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Research Article

Infusing Culture into the Long-Term Care Environment to Improve Public Health and Quality-of-Life Experience

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ABSTRACT

This article examines long-term care quality from a cultural perspective, using Hawaii as its locale. Discussions will center around communication and language, socialization and activities, morals, values, and beliefs. Analyzing the role culture, cultural understanding, and cultural competence plays in the long-term care environment, especially to improve public health and quality of life, ensures programs and services meet the psycho-social needs and promote health, happiness, and satisfaction for the consumer. Based on this study, suggested strategies are relevant and recommended for other US and European long-term care providers to incorporate into their organizational culture when providing long-term care services and support (LTSS).

Keywords: long-term care, culture, cultural competence, quality of life, Hawaii culture

INTRODUCTION

Culture is a set of customs and traditions, beliefs and values, race and religion, and patterns of human behaviors, characteristics of everyday life shared by people in a place or time. Culture influences a person's interactions with the environment, their health, and their quality of life. Social determinants of health (SDOH), five domains that affect a range of health, functioning, and quality-of-life outcomes and risks, must be acknowledged by long-term care providers, since these factors play a role in the overall long-term care experience (ODPHP, 2021a). The domain of social and community context focuses on the relationships and interactions between family, friends, and the community and stresses social support and building positive relationships. The domain of health care access and quality ensures people get the health services they need, including long-term care, and improving communication through awareness of a person's needs. The cultures of Hawaii reminds us to be peaceful, kind, compassionate, and to take care of our environment and each other. Hawaii's cultures are filled with customs, traditions, music, stories, morals, beliefs, and values that must be considered when providing services and support in the LTC environment.

The Institute of Medicine's Crossing the Quality Chasm: A New Health System for the 21st Century (2001) proposed six domains of health care quality; safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Patient-centeredness is defined as providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions (IOM, 2001). The Criteria for Designing or Evaluating a Long-Term Care System developed by St. Joseph's College of Maine (1993) lists in Criterion I, addressing quality of care and focusing on recognizing the needs, rights, and responsibilities of individuals through being consumer-driven; meeting the needs of consumers; focusing on the individual and his/her unique needs and respecting different cultures and cultural values (SJCM, 1993). This article will examine long-term care quality from a cultural perspective, using Hawaii as its locale. Specifically, creating and sustaining an environment that humanizes and individualizes each resident's/client's quality of life will improve overall health and wellbeing. Discussions will center around communication and language, socialization and activities, morals, values, and beliefs and offer public health strategies that other US and European long-term care providers can incorporate into their organizational culture when providing long-term care services and support (LTSS) in order to enhance quality of life.

LAYING THE FOUNDATION: CULTURE, CULTURAL COMPETENCE, AND QUALITY OF LIFE

Culture is multi-faceted and can be defined in various ways including a particular set of customs, morals, codes, and

traditions from a specific time and place; an integrated pattern of human behaviors (thoughts, communication, actions, customs, beliefs, values) and institutions/group (racial, ethnic, religious, or social); the beliefs, values, behaviour, and material objects that constitute a peopleʻs way of life; the customary beliefs, social forms, and material traits of a racial, religious, or social group; or the characteristic features of everyday existence shared by people in a place or time. What is similar with each of these definitions is that culture defines who people are (beliefs and values) and why they do things (actions). Culture is oftentimes "who we are", oneʻs identity. Culture can explain illness, how illness can be cured or treated, and who should be involved in the health care process. Every culture has beliefs about health, disease, treatment, and health care providers. Cultural health beliefs affect how people think and feel about their health and health problems, when and from whom they seek health care, and how they respond to recommendations for lifestyle change, health-care interventions, and treatment adherence, which can affect the quality of care/quality of life a person receives or experiences (IOM Committee on Health Literacy, 2004).

Similarly, cultural competence has multiple definitions. A project of the National Center for Cultural Competence at Georgetown Universityʻs Center for Child and Human Development (2004) noted there is no one definition of cultural competence but credited the work of Cross et al in 1989 as offering a definition of cultural competence that is a solid foundation for the field (Goode et al., 2004). Cross et al. (1989) defined cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals enabling them to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs (Cross et al., 1989). Cultural Competence is one of six points along a continuum from cultural destructiveness to cultural proficiency, where acceptance and respect for differences, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to meet the needs of minority populations are embodied (Cross et al. 1989).

Federal regulations, including F-tag 675, identify quality of life as a fundamental principle that applies to all care and services provided to long term care (LTC) facility residents (NCCAP, 2021a). Quality of life is a reflection of the way patients perceive and react to their health status and to other, non-medical, aspects of their lives. Leaders of LTC facilities have the responsibility to create and sustain an environment that humanizes and individualizes each residentʻs quality of life ensuring, among other obligations, that the care and services provided are person-centered, and honor and support each residentʻs preferences, choices, values, and beliefs (NCCAP, 2021a). The Intitute of Medicine (IOM) in 1986, published a report titled, "Improving the quality of care in nursing homes" identifying a sense of well-being, self-esteem, and self-worth as enhanced by personal control over choices, privacy during visits and treatments, and opportunities to engage in religious, civic, recreational, or other social activities. A personʻs culture, life experiences, beliefs, and values play a role in how these opportunities are incorporated into oneʻs daily lives.

Quality of life is closely related to the quality of resident-staff relationships. Kindness, courtesy, and opportunities to make choices are expectations that lend itself to improved satisfaction. Competent, caring staff who provide services where dignity, privacy, and human needs are respected and provided add to the quality experience. Since many residents in LTC facilities spend months, if not years, receiving LTSS, quality of life is as important as quality of care. The well-being of the resident must be paramount in LTC settings and to be non-compliant in this area can lead to potential abuse, neglect, loss of dignity, and disregard for oneʻs values, beliefs, and culture. Of note, the Long-Term Care Minimum Data Set (MDS), a standardized, primary screening and assessment tool which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid, contains items that measure physical, psychological, and psycho-social functioning and data on race/ethnicity, language needs, preferences for customary routine and activities, and participation in assessments and goal settings (ODPHP, 2021b). The completed MDS is submitted to the Centers for Medicare and Medicaid (CMS) however, the information from the MDS should then be used as the basis for developing individualized care plans focused on, among other priorities, addressing the resident's quality of life.

The central focus of many regulations, including F-tag 684, is the LTC facility's responsibility to identify and provide needed care and services that acknowledge each resident's preferences and goals for care that are resident-centered (Elizaitis, 2018). The intent of F-tag 684, Quality of Care, is to ensure the care and services provided meet professional standards of practice and meet each resident's physical, mental, and psychological needs (Elizaitis, 2018). The World Health Organization (2021) defines quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. Quality of [health] care includes effectiveness, safety, people centered, timely, equitable, integrated, and efficient. Ensuring the resident and/or resident representatives are included in the ongoing care planning process allows for the resident's beliefs, values, and choices to remain part of the conversation. While the focus of this article is about quality of life and not quality of care, culture can affect one's health, disease, treatment, and care decisions, which can affect a resident/client's quality of life.

BACKGROUND: HAWAII, THE 50TH STATE

Hawaii consists of eight major islands, from west to east, Niʻihau, Kauaʻi, Oʻahu, Molokaʻi, Lānaʻi, Kahoʻolawe, Maui, and Hawaii [island]. Seven of the eight islands are inhabited by the 1.416 million people, some of whom need access to LTSS (U.S. Census Bureau, 2020). As of 2019, 19% of the population were persons 65 years and older and females were 50% of the

population (U.S. Census Bureau, 2020). Race was described at 37.6% Asian alone, 25.5% white alone, 24.2% two or more races, and 10.1% Native Hawaiian and other Pacific Islander alone (U.S. Census Bureau, 2020). The two official languages of Hawaii are English and Hawaiian; however, the Hawaiian Creole English dialect is also used by Hawaiian residents. Other languages spoken by people living in Hawaii include Japanese, Chinese, Korean, and the major Filipino languages of Tagalog, Ilocano, and Visayan. Hawaii is both multilingual and multicultural, with a mixture of influences from the East and the West. According to the Hawaii State Dept of Health's Office of Health Care Assurance (OHCA), which performs licensing activities on healthcare facilities, agencies, and organizations in Hawaii, including long-term care providers, Hawaii has approximately 44 nursing facilities, 45 adult day health or adult day care centers, 17 assisted living facilities, 118 home care agencies, a few hundred adult residential or expanded adult residential care homes, and thousands of unpaid family caregivers (OHCA, 2021). Hawaii has been described as racially and ethnically diverse, multi-generational (housing), and a family-oriented culture with strong norms and expectations of family support as one ages. Each of these providers, paid or unpaid, prioritize the cultural needs of their resident/client/family populations enhancing their quality of care/quality of life.

Zimmerman (2017) describes culture as the characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music, and arts. Culture is a group identity fostered by social patterns unique to the group. The cultures of Hawaii reminds us to be peaceful, kind, compassionate, and to take care of our environment and each other. Hawaii's cultures are filled with customs, traditions, music, stories, morals, beliefs, and values that must be considered when providing services and support in the LTC environment. Equally important is ensuring the LTC organization and workforce are culturally competent to provide care to residents with diverse values, beliefs, and behaviors. The Resources for Integrated Care (RIC) (2019a) defines culturally competent organizations as those that respect and value cultural and linguistic diversity within its staff and offers the support its staff needs to provide culturally competent care.

DISCUSSION: ADDRESSING CULTURE AND CULTURAL COMPETENCE IN HAWAIʻI'S LTC

Lynn Breedlove and Jennifer Roy (n.d.) assert providers often fail to meet the linguistic, cultural, and religious needs of LTC consumers. They describe cultural competence as a combination of sensitivity, attitudes, skills, and knowledge that allow an individual or system to establish and maintain productive relationships with members of a different ethnic group or culture (Breedlove et al., n.d.).

Several of Hawaii's LTSS (i.e. nursing facilities, adult day care, and case management providers) have policies ensuring reasonable steps are taken to ensure persons with Limited English Proficiency (LEP) have meaningful access and equal opportunity to participate in the services, activities, programs, and other benefits of the facility. The goal is to ensure meaningful communication with LEP residents/clients and their authorized representatives involving their medical conditions and treatment. The policies also ensure that the communication of information contained in vital documents such as waivers of rights, consent to treatment forms, financial and insurance benefits forms, and admissions forms are in a language that is understood by the person with LEP or that an interpreter, translator, or other aid is available at no cost to the person being served. Staff are provided notice of the policy and procedures and staff who may be in direct contact with LEP individuals would be trained in effective communication techniques, including the effective use of an interpreter. Regular review of the language access needs of the resident/client population will be conducted and updated as needed. Monitoring of implementation of the policy is part of the quality assurance program.

Staff training could include the U.S. Department of Health & Human Services (DHHS), Office of Minority Health's (OMH), Think Cultural Health Guide to providing effective communication and language assistance services online training. This Guide is designed to help organizations provide effective communication and language assistance services to culturally and linguistically diverse individuals receiving care and services. Two training tracks are available, one for administrators and the other for direct service providers. Trainings include planning, implementing, and evaluating effective communication and language assistance services, information on cross-cultural communications skills, and building awareness of ones own cultural beliefs to be more responsive to residents/clients. This training also reviews the National CLAS (culturally and linguistically appropriate services) Standards that eliminates health inequities and ensures services are respectful and responsive to the health beliefs, practices, and needs of diverse residents/clients.

Some of Hawaii's LTSS providers ask new residents/clients what their primary language is and their religious affiliation upon admission to the program or facility. The responses guide the workforce toward specific actions to address communication and religious needs. In a few of Hawaiʻi's nursing facilities, the activities and social work departments alert staff to the communication needs of the resident, place language cards at the bedside, and contact religious or spiritual representatives to provide for the resident's needs. The language and basic phrases cards list frequently used words such as tired, eat, bathroom, good morning, and good night, translated into the resident's primary language that care staff can refer to and use when communicating with the resident. The religious or spiritual representative can also become a vital member of the care team should the resident need religious guidance on health care decisions. Many nursing facilities offer different religious services, such as Catholic mass or Buddhist worship, in their calendar of events or offer scheduled one-to-one time, such as with a Mormon missionary/ies. In a 2014 article by BRIA Health Services, the authors noted that religion yielded psychological benefits in seniors including an optimistic outlook on life and illness, a sense of purpose in life, and a greater ability to cope with illness, disability, and death. Nancy C. Kehoe, RSCJ, Ph.D.

developed 14 spiritual needs of seniors, including a need for meaning, purpose, and hope, a need to engage in religious behaviors, and a need to prepare for death and dying, that becomes particularly important in long-term care when residents are going through periods of loss and adjustment (BRIA Health Services, 2014). Religious and spiritual people often use their faith and beliefs to cope with losses and so it is critical to continue to provide religious services to seniors who want them.

DHHS' Centers for Medicare & Medicaid Services (CMS), Guidance to Surveyors for Long Term Care Facilities F-tag 679 (§483.24(c)(1)) Activities states the facility must provide an ongoing program to support residents in their choice of activities designed to meet the interest of and support the physical, mental, and psychological well-being of each resident, encouraging both independence and interaction in the community (RIC, 2019b). The intent of the F-tag is to ensure implementation of ongoing resident centered activities that incorporates the resident's interests, hobbies, and cultural preferences and create opportunities for each resident to have a meaningful life (NCAAP, 2021b). Many long-term care providers in Hawaii meet this requirement by incorporating culture into activities, food choices, and community interactions. At several nursing and assisted living facilities, activity directors schedule cultural celebrations such as Bon Dance (Japanese), May Day (Hawaiian), and Chinese New Year (Chinese); Food Service Directors offer cultural foods including spam musubi ("local"), saimin (Japanese), pancit (Filipino), lau lau (Hawaiian), and dumplings (Chinese); and volunteers from the community come to visit and provide cultural performances of song, dance, and stories. These cultural opportunities promote residents/clients' own cultures and allow them a chance to learn about and experience new cultures.

Hawaii is multi-culturally and multi-linguistically diverse so another strategy to meet resident/client needs, with a focus on culture and cultural competence, is through recruiting a direct care workforce that reflects many aspects of diversity such as race, language, sexual orientation, faith, and country of origin, and mimics the resident/client population of the LTSS provider. A diverse workforce, particularly when direct care workers' cultural and linguistic backgrounds match their clients' backgrounds, is important for providers committed to addressing the needs of the increasingly diverse population. An inclusive environment helps individuals from diverse backgrounds feel understood and valued. A research report by the University of California, San Francisco, Health Workforce Research Center on Long-Term Care (2018) found at a national level, the overall LTC workforce was relatively racially and ethnically diverse with African American and Filipino healthcare workers substantially overrepresented and differences in the racial and ethnic composition of the LTC workforce was dependent on the care delivery setting (i.e., home health care, skilled nursing facilities, residential care facilities, and private households). The research results were not clear as to the relationship between the ethnic diversity of the resident/client population per care delivery setting and the ethnic diversity of that care delivery setting's LTC workforce. The relationships between ethnicity/race and the care delivery system might be more significant when individual states are studied. In Hawaii, approximately 74% of the population is an ethnic minority with 71.6% of its healthcare workforce Asian Americans and Pacific Islander Americans (AAPI) and another 10% AAPI immigrants (New American Economy Research Fund, 2020). This relationship between ethnicity/race in the population and ethnicity/race in the workforce could mean that the LTC environment in Hawaii has a diverse enough workforce to address culture in relation to a resident/client's quality of life; however, further research is needed in this area.

STRATEGIES TO INCLUDING CULTURE AND CULTURAL COMPETENCE INTO QUALITY-OF-LIFE PROGRAMS IN LTC

Cultural competence is the ability to interact effectively with people from different cultures. This ability depends on awareness of one's own cultural worldview, knowledge of other cultural practices and worldviews, tolerant attitudes towards cultural differences, and cross-cultural skills (Alpert, 2021). Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures, and work with varying cultural beliefs (Alpert, 2021). Infusing culture and culture competence in the LTSS environment has yielded several strategies suggestions, some that are already in place in Hawaii's LTC environments:

Communication and Language:

1. Ask the resident/client or representative, upon admission to the program/service, what is their preferred language and how they would like to communicate with you.
2. Post frequently used words or basic phrases at the bedside to communicate in the resident/clients preferred language.
3. Set up third-party interpreter services should the need arise. DO NOT use family members as interpreters for legal documents or to discuss important topics with residents/clients.
4. Develop a list of bilingual staff willing to participate in translation should the need arise.
5. Translate important documents (i.e., admission packets, informed consent, advanced directives) into languages most of your resident/client population will understand.
6. Develop organizational policies and procedures to guide staff when faced with situations where English is not the resident/clients preferred language.
7. Provide staff training on communication and language techniques for residents whose primary language is not English, including non-verbal communication training.

Socialization and Activities:

1. Ask the resident/client what types of activities they are interested in participating (i.e., group, individual, reading, music, etc.).
2. Incorporate cultural celebrations into the activities calendar.

3. Bring in volunteers and visitors from diverse cultural backgrounds to share music, art, and stories of their culture, race, or ethnicity.
4. Provide cultural menus on special days or as a regular choice for meals.
5. Schedule time to reminisce, so residents/clients can share their history, experiences, and stories.

Quality of Life Needs (i.e., religion, ethnic/race, values, beliefs)

1. Ask the resident/client what religious/spiritual affiliation they have and how they would like to participate in worship.
2. Ask the resident/client their ethnicity/race and activities they enjoy doing related to this.
3. Ask about schedules including meals, sleep, activities, etc.
4. Address any accommodation issues related to the resident/clients' values and beliefs.

Organizational

1. Revisit the mission, vision, and values proposition focusing on the importance of culture and cultural competence throughout the organization.
2. Develop policies and procedures that address culture and cultural competence, quality-of-life, dignity and respect, and abuse and neglect.
3. Design signage and marketing materials in different languages.
4. Develop (or use premade) professional development trainings addressing culture and cultural competence, including cultural diversity, cultural sensitivity, and non-discrimination training. Remember, Think Cultural Health from the Dept. of Health and Human Services. This should be scheduled on a regular basis.
5. Work toward ensuring an ethnically diverse workforce that is like the organization's resident/client population.
6. Foster an environment of non-discrimination, acceptance, kindness, and support of all cultures.
7. Develop a culture, cultural competence, and diversity committee made up of staff and, if possible, residents/clients to address issues related to communication and activities at the facility.
8. Use assessments, like the MDS, to develop individualized care plans that account for language and communication, ethnicity and race, preferences, and goal participation.

CONCLUSION

Leaders of LTSS have the responsibility to create and sustain an environment that humanizes and individualizes each resident's/client's quality of life ensuring that the care and services are person-centered and honor and support preferences, choices, and beliefs. Kindness, courtesy, and opportunities to make choices are expectations that lend itself to improved satisfaction. Culture is a group identity fostered by social patterns and filled with customs, traditions, music, stories, morals, and values that must be considered when providing services and support in the LTC environment. Ensuring ethnic and racial diversity in the workforce, similar to the resident/client population, and ensuring a culturally competent organization that respects and values diversity leads to a satisfying quality-of-life experience.

Infusing culture into long-term care that considers social determinants of health (SDOH), namely social and community contexts and health care access and quality, while also recognizing quality of life factors, such as communication and language and socialization and activities ensures an overall positive experience for the resident/client of long-term care. In Hawaii, culture is infused into the daily lives of its people and affects their health, happiness, and satisfaction with life. While this study has focused on Hawaii culture, these public health strategies are relevant and can be utilized by leaders in LTC in other states in the U.S., and for European nations. Essentially, public health leaders must prioritize the psycho-social aspects of life and understand its importance as they develop programs and services for the LTC consumers stressing kindness, compassion, and responsibility through cultural understanding and cultural competence.

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