THE WHITE WORLD OF NURSING HOMES: THE MYRIAD BARRIERS TO ACCESS FACING TODAY'S ELDERLY MINORITIES

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In this note, Ms. Aeschleman explores the cultural, social, and economic barriers faced by elderly minorities in need of nursing home care. Ms. Aeschleman argues that minority elders face greater economic barriers to nursing home access than Whites because of factors such as lower average incomes and a lack of access to and assistance with government programs. Culturally, Ms. Aeschleman argues that minorities face barriers to nursing home care because of language differences, the location of nursing homes within communities, traditions, and both overt and indirect acts of discrimination from nursing home staff, administrators, and White clients. Following a discussion of these barriers, Ms. Aeschleman suggests options to give elderly minorities equal access to nursing homes through federal and state incentives, as well as community-based activism and awareness campaigns.

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I. Introduction

As individuals grow older and face more serious health problems, the need for nursing home care may be realized. In the latest National Nursing Home Survey, 1,385,400 elderly[1] individuals utilized nursing home care.[2] A nursing home is an institutional living arrangement where individuals pay a fee to receive food, shelter, and care for their daily needs.[3] Nursing homes are often viewed as the primary means for taking care of older persons who are no longer able to take care of themselves.[4] These persons may find themselves in the situation where they "have weathered life's adversities . . . [t]hey have usually lived an adventure of exploration and autonomy. Yet when they are older, it is they who are often faced with the crushing realization that they are no longer in control over their lives."[5]

When individuals come to the point where they can no longer independently care for themselves, the decision must be made to seek help. However, the factors in determining whether a minority elder will enter a nursing home can sometimes be vastly different from the factors considered by White elders.[6] Among the considerations are cultural differences, whether a facility is located in the area, and whether sources of financial assistance are available.[7]

Minority elders face multiple barriers when they become ill and can no longer rely on family members for care.[8] Some of the economic barriers minorities may face include the inability to afford nursing

1. An elderly person for this survey was someone who had attained the age of 65. *See* Centers for Disease Control & Prevention, *1995 National Nursing Home Survey* (visited Feb. 19, 2000) <http://www.cdc.gov/nchswww/datawh/statab/pubd/ad289tb1.htm> [hereinafter *Survey*].

2. *See id.*

3. *See* Theresamarie Mantese & Gerard Mantese, *Nursing Homes and the Care of the Elderly*, 51 J. MO. B. 155, 156 (1995).

4. *See* National Senior Citizens Law Ctr., *Representing Older Persons*, 152 PLI/CRIM. 113, 116 (1985).

5. Mantese & Mantese, *supra* note 3, at 155.

6. *See* KYRIAKOS S. MARKIDES & MANUEL R. MIRANDA, MINORITIES, AGING, AND HEALTH 350–54 (1997). The authors list the various considerations in deciding whether a minority elder will enter a nursing home, including amount of insurance, preferences in living arrangements, cultural differences among providers and minority patients, and a lack of facilities in minority areas. *See id.* White patients need not particularly worry about cultural differences or whether the administrators and staff will speak their language. *See id.*

7. *See id.*

8. *See infra* notes 9–15 and accompanying text.

home care due to low rates of private insurance,[9] difficulties in obtaining Medicare coverage because of expensive premiums,[10] and a nursing home's preference for private-pay individuals rather than Medicaid recipients.[11] Cultural barriers include racial and ethnic discrimination on the part of nursing home administrators,[12] aversion to nursing homes due to traditions and familial ties,[13] language barriers,[14] and a lack of nursing homes in heavily populated minority areas.[15] These barriers make it difficult for minorities to obtain access to nursing home care, even though many minorities have poorer health than their White counterparts.[16]

The issue of nursing homes will become increasingly important in the near future due to the dramatic projected growth of elderly minorities.[17] By the year 2050, the Hispanic elderly population will increase from 1.9 million to 13.8 million, African Americans from 2.8 million to 7.6 million, Asians from 783,000 to 4.98 million, and American Indians from 149,000 to 473,000.[18] These increases will present an even greater need for nursing home care among minority elders. Thus, solutions to redress the barriers to access must be sought now.

Part II of this note addresses the background of antidiscrimination policies in nursing homes under Title VI of the Civil Rights Act and also explains the Medicare/Medicaid polices with regard to nursing homes. Part III explores the myriad barriers to minority access to

9. *See* Centers for Disease Control & Prevention, *Health Care Coverage for Persons 65 Years of Age and Over, According to Type of Coverage and Selected Characteristics: United States, Selected Years 1984–1996* (visited Feb. 19, 2000) <http://www.dcd.gov/nchswww/fastats/pdf/hu98t134.pdf>.

10. *See* Jacqueline L. Angel et al., *Nativity, Declining Health, and Preferences in Living Arrangements Among Elderly Mexican Americans: Implications for Long-Term Care*, 36 GERONTOLOGIST 464, 465 (1996).

11. *See* MARKIDES & MIRANDA, *supra* note 6, at 337.

12. *See* David Falcone & Robert Broyles, *Access to Long-Term Care: Race as a Barrier*, 19 J. HEALTH POL. POL'Y & L. 583, 592 (1994).

13. *See* GERONTOLOGICAL SOC'Y OF AM., FULL-COLOR AGING: FACTS, GOALS, AND RECOMMENDATIONS FOR AMERICA'S DIVERSE ELDERS 95 (Toni P. Miles ed., 1999).

14. *See* ETHNIC DIMENSIONS OF AGING 166 (Donald E. Gelfand & Charles M. Barresi eds., 1987).

15. *See* Richard Eribes & Martha Bradley-Rawls, *The Underutilization of Nursing Home Facilities by Mexican-American Elderly in the Southwest,* 18 GERONTOLOGIST 363, 366 (1978).

16. *See* Steven P. Wallace et al., *The Persistence of Race and Ethnicity in the Use of Long-Term Care*, 53B J. GERONTOLOGY: SOC. SCI. S104, S104 (1998).

17. *See* Steven P. Wallace et al., *The Consequences of Color-Blind Health Policy for Older Racial and Ethnic Minorities*, 9 STAN. L. & POL'Y REV. 329, 330 (1998).

18. *See id*. at 340.

nursing homes, while also clarifying how economic and non economic deterrents affect access to nursing homes. Part IV recommends several solutions to decrease or even eliminate these barriers.

II. Background

A. The Underrepresentation of Minorities in Nursing Home Care

Unfortunately, long-term care is neither provided to nor utilized by non-White racial groups in proportions comparable to Whites. For example, one study found the White population in nursing homes to be a glaring 93% of all inhabitants.[19] According to the U.S. Census of Population, in 1996, 3.3% of Whites were institutionalized, 3.1% of Blacks, 1.6% of Hispanics, 1.2% of Asians, and 2.3% of American Indians, even though minorities tend to have more overall health problems than Whites.[20] These statistics demonstrate that Whites are nearly twice as likely as Hispanics to enter a nursing home,[21] even though Hispanics have higher reported rates of poor health.[22] Additionally, Hispanics are often more functionally impaired at an older age than other ethnic groups, and this impairment requires attention above and beyond what typical family members are able to provide.[23] While African American institutional percentages are similar to Whites, those below age seventy-five suffer from poorer health more often than Whites of the same age.[24] This suggests a greater need for

19. *See* Mantese & Mantese, *supra* note 3, at 156; *see also* Wallace et al., *supra* note 16, at S104 (stating that the use of "institutional long-term care by older African Americans, Latinos, and Asian Americans is substantially lower than that of non-Latino Whites").

20. *See* Christine L. Himes et al., *Living Arrangements of Minority Elders*, 51B J. GERONTOLOGY: SOC. SCI. S42, S45 (1996) (discussing the living patterns of minorities and how these patterns affect the rate of institutionalization); Wallace et al., *supra* note 16, at S104 (discussing the higher rates of death and disability among African Americans and the higher rates of diabetes, accidents, and chronic liver disease among Hispanics). The near equal rate of African American presence in nursing homes to Whites is actually not an indication of ease of access for African Americans because the health of elderly African Americans is generally worse as compared to White elderly. *See* Wallace et al., *supra* note 16, at S104.

21. *See* Himes et al., *supra* note 20, at S44.

22. *See* Wallace et al., *supra* note 16, at S104.

23. *See id*. Furthermore, at the time of nursing home admittance, Hispanics were "significantly younger and functionally more impaired, both physically and somewhat mentally, than their non-Hispanic counterparts." David V. Espino & Michael Mulvihill, *Hispanic and Non-Hispanic Elderly on Admission to the Nursing Home: A Pilot Study*, 28 GERONTOLOGIST 821, 823 (1988).

24. *See* Linda L. Belgrave et al., *Health, Double Jeopardy, and Culture: The Use of Institutionalization by African-Americans*, 33 GERONTOLOGIST 379, 381 (1993).

nursing home care for African Americans.[25] Because minorities constitute roughly 16% of the total elderly population, the percentage of minorities in nursing homes should roughly correspond to this percentage,[26] and should probably even exceed this percentage because minorities tend to have more health problems than Whites.[27] However, minorities constitute a mere 7% of the total nursing home population.[28]

B. Title VI of the 1964 Civil Rights Act

Title VI provides: "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[29] Title VI essentially mandates desegregation of any program receiving federal funding.[30] Although this statute appears to legally eliminate discrimination in nursing homes, the effects are not widespread. In 1995, only 8.2% of nursing home facilities were classified as governmental, with 66.1% classified as proprietary, and 25.7% classified as voluntary nonprofit.[31]

Consequently, although Title VI certainly paves the way for the federal government to withhold funds or take other action against nursing homes with discriminatory practices,[32] the government, or private citizens, may take action only against those facilities that are run by the government,[33] which constitute approximately 8.2% of the facilities in the United States.[34] Because so many nursing homes are privately owned, minorities who are victims of discrimination are extremely limited in their courses of action. In order to bring a private

25. *See id*.
26. *See* Wallace et al., *supra* note 17, at 340 (using a table from the U.S. Census Bureau, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995–2050*, at 25–1130 (1996)).
27. *See id.* at 331.
28. *See* Mantese & Mantese, *supra* note 3, at 156.
29. 42 U.S.C. § 2000d (1994).
30. *See* Gretchen Schafft, *Nursing Home Care and the Minority Elderly*, 8 J. LONG-TERM CARE ADMIN. 1, 6 (1980).
31. *See Survey, supra* note 1.
32. *See* Schafft, *supra* note 30, at 12.
33. *See id.* at 6. Moreover, compliance with Title VI seems to be somewhat voluntary in that finding a violation has been referred to as a "paper shuffling exercise." *Id*. at 14–15.
34. *See Survey*, *supra* note 1.

suit against a facility not receiving federal funds, the petitioner must prove the difficult standard of intentional discrimination.[35] However, for the small percentage of nursing homes that are government run, individuals may file private lawsuits to eliminate discrimination or terminate the assistance provided by the federal government.[36]

Following the lead of Title VI, Congress passed the Older Americans Act (OAA) in 1987, which mandates that "services be provided to America's older citizens with a focus on those of 'greatest economic need with particular attention to low-income minority individuals.'"[37] Although this objective certainly appears powerful in the abstract, it is difficult to implement due to the many barriers that exist among minority groups.[38]

C. The Role of Medicare and Medicaid in Nursing Home Funding

Medicare and Medicaid play a significant role in the funding of nursing home care, with Medicaid paying for approximately forty-seven percent of the total cost.[39] Medicare is "a federally funded system of health insurance for the aged and disabled;"[40] namely those persons "age sixty-five and over, the permanently disabled, and those in need of kidney dialysis."[41] If a person is covered under Medicare, the program will pay for up to one hundred days in a nursing home, but after twenty days, the patient must contribute ninety-seven dollars per day.[42] Other conditions must also be met to procure reimbursement, including: (1) skilled nursing home services, (2) daily services, (3) services provided on an in-patient basis, (4) a hospital stay of at least three days within thirty days prior to entering the nursing home, and (5) services must be performed by a Medicare-certified facility and in a Medicare-certified bed.[43] Although Medicare is one option of payment for a short-term stay, monthly premiums are re-

35. *See* Schafft, *supra* note 30, at 9–14. Title VI only applies to those facilities receiving government aid, thus an individual may not sue a private agency under Title VI. *See* 42 U.S.C. § 2000d (1994).

36. *See* National Senior Citizens Law Ctr., *supra* note 4, at 120.

37. Dale E. Yeatts et al., *Service Use Among Low-Income Minority Elderly: Strategies for Overcoming Barriers*, 32 GERONTOLOGIST 24, 24 (1992).

38. *See id*.

39. *See* Harry S. Margolis, *A Proposal for Reform of Medicaid Rules Governing Coverage of Nursing Home Care*, 9 STAN. L. & POL'Y REV. 303, 304 (1998).

40. Mantese & Mantese, *supra* note 3, at 156.

41. Wallace et al., *supra* note 17, at 332.

42. *See* 42 U.S.C. § 1395d(a), (e) (1994); *see also* Margolis, *supra* note 39, at 304.

43. *See* Mantese & Mantese, *supra* note 3, at 156.

quired.[44] Because more than half of residents admitted to nursing homes stay for short periods of time (less than the one hundred day limit of Medicare), Medicare plays an important role in nursing home care.[45] If a person cannot afford the premiums, that person must find another source to pay for the care; specifically Medicaid, private insurance, or private funds.[46] Medigap insurance policies usually pay the copayments, but many minorities do not have supplemental insurance beyond Medicare or Medicaid to cover this gap in insurance coverage.[47]

Medicaid remains "a jointly funded [federal/state] program that pays for necessary medical care for indigent individuals."[48] This means that within federal guidelines, the states may determine their own criteria for individual Medicaid eligibility.[49] Thus, criteria that would qualify one for Medicaid in California, a state with less stringent eligibility criteria,[50] would not necessarily qualify one for aid in Texas, a state with very stringent standards.[51] There are two classes of Medicaid eligibility: categorically needy (those who qualify under the Aid for Families with Dependent Children or the Supplemental Security Income programs) and medically needy (certain groups the state deems needy, typically the aged, or blind, regardless of whether they would qualify for Medicaid financially).[52]

Today, Medicaid is the primary source of payment for long-term nursing home care.[53] In order to be eligible to receive Medicaid, an applicant must not have more than $2000 in "countable" assets.[54] The term "countable" includes many types of belongings, therefore, Medicaid recipients are quite limited in what they may own as assets.[55] For those who qualify, Medicaid covers basic and skilled care in nursing

44. *See id.*
45. *See* National Senior Citizens Law Ctr., *supra* note 4, at 115.
46. *See* Margolis, *supra* note 39, at 304–05.
47. *See id*. at 304; *see also* MARKIDES & MIRANDA, *supra* note 6, at 409.
48. Mantese & Mantese, *supra* note 3, at 156.
49. *See Significant Gaps in Hispanic Access to Health Care: Hearings Before the House Select Committee on Aging and the Congressional Hispanic Caucus*, 102d Cong. 17–19 (1991) [hereinafter *Hearings*] (statement of Eleanor Chelimsky, Assistant Comptroller General).
50. *See id.* at 17–18.
51. *See id*. at 18.
52. *See id*. at 1.
53. *See* Margolis, *supra* note 39, at 305.
54. *See id*.
55. *See id*.

homes.[56] Thus, although Medicare and Medicaid help cover much of the cost of nursing homes for those who are unable to do so, large gaps of uncovered individuals still exist between those who receive Medicaid and those with private or supplemental insurance, with a majority of minorities falling within this gap.[57]

D. Poverty as It Relates to Underrepresentation

Because the Civil Rights Act was not passed until 1964, today's elderly minorities lived most of their lives in a time when segregation was overt.[58] Many worked their entire lives without receiving the benefits taken for granted by most, such as health insurance, pensions, and other benefits.[59] These conditions limited the economic and social opportunities of minority elders; thus, many older minorities have lower incomes, poorer health, and more difficult living conditions than elderly Whites.[60]

Poverty plays a critical role in nursing home care for several reasons. First, the cost of nursing home care for most people varies between $30,000 and $60,000 per year.[61] Without some type of private or governmental insurance, the cost of nursing home care is staggering, which discourages many people from taking advantage of such a service. Additionally, some people cannot afford the premiums for Medicare,[62] even though it provides only limited reimbursement for nursing home care—typically the first one hundred days in a nursing home plus a copayment after twenty days. Thus, they rely on Medicaid, which also has several gaps in coverage qualifications.[63] Consequently, many individuals are left without any form of insurance or government benefit and, therefore, cannot take advantage of nursing home care.[64]

In 1997, the U.S. Bureau of the Census found that 8.9% of Whites, 23.95% of Blacks, and 23.8% of Hispanics aged sixty-five and over

56. *See* Mantese & Mantese, *supra* note 3, at 156.
57. *See* MARKIDES & MIRANDA, *supra* note 6, at 337–38.
58. *See* Wallace et al., *supra* note 17, at 330.
59. *See id*.
60. *See id*.
61. *See* Mantese & Mantese, *supra* note 3, at 156.
62. *See* Belgrave et al., *supra* note 24, at 382.
63. *See* National Senior Citizens Law Ctr., *supra* note 4, at 119.
64. *See* United States Census Bureau, *Health Insurance Coverage: 1997* (visited Feb. 19, 2000) <http://www.census.gov/hhes/hlthins/hlthin97/hi97t2.html>.

lived in poverty.[65] Whites have "about 10 times the assets of those [families] headed by African Americans and Latinos, a gap that remains at almost three to one even when comparing families in the highest income quintile of each race/ethnicity."[66] The reality is that minorities rely heavily on government funding for health care expenses because more minorities live in poverty than Whites.[67] However, minorities are not reaping the benefits of such aid when it comes to nursing home care and are continually underserved in poverty programs.[68] Thus, the combination of a lower income and inadequate government aid means many minorities lack the funds necessary to cover the costs of nursing home care.[69]

III. Analysis

A. Financial Barriers to Minority Access of Nursing Homes

The disturbing fact that minorities either do not or cannot utilize nursing home care may be explained by several significant barriers, including money, discrimination, and lack of knowledge.[70] Within the economic category, poverty, private insurance, and government insurance all play instrumental roles in determining whether an individual will obtain the needed care or be cast from the system and have to rely on family for everyday care.[71] With 30% of nursing home users covering their nursing home care costs through out-of-pocket payments, it is no surprise that those individuals without a lot of money do not fall within this large percentage of users.[72] Even more upsetting are the statistics on those who have no insurance. In 1997, 12% of Whites, 21.5% of Blacks, 20.7% of Asians, and 34.2% of Hispanics had no insurance coverage for the entire year.[73] Without insurance or a pension, there is almost no chance for a low-income person to be able

65. *See* Wallace et al., *supra* note 17, at 340.
66. Wallace et al., *supra* note 16, at S110–11 (using statistics from the U.S Bureau of the Census, *Asset Ownership of Households: 1993*, CURRENT POPULATION REPORTS P70-47 (1995)).
67. *See id*.
68. *See* Ada C. Mui & Denise Burnette, *Long-Term Care Service Use by Frail Elders: Is Ethnicity a Factor?*, 34 GERONTOLOGIST 190, 190 (1994).
69. *See* Margolis, *supra* note 39, at 304.
70. *See* Yeatts et al., *supra* note 37, at 25–26.
71. *See* Marcia K. Petchers & Sharon E. Milligan, *Access to Health Care in a Black Urban Elderly Population*, 28 GERONTOLOGIST 213, 213 (1988).
72. *See* Margolis, *supra* note 39, at 304.
73. *See* United States Census Bureau, *supra* note 64.

to afford a nursing home, unless the individual receives Medicaid. For instance, one study found that "African Americans had less access to care than Whites as a result of their lower incomes, lower rates of insurance, and being less likely to have a regular source of care."[74]

1. LACK OF PRIVATE INSURANCE

In 1997, private insurance coverage of individuals age sixty-five and older showed tremendous differences between racial and ethnic classifications.[75] While only 44% of Blacks, 32.2% of Asians, and 38.6% of Hispanics had some form of private insurance, 75.3% of Whites had private coverage.[76] Low levels of private insurance may be attributed to unemployment, low levels of education, difficult Medicaid requirements, and jobs that do not provide health benefits.[77] In addition, as is the case with many Hispanics, public insurance does not compensate for the lack of private coverage.[78] This lack of insurance is evidenced by low rates of private "medigap" insurance.[79] Consequently, lack of affordability creates a substantial barrier to minority nursing home care.[80]

2. DIFFICULTIES IN OBTAINING MEDICARE COVERAGE

Medicare covers approximately 9% of the total cost of nursing home care, however, this percentage does not represent the need for Medicare by certain minorities.[81] This need is offset by a general difficulty in acquiring Medicare because of the premiums.[82] If an individual cannot afford to pay the Medicare premiums and copayments, Medicare is not a viable option for coverage. Unfortunately, the poor and elderly make up a large portion of those individuals who cannot

74. Wallace et al., *supra* note 16, at S105 (using information from L. J. Cornelius, *Access to Medical Care for Black Americans with an Episode of Illness*, 83 J. NAT'L MED. ASS'N 617, 626 (1991)).

75. *See* Centers for Disease Control & Prevention, *supra* note 9.

76. *See id.*

77. *See* Ronald J. Angel & Jacqueline L. Angel, *The Extent of Private and Public Health Insurance Coverage Among Adult Hispanics*, 36 GERONTOLOGIST 332, 332 (1996).

78. *See id.* at 332 (only 18% of Hispanics received Medicaid in 1990 even though 48% reported having no private insurance).

79. *See* Wallace et al., *supra* note 16, at S104.

80. *See* Margolis, *supra* note 39, at 304.

81. *See id*; *see also* Wallace et al., *supra* note 17, at 340 (reporting 14% of Whites, 31.4% of Blacks, and 28.4% of Latinos were covered by Medicare only).

82. *See* Angel et al., *supra* note 10, at 465.

afford Medicare.[83] Another explanation for this consequential lack of Medicare is a lack of participation in the Social Security program.[84] Whatever the reasons, elderly minorities are severely disadvantaged without Medicare coverage. Typically, the result is complete reliance upon Medicaid coverage.[85]

3. THE DETRIMENTAL RELIANCE ON MEDICAID BY THE MINORITY ELDERLY

Medicaid covers by far the largest portion (between 40% and 50%) of nursing home expenses.[86] In 1996, Whites constituted 45% of the population receiving Medicaid, Blacks composed 24%, Hispanics 17%, Asians 2%, and American Indians and Alaskans 1%.[87] An examination of the elderly poverty rates, however, suggests a different outcome. In 1996, 8.9% of elderly Whites lived in poverty, compared to 23.95% of Blacks, and 23.8% of Hispanics.[88] Because Whites were the least likely to live in poverty, they should also represent the lowest percentage of Medicaid recipients. However, Whites make up the largest portion of users.[89]

In addition to minority groups receiving Medicaid benefits at percentages below the corresponding poverty lines, nursing home care providers also tend to discriminate against Medicaid beneficiaries, thus further hindering minority access to nursing homes.[90] Facilities are allowed to charge "private-pay residents rates that are higher than those paid by government programs, primarily Medicaid, for identical services."[91] Thus, nursing homes have a financial incentive to maximize the number of residents who have private insurance or pay out of their own pockets.[92] Medicaid imposes no requirements on

83. *See* Belgrave et al., *supra* note 24, at 382.
84. *See* MARKIDES & MIRANDA, *supra* note 6, at 352.
85. *See id.* at 354.
86. *See* Margolis, *supra* note 39, at 304 (stating that "Medicare covers nine percent of the nursing home costs, patients and families pay thirty percent, private insurance covers three percent, and Medicaid, the health insurance of last resort, covers forty-seven percent"); *see also* Wallace et al., *supra* note 17, at 335.
87. *See* Health Care Fin. Admin., *Medicaid Recipients and Vendor Payments by Race* (visited Feb. 19, 2000) <http://www.hcfa.gov/medicaid/2082-8.htm> [hereinafter *Medicaid Recipients*]. Eleven percent were unknown for this survey.
88. *See* Wallace et al., *supra* note 17, at 340.
89. *See Medicaid Recipients*, *supra* note 87.
90. *See* MARKIDES & MIRANDA, *supra* note 6, at 337.
91. National Senior Citizens Law Ctr., *supra* note 4, at 118.
92. *See* Schafft, *supra* note 30, at 18.

nursing homes with regard to which individuals must be given care.[93] Consequently, nursing homes "determine their own level of participation, use Medicaid for their own purposes, and make unilateral (and usually unchallenged) decisions as to whether to admit or refuse Medicaid recipients seeking admission."[94] Furthermore, nursing home facilities may manipulate their Medicaid contracts with the state to limit the number of beds in their facilities that are available for Medicaid recipients.[95]

At least one court has found that limiting the number of beds available to Medicaid recipients has a disparate impact upon minorities, thus violating civil rights Medicaid regulations.[96] In *Linton v. Carney*,[97] a Tennessee federal court overturned a "program allow[ing] nursing home operators to give preference to private pay patients by reserving for their exclusive use beds which [were], due to lack of certification, unavailable to Medicaid patients."[98] Thus, trying to limit the beds available for Medicaid recipients in favor of private-pay individuals had a disparate impact and was held unlawful.[99]

Many minorities do not even have the option of acquiring Medicaid because they lay in the no-man's-land of health care—they have too much money to qualify for Medicaid,[100] yet they cannot afford the monthly premiums of Medicare.[101] Because many minorities fall into this category, they are excluded from any type of coverage and are thus detrimentally impacted by the gap in insurance coverage.[102]

Yet another dilemma for minorities is the "spending down" of assets in attempts to gain access to a nursing home bed. These individuals, typically Whites, are not poor enough to receive Medicaid because they are above the $2,000 asset requirement imposed by the government,[103] yet they cannot afford to pay for nursing care costs

93. *See* National Senior Citizens Law Ctr., *supra* note 4, at 118.
94. *Id.* (stating that facilities create their own level of participation because participation in Medicaid creates only limited obligations under federal law).
95. *See id*.
96. *See* Linton v. Carney, 779 F. Supp. 925, 935 (M.D. Tenn. 1990).
97. *See id.*
98. *Id*. at 932.
99. *See id*.
100. *See* MARKIDES & MIRANDA, *supra* note 6, at 338.
101. *See id.*
102. *See* National Senior Citizens Law Ctr., *supra* note 4, at 119.
103. Individuals are allowed to keep household and personal belongings, a prepaid funeral plan, a car with an equity value of $4500 or less, up to $1500 in life insurance, and many times, the home. *See* Margolis, *supra* note 39, at 305.

through private means or insurance. Thus, they must dispose of any assets over $2,000 to qualify for Medicaid. The individual uses whatever money he or she has to pay the initial fee to the nursing home, leaving no money to cover the cost of care upon entering the nursing home. The individual is then eligible to obtain Medicaid to pay for the cost of care. The result of such a policy is that minority residents are disadvantaged because they are less likely to have private funds to cover the initial fee.[104] Because nursing homes typically prefer residents who can pay an initial up-front fee, they will admit those individuals, typically Whites, who will pay the fee and then deplete their funds and rely on Medicaid.[105]

The ability to "spend-down" is more difficult now due to the Omnibus Budget Reconciliation Act of 1993 (OBRA), which "(1) eliminates the use of income-only trusts, (2) permits states to apply eligibility rules to home-care benefits, and (3) imposes more stringent estate recovery provisions."[106] Although "spending down" is less of a problem than it used to be because of OBRA, it still occurs, and thus, detrimentally impacts minorities.[107]

4. LACK OF PRIVATE PHYSICIANS TO REFER MINORITIES TO NURSING HOMES

Entry into nursing homes is often achieved through private physicians who refer their patients.[108] However, far fewer minorities than non-minorities have private physicians that they visit on a regular basis,[109] thus this route to nursing homes is closed to them.[110] More minorities rely solely on Medicare insurance as compared to Whites, who have a higher rate of participation in Medicare in addition to private insurance.[111] Furthermore, those individuals with only Medicare are less likely to have a primary physician or a usual source of care when problems arise.[112]

104. *See* Schafft, *supra* note 30, at 18–19.
105. *See id.* at 5.
106. Mantese & Mantese, *supra* note 3, at 157.
107. *See* Schafft, *supra* note 30, at 18–19.
108. *See id.* at 5.
109. *See id*.
110. *See id*.
111. *See* Wallace et al., *supra* note 17, at 333.
112. *See id*. Furthermore, Blacks in particular are more likely to have clinics as their regular source of care instead of a particular physician. *See* MARKIDES & MIRANDA, *supra* note 6, at 322.

B. The Nonfinancial Barriers Facing Minority Applicants to Nursing Homes

One reason that is offered to explain why the minority elderly's population percentages in nursing homes are not proportional to the general population is related to familial bonds, wherein minority elderly prefer to live with family in their old age.[113] For example, among Hispanics, it appears that nursing homes are sought only as a last resort.[114] Explanations for underutilization, which include societal discrimination and strong ties to family, all play into the decision of whether to enter a nursing home.[115] These factors actually become additional barriers rather than merely a choice to enter a nursing home facility.[116] But one thing remains clear—"the minority elderly population is increasing and their cultural, social, and linguistic uniqueness will require that more than age and functional ability be considered in the development of long-term care policies."[117]

1. DETRIMENTAL RELIANCE ON FAMILIAL TIES

Minority communities tend to have patterns of strong familial support, especially when the elderly are involved.[118] Among African American families, "strong filial bonds exist, and the norm of reciprocity is central to the family. Thus, elderly parents are cared for and supported in part because family members feel obligated to give back to the older generation that cared for them."[119] Hispanics are similar in maintaining a culture based on strong family ties, thus, most Hispanics tend to live near family members to facilitate care.[120] Asian American traditions foster "internal cultural mechanisms [that] help shape their support system, which includes having values that address the care and support of elderly family members."[121] Native Americans, similar to African Americans, live within extended fami-

113. *See* GERONTOLOGICAL SOC'Y OF AM., *supra* note 13, at 95.
114. *See* Espino & Mulvihill, *supra* note 23, at 823.
115. *See* Mui & Burnette, *supra* note 68, at 197.
116. *See id*. at 196–97.
117. Angel et al., *supra* note 10, at 465 (quoting Fernando Torres-Gil, Assistant Secretary for the Department of Health and Human Services Administration on Aging).
118. *See* GERONTOLOGICAL SOC'Y OF AM., *supra* note 13, at 95–97.
119. *Id*. at 95.
120. *See id*. at 95–97.
121. *Id*. at 96. These internal cultural mechanisms include a sense of shame that is used to reinforce those behaviors that society deems appropriate, which includes a sense of family loyalty. *See id.*

lies that provide care for the elderly.[122] However, for Native Americans, the tribe represents the social support framework.[123]

In today's society, a minority elder's place of residence may determine who can help with daily activities and sometimes more complex tasks.[124] However, due to low incomes, inadequate housing, and distance, many family members are not able to give the care they might otherwise be able to provide.[125] Economic constraints limit options in living arrangements, and because many women now have to or want to work outside of the home, they are not able to give full-time care to older parents.[126] Elderly minorities may believe that their children will care for them when that is not actually possible, thus, nursing homes become an important alternative.[127]

Within this context, it becomes easier to understand the elders' reliance upon family members for care. However, another cultural aspect must be looked at to understand why minorities do not want to live in nursing homes—depersonalization.[128] A study of Mexican Americans showed that four characteristics of treatment are desired in a personalized caretaker-patient relationship: "*respeto* (respect), *dignidad* (dignity), *delicadeza* (gentleness), and *comprension* (understanding)."[129] These qualities may be difficult to find among nursing home staff, but family members are much more likely to fulfill these desires.[130] Elders will likely feel more comfortable with family members, thus many minority children feel it is their duty to provide a home for their parents even though professional help may be needed.[131]

2. DISCRIMINATION ON THE PART OF ADMINISTRATORS

Unfortunately, race is often "a predictor of nursing home admission, independent of caregiver burdens, nursing home bed supply, functional and cognitive impairments, social support, and a variety of

122. *See id*. at 97.
123. *See id*.
124. *See* Angel et al., *supra* note 10, at 465.
125. *See id*.
126. *See id*. at 470.
127. *See id*.
128. *See generally* ROSINA M. BECERRA & DAVID SHAW, THE HISPANIC ELDERLY: A RESEARCH AND REFERENCE GUIDE 28–29 (1984).
129. *Id*. at 28.
130. *See id*.
131. *See* Schafft, *supra* note 30, at 4 (stating that there is a desire to provide a comfortable setting for the elderly, thus care is relegated to the homes of family members).

other factors."[132] Because administrators, or their residents, may have prejudices, discrimination sometimes plays a role in the denial of a nursing home bed to an elderly minority in need of care.[133] Administrators may attempt to please residents by placing them with a roommate of the same race or try to limit residents of the facility to one race.[134]

A 1994 study analyzed the differences in discharge delays from a hospital to a nursing home.[135] The results showed that Whites had to wait approximately eight days for a nursing home bed, while non-Whites had to wait approximately twenty days.[136] The only other explanation aside from discrimination was the preference to keep the patient among family members instead of placing the family member in an institution.[137] However, because the placement decision had already been made, the preference to keep parents with the family could not have played a role in the delay.[138] Thus, regardless of the patients' "ages, sex, condition(s) or special care requirement(s), the cooperativeness of their families, their behavioral state, how they [would] pay for long-term care, or whether there were financial preparedness problems," non-Whites experienced longer discharge delays.[139] The most likely explanation is discrimination.[140]

3. LANGUAGE AND OTHER CULTURE-SPECIFIC BARRIERS

When nursing homes serve residents of several different ethnic backgrounds, "[p]ractitioners who are not from the same ethnic culture may attempt to deal with problems in ways that are inimical to that culture or that encourage the elderly individual to change long-

132. Wallace et al., *supra* note 16, at S104 (citing six studies by different researchers that eliminate the factors listed).
133. *See* BRUCE C. VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY 14 (1980); Schafft, *supra* note 30, at 2.
134. *See* Falcone & Broyles, *supra* note 12, at 592. The same study indicated that discrimination is most likely due to the preference of the owners and operators of the nursing homes rather than the preferences of the patients. *See* MARKIDES & MIRANDA, *supra* note 6, at 339.
135. *See* Falcone & Broyles, *supra* note 12, at 589.
136. *See id*.
137. *See id*. at 588.
138. *See id*.
139. *Id.* at 591.
140. *See id*. at 592.

ingrained and culturally related habits."[141] This view of the importance of tradition leads minority users to perceive non-ethnic staff as a threat to their adherence to tradition.[142] Furthermore, ethnic elderly may feel uncomfortable in an almost all-White facility.[143]

Language continues to be a difficult barrier to utilizing services for many ethnic elderly.[144] Of the entire minority population, the elderly are the least likely to speak English due to minimal contact with the language.[145] Many Spanish-speaking elders have difficulty filling out forms that are written only in English and find that the staff and administrators are not helpful or friendly.[146]

Moreover, most nursing homes do not serve the types of foods that minorities are accustomed to consuming.[147] Food "is a very important part of ethnic identity and it may become even more important as other characteristics such as ethnic dress, the mother tongue, and the ethnic neighborhood become less common."[148] For example, American Indians have very different diets and perform different activities than other ethnic groups.[149] Because most of the staff and administrators of nursing homes are not Native American,[150] they are less likely to understand the importance of Native American traditions. Thus, most Native Americans have a preference not to live in public or private nursing home facilities that are run by non-Native Americans.[151]

Most of the staff employed in nursing homes are White,[152] thus many minority elderly feel uncomfortable receiving care from someone who may not understand ethnic traditions or speak their lan-

141. DONALD E. GELFAND, AGING: THE ETHNIC FACTOR 64 (1982) (stating that these habits include "changes in diet, residential location, or traditional relationships with other family members").
142. *See id.*
143. *See* Wallace et al., *supra* note 16, at S111.
144. *See* ETHNIC DIMENSIONS OF AGING, *supra* note 14, at 166.
145. *See id.*
146. *See* BECERRA & SHAW, *supra* note 128, at 29.
147. *See* MARKIDES & MIRANDA, *supra* note 6, at 209, 241. The diets of most African Americans and Hispanics are quite different from the diets of Whites. *See id.*
148. DONALD E. GELFAND, AGING AND ETHNICITY: KNOWLEDGE AND SERVICES 173 (1994).
149. *See* Spero M. Manson, *Long-Term Care in American Indian Communities: Issues for Planning and Research,* 29 GERONTOLOGIST 38, 39 (1989).
150. *See* Schafft, *supra* note 30, at 25.
151. *See* Manson, *supra* note 149, at 39.
152. *See id.*

guage.[153] "Even if a staff member is able to speak the client's language, there is no guarantee that he or she will evidence a comparable sensitivity to the norms and beliefs of the client."[154] With few exceptions, the doctors in nursing homes are White.[155] If residents do not feel comfortable telling their doctors what is ailing them or what could be improved about the kind of care they receive, then the patient will most likely not want to remain in the home.

4. LACK OF NURSING HOMES IN HEAVILY MINORITY-POPULATED AREAS

Yet another explanation for lower nursing home care utilization among minorities is the nonexistence of nursing homes within minority communities.[156] For example, in Texas, where many elderly Mexican Americans reside, the elderly tend to live in the southern and western parts of the state, while the long-term care facilities tend to be in the northern and eastern parts of the state.[157] Native Americans experience similar results because "skilled and intermediate care facilities are extremely rare in Indian and Native communities . . . . Their distance and orientation to non-Indian populations present a number of problems for the elderly Indian resident and his or her family."[158] Because minorities tend to rely heavily on their families, it is extremely hard for them to reside in nursing homes that require long-distance travel.[159] Additionally, the further away nursing homes are from an applicant's residence, the less likely that individual is going to be aware that the facilities even exist.[160]

153. *See id*. In fact, the cultural insensitivity of staff is cited by Native Americans at non-Native American nursing home facilities as the major source of dissatisfaction. *See* Manson, *supra* note 149, at 40.

154. GELFAND, *supra* note 141, at 67. A prime example of insensitivity is the increased status that comes with age in the Chinese culture; thus, a young person may not be the appropriate person to care for an elder. *See id*. Similarly, men in the Latin culture may have a problem if the caretaker is female due to the belief among some elders that men should not take advice about health problems from women. *See id*.

155. *See* Schafft, *supra* note 30, at 20.

156. *See* Eribes & Bradley-Rawls, *supra* note 15, at 366.

157. *See* MARKIDES & MIRANDA, *supra* note 6, at 355.

158. Manson, *supra* note 149, at 39; *see also* GERONTOLOGICAL SOC'Y OF AM., *supra* note 13, at 77.

159. *See* GERONTOLOGICAL SOC'Y OF AM., *supra* note 13, at 77.

160. *See* GELFAND, *supra* note 148, at 160.

5. A LACK OF KNOWLEDGE REGARDING SERVICES

A general lack of knowledge can be divided into three areas: an awareness of the need, an awareness of services to meet that need, and an awareness of how to obtain the appropriate service.[161] As for an awareness of the need, many elderly do not recognize the symptoms of a particular ailment or realize that their condition requires daily monitoring or professional help.[162] Moreover, even when individuals recognize such a need, they may not know of any nursing homes in the area that are able to provide such services.[163] Ethnic elderly may be aware of certain services, but do not know that the services are available to them.[164] Obtaining services, especially among those minorities who do not speak English as their native language, may be very difficult and confusing because of the formalities involved in nursing home care.[165] White elders are typically more informed about their options because they have friends or family members that use or know about such services; however, minority elderly typically lack this link to information.[166] Consequently, a lack of knowledge precludes many minorities from effectively taking part in the care that nursing homes may be able to provide.[167]

If one examines all the cultural reasons why minority elderly may not enter a nursing home, a pattern begins to emerge wherein these cultural explanations become actual barriers. A lack of nursing homes within a reasonable distance certainly decreases the likelihood that minorities will have the option of utilizing care. Furthermore, a lack of knowledge regarding minority traditions and languages on the part of health care providers is a barrier because ethnic minority elders may not be able to communicate their needs to care providers. Thus, while some researchers argue that minority elderly willingly choose not to enter nursing homes, these choices are actually often

161. *See id*. at 150.
162. *See generally id*. *See also* Yeatts et al., *supra* note 37, at 25 (stating that very few elderly recognize a need for services, even when extensive physical impairments exist, thus the perceived need for nursing home care is directly affected).
163. *See* Schafft, *supra* note 30, at 20. Most minorities acted solely upon recommendation because they were uninformed about their options in obtaining nursing home care. *See id*.
164. *See* GELFAND, *supra* note 148, at 151.
165. *See id*. at 149.
166. *See id*. at 151.
167. *See id*.

made in response to the barriers that persist within the healthcare industry.[168]

IV. Recommendations to Redress the Barriers to Minority Access to Nursing Home Care

A. Curing Economic Barriers

The federal government subsidizes nursing home care through Medicare and Medicaid.[169] In 1998, Medicare covered roughly 9% of all nursing home funding, while Medicaid paid for approximately 47%.[170] Nursing home care constituted 20% of the total Medicaid budget in 1995, and the numbers keep increasing.[171] Because the federal government reimburses the states for Medicaid recipient expenditures, an important avenue toward reforming discriminatory practices lies in how the federal government spends the budget.[172]

One way to deter discrimination against Medicaid applicants, and thus many minority applicants who rely on Medicaid, is to require those facilities which rely on Medicaid reimbursements to provide care on a nondiscriminatory basis.[173] Although those facilities that are federally run are already required to provide nondiscriminatory care under Title VI,[174] the state governments should require that private facilities also provide nondiscriminatory care regarding Medicaid patients in order to receive Medicaid reimbursements.

Because private patients typically pay a higher rate for care,[175] a nursing home will typically want to admit as many private-paying applicants as possible. However, that practice normally leads to resistance in admitting Medicaid patients. Therefore, either the federal government or the individual states should equalize the payment rates for both private-paying and Medicaid residents. In doing so, the desire to discriminate against Medicaid patients will decrease because the nursing homes will not receive more money from the private-pay

168. *See* Mui & Burnette, *supra* note 68, at 197; Yeatts et al., *supra* note 37, at 26.
169. *See* Margolis, *supra* note 39, at 304–05.
170. *See id*. at 304.
171. *See id*. at 305.
172. *See* National Senior Citizens Law Ctr., *supra* note 4, at 118–25 (stating several problems that exist in the ways nursing homes discriminate against Medicaid applicants and how these practices may be curtailed).
173. *See id*. at 119.
174. *See* 42 U.S.C. § 2000d (1994).
175. *See* National Senior Citizens Law Ctr., *supra* note 4, at 118.

patients than the Medicaid patients.[176] The nursing home facilities would not lose any money if the state adjusted the present reimbursement rate. Then the Medicaid rate would increase, and the private-pay rate would decrease so that the rates would meet in the middle. By increasing the state-paid rate, Medicaid recipients would have a better chance of gaining access to a facility because nursing homes would have an increased financial incentive to admit a greater number of Medicaid patients.[177] Several states, including Ohio and Florida, have had success with this method for increasing access to Medicaid patients.[178]

Waiving, or at least greatly reducing, Medicare premiums for those individuals who are below a certain income level would also help some minorities gain access to nursing home care on a temporary basis.[179] Many minorities fall in between the gap of Medicaid eligibility and being able to afford the Medicare premiums.[180] Those who cannot obtain either should receive a waiver, or reduction, of the Medicare premiums. Because many minorities have lower paying jobs, in part because of past societal discrimination, they should not be hindered from receiving health care benefits based on past employers not offering health care benefits.

Many states continue to increase the out-of-pocket costs, such as the monthly premiums, related to Medicare.[181] Increased out-of-pocket costs are more detrimental to minorities obtaining health services because fewer minorities have supplemental private insurance.[182] Furthermore, more minorities rely solely on Medicare, whereas most Whites have supplemental insurance in addition to Medicare.[183] The National Center for Health Statistics compiled the relevant figures for health insurance—12.3% of Whites relied only on

176. *See* GENERAL ACCOUNTING OFFICE, NURSING HOMES ADMISSION PROBLEMS FOR MEDICAID RECIPIENTS AND ATTEMPTS TO SOLVE THEM 4 (1990).
177. *See id.* at 25–26.
178. *See id*. at 25. Ohio provided a financial incentive to admit more Medicaid payments by decreasing the difference between Medicaid and private-pay rates to five dollars per day and experienced a 15% increase in Medicaid admittals. *See id.* Similarly, Florida increased Medicaid rates, thereby decreasing access problems. *See id*. at 26. This solution helped Florida move from one of the worst Medicaid-payment rates to the top 50th percent. *See id.*
179. *See* Wallace et al., *supra* note 17, at 333.
180. *See* MARKIDES & MIRANDA, *supra* note 6, at 338.
181. *See* Wallace et al., *supra* note 17, at 332.
182. *See* MARKIDES & MIRANDA, *supra* note 6, at 408.
183. *See id.*

Medicare for health insurance, compared to 34.6% of African Americans and 23.2% of Hispanics.[184] Even more telling are the statistics for those individuals who have Medicare and private insurance—80.3% of Whites had Medicare and private insurance, whereas only 44.9% of African Americans and 49.2% of Hispanics had the equivalent.[185] Hence, the states should not raise Medicare monthly premiums to decrease the total health payments because it disproportionately hurts minorities.[186]

B. Solutions for the Cultural/Noneconomic Barriers

In order to combat discrimination, states might also withhold Medicaid payments to nursing facilities that have received complaints about unfair treatment based on race. Any facility found to base decisions on racial classifications should lose its refunds from the government and not be able to continue reimbursement plans until it makes up for its past discrimination. A nursing home should not be able to deny admission to an applicant based on the administrators' or their clients' preferences, especially when that facility is receiving federal money. The applicant or resident who experiences subtle discrimination should be able to report a facility to the Department of Health, Education, and Welfare or the Office of Civil Rights.

Because nursing facilities are not typically located in highly minority-populated neighborhoods, those new institutions that will be run by the federal government should be required to build in minority areas to increase access for minorities. Because so few institutions, merely 8.2%, are federally run,[187] those nursing homes wanting to open in large cities should be required to establish themselves in highly minority-populated areas to minimize the location barriers that currently exist.

Nursing homes that receive federal or state money through Medicaid reimbursement plans should also be required to disseminate literature in minority communities to educate the public on the positive aspects of nursing homes. To facilitate understanding among those individuals who do not speak English as their primary language, this material should be dispersed in several different lan-

184. *See id*. at 409.
185. *See id*.
186. *See id*. at 408.
187. *See Survey, supra* note 1.

guages. Furthermore, through the use of public media, social groups, staff, church leaders, and role models in the community, information regarding different facilities could increase awareness, and thereby increase participation.[188] Because churches play a crucial role in many minority communities, church leaders, in particular, should be sought out to convey information to those in need.[189] Additionally, minority-oriented radio, TV, and newspapers are excellent ways to reach out to these elderly individuals and inform them of available services.[190]

To make minorities feel welcome within the facility, the administrators and staff need to learn about the different communities in order to open their facility to every race.[191] The administrators and staff must be examples in setting the right tone for cross-cultural relationships.[192] They should closely monitor relations between the staff and residents, and between the residents themselves. No verbal or physical abuse should be tolerated among the residents, and the staff should encourage and help residents develop relationships within the home.[193] Most important is a need for sensitivity, having respect for different ethnic groups, and realizing the uniqueness of cultural practices.[194] This means that staff members need to pay close attention to the cultural norms of each ethnic group, such as what role marital status and gender play in the respective cultures.[195]

In order to help elderly minorities who do not speak English fluently feel more comfortable in a nursing home setting, where English is almost exclusively spoken, more minority staff and administrators need to be hired to ensure that customs are not ignored.[196]

188. *See* ETHNIC DIMENSIONS OF AGING, *supra* note 14, at 172 (stating that retired minority professionals serve an important function because they are often active in civic and political affairs and maintain links with the ethnic community, thus relating "to the older persons as peers, sensitive to their needs"); GELFAND, *supra* note 148, at 162–63; Yeatts et al., *supra* note 37, at 27.

189. *See* ETHNIC DIMENSIONS OF AGING, *supra* note 14, at 172. The authors document the importance of the church in Portuguese and Hispanic cultures due to the active role of the church (through the well-respected clergy) in helping elders locate support. *See id*.

190. *See* MARKIDES & MINDEL, AGING AND ETHNICITY 227 (1987).

191. *See* Schafft, *supra* note 30, at 25.

192. *See id*.

193. *See id*.

194. *See* MARKIDES & MINDEL, *supra* note 190, at 226.

195. *See id*.

196. *See id*.; *see also* Daniel Jones & Amelsvoort Jones, *Communication Patterns Between Nursing Staff and the Ethnic Elderly in a Long-Term Care Facility*, 11 J. ADVANCED NURSING 265, 271 (1986); Yeatts et al., *supra* note 37, at 29.

> The first-generation ethnic aged person's lack of experience with individuals from other cultures may make him or her nervous or even hostile toward service providers whose backgrounds are distinctly different from his or her own. At a minimum, this tension may be express[ed] in language or communication difficulties between staff and clients. Even if a staff member is able to speak the client's language, there is no guarantee that he or she will evidence a comparable sensitivity to the norms and beliefs of the client.[197]

Training programs need to place an emphasis on recruiting minority students, volunteers, and religious leaders in order to ease the transition into a nursing home and keep the residents content.[198] Additionally, more minority professionals need to be hired to reflect the communities they serve. "Good cross-racial interactions are not served in integrated homes where all the minority personnel are in menial positions."[199]

Although quite controversial, there remains the possibility of "clustering" certain ethnic groups together.[200] For example, because there are large communities of certain ethnic groups in some areas, nursing homes could group members of the same ethnic background together in groups or wings of the home. By doing this, the home could achieve a mixture of ethnic groups in the entire home, yet cater to certain groups in particular wings or rooms. This arrangement might also keep room/wing-mates satisfied because they would share the same ties with those persons nearby. If separate facilities or wings are not appropriate, then the facility could have separate health services and cultural activities scheduled for different days of the week.[201] Although this practice may seem discriminatory, not making "such a separation may permit the discomfort barrier to operate, resulting in minority elderly choosing not to obtain needed services."[202] The goal is not to completely segregate different ethnic groups; clustering is preferential to an entire home being of one ethnic group. However, complete integration is definitely better than clustering. Clustering would only be preferential where minorities do not enter into nursing homes because of the above listed reasons and fears.

197. GELFAND, *supra* note 141, at 67.
198. *See* Schafft, *supra* note 30, at 25.
199. *Id*.
200. *See* GELFAND, *supra* note 148, at 185; Jones & Jones, *supra* note 196, at 271.
201. *See* Yeatts et al., *supra* note 37, at 29.
202. *Id*.

Lastly, nursing homes also can introduce more family events within the nursing home. Because family life plays a substantial role in most minority households,[203] introducing specific family events or days where family members are encouraged to come and participate in group activities helps residents feel they are maintaining the integral family ties that were in place before they came to the nursing home.

V. Conclusion

Together, economic and social barriers create many hardships for minorities who wish to enter a long-term care facility. Several solutions exist whereby nursing facilities and the state and federal governments can help minorities achieve equal access to long-term care. Because the minority elderly will greatly increase in numbers in the coming years, these solutions need to be implemented now to ensure that the situation is corrected before more minority elderly are forced to go without needed long-term nursing home care.

203. *See* GERONTOLOGICAL SOC'Y OF AM., *supra* note 13, at 95–97.