From Hospital to Home: Assessing the Transitional Care Needs of Vulnerable Seniors

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Purpose: This qualitative study assessed the needs of patients and caregivers during the transition from hospital to home. We specifically identified unmet needs of ethnic minorities, recent immigrants, and seniors with limited English proficiency (LEP). Findings are translated into recommendations for improving services to these groups during health care transitions. Design and Methods: This needs assessment included extensive analysis of qualitative data collected from 20 language-, culture-, and ethnic-specific focus groups with caregivers who recently assisted a senior after a hospital discharge. Findings from these focus groups were supplemented by 5 in-depth, longitudinal case studies of recently hospitalized seniors and their caregivers. Results: Inadequate information and training at discharge were themes that spanned all groups, despite ethnicity or language. Additional unmet needs were identified for ethnic minorities, those with LEP, and recent immigrants, including lower levels of social support than might be expected, lack of linguistically appropriate information and services, and cultural and financial barriers to using long-term care services. Implications: As ethnic diversity increases among older Americans, it will become increasingly important to design health care services to meet the needs of diverse groups. Recommendations include assessments of informal care, bilingual information and services, partnerships with community agencies providing culturally competent services, and expansion of home- and community-based services to near-poor seniors.

Key Words: Hospital discharge, Minority, Aging, Transitional care

Health care transitions, such as a discharge from hospital to home, have been identified as events when seniors are at risk for medication errors, therapeutic errors, and infection that lead to unnecessary hospital readmissions (Coleman & Boul, 2003; Coleman, Smith, Raha, & Min, 2005; Naylor, 2004). Research shows that one quarter to one half of adverse events leading to rehospitalization may be preventable or ameliorable (Forster et al., 2004; Naylor, 2003). In light of this, the period surrounding health care transitions is a potentially fruitful area for interventions aimed at reducing unnecessary readmissions. Transitional care is a term denoting care provided to patients as they move from one care site (or one care level) to another and refers to care that aims to provide coordination and continuity of health care across care sites (Coleman, 2003; Coleman & Berenson, 2004; Jones & Foster, 1997). Some models of transitional care for seniors have shown promising outcomes, including reduced rates of medication errors and preventable rehospitalizations, reduced costs, and increased patient satisfaction with the discharge process (Coleman, 2003; Coleman & Berenson, 2004; Coleman et al., 2004; Naylor et al., 2004).

Some of the most vulnerable groups during health care transitions include seniors who are ethnic minorities and seniors who are recent immigrants. Compared with the general population, ethnic minorities have slower rates of recovery after hospitalization and increased incidence of potentially preventable rehospitalizations (Davis, Liu, & Gibbons, 2003; Jiang, Andrews, Stryer, & Friedman, 2005; Lafata, Pladevall, Divine, Ayoub, & Philbin, 2004; Sands et al., 2005). Immigrant seniors have
lower rates of service use after hospitalization, despite functional limitations (Kuo & Torres-Gil, 2001; Osacar, 2004; McCormick et al., 2002). Although no studies to date examine the interaction between limited English proficiency (LEP) and health outcomes after a hospitalization, LEP has generally been shown to be associated with lower health utilization (Derose & Baker, 2000). Furthermore, communication theory suggests that certain groups, especially underserved and low-literate groups, experience “knowledge gaps” that may hinder their ability to access and use health care information (Freimuth, 1989).

Most evaluations of models aimed at improving transitional care for seniors have not included sufficient samples of ethnic minorities, recent immigrants, or LEP seniors to determine effectiveness in these groups. Only one study to date has evaluated a transitional care program provided specifically to ethnic minorities and Spanish-speaking seniors with heart failure, and it showed modest reductions in rehospitalizations (Sisk et al., 2006).

This gap in the literature is significant because the aging population in the United States is becoming more ethnically diverse. For example, estimates show that the population of minority elders in the United States will increase even more rapidly than the general population. By 2050, demographers estimate that one in four older adults in the United States will be from an ethnic minority group—representing a 385% increase. In California, demographers predict that by 2050, Whites will make up only 31.2% of the older-than-65 age group, whereas the proportion of Hispanics and Asians will increase dramatically to 41.3% and 17.9%, respectively. Thus, socioeconomic, racial or ethnic, and cultural factors, as well as language and literacy, will be increasingly important to consider in designing future transitional care models.

To address this research gap, we conducted the hospital-to-home study, a qualitative needs assessment of transitional care for older adults in one ethnically and socioeconomically diverse region: the San Francisco Bay Area. (The study included four San Francisco Bay Area counties: Alameda, San Francisco, San Mateo, and Santa Clara.) The study’s objectives were as follows:

- To assess the services available to patients and caregivers during the transition from hospital to home.
- To assess unmet needs of seniors and their caregivers.
- To identify populations that are especially vulnerable and assess any unique needs.
- To make recommendations to improve transitional care to meet the needs of culturally diverse seniors and caregivers in the San Francisco Bay Area.

**Design and Methods**

The design of this qualitative needs assessment was informed by the social ecological model of health behavior (McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokals, 2000). This framework, illustrated in Figure 1, describes several levels of influence that determine health-related behaviors, each level a potential target for health promotion interventions. Guided by the social ecological framework, this study examined how the social environment, including individual, interpersonal, organizational, community, and policy factors, affected people’s experiences and behaviors during care transitions.

To examine the five levels of the social environment (individual, interpersonal, organizational, community, and policy factors) surrounding care transitions, we combined the use of both focus group and case study methodologies. Focus groups were conducted first, followed by more in-depth case studies designed to further elucidate findings from analysis of focus group data. In both methodologies, we put special emphasis on exploring a range of caregiver and care recipient conditions and experiences (individual level); interactions between seniors, caregivers, and health providers (interpersonal level); seniors’ and caregivers’ access to and experiences with service use and health care delivery (organizational level); and seniors’ and caregivers’ connections with and support from the community (community level). Also on the community level, we looked at how culture, ethnicity, language, and experiences of discrimination affected the hospital-to-home transition. At the policy level, we examined how public programs such as Medicare and Medicaid, private insurance, and access to other public programs affected the experience of assisting a care recipient home after a hospital stay.

**Focus Groups With Caregivers: Methods and Sample**

Twenty focus groups were conducted with 159 caregivers who had recently assisted a care recipient home from the hospital (see Table 1). Groups had an average of 8 participants. Focus group
participants were separated into groups by language and culture. Focus group theory asserts that participants should be selected for compatibility because when participants perceive each other as fundamentally similar, they can spend less time getting to know each other and more time discussing the issues at hand (Morgan & Scannel, 1998). This may be especially true when the topic of the group touches sensitive subjects such as how culture and ethnicity play into health care experiences.

To conduct groups that represented the ethnic and cultural diversity of the San Francisco Bay Area, researchers formed partnerships with community-based organizations (CBOs) such as senior service agencies and immigrant and refugee organizations. CBOs were selected based on the particular language, culture, or ethnicity of the groups they served. These organizations received a stipend for their participation and represented some of the largest ethnic, language, and cultural groups in the San Francisco Bay Area. These CBOs assisted in the recruitment and coordination of all focus groups. Employees from the CBOs were trained to use purposive sampling techniques to screen potential participants, ensuring that all participants met language, ethnicity, and caregiving inclusion criteria of the group they were hosting.

To allow researchers to look at hospital transition issues associated with culture and ethnicity, attempts were made to conduct at least two focus groups in each language, ethnic, or cultural group. Because the San Francisco Bay Area is a highly diverse region, we purposely oversampled people of color to add to our understanding of any unique issues for these rapidly growing groups (see Table 1). The final sample reflected a wide variety of ethnic groups, including Asian (42%), White (22%), Latino (16%), African American (14%), and Russian (6%).

Eleven groups were conducted in English, 3 in Spanish, 2 in Vietnamese, 1 in Russian, 1 in Cantonese, and 2 in Tagalog. (Although an attempt was made to include at least two groups for each language or cultural group, researchers were unable to coordinate a second group with Russian participants. For Chinese participants, one group was conducted in Cantonese and the other was

Table 1. Focus Group Participants by Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of participants</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>35</td>
<td>22</td>
</tr>
<tr>
<td>Latino</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>African American</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Filipino</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Chinese</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>South Asian</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Russian</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>159</td>
<td>100</td>
</tr>
</tbody>
</table>
conducted in English.) Among the English-language focus groups, 7 were culture or ethnic specific, including 2 with African Americans, 2 with South Asians, and 1 with Chinese. Also conducted in English were two focus groups with caregivers from the lesbian, gay, bisexual, and transgender (LGBT) community. The other four English-language groups were made up of either all White participants or mixed ethnicities and cultures (see Table 2).

To be eligible for the focus groups, caregivers had to report providing care at least 2 hrs per week to a care recipient who was 50 years or older and had been discharged from the hospital within the past 12 months. We excluded formal caregivers such as paid home health care workers, but included family caregivers who were paid through In-Home Supportive Services (IHSS). There were no requirements about the type of care a caregiver had to be providing to be included in this study. Our definition of caregiving was intentionally broad to include caregivers who performed a wide variety of tasks, including skilled nursing care, personal care, housework, transportation, financial assistance, and emotional support.

Participating caregivers included family members (48%), friends (14%), and paid informal caregivers (14%). Their average age was 54 years. Caregivers reported the following medical conditions that led to the hospitalization of their care recipients: heart attack (11%), other heart condition (13%), stroke (12%), injury (12%), cancer (12%), infection (10%), diabetes-related illness (11%), and dementia-related illness (9%). Due to the diversity of the relationships and responsibilities of caregivers who participated, caregiver-reported data on illness burden and complexity of medical regimen were deemed unreliable and are not reported. Caregiver participants reported that more than 60% of their care recipients were born outside the United States. Their average age was 75 years.

Case Study Methods and Sample

Focus group findings revealed certain vulnerable groups, including ethnic minorities, those with LEP, and recent immigrants who had particularly difficult experiences with transitioning home after a hospital stay. Partners from CBOs were asked to help identify seniors who were recently discharged from the hospital and who fit into some of the above categories so that in-depth and longitudinal analysis of their transitional care experience could be conducted in the form of case studies. The five seniors selected were age 60 or older and had been discharged from the hospital within a month of the baseline interview. The seniors who were enrolled in the case studies were then asked to identify up to two informal caregivers who assisted them during their transition home. Three of the seniors identified two informal caregivers to participate in the study. One senior identified only one caregiver; and one senior, who was selected because she had little informal support, identified no informal caregivers (see Table 3). All case study subjects participated in two in-depth interviews, a baseline interview within a month of discharge and a second interview 4–6 weeks after the baseline interview. Interview guides were semistructured with domains developed from the focus group findings. Individual problems and issues related to care transitions that were mentioned by participants in the baseline interview were discussed in the follow-up interview. Interviews were conducted in the participant’s preferred language.

Data Analysis.—Focus group discussions with caregivers were recorded and transcribed verbatim. Non-English transcripts were translated into

Table 2. Focus Groups by Ethnicity, Language, County, and Number of Participants

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Language</th>
<th>County</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>English</td>
<td>Alameda</td>
<td>2</td>
</tr>
<tr>
<td>White</td>
<td>English</td>
<td>San Francisco</td>
<td>10</td>
</tr>
<tr>
<td>White</td>
<td>English</td>
<td>Santa Clara</td>
<td>11</td>
</tr>
<tr>
<td>Mixed ethnicity</td>
<td>English</td>
<td>Santa Clara</td>
<td>5</td>
</tr>
<tr>
<td>African American</td>
<td>English</td>
<td>Alameda</td>
<td>6</td>
</tr>
<tr>
<td>African American</td>
<td>English</td>
<td>San Francisco</td>
<td>12</td>
</tr>
<tr>
<td>South Asian</td>
<td>English</td>
<td>Alameda</td>
<td>6</td>
</tr>
<tr>
<td>South Asian</td>
<td>English</td>
<td>Santa Clara</td>
<td>5</td>
</tr>
<tr>
<td>LGBT, mixed ethnicity</td>
<td>English</td>
<td>Alameda</td>
<td>5</td>
</tr>
<tr>
<td>LGBT, mixed ethnicity</td>
<td>English</td>
<td>San Francisco</td>
<td>6</td>
</tr>
<tr>
<td>Chinese</td>
<td>English</td>
<td>San Francisco</td>
<td>10</td>
</tr>
<tr>
<td>Chinese</td>
<td>Cantonese</td>
<td>Alameda</td>
<td>8</td>
</tr>
<tr>
<td>Filipino</td>
<td>Tagalog</td>
<td>San Mateo</td>
<td>11</td>
</tr>
<tr>
<td>Filipino</td>
<td>Tagalog</td>
<td>Alameda</td>
<td>8</td>
</tr>
<tr>
<td>Latino</td>
<td>Spanish</td>
<td>San Francisco</td>
<td>9</td>
</tr>
<tr>
<td>Latino</td>
<td>Spanish</td>
<td>San Mateo</td>
<td>8</td>
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<tr>
<td>Latino</td>
<td>Spanish</td>
<td>San Mateo</td>
<td>9</td>
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<tr>
<td>Vietnamese</td>
<td>Vietnamese</td>
<td>Alameda</td>
<td>10</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Vietnamese</td>
<td>Santa Clara</td>
<td>9</td>
</tr>
<tr>
<td>Russian</td>
<td>Russian</td>
<td>San Francisco</td>
<td>9</td>
</tr>
</tbody>
</table>

Note: LGBT = lesbian, gay, bisexual, and transgender.
English. Bilingual research staff who attended focus groups reviewed all transcripts for accuracy. Case study interviews were not recorded. Interviewers were trained to take detailed fieldnotes. These notes were then transcribed into transcripts. Focus group and case study discussion guides were semistructured using domains that were informed by the social ecological framework and further refined by a systematic literature review. These domains included service use, information seeking, information use, unmet needs, barriers to care, unmet needs of specific groups, and suggestions for improvement.

Qualitative thematic analysis was employed. A list of preestablished coding categories was created, informed by both the systematic literature review and the theoretical framework and, in the instance of the case studies, informed by the focus group results. Preliminary coding was performed by the lead researcher on one fourth of the transcripts using a combination of preestablished coding lists as well as open coding to create the initial draft codebook. A second researcher was then asked to use the initial draft codebook to independently code the same transcripts. Initial counts of interrater agreement were 82%. The research team then completed an iterative process in which codes were modified, merged, and added until counts of interrater agreement reached 90%. To further ensure parsimony, codes were then organized into families of similar codes and placed into a social ecological framework (see Table 4). This exercise served to further streamline the coding process by preventing repetition in the coding. Data were organized and analyzed using Atlas.ti Qualitative Software (version 5.2.9). Data from the case studies were used to validate and further clarify themes from the focus groups.

Results

Some of the most commonly reported deficits in the transitional process that emerged from both the focus group and the case study analyses were prevalent across all groups, including those comprising English speakers and White caregivers. These general themes focused on the inadequacies of information and training for patients and caregivers. These general themes confirm findings from earlier research and reinforce the importance of providing adequate information and assistance to caregivers during the transition from hospital to home. General themes about inadequate information and assistance are summarized briefly in the following:

Inadequate caregiver training: Caregivers reported providing a wide variety of tasks for care recipients after hospitalization. Some provided just meals or financial help. Others performed personal care tasks like bathing, transferring, and feeding. Many caregivers in our study also reported providing skilled nursing-level care, such as catheter care or feeding tube maintenance. Although caregiving tasks were often demanding or complex, caregivers

<table>
<thead>
<tr>
<th>Case study</th>
<th>Participants (all names are fictitious)</th>
</tr>
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<tbody>
<tr>
<td>Case study 1</td>
<td>Senior Ms. P, a 78-year-old White woman, living alone with no formal caregivers</td>
</tr>
<tr>
<td>Case study 2</td>
<td>Senior Mrs. W, a 91-year-old African American woman living with family</td>
</tr>
<tr>
<td>Case study 3</td>
<td>Senior Mrs. E, a 70-year-old White woman living in a board-and-care facility</td>
</tr>
<tr>
<td>Case study 4</td>
<td>Senior Sra. M, a 61-year-old Spanish-speaking Latina living alone and cared for by friends</td>
</tr>
<tr>
<td>Case study 5</td>
<td>Senior Mr. C, an 81-year-old Korean American man living with grandchildren</td>
</tr>
</tbody>
</table>

Note: IHSS = In-Home Supportive Services.
reported that they received inadequate training from hospital personnel. Caregivers often reported that this lack of training contributed to the emotional burden of caregiving. To compensate for the lack of training, many caregivers relied on their own past experiences with illness to inform them about how to perform caregiving tasks.

_Inadequate information from hospital discharge planners._ Caregivers in this study reported that family and friends, not health care professionals, were the most common source of information about how to provide postdischarge care. Family and friends often provided advice on how to perform personal care tasks and on specialized diets for care recipients, and suggestions for home- and community-based services. For many, friends and family were the only source of information. Although many reported receiving lists of home care agencies or other services from hospital discharge planners, they also reported that these lists were inadequate. Caregivers wanted more professional assistance assessing the quality, appropriateness, and eligibility requirements of different community-based services. In addition to information from family and friends, many caregivers in this study reported that they relied heavily on their own experiences either as patients themselves or as past caregivers. When caregivers did receive information from health care professionals, they often felt it was too general and not tailored to their family’s particular needs.

_Caregivers and seniors relied on informal support rather than paid service agencies._ Study participants reported that they were more likely to rely on friends and family for assistance with respite care, meals, transportation, and emotional support during the hospital-to-home transition. Many caregivers reported that they used no formal services and that help from friends and family was the only assistance they received.

**Unmet Needs of Ethnically, Linguistically, and Culturally Diverse Groups**

One of the main objectives of this research was to identify groups of seniors and caregivers who may be particularly vulnerable to poor health outcomes during and after a hospital discharge. Three main groups of vulnerable seniors emerged: ethnic minorities, those with LEP, and recent immigrants. The following section describes themes that were specific to some or all of these groups.

In the language-, culture-, or ethnic-specific focus groups and case studies, participants were asked, “How is it different taking care of someone in the (ethnic/cultural) community?” Participants reported the specific needs and challenges faced by caregivers and care recipients in their communities during the hospital-to-home transition. They also reported aspects of their cultures that provided strength and support to them as caregivers.

**Filial Piety and Barriers to Formal Support.**—One theme that emerged from all the ethnic-specific focus groups was that the value of filial piety, or the cultural imperative of family members to care for seniors, posed a barrier to utilizing formal services during times of transition. This theme emerged in Spanish, Chinese, South Asian, Vietnamese, Russian, and Tagalog groups but did not emerge in the primarily White, English-speaking groups.

_We came from the Russian culture. In our culture we don’t send our older relatives to nursing homes. We think it’s natural to take care of them. That is the way we were raised._—Russian caregiver
I’m Mexican. Usually, the family is responsible; although we have nursing homes, tradition dictates that one takes care of their own elderly.—Latino caregiver

Respecting your elders is such an important part of the Chinese culture... it’s drilled into you from when you’re born like, I’m taking care of you now, so you’d better take care of me when I get old [laughter]. They really don’t let you forget.—Chinese caregiver

As a result of filial piety, many of the study’s caregivers from certain ethnic groups reported having fewer options for using formal long-term care services. This issue was further explored in the case studies.

In one case study, we followed an 81-year-old Korean man who had immigrated to the United States 30 years ago. Unlike many immigrants who had immigrated more recently, his informal support system was not compromised. He was a widower, but had nine children and many grandchildren living locally. He had been hospitalized repeatedly in the past few years due to many complicated chronic illnesses. He has no income and is supported financially and socially by his children and grandchildren. The wives of his second son and grandson have been assisting him with most household tasks, such as cooking, cleaning, and laundry. Despite his low income and high care needs, he received no services from outside agencies. Both the senior and his interviewed caregiver expressed some pride in the fact that all his care needs were accommodated by family members and that he did not need outside help.

The case study provided more in-depth explanation of how the value of filial piety often manifested as a double-edged sword, inspiring pride among family members who provide all the care but also imposing an additional cultural barrier to accessing formal services.

Lack of Linguistically Appropriate Information and Services.—Approximately 50% of caregivers in this study reported that they or their care recipient had LEP. A major theme that emerged from LEP focus groups was the problems associated with the lack of linguistically appropriate information and services. Although lack of bilingual health care services is a problem at any time, participants in this research reported that it is especially problematic after a hospital discharge, when seniors typically have new, more complex care needs. Caregivers who participated in the focus groups requested having individualized discharge instructions, lists of available community services, and caregiver instructions in their native language. Despite the fact that Spanish is the most common non-English language spoken in the region, even Spanish speakers often do not receive written materials translated into their own language. Instructions in other languages, such as Chinese, Russian, Tagalog, and Vietnamese, are particularly rare.

We could’ve had more information. It would be nice if they gave us some reminders, some book of instruction. It would be nice to have it in Russian.—Russian caregiver

In one case study, a monolingual Spanish-speaking senior who was hospitalized for a stroke reported that upon her discharge, she was given discharge instructions only in English, which she was unable to read. Her caregiver (a nonrelated neighbor paid through the IHSS program), also Spanish speaking, could not read the discharge instructions and reported drawing on her own past experiences undergoing rehabilitation for a knee injury to inform her about how to provide care for her friend. This case study highlights how the lack of linguistically appropriate information causes caregivers to compensate by using their own experiences rather than professional training to inform how they care for loved ones.

Inadequate Informal Support.—Findings from other studies have shown that seniors who live alone or with non–family members have higher rates of preventable rehospitalizations than those who live with a family members (Aliyu, Adediran, & Obisesan, 2003; Mahoney, Eisner, Havighurst, Gray, & Palta, 2000). Our research supports these findings and further shows that recent immigrants and LGBT seniors can also be at risk due to lower levels of informal support after hospital discharge. Study participants reported that the lack of informal support is often exacerbated by the fact that health care professionals often fail to recognize the problem and erroneously assume higher levels of support.

My friend lives alone. So when he goes to his doctor’s... there is this mentality about a group of gnomes that must live with him, or little elves, little helpers. And they are not there.—LGBT caregiver

Seniors who live alone are especially at risk after a hospital discharge. One 78-year-old woman profiled in a case study lived alone and had no children. When her home care services were cancelled
due to inconsistent financial records, she had no one to help her bathe. As a result, at the time of the follow-up interview, she had not been able to bathe thoroughly for 2 weeks.

After I came home from the hospital, I had a [home health aide] for a few weeks who helped me take a shower. Two weeks ago they cancelled her because they said my insurance didn’t cover it. I can wash my front by myself, but I can’t do my hair. Since they cancelled her, I haven’t washed my hair in two weeks. Can you imagine?—Senior who lives alone

Interestingly, although compromised informal support is a theme that you would expect among all seniors who live alone, it was particularly prevalent in the groups comprising recent immigrants. Approximately 60% of the care recipients who were part of this research were immigrants from Russia, South Asia, Vietnam, China, the Philippines, and Latin America. Many immigrant participants reported feeling isolated and unsupported during a health care transition because their informal support networks had been compromised by the act of immigration:

I really wasn’t prepared for it and emotionally I felt terrible because I arrived to this country alone with my husband. My two only children are in El Salvador, so I felt I had no support from anyone.—Immigrant caregiver

Challenges for Low- and Middle-Income Elders. Bernheim and colleagues (2007) found that seniors with lower socioeconomic status have higher rates of rehospitalization and mortality after hospital discharge. Less is known about seniors who are near poor or who are middle income. Although focus group participants were not asked to report their income, they were asked about their care recipient’s insurance status. For those who responded, 111 were on Medicare, 97 had Medicaid, and 35 had private insurance.

The vulnerability of low-income seniors after hospitalization emerged as a notable theme in the African American, Latino, and all recent immigrant focus groups in particular. Low-income caregivers and seniors in this study reported being unable to afford personal care services, to find affordable and accessible housing, and to afford home modifications like bathroom bars and ramps that care recipients needed after a hospital stay. They also reported that although they qualified for Medicaid-funded home care services, the hours they qualified for were often inadequate.

The issues of middle-income or near-poor seniors emerged more often in the White and LGBT groups. Middle-income seniors who do not have the money to pay for services themselves but do not qualify for most means-tested assistance programs are particularly at risk for not getting the services they need.

You know, if you are wealthy this isn’t a problem. And if you’re poor, I admit it’s a problem. But for the people in between, it’s really tough. It’s really tough and I just hit this blank wall over and over and over again.—Caregiver for middle-income senior

The most problematic areas for middle-income caregivers were the inability to pay for home health care and home modifications to ensure the safety of the senior.

Discussion

This study confirms past findings about the needs of all seniors and caregivers who experience a hospital-to-home transition and offers new insights into the particular needs of seniors and caregivers from diverse ethnic and cultural groups. The study was guided by the social ecological framework that posits the important influences of multilevel interactions on people’s health. In keeping with this model, we examined individual-, interpersonal-, organizational-, community-, and policy-level factors that affected the experiences of caregivers and seniors during health care transitions.

On the individual level, we found that sociodemographic factors such as ethnicity, immigration status, and LEP were important in affecting the experiences of caregivers assisting a care recipient home after a hospital stay. In particular, ethnic minorities, recent immigrants, and LEP caregivers experienced more barriers to accessing appropriate services and information after discharge than did White, English-speaking, and higher-income groups.

On the interpersonal level, we report lower levels of informal support especially among recent immigrants and LGBT caregivers. These lower levels of support among recent immigrants can be surprising given stereotypes of intergenerational support in ethnic minority communities and are exacerbated by the failure of health care professionals to recognize the problem. Seniors in the LGBT community were also identified as vulnerable because many live alone. Although this is not a well-studied area, some possible explanations for
this are that LGBT seniors may be less likely to have children or may be more likely to have moved away from family to relocate in the San Francisco Bay Area.

On the organizational level, poor hospital discharge planning has been identified as a primary factor contributing to poor outcomes for seniors after hospitalization (Latimer & Mezey, 2001; LeClerc, Wells, Craig, & Wilson, 2002; Naylor, 2004; Proctor, Morrow-Howell, Albaz, & Weir, 1992). Results from our study support these findings. Some deficits in the discharge planning process that were reported consistently in all focus groups, despite ethnicity or language, were related to a lack of information and training for caregivers and a lack of referrals to appropriate community services. For seniors and caregivers with LEP, the problem of lack of information and training was particularly exacerbated because of the dearth of linguistically appropriate information and training available in hospitals.

On the community level, we found that many participants reported a lack of community resources, which resulted in inadequate services during the postdischarge period. In contrast, members of ethnic minority communities and new immigrants reported a high level of satisfaction with services provided through organizations such as refugee organizations, local health centers, and faith-based organizations that had language- and ethnic-specific services in place.

Recommendations for Transitional Care Programs for Ethnically Diverse Seniors

In recent years, new models of care have emerged that focus on filling the service gaps when individuals transition across care sites. These models have come to be known as “transitional care models.” Many transitional care models, such as those developed and tested by Naylor (2004) and Coleman (2003), have shown positive results in improving the experience of older adults after a hospital discharge, including reduced rehospitalizations, reduced medication errors, increased levels of satisfaction for patients and caregivers, and cost-effectiveness. As new models of transitional care emerge, we offer recommendations aimed at ensuring that transitional care practices meet the needs of the vulnerable groups of seniors identified in this research.

Research on communication and health promotion indicates that interventions are more effective when the intended beneficiaries participate in their design and when the intervention builds on people’s self-identified needs (Merriam, 2001; Sokal-Gutierrez et al., 2003). Given this, we recommend that all models of transitional care be tested with sufficient samples of ethnically and linguistically diverse populations. Community-based participatory designs are well suited for tests of new models of care that have shown positive results in general populations but may need to be modified to serve ethnically diverse seniors and their caregivers.

Research also shows that interventions are most successful when they are designed to connect consumers with existing local resources (Sokal-Gutierrez et al., 2003). We therefore recommend that, whenever possible, models of transitional care include partnerships between hospitals and CBOs that serve ethnically diverse populations. Currently, most models of transitional care are hospital based and do not include partnerships with community-based service agencies. Creating partnerships between hospitals and CBOs that serve ethnic-specific or ethnically diverse populations may address many of the gaps in care reported in this study, such as lack of referral to agencies where linguistically appropriate information and training can be accessed.

Partnerships between hospitals and CBOs can facilitate referrals to existing community services. Caregivers representing African American seniors, Latino seniors, and seniors who were recent immigrants were more likely to report problems during their transition associated with lack of services after discharge. Although hospital discharge planners may be aware of some basic community services that exist, they often fail to refer patients to smaller, more culturally specific services in the community. Examples include immigrant or refugee organizations, faith-based services, and other grassroots language- or culture-specific community-based service agencies that are not well publicized. In an environment of scarce resources where it is difficult to expand or create new services, it is especially important to leverage existing services whenever possible. Partnerships between hospitals and CBOs could work to increase hospital discharge planners’ awareness of culturally competent services in the community and increase appropriate referrals of these seniors to existing services.

Partnerships between hospitals and CBOs also have the potential to increase access to linguistically appropriate information and training for caregivers. Our study shows that informal caregivers were
often unprepared to provide the highly complex and skilled nursing-level care required for their care recipients following a hospitalization. Caregivers with LEP are less likely than English speakers to receive training in caregiving tasks. Similarly, whereas many English-speaking caregivers reported getting inadequate information at discharge, LEP caregivers often reported receiving no information at discharge. Training and information for caregivers needs to be provided in the person’s native language. Many CBOs that serve ethnic-specific or culturally diverse populations may already have training materials translated into non-English languages. They may also have the capability to provide training in languages other than English. Partnerships between agencies can expand access to these linguistically appropriate information and training materials.

A third recommendation to address gaps in care for vulnerable populations is to include accurate assessments of informal support in all discharge plans. Our findings suggest that rates of compromised informal support may be higher in certain populations, especially among recent immigrants and LGBT seniors. Both groups struggle with the assumptions made by health care professionals that they have high levels of informal support, when in reality their social support networks are often compromised. Accurate assessments of informal support are also especially important for seniors whose culture promotes the ethic of filial piety, resulting in increased barriers to seeking formal support services. A simple assessment of informal support, informal caregiver competencies, and barriers to accessing formal services should be included as standard procedure during the discharge planning process.

Our final recommendation is to expand existing home- and community-based services to near-poor seniors. In our study, caregivers from all groups report problems during their transition associated with low and near-poor incomes. Participants who did not qualify for means-tested services experienced great difficulty paying for personal care services and home modification in particular. Transitional care programs that serve diverse groups should focus on expanding home care services to include near-poor seniors. Although we acknowledge that this recommendation requires additional resources, we also feel that it is unrealistic to suggest that the critical gaps in transitional care for seniors can be addressed without some increases in expenditures. Given the cost-effective nature of many transitional care interventions, the system may recover some costs through reductions in hospital-based care.

**Study Limitations and Future Research**

Several study limitations should be noted. Although we collected and analyzed rich qualitative data, findings cannot be generalized to the overall population of seniors due to the absence of a randomized sample. However, the value of the qualitative evidence is strengthened by the agreement of findings from two different “triangulated” data sources. Current findings are limited to themes that emerged in focus groups and case studies and are reported as similar issues across vulnerable groups rather than differences between groups.

Directions for future research should include quantitative studies with larger samples of ethnically diverse seniors so researchers could detect differences among different ethnic groups, socioeconomic groups, and language groups. Further research into the informal support systems for LGBT seniors is also recommended. Other important factors related to the transitional care experience, such as the complexity of medical regimen, illness duration, frequency of hospitalization, and illness burden, will need further exploration among diverse, multiethnic groups. Finally, there is a critical need for intervention research that translates effective transitional care models to diverse populations of seniors and caregivers.

**References**


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