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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Should Be the Scope of Long-Term Care Organizations' Obligations to Offer Culturally and Linguistically Appropriate Services to Patients?

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Abstract

Limited access to health services, decreased quality of care, and worse health outcomes are well documented barriers people with limited English proficiency (LEP) face in US health care. Laws enacted since the 1964 Civil Rights Act recognize such barriers and have helped generate demand for culturally respectful health service provision, assessment of cross-cultural relations, and adaptation of services that fail to meet persons' needs and improve quality of life. Yet, as this commentary on a case considers, even with legal protections for language services for patients with LEP, long-term care facilities face limited resources and thus have limited capacity to offer such services.

Case

JK is an 85-year-old, widowed, native Bosnian speaker with limited English language proficiency (LEP), who is admitted to a nursing home. JK experiences chronic physical illness and cognitive dysfunction and can no longer live in her home since the death of her 69-year-old daughter, who was her caregiver. JK came from Bosnia-Herzegovina to the United States many years ago with her husband to live with her daughter and has no remaining family in the United States. JK briefly communicates via an online interpreter service daily with staff during rounds, but otherwise she interacts only minimally with others. JK has become socially withdrawn and depressed, has minimal appetite, and is losing weight.

When JK is visited by a Bosnian-speaking friend of her daughter, who brings Bosnian food, she eats and converses with ease and joy. JK's visitor informs the staff that JK is not comfortable talking about her body or how she is feeling with the interpreter offered by the online international language service, who is Serbian.

JK's caregivers' encounter with JK's visitor illuminated for them how profoundly the linguistic and food services they have been offering JK undermine her well-being and

their capacity to understand her needs. A case worker requests better services during her regular meeting with liaisons at the company that owns and operates the facility and several others in the region. The appeals are denied since they would be “too costly” and “impossible to provide to all patients.” JK’s caregivers are distressed about being unable to provide services that would offer such clear benefit and wonder what to do.

Commentary

JK’s story highlights some of the ethical challenges faced by caregivers in providing linguistically and culturally appropriate care for patients with LEP, who have higher mortality due to sepsis, higher readmission rates, and greater social needs than English-proficient (EP) patients.^{1,2,3,4} Health care barriers for people with LEP are well known and have been documented for decades. Language barriers associated with LEP affect communication between health care professionals and patients, resulting in worse health outcomes.^{4,5,6,7,8} For example, history-gathering difficulties or decreased use of screening services as a result of LEP can delay or prevent clinicians’ identification of illnesses,^{3,4,5,6,7} including cardiovascular disease, as patients with LEP are less likely to report cardiovascular symptoms than those without LEP.⁸ Additionally, language barriers can limit the therapeutic alliance if patients have difficulty explaining illnesses or clinicians have difficulty explaining treatments. Patients with LEP are also less likely to be active in seeking medical treatment or to be aware of what services are available.³ Even if they are able to access care, they may have difficulty in adhering to treatment due to challenges in understanding the health care plan and unmet social needs. Poor chronic disease management due to negative social determinants of health (eg, unmet social or medical-legal assistance needs, poor health literacy, or poor understanding of medical benefits) has also been associated with language barriers.^{3,7,8}

Access to **formal interpreters** or bilingual staff improves health outcomes and quality of care (though ad hoc interpreters have not been shown to be effective in improving health outcomes).^{4,6,7} However, interpreter use can also be limiting due to concerns about the accuracy of the interpretation.³ (Is it verbatim? Does some word or expression translate appropriately? Does the interpreter explain directions with the appropriate amount of detail?). Given these overall barriers and worse medical outcomes for patients with LEP, patients with LEP in long-term care facilities (LTCFs) are a vulnerable population. As the US population ages, minority and LEP populations are projected to represent a larger proportion of the geriatric patient population.⁹ While federal nondiscrimination regulations to protect the legal right of patients with LEP to receive health services in their preferred language exist,¹⁰ concerns about noncompliance highlight the importance of identifying and addressing language and cultural resources in LTCFs.^{7,9}

Legal Obligations

Beyond ethical obligations for language-concordant care, organizations have a legal obligation to provide linguistically appropriate services. Title VI of the 1964 Civil Rights Act prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.¹¹ The law prohibits not only intentional discrimination, but also administrative procedures, criteria, or methods that are discriminatory without intent. These practices must be discontinued if any alternatives are available for achieving the same objectives with less discrimination. In 1974, *Lau v Nichols* established that discrimination based on national origin included discrimination based on language.¹⁰ It was not until 2000 that an executive order and Office of Civil Rights (OCR) policy guidance were issued to ensure

providers' compliance with their Title VI obligations to provide equal access to language services.^{10,12} Major federal laws affecting language access include, among others, Section 1557 of the Affordable Care Act of 2010, which requires that covered entities take reasonable steps to provide language services¹³; the Hill-Burton Act (also known as Titles VI and XVI of the Public Health Service Act), which requires that Hill-Burton-funded facilities provide language services for languages spoken by at least 10% of local households¹⁴; and the Emergency Medical Treatment and Labor Act (EMTALA), which requires that hospitals with emergency departments provide easy-to-read signage about patients' rights under the law in the languages of the population served.¹⁵ The extent of providers' obligations is determined by 4 factors specified in OCR policy guidance: (1) the number or proportion of persons with LEP served, (2) the frequency of contact with a particular language group, (3) the nature and importance of a program or service, and (4) resources required and available.¹² These factors allow for differentiation of obligations between different facilities (eg, between larger, urban facilities serving a diverse population vs smaller, rural facilities serving a more homogenous population) that receive federal funds.¹² Several states have also established additional laws specifically addressing LTCFs and language availability.¹⁶

Interpreters, however, may also need to act as cultural brokers to facilitate communication and understanding since linguistic competency is intertwined with cultural competency.¹⁷ The US Department of Health and Human Services developed cultural and linguistic competency guidelines for providers, the National Standards for Culturally and Linguistically Appropriate Services (CLAS),¹⁸ although hospitals' application of and compliance with these standards is inconsistent.¹⁹ CLAS standards focus on improving quality of care for patients through care and services that are respectful of and responsive to patients' cultural and linguistic needs.¹⁸ CLAS standards also provide guidance for health care organizations on meeting federal regulations for language services for patients with LEP.^{18,19}

Geriatric LEP Inequity

Studies have shown that in geriatric populations, as in the general population, individuals with LEP have worse access to care and health status than EP individuals.^{20,21,22} Furthermore, minorities and patients with LEP are more likely to be in **lower-quality LTCFs** that have deficiencies, lower staff investment, poor financial viability, and worse health measurements of care.^{21,23,24,25}

The 1987 Omnibus Budget Reconciliation Act set forth quality of care mandates for nursing homes and rights for nursing home residents, including the right "to be fully informed in language that he or she can understand,"²⁶ be it orally or in writing.²⁷ The Centers for Medicare and Medicaid Services (CMS) State Operations Manual highlights this requirement, stating that "health information and services" must be provided in a manner that "makes sense" to the resident or their representative and that LTCFs must offer language assistance and provide qualified interpreters as needed.²⁸ Communication, including speech and language, is regarded as part of the activities of daily living that LTCFs must provide the resident "to maintain or improve his or her ability to carry out the activities of daily living."²⁸ Beyond these responsibilities, LTCFs are expected to "incorporate the resident's personal and cultural preferences" in goals of care and to provide "culturally-competent" comprehensive care plans and staff.²⁸ Cultural appropriateness extends to resident needs and preferences for nutrition (food and meals), although this responsibility to individual patients may be limited based on the "overall cultural and religious make-up of the facility's population."²⁸ Failure to

comply with cultural and linguistic requirements qualifies as noncompliance. For example, failure to accommodate cultural dietary needs or beliefs is a level 2 deficiency, with deficiencies being categorized according to severity of harm to patients on a scale of 1 to 4 (with 4 being the most severe).²⁸ Facilities are expected to exhibit “good faith” attempts to address noncompliance with regard to the severity and frequency of the infraction, with investigators determining “good faith” on the basis of evidence of the facility’s actions as a whole.²⁸

Conclusion

JK’s case highlights ongoing health disparities and challenges on linguistic and cultural levels within LTCFs, despite legislated requirements for language services. While JK’s LTCF has provided interpreter services, it has failed to account for the cultural suitability of the situation. JK demonstrates clear distress with her Serbian interpreter. Although JK’s experiences with the Bosnian War and other Balkan conflicts are unclear, high levels of general psychological distress have been found in survivors and participants of the Bosnian War and other groups involved with armed conflicts.^{29,30} The CMS manual specifically mentions that LTCFs need to address mental distress and possible posttraumatic stress disorder, including in “racial, political, or cultural groups” that have “witnessed or been subjected to intentional and systematic destruction.”²⁸

JK’s improvement with visitors from members of her cultural group and with dietary changes highlights the impact on her well-being of the LTCF’s failure to provide culturally competent care. LTCFs have a legislated obligation to provide language services “in a way that makes sense” to residents.²⁸ It is arguable, depending on JK’s experiences, that her psychological distress due to the LTCF’s noncompliance with cultural and linguistic requirements may constitute “actual harm that is not immediate jeopardy” (a level 3 deficiency) as opposed to “no actual harm with a potential for more than minimal harm” (a level 2 deficiency).²⁸ JK’s ongoing depression and weight loss already suggest evidence of actual harm, depending on her medical condition. Further exacerbation of these symptoms could qualify as “immediate jeopardy to resident health or safety,” the highest level of deficiency an LTCF can be charged with for individuals within their care.³¹

While LTCFs have both ethical and legal obligations to implement a linguistically and culturally competent system of care to improve residents’ quality of life, inadequate resource availability continues to hamper its realization. JK’s caregivers were motivated to improve her care, but, as in many other cases, their appeals for cultural appropriateness of linguistic and food services, though required by law, were deemed “too costly.” Depending on the demographics of her area, JK’s care may in fact exceed legally required language services per Title VI in the provision of an ethnically Serbian language interpreter instead of a Bosnian one. In this case, the LTCF could have written and translated questions with responses in the form of ratings regarding her experiences with the translation service so that she could give a general response as to whether she felt it was satisfactory or had concerns or experienced discomfort without the presence of the translator that could be investigated further. Given JK’s cultural background and age, along with associated global events, the LTCF could have also checked to see whether available translators could have caused JK some psychological distress.

Health care professionals and LTCFs have a moral as well as a legal imperative to reduce the barriers to care faced by patients with LEP. It is perhaps a poignant reminder

that Neil Armstrong stepped on the moon just 8 years after President Kennedy's call, whereas one elderly widow continues to struggle to obtain services and rights legislated nearly 6 decades ago and reinforced routinely by numerous acts of Congress and actions of presidential administrations.

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Editor's Note

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Conflict of Interest Disclosure

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