottawa area, having free bus passes for seniors on Wednesdays was welcomed by focus group participants, but more help was required to access health care. [10]

> *Lower the bus pass price for seniors so they can go any day - to make it accessible (immigrant senior focus group participant).*

> *Free bus rides for seniors should be at least for three days. Because the seniors can get to their medical appointments … Making services accessible throughout three days (immigrant senior focus group participant).*

While some seniors were able to use buses or drive themselves, in other cases seniors looked to family members who assumed much of the responsibility for arranging transportation. Informal caregivers' experience of making arrangements for Para Transpo was often frustrating and unsuccessful. One informal caregiver noted that some seniors feared using Para Transpo – so were dependent on their informal caregivers for all transportation. Parking passes for hospitals etc., were seen as useful to reduce costs.

Lack of transportation providing access to health care and mental health services was a barrier to care and a gap in services that survey respondents also identified.

10 http://www.octranspo.com/tickets-and-passes/senior_fares

Living arrangements and immigrant seniors' health

Immigrant seniors and all other study respondents, expressed their preferred living arrangements as those that support living in the community as independently as possible for as long as possible. Many immigrant seniors saw long-term care facilities as places where they waited to die. Informal caregivers thought that immigrant seniors also tended to live longer in their familiar environments than in institutional care.

> *I will try and live independently (immigrant senior focus group participant).*

> *I don't want to go into a nursing home. I really want to stay at home. I don't want the government to cut any funding for home services. I want to stay home longer (immigrant senior focus group participant).*

Living at home with supports in place as seniors get older and less able to manage, was seen as critical for maintaining health and preventing having to move to a nursing home or long-term care. These supports included help with shopping, food preparation and cooking, housekeeping, laundry, and washing; putting in place home adaptations and accommodations for managing limited mobility and safety, such as emergency buttons, in addition to in-home nursing personal and health care.

> *Some of the seniors over 90 are still living independently in seniors housing. They don't want to move to long term care, but want to stay mainly in their unit. Meal preparation is an issue because they can't go out to do grocery shopping and they want someone coming over to make fresh meals for them (informal caregiver focus group participant).*

Eating cultural food was seen as an important component of healthy living. Services such as Meals-on-Wheels and services that provided frozen food were perceived to be limited in their capacity to provide culturally acceptable food.

Some seniors expressed their interest in having family members live with them or support them so that they could be cared for. However, one thread that recurred in the focus groups and interviews was the immigrant seniors' expression of not wanting to be a problem or a burden to their own children and family in their old age.

> *Even though they are very good for me. ... I don't want to bother them and to be a burden (immigrant senior interviewee).*

In some cultures, however, children are expected to assume responsibility for their parents as informal caregiver focus group participants commented.

Whether at home or in institutionalized care, being able to live in an environment which supported the immigrant senior's language and culture, was fundamental.

> *I would love to have a (same language) speaking nurse or home support worker – to enable and help me to stay at home (immigrant senior focus group participant).*

Living arrangements in the future

"Where would you like to live in the event that your health becomes worse than it is now?" Immigrant seniors acknowledged the possibility of a move from community-based living to institutional care. Informal caregivers who were family members also acknowledged there may be a need to discuss housing options and living arrangements, consider moving or making other efforts to ensure everything the immigrant seniors might need is available, allowing them to live comfortably or independently even as health deteriorates. Privately-provided accommodation such as retirement residences were proposed, yet the ability to pay for (private) residential care was seen as highly constrained for study participants, most of whom were low income. The availability and quality of any government-provided accommodation was also questioned by participants.

While long-term care was recognized as needed, this form of living arrangement also raised the ongoing concern of language and cultural suitability for diverse populations of immigrant seniors. Food is an important and essential part of supporting health, and was a central concern for immigrant seniors and their informal caregivers, in this example, for those who were Chinese speaking.

> *For long term care … the meal plan for old people...Chinese old people prefer to eat hot prepared meals (they don't like cold food). That's a cultural difference. Culture food. … We have a lot of parents of the age to go to the long term care, and we have to convince our parents. Our parents right now, they have a language problem. We need a Chinese speaking nurse and also the meal plan (the language and understanding of the culture). We can immediately improve by putting a Mandarin-speaking nurse on the long term care unit and think about a meal plan, even if we pay to help them accommodate with that environment (informal caregiver).*

Although many thought accessing long term care was in the future, a lack of current space and waiting lists for suitable long term care made solving the living situation for some immigrant seniors presently of great urgency.

> *Too old or too sick. Health crisis. Whether they can get timely treatment or they can move to some long term care facilities. Is there space? We know there are lots of people waiting for those kinds of services. That is my concern. My concern is whether they are available or if we have to wait for a few months or a few years before we can get the help (informal caregiver).*

> *This question I ask you or anybody. For my parents they need immediate assistance – they cannot … where can we send them? (informal caregiver)*

> *So we need some place. We need somewhere. I think this is emergency situation. That's important because otherwise like my parents said – we're there just waiting for death. They can't speak their language, so how can they ask them for help? (informal caregiver).*

Box 3: A call to accommodate immigrant seniors with housing that meets their health needs

> *We request for Ottawa senior housing. My mother has an issue with my dad - he has sleep disorder. My Mom asked for two bedrooms - denied - the house registry (said) we only support those people who have wheelchair or need equipment (housing policy)…*
>
> *When they do this long term care placement, they can only do one by one, they cannot do that together. If they do – one is on the waiting list, one is higher priority. Long term care is for 24 hour care – try to do this together* (informal caregiver).

Social determinants of health and immigrant seniors' health care

The social determinants of health are the conditions in which people live, work and age which impact their health. These include things like housing, food security, social inclusion, income, transportation, education, health care and others (Commission on Social Determinants of Health, 2008; Marmot, Friel, Bell, Houweling, & Taylor, 2008). To draw on the knowledge and experience of the organizations and their recognition of social determinants of health that are assistive of the health and health care of immigrant seniors, surveyed organization respondents were asked: "What are the four most important social determinants of health you think are needed for immigrant seniors' health in your sub-region of the Champlain LHIN?"

Housing received the highest response, followed by health care, followed by food security and transportation and social inclusion (See Table 3 below).

Table 3: Frequency and order of responses to social determinants of health for immigrant seniors' health by percentage and count

	Social determinant of health	Percentage	Count
1	Housing	70.50%	31
2	Health care	63.60%	28
3	Food security	52.30%	23
4	Transportation	47.70%	21
5	Social inclusion	47.70%	21
6	Income security	45.50%	20
7	Assistance with daily living	27.30%	12
8	Physical activity	15.90%	7
9	Education	6.80%	3
	Other...	4.50%	2
	Number of respondent organizations = 44		44

Note: Not all respondents selected four determinants of health.

INFORMAL CAREGIVERS AND IMMIGRANT SENIORS' HEALTH CARE

Informal caregivers have important roles to play in the care of older people. Most informal care (about 80%) comes from unpaid family members, friends and neighbours (Canadian Institute for Health Information, 2011). Informal caregivers who look after very elderly parents, are often seniors themselves. One environmental scan of the literature with regard to informal caregivers who include family, friends and neighbours who are unpaid, found that informal caregivers provide the "bulk (70-90%) of the care required by older persons to keep them independent, thereby moderating demand for costly hospital and institutional care" (A. P. Williams, Peckham, Rudoler, Tam, & Watkins, 2013, p. ii).

Immigrant seniors in this study typically mentioned family members as the first 'go-to' people for assistance. Others mentioned volunteers and neighbours, and individuals that they became acquainted with casually or through community connections.

> *There is a woman who does the shopping for me. She puts everything in my fridge. Every day. She's not my friend. I trust her so I give her my card. She takes the money from the card. ...we just met with her. I was at the market. She saw me, and the way that I was walking. I can't see well. She asked me if I can't see. Shopping and withdrawing money from the bank. Whenever you need that I will come and do that for you for the sake of Allah. Starting from that day she did that (immigrant senior focus group participant).*

Many informal caregivers may have exchanged paid work for unpaid caregiving responsibilities, which results in some informal caregivers' foregoing opportunities in the labour market and experiencing their own financial need (Bolin, Lindgren, & Lundborg, 2008). Some studies have suggested that informal caregivers can also be at risk for mental and physical health problems, at least in part as a result of caregiving, but also in response to a range of external factors linked to caregiving (Brodaty & Donkin, 2009; Pinquart & Sörensen, 2007; Trivedi et al., 2014). This study also had similar findings:

> *"This is my problem, because now I am seeing a counsellor. I am on stress medication...I am seeing a counsellor"*
> *(informal caregiver).*

> *"It's stressful because I have to do many things – multi task - when my kids cannot have a life anymore because I am in high stress situation… I feel sorry for my parents and for myself as well. What I am doing? Why is my life like this? It so stressful. …I start feeling my health problems and complaining more often than before. I had to get a stress test from the hospital. The doctors said it was related to stress. My work is stressful as well. Problem is how can I balance that?"*
> *(informal caregiver).*

While informal caregivers may have their own personal life issues and others which emerge as a result of caregiving, their contribution to care and the knowledge they have of the person they look after is invaluable (Wiles, 2003). Survey respondents also recognized the burden of care which falls to informal caregivers and the need to provide support to them as well as to immigrant seniors:

> *"Investments in informal caregiver supports and cultural accessibility would be priorities for us"*
> *(survey respondent).*

> *"Need to increase informal caregiver support and respite care for the informal caregiver, as a result of the increasing informal caregiver burden and complexities related to seniors' health"*
> *(survey respondent).*

AGE, SEX AND ETHNO-CULTURAL BACKGROUNDS – LENS ON IMMIGRANT SENIORS' HEALTH CARE

Health care in Canada is intended to be available and accessible to all without financial or other barriers. However different populations show differences in population health outcomes. Population characteristics or stratifiers such as age, sex and ethno-cultural background can operate separately and together in conjunction with certain processes and health system structures, to produce differences in treatment of populations, resulting in poorer health outcomes (Ferrer, Grenier, Brotman, & Koehn, 2017; Hankivsky et al., 2010; Ontario Human Rights Commission, 2000). Differences or discrimination in treatment as a result of being old, male or female, from certain ethno-cultural backgrounds or all of these in combination, can have potential for harm, lead to health inequity and unequal health outcomes across populations.

Our study took an approach to collecting evidence about the potential impacts of age, gender and ethno-cultural backgrounds by asking questions about age, sex and ethno-cultural background and experience to all study participants. Most focus group participants responded to the questions about age, sex and ethno-cultural background with a collectively voiced and emphatic 'No' – some noting that "*Sometimes you are treated better because of your age" (*immigrant senior focus group participant*).* The summary table (Table 4) reports the survey organization responses to all categories – age, sex and ethno-cultural backgrounds.

Age

In the focus groups, immigrant seniors felt they were being dismissed when doctors told them that their condition arose as a result of their age.

> *"I feel they are leaving me because they feel that I am old. I feel dismissed."*
> *(immigrant senior focus group participant).*

> *"Sometimes he comments when I describe symptoms – it's your age. It's happened to some people. The doctors should avoid this. Normal aging process is what they say?"*
> *(immigrant senior focus group participant).*

> *"My doctor treats me differently because of my age, always threatening me... Doctor says "if you keep eating those things (cultural foods) you will die, like the other lady." Kept telling me that. My doctor always says something threatening. So, you're going to die because of this, because of that. So I finally switch to another doctor "*
> *(immigrant senior focus group participant).*

Survey respondent organizations were asked "Do you think that immigrant senior patients/clients are approached differently anywhere in the health system because of negative attitudes towards age?" Twenty-three (23) said no, 3 said yes and 17 said sometimes. The comments that accompanied the response were varied. Some survey organization respondents stated that the question was not applicable to them (e.g. *Since we serve less than 5% of the senior population per year, including seniors, we really cannot answer this question)*; or "*Nous nous adaptons aux besoins de l'individu peu importe son âge*," and "*not because of age and our immigrant senior population is nominal".*

Some respondents noted that observed differences in approaches to caring for immigrant seniors might be attributed to their age and language differences, and another suggested age and mental health conditions. These responses also suggested that some factors or stratifiers can intersect with others, to bring about differences in approach.

Table 4: Summary of survey organization responses to perspectives on differences in care based on age, sex and ethno-cultural background

Differences anywhere in the health care system?	Yes	No	Sometimes	Total responses
Age	3 (7.0%)	23 (53.5%)	17 (39.5%)	43
Sex	3 (7.0%)	28 (65.1%)	12 (27.9%)	43
Ethno-cultural background	5 (11.6%)	19 (44.2%)	19 (44.2%)	43

Total responses for all categories = 43

Sex

We were interested in learning whether immigrant seniors were sometimes cared for differently in the health care system because of their sex (male or female)[11]. Immigrant seniors' focus groups collectively voiced that they were not treated differently because of their sex. One male focus group participant, however, noted "Ministry of Health has sexual discrimination against men, because bone density covered for women not for men." Another focus group respondent noted how the sex of the immigrant senior patient may be a factor in the way that they (immigrant seniors) treated service providers who are male or female.

> *Some of the seniors will treat the providers differently. Depends on your cultural background. They would treat the male providers (physicians) better than the females in certain cultures (immigrant senior focus group participant).*

> *In response to the question – "Do you think that immigrant senior men or immigrant senior women receive different treatment anywhere in the health care system because of negative attitudes towards their sex?", twenty-eight (28) respondent organizations replied 'No', 3 replied 'Yes' and 12 replied 'Sometimes'. Comments to this question suggested little in the way of personal knowledge, evidence or information that would support a finding of different care because of sex. Some organizations reported treating everyone respectfully or equally regardless of sex.*

> *For example: All … are treated with respect (survey respondent). The services are equal and the standards are the same for all without any distinction whatever the cultural origins, sex or age (survey respondent).*

However, one survey organization observed challenges:

> *In cultures where a male family member needs to be present, it is sometimes a challenge to ensure that the needs of older female clients are met, or even recognized. Scheduling of appointments and more private conversations are sometimes difficult (survey respondent).*

Another organization respondent said that there were differences "*due to lack of cultural competency in some organizations as it relates to intersection of gender and culture*," suggesting that other organizations may lack awareness of actual or potential differences in treatment.

Ethno-cultural background and health care

For the immigrant seniors' focus groups, the question related to ethno-cultural background was, "In your experience as a senior, have you ever thought that health care providers (doctors, nurses and others), have treated you poorly or made you feel inferior based on your ethno-cultural background?" We also used the terms ethnic ancestry, heritage or background.

11 In all the focus groups, participants were given opportunity to identify sex and gender diversity in confidence. None reported any sex or gender diversity other than male or female.

One individual said that she had been treated differently because of her colour. [12]

> *I feel I've been treated differently because of my colour. I feel everyone in the health care system judges me because of my colour. Outside the health system, I get a different treatment because I look different, because of my colour. I have been living with that ethno-cultural thing my whole life, so I accept that I have been treated in a different way (immigrant senior focus group participant).*

Another woman who wore a hijab thought that a health professional treated her differently because of her ethno-cultural background:

> *For me the pharmacist at (name of pharmacy), whenever she sees me, she asks someone else to serve me three times now. Why should I suffer? Why should I see that? After three times, I withdrew my business from that pharmacy (immigrant senior focus group participant).*

Neither of the informal caregivers' focus groups made any observations of difference in terms of immigrant seniors' treatment with regard to age, sex and ethno-cultural background.

> *No (all)... on the contrary. They are treated well... in a good manner.*

However, there was preference of women immigrant seniors to be cared for by their daughters rather than their sons, and informal caregivers also noted that women especially older women "don't feel comfortable with doctors of the opposite sex".

In response to the question, "Do you think that immigrant seniors are cared for differently anywhere in the health care system because of negative attitudes towards immigrants?," five survey respondents responded "Yes", 19 responded "No", and 19 responded "Sometimes". This category (immigrants) raised a higher number of 'yes' and 'sometimes' responses and lower 'no' responses, in comparison to the age and sex categories (see summary Table).

Many of the survey respondents' comments spoke to lack of awareness of cultural needs or lack of ethnic/cultural sensitivity - one citing "ignorance", and organizational inability to communicate because of limited language. The implications of these comments generated by organization heads were that many providers lack resources and/or knowledge with regard to cultural sensitivity and competency.

> *Not necessarily, because caregivers are prejudiced, but more so due to lack of information on other cultures that are different from mainstream culture (survey respondent).*

> *Issues relate to lack of ethnic/cultural sensitivity. I can offer a book full of details (survey respondent).*

Exceptions to these comments were services targeted at ethno-cultural (language) groups that were specifically designed to accommodate immigrant seniors, and statements expressing commitment to cultural diversity, e.g. "*we embrace cultural diversity.*" Organizations in isolated and rural communities mostly indicated that there was no contact with immigrant seniors.

12 The experience of this woman suggests acceptance of structural and systemic racial discrimination and disadvantage. This has been identified in the literature as internalized racism. There is a vast literature on discrimination and racial inequalities and inequity in health and health care. See, for example, (Fleras, 2014; Hyman, 2009; D. R. Williams & Mohammed, 2009), and, in relation to indigenous peoples (Allan & Smylie, 2015).

PRIORITIES

What would be the most important priority for immigrant seniors' health? Language -enabled communication and culturally sensitive access to health care was named as the key priority by survey respondents, immigrant seniors and informal caregivers. The project's findings suggest that language and culture are not really separable and cultural competence and sensitivity helps to increase understanding in communication. Other priorities were also proposed to improve immigrant seniors' access to the health care system, and described in the following sections.

a. Address language and culture in health care of immigrant seniors

Access to the health care system includes all aspects of communication from patients' contacting the health system to make appointments through to their waiting to hear from specialists. Offering different languages or providing interpretation/translation is a priority for immigrant seniors' encounters with the health system, as well as for those who live and receive health care in the community. Having services delivered by workers who speak the languages of immigrants was a high priority.

b. Understand cultural standpoints

Examples of where understanding cultural standpoints would make a difference include acknowledging that when practitioners inform and involve patients in decision-making, while considered appropriate for many Canadians, this can sometimes result in difficulties in communication. For example, it became clear in some focus groups that some seniors from diverse cultural backgrounds expected doctors and other health professionals to directly tell them what to do.

Another example was that some cultural standpoints preclude many individuals and their caregivers from discussing death, dying and planning for the future. Where an illness is associated with dying and death, the topic is not always open for discussion in some cultures.

When I was recently in a hospital with another senior who was over 92 - the doctor … eventually trying to ask him if she needs (resuscitation), ... It's very hard for the family members to ask the question to the senior. Because we don't usually talk about this, whether to put the senior on a machine or not (immigrant senior focus group participant).

She (my mom) doesn't like talking about that stuff. It's taboo. She says, "What do you mean? Do you want me to die, do you hope that I will die now? What do you mean?"(informal caregiver focus group participant).

My dad went to one seminar which introduces preparation for the seniors. He came back and said maybe we should make some arrangements. He just said that once and never said that again ...It may be easier to accept from others, rather than hearing it from your children. Sometimes it's hard to say that in the family (informal caregiver focus group participant).

For some informal caregivers, there are added pressures when seniors are dying: although there are some supportive caregiving facilities (e.g. hospice and palliative care), these facilities are not able to offer care in the language of the individual – which places more stress on informal caregivers. The concept of hospice can conflict with some cultural backgrounds. Other concepts that come up in the health care system such as do-not-resuscitate (DNR)[13] orders and Advance Care Planning and Advance Care Directive seemed unfamiliar to some focus group participants.[14]

13 Also known as no code or allow natural death. For information about DNR and the DNR Confirmation Form in Ontario, see https://blogs.ottawa.ca/physicians/2015/05/01/the-ontario-dnr-confirmation-form-what-your-patients-need-to-know-about-their-dnr-order/

14 See, for example, http://eol.law.dal.ca/?page_id=231 and http://www.advancecareplanning.ca/about-advance-care-planning/

Box 4: An example of a lack of cultural competence

In this example related in a focus group, the informal caregiver held the position of communicator, interpreter and mediator of information between the physician and the patient (who was the informal caregiver's mother). The informal caregiver's cultural responsibility–to maintain the optimism of the family member - was undermined with adverse consequences for the informal caregiver and parent.

Addressing death issues with the immigrant community sometimes is hard. ... In my culture when people are dying, we usually don't tell them the outcome. Everybody in the family will know they are dying, but not them. Because we believe this will put them down and they will give up and they will not fight the disease they are having.

That lady - she was dying. The son (my friend) took her to see the physician: the son was doing the translation. The physician felt that the son was not translating the whole thing and the son - he doesn't translate that she is going to pass away in two weeks. The physician felt that maybe the son did that (for the reason that her death would benefit him). So what happened is that the doctor told the son to go out. They brought an interpreter. So they told her through the interpreter that she was dying. Without the son being in the room. In two weeks she died. It was so traumatic for the son not being with his mom... the physician wanted her to know she was dying so if she wants to do something she'll do it before she dies. And the son didn't want her to give up. … She was devastated to hear that news that she was dying and nobody was with her in the room supporting her, and the son was so upset.

(Somebody in the group says: they have to tell you - you are dying).

Yes, but that's how we look at it in our culture. It's not that we want to take anything away from the senior. We don't tell them they are dying. We support them until the end.

c. Offer specific programs for immigrant seniors

Some immigrant seniors indicated that programs designed specifically for them are very important in helping to address their health and well-being.

They (health care providers) have no time to listen to you. Being able to come to a place like this ... ff we didn't have a place like this[15], we get depressed. We have time to listen to each other (immigrant senior focus group participant).

Being with community where people can find support to listen to their concerns in their own language, helped to prevent social isolation and depression. Some program offerings in the Champlain LHIN currently address this (See Appendix A).

d. Address waiting lists

All focus groups made mention of waiting times in several parts of the system, family doctor[16], specialist care, hospital and emergency room care, home health care or help with personal care and housework at home. Waiting, sometimes in pain, and delays in getting appointments or seeing a specialist seemed to be one of the highest priorities to address for immigrant seniors. Emergency rooms were viewed by some as a solution to getting and receiving care: even though you wait in the emergency room, you "*get everything at the emergency room.*" Senior citizens' challenges accessing their doctor when needing care have also been noted in the literature (Canadian Institute for Health Information, 2011).

15 "a place like this" refers to a regular program where immigrant seniors' get together and speak the same language.

16 only one participant reported that he was not able to find a family doctor

e. Provide appropriate homes and facilities for immigrant seniors

Many immigrant seniors were housed in the community, which matched with the desire across all informants for immigrant seniors to live in the community and receive health services close to home.

... Moving care closer to home, by the most appropriate provider, for the best quality care. Less institutional care. (survey organization respondent).

However, community housing policies were thought to be inflexible in accommodating families to help with their care and health care. The ideal living arrangement was:

... They have some kind of senior residence, like their own apartment in their own building, where so many people speak the same language. And they can for instance, every evening and during the daytime come downstairs to the lobby…They always dream about that – meals, their own apartment. Some can cook their own meals. But for this .... their own social life (informal caregiver).

There is a seniors building where lots of (name of language spoken) seniors live there and we find seniors support each other. They knock on doors when they don't show, to see them. If one of them is having a surgery, they cook and take food to that person. Clean for each. They look after each other in that building (informal caregiver).

In the Champlain LHIN health care system, there are different levels of health care from home-supported health care through to long-term care and 24-hour nursing care. However, immigrant senior focus group respondents, in particular, identified an urgent need for facilities (*We need those kinds of care and we don't have a place to go. We need immediate assistance).* Although these facilities are not always a solution for some families who are culturally required to take care of their seniors.

Part of taking care of your elders - it's not only that you love them and you take care of them, part of it is how the community will look at you...

If I put my mother in a nursing home, people will say what a bad daughter. A good daughter or good son ... will sacrifice themselves for their parents (informal caregiver).

f. Improve health literacy and help seniors to take care of themselves

Immigrant seniors' focus groups indicated many had difficulties finding their way around the health care system; many needed information that addressed their lack of awareness of services and options regarding their health; and many needed assistance in managing their (patients) own health information.

... there should be a central mechanism ...without spending a lot of money doing it ... e.g. passport of my health – a very simple document which will create ownership.. and remembering what you have, what you need, what you have had happen to you so far – and then because it is yours – it is your ownership (of your health) to remember all the things, and secondly, you present it to your health provider – and will make it easier for the health provider to give you treatment (immigrant senior focus group participant).

Key observations of staff who were present in some focus groups was that some immigrant seniors' difficulties stemmed from a lack of literacy in their own language.

How can you access information if you can't read or write? Some come here (to Canada) to raise their grandchildren so they don't go to (community-based) programs. They still survive. This speaks to their resilience (staff member).

g. Address out-of-pocket costs of health care

Because some seniors do not qualify for assistance with eyeglasses, dental care, hearing aids and medication etc., help to pay with their costs was brought up as a priority.

Seniors would maybe like some waiving of fees for dentures, dental care, hearing devices, eye glasses, canes, the walkers. etc.

h. Provide affordable, accessible and available transportation

Transportation was seen as fundamental for seniors' health, enabling access to the health care system and helping to avoid social isolation and promoting mental well-being. Addressing the cost, accessibility and availability of transportation was raised in all focus groups as a key priority. Improving Para Transpo, including improving access to the organization to book appointments, was seen as a priority by focus group participants.

i. Assist organizations to improve immigrant seniors' health and health care

Survey respondents' answers to the question "Regardless of what services/programs your organization currently offers, what would be of assistance to your organization in improving immigrant seniors' health and health care?" There was little difference in scoring for importance between the different statements, suggesting that there were few items that respondent organizations did not see as important in assisting them in improving immigrant seniors' health and health care. In the following table (Table 5), we have included the top 10 items by number of responses.

Table 5: What would assist respondent organizations in improving immigrant seniors' health and health care - Top ten items by rank and number of responses

Ranking	Top Ten	Items assisting in improving immigrant seniors' health & health care	Number of responses	Percentage of responses
1.	1	6. Increase all staffs' cultural competency/sensitivity	34	(100.0%)
1.	2	10. Improve timely access to health care	34	(100.0%)
1.	3	21. Include informal caregivers (e.g. family members) in health care appointments	34	(100.0%)
2.	4	11. Provide information about health and health care in their language	33	(97.1%)
2.	5	13. Provide culturally appropriate services	33	(97.1%)
2.	6	15. Include informal caregivers in regular communications re health care test results, prescriptions & patient/client outcomes	33	(97.1%)
2.	7	25. Offer mental health and memory care services	33	(97.1%)
3.	8	5. Provide age-specialized health care for immigrant seniors (e.g. geriatric nursing; specialized geriatric services)	32	(94.1%)
3.	9	12. Implementing programs based on a chronic disease management model[1]	32	(94.1%)
3.	10	28. Increase in-home personal support (e.g. personal support and homemaking services, e.g. by a personal care support worker (PSW) or health care aide (HCA).	32	(94.1%)

j. Make investments in integration and coordination of care; and outreach and communication

We asked organization respondents, "If you were given additional operational funding to meet the health needs of immigrant seniors, in what two areas of your operations would you invest this money?" Of the 32 responses to this question (50% of all respondents), i) organizational administration including integration and coordination of services[17], and ii) outreach and communication with members of the community, received the most responses.

Integration and coordination of care as organizational priorities, captures a goal and direction of enhancing coordination of services and smooth transitions between care types and health system components, particularly for targeted populations including people with complex needs and seniors.[18] These included, for example, mental health and addiction services as part of integrated and coordinated services, and transitions and integration of care from hospital to community. One survey respondent noted that there were very few seniors' and immigrant seniors' services in mental health and addictions.

The themes of integration and coordination of care and outreach and communication also underscored the importance of interpretation for immigrant seniors.

> *Primary care and related services (interpretation). Many seniors are better served via home visits by the primary care provider. These encounters are time consuming and costly however serve the senior well (survey organization respondent).*
>
> *Other areas for operational funding included space for new staff[19] and resources to expand service access and delivery on evenings and weekends.*

Box 5: Programs and services that applied to immigrant seniors

The following programs and services were listed by organizations as specific to immigrant seniors:

- The Thelma Steinman unit and diverse seniors unit of Jewish Family Services (JFS), wich offers a number of different services to immigrant seniors in Russian, Yiddish and English
- Yet Keen Seniors Day Centre for Chinese speaking seniors (serving Chinese-speaking adults 60 years and older)
- Primary Care Outreach (Primary Care Outreach to Seniors in English, French and a variety of other languages with the assistance of a cultural interpreter).
- An Arabic-speaking senior women's group
- Multicultural mental health
- *Centre de gestion du sevrage, support au logement et aide à la vie autonome*
- Interpretation and cultural liaison services

In addition to the above Box, see Appendix A for a list of services and programs provided by surveyed organizations.

17 Integration and coordination of services reflected a Champlain LHIN's system imperative.

18 http://www.drdh.org/Documents/6_Champlain_LHIN_Integrated_Health_Service_Plan_2013_16.pdf

19 Organization respondents listed a range of health professionals and allied health workers. Ten (10) organization respondents identified social workers with specialization in gerontology.

RECOMMENDATIONS TO THE CHAMPLAIN LHIN HEALTH CARE PLANNERS

Health is everything
(immigrant senior focus group participant).

There are a number of recommendations to assist and improve health care and quality of life of seniors that for so many focuses completely around their health. Recommendations to the Champlain LHIN are drawn from the study's findings and address priority themes from all respondents. These recommendations were developed with the Project's Advisory Committee.

Immigrant seniors acknowledged that the health care system is one focus, but also recognized that the social determinants of their health are also closely entwined - living at home with support is seen as critical for maintaining health and preventing involvement with the organized and institutional health care system.

Recommendation (a) Recognize the population health of immigrant seniors

Recognizing the population health of immigrant seniors recognizes two demographic trends, population aging and diversity. Population-based approaches to health care can recognize immigrant seniors as a population, but with understanding that within this population there are subgroups whose members do not have personal resources, social capital or basic literacy that would enable them to live independent and healthy lives in the community. Some immigrant seniors experience significant economic disadvantage, are vulnerable to worsening health, and experience social isolation and marginalization. A complex health system that is designed and structured for a literate and mainstream-focused Canadian context, sets some immigrant seniors at considerable disadvantage, and impacts their health care providers who are trying to provide quality care to patients.

For the population of immigrant seniors as a whole (bearing in mind that although diverse, they are also a sub-population of the seniors' population in Canada) it may be more useful to focus on immigrant seniors' health status rather than their age. Although decreases in optimal health tend to parallel increasing age for some members of the seniors' population, shifting the focus from health care illness/disease/poor health to health promotion and prevention of disease for those who are 'healthy' – may help to preserve good health and have greater relevance rather than a single focus on the provision of health care.

Recommendation (b) Address language and culture in health care of immigrant seniors

Pro-active approaches to improving immigrant seniors' health and health care, by improving all aspects of access to the health care system particularly through communications and language, can help to address health inequalities and health inequities. All study informants, staff and the Project Advisory Committee members stressed the imperative that the health care system should understand and accommodate immigrant seniors' languages and cultures as the underpinning of their health care.

Recommendation (c) Address the social determinants of immigrant seniors' health

Perhaps one of the most difficult challenges in planning services designed to impact the health care and health outcomes of immigrant seniors is the understanding that health does not originate in the provision of health care alone but in non-health implicated sectors and areas of life. Addressing these factors – social determinants of health - outside the health system that increase risk to health - can be critical for the prevention of health problems, and suggests planning to increase the connectivity of sectors and systems (for example, developing linkages of health care system with the settlement sector which is typically the first point of contact for many newcomers to Canada).

Income is an important determinant of health. There was a good deal of discussion in the focus groups on the costs of health care, referring to the out-of-pocket costs that immigrant seniors can incur. The word 'poverty' was not used, but the analysis of focus group participants' characteristics indicated that many immigrant seniors were personally without much in the way of income and adequate resources.

In recent years, there has been more of an emphasis in Canada on the development of age-friendly communities to help support the health and well-being of older Canadians by maintaining involvement in their communities.[20] Age-friendly incorporates the concept of protecting those seniors who are vulnerable through the provision of services such as, for example affordable housing which is safe and well-designed for seniors, and public transportation which is affordable and accessible.[21] Community health centre models, for example, which operate at the local level are recognized and well-placed to mediate the effects of social isolation, poverty, and basic health literacy on immigrant seniors. At the municipal level, planning for housing for the population of seniors and specifically immigrant seniors, and engaging multiple sectors in planning will help to effectively meet health and social needs.

The Champlain LHIN's consultations on sub-region development in 2016, also found an approach to be focussed on population health and health equity. The consultation noted "(a) variety of populations and unique community characteristics that will need special attention …"[22]

> *Solutions – language-based, homes and community-based life that they can participate in and negotiate. Food and culture (including social life) that is familiar (summary) Muslim food – but not necessarily religious… (survey organization respondent)*

Recommendation (d) Focus on promoting health and preventing illness

Closely in line with the social determinants of health is health promotion and the prevention of illness. Improving community-based programming for immigrant seniors and their informal caregivers was also seen as important in promoting health including mental health, preventing illness and reducing social isolation. Some immigrant seniors indicated that programs designed specifically for them are very important in helping to address their well-being.[23] Being with community where people can find support to listen to their concerns helped to prevent depression.

> *Our health depends on a place like this, where we can come, socialize in our own language, and share stuff with each other. Immediately our well-being is better… All this is very valuable for our health. We are better when we are (here). ... (immigrant senior focus group participant).*

20 Public Health Agency of Canada (2012) Age-Friendly Communities in Canada: Community implementation guide

21 p5. Age-Friendly Rural and Remote Communities: A Guide
http://www.phac-aspc.gc.ca/seniors-aines/publications/public/afc-caa/rural-rurales/index-eng.php

22 Champlain LHIN (2016) Sub-Region Development Summary Report. p.3 Accessed from
http://www.champlainlhin.on.ca/GoalsandAchievements/OurStratPlan/SubRegions.aspx

23 There were some indications from staff that not everyone participates in programming even though the immigrant seniors themselves ask for it. (I have to tell them maybe three times there's a program in the building– they don't come. They don't come.)

We all have depression. We would constantly be visiting the doctor ... and being depressed...they have no time to listen to you. Being able to come to a place like this... If we didn't have a place like this, we would get depressed. We have time to listen to each other (immigrant senior focus group participant).

Recommendation (e) Improve access to mental health services through immigrant-serving community organizations

Research project participants were very cognisant of mental health problems including dementia and Alzheimer's, and elder abuse[24]. Improving access to mental health services by supporting immigrant-serving community organizations in collaboration with services and supports in the mainstream mental health system capitalizes on the knowledge that local agencies and organizations have about the needs of the populations they serve. While community-based integrated mental health services "address the social determinants of migrant mental health, are gender and life stage sensitive; and recognize both the challenges and resiliencies of diverse groups of migrants"(Khanlou, 2010, p. 16), immigrant-serving community organizations have been identified as important for mental health services, because they "have an important role to play in assessing local mental health needs and strengths, and taking action on local priorities" (Government of Canada, Robert, & Gilkinson, 2012, p. 25; Mental Health Commission of Canada, 2012, p. 84). Increasing access to health care will be facilitated through interpretation/translation.

Recommendation (f) Support informal caregivers

The findings from this study and a number of reports suggest strongly that support for informal caregivers is important to address (Accreditation Canada, n.d.; Balance of Care Research Group University of Toronto, Williams, Peckham, Rudoler, & Watkins, 2012; Donner et al., 2015). This recommendation is in part based on evidence that shows that, with the assistance of informal caregivers, institutionalization of seniors can be delayed and reliance on formal care reduced, avoiding some of the increase in costs for long-term care and healthcare systems (A. P. Williams et al., 2013, p. 37).

Recommendation (g) Increase access to dental care

Increasing access to health care, which includes dental care for immigrant seniors, will be facilitated through interpretation/translation which is especially important for those with little to no literacy in their language(s) of origin. With respect to dental care, cost is a barrier for immigrant seniors. King (2010) has recommended "Explore opportunities for better integration and/or alignment of low-income oral health services in Ontario, including integration and/or alignment with the rest of the health care system" (King, 2012, p. 5)

Recommendation (h) Collect data and provide information

An important question for Canada is whether health care is delivered in a fair way to everyone. Answering this question is sometimes done using a tool called a health equity impact assessment which helps to determine the effects of a policy, program or service on a population.

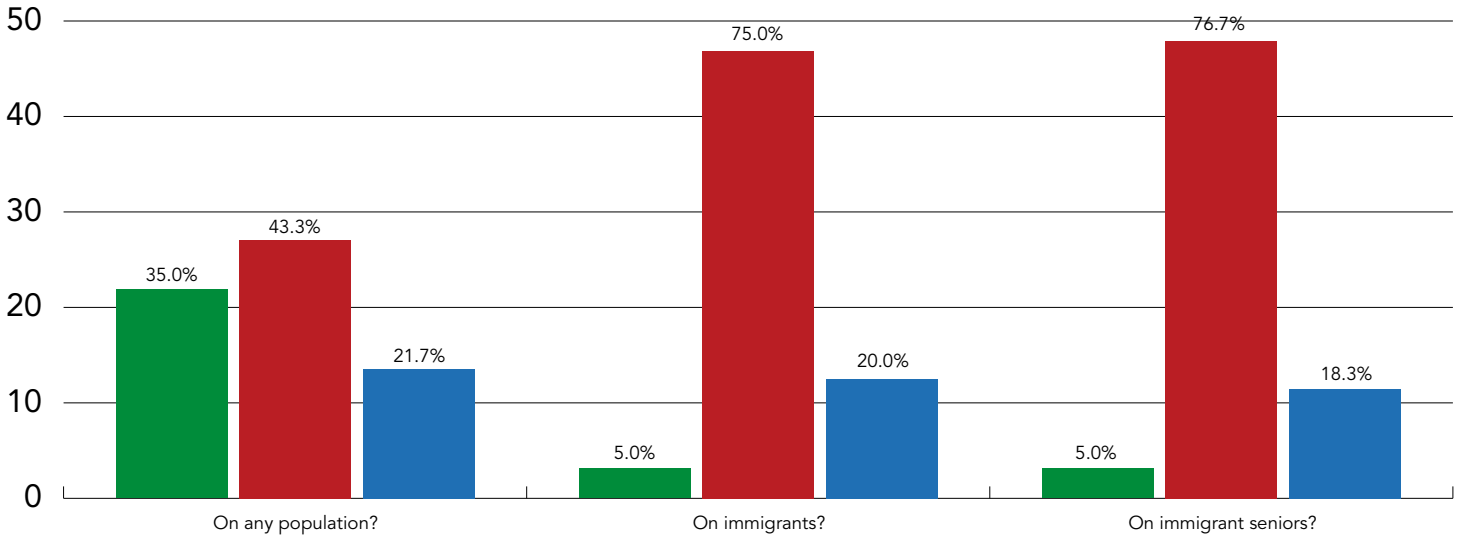
Responses to the survey of health care organizations in the Champlain LHIN strongly suggested that health care organizations could benefit from increased support and capacity with regard to data collection and health equity assessments. For example, thirty-four (60%) of respondent organizations did not collect data nor had they access to data that could show how many immigrant seniors they served. Where differences in sex have been shown to produce inequitable health outcomes for populations of women and men, disaggregated data is an important adjunct in prioritizing and planning services. While eighty-three percent (20) of survey organization respondents reported disaggregation (separation) of data by sex, 16.7% (4) of respondent organizations indicated that they did not disaggregate their data by sex.

Organizations were asked if they had ever made use of a population health equity impact assessment (or other equity tool or lens). Firstly, 35% of survey respondents had utilized health equity assessments on a population, with 21.7% using them sometimes (Column 1). However, 43.3% did not make use of them. Roughly the same number of survey respondents did not use health equity assessments on immigrant or immigrant senior populations (Columns 2 & 3). While the use of health equity assessments for any

24 Elder abuse has been identified as a significant health, mental health and social problem for seniors. Concern was also expressed by staff about a lack of culturally-sensitive emergency shelter beds for immigrant senior women in abusive situations.

population suggests some usage, the lower percentages for immigrants and immigrant seniors' populations suggest that specification of immigrant populations in conjunction with equity assessments is only made by one quarter of organization respondents.

Chart: Use of health equity assessments in surveyed organizations



Green = Yes
Red = No
Blue = sometimes

A lack of data about immigrant seniors' and their health care was evident. Data for planning purposes is needed by community-based organizations as well as the LHIN to support informed decision-making and priority-setting in health care. Gearing data collection (e.g. regional level data sorted or disaggregated by population group characteristics e.g. country of origin, income level, sex and age) towards an aim of using this data to provide important information, for example about service provision and patient satisfaction, can make a positive difference in the future (Government of Ontario, 2017, p. 16; Ontario Human Rights Commission, 2000). Research about the immigrant seniors' population will also increase knowledge about the diversity of the population and the challenges that are faced in negotiating health and social sectors in the region.

In terms of the provision of information, in addition to data-sharing with organizations, we recommend that the LHIN adds a section on its website for immigrant health to incorporate information and resources for immigrant seniors which could be used by themselves or by health workers. Other websites incorporate internet-based translation applications to their websites, and this is something that could also be considered.

Box 6: Summaries of priorities, top organizational improvement items and recommendations to improve immigrant seniors' health and health care in the Champlain LHIN region.

Summary of priorities from research findings

- Address the language and cultural needs of immigrant seniors
- Offer specific programs or immigrant seniors
- Provide appropriate, affordable housing and living arrangements to support their health and community living
- Improve health literacy and health information
- Provide affordable, accessible and available transportation, including Para Transpo in Ottawa
- Address access, availability and affordability problems e.g. waiting lists, out-of-pocket costs for drugs; eye, ear and dental care; and assistive devices

Summary of top-ranked items to assist organizations from survey responses

- Increase staff's cultural sensitivity and competence; and provide culturally appropriate, age-specialized and timely health care services including information about health and health care in immigrant seniors' languages.
- Offer mental health and memory care services
- Increase in-home personal support
- Include informal caregivers regularly in communications about their immigrant seniors' health (health care test results, prescriptions & patient outcomes)
- Implement programs based on a chronic disease management model [3]

Summary of recommendations from all project sources

- Recognize the population health of immigrant seniors; focus on promoting health and preventing illness.
- Improve all aspects of access to the health care system for immigrant seniors through good communications based on language spoken and cultural sensitivity and competence.
- Support the social determinants of health to include community-based living and culturally acceptable accommodation, and develop community-based programming for immigrant seniors
- Support informal caregivers
- Increase access to mental and dental care
- Collect data and provide information

Findings and recommendations stemming from this study strongly suggest the enhancement of planning capacity in the LHIN which focuses on the provision of services for immigrants, including the sub-population of immigrant seniors.

FUTURE RESEARCH

9a Rural area research

Rural areas form a significant proportion of the Champlain LHIN. Population data suggest that the numbers of immigrant seniors are extremely low in rural areas. Access and utilization of health care by seniors is unclear in rural regions (Mattson, 2010). That immigrant seniors may experience increased social isolation and environmental challenges in relation to living in rural locations, suggests a need for further research to investigate their access to health care.[25]

9b Best practices in immigrant seniors' health and health care in the Champlain LHIN

Our search for best practices in immigrant seniors' health and health care in the literature has suggested potential benefit from further work. Aligning this research project's findings with the literature and developments and innovations in the Champlain LHIN with input from service providers can provide directions for best practices in the region.

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25 http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/public/healthy-sante/age_friendly_rural/AFRRC_en.pdf p. 6 See also https://www.ruralhealthinfo.org/topics/transportation#consequences. A study in Guelph etc. https://www.wdgpublichealth.ca/sites/default/files/wdgphfiles/sdoh-wdg-report-2013-for-web.pdf

CONCLUSIONS

Immigrant seniors are at the centre of two dominant demographic trends in Canada: aging and diversity. Planning for the population of immigrant seniors is central to equitable health services in the future. We leave the last word to one of the immigrant seniors who was interviewed:

> *… I would tell my doctor please take care of seniors, give the senior a good health care and don't think that now that they can't do anything for this country. Because they used to be very useful for the country, so now please give them a very good health care.*

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Appendix A: Surveyed organizations and their programs

The survey was targeted at all organizations receiving funding from the Champlain LHIN.

- Sixty-four organizations submitted surveys
- One third (36.5%) received 90-100% of their funding from the Champlain LHIN, over 2/3 of respondents received 50% or more of their funding from the LHIN
- Just under 40% (two-fifths) of organizations provided services to the whole of the geographic Champlain LHIN region. The remainder provided services at the sub-regional level (See Figure 1: Sub-regions of the Champlain LHIN)
- Organizations operated in five primary service categories – hospital (16.4%); long-term care home (16.4%); mental

health and addiction services (23%); home and community care (26.2%); and community health centres (18%).

- Majority of services were in primary care (23 organizations); health promotion and community development (24 organizations) and addictions and mental health (25 organizations)
- Respondent organizations delivered care in: a health-related institution (40%); through a community program that is not conducted in a health institution (30%); in a community health centre (8.3%); in immigrant seniors homes (5%) and in other locations that included hospice, and residential treatment centres for addiction and substance abuse (16.7%)

In addition to a wide range of services and programs identified in the table below organizations indicated other services and specific areas of service to immigrant seniors (33 individual entries).

Table 6: Services and programs delivered by surveyed organizations

Response	Percentage	Count
Primary care	38.3%	23
Health promotion and community development	40.0%	24
Addictions and mental health	41.7%	25
Food security	16.7%	10
Women's health and development	10.0%	6
Education	21.7%	13
Indigenous community and cultural services	8.3%	5
Immigration and settlement	6.7%	4
Family services (includes adult daycare)	18.3%	11
Accessibility services for people with disabilities	16.7%	10
Housing/accommodation (including respite care for immigrant seniors)	16.7%	10
Community economic development and social enterprise	3.3%	2
Public and community safety	8.3%	5
Emergency preparedness and disaster relief	8.3%	5
Francophone community and cultural services	11.7%	7
Employment services	5.0%	3
Legal services	0.0%	0
Transportation	20.0%	12
Senior Friendly Hospital Initiatives	15.0%	9
Specialized Geriatric services	25.0%	15

Response	Percentage	Count
In-home nursing	5.0%	3
In-home therapy	1.7%	1
In-home personal support (including personal support and homemaking services provided e.g. by a personal care support worker (PSW) or health care aide (HCA).	16.7%	10
		60

In addition to the checklist, respondents described several types of services and programs for immigrants and seniors. These included:

Hospital services: acute and subacute health services, complex continuing care, rehabilitation, hospital services.

Newcomers' health clinic, 'centre de gestion du sevrage, support au logement et aide à la vie autonome(als),' hospice care, and traditional medicine.

Diabetes screening, education, and self-management of diabetes, and foot care.

Day programming included 'day away' services and drop-in programming.

Mental health services included peer resource centres and intensive case management. Counselling and integration of seniors was mentioned, and a program supporting Seniors' Pride. Community support and cultural services were named but not specified further.

Outreach programming included multicultural, newcomers and seniors outreach. Programs to reduce seniors' isolation, and telephone assurance (where check-in calls are made to target populations) were mentioned.

Prevention and health promotion programs such as multicultural and seniors' outreach programming, and a "multi-cultural safety awareness initiative for people with dementia who go missing or become lost, and those who care for them."[26]

Educational programming included English language training.

Food-related programs (congregate dining, Diner's clubs, community lunches, frozen food and meals-on-wheels (po-pote roulante).

Other services included homemaking referrals, friendly visiting, a 'handy helper' and a home maintenance program, and equipment lending.

Finally, organizations identified programs that only served immigrant seniors. These examples can be found in the main text of the report.

26 http://alzheimerottawa.ca/multi-lingual-wandering-prevention-program-finding-your-way-expands/

Appendix B: Dental (oral) health – some notes from the literature

"The aging process can be as hard on our mouths, teeth and gums as it is on other parts of our bodies. As we get older, we are more susceptible to the buildup of plaque and the weakening and cracking of older fillings. In addition, there is a tendency for our teeth to become brittle, and many seniors suffer from diminished muscular control, which can make chewing or wearing dentures more difficult. Finally, the older we get, the more vigilant we need to be against developing gum disease."(Ontario Dental Association, 2010, p. 7)

"Oral health is important for the overall well-being of children and adults, and poor oral health has been linked to other diseases and serious health conditions such as respiratory infections, cardiovascular diseases, diabetes and poor nutritional status." (Bhuiya & Wilson, 2016, p. 3). Relationships have also been identified between bone metabolism (osteoporosis); poor oral health and substantial weight loss, dehydration and infirmity (King, 2012). This is particularly the case for the more vulnerable seniors, "particularly those living in long-term care homes" (Ontario Dental Association, 2010, p. 3).

Sabbah (1998) and Health Canada (2010) reported that "increasing age predicts higher utilization of physicians but lower utilization of dentists, and that poor general health predicted highest attendance of a physician but lowest utilization of dentists. For dental care, *socio-economic factors determine dental care utilization to the extent that visiting a dentist is opposite to the expected needs*" (Health Canada, 2010, p. 13; Sabbah, 1998).

We found little in the way of literature on oral (dental) care related specifically to immigrant seniors, however, the literature cited here suggests that, in addition to natural aging processes and impacts on dental health, 'vulnerability' and low-income and poverty are determinants of oral health (Canadian Academy of Health Sciences, 2014; Sadeghi, Manson, & Quiñonez, 2012). Challenges in accessing and paying for dental health care exist for disabled, refugee and new immigrant populations, and they experience an "inordinate burden of oral disease compared to their general Canadian counterparts (Canadian Academy of Health Sciences, 2014, p. 36).

> *Challenges exist for disabled, refugee and new immigrant populations as well. These groups suffer an inordinate burden of oral disease compared to their general Canadian counterparts. they often experience limited incomes, and while they sometimes have access to some public support (disabled and refugee populations specifically), they also experience significant barriers in accessing dental care. For example, the federal government has historically supported some refugees, but the coverage is limited and the timeline of coverage is short (often only one year from entry)… In addition, no province other than Quebec offers support for refugees. Furthermore, new immigrants have no public support for oral health care unless they qualify for social assistance coverage, and here too, the challenges of poverty are at play.*
> *(Canadian Academy of Health Sciences p. 36.)*

Arlene King as the Chief Medical Officer of Health in Ontario, noted in her report which aimed to raise awareness of the importance of oral health and equitable access to oral health services, that low-income Ontarians including seniors "*do not have adequate access to preventive oral health services or treatment when and where they need it*"(King, 2012).

Publicly-funded programs such as ODSP only provide limited dental and other oral-health-related services (Quiñonez, Gibson, Jokovic, & Locker, 2009). Some seniors who are no longer eligible for ODSP, may be eligible for Extended Health Benefits (EHB) if their health care expenses are high (this includes help with dental, vision and hearing). Many immigrant seniors may need to pay for dental services either through private insurance, the extent of which depends on their plans' terms and/or out-of-pocket, which can pose a significant barrier to access dental services needed. (Many retirees lose non-wage benefits on retirement).

A Public Health Ontario study reported a summary of oral health status and access to dental care among different socio-demographic subgroups of the Ontario population using Canadian Community Health Survey (CCHS) data

from 2005 (Sadeghi et al., 2012). In general, older adults are less likely to be insured for dental care (36%) than the general population of Ontarians (68%) (See Sadeghi et al. (2012)). Those 65 years of age and older were more likely to visit a dentist only when an emergency occurs. This is in comparison to most Ontarians (80%) who "*tend to visit a dentist for preventive purposes while one in five visits a dentist only in emergencies*"(Sadeghi et al., 2012, p. 1). Sex differences on a number of measures were recorded as "not prominent" in the study's findings by the author. With regard to immigrant status, (comparison of immigrant and non-immigrant status), the table provided only compared all immigrants and all non-immigrants, with no disaggregation by age group. (See Table below).

Table 7:
Access to dental care among Ontario residents according to their sociodemographic characteristics

Immigrant status	Visited a dentist in the last year	Reported that cost was a barrier (%)	Only visited dentist in an emergency (%)	Has dental insurance (%)
Immigrant	66.3 (65.2-67.3	19.3 (17.3-21.4)	25.3 (24.3-26.3)	59.2 (58.1-60.3)
Non-immigrant	73.8 (73.3-74.3)	20.2 (19.1-21.3)	17.2 (16.7-17.6)	71.7 (71.2-72.2)

Source: (Sadeghi et al., 2012) from CCHS 2005 data (prevalence and 95% confidence interval)

Some professional associations have suggested strategies for the oral health of seniors. Both the Registered Nurses' Association of Ontario and the Canadian Dental Association have suggested similar long- and short-term strategies to improve oral health and access to care for seniors (Canadian Dental Association, 2010; Registered Nurses' Association of Ontario, 2008). A few years ago, the federal government added an Office of the Chief Dental Officer to provide policy leadership and direction in the area of oral health and oral health care across Canada (a similar office had not been in place for approximately thirty years). A President of the Canadian Medical Association (CMA) has suggested that Medicare be extended to include oral health care (Smith, 2007). Finally, the Canadian Dental Association now recommends that governments establish a "dental safety net" for all disadvantaged Canadians, changing its former policy position of targeting specific vulnerable groups, particularly children (Canadian Dental Association, 2010).

Appendix C. Help and Resources for Immigrant Seniors

If you are experiencing distress, **emergency help** is available as follows:

The Distress Centre of Ottawa answers calls for help in **English** at any time of day or night 365 days per year. All calls are confidential and free. Distress Line (Ottawa/Gatineau) **613-238-3311** (English only). If you are encouraged to connect to the hospital system, other languages are available.

Mental Health Crisis Line (Ottawa) **613-722-6914** (**English and French**) The Mental Health Crisis Line is available 24 hours per day, 7 days per week, 365 days per year. All calls are confidential and free. If you are connected with the hospital system, other languages are available.

Ontario 211 – Call **211** (http://211ontario.ca) Ontario **211** is a helpline and online database of Ontario's community and social services. Available 24 hours per day, 7 days per week, 365 days per year. All calls are free and confidential. (Services are available in over 100 languages).

Ontario 211 Help Line: **TTY: 1-888-340-1001** (Deaf, oral deaf, deafened and hard of hearing people). Online chat is also available.

If your distress is associated with elder abuse or violence, please call: **SENIORS SAFETY LINE: 1-866-299-1011**

If you are experiencing distress after the interview, you might **contact one of the following organizations for help**. These organizations typically operate during business hours, and offer a range of services.

South-East Ottawa Community Health Centre (SEOCHC). Call **613-737-4809** - ask for an appointment with an Intake Worker OR:

Come to SEOCHC Social Services Walk-In offered Monday to Friday 1 to 2:30 pm with **French, English, Somali and Arabic** available. Walk-Ins are on a first-come first-served basis.

SEOCHC also offers clinical counselling up to 12 sessions and has a Walk-In Counselling Clinic every Tuesday 11:30 am to 6 pm with services in different languages. Contact Jewish Family Services at the SEOCHC Hunt Club location (Hunt Club/Riverside Site 3320 Paul Anka Drive Ottawa, Ontario K1V 0J9) for support in **Arabic**. Telephone number: **613 247 1600 ext. 327.**

OCISO Ottawa Community Immigrant Services Organization **613-725-0202** (main administration office). (https://ociso.org/). Has counsellor and crisis intake workers. May refer on. Clinical counselling is offered in **English, French, Spanish, Arabic, Farsi, Dari, Nepali, Hindi, and other languages** as needed.

Somali Centre for Family Services **(613) 526-2075** Provides assistance to refugees, and to immigrants in need of settlement support and integration services. SCFS hosts multiple social events for seniors throughout the year. The website is available in multiple languages. Staff speak **Somali** and **Arabic**. (http://www.somalifamilyservices.org/).

Ottawa Chinese Community Service Centre (**613) 235-4875 (Cantonese, Mandarin).** Offers a walk-in Counselling service on Tuesdays between 11:00 am and 5:00 pm (Call 613-235-4875).

Jewish Family Services. Evening appointments for counselling are available. Jewish Family Services' for Diverse Seniors Contact Laura Thomas at 613-722-2225 ext. 313. Jewish Family Services' Thelma Steinman Seniors Support Services offers Programs and services for Jewish seniors including informal caregiver support in **English, Russian and Yiddish**.

In general: For services in **Arabic** contact South East Ottawa Community Health Centre 613-247-1600 ext. 327.

For services in **Chinese or Mandarin** contact Ottawa Chinese Community Service Centre 613-235-4875 ext. 137.

For services in **Somali** contact Somali Centre for Family Services 613-526-2075 ext. 229.

For services in **Punjabi**, contact 613-722-2225 ext. 497. (Jewish Family Services)

For services in **French and Kinyarwanda** contact Economic & Social Council of Ottawa-Carleton 613-248-1343 ext. 331. http://www.cesoc.ca/index.php/en/

For service information in **English, Urdu, Punjabi, Hindi** or other languages contact Ottawa Community Immigrant Services Organization 613-725-5671