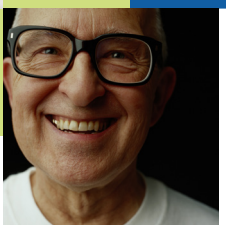

Communicating With Older Adults

An Evidence-Based Review of What Really Works

Developed by

THE GERONTOLOGICAL SOCIETY OF AMERICA

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Recommendations for Communicating With Older Adults

General Tips for Improving Interactions With Older Adults

1 Recognize the tendency to stereotype older adults, then conduct your own assessment.

2 Avoid speech that might be seen as patronizing to an older person ("elderspeak").

General Tips for Improving Face-to-Face Communication With Older Adults

3 Monitor and control your nonverbal behavior.

4 Minimize background noise.

5 Face older adults when you speak with them, with your lips at the same level as theirs.

6 Pay close attention to sentence structure when conveying critical information.

7 Use visual aids such as pictures and diagrams to help clarify and reinforce comprehension of key points.

8 Ask open-ended questions and genuinely listen.

Tips for Optimizing Interactions Between Health Care Professionals and Older Patients

9 Express understanding and compassion to help older patients manage fear and uncertainty related to the aging process and chronic diseases.

10 Ask questions about an older adult's living situation and social contacts.

11 Include older adults in the conversation even if their companion is in the room.

12 Customize care by seeking information about older adults' cultural beliefs and values pertaining to illness and death.

13 Engage in shared decision making.

14 Strike an appropriate balance between respecting patients' autonomy and stimulating their active participation in health care.

15 Avoid ageist assumptions when providing information and recommendations about preventive care.

16 Providing information to patients is important, but how you give information to patients may be even more important.

17 Use direct, concrete, actionable language when talking to older adults.

18 Verify listener comprehension during a conversation.

19 Set specific goals for listener comprehension.

20 Incorporate both technical knowledge and emotional appeal when discussing treatment regimens with older patients.

21 To provide quality health care, focus on enhancing patient satisfaction.

22 Use humor and a direct communication style with caution when interacting with non-Western older patients.

23 Help Internet-savvy older adults with chronic diseases find reputable sources of online support.

24 If computers are used during face-to-face visits with older adults, consider switching to models that facilitate collaborative use.

Tips for Communicating With Older Adults With Dementia

25 Maintain a positive communicative tone when speaking with an older adult with dementia.

26 Avoid speaking slowly to older adults with dementia.

27 Pose different types of questions to patients with dementia according to conversational goals.

28 When communicating with older adults with dementia, simplify sentences by using right-branching sentences.

29 Use verbatim repetition or paraphrase sentences to facilitate comprehension in older adults with dementia.

Have you ever found yourself in one of these situations?

- *You are talking with an older woman who you think may have a hearing impairment. You talk louder, but she still seems to have some problems hearing and understanding you. She also seems to have problems complying with instructions for taking medication and often returns to the office with the same problem.*

- *As you talk with an older man about his diabetes, you get the feeling that he doesn't really understand you, despite ensuring you that he does when you ask him. When you explain why and how to take the metformin that has just been prescribed, the patient appears to be listening, smiles, and nods his head "yes" in response to questions. Nonetheless, you sense that he will not be able to take the medication correctly when he returns home.*

- *You are in the middle of a patient visit that seems to be productive and progressing in a positive manner. All of a sudden, you begin to sense the patient has become quiet and withdrawn. Even direct questions—for example, "Is everything okay?" and "Is anything the matter?"—are met with sullen denials. You know you did something to contribute to this change in the patient's demeanor, but you just can't figure out what.*

How would you resolve these situations? Formulate a strategy as you read through the recommendations for communicating with older adults —then turn to page 35 to see what the experts would do.

Introduction

The older population in the United States—comprising individuals 65 years of age or older—numbered 40.4 million in 2010 (the most recent year for which data are available).[1] This represents a 15% increase from 2000, when there were 35 million people 65 years of age or older.[1] The older population is projected to increase to 55 million by 2020 and to 72.1 million by 2030.[1] At that point, nearly one out of every five Americans will be 65 years of age or older.[1]

Data compiled by the Administration on Aging indicate that only 40% of noninstitutionalized older adults reported their health as excellent or very good during the period from 2000 to 2009, compared with 64.7% of adults 18 to 64 years of age.[1] Most older adults have at least one chronic medical condition (e.g., hypertension, arthritis, cardiovascular disease, diabetes), and many have multiple conditions.[1] As a result, older adults make nearly twice as many physician office visits per year (average 7.1 office visits) as do adults 45 to 65 years of age (3.7 office visits).[1] According to the American Society of Consultant Pharmacists, adults 65 to 69 years of age take an average of 14 prescription medications per year, and adults 80 to 84 years of age take an average of 18 prescription medications per year.[2]

Interactions between older adults and health care professionals are influenced by the expectations and stereotypes that each party brings to the encounter. For example, there is some evidence that health care professionals are more condescending and have less patience when interacting with older adults.[3,4] They also spend less time with older patients, take a more authoritarian role, provide less information (e.g., about medications), and often fail to address important psychosocial and preventive factors (e.g., quitting smoking).[3,5] Conversely, older patients may withhold information about symptoms or conditions that they perceive to be "normal" for their age—for example, pain that could be diagnostically important.[3,6,7]

Communication between older adults and health care professionals is further hindered by the normal aging process, owing to specific age-related problems (e.g., sensory loss, decline in memory, slower processing of information) or psychosocial adjustments to aging (e.g., loss of identity, lessening of power and influence over one's life, retirement from work, separation from family and friends).[3,8] Unfortunately, unclear communication can cause an entire health care encounter to fall apart.[9] Breakdowns of communication have been cited as contributors to health care disparities and other counterproductive variations in rates of health care utilization by *all* patients, not just older adults.[10]

As the number of Americans 65 years of age and older continues to rise, health care professionals are increasingly likely to experience the challenge of communicating effectively with older adults. This publication compiles evidence-based recommendations for improving face-to-face communication with older patients. The recommendations were contributed by experts in the fields of gerontology and communications. Each recommendation is accompanied by a brief explanation of the rationale, tips for implementing the recommendation in busy health care settings, and selected references for further reading. The objective is to encourage behaviors that consider the unique abilities and challenges of older adult patients and produce positive, effective interactions among everyone involved.

Changes Associated With Normal Aging and Pathological Aging

The older population is not homogeneous; in fact, it is one of the most diverse groups in society. What is true for one 75-year-old adult is not necessarily true for others. Nonetheless, there are certain changes commonly associated with normal aging, as well as changes that might be expected as part of an aging-related health problem such as Alzheimer's disease. All of these changes can contribute to challenging health care communication interactions.

It is important to be aware that much remains unchanged by the aging process. For example, there is no evidence of decline in most aspects of language ability among older adults, including the use of language sounds, meaningful combination of words, and verbal comprehension. Vocabulary may continue to improve with age. Similarly, crystallized intelligence—the knowledge acquired through education and experience—remains stable or increases with age.

Hearing Deficits

Hearing loss is the third most common chronic condition reported by older adults. The estimated prevalence of significant hearing impairment among people 65 to 75 years of age is approximately 30% to 35%; among people 75 years of age or older, the prevalence increases to 40% to 50%. Men are more likely than women to have hearing impairment.

Normal age-related hearing loss—presbycusis—usually results from the cumulative effects of lifetime exposure to noise. It is focused in the high-frequency areas of the spectrum. This affects the ability to hear and distinguish certain speech sounds (e.g., "s" and "th"); as a result, speech in general sounds mumbled and unclear. People with presbycusis also have difficulty hearing high-pitched sounds (e.g., the nearby chirping of a bird or ringing of a telephone). Ironically, some sounds may seem overly loud.

Vision Deficits

Age-related changes in vision include problems reading small print, seeing in dim light, reading scrolling or other externally paced displays, and locating objects visually. Approximately one out of six Americans 70 years of age and older has impaired distance visual acuity. However, only 15% to 20% of older adults have vision deficits severe enough to impair driving ability, and only 5% become unable to read.

Almost all adults older than 55 years of age need glasses at least part of the time. The most common problem is presbyopia—a condition in which the lens of the eye loses its ability to focus, making it difficult to see text or objects up close. People usually begin to notice the condition when they are approximately 45 years of age and realize that they need to hold reading materials further away than usual to bring the text into focus.

Reductions in peripheral vision can limit social interaction and activity. For example, older adults may not communicate with people sitting next to them because they cannot see them well (or at all).

Many older adults have difficulty driving at night because of problems with glare, brightness, and darkness. Substantial difficulty with night driving may be the first sign of a cataract. Although cataracts are common among older adults, they are *not* a normal age-related change.

Decrements in Language Comprehension and Production

Many age-related changes in language comprehension are attributable to a gradual and steady decline in working memory—the brain system that provides temporary storage and manipulation of the information necessary for complex cognitive tasks (including language comprehension).

Reduced information processing speed and capacity lead to problems in understanding complex sentence structures. Grammatically complex sentences put more strain on processing resources because the listener must keep more information "in mind" in order to understand the whole sentence. Older adults also *produce* less grammatically complex sentences, probably as an accommodation to their own declining working memory capacity.

Long-term memory typically is unimpaired, such that older adults do not forget general knowledge, vocabulary, or family history. However, older adults may experience more difficulty retrieving certain types of information from long-term memory, especially people's names. It is very common for older adults to have a "tip of my tongue" experience when trying to recall the name of a famous person. Names are particularly problematic because they tend to lack good connections to other mental concepts. The word "farmer" has all sorts of complex connections and associations (barns, cows, the smell of manure) that can help recall; the name "Mrs. Farmer" lacks similar connections, especially if Mrs. Farmer isn't actually a farmer.

Dementia

Cognitive changes in older adults are highly variable from one person to another. Dementia is a general term applied to a decline in mental ability severe enough to interfere with daily life. Alzheimer's disease is the most common form of dementia, accounting for 60% to 80% of all cases. The vast majority of the more than 5 million Americans with Alzheimer's disease are 65 years of age or older.

The classic clinical presentation of Alzheimer's disease begins with vague symptoms of memory loss and confusion that worsen gradually. As the disease advances, patients experience disorganized thinking, impaired judgment, trouble expressing themselves, difficulty recognizing familiar people, and disorientation to time, space, and location. Most patients also develop neuropsychiatric or behavioral symptoms at some point during the course of the disease.

Patients with Alzheimer's disease and other forms of dementia pose considerable communication challenges. Although communicating with patients with dementia is not the main focus of this article, a few tips are offered at the end of the publication.

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1 Recognize the tendency to stereotype older adults, then conduct your own assessment.

Rationale

When we encounter individuals for the first time, we often rely on stereotypes to reduce our uncertainty regarding how to respond to them effectively and appropriately. In the case of older adults, we may use initial impressions about their physical appearance in combination with voice cues to respond with our stereotypic beliefs about older individuals. In other words, if we categorize certain people as older adults, then we believe we have a greater degree of certainty concerning how to interact with them appropriately. Consequently, our stereotypic beliefs about older adults—especially concerning diminished abilities—can lead to inappropriate, perhaps even demeaning, responses toward them.

What You Should Do

The first step is to recognize your own stereotypic beliefs about older adults and acknowledge the possibility that you might be relying on initial perceptual cues to guide your interaction. Next, ask a few questions at the beginning of the interaction to engage the individual in a brief dialogue that may provide a more accurate basis for assessing the person's linguistic facility, ability to comprehend English, cognitive capacity, and hearing ability. Depending on the history of your relationship with the patient, questions could be as simple as:

- "What brings you in today?"
- "I noticed that you started on a 'water pill' diuretic medicine last time you were here. How has that been going for you?"
- "How have you been doing with this warm weather we've been having?"

The goal is simply to initiate the encounter with a prompt so you have some patient-generated information to help you more accurately assess the individual's capabilities. Adapting your style of communication to the actual, not stereotyped, abilities of the individual will provide a foundation for more effective interactions.

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Mulac A, Giles H. "You're only as old as you sound": perceived vocal age and social meanings. *Health Commun.* 1996;8:199-215.

2 Avoid speech that might be seen as patronizing to an older person ("elderspeak").

Rationale

Younger people sometimes address older adults in a style of speech characterized by the use of simplified vocabulary (e.g., only using short words), endearing or diminutive terms (e.g., sweetie, cutie), and exaggerated intonation (e.g., unusual stress on certain words, "sing-song" pitch variation). This style of speech may be based on a desire to express caring or sympathy for the older person; conversely, it may be based on a stereotype that all older people are mentally impaired in some way. In either case, this style of speech is viewed negatively by the majority of older adults, who equate such "baby talk" with being treated like a child. Elderspeak may make some older adults feel disrespected and powerless and can lead to actual physical health consequences. Among older adults with Alzheimer's disease or other forms of dementia, being addressed with baby talk can result in more resistance to care and more aggressive behaviors.

What You Should Do

Avoid using terms of endearment (e.g., honey, darling). It is true that these terms can convey affection, and some older people do indicate they feel cared for when addressed in this manner. Nonetheless, communication scientists agree that there are other ways of expressing affection and caring that convey the same emotion while not infantilizing the recipient. One example is to use a person's name while smiling and expressing caring content: "Mr. Smith, would you like me to bring you a cup of coffee?" Addressing a person as "Mr. Smith," "Mrs. Jones," etc., usually is a safe approach. Using the person's first name also can be acceptable if you have frequent contact with the person and ask his or her permission ("May I call you James?").

Avoid using high and variable pitch. High pitch is more difficult for older adults to comprehend because of hearing problems, and extremely variable pitch produces an irritating tone.

Avoid using simplified vocabulary. As a general rule, older adults maintain their existing vocabulary or continue to improve it. They have no greater problem understanding complicated words than do members of other age groups, so there is no need to simplify the words you use. Medical jargon is an exception, as it is for all patients. Correct medical terminology should be used for clarity, but it always should be followed immediately with a nontechnical explanation.

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3 Monitor and control your nonverbal behavior.

Rationale

Nonverbal communication encompasses eye contact, facial expressions, tone of voice, speech rate, speech volume, body positioning, use of space, and other behaviors. The nonverbal behaviors that you do or do not exhibit when interacting with older adults can have a profound impact on both your effectiveness in presenting information and the quality of your relationship with the other person. The additional cues provided by nonverbal behaviors may facilitate accurate information processing by older adults who have vision or hearing impairments or require additional time for processing. At the relationship level, the presence or absence of nonverbal behaviors has the potential to communicate—consciously or subconsciously—whether you are interested in and concerned about the other person, whether he or she should trust what you are saying, and whether that person will feel comfortable sharing information with you.

What You Should Do

Maintain eye contact with patients instead of focusing on something else (e.g., patient chart, computer screen). If you suspect that the person has a hearing impairment, increase your speech volume *slightly*, speak a bit more slowly, and present information as clearly as possible. Avoid shouting; speaking unnaturally loudly tends to raise the pitch of the voice and make it more difficult for hearing-impaired listeners to understand what you are saying. Refrain from engaging in behaviors such as frequently glancing at your watch, looking or sounding impatient, standing up and continuing to talk, or "talking with one hand on the doorknob."

If you rush through information without vocally emphasizing the information (e.g., because you are speaking while writing a prescription or looking at a computer screen), you may be communicating nonverbally that the information is not very important. Similarly, you may verbally state to patients that you are very concerned about them; however, if your nonverbal behavior consistently sends the message that you are preoccupied, busy, or uninterested in what patients have to say, then it is more likely that they will accept the interpretation based on your nonverbal cues because those cues are seen as more believable.

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4 Minimize background noise.

Rationale

Age-related hearing loss makes it difficult for older adults to understand and remember speech in the presence of background noise, especially multiple competing conversations. Although older adults can compensate to some extent by devoting more cognitive resources to comprehending what is being said, this effort may be at the expense of other comprehension processes such as drawing inferences or encoding the information into long-term memory. Conversing in a quiet environment helps to improve the older adult's perceptual processing of speech (e.g., recognition of spoken words), freeing cognitive resources for other comprehension processes such as integrating concepts with knowledge to better understand the message.

What You Should Do

When talking to older adults, make sure that the environment is as quiet as possible. It is especially important to avoid interference from competing conversations. If it is possible to close a door to a noisy hallway or move from a public area to a private office, do so. If ambient noise is constant—for example, background music is piped through speakers or a television is kept turned on in a waiting area—consider restructuring the environment to remove those sources of noise.

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5 Face older adults when you speak with them, with your lips at the same level as theirs.

Rationale

Older adults with age-related hearing loss often try to compensate by reading the speaker's lips. Even older adults with substantial hearing loss will supplement whatever they can hear (e.g., intonation) with lip reading. This is possible only if the older adult can *see* the speaker's lips, preferably at face level.

What You Should Do

If the person you are speaking with is sitting, sit facing that person directly. If the person is standing or sitting on a raised bed, stand and face that person directly.

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Mini Case: Mrs. Smithberger

Mrs. Smithberger was taken to the emergency room by her daughter after falling in the bathtub. The X-ray showed that she had broken her hip, necessitating transfer to another hospital for surgery. The physician turned to Mrs. Smithberger's daughter and said, "We would like to transfer your mother to another hospital for surgery. Where would you like her to go? General Hospital is closest. Would you like to go there?" The daughter replied, "My mother normally goes to Grace Hospital. But, if General Hospital is closer.... What do you think? Which one is better?"

Suggestions for Improvement

The physician should begin the encounter by addressing Mrs. Smithberger directly to determine her preference about where to go. If the daughter responds on her mother's behalf, the physician should bring Mrs. Smithberger into the conversation by asking whether she prefers Grace Hospital and why. The physician also should explain to both Mrs. Smithberger and her daughter which hospital might provide better treatment and care regarding the surgery and the recovery aftermath.

6 Pay close attention to sentence structure when conveying critical information.

Rationale

Although many aspects of functioning are well preserved into late adulthood, short-term (working) memory does decline. Short-term memory is critical in processing complex sentence structures, particularly sentences with embedded clauses. Older and younger adults are equally good at understanding a sentence such as "The brown dog sat on the rug." Older adults have a more difficult time with a sentence such as "The brown dog *that I saw running away from the car yesterday* sat on the rug." (Embedded clause appears italicized.)

Long and complex sentence structures challenge memory because understanding the entire sentence involves holding a number of "pieces" of information simultaneously in short-term memory. Extensive published research demonstrates that older adults have an especially difficult time processing sentences with multiple embedded clauses.

What You Should Do

When conveying critical information, chunk individual pieces of information into separate sentences. Consider the following sentence:

> "You have arthritis of the hip which is making it painful for you to walk and may eventually require hip replacement surgery if we cannot control your pain with medications."

To understand this sentence, the listener must retain the word "arthritis" in short-term memory while processing that (1) arthritis is causing pain while walking and (2) surgery may be necessary if medication therapy is ineffective in controlling the pain.

This sentence needs to be cut into its constituent parts, each of which must be meaningful on its own. In this case, the sentences are relatively short:

> "You have arthritis of the hip. The arthritis is causing pain when you walk. Taking medication should help to control your pain. If the pain continues, we might need to consider hip replacement surgery."

However, short sentences don't always help:

> "You have arthritis. The arthritis is in your hip. Arthritis causes pain when you walk."

These short sentences provide information in a disjointed and fragmented manner that actually makes it more difficult to tie the pieces together.

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7 Use visual aids such as pictures and diagrams to help clarify and reinforce comprehension of key points.

Rationale

There are several reasons why visual aids such as pictures and diagrams may support language comprehension and learning during conversation. Visual aids can reduce the need for complex verbal description as well as the cognitive effort required to understand these descriptions. By simply pointing to a graphic, both speakers and listeners can accurately and easily refer to visually shared information. Shared visual aids also help conversational participants coordinate their attention on key information. Visual aids are better able to illustrate complicated relationships among concepts compared with using words alone. In addition, visual aids may help to address hearing-related communication problems by providing visual as well as auditory information.

What You Should Do

To be effective, visual aids must be well designed with large, easily seen components. For example, the United States Pharmacopeial Convention (USP) offers a library of standard graphic images ("pictograms") intended to help convey medication instructions, precautions, and warnings to patients; they can be accessed at http://www.usp.org/usp-healthcare-professionals/related-topics-resources/usp-pictograms.

Graphic elements should be relevant to the text content, explicitly depicting and elaborating concepts. Visual aids that contain irrelevant information may be especially distracting to older adults because of age-related difficulties in inhibiting irrelevant information. For example, a cross-sectional diagram of an artery is relevant to a discussion of the pathophysiology of hypertension; a photo showing a smiling patient with his family is not. In one recent study, patients who knew the least about their medical condition were more likely to look at the less relevant graphic in educational materials, possibly interfering with comprehension.

Use visual aids interactively during the conversation to ensure that you and the listener are coordinating your attention on key concepts. For example, point to relevant parts of the aid at appropriate moments.

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8 Ask open-ended questions and genuinely listen.

Rationale

One of the complaints expressed most frequently by patients about their health care is that their providers do not listen to them. Some studies have suggested that even when health care providers do listen, they have a tendency to interrupt patients within 18 seconds.

Older adults have valuable information to offer, but this information may not be shared if the health care provider (1) appears to be uninterested or too busy, or (2) fails to request the information. Patient concerns, questions, or misunderstandings about diagnostic information, treatment plans, or medication instructions may not be raised and addressed, thus contributing to subsequent nonadherence complications. Asking patients open-ended questions has the potential to elicit useful information, assess the patient's level of health literacy, create an active dialogue between health care provider and patient (rather than a monologue from an active provider to a passive patient), and ultimately improve health outcomes.

What You Should Do

Resist the temptation to fire off a series of yes/no questions ("Are you sticking to your diet?""Do you still have trouble sleeping?""Did your doctor tell you how to take your medication?"). Instead, strive to formulate questions in a more open-ended format that allow patients to address the question from their point of view and in their own words ("Tell me about how your diet has been working out for you.""How has your sleeping been going?""How did your health care provider tell you to take this medication?"). When the patient begins talking, focus on the patient, maintain eye contact, and try to read the patient's nonverbal behavior. Listen to how the message is being expressed as well as the content of the message. Ask questions and paraphrase what the patient has said to clarify meaning and demonstrate that you are truly listening.

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9 Express understanding and compassion to help older patients manage fear and uncertainty related to the aging process and chronic diseases.

Rationale

Many older patients experience anxiety, uncertainty, and frustration with regard to their own aging process as well as aging-related chronic diseases. In addition to being concerned about possible health deterioration and medical expenses, older patients also struggle with the potential impact of their declining health on family members and interpersonal relationships.

Available evidence suggests that physicians spend less time talking with older patients, and the conversation is primarily focused on biomedical issues. They have limited time and skills for addressing psychosocial concerns. Neglecting to inquire about an older patient's psychosocial state may result in incomplete medical recommendation and suboptimal patient satisfaction. Developing a better understanding of the aging process beyond the "hard" medical information is imperative.

What You Should Do

Consider the psychosocial status of older patients as part of the diagnostic process. Start with a question such as "How are you?" and convey a genuine interest in the patient's response, beyond simple pleasantries. Explore older patients' emotions if they seem to be distressed by their medical conditions and treatments; at the same time, be sensitive to patients' willingness to discuss personal feelings and fear. If an older patient's treatment results indicate areas of improvement, point to those positive results as a way of reassuring the patient.

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10 Ask questions about an older adult's living situation and social contacts.

Rationale

Older adults are more likely than other patients to be living in environments that place them at risk for abuse or exploitation. Health care visits provide an opportunity to explore an older adult's living situation and social contacts—issues that ultimately could have more serious health consequences than the stated reason for the visit.

What You Should Do

If an older adult raises any issues or concern about his or her personal living environment, probe a little. For example, older adults who mention that a caregiver is a "bit rough"—or that they prefer one location or environment over another ("I don't like to go over to my brother's house")—could be an indication of an abusive relationship or a living situation that is problematic in some way. Nonintrusive questioning (e.g., "When John is rough with you, what does he do?") might draw out important information that requires follow up in the interest of patient safety.

Any person who suspects that elder abuse may be occurring should make a report to the local adult protective services agency. A local law enforcement agency should be contacted if an older adult appears to be in a life-threatening situation or immediate danger. Experts recommend always erring on the side of caution and reporting, because appropriate intervention can save the health, dignity, assets, or even life of an older adult.

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11 Include older adults in the conversation even if their companion is in the room.

Rationale

It is common for a family member or caregiver to accompany an older adult to a medical appointment. Family members or primary caregivers may begin to "speak for" the older adult—for example, by reporting problems and symptoms to physicians or offering their assessment of the older patient's response to medication therapy. The family members or caregivers also may begin to assume a shared role with the physician regarding the diagnosis and evaluation. When the family member or primary caregiver "speaks for" or "speaks past" the older patient, the conversation may shift from being a dyad of the health care provider and older patient to a dyadic relationship occurring with the health care provider and caregiver. This shift has the potential to disenfranchise the older patient.

Although it may be necessary at times for a family member or caregiver to contribute additional information about the older patient, it should not replace the direct communication between the health care provider and the patient. When an older patient is excluded from the conversation or is talked over by the caregiver, it may reinforce the stereotypes of perceived dependency and incompetence of the patient.

What You Should Do

Create a triadic conversation by maintaining a direct communication channel with the older adult. Maintain silence after speaking to allow time for the older adult to respond. If you need to solicit additional information from the family member or caregiver, maintain eye contact with the patient and avoid referring to the older adult in the third person (e.g., "Did she complain about the side effects?").

If a family member or caregiver seems to talk over the patient, direct the conversation back to the patient, and use inclusive terms such as "we" or "you" to maintain a sense of joint voices. Have the older adult verify information provided by the family member or caregiver to help establish the patient's autonomy and responsibility for personal health.

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12 Customize care by seeking information about older adults' cultural beliefs and values pertaining to illness and death.

Rationale

Human beings are culturally bound and develop ways to understand relationships among people, nature, life, and death. As a result, people from different cultures may have different perceptions of standard Western health care recommendations and practices. For example, many Asian Americans and Hispanic Americans believe in alternative care practices such as home remedies and folk healers. They may not adhere to prescribed medications, and they may engage in folk therapies without informing the physician. Hispanic Americans may not utilize medical resources because of language barriers.

Research shows that a lack of understanding about cultural practices—coupled with an unwillingness to acquire such information from the patient—can result in inaccurate patient evaluation and diagnosis. It also has the potential to cause dissatisfaction with health care providers and may increase the possibility of poor adherence to treatment regimens.

What You Should Do

Health care professionals should adopt a holistic approach to patients' health care behaviors by acknowledging the possible value of alternative approaches and assessing patients' perceptions of these alternative approaches. Show an interest in the older patient's cultural background by asking questions such as:

- "What types of traditional or alternative medicine do you use?"
- "What roles do native or traditional foods play in your health?"
- "Do your health beliefs or traditional medical practices differ from what you find in medical care or community health settings here?"

Administer an oral survey such as the Holistic Complementary and Alternative Medicine Questionnaire (HCAMQ) to obtain the patient's belief about alternative methods. Take the time to explain the reasoning behind Western approaches to health, prevention, and treatment to increase patient understanding, and arrive at treatment decisions together.

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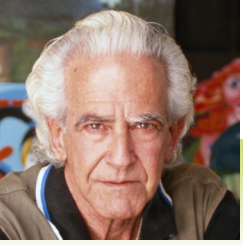

13 Engage in shared decision making.

Rationale

Shared decision making is an important part of the health care process for patients of all ages. Health care professionals tend to be authoritarian in their approach, particularly with older patients. Involving the patient in decision making engenders trust, reduces malpractice claims, and enhances patient and provider satisfaction. Perhaps most important, shared decision making leads to better patient adherence to treatment recommendations. Shared decision making is especially appropriate in situations where there is more than one reasonable course of action and no one option is clearly superior.

What You Should Do

Provide older adults with complete and impartial information about the pros and cons associated with each treatment option. If the options are complex, consider providing written information. Ask questions throughout the discussion to gauge the patient's comprehension.

Aspects of the older patient's life situation may become apparent during the course of the discussion. Some of this information—for example, access to transportation, family support, willingness to endure pain or long-term disability in the course of treatment—could be relevant to the health care decision. It is perfectly appropriate for health care providers to give recommendations based on their own perspective; however, recommendations should be offered in the spirit of informing a treatment decision made jointly with the patient (and involving other parties as appropriate).

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14 Strike an appropriate balance between respecting patients' autonomy and stimulating their active participation in health care.

Rationale

Patients who are encouraged to participate more actively in their treatment decisions have more favorable health outcomes. However, not all older adults will be comfortable with the same degree of participation. Consequently, it is important to strike a balance between stimulating older patients' active participation in health care and respecting patient preferences and autonomy.

What You Should Do

Try to identify older patients who might benefit the most from enhanced involvement—patients who want to be more involved in their care but lack the necessary skills. One way to do this is to offer patients choices whenever possible. A patient who quickly defers to the health care provider's expertise most likely is not comfortable with enhanced involvement; a patient who engages in a discussion of the choices, expresses opinions, and asks for additional information is ripe for enhanced involvement. Patients who may have served as "advocates" for others in terms of navigating the health care system and making medical choices also may be interested in being more involved and proactive regarding their own care.

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15 Avoid ageist assumptions when providing information and recommendations about preventive care.

Rationale

One of the most important ways ageist assumptions emerge in the health care setting is thinking that preventive care is not important after a certain age. Physicians typically provide fewer preventive care recommendations to older patients, especially recommendations regarding smoking cessation and physical activity. Physicians also may "conspire" with their patients to reinforce myths about what is to be expected with age—for example, that certain symptoms or problems are unavoidable.

What You Should Do

Ask patients about all aspects of health behavior, including smoking, diet, and exercise. Make recommendations that will support optimal health. It is a myth that "you can't teach an old dog new tricks"; older adults are as capable as younger patients of changing health behaviors when they are provided with compelling information about the likely benefits. If an older patient indicates that a problem is not worth addressing because it is "normal" for aging or "the best I can expect," use open-ended questions to explore the patient's perspective. Use evidence-based judgment to differentiate what may be a normal age-related phenomenon from one that might indicate an underlying and treatable problem.

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16 Providing information to patients is important, but how you give information to patients may be even more important.

Rationale

Because many older adults have one or more chronic medical conditions and typically are using multiple medications, they have a clear need for information from their health care providers. However, evidence exists that older adults may in fact receive *less* information from their health care providers than younger patients. In addition, the information presented to older adults may be less helpful due to limitations such as vision or auditory impairments, information processing difficulties, or memory deficits. Therefore, health care providers need to give careful consideration to both the amount of information presented to older patients and the methods by which the information is delivered.

What You Should Do

Simplify the information you provide to patients. Basic medical terminology may be confusing to all patients, especially patients with a low level of health literacy and patients for whom English is not their first language. Although there may be a range of topics that needs to be discussed—the diagnosis, what caused the disease or condition, what treatments are indicated, etc.—it is important not to overload patients with information.

Whenever possible, create an outline of the issues you need to discuss with the patient and present them one at a time. Providing patients with a brief summary of discussion points and care instructions increases the likelihood that information will be understood and retained.

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17 Use direct, concrete, actionable language when talking to older adults.

Rationale

Concrete language communicates observable, tangible objects, actions, and characteristics perceived through the senses; abstract language communicates intangible concepts or ideas that have no physical referents. Using concrete language with clear, direct, and precise meaning can improve comprehension in several ways. Because concrete language typically is less linguistically complex, it requires fewer cognitive resources to recognize and integrate into a mental representation of the message. Vague or abstract language—for example, "take twice a day"—requires listeners to draw inferences that may be incorrect. "Take in the morning and in the evening" is more specific and is less likely to be misunderstood. Concrete language thus can improve patient comprehension of health information.

Concrete language also encourages the use of multiple routes to encoding and retrieving the information from memory. For example, texts that are rated as more concrete tend to be better remembered.

What You Should Do

When talking with older adults—especially when providing instructions—try to use concrete, direct words rather than abstract, vague words. For example, say "Swallow two tablets in the morning and two tablets in the evening" rather than "Take two pills twice a day." Research shows that older adults are better able to follow medication-taking instructions that include time periods (e.g., in the morning) rather than time intervals (e.g., every 4 hours) or a specific number of times per day (e.g., twice a day).

Note that concrete language does not necessarily involve shorter words and sentences. The more direct phrase "Swallow two tablets in the morning and two tablets in the evening" is longer than the phrase "Take two pills twice a day," but it is more likely to be remembered. Overuse of simple, short words also can be seen as patronizing by some older adults.

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18 Verify listener comprehension during a conversation.

Rationale

Successful communication involves establishing common ground: speakers and listeners must agree that information is mutually understood and accepted as relevant to shared goals. Common ground is more likely to be achieved when the speaker seeks—and the listener provides—explicit evidence that presented information is understood. Actively seeking verification of listener comprehension affords the speaker an opportunity to clarify the intended message if needed and tailor the information to the listener.

Verifying comprehension is especially important when communicating with older adults. Older listeners may be reluctant to interrupt a conversation to indicate that they do not understand, especially if they are talking with a health care provider.

What You Should Do

Teach-back techniques are useful for confirming older patients' understanding of information provided during health care encounters. Teach-back techniques involve asking listeners to explain what they have been told in their own words. The health care professional would pose a question, such as "I want to make sure I explained everything clearly. If you were trying to explain to your husband how to take this medicine, what would you say?" Use of teach-back techniques by physicians has been associated with better patient outcomes.

Kemp and colleagues found that patients prefer "collaborative teach-back"—a patient-centered approach that incorporates elements such as addressing patients' feelings and the sharing of power and responsibility. For example:

> "I imagine you're really worried about this clot. I've given you a lot of information. It would be helpful to me to hear your understanding about your clot and its treatment."

This approach was preferred to a yes/no approach ("I've given you a lot of information. Do you understand?") or a directive teach-back approach ("It's really important that you do this exactly the way I explained. What do you understand?").

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19 Set specific goals for listener comprehension.

Rationale

Checking and verifying listener comprehension may be more effective if speakers set specific goals for listener comprehension ("teach-to-goal" technique). Having a measurable target comprehension goal—for example, ensuring that the listener can accurately explain five critical concepts—may encourage more active monitoring on the part of the speaker and may further support tailoring of the information to the listener. Having specific comprehension goals also may encourage listeners to pay closer attention to the information being presented.

What You Should Do

In the teach-to-goal approach, rounds of teach-back or other methods of confirming listener comprehension are repeated until the listener exhibits mastery of the learning goal. Sudore and colleagues used this strategy to verify understanding of an informed consent form among 204 ethnically diverse adults (mean age 61 years) who reported speaking either English or Spanish "well" or "very well." One third (32%) of the participants had not completed high school, and 40% had limited literacy. After the consent form was read aloud to participants in English or Spanish, participants were presented with seven true/false statements designed to measure their understanding of information included in the form. If they responded incorrectly to any of the statements, the corresponding sections of the form were read aloud again and the statements were repeated. Only 28% of participants responded correctly to all of the statements on the first pass; 52% required a second pass, and 20% required three or more passes. With repeated passes through the teach-to-goal process, complete comprehension eventually was achieved by 98% of participants.

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20 Incorporate both technical knowledge and emotional appeal when discussing treatment regimens with older patients.

Rationale

One of the major problems in health care delivery is patient adherence. Research shows that adherence among older patients correlates directly with the amount of time physicians spend explaining what the treatment regimen entails and why it is important. Working with patients to establish treatment goals increases their sense of responsibility and contributes to higher rates of adherence to the treatment regimens. Socioemotional selectivity theory suggests that older adults are more likely to recall information associated with feelings and positive attributes of a message. Older adults also tend to respond more to messages associated with connectedness to family and community.

What You Should Do

Help older patients envision time with family and loved ones as part of the goals of treatment. In addition to providing technical information about procedures and treatments, include positively worded and emotionally appealing messages, such as rewards and benefits of medication adherence (e.g., "If you are willing to commit to taking this medication every day for at least 6 months, you will have more energy for visiting your children and grandchildren and having a good time with them"). Incorporate emotionally appealing images and messages into printed brochures and information kits to help older patients retain information and increase their motivation to follow through with the treatment regimen. However, this should not come at the expense of being practical and realistic. Make patients aware of possible treatment risks and adverse effects in addition to likely benefits in order to provide an honest, balanced picture.

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21 To provide quality health care, focus on enhancing patient satisfaction.

Rationale

Patients are most likely to be dissatisfied with a health care provider and the quality of care provided if they feel that the health care provider (1) does not communicate in a warm and friendly manner, (2) is not aware of or interested in their concerns, (3) does not listen to them, (4) does not provide clear and useful information, or (5) fails to involve them as active participants in medical decision making. Why should health care providers be concerned with patient satisfaction? At a minimum, patients may decide to leave a health care practice if they are not satisfied with the communication relationship with their providers. There also is some evidence that the risk of malpractice litigation increases when patients are not satisfied. On a more positive note, studies have found a significant relationship among effective patient communication, patient satisfaction, and improved health outcomes.

What You Should Do

There are many ways to encourage patient satisfaction. In all health care settings, patient satisfaction can be enhanced by taking a moment to socialize with the patient to create a sense of connection and rapport before initiating activities related to the purpose of the patient's visit. In a medical office setting, practices that help to enhance patient satisfaction include:

- Scheduling appointments with older adults earlier in the day, when things are less hectic.
- Making sure that someone greets patients by name.
- Providing assistance to patients who need help completing forms.
- Having someone check on patients if they are kept waiting.
- Saying goodbye at the conclusion of the visit.

In a hospital or other inpatient setting, health care team members are encouraged to take the following steps:

- Introduce themselves to all patients, including their name and professional role.
- Remember that routine procedures and hospital protocols are not routine for their patients.
- Ask patients if they have any questions during their inpatient experience.
- Genuinely listen to patient concerns and provide follow-up action or information as needed.
- Ensure that discharge plans are communicated clearly, both orally and in writing.
- Contact patients after discharge to address ongoing or emerging concerns.

No matter the setting, patient satisfaction always will be enhanced if all members of the health care team treat patients with dignity, courtesy, and respect.

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22 Use humor and a direct communication style with caution when interacting with non-Western older patients.

Rationale

Research shows that the use of humor by health care professionals eases tension associated with medical visits and helps to put patients at ease. It also is associated with improved physical health and increased trust between physicians and patients. Moreover, an individualistic culture (such as the United States) prefers a direct, assertive, and expressive communication style.

In contrast, many ethnic minorities in the United States prefer an indirect communication style and use of deference language based on age, sex, and social status. Physicians who use humor and a direct communication style when interacting with non-Western older patients—especially patients who would occupy a higher status than the physician in the patient's cultural norm—may be perceived as condescending and disrespectful. Violation of such cultural expectations could lead to patient dissatisfaction and distrust, as well as a reluctance to disclose needed health information.

What You Should Do

Be personable, but use humor with discretion. Do not use humorous messages to comment on an older patient's clothes, culture, age, sex, rituals, family, body shape or size, or important health beliefs. Avoid using humor during physical examination, especially when examining a patient of the other sex.

Assume that older patients prefer a formal manner of address unless the patient indicates otherwise. Avoid interpreting older patients' passive communication styles as a sign of submission. Engage in active listening for indirect responses and use a respectful tone to encourage the older patient to elaborate if the answer is vague or overly brief. When older patients talk about their past achievements and experiences, try to engage in the conversation instead of being nonresponsive or dismissive.

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23 Help Internet-savvy older adults with chronic diseases find reputable sources of online support.

Rationale

Having a chronic disease significantly increases an Internet user's likelihood of using a blog or contributing to an online discussion, electronic mailing list, or other forum for people with health problems. In a recent Pew Internet survey, 23% of Internet users living with hypertension, diabetes, heart conditions, lung conditions, cancer, or some other chronic ailment reported having gone online to find others with similar health concerns. Other Internet users who were likely to seek online connections included people caring for a loved one; people who experienced a medical crisis in the past year; and people who had experienced a significant change in physical health, such as quitting smoking or weight loss or gain.

What You Should Do

For Internet-savvy older adults, provide a list of reputable online resources about their medical condition. A good starting point is MedlinePlus, a service of the U.S. National Library of Medicine (part of the National Institutes of Health). This website (http://www.medlineplus.gov) supports condition-specific searches for information about symptoms, diagnosis, treatment, current research, and patient advocacy groups.

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24 If computers are used during face-to-face visits with older adults, consider switching to models that facilitate collaborative use.

Rationale

Despite growing familiarity with and use of computers by many older adults, the reduced hand–eye coordination and manual dexterity that may accompany aging can make use of a computer mouse difficult and often frustrating. Newer technology—for example, large, flat, table-like touch-screen computers—can help to minimize that frustration. Older adults who may previously have considered computers in the examination room to be a distraction for their health care provider, or who were eager to be more engaged in their own medical treatment but could not do so easily because of technological challenges, have been shown to respond very well to new computer styles that can be used alongside their health care provider. This helps to reinforce the partnership between the patient and the clinician while building the patient's confidence in his or her role as a team member.

What You Should Do

Consider replacing existing computer terminals with large, horizontal, touch-screen computers that can be used in a collaborative manner by health care providers and patients.

For More Information

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25 Maintain a positive communicative tone when speaking with an older adult with dementia.

Rationale

Older adults with dementia retain their ability to process the tone of communication. A soft tone and patience facilitate responsive behaviors and reduce the likelihood of problem behaviors such as agitation. In contrast, using critical emotional expression has been linked with problem behaviors.

What You Should Do

Avoid high-pitched and loud utterances. Provide statements that are encouraging and affirming. If you observe problem behaviors—for example, if an older woman with dementia keeps pulling away when you trying to comb her hair—acknowledge the feelings that the patient seems to be expressing ("I know you don't like to have your hair combed; I'll be done quickly").

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Mini Case: Mrs. Baldwin

The following exchange occurs between a nursing home staff person (Irene) and a resident with Alzheimer's disease (Mrs. Baldwin).

Irene: We're starting bingo in five minutes. Time to get moving! Give me your hand.
Mrs. Baldwin: What?
Irene: Didn't you play last week?
[No response from Mrs. Baldwin]
Irene: If we don't get going, we'll miss the game. Let's go.
Mrs. Baldwin: No.

Suggestions for Improvement

In this version of the exchange, Irene uses open-ended questions and her knowledge of Mrs. Baldwin's life history to engage her in a more appropriate activity.

Irene: Hello Mrs. Baldwin. Bingo starts soon. Are you interested in going?
Mrs. Baldwin: No.
Irene: What do you like to do for fun?
Mrs. Baldwin: Not bingo!
Irene: I know you used to be a high school teacher. The new poetry group might be a good fit.
[No response from Mrs. Baldwin]
Irene: Would you like to try the poetry group?
Mrs. Baldwin: I don't know.
Irene: You can try it for a few minutes and leave if it isn't fun.
Mrs. Baldwin: I don't know where it is. I always get lost in this place.
Irene: Oh, I would never let you be lost.
Mrs. Baldwin: No, you wouldn't.

26 Avoid speaking slowly to older adults with dementia.

Rationale

The term "working memory" refers to the temporary storage and processing of information that is required for complex tasks such as learning and language comprehension. Speaking slowly places an additional burden on working memory in patients with dementia, because they have to hold onto the words in a sentence for a longer time before comprehending the completed sentence. This increases the possibility of misunderstandings.

What You Should Do

Do not deliberately reduce your rate of speech; you are more likely to sound monotone and contrived. There is no need to speak slower or faster than your normal speech rate. The goal is to be clear in your enunciation of words while maintaining the intended intonation of your sentence.

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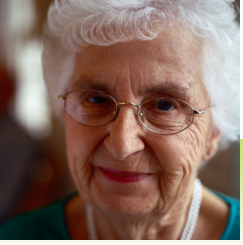

27 Pose different types of questions to patients with dementia according to conversational goals.

Rationale

Questions should not "test" the older adult with dementia. If your communication goal is to gather information—to get a specific answer and complete a task—use closed-ended choice questions or yes/no questions. If your goal is to encourage conversation with no urgency, use open-ended questions.

What You Should Do

Use closed-ended questions for gathering specific information. Examples include:

- "Would you like pasta or rice?" (Choice question)
- "Are you hungry?" (Yes/no question)

Use open-ended questions for encouraging conversation. Open-ended questions that require semantic memory (i.e., knowledge of the meaning of words, concepts, rules, and customs) are more likely to be successful than open-ended questions that tap into episodic memory (i.e., knowledge of specific events that occurred at a particular time). For example, pose a question such as:

- "What *movie* would you like to watch?" (Open-ended question tapping into semantic memory)

Avoid questions such as:

- "What movie did you watch *last night*?" (Open-ended question tapping into episodic memory)

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28 When communicating with older adults with dementia, simplify sentences by using right-branching sentences.

Rationale

In a right-branching sentence, the main clause is followed by a subordinate clause:

Take your seat and you won't miss the movie.

A left-branching sentence has an embedded clause that interrupts the main clause:

If you don't want to miss the movie, you should take your seat.

Right-branching sentences require less temporary storage of information; consequently, they are less taxing on working memory.

What You Should Do

Avoid sentences that *begin* with subordinating conjunctions—words and phrases such as "if," "although," "even though," "while," "since," "given," "after," "before," "as long as," "once," "because," and "unless." Sentences that begin with words or phrases such as these require the listener to hold information in the subordinate clause in order to understand the sentence. Holding information and remembering grammatical rules put a strain on working memory.

As shown in the example above, connect two ideas in a sentence using "and" instead of beginning sentences with subordinate clauses.

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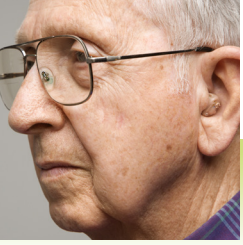

29 Use verbatim repetition or paraphrase sentences to facilitate comprehension in older adults with dementia.

Rationale

Verbatim repetition aids in comprehension by helping the older adult with dementia to recall what was forgotten from the original sentence. Verbatim repetition also reinforces the memory trace of the original sentence. Paraphrasing, by changing the content or structure of the original utterance, can facilitate comprehension when the older adult has difficulty understanding the original utterance.

What You Should Do

Paraphrasing can be accomplished by removing the part of the sentence that created the misunderstanding or by substituting the trouble source with an element that has the same meaning. For example:

> ***Original sentence:*** "Dr. Wilson, who works adjacent to the pharmacy, is closing his office."
>
> ***Paraphrased sentence:*** "Dr. Wilson is closing his office." (The extra information "who works adjacent to the pharmacy" might create a misunderstanding and was omitted.)
>
> ***Paraphrased sentence:*** "Dr. Wilson, who works *next* to the pharmacy, is closing his office." (The word "adjacent" was replaced with the word "next" to facilitate comprehension.)

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Case Resolutions

- *You are talking with an older woman who you think may have a hearing impairment. You talk louder, but she still seems to have some problems hearing and understanding you. She also seems to have problems complying with instructions for taking medication and often returns to the office with the same problem.*

  Resolution: Hearing problems in older adults usually are not helped by talking louder. Indeed, louder talk can actually be more difficult to understand because it is usually at a higher pitch. Instead, focus on (1) always facing the patient directly at her level, (2) talking more clearly and only slightly louder, and (3) supplementing verbal recommendations with clear written instructions.

- *As you talk with an older man about his diabetes, you get the feeling that he doesn't really understand you, despite ensuring you that he does when you ask him. When you explain why and how to take the metformin that has just been prescribed, the patient appears to be listening, smiles, and nods his head "yes" in response to questions. Nonetheless, you sense that he will not be able to take the medication correctly when he returns home.*

  Resolution: After you provide information, ask the patient open-ended questions to elicit comprehension of the information. In this case, you might ask the patient to explain when and how he will take metformin. This "teach-back" strategy may be especially helpful if you set specific communication goals for the interaction (teach to goal).

- *You are in the middle of a patient visit that seems to be productive and progressing in a positive manner. All of a sudden, you begin to sense the patient has become quiet and withdrawn. Even direct questions—for example, "Is everything okay?" and "Is anything the matter?"—are met with sullen denials. You know you did something to contribute to this change in the patient's demeanor, but you just can't figure out what.*

  Resolution: One possible explanation is that in your effort to gather clinical information efficiently, you interrupted the patient on more than one occasion, and you often focused on the patient's chart or your laptop rather than looking directly at the patient. If you exhibited these behaviors on a repeated basis, you may have been communicating to the patient that you either were not interested in or were not concerned about what he or she was saying. By monitoring and controlling your nonverbal behavior, you can avoid unintentionally sending messages to patients that create barriers to open and effective exchanges of messages and have the potential to significantly reduce patient satisfaction.

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