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## “They Say that this Clinic is for Migrants”: Cultural Sensitivity in a Rural Health Center

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“They Say that this Clinic is for Migrants”:  
Cultural Sensitivity in a Rural Health Center

Nadine I. Ohlinger

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Arts  
Department of Anthropology  
College of Liberal Arts and Sciences  
and  
Master of Public Health  
Department of Community and Family Health  
College of Public Health  
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I dedicate this thesis to my husband Landon, for his love, support, and patience throughout this project, my daughter Isbel, for teaching me to slow down, and my mother, whose constant encouragement helped me finish this project.

In loving memory of my aunt, Gloria Royce, who inspires me to improve the quality of health care that we receive, and my father-in-law Fred Ohlinger, whose wisdom guides me daily.

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**“They Say This Clinic is for Migrants”:  
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**ABSTRACT**

The growing number of minority populations living in the United States makes it mandatory that all health care organizations seek to be culturally sensitive. There is no consensus on the definition of the term cultural sensitivity. The goal of this thesis is to define what cultural sensitivity means in a rural health center, from the perspective of the staff as well as the Hispanic patient. Anthropological methods, such as participant observation, semi-structured interviews, and archival data analysis, show that the qualities that Hispanic patients value in a clinic are 1) attention, 2) availability of Spanish language, 3) financial assistance, 4) solution to their health problems, 5) presence of Hispanics around the clinic, and 6) clinic services. Furthermore, 90% of staff responses indicate acceptance and respect of patients’ health beliefs and practices. Results demonstrate that while the clinic is culturally sensitive, there are a few recommendations that would improve the quality of care that Hispanics receive. Based on the results of the data collection, a practical model for other rural health centers to build upon a culturally sensitive health care system is developed.

## **Chapter One**

### **Introduction**

Cultural competence and cultural sensitivity are concepts that are well known in the health care industry. However, there is no consensus in the literature on the definition of cultural sensitivity. Anthropological concepts and methodology provide an excellent approach to tackle the issues of cultural competence/cultural sensitivity from both an emic and etic perspective. This study combines public health and anthropology to evaluate what cultural sensitivity means to Hispanic patients and rural health center staff.

The following is a true story about a migrant farm worker. It is also a typical story. A pseudonym has been used to protect the patient's identity. Margarita is seven months pregnant. She is supposed to be working in the fields today, but instead she is taking the day off to go to the local clinic so that she can see the midwife about the stomach pains she has been having. Her brother in law drops her off at the clinic early in the morning before it even opens, and she does not have a ride home from the clinic. At the clinic, she does not understand the forms she is given to fill out, and is unable to communicate this to the front desk personnel because they do not speak Spanish. She sees no indication in the lobby that the midwife will understand her either, so she starts to walk home. On her way home, she goes into premature labor, and her unborn child suffers from fetal distress and dies.

Margarita's situation could have been ameliorated if the clinic had provided her with transportation, Spanish-speaking personnel, forms in Spanish, and an inviting

environment for Spanish speaking patients. There is a movement within the health care industry that has received much attention recently: cultural sensitivity and/or cultural competence. Cultural sensitivity is defined as “the extent to which ethnic or cultural characteristics, experiences, norms, values, behavior patterns, and beliefs of a target population, and relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health interventions, including behavioral change materials and programs” (Reniscow, et al 2002:493).

Because of the well known expansion of minority populations, now more than ever health care providers will need to take into account non-medical factors of patients’ situations, such as their cultural background. If the goal of health care is to improve overall health, cultural competence is imperative. There is a direct relationship between culturally competent health care and an improvement in access to and quality of care, and ultimately health outcomes. In any health care situation, there is an amalgamation of three cultures: the patient’s, the doctor’s, and the health care organization’s. In order to establish congruence and cultural sensitivity, the three cultures have to come together and understand the interrelationship of the health care situation.

Although the need for culturally sensitive health care is heavily cited in the empirical literature, there is no consensus as to the definition of cultural sensitivity. This project will attempt to define what cultural sensitivity means in a rural health center, from the perspective of the staff as well as the Hispanic patient. The goal of the project is to characterize the role of cultural sensitivity in a clinic whose mission is to “provide all services in a culturally sensitive manner in order to promote healthy outcomes in the population [it] serves” (Suncoast Community Health Centers 2002). While there are

many models that attempt to operationalize cultural sensitivity or cultural competence, the ultimate goal of this project is to develop a model that other rural health centers can use to build upon a culturally sensitive health care system.

This project came about from an applied anthropology and public health internship that I had at a clinic in west central Florida (HC). As a health educator I was able to conduct participant observation, understand the administrative processes of a health care organization, and develop trusting relationships with patients and staff. My position as health educator was enriched because in addition to my graduate school training in the field of health education, I also had the insight from my anthropological background and training in applied anthropology. This provided an excellent opportunity to contribute to public health and anthropological research by developing a qualitative study of cultural sensitivity, a topic that is very evident in the clinic.

This qualitative study uses grounded theory to examine the extent to which a clinic that caters to many migrants and Hispanics is culturally sensitive. Unlike most studies conducted on the topic of cultural competence or cultural sensitivity, this study utilizes anthropological research methods to attain a holistic perspective of what providing culturally sensitive services really means in a rural health center.

Chapter Two provides an overview of the literature that is relevant to cultural competence and establishes the need for cultural competence/cultural sensitivity. In addition, a review of the anthropological literature on Hispanic cultural values, such as *familismo*, *fatalismo*, *respeto*, *simpatía*, and *personalismo*, as well as Hispanic health beliefs is also examined. Other anthropological contributions, such as the concept of worldviews, Kleinman's explanatory model, and successful culturally competent health

care programs are dissected. A brief synopsis of biomedical culture is also provided in Chapter Two. The terms “cultural competence” and “cultural sensitivity” are defined and the factors relevant to cultural sensitivity are discussed. Finally, chapter two also reviews some of the models of cultural competence.

Chapter Three describes the methodology employed to complete this study. Within this chapter, the internship that preceded and inspired this study is also discussed. The goal of the study is to define what cultural sensitivity means in a rural health center, from the perspective of the staff as well as the Hispanic patient. The qualitative methodology included thirty-one open-ended interviews with patients, twenty-one open-ended interviews with staff members, participant observation, structured observations, and analysis of archival data. The research questions that guided this study are:

- 1) What does cultural sensitivity mean to patients?
- 2) What does cultural sensitivity mean to HC staff?
- 3) Does cultural sensitivity mean different things to patients and staff?
- 4) What makes a clinic culturally sensitive?

The informed consent process, sampling, and analysis of the data are discussed in this chapter. The limitations and bias associated with this study are also reviewed.

Chapter Four presents and discusses the main findings from the data collection methods and analysis. Results of the patient interviews show that the most important factors that keep patients coming to the clinic are: 1) the staff gives them attention; 2) services are available in Spanish; 3) financial assistance is available; 4) they are given a solution to their health problem; and 5) there are Hispanics everywhere throughout the clinic. The majority of the patients believed that the clinic does understand and have

knowledge of the cultural values that Hispanics share. Results from the staff interviews illustrated that medical assistants should be required to complete medical interpretation training. In addition, slightly more than half of the staff interviewees reported that they had not received cultural competence training. In this chapter, the staff members' various definitions of cultural sensitivity are presented, as well as their perceptions of how the clinic practices cultural sensitivity. In addition, Chapter Four presents the staff respondents' examples of how they believe they are culturally sensitive. Findings show that although staff members can not give an exact definition for the term cultural sensitivity, they intuitively know what it means. The majority of respondents exemplified how they are aware of the cultural values that Hispanics share as well as their health beliefs.

The final chapter, Chapter Five, offers conclusions and recommendations for the HC, based on the findings presented in Chapter Four. In this chapter, the literature reviewed in Chapter Two is connected with the findings discussed in Chapter Four. In addition, this chapter also presents the project's contributions for anthropology, applied anthropology, and public health. Based on the findings from the data collection, the recommendations are intended to improve the excellent services that the HC provides.

## **Chapter Two**

### **Literature Review**

#### **Introduction**

This chapter examines and reviews the literature that is related to this study. The first section orients the reader by providing a background on the importance of eliminating health disparities, and outlines various barriers to healthcare. Relevant information on the health beliefs and cultural values of Hispanics is also presented in this chapter. In addition to an understanding of Hispanic patients' culture, a background on biomedical culture is also provided. This chapter also defines the term cultural sensitivity, and discusses the significance of cultural sensitivity in health care. The various models of cultural competence are discussed in this chapter as well. Lastly, within this chapter, the reader will be introduced to the contributions that anthropologists have made towards understanding the dynamics that impact the health care of Hispanics.

#### **Background of the Problem**

The US Department of Health and Human Services issued a document, "Healthy People 2010", which highlights the health priorities that are necessary to "ensure that good health, as well as a long life, are enjoyed by all" (US Department of Health and Human Services 2003a). One of the goals of Healthy People 2010 is to eliminate health disparities among populations. Race and ethnicity are considered factors that contribute to health disparities, for example the higher rates of Hispanics who die from diabetes,

African Americans who die from heart disease, or Vietnamese who die from cervical cancer. However, the higher prevalence of disease among certain populations cannot be attributed to one single factor, such as biologic or genetic characteristics. Rather, health disparities are the result of a complex relationship of genetic, environmental, and sociocultural factors.

In the publication titled, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (2002), The Institute of Medicine (IOM) conducted a review of literature and determined that “the preponderance of studies...find that even after adjustment for many potentially confounding factors – including racial differences in access to care, disease severity, site of care (e.g., geographic variation or type of hospital or clinic), disease prevalence, co-morbidity or clinical characteristics, refusal rates, and overuse of services by whites – racial and ethnic disparities remain” (p. 8). The IOM authors (2002) also found that in many studies there is a direct relationship between health care disparities and worse health outcomes, and that the cause of disparities appears to be closely related to factors related to the health system, health care providers, and patients.

Within Healthy People 2010, access to care has been labeled as one of the ten leading health indicators that will be used to measure the health of the nation over the next ten years. There are many dimensions involved with access to care. For instance, income level, health insurance, and ongoing sources of primary care are all factors that directly relate to access to care. There are several barriers to accessing care, including financial, structural and sociocultural barriers. Financial barriers include not having adequate health insurance or financial capability of paying for health services. Many



studies have been conducted, which establish that there is a relationship between lower socioeconomic status (SES) and poorer health (Feinstein 1993, House et al. 1996, and Marmot & Wilkinson 1999). Structural barriers refer to the lack of available providers to meet health care needs, as well as the lack of transportation and health care facilities available. Finally, sociocultural barriers are those factors such as cultural or language differences which prevent an individual from seeking or obtaining adequate care (Cooper, Hill, and Powe 2002, and US Department of Health 2003b). Ethnic minority populations who face individual and institutional discrimination are more likely to confront stressors, such as financial, structural, and sociocultural limitations. This thesis project focuses on the sociocultural barriers to health care that ethnic minority populations confront daily.

### **Anthropological Contributions**

Anthropology basically translates as the study of human beings. At the heart of being human is the concept of culture. The power of culture and its influence on health is a well known subject among many in the health professions. In an attempt to define the nebulous term culture, many have offered definitions. The result is a wide array of definitions, which one can pick and choose depending on the study at hand. For this study, the term culture is defined as “that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (Tylor 1871:1). Specifically, culture encompasses values, beliefs, and perceptions of the world, which are shared by a group of individuals. It is these values, beliefs, and perceptions that manifest in people’s behavior.

Medical anthropology is a field of anthropology that “encompasses the study of medical phenomena as they are influenced by social and cultural features and social and

cultural phenomena as they are illuminated by their medical aspects” (Lieban 1977:15). According to Lieban (1977), health and disease are not only related to biological factors, but also to a person’s socioeconomic resources and how he/she utilizes those resources. A person’s culture will determine the type of health care that he/she will seek and the way that he/she will perceive illness and its symptoms (Kleinman et al. 1978). Furthermore, culture will also influence the level of importance that a person will place upon changing his/her health-related behavior. Success of a culturally sensitive health care program will take place only if the program is developed and implemented within the framework of the community’s culture.

Anthropological methodology, such as participant-observation, unstructured interviews, ethnographies, cross-cultural comparisons, as well as being culturally relative guarantees that health care providers will have a better understanding of a target population’s culture. One of the outstanding features of anthropology is its holistic perspective. It encompasses the social, political, economical, and environmental aspects of a person’s life. Many anthropologists have been involved in the successful development and implementation of culturally competent health care programs. In a diabetic educational program for Puerto Ricans in New York City, Brosnan (1976) examined Puerto Rican kinship system, household organization, economic system, customs and values, and beliefs about health and illness. Brosnan’s investigation into the Puerto Rican culture found that Puerto Ricans have a fatalistic view towards life and rely heavily on family and close friends for support. The author suggested effective ways to address diabetes education programs such as involving the entire family in the education process, which should be conducted in the patients’ homes during evening hours.

Another anthropologically-based study on adolescents with asthma showed how an anthropological approach to health care is ideal. Rich et al. (2000) sought to learn more about adolescents' beliefs about asthma and the role of asthma in their daily life experience. Study participants were given a video camera to document their lives as it relates to their asthma. Upon analyzing the video footage, the authors found that participants were improperly using their inhalers, despite many health education attempts. Because the adolescents were empowered with the video camera, they were able to show many different aspects of their lives that a questionnaire would not illuminate. For instance, the video demonstrated how asthma affected the family and other unknown environmental factors evident only through the camera lens. The visual anthropology approach of using a video camera not only empowered the participants, but also proved to be an effective health education strategy as it portrayed real-life experiences of people living with asthma.

In aiming to understand the factors that relate to the prevention of chemical exposure among farmworkers, Quandt et al. (1998) conducted formative research using methodology such as ethnography, participant observation, unstructured and structured interviews, and focus groups. The authors found that the farmworkers do not believe that they are susceptible to chemical exposure, and if they do get exposed, it is out of their control. While they did not discuss the development of a prevention program, the authors showed how anthropological methods can be used to successfully determine a population's beliefs and values of a health-related issue, as well as other social and physical environment-related issues.

Many times, patients are labeled as “noncompliant” when in actuality their worldview is not compatible with Western or biomedical worldview. In order to understand a patient’s behavior, one needs to understand his/her worldview, which “consists of [his or her] basic assumptions about the nature of reality” (Galanti 1991:5). Worldview is defined by people’s religion, and their relationship to nature (Galanti 1991). For instance, voodoo death is a phenomenon that occurs in countries, such as Haiti, which Western practitioners with a different worldview are constantly seeking to explain. To a Haitian, a voodoo death occurs when someone is cursed by another person. However, Western doctors and scientists have numerous scientific explanations, such as stress or loss of will to live (Galanti 1991). Both worldviews have a different understanding of voodoo death.

Kleinman et al. (1978) begin to address the concept of worldview when they distinguish disease as the biologic (or Western) “maladaptation” of the body, and illness as the culturally constructed experience which explains discomfort. An individual’s explanatory model explains how that individual perceives the causes and symptoms of his/her illness. Kleinman et al.’s (1978) work on explanatory models has served as a useful guide for health care professionals. They suggest a patient-centered focus of determining the health problem by asking questions such as:

What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How does it work? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment? What are the chief problems your sickness has caused for you? What do you fear most about your sickness? (Kleinman et al. 1978:256)

The patient's explanatory model will reveal the hidden cultural meanings that are related to his/her illness, such as beliefs, values and attitudes. Several studies have shown that a population's worldview will greatly affect the manner in which it interprets health interventions (Britton 1996, Cassidy 1987, Ito 1999, Olson 1999, Opala 1996). For example, Brooke Olson (1999) found that many Native Americans view diabetes as a "white man's disease" (p. 191) and are therefore reluctant to seek and are suspicious of biomedical treatment. According to Olson (1999), Indians view a large body as a sign of health and wealth, and educational interventions that focus on weight loss are futile. Consequently, Olson suggested culturally appropriate educational strategies such as native games, stories, and talking circles. Olson's research shows that health care interventions must be tackled from a population's worldview.

In the health care industry, the culture of the patient, the patient's family, the provider, and the health care organization merge together to form relationships, which will ultimately affect the quality of care that minority groups receive. It is impossible to know about every single culture that exists. However, it is mandatory that health care providers become knowledgeable about the cultures of the patients who visit their health care agency. For this study, the most prominent cultural groups that attend the HC are Hispanics who share similar cultural values. The following section discusses the health-related cultural values that many Hispanics share.

### **Who is Hispanic?**

Throughout this paper, the term Hispanic will refer to a group of people who share similar cultural values, and in many cases language. It is important to note that not all Hispanics share the same health beliefs and cultural practices (Kittler & Sucher 1995).

Many factors, including politics, health beliefs, level of acculturation, and socioeconomic status will affect the approach that many Hispanic patients will take on their health care. I will distinguish the specific cultural groups when describing differences or similarities of patients in order to avoid overgeneralization.

### **Cultural Values**

The cultural concepts of *familismo*, *fatalismo*, *respeto*, *simpatía*, and *personalismo* make up a unique belief system that has an impact on the health behavior of some Hispanics, such as Mexican Americans, Puerto Ricans, and other Central American groups. *Familismo* describes the strong concept of family among Hispanics where the mutual needs of the family unit are more important than the needs of individual family members (National Council of La Raza, 1998). In addition, among Hispanics, family and extended family are very involved in the health and well being of the entire family. The extended family includes *compadres*, who are individuals that became a part of the family because they were asked to be godparents or were long time friends of the family. *Padrinos* (godparents) are also very involved in an individual's health care and decision making process (Zoucha 2000).

*Respeto* refers to the importance of proper and moral behavior in front of another person. Hispanics regard doctors with high respect. Although they might not understand a treatment regimen, they will follow doctors' orders to show respect. Moreover, Hispanic patients expect respect from their health care providers, and will not return to them if they feel they have not received it (National Council of La Raza 1998). To show respect, health care providers should address their Hispanic patients using formal Spanish terms, such as *usted* (formal you), and/or *Señor* or *Señora* (Mr. or Mrs.). Health care

providers should also recognize the eldest male member or father as head of household, and should establish a personal relationship with him as an entrée to the rest of the family. The head of household should always be included in the conversation, or at least be asked permission to speak to the family member privately. By recognizing the head of household, the health care provider shows that he/she has respect, which will lead to less friction during the patients' course of health care (Zoucha 2000).

*Fatalismo* is a cultural concept that describes how natural illness is caused by God's will, therefore, there is very little that an individual can do to prevent or survive the disease (National Council of La Raza 1998). For this reason, little interest in preventive health behaviors is displayed (Gans et al. 1999, and Quatromoni et al. 1994). Quatromoni et al. (1994) found that Mexican-Americans and Puerto Ricans believed that preventive measures were "ineffective" (p. 873), and therefore not necessary for good health. In fact, feeling healthy was more important to diabetic Hispanics than measuring glucose levels (Quatromoni et al. 1994).

*Simpatía* describes the value of being polite and pleasant. In fact, health care providers who have a neutral attitude are regarded as negative in the Hispanic culture (Flores 2000). *Personalismo* is the Hispanic value based on friendliness, trust, and intimate relationships, especially with health care providers. For instance, Hispanics regard physical touch as a means of communication. It is quite common to see family members and friends openly embracing and showing affection to one another. Although Hispanics are more conservative with strangers, health care professionals could begin to establish *personalismo* with his/her Hispanic client by offering a handshake, and/or asking about the client's family before dealing with the actual business of health care. If

a provider is distant the client might not return for his/her next appointment (National Council of La Raza, 1998).

Along the lines of *personalismo*, Mexican Americans associate attention spent on someone as a sign showing that the person cares for the individual who is receiving the attention (Zoucha 2000). For instance, if a health care provider spends time listening to a person's concerns regarding his/her health, then the person is regarded as caring because he/she is giving the patient attention. Health care providers should take time to engage in small talk by asking about the family, and avoid feeling rushed. This allows the patient to feel like the health care provider cares for him/her.

All of the Hispanic cultural values, *familismo*, *fatalismo*, *respeto*, *simpatía*, and *personalismo* can occur to different degrees, depending on such factors as the individual's level of acculturation, education, gender, socioeconomic background, and age. Over time, if a health care provider shows respect with a person's culture, he/she will establish *confianza*, or trust, with the patient (National Council of La Raza 1998). The lack of attention to these Hispanic values can lead to patients not having a connection with their health care provider, not being compliant, and not being satisfied with the quality of care.

### **Acculturation**

A patient's level of acculturation has a direct effect on his/her approach to health care, affecting perception and health seeking behavior. Acculturation is defined as a "multidimensional process in which individuals whose primary learning has been in one culture takes over characteristic ways of living from another culture" (Hazuda, Haffner, Stern, and Eifler 1988). Acculturation occurs in different degrees for different cultural



factors, such as language use, family structure, and health behaviors (Borrayo & Jenkins 2003). In terms of access to care, a person with a lower acculturation level is more likely to encounter language barriers, which will directly affect access to health care. Perception of quality of care may also vary according to acculturation level. For instance, a person who has recently moved to the United States and has a different worldview and is accustomed to a different approach to health care might have a different perception of the quality of his/her health care than a person who has been actively participating in US health care for many years. The relationship between acculturation and health is complex and dependent on other variables. Generally speaking, lower acculturation levels have been associated with better health, while higher acculturation levels are associated with poorer health (Clark & Hofsess 1998). For instance, acculturation leads to many unhealthy eating habits existent in the United States, such as increased consumption of high-fat salad dressings, and high sugar drinks, such as soda and Kool Aid, which have replaced traditional fruit-based beverages (Aldrich & Variyam 2000, and Pérez-Escamilla et al. 2001).

There exist tools that have been validated to measure the acculturation levels of Mexican-Americans specifically. However, measuring levels of acculturation of each patient interviewed is beyond the scope of this study. There are many complex factors related to acculturation level, which will not be determined in the patient interview. Therefore, for this study, I will not be measuring acculturation level. However, it is an important factor that health care providers should be aware of, as it may affect the way that they communicate with their patients, how patients understand them, and consequently how patients will practice their own health care.

## **Health Beliefs**

The Western biomedical model explains that disease is caused by some agent, such as a bacteria or virus. Many Hispanics attribute the onset of disease to witchcraft (unnatural) or an imbalance of hot and cold qualities (natural). It is important to note, however, that some Hispanics, depending on factors such as socio-economic class or education level may not believe in witchcraft. Hispanics tend to have both a biomedical and folk belief system, as evident in the example of diabetes (Castro, Furth, & Karlow 1984). For example, as a result of this belief system, Hispanics do not view diabetes as a disease occurring as a result of witchcraft, but recognize it as naturally occurring (Weller, et al. 1999). Mexicans also attribute strong emotions, such as fright and anger, to diabetes onset (Poss & Jezewski 2002, and Weller et al. 1999). Weller et al. (1999) also found that overall among Hispanics, diabetes is thought to be hereditary, or occurring as a result of eating sweets. Similarly, several studies conducted specifically with Mexican-Americans found that Mexican-Americans have a dual belief system, seeking treatment from a folk healer for certain health conditions, and from a doctor for other health conditions (Chávez 1984). Furthermore, when Mexican-Americans do seek treatment from biomedical professionals, they perceive the doctors to be lacking in understanding (Chávez 1984). For this reason, it is imperative that health care practitioners have a clear understanding of the health beliefs and cultural values of their patients.

Mexican-Americans may sometimes use home remedies first, and then seek treatment from a doctor (Chávez 1984). Several studies indicate that Hispanics use folk remedies to treat diabetes although the remedies are supplemental to and not in lieu of their prescribed medicine (Hunt, Arar, & Akana 2000, Quatromoni et al. 1994, and

Weller et al. 1999). It is important for health care professionals to be aware of and understand the health beliefs of Hispanics in order to provide culturally sensitive health care.

### **Folk Illness**

A folk illness is defined as “syndromes from which members of a particular group claim to suffer and for which their culture provides an etiology, a diagnosis, preventive measure, and regimens of healing” (Helman 2000:86). A folk illness attributes more than just symptoms as the cause for illness. For instance, a sick patient can suffer from changes in the environment, be a victim of supernatural forces, or be having trouble in the family. Individuals, belonging to a certain cultural group, learn about folk illnesses by learning how to express them and respond to them. One of the more prominent folk illnesses in Mexican culture is *empacho*. *Empacho* occurs when the intestines are blocked by a foreign matter, such as food (Trotter 1985). According to Trotter (1985), eating improperly cooked foods, eating *empacho*-causing foods at the wrong time (such as bananas late at night), and swallowing chewing gum are some of the causes of *empacho*. Some of the remedies for *empacho* include stomach massage and the use of *greta*, which is a powder that has high lead content and results in lead poisoning. In essence, health care providers should be aware of the folk illness of the population with which they work so that they can accurately diagnose and treat a patient’s health condition.

## **Migrant Farmworkers**

According to the National Center for Farmworker Health, approximately “85% of all migrant workers are minorities, of whom most are Hispanic (including Mexican-Americans as well as Mexicans, Puerto Ricans, Cubans, and workers from Central and South America)” (National Center for Farmworker Health 2005). At the HC, migrant workers encompass 30% of all patients who utilize clinic services. A migrant farmworker is “an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purpose of such employment a temporary abode” (US Department of Health and Human Services 1980). As agricultural workers, migrants endure hard physical labor, fatigue, poverty, prejudice and hostility (Coughlin & Wilson 2002). In addition, migrant farmworkers are also exposed to health hazards and unhealthy living and work conditions. Consequently, their health care tends to be more focused on acute care, rather than preventive care (Coughlin & Wilson 2002, Meister 1991).

Migrant farmworkers are unique with respect to health care issues because of their migratory nature, which affects income, educational level, health status, and health behavior. Factors that impede access to health care include affordability, language, and transportation (Coughlin & Wilson 2002, Gwyther, & Jenkins 1998, and Napolitano & Goldberg 1998). Legal status is also a barrier to obtaining health care, since approximately one-third of all migrant farmworkers are either undocumented or unauthorized to work in the United States (Coughlin & Wilson 2002). Even though some migrants may be eligible for Medicaid, most do not have health insurance and do not participate in Medicaid because of lack of awareness of benefits, and inconvenient hours

and locations of enrollment offices (Gwyther & Jenkins 1998). Farmworkers work long, nontraditional hours and are not likely to take time off from work to tend to health care matters (Coughlin & Wilson 2002, and Napolitano & Goldberg 1998). Furthermore, they typically do not appear at the clinic seeking preventive or chronic illness care. Rather, they focus on getting treatment for their acute illnesses. A further challenge to health care providers is that migrant farmworkers are hard to reach because of their migratory nature, and because their residence tends to be isolated in rural agricultural communities (Coughlin & Wilson 2002). For these reasons, it is imperative that migrant health centers are culturally sensitive.

### **Biomedical Culture**

Like the patients, health care providers also have their own culture, which is a mixture of their own cultural roots and Western biomedical culture. In general, members of the biomedical culture have high social status and high earning power, and have their own set of medical lingo, which laypeople can not understand. Their view of health and medicine is that in order for something to exist, it must be measured and observed. Medical school students are taught to emphasize the individual patient, rather than his/her family or community (Helman 2000). The health care provider's beliefs and values combine to form a worldview that is often very different than the patient's worldview. A patient is likely to feel misunderstood and dissatisfied if a provider fails to consider the patient's worldview, and recognizes his own as the right one. Anthropologists have found that an individual's education, beliefs, social and cultural background will "help determine what is said, how it is said, and how it is heard and interpreted" in a consultation (Helman 1985:8). A health care consultation is successful when both

provider and patient respect one another's beliefs and values, and a treatment regimen which blends both cultures is established. Patients are more likely to trust the provider and adhere to the treatment regimen.

### **Cultural Sensitivity**

Almost one third of the nation's population consists of ethnically diverse groups, and by 2050 that number will increase to almost one half of the US population (Wells 2000). Health care professionals will encounter more and more patients who have different languages, customs, beliefs, values, and behaviors than their own. Because of this demographic shift, the need for culturally sensitive interventions is strong, especially in community health centers that are most likely to serve diverse populations.

The shift toward cultural competence is a strategy that is recognized by the entire medical community as a way to decrease the health disparities gap. Recently on January 4, 2005, congress introduced a bill entitled "Healthy People, Healthy Choices Act of 2005". The Act documents that "a lack of access to culturally sensitive medical care and guidelines for healthy eating and exercise habits contributes to poor health outcomes for minority citizens" (Library of Congress 2005). The Act also authorizes grants and use of money towards conducting minority health programs.

The Department of Health and Human Services, Office of Minority Health (2001) has developed National Standards for Culturally and Linguistically Appropriate Services in Health Care. The Standards can be seen in Appendix F of this thesis. In the document titled "A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care" (2001), health care organizations are given a step-by-step guide on how to become culturally competent,

with checklists within each section. The entire guide is thorough, covering every single aspect of cultural competence, and is available for free on the Office of Minority Health's website, [www.omhrc.gov/clas](http://www.omhrc.gov/clas), and is an excellent resource for health care organizations that aim at becoming and continuing to be culturally competent. A list of other excellent cultural competence resources is available in Appendix G of this thesis.

### **Definition of Cultural Sensitivity**

There is no accepted definition for the term “cultural sensitivity” in the empirical literature. Cultural sensitivity is used interchangeably and can be synonymous with many other terms such as cultural competence, culturally relevant, culturally appropriate, and cultural diversity. All of these terms are synonymous and convey the idea of improving and promoting cross-cultural understanding. Cultural competence has been defined as:

a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs 1989).

For the purposes of this study, the definitions for these terms are used interchangeably. However, Glanz, Rimer, and Lewis (2002) offer a holistic definition for cultural sensitivity, which is the operational definition that will be used throughout this project. They define cultural sensitivity as:

The extent to which ethnic or cultural characteristics, experiences, norms, values, behavior patterns, and beliefs of a target population, and relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health interventions, including behavioral change materials and programs (Renisow, et al 2002: 493).

This definition of cultural sensitivity is distinguished from the term cultural competence because it emphasizes health interventions, materials, and messages as the focus. The difference between cultural competence and cultural sensitivity is that cultural

competence emphasizes the capacity to be culturally sensitive at the interpersonal, individual level.

Whichever definition for cultural sensitivity/cultural competence is being used, it nevertheless emphasizes the integration of cultural knowledge and awareness into policies, practices, and attitudes of an organization in order to increase the quality of health care, which will inevitably result in better health outcomes for patients. Without the integration of cultural sensitivity into organizational culture, culturally sensitive efforts on the individual level are less likely to be effective.

### **What it Means to be “Culturally Competent”**

Health care professionals should first have the knowledge and awareness of cultural information, such as health beliefs of a particular ethnic group, and incorporate that information into the plan of intervention. They should recognize and respect not only the patient’s ethnic group, but also the environment in which the patient lives, as well as effective interventions that work with that particular ethnic group. While it may be impossible to know everything there is to know about a particular culture, an “ethnographic” approach to cultural competence will help practitioners arrive at an understanding of an individual’s culture (Bonder, Martin, & Miracle 2001). Influenced by anthropological methods, the process of “learning how to ask” includes inquiry, reflection and analysis, and evaluation and assessment throughout the interaction between patient and provider (Bonder, Martin, & Miracle 2001). For instance, further inquiry into a patient’s background can include questions about social networks, and health beliefs of his/her particular health condition. A culturally competent healthcare system whose Hispanic population is twenty percent should include Hispanic staff members who speak



Spanish and are trained in medical interpretation, cultural sensitivity workshops for all staff, and patient education materials available in Spanish (Rorie, Paine, & Barger 1996).

### **Factors Affecting (or Related to) Cultural Sensitivity**

Some of the factors that hinder Hispanics' access to health care are high cost of health care, undocumented immigration status for a large percentage of individuals, lack of health insurance, language barriers, and the unsuitable operating hours and locations of some health care organizations that cater to the Hispanic population (Chávez 1984). An understanding of the cultural issues surrounding a health care practice is essential in the provision of effective care and delivery of services. Language is a barrier to health care that affects many people, and can result in a patient never returning for health care. Several studies that conducted patient satisfaction surveys with Spanish speaking patients, as well as patients who spoke English found that Spanish speaking Latino respondents were more dissatisfied with the provider communication than the white English speaking respondents (Carrasquillo et al. 1999 and Morales et al. 1999). Difficulties in understanding a health situation can result in patients improperly following treatment regimens, not returning for follow up visits, requiring more unnecessary diagnostic tests, or being labeled as "noncompliant" (Singleton 2002).

In addition to patients' cultural barriers, organizational barriers also affect the degree to which a health care system exhibits cultural sensitivity. In order to be culturally sensitive, health care centers should have interpreters onsite, or at least should have the ability to make them available as necessary (Betancourt et al. 2003). Interpreters should be cautiously distinguished from bilingual workers because they are specifically trained to interpret in medical settings and use medical terminologies.

Bilingual workers used as interpreters are often called ad hoc interpreters. Using ad hoc interpreters can result in many communication errors, including omissions, additions, substitutions, and abbreviations of what the patient and provider were saying (Baker, Hayes & Fortier 2003). In addition, many ad hoc interpreters may permit his or her own cultural values and beliefs to distort the practitioner's message, and therefore inaccurately convey the message to the patient (Bonder, Martin & Miracle 2001).

Many health care centers use untrained staff, such as front office personnel, or patients' family members as interpreters. In addition, some clinics use the patient's family member to translate medical information when an interpreter cannot be found. This poses a problem for the patient as well as the provider, who is expected to convey private health information about the patient (Singleton 2002). Use of an interpreter raises issues of privacy concerns for the patient. Whether a patient knows the interpreter well, or not at all, he/she may be uncomfortable sharing his/her personal problems, and may be less likely to open up to the provider. In addition to not having adequate interpretation training offered to staff, many health care organizations also do not offer training to providers on how to use an interpreter (Baker, Hayes & Fortier 2003). Often times, these approaches to interpretation result in misunderstanding and miscommunication between patient and provider.

Baker, Hayes & Fortier (2003) conducted a study with approximately four hundred Spanish speaking patients at a hospital to determine patients' satisfaction with their provider and interpreter. They found that the patients who communicated in Spanish with their provider had higher satisfaction ratings with their providers than patients who communicated with their provider through an interpreter. Their results also

showed that patients who used an interpreter perceived their provider as less respectful and less friendly. Furthermore, patients who did not have an interpreter, but believed they should have had one, had the lowest level of satisfaction with their provider (Baker, Hayes & Fortier 2003). While having an interpreter is better than not having one at all, providers should be encouraged to make every possible effort to ensure a connection with their patient.

In addition to having adequately trained medical interpreters, health care centers should also have written information, including administrative forms and educational materials that are culturally appropriate, written in low literacy levels, and properly translated in the common non-English language, such as Spanish. Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (National Library of Medicine 2000). In 1993, approximately one quarter of the US population had “marginal” literacy skills. Most health education materials are written above a tenth grade level, even though many adults read below this level. Efforts to address low health literacy include assessing patients’ literacy levels, revising education materials into plain language, and providing patients with oral and video instruction in addition to written materials (Singleton 2002).

### **Models of Cultural Competence**

Like the many definitions of cultural competence that exist in the health care industry, so are there are a number of models of cultural competence that aim at helping an organization achieve or improve cultural competence. There appears to be a consensus in the empirical literature which suggests that organizations progress through

developmental stages until ultimately accomplishing cultural competence. The specific stages that organizations must undergo are yet to be in harmony, but there is an essence that progression is necessary. For this study, only a selected few models will be discussed to give the reader a sense of the kind of work that is published on the topic of cultural competence.

The most widely cited model is the Cultural Competence Continuum (CCC) (Cross et al. 1989). The CCC includes six hierarchical levels of cultural proficiency. For instance, individuals or organizations that are at the “cultural destructiveness level” have attitudes of superiority and practices that suppress other cultures. An organization that acknowledges cultural differences and is not destructive towards other cultures but still does not have the capacity to help other cultures is in the “cultural incapacity” level. In this level, the organization still believes that the Western health care approach is superior. Once the organization recognizes that Western medicine is not superior, it will begin to move from the “cultural blindness” level. Cultural blindness describes an organization that believes that there are no cultural differences. In the “cultural pre-competence” level, the organization identifies its weaknesses and seeks to improve efforts to become culturally competent. The “cultural competence” level includes attitudes of acceptance and respect of culturally different health beliefs and practices, active training of staff to be culturally competent, and institutionalized dimensions of cultural competence in the health care organization’s policies. The final stage, “cultural proficiency” categorizes organizations that embrace diverse cultures, serve as role models, actively participate in cultural competence research and disseminate information.

This model extends the definition of cultural competence into serving the greater research and academic community.

Similar to the CCC, the Cultural Development Model (CDM) also includes six stages along a continuum that lead to cultural competence (Wells 2000). However, unlike the CCC, the CDM divides the stages into a cognitive phase and an affective phase. The first three stages of the cognitive phase are “cultural incompetence”, “cultural knowledge”, and “cultural awareness”. Once the organization recognizes and understands the cultural implications of health behavior, it moves into the affective phase. The affective phase consists of “cultural sensitivity”, which is “the integration of cultural knowledge and awareness into individual and institutional behavior”. The fifth stage of the affective phase is “cultural competence”, which considers organizations that habitually undertake culturally appropriate health care interventions. Finally, like the CCC, the “cultural proficiency” stage includes the institutionalization of cultural competence, as well as teaching and research. Both the CCC and CDM consider barriers to progression through the levels or stages that lead to cultural competence. Barriers such as lack of interpreters, lack of diversity among personnel, and lack of an understanding of the health beliefs of other cultures can prevent awareness and action (Wells 2000).

Unlike the CCC and the CDM, The Process of Cultural Competence in the Delivery of Healthcare Services model assumes that cultural competence is an ongoing, “lifelong” process, rather than a process that ultimately ends in “cultural proficiency” like the CCC and the CDM profess. The author of the model, Campinha-Bacote (2002), asserts that the development of the model was influenced by her nursing background as well as her interests in medical anthropology. Her influence from medical anthropology

is evident in one of the five assumptions of the model which states that “there is more variation within ethnic groups than across ethnic groups” (Campinha-Bacote 2002:181).

The model consists of five constructs which are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Specifically, cultural awareness is the awareness of one’s own background and the recognition of personal biases and prejudices of other cultures. Cultural knowledge involves understanding patients’ worldviews, as well as patients’ disease incidence and prevalence, and treatment efficacy. Cultural skill is the healthcare providers’ ability to obtain accurate cultural information related to the patient’s health problem. Cultural encounters is a construct that reinforces and supports providers to interact with patients and refine and modify their existing beliefs about their patients’ cultural background. It is within this construct that providers are encouraged to evaluate patients’ linguistic needs to determine if an interpreter is in need. Lastly, cultural desire describes the provider’s motivation to fulfill the previous four constructs as wanting to become more culturally competent, rather doing it just to fulfill a requirement, for example. This construct emphasizes the provider’s “genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants” (Campinha-Bacote 2002).

Finally, Purnell’s Model for Cultural Competence draws specifically from the field of anthropology, among other disciplines, and emphasizes the dynamics of culture (Purnell 2000). The Purnell Model was developed with the intention of being used by all health care disciplines across all health care settings. The model is based on nineteen major assumptions, which will not be enumerated in this paper. However, the

assumptions cover broad perspectives on culture, such as assumption number 3 “one culture is not better than another culture; they are just different.” The model also covers more specific assumptions, such as number eight, “if clients are coparticipants in care and have a choice in health-related goals, plans, and interventions, health outcomes will be improved.” This comprehensive model stands out from the other cultural competence models because it takes the extra step to operationalize the often blurry term culture. Like most models, however, this model is not specifically aimed at one particular culture, but rather attempts to generalize the idea of cultural competence across cultures as well.

Visually, the circular model is composed of rims which represent the global society level, community level, family level, and personal level. The interior of the model is composed of 12 pie-shaped cultural domains, such as communication, family roles and organization, nutrition, and death rituals (Purnell 2000 and Purnell 2002).

The models described in this section stand as evidence that cultural competence is not only a necessity, but also that it is receiving the attention required to impact the enormous health disparities gap. An examination of the various models reveals that there are many similar concepts that lead to cultural competence. Both Camphinha-Bacote’s model and Purnell’s model of cultural competence involve detailed information and emphasis on the term culture, whereas the CCC and CDM emphasize the stages that lead to cultural competence. The CCC and the CDM serve as more practical tools that health care organizations can use to assess and track their own progress of attaining cultural competence (or cultural proficiency). Ideally, a model that combines the detailed attention to the concept of culture and all the factors related to culture with a stages-oriented approach that can guide health care agencies to visually determine a starting and

ending point should be developed. In Chapter Four, a cultural sensitivity model for rural health centers with a large Hispanic population is discussed. The model, which is based on the HC in this study, is intended to serve as a practical tool of cultural sensitivity for rural health centers (Figure 13).

### **Summary**

With the growing number of non-English speakers, it is imperative that health care centers provide adequate training to health care providers to improve and enhance communication skills, as well as to increase levels of knowledge and awareness of other cultures. This chapter discussed the issues related to cultural sensitivity, such as patients' culture, and biomedical culture. In addition, this chapter also summarized the literature that documents the importance and necessity for cultural competence and cultural sensitivity in health care. Chapter Three outlines the methodology used to carry out this project, as well as the research questions that guided the data collection.



## **Chapter Three**

### **Methodology**

#### **Introduction**

The process of investigation for this study is discussed in this chapter. The research design was developed to understand the extent to which a rural health clinic is culturally sensitive. The data collection methods used in this design were chosen with the intention of triangulating the data. Triangulation is a research technique that employs several different methods of data collection to cross-check the data and ensures that the data are valid and representative of the research topic (Schensul, Schensul, & LeCompte 1999). A discussion of the internship setting, as well as the informed consent process is also discussed in this chapter. In addition, ethnographic data collection methods used, including open-ended interviews, observations, and archival records, and the path taken to analyze this study is also clarified in this chapter.

#### **Internship Setting**

The data for this project were collected at a rural health center (HC) in West Central Florida. The HC is a not-for-profit primary health care provider that offers comprehensive services in a rural town in Florida. The mission at HC is to “provide all services in a culturally sensitive manner in order to promote healthy outcomes in the population [it] serves” (Suncoast Community Health Centers 2002). The services that the HC provides are medical, dental, mental health, transportation, health education, pharmacy, and referrals. In 2003, the HC served 12,000 patients. Approximately 59% of

the patients were Hispanic. Furthermore, 49% of all patients consider Spanish to be their primary language. Thirty percent of all HC patients are farmworkers and their families, while the remaining 70% are area residents.

My role in the internship was part-time public health educator for approximately one year. My primary responsibility at the HC was to implement a health literacy program. As a health educator, my daily tasks included assessing patients' health behaviors, developing patient action plans, teaching diabetes and hypertension classes, and maintaining accurate records of daily activities. In addition, I also acted as a resource person for diabetes and hypertension information for patients and staff, and collaborated with health care staff to implement the health literacy study. Having worked at the clinic, I gained *entrée* with staff members and conducted participant observation. As a fellow employee, patients and staff were able to trust me and perceive me as not a stranger.

The goal of this project is to define what cultural sensitivity means in a rural health center, from the perspective of the staff as well as the Hispanic patient. Open-ended semi-structured interviews were conducted with thirty-one Spanish speaking patients and twenty-one staff members.

### **Research Questions**

The following research questions guided the focus of the research study:

- What does cultural sensitivity mean to patients?
- What does cultural sensitivity mean to HC staff?
- Does cultural sensitivity mean different things to patients and staff?
- What makes a clinic culturally sensitive?

## **Informed Consent**

The USF Institutional Review Board (IRB) reviewed and approved this project. Staff members who participated in the interviews were asked to sign consent forms, which explained the project and informed them of their rights as participants of a study. Because most of the patients at the clinic are illiterate and undocumented, it would be inappropriate and unethical to ask them to sign a formal document. Consequently, the IRB granted a waiver of written consent from patients, and allowed patients to give oral consent. In order to obtain oral consent, I read the patient interviewees a shorter version of the consent form, which I wrote at a low literacy level and translated into Spanish. The waiver of written consent did not affect the rights and welfare of the participants. I provided them with information about the study and assured them that their participation would not affect their healthcare and that their name would not be used to identify their answers.

## **Interviews**

I conducted approximately fifty-two semi-structured, open-ended interviews with patients, front office personnel, medical assistants, providers, and stakeholders in administration. Twenty-one staff members were interviewed. The goal of the staff interview questions was to determine the extent to which staff members were aware of the term cultural sensitivity, what the term means, and their perception of how the clinic enforces cultural sensitivity. Unfortunately, the staff interview questions were not pilot tested because of the lack of time that the staff had to participate in the interviews.

Thirty-one Spanish-speaking patients were interviewed. The goal of the patient interviews was to give the patients a voice and determine patients' perceptions of what

qualities they seek in a clinic. While the main goal was to assess what cultural sensitivity means to patients, the interview did not directly ask the patients that question. It is difficult to ask patients their opinion of culturally competent services when more than likely they have never heard that term used before. The questions focused more on the likes and dislikes of a clinic to determine patterns and themes that relate to cultural competence. I composed and translated into Spanish the patient interview questions. Two different Mexican American staff members reviewed and corrected the translation for clarity, content, appropriateness, and literacy level. The patient interview questions were pilot tested with four Spanish-speaking patients. The patient interview consisted of sixteen open-ended questions and lasted approximately twenty minutes.

### **Sampling**

For this project, a convenience sample of Hispanic patients at the HC was used. Participants were determined by criterion-based selection because the study aimed at understanding patterns and variability among Hispanics. The only inclusion criteria were that the patients must be Spanish speaking-only, and they must be patients of the clinic. In addition, patients must have been older than eighteen years of age. Gender was not a factor in determining participation for this study. The only patients who were not eligible were those who did not speak Spanish and were not patients at the HC. They were not eligible because they were not the focus of the study. Unfortunately, the HC data system does not distinguish nationalities. As previously stated, there are many differences among Hispanics, such as Mexicans and Colombians. Ideally, patients would have been sampled according to their nationality. However, because average estimates of the

patients' nationalities were not available from the clinic, sampling was not intentionally performed by different nationalities.

In order to obtain an unbiased sample, I interviewed Spanish-speaking patients, as labeled by the front desk, as they entered the clinic at any given time. For example, I approached the front desk at 10 a.m. and attempted to interview the next Spanish-speaking patient who approached the front desk. While the patient waited for her name to be called, the interview was conducted. Interviews took place in a private room, where the patient could still hear if she was being paged by her physician or nurse.

Staff members were determined for the interview process by way of a convenience sample. I approached the staff member and asked if they wanted to participate in the interview and whether or not they had time at that moment. If the staff member was interested but did not have time at the present moment, I scheduled a time that was convenient for the staff member. Interviews were conducted in private rooms.

### **Observations**

For the observation component of the project, previously recorded notes were used. I had previously observed patient/provider interaction, patient/front desk interaction, and overall clinic atmosphere for a different project. Observation was chosen as a method because the interactions between patient and provider during a clinic visit are an important component in determining cultural sensitivity. During the observations, I closely observed how the doctors communicated with non-English speaking patients, and what efforts they made, if any, to address cultural issues. In addition, I also observed the interpretation process between the provider, the patient, and the interpreter.

## **Archival Records**

Administrative documents related to policy, such as strategic plans, and records showing the accreditation process were reviewed. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) is an organization that establishes standards and renders accreditation to health care organizations. While it does not have a specific compliance standard that relates to cultural competency, it does have a section titled “Patient Rights and Organizational Ethics”. Under this section, the question “Are the patients treated as individuals with unique personal and health needs?” is addressed. Ways in which the HC has attempted to address this standard to JCAHO compliance were explored.

Small samples of the various health education materials that are given to patients were also reviewed. The quality improvement manager acquired the health education materials from the clinic providers and passed them on to me for use in this study. Items related to cultural sensitivity, including availability of information in Spanish, and readability in Spanish guided the review process. There are many different tools used to assess the readability level of reading materials. Because it is most used, I applied McLaughlin’s (1969) SMOG Readability Formula. Contreras et al (1999) conducted a study to that determined that the SMOG formula is also valid with Spanish health education materials. Materials were also evaluated for their print quality and for the presence of graphics, which also aids low literacy patients to understand the information on the handout.

## **Analysis**

The interviews were not tape recorded, and therefore were not transcribed. The PI took notes on all interviews and typed the notes on the word processor. Notes were taken on what the participant said, using shorthand and abbreviations, and facial expressions and reactions in order to accurately portray the context of the interview and the interviewee. A top to bottom analysis approach was used to code observations and interviews by categories and themes in order to determine patterns and recurring themes. The study data was inputted into qualitative data analysis software, Ethnograph, which was later used to code, sort, and analyze the data.

The archival data was reviewed for relevance to cultural sensitivity policies. Each administrative record was reviewed and discussed in the results section. The health education materials were analyzed using the SMOG Readability Formula. The quality of the handout was evaluated using the categories “legible” or “illegible”. The results were then displayed in a frequency distribution to determine overall patterns.

## **Limitations**

For this project, there were many limitations, which one is likely to encounter at any time when conducting research at a very busy rural health center. One limitation is that most patients were migrants, and probably had illegal residence status. Migrant workers who are typically marginalized do not have much trust for strangers and are apprehensive when asked to participate in a “study”. Some of the patients required a lot of probing and even then, they still did not want to talk very much. I tried as much as possible to get them to feel comfortable with me by explaining who I was and where I was from, and by helping them if they asked me for help (ie – translating a document for

them). Unfortunately some of them did not voice their opinion fully. Another limitation is that I was at the whim of patients' availability. If patients were called during the interview, they had to stop the interview process. Some of them did not return to me to finish the interview. This happened with six patients. Those interviews were not considered for this project.

Another major limitation was the staff's lack of time to participate in the interviews. Because there is a heavy patient load, they always seemed in a hurry. Furthermore, none of the staff members wanted to sacrifice their lunch hour or come in early or stay late for the interview. Therefore, the interviews were conducted while they were working, taking their fifteen or twenty minute break. This type of setting is not relaxed and not ideal for interviews. Nevertheless, I was able to get complete responses from all the interviewees. A further weakness of this study is that it focused on only one ethnicity, Hispanics. There are many other cultures that attend the clinic, and they all have their own individual health beliefs.

Finally, one more weakness of this study was that I was not able to assess the cultural competence levels of the staff members due to the time constraints with staff members. There are many instruments that health care organizations can use to evaluate the levels of cultural competence of the staff. In order to get a definite idea of whether or not the staff members are culturally competent, they should be evaluated using a validated instrument that precisely tests for cultural competence levels. This way the clinic can target where specific improvements are needed when providing cultural sensitivity training to the staff.



In a follow up study, it would be interesting to measure the acculturation of the patients. Acculturation levels would be interesting to know in the patient interviews because there might be a correlation between time living in the country and perception of whether or not the clinic is a good clinic.

### **Bias**

Because of the time issue, the way I sampled the patient interviews might not be that representative because I only sampled those who were in fast track, where there is always at least a thirty minute wait. I was not able to interview patients with appointments because they were seen by the doctor right away.

Another bias is my own, as a clinic employee. Although I did my best to be as objective as possible, it is undeniable that I brought in my own experience and my own biases to the project. Selection of the staff members could have been biased because there is a possibility that those who interviewed with me may have felt more amiable towards me than others who chose not to engage in the interview.

### **Summary**

This chapter outlined the research questions used to guide the data collection process. In addition, this chapter also dissected the different forms of data collection methods used to address the research questions. Finally, the analysis protocol was also discussed for each method of data collection, as well as the process of ensuring participants' informed consent. The results of these data collection methods are discussed in the next chapter.

## **Chapter 4**

### **Results and Discussion**

#### **Introduction**

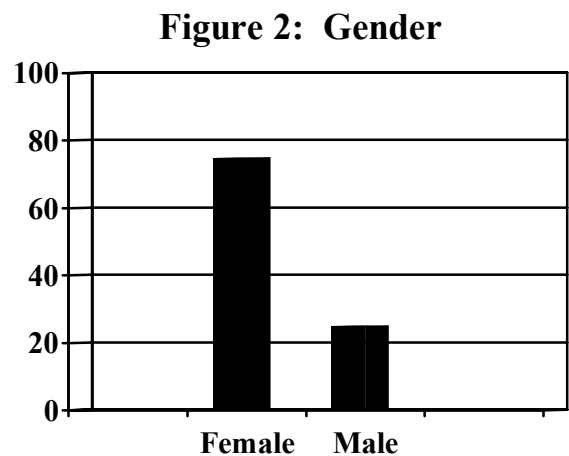
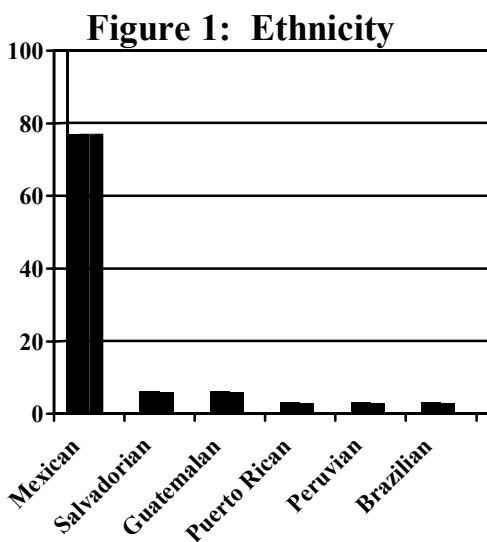
In this chapter, the findings from this study are reported and discussed. Results are first grouped by type of data collection, then by themes or topic. Where applicable, figures are provided to illustrate the frequency distribution of the data. The research questions are also addressed throughout this chapter.

#### **Patient Interviews**

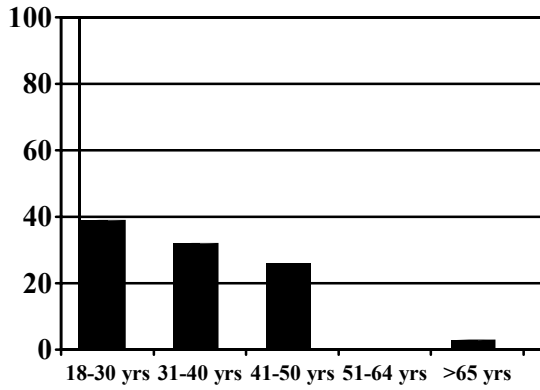
##### **Demographics**

In May of 2003, 59% of the total population of patients at the HC was Hispanic. In addition, almost half of the patients spoke Spanish. For this project, a total of thirty-one patients were interviewed. As seen in Figure 1, roughly 75% of the respondents were from Mexico, the remaining 25% were from El Salvador (n=2), Guatemala (n=2), Puerto Rico (n=1), Peru (n=1), and Brazil (n=1). Note: The patient from Brazil was interviewed in Spanish. Figure 2 shows how twenty-three (74%) of the interviewees were female. Approximately 39% of the interviewees were between eighteen to thirty years old, 32% were between thirty-one to forty years old, 26% were forty-one to fifty years old, and one patient was over the age of sixty-five. None of the patients were between fifty-one and sixty-four years old. A distribution of the respondents' ages is illustrated in Figure 3. In terms of insurance, the majority of the patients sampled (71%) did not have any type of insurance. This is representative of the general clinic statistics, in which two-thirds of the

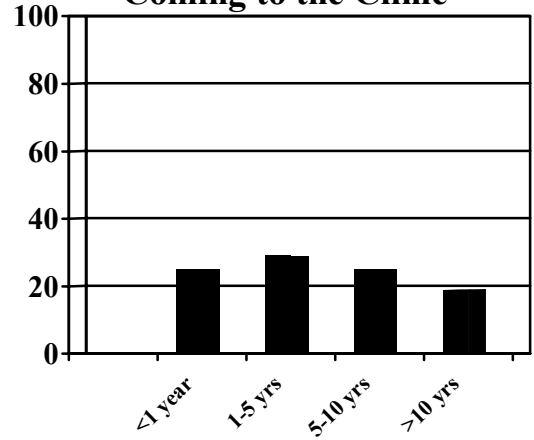
clinic’s population is migrant workers, most of whom do not have medical insurance. The remaining 30% of the interviewees were evenly distributed as either having Medicaid (n=3), county insurance (n=4), or private insurance (n=2). Fortunately, there was a fairly even distribution of the length of time that the patients had been attending the clinic (Figure 4). Furthermore, there was no difference in the responses between those patients who had been attending the clinic for many years, and those who had just started coming to the clinic. One-fourth of the respondents reported that they had only been coming to the clinic for less than one year. Slightly more patients (29%) said that they had been attending the clinic anywhere from one to five years. Another 25% said they had been visiting the HC between five to ten years, and 19% said they had been going to the clinic longer than ten years. One interviewee reported that she had been coming to the clinic for eighteen years, while another patient, who had been attending the HC for five years, said that “since she arrived [to the clinic], they made [her] get to know this place.”



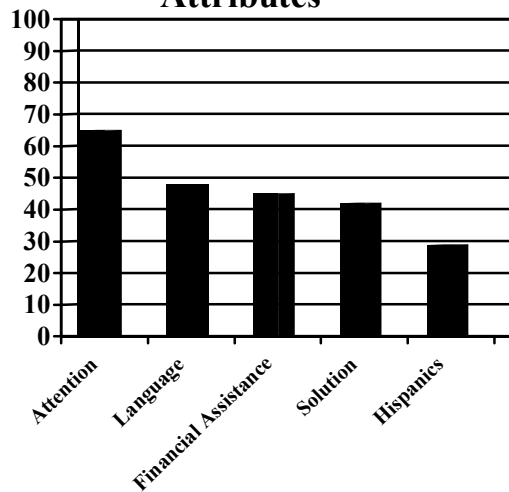
**Figure 3: Age Distribution**



**Figure 4: Length of Time Coming to the Clinic**



**Figure 5: Positive Clinic Attributes**



Within this subsection, the results of the patient interviews are presented. This section reviews the answer to Research Question #1: What does cultural sensitivity mean to patients? Because the term cultural sensitivity is a foreign word to most patients, the interview question aimed at finding out what qualities patients look for in the clinic. The qualities, according to the interviewees, are 1) attention; 2) language; 3) financial assistance; 4) solution; 5) Hispanics; and 6) clinic services. In addition, the results of what patients do not like about the clinic, which is the long wait, and their perceptions on health education materials are presented and discussed. Patients also offered their suggestions for ways to improve the clinic. The results of their comments are also listed in this section.

### **What Patients Like About the Clinic**

The distribution of the following factors is illustrated in Figure 5.

#### **Attention**

Overwhelmingly, 65% of the patients reported that they are pleased with the attention that the staff gives them. These findings confirm other studies which show that patients value the attention that staff gives them, and associate that attention as a sign that the health care provider cares for him/her (Zoucha 2000). Responses within this theme ranged from feeling like they are taken care of, treated right, served well, and looked after. For instance, one patient who had been coming to the clinic for five years said, “They treat me well. In all my appointments when I’ve come here, they have always welcomed me.” Another patient describes how attentive the staff members are when she said, “What I like about this clinic is that they care about their patients because they look for them, they call them.” A different patient gladly offered her praises of the clinic

when she stated that “another thing [she] like[s] is that they’re always trying to take care of [patients], even if [they] miss an appointment. They’ll always call, they’re always concerned.” A critical factor that keeps patients coming back to the clinic is that they feel like they are not neglected, but rather nurtured and respected.

### **Language**

Slightly less than half (48%) of the patients interviewed responded that one of the characteristics that they like about HC is that the staff members speak Spanish. Spanish is the primary language of over 50% of the clinic’s patients. Many patients felt that “[the staff] know[s] [their] culture because they speak Spanish.” According to patients, speaking Spanish is directly related to understanding Spanish culture, which in turn made them feel comfortable receiving health care from the staff. Speaking Spanish fluently typically grants a person access and sensitivity to the dynamics of the culture which many Hispanics share. Cultural nuances such as *respeto*, *familismo*, and *personalismo* are intertwined with the Spanish language. For instance, when asked to talk about the reasons that they feel the clinic does or does not understand the culture of most Hispanics, 39% of the patients answered that the clinic is knowledgeable of their culture because “there is a lot of people that speak Spanish.” One patient’s response for why she feels comfortable coming to the clinic is an example of the strong connection between language and culture:

“Before I was very scared, because the doctors were very direct, they didn’t know how to tell you things, and one would feel bad. But when one knows how to talk to you, they especially say it more gently. If you returned, they would scold you. Now the majority speak more. Also, before you always had to bring an interpreter.”

Many patients simply felt that they like the clinic because the staff speaks Spanish. The existence of a Spanish speaking staff is something that most patients mentioned in their interview. As one patient stated, “the majority of people speak Spanish. I don’t leave with any doubts. I ask them and they answer me.” In fact, all of the medical assistants at the HC speak Spanish fluently.

The reality of the quality of health care that Hispanics receive, especially those who do not speak English, is daunting. Many health care workers do not speak Spanish, and either do not have an interpreter at all, or do not have one that is properly trained to interpret medical information. When the patients were asked how their communication was with clinic personnel, all patients, with the exception of one person, said that the communication between them and their provider and medical assistant was “fine”. Many patients commented that if their provider didn’t speak Spanish, they always had an interpreter who did speak Spanish. One patient felt that the interpreter was not paying attention to her, and therefore she did not ask the doctor the questions that she had.

One of the patients who had been coming to the HC for nine years touched upon this reality when asked in what ways the clinic makes her feel comfortable. She shared a story about why she liked the clinic.

[The HC staff] is nice. I like the midwife. The other midwife from Joyce Ely doesn’t speak Spanish and I felt bad because she told me that I had to be operated so I wouldn’t get pregnant and I felt that was wrong for her to tell me that. So I came here, and I told the midwife the symptoms I was feeling, “*como Mexicanos*”, like Mexicans, the shakes, and she told me everything was okay. I later found out that I could take a different type of birth control and not have to be operated.

This patient’s story is representative of the experience of many other migrants and non-English speakers. In the case of this patient, there was obviously a lack of

communication between the patient and provider because of the language barrier. Many patients also feel more open to discuss their symptoms and medical concerns if they know that someone will understand them. One patient stated that she “ask[s] everything because [her doctor] speaks Spanish.” Another patient demonstrated her commitment to the HC when she stated, “We understand the doctor, that’s why I come all the way over here from Lakeland.”

One patient described an incident that happened to her over four years ago. She explained:

“[the doctor] was checking my heart, right as I started coming to the clinic. They gave me medicine that I didn't need. It wasn't for my condition. It could have been because they might not have understood the symptoms that I told them. Later, they just told me to throw that medicine away.”

Her response depicts the reasons why the existence of properly trained medical interpreters is imperative in order for health care centers to become culturally sensitive.

### **Financial Assistance**

Approximately 45% of the respondents expressed that the clinic’s policies of financial assistance is one of the reasons why they feel comfortable coming to the clinic. In terms of financial assistance for patients, the clinic has a strict policy of not turning anyone down because they can not afford medical care. The clinic operates on a sliding fee scale. There are financial counselors who counsel patients to determine whether they are eligible for Medicaid or county insurance. Patients who are not eligible for government subsidized insurance are classified into different pay categories, based on



their income. For instance, when asked if she has ever had trouble receiving medical care at the clinic, one patient said:

“No, because I didn’t know that my Medicaid expired. They sent me to the financial counselor and she gave me a chance, and they took care of me even though I only had eight dollars. Here there’s more availability, because other places tell you ‘I’m sorry, come another time’.”

Medical and dental care is available to all patients, even if they can not afford to pay for the services at the time they are rendered. Other services such as prescriptions are offered at low prices, while others such as transportation, outreach, and health education are completely free of cost. One of the patients confirmed the clinic’s policy when she stated that “there are good doctors. Sometimes if one can’t pay everything at the moment, one can say I’ll give you this much money on this date.”

Another patient articulated her appreciation for the clinic when she said “here there is a [financial] plan that they can help you out according to your salary. That is a big help. They’ve always treated me well and given me a hand.”

An essential component of culturally sensitive health care is making services accessible to all patients. One patient represented the voice of the migrant community when she stated that “they say that this clinic is for migrants. When it rains, we don’t get paid, and this clinic helps in that manner.” The HC accommodates migrant workers, who are not only uninsured, but also whose incomes are not always consistent or reliable, with their flexible financial policy.

### **Solution**

Curiously, a significant number of patients (42%) conveyed that one of the reasons why they continue to come to this clinic is because they are offered a solution, or a prescription, to their medical problem. Precisely phrased, one patient said what she

liked was “the effectiveness, every time that [she has] come with a problem, they have given [her] a solution.” A few of the patients (n=3) expressed satisfaction that their children received a prescription and felt better. One patient declared that “[she] [has] never wanted to change to another clinic because they give [her] medicine. When [she] brings her baby sick, they take care of him.” Another patient asserted her views when she said, “What I like – they give me medicine and cure me. I come with all kinds of problems and they help me. There’s nothing I don’t like.” Finally, one patient iterated her feelings about why she doesn’t go to other clinics when she stated “I don’t know the pediatrician well. The pediatrician before was very good. She tended to us very well, she gave me prescriptions, and she was very good. When I go to other clinics, they don’t give me prescriptions.”

### **Presence of Hispanics**

Twenty-nine percent of the patients interviewed reported that the presence of Hispanics all over the clinic is what they like. Some patients commented about how the HC tends to so many other Hispanic patients. For instance, one patient said “they know us well because Hispanic people have been coming for so long.”, and that is why they continue coming. Other patients remarked on the large percentage of Hispanics that work at the clinic.

### **Clinic Services**

Unexpectedly, only 3 patients, 10%, named the availability of transportation as one of the reasons why they like coming to the clinic. One of the leading factors that obstructs migrant workers from attaining health care is lack of transportation. The HC

offers this service free of charge to all patients who need it. Several of the patients expressed their gratitude for transportation. For instance, one patient said:

“What I like. That's hard. The services that they offer. When they go to your house, when you don't have a car, when I don't have money, they still offer you their services. Don't like. Well, nothing, I like everything.”

Another patient said “I feel great here because I have a ‘special’ child I bring here with me and when he has to go to Tampa, the van takes us, so I have no complaints.” Patients did not recognize any other clinic services as reasons for why they come to the clinic. In essence, although there were only three patients that discussed, if briefly, transportation, it demonstrates the importance of having that service available.

### **What Patients Do Not Like About the Clinic**

This section discusses the results of what patients do not like about the clinic. Half of the respondents felt that there is nothing that they do not like about the clinic and that “everything is fine.” Only a couple patients had specific complaints or needs, such as the bathrooms needed to be fixed, and the need for another clinic closer to Tampa. However, more than half of the patients complained about the long wait time when they come in for services.

#### **Long Wait**

The HC sees patients with and without appointments. Patients who have appointments generally do not have to wait more than twenty minutes to be seen. Those patients who do not have appointments are directed to fast track. There is always a long wait time in fast track. Patients can expect to wait at least three hours, if not all day, to be seen by a doctor or nurse practitioner. Slightly over half of the patients (55%) interviewed responded that they do not like the long wait that is constant at the clinic. It

is important to note that all of the patients who were interviewed for this study did not have appointments. They had to wait a long time to be seen by the doctor, which is what made it possible to conduct the interviews for this study.

Many of the patients were passionate when they conveyed their dissatisfaction with the long wait time. For instance, one patient said, “I get so angry. I get here at 9 a.m. and I don’t leave until 5 p.m. They should send me home and tell me when to come back. They know better when it’s my turn.” Similarly, other patients complained about not being able to eat or make other plans for the day because they had to spend the entire day waiting for their turn in the clinic. One patient voiced her opinion when she said that

“the staff should communicate with patients, say ‘you know what, we have a lot of patients, but come back in one to two hours.’ So I can get stuff done. They should tell patients how long they’ll wait. Many patients don’t talk because they’re afraid, so they wait all day.”

Another patient, who was also annoyed with the long wait time, said that “they should respect people’s times. You have an appointment for two to three months, and then when you come, they can’t even attend you in time.” Along the lines of respect, another patient also felt that “they make [patients] wait every single time. They don’t respect [the patients].” Other respondents (23%) reported that they have heard other patients complain about the long wait. Some patients criticized the long wait time and asserted that “since they make [patients] wait so long, it makes [patients] not want to come. [Patients] have to wait too long.”

Although many of the patients complained about the long wait time, a few of the patients expressed their tolerance because the benefits outweigh the drawbacks. For example, one patient who felt “there are no bad things” at the clinic expressed that “It could be the long wait, but one has to understand that that is normal.”

When asked whether they had ever experienced problems receiving medical care at the clinic, 93% of the patients expressed that they had never had any problems receiving medical care. Only two patients had specific complaints about the providers who treated them. According to one of the patients, she has heard other patients complain about a provider being too harsh and antagonistic.

### **Patients' Suggestions for Improvement**

One of the questions in the interview asked patients what they felt should be improved at the clinic. The majority of the patients, 14%, either did not know or felt that everything was fine at the clinic. Thirty-two percent of the patients confirmed that the long wait needs to be improved. Other suggestions for positive changes included increasing the number of doctors, fixing the bathrooms, and having a seminar on customer service to improve employees' attitudes. One patient had a suggestion for improving the clinic when she stated:

“What I like. We work in the "campo", if we get out late, we have a day that it is open late. Sometimes if the day care says my daughter is sick, then we can run over here. But we would like it if they could be open late another day. Up north they have two days they open late you know, since we work late. It would be great if they could be open on Saturdays.”

### **Patients' Perceptions of Whether the Clinic Understands**

#### **the Cultural Values of Hispanics**

The majority, 90%, of the patients interviewed believed that the clinic does understand and have knowledge of the cultural values that Hispanics share. Nearly all of the reasons were because most of the staff speaks Spanish and is Hispanic. For instance, one patient explained:

“The customs are in the language. Yes, they understand our customs, because the doctors, knowing the language, can answer your questions, because the customs are in the language. When you come from Mexico, you come with a ton of pills and they know that that’s the custom that we Mexican have. But I think they do know our culture.”

Another patient responded that “they have always treated [her] with respect. When [patients] come from the ‘*campo*’ [the field], [they] are dirty. The people from [the HC] know that [patients] work in the fields.” The small percentage of patients who did not feel that the clinic understood their culture stated that “they don’t understand. They are different. They are accustomed to one thing. For example, I don’t know if my doctor will like me or not because I’m Hispanic because there’s a lot of racism.”

### **Patients’ Perceptions on Educational Information Handouts**

The availability of Spanish materials is one of the key components of a clinic that is culturally sensitive. Administrative forms, educational information passed on to patients, as well as prescription information should be available in Spanish. One patient said “I like them. They give me the medicine in Spanish. They explain things to me in Spanish. Everything is in Spanish.” When patients were asked how they feel about the educational information that the doctors or nurses occasionally give to them, 70% said that they felt fine with the educational information. Very few patients elaborated on this question, even after probing. A few patients acknowledged that they “understood [the information] because they give it to [patients] in [their] language.” The remaining 30% of patients said that they had never been given any handouts.

### **Staff Interviews**

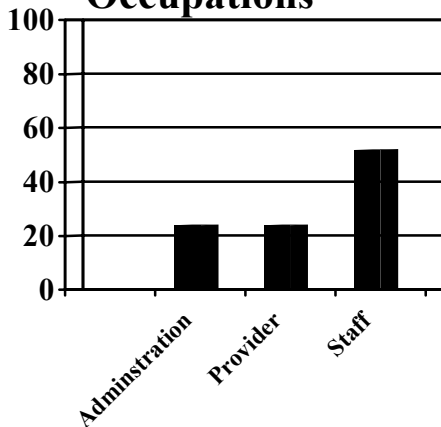
This section addresses the results of the interviews conducted with HC employees. The interview questions addressed Research Question #2: What does cultural sensitivity

mean to HC staff? Related to this question, the interviewees were surveyed about the extent of their training and what type of training on cultural sensitivity they have had. These results are also discussed in this section. Staff also proposed their ideas for improvement and proclaimed their opinions on the health care needs of migrant workers in general.

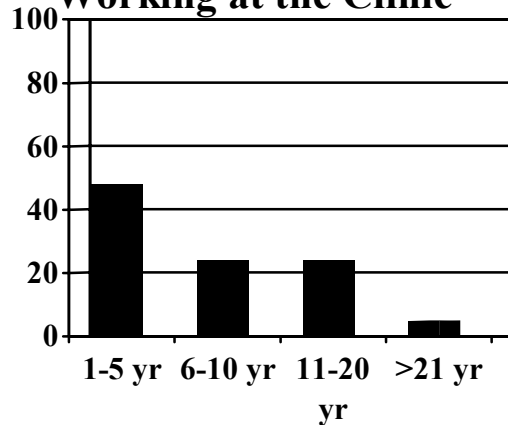
**Demographics**

A total of twenty-one HC employees were interviewed. Five of the respondents were administrators, five were doctors or nurse practitioners, and eleven were staff members, such as front office personnel and medical assistants (Figure 7). When asked to describe their job at the clinic, some of the interviewees simply stated their position, while others described their job. Those that described their job provided insight into the general attitude of the workforce. For instance, one provider said he “go[es] above and beyond to help get medicines, acquire medicines, [and] get the best deals.” Another respondent, whose job involves constant contact with patients, commented, “I love my job, I deal with patients, they talk to me, I love being around people.”

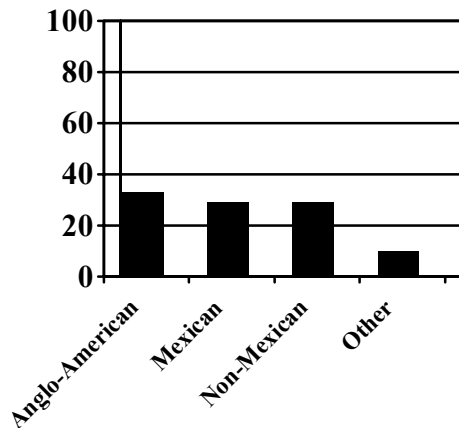
**Figure 6: Distribution of Occupations**



**Figure 7: # Years Working at the Clinic**



**Figure 8: Staff Ethnicity**



Forty-eight percent of the interviewees had been working there between one to five years. Another 24% had six to ten years experience at the clinic. In addition, 24% of the respondents had been working there between eleven to twenty years, and one staff member had been working at the clinic for twenty-six years (Figure 7).

In terms of the employees' backgrounds, 33% were Anglo-American, 29% were Mexican, 29% were Hispanic non-Mexican such as Puerto Rican and South American, and 10% were Philipino and Indian. This sample is representative of the general staff demographics. Based on my participant observation, which spanned over one year at the clinic, 100% of the medical assistants were bilingual. Many of them were raised in the same community where the clinic is located. Two providers out of seven providers were bilingual and of Hispanic descent. The remaining providers utilized their medical assistants as interpreters.



## Cultural Sensitivity Training

Approximately 29% of the staff members had never had any kind of training on cultural sensitivity. Another 33% of the interviewees had not had formal training on cultural sensitivity (Figure 9). Rather, they reported that the only kind of training they have had on the topic is through experience. One staff member who identified herself as Mexican emphasized the lack of training that she had in nursing school and the importance of hiring staff members that share the same culture of the patients. She responded that the only cultural sensitivity training that she has had was being “brought up in church, morals from [her] parents and community. Teach you what you believe in but you don’t disbelieve in what people think. In nursing they give you a book with a couple of paragraphs.” Twenty-nine percent of the staff interviewed said that they had either been trained in school or they read their own literature on the subject (Figure 9). The HC human resource department offered training according to only 24% of the respondents. Nineteen percent of the interviewees stated that they learned how to be culturally sensitive from their coworkers. Three respondents felt that they followed their instincts when it came to cultural sensitivity. As one staff member said, “it’s more or less common sense...how you would want to be treated.”

When asked how often they receive training, more than 50% of the staff members reported that they receive no training, or not often. Twenty-four percent of the interviewees said they receive training yearly, and 14% said they receive training every day. Those who said they receive training every day felt that being in the work environment trained them on how to be sensitive to other cultures. One staff member said

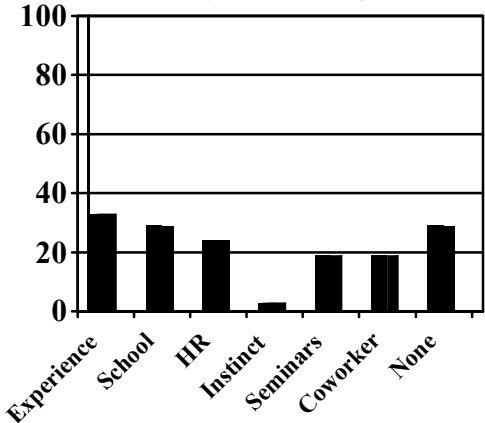
“everyday you work, that’s training. You learn from patients, patients bring medicine from Mexico, they trust their doctor, and we have to accept their feelings about what is good in their country is good here. I think to myself at least they are using something.”

One member of administration explained the clinic’s policy on cultural sensitivity training:

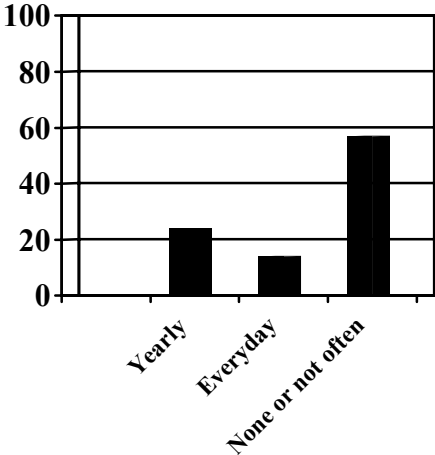
“Everyday. Every employee gets it upon orientation. We talk about it periodically every 6 months. Our policy is built around cultural sensitivity because it is so important to all cultures. How they approach getting health care starts at the front. Immediately we don’t turn away. We show we’re understanding of the situation they’re in. Policies, ethics, start there. Health care practices, health education, try to build that around their beliefs their views of authority, health diet, etc. Try to do all to make it available and open. As for disease management and medicines they take, we gear everything and ensure that our staff is sensitive to that.”

Inconsistent with the administrators response, only 24% of the staff mentioned that they had received cultural sensitivity training with human resources.

**Figure 9: Kind of Cultural Sensitivity Training**



**Figure 10: Extent of Cultural Sensitivity Training**



### **Medical Interpretation Training**

Only two out of eleven medical assistants reported that they had received training on medical interpretation. In support of the idea that medical interpretation training should be required at the clinic, one of the providers commented, “We have assistants that translate, and most of the time it helps, but sometimes they have limited experience in medical terminology so I ask patients more questions and get the answer I’m looking for.” Although all medical assistants are bilingual, if they are not properly trained in medical interpretation, they are not aware of medical terminology, communication techniques, and the role of an interpreter.

### **Staff’s Perceptions of Cultural Sensitivity**

#### **Definition of Cultural Sensitivity**

There were two purposes of asking staff members to define the term *cultural sensitivity*: to determine whether employees had heard of the term, and explore the different definitions of the term. All of the staff members were able to define *cultural sensitivity* in some way. Although there was no consensus on the definition of the term, most definitions involved one or more of the following descriptions: action, understanding, knowledge, respect, and sensitivity. Seven respondents included an action word in their definition, such as “using appropriate language and mannerisms” and “trying to find somebody to help them who speak their language.” Six people also included having an understanding of another person’s culture in their description of cultural sensitivity. For instance, one definition given was “People, they feel they belong to a certain culture, feel offended by other cultures or by rules or hospital policies from this country, we try to understand their culture, have to be very sympathetic.” Three

interviewees included knowledge as a component of cultural sensitivity. For instance, one person said cultural sensitivity is “knowing where people are coming from, whether poor, middle class, or wealthy, and trying to understand their ethnic background.” Other descriptions of cultural sensitivity included “being sensitive to different cultures in the area” and “respecting beliefs of the person.” One provider expressed how important cultural sensitivity is when she said:

“you have to see and know ideas of patient culture – know which country they came from, what are the norms for them, their food, their dress, traditional culture for delivery, beliefs, what mother in law wants patients to do, what medicine they are used to taking, sometimes you have to respect their idea or educate them, because the home environment sometimes will not allow them to take treatment.”

Although it is beyond the scope of this study to perform a linguistic analysis of the term cultural sensitivity and all of the forms of the definition given in the interviews, it is possible to determine that staff members are aware of the term, and sufficiently know what it means. As was expected, members of the administration team had a much more clear idea of what cultural sensitivity meant. Their definitions were more holistic and went beyond the basic definitions that other staff member’s provided. For example, one administrator gave the definition as

“One’s insight and understanding of another’s responses and actions based on the values that they have learned or developed from their family, towns, or country. Accepting of it. Not necessarily accept it but be aware that it exists and use it in dealing with people – aware of their customs.”

### **Why Be Culturally Sensitive?**

Staff members were asked whether or not they felt that cultural sensitivity was relevant to the clinic. Of all the responses, 48% believed that the clinic should be culturally sensitive because of the diverse population that attends the clinic. For instance,

one staff member said that because the HC “[has] many different people from different economic backgrounds, and education levels, their intellectual attitude about health care can vary, according to how their culture defines them.” Slightly less than one-fourth of all the interviewees believed that cultural sensitivity is essential, otherwise patients will not return to the clinic. One staff member reinforced the importance of cultural sensitivity when she said

“this is the place where most of the community comes. They come sick and we have to treat them how we would want to be treated. We have to be sensitive. Every person is different but we have to be that way for the community so they can come see us.”

Another 14% of the respondents believed that the only way that the clinic can achieve compliance is by being culturally sensitive. As one administrator pointed out

“if an individual comes from a culture where they believe certain disease comes from A and you’re not doing A, then the treatment course might not respond or they might not engage in treatment at all. If you don’t realize what’s playing in the background, then you might ruin the chance at getting well.”

Staff members were asked to describe the ways in which cultural sensitivity affects health. Approximately 33% of the responses believed that there was a relationship between cultural sensitivity and patient compliance. For instance, one staff member responded:

compliance – if you try to explain the reason you are doing it, in spite of what’s on their mind, they’ll comply because they know the reason. If it’s adjusted to their culture they comply. Just like diet. The policy of this clinic is cultural sensitivity – take anybody whatever income or culture. Open to any culture.

Another 38% of the responses recognized that cultural sensitivity affects health outcomes. A nurse commented that “people tend to get healthier sooner if you let people believe in whatever it is that they believe. It helps them heal faster.” One provider

expressed her conviction on the value of cultural sensitivity when it comes to health when she declared “tremendously – because they can bring disease under control and reduce their chances of heart attack. Emotionally they are tuned in with you. They trust you more.” Similarly, 19% of the responses felt that cultural sensitivity affects health because patients will have more trust on the health care team, which will ultimately increase health outcomes.

Fourteen percent of the staff members did not feel that there was a relationship between cultural sensitivity and health outcomes. This could be because there is not a strong emphasis on cultural competence or cultural sensitivity training at the clinic, as supported by the statistics from this study. Fifty-seven percent of the interviewees responded that they had received either no training or not often on cultural sensitivity. Those who did not acknowledge a relationship between health and cultural sensitivity exemplify the lack of clarity of the term, and the need for greater understanding of the purpose and reason for achieving cultural sensitivity.

### **Cultural Sensitivity in Action**

Staff members, providers, and administrators were asked to discuss in what ways they practice cultural sensitivity. This was the key question in the interview because it allowed respondents to contextualize their understanding of the term cultural sensitivity. All of the respondents, except two, showed ways in which they were culturally sensitive. Only two respondents replied that they practice cultural sensitivity training by treating everybody equally and “not being different with anybody”. When one understands and is aware of the dynamics of different cultures and how they influence patient’s health beliefs, then one can customize the approach that each person receives on an individual

basis and attain justice. Ninety percent of the interviewees demonstrated that they understand and are aware of the cultural values that Hispanics share and explained how their behavior embodied the meaning of being culturally sensitive. Unfortunately, it is not possible to present all of the responses in this paper. However, a chosen few can portray the magnitude to which the HC is culturally sensitive. A Mexican staff member responded:

“when I see patients, I see where they come from, I am sensitive to their feelings and beliefs, etc. People don’t believe in receiving prenatal care ‘cuz they don’t see the midwife until labor in their country, so I have to educate them. I do a lot of education, get to their level of understanding. That’s the challenge. I use simple words and make them to repeat what I said, at least a sentence because sometimes they speak little Spanish (if they speak a native dialect).”

One staff member shows how she is culturally sensitive when she says that

“When you have Mexican children, you are supposed to touch them because if you don’t, you have envy. I speak Spanish so that helps. I don’t want to offend people, so I use words they’re comfortable with. I gear vocabulary to their level of understanding.”

One member of administration provided this explanation:

As I’m thinking of a special treatment or regimen, I ask myself ‘is this something the patient will intellectually agree with? Will they buy into it?’ Ask my medical assistant if they think they’ll agree. I use my experiences and employ them in my thought process to help me decide.

Another staff member illustrates awareness of her own culture and how that can affect cultural sensitivity when she stated, “We all have different cultures, with different expressions, so we have to be careful the way we express ourselves to not offend them. In the time I’ve been here, I’ve adapted to the way I behave around them to make them comfortable.”

All of these responses, in addition to those not reported in this paper, show that the staff members at the HC are aware of the term cultural sensitivity, whether it be intuitively or intellectually. The fact that they adjust their behavior based on a person's culture confirms that they know the culture.

### **Staff's Awareness of Hispanic Values and Health Beliefs**

Although the question was not specifically asked, many staff members expressed their awareness of Hispanic values and health beliefs. For instance, one nurse showed her awareness of Mexican health beliefs when she said "things like umbilical cord, they put bands around them, as long as it stays clean and doesn't hurt the baby, I respect their beliefs." Another provider said:

"With the female population, most Latinas appreciate touch, eye contact, humor. I try to deal with them in ways that they are comfortable with. With males, they are more reserved with language and mannerisms, until I gain trust. So I tend to be more reserved and try to be more professional. Talk about my personal life. Keeping it medical, collegiate, don't just keep it on that level. Also talk about their personal and home life. Not just about health."

Another nurse commented on Mexican health beliefs:

"most of our patients come in with their beliefs. We've been known to have patients who believe they had evil eye and we honor that. One time I had a patient that died, two year old when he came to the clinic, and the mom insisted it was evil eye. We as Mexicans don't believe in having pelvic exam if lady is a virgin, we have to honor that, we have all kinds of religions coming in."

*Respeto* is a value that many Hispanics share, and one that has a great impact on health care. A provider who has a clear understanding of *respeto* would know that doctors are regarded with utmost respect, and that the eldest male member of the family and/or father is the head of household. One provider showed his awareness of the concept of *respeto* when he said it's imperative to "understand if they don't look you in



the eye, its not disrespect but being respectable.” Another medical assistant describes her awareness of the Hispanic value of *respeto* when she said:

“If a patient comes, sometimes the husband wants to speak for the wife. If you are gonna give them care then you have to get used to it. Sometimes I know where they’re coming from. The stuff they use. I learn from them, ask questions when it comes to medicines. They bring their own stuff. I try to understand why they use what they use. You might think it’s dumb but that’s just them. I try to understand where they come from (beliefs, background, etc.)”

### **Staff Perceptions of How the Clinic Practices Cultural Sensitivity**

Staff members were asked to describe the ways in which the clinic did or did not practice cultural sensitivity. The largest percentage of responses, 43%, named language as the key reason for why the clinic was culturally sensitive. This is consistent with patients’ responses of what they like about the clinic and what keeps them coming. However, there are other dimensions of cultural sensitivity that the clinic does exhibit, though not to the same extent as language. For instance, other staff members responded that the clinic’s flexible financial policy makes the clinic culturally sensitive. Only one staff member suggested the availability of transportation as a reason for why the clinic is culturally sensitive. Thirty-eight percent of the respondents stated that the clinic is culturally sensitive because of the way it treats patients, either respecting their beliefs, treating them equally, or doing things the patients’ way. For example, one staff member asserted:

“I see [cultural sensitivity] every day that I’m here. They don’t get in the patients’ business. They don’t dictate to patients how to live their lives. Having bilingual employees, handouts in English and Spanish, having medical assistants that speak Spanish in every single doctor’s office, we celebrate *5 de Mayo*, which I’m sure other clinics don’t do.”

One provider who doesn't speak Spanish commented:

“Overall, everybody is trying to respect patients’ feelings. We even go to the extent if they bring medicine back from another country, we go to this book in the pharmacy and see if we can find the equivalent. Educational materials in Spanish, handouts we give, and if we don’t, we try to make sure they have a son/daughter who reads English. Sometimes patients bring us Spanish foods and we accept that happily in order for them to trust us, that we can mingle with you. They bring me presents, I display them to make them happy that yes, we appreciate them.”

In a separate question, staff members were asked to specify how they think the clinic tries to overcome patients’ barriers to health care. This question was asked to elicit responses from staff members who might not have had a clear understanding of the term cultural sensitivity. Interestingly, the results from this question were different than the results from the question on how the clinic practices cultural sensitivity. Essentially, both questions were the same because the goal of cultural sensitivity is to alleviate patients’ barriers to health care. Where almost half of the responses believed that language is what makes the clinic culturally sensitive, only 24% of the respondents named language as a factor for how the clinic tries to overcome patients’ barriers to health care. For instance, employees mentioned the existence of bilingual workers and bilingual pamphlets. The difference in responses can be attributed to an unclear idea of what cultural sensitivity is. In addition, some staff members may not view language as a barrier to health care.

When asked how the clinic minimizes patients’ barriers, just over 80% reported various services that the clinic offers. The most frequent clinic service named that overcomes patients’ barriers was transportation. For instance, one person articulated that

“Because sometimes it’s hard to reach [patients], I think teaching them, through leaflets. Transportation, we’re a free clinic, based on their income. We let them know this. But transportation is the big problem. We have people who go out of their way to pick them up, like employees, we will go find them if something is wrong with the test results. One way or the other, we’ll do our best.”

Staff members mentioned that having all the services available in one location helped patients receive better health care. Other services mentioned include referrals, health education, and outreach. More than half the staff, 62%, also pointed out that the clinic helps patients overcome barriers by providing financial assistance, whereas only 14% named financial assistance when asked how the clinic is culturally sensitive. These results may also suggest a cloudy comprehension of what cultural sensitivity means.

#### **How Staff Members Would Measure the Impact of Cultural Sensitivity**

Slightly less than half, 48% of the staff interviewed believed that the way to determine whether or not cultural sensitivity is having an impact on health outcomes is to monitor patients’ compliance and health results. For instance, one person responded, “If they’re keeping up with their medications and losing weight like they’re told to, its by them coming back to us and you only see the difference as they come back.” Another staff member replied, “They heal faster and recover at a faster pace, measured by the time that it takes to heal.” Four interviewees, 19%, believed that patients’ testimonies are the way to determine if the clinic is culturally sensitive. One informant stated, “every day we receive new people that say my people sent me here, stuff like that.” Another person answered, “Patient’s testimony – they’ll come back and tell us. We made an impact in their life and in their situation, and the fact that they come back.”

## **Is There Room for Improvement?**

HC employees were asked if they felt there were any barriers that kept the clinic from being culturally sensitive. Eight employees, 38%, responded that there were no barriers. The remainder of the staff members revealed a number of barriers to health care at the clinic. Two employees recognized that a major barrier to providing optimal health care to patients is a tight budget, or lack of funding. One person criticized the health care system when she said that “it has turned into a thing of money.” Another employee expressed that

“Sometimes [the clinic] can really be so focused on the finances that we lose sight of individuals falling through the cracks. Unless we start probing, there are people that don’t come to the window because they don’t have money. We’re not open on weekends. We should take a mobile van to Wimauma. But that’s not cost effective.”

Two employees mentioned that the clinic hours, such as not being open on weekends, are barriers to patients. One nurse contextualized the patients’ perspective when she stated

“More financial help, longer clinic hours. I wouldn’t mind so as long as our people would be seen. There is such a need for night hours and weekends for our patients that work. Coming from that background, we did without because my dad was the one that drove and he worked late so we never went to the doctor.”

Another medical assistant expressed the plight of migrant workers when she said “a lot of people don’t want to miss work, that’s why there’s non-compliant patients, but there’s no way to help them, a lot don’t want to miss work because they’re on a budget”. Other barriers cited include not having enough time with patients and a lack of diversity among administrators.

Employees offered a variety of ideas that can grant patients more access to health care. Five respondents felt that there was nothing else that the clinic needs to do to be

culturally sensitive, because “the only thing that they have left to do is take [patients] by their hand and pick them up and bring them to the appointment.” The most prominent suggestion, 33%, for becoming more culturally sensitive was to educate the staff. For instance, one employee offered her opinion when she stated

There are times that patients leave the clinic and there is miscommunication and they leave embarrassed. They don't ask their opinion. More educating the staff, and transportation is too limited. They need more drivers or vans. Or more buses for those that are far.

Another respondent supported the idea of continuing education, “research more different cultures’ customs, find out any subtleties we might not be aware of.” When a member of administration was asked whether the clinic places enough importance on cultural sensitivity, the response was “yeah, we don't, but when do we do it? Train support staff and let them role play, let providers learn through osmosis, learn from staff.” As stated by the administrator, providers and staff may be willing to become culturally competent, but the reality of the health care industry is different. This person's comment hints at the institutional level barriers to cultural competence, such as lack of time and funding.

Several staff members believed that hiring more employees from the community would make the clinic more culturally sensitive. In their review of literature related to cultural competence, Betancourt et al (2003) found that minority populations make up less than 20% of all city and county health officers. Furthermore, the authors assert that a lack of diversity in the leadership and workforce of an organization is more likely to result in poorly designed delivery systems, and a disconnection between health care systems and the communities they serve.

Fourteen percent of the interviewees recommended that the clinic should make more of an effort to seek out patients, such as advertising with newspapers and instituting

a mobile van. A couple suggestions focused on logistics, such as hiring more doctors and broadening the parking lot.

### **Staff as Advocates for Migrant Workers**

With the exception of four staff members, all interviewees demonstrated that working at the clinic is more than just a job, it's a mission. The majority of employees at the clinic work there because they believe in helping those who need help the most. For instance, when asked what changes should be made in the health care system to better meet the needs of migrant workers, one participant asserted, "recognition, to begin with, people don't even recognize that there is a migrant population to begin with – the produce they buy, who they came from. They don't just cross borders." Another member of administration reported how the clinic itself is making small changes to meet the needs of migrant workers when she said:

"There should be a linking of health education information, so you could see their records online. Migratory activity makes it difficult to take records with them. There should be a national linking of health information. We're already starting it with immunizations. We're piloting it in [a pediatric clinic affiliated with the HC]. It's a Florida program, linking Florida. Anywhere in the state of Florida we'll be able to see them. Eventually, they will link nationally."

A few employees expressed their opinion on insurance:

"Insurance – a lot don't have social security so they don't have insurance. A lot of them can't even afford \$15 on scale A – that would help them out with medicines."

"Give people that work in the fields insurance. Obligate employers to give private insurance, because they pay their taxes, with proper health care, it prevents diseases."

The organizational culture at the HC is one that advocates for the community in which it stands. From the top level of the organization, administrators and policy makers

at the HC advocate for the rights of migrant workers and exercise their power to offer migrant workers the best quality of health care. The staff members also feel strongly about advocating the rights of migrant workers, expressing their strong beliefs about the population. The clinic allows patients to feel freedom: when the patients come to the clinic, they know their rights and beliefs are respected and no one will try to change them.

### **Comparison of Patient and Staff Responses**

This section answers Research question #3: Does cultural sensitivity mean the same thing to patients and staff? While there is no standard definition for cultural sensitivity, it is possible to determine where the similarities and differences are between patients and staff and providers. These results can be used to customize cultural sensitivity training by reinforcing the similarities and emphasizing the differences as points for greater understanding. The results are compared in this section.

Both staff members (43%) and patients (48%) agreed that language is an important factor in being culturally sensitive. More patients (62%) than staff (38%) considered personal attention to be an issue that affects whether or not patients keep coming to the clinic.

Patients named several other factors that keep them coming to the clinic, which staff members did not recognize as factors for what makes the clinic culturally sensitive. Patients said they want a solution to their problem. Not one staff member mentioned that as a value of being culturally sensitive. However, staff members (80%) did mention that the services that the clinic offers are what make the clinic culturally sensitive. The clinic services are in essence a solution to patients' problems. The presence of Hispanic

patients and staff was another reason that patients named as what they like about the clinic. Staff members did not recognize this as a component of cultural sensitivity.

### **Observations**

While it is imperative that individual staff members behave in a culturally competent manner, it is only a small component of achieving cultural competence. As cultural sensitivity was previously defined, it is “the extent to which a population’s cultural beliefs are incorporated in the design, delivery, and evaluation of targeted health interventions, including behavioral change materials and programs” [Renisow, et al 2002: 493]. As a participant observer, I worked as a health educator teaching diabetes and hypertension classes. I was able to experience the reality of the clinic day in and day out, observe problems with patients and how staff reacted to those problems, and observe how patients interacted with the staff. Participant observation conducted in the doctors’ offices, front desk area, and general clinic area sheds some light on the degree to which the clinic practices cultural sensitivity.

One obvious characteristic of the HC is that all medical assistants are fluent in Spanish. The presence of Spanish-speaking is ubiquitous in the clinic. One can turn a corner and hear employees speaking Spanish to each other and to patients. In the employee break room, the predominant language is Spanish. Beyond speaking Spanish, many of the medical assistants live in the HC community, and identify with many of the migrant patients. Some were raised as migrants themselves, and their parents worked in the fields until nighttime. Front office personnel have fostered personal relationships with the patients. They refer to patients as “*mija*”, which is a term of endearment in Spanish. According to one key informant who has close ties with the patients, “patients



call this place the Mexican clinic.” Before even entering the clinic, one sees members from the community standing outside selling traditional Mexican foods, such as tacos, burritos, and homemade ice cream. Outside, the parking lot is always full of cars. Patients sit outside waiting for their rides to pick them up. Inside, there are posters and signs written in Spanish so that all Spanish speaking patients can understand. Doctors’ offices and waiting rooms have Spanish magazines and other Spanish reading materials. There is a constant feeling of frenzy because there are so many patients and so little time to see them all. At any given time, the lobby is full of patients waiting to be seen by the doctor. Mothers are there with all their children, who are growing eager and anxious while they endure the long, sometimes all-day wait to be seen by the doctor.

### **Front desk-patient interactions**

Front desk personnel were formally observed on one busy Monday morning. There was a constant flow of patients. There were three staff members there, all who spoke Spanish fluently and were of Mexican descent. One worker had been there for only two months, the other for one year, and the other had been working at the clinic for five years. One of them confirmed that patients are never sent away. If they owe money, their record is highlighted and sent to the financial counselor, who then tries to qualify them for insurance, or classifies them on a pay scale and/or sets them up on a flexible payment plan. An American employee, who speaks Spanish, shouted from the back of the office, and asked what “bodega” meant. The front desk personnel offered two different meanings of the word, but the right meaning of the word was chosen based on the patient’s ethnicity. A patient came in because her doctor had sent her a letter, written in Spanish, but she needed someone to explain the letter to her. She was registered to see

a doctor in fast track to have the letter explained to her. It may have been that the woman was illiterate, or that she spoke little Spanish and spoke mostly an indigenous language from Mexico. A similar incident occurred during an interview with a patient. After the interview, the woman frantically asked me to interpret a letter, which was from her finance company. She also asked me for some advice, based on what the letter said. She told me about how hard it is to be poor and that no one understands.

### **Fast-track observations**

Structured observations took place over one week span, usually in the mornings. It was not possible to select patients who went through fast track according to language spoken. Rather, observations were conducted during a specific time, with all patients entering the office during that time. However, results will be reported on observations with Spanish speaking patients only. All medical assistants in the fast track area spoke Spanish fluently. The triage nurse, Graciela (a pseudonym), identified herself as Mexican. Her office is warm and friendly with depictions of her own cultural background. On the wall, there is a miniature Mexican house, an indigenous Mexican tapestry, a Mexican hat, and pictures of herself and her friends. She appeared to be very in tune with Mexican patients' cultural beliefs. While embracing the biomedical beliefs that she learned in nursing school, Graciela admittedly also encourages patients to take home remedies. Her job as triage nurse was to identify the problem, find out what treatment patients' are undergoing, and send them to the right place. After observing her office, it was obvious that this position requires someone like Graciela to effectively diagnose patients. One patient entered the office with extremely high blood pressure and insisted that it was because of the air conditioning. Although I did not hear Maria or the

doctor explain to the patient that it was not because of the air conditioning that she had high blood pressure, the patient was immediately sent to the hospital.

### **Provider observations**

All patients were asked permission to be observed. A total of four, out of seven, providers were observed either in their offices or in the fast track area. One provider spoke Spanish fluently and did not have an interpreter, while the remaining three providers did utilize interpreters. It was during their office visits that I was able to examine how the interpreters communicate information between the doctor and the provider. Two out of four medical assistants, who were all bilingual, reported that they had medical interpretation training. Structured observations with one medical assistant who had no medical interpretation training provided much evidence for why medical interpretation training should be mandatory for all medical assistants. During a visit with a patient, the patient talked mostly to the assistant, rather than the doctor. The assistant seemed to be the focus of the interaction, because the provider looked at the assistant during the visit. When the provider asked the patient a question, she looked at the assistant, rather than the patient. There was even a time that the assistant answered the patient's question herself, without translating the question to the doctor. The provider did not ask the assistant to translate the question either. Baker, Hayes & Fortier (2003) assert that when providers do not look at their patient, but rather at the interpreter, they are effectively decreasing the patients' sense of connection to the provider. For this reason, the HC should train providers on how to use their interpreters to effectively communicate and develop a relationship with their patients.

Another provider, who spoke little Spanish, showed her frustration with a patient who was labeled as “noncompliant”. The patient had returned from Mexico four months prior to the office visit and had run out of her diabetes medication three weeks ago. She also had not followed through with obtaining her insurance. She had problems with her feet, and needed to be referred to a podiatrist and cardiologist. The provider showed disapproval by throwing her hands up and shaking her head in disapproval. There was no apparent reaction from the patient; however that could have been because the patient was trying to be respectful of the provider.

During another provider’s office visits, he spoke to patients in very basic, simple elementary Spanish. Although there was a translator in the office, he spoke directly to the patient in Spanish, and understood the patient’s responses. The doctor and patient, who were laughing together, had a personable relationship. Another provider, who says “it’s more than just being Hispanic or knowing the language”, expressed his views on cultural competence when he stated that “Not all cultures are the same. I learn a new Mexican word every day.” He mentioned a “*sobadora*”, which is a person that massages, and said he has to “know his competitors” and know what other traditional treatments his patients are getting. This provider asked patients whether they prefer to speak Spanish or English. One patient complained of a “*mermada*”, a Mexican term for stuffy nose, and the doctor explained to her that she was having allergies. He used very simple terms, “*polvito verde*”, or green powder, to explain that pollen was causing her stuffy nose. He also let the patient know that medicines are cheaper at the clinic than anywhere else. This patient’s visit with the doctor lasted only five minutes. However, the visit seemed to have lasted longer because the doctor was constantly communicating with the patient,

even while examining her. During another patient's visit, the same provider used the word "animales" to explain to the patient that her results from the stool examination did not have parasites. He broke the explanation down into terms that the patient would understand.

## **Archival Data**

### **Administration Records**

The HC provides patients with a "Patient Satisfaction Survey". The survey is in English as well as Spanish. The survey asks patients to give a grade, from A = excellent, to F = poor, on four categories related to providers, cleanliness, registration, and access. Each survey asks four questions on one of the categories, and every month, a different category is surveyed with a minimum of one hundred patients. Some of the questions on the survey evaluate the willingness of the provider to answer patients' questions, how easy it was to make an appointment, and the condition of the waiting room. The patients also have a "comments" section where they can express their opinions. This survey is the clinic's way of assessing patients' needs and improving quality of care. According to the "2002 Patient Satisfaction Report Card," patients showed more than 90% satisfaction with all the categories in the survey. The biggest concern from the survey was patient waiting time, in which there is an 84% satisfaction rate. Unfortunately, the clinic did not analyze the results from this survey by language. There is no way of knowing what percentage of Spanish-speaking patients actually participated in the survey, and how they felt about each category.

In 2003, the HC conducted the Patient Satisfaction Survey with Spanish speaking patients. Employees asked a total of one hundred and eighty-five patients questions in a

face-to-face interview. The results from the HC survey were similar to the results obtained from the present study. A high percentage of patients (67%) showed overall satisfaction with various aspects of the clinic. Moreover, 97% of the Spanish-speaking patients surveyed felt that they understood what their physician explained regarding their health problem. Seventy-four percent said that they would return to the clinic and almost 100% said they would recommend the clinic to friends and family. In this report, the clinic recognizes the need to train the staff regarding low literacy Spanish speaking patients and proper interpretation. The report recommends the use of ad hoc interpreters, and emphasizes that “all health care organizations should assure that Spanish speaking patients have access to trained medical interpreters.” However, there is no evidence that the HC is making efforts to properly train their bilingual staff members on medical interpretation.

The HC publishes a newsletter that is circulated to all staff members at staff meetings every other month. I had access to two of the newsletters. Both of the newsletters consisted of information about staff birthdays, anniversaries, and other pertinent information helpful to employees. Regrettably, neither of the newsletters shared information on how to become more culturally sensitive, nor clues on raising awareness on patients’ cultures.

Another document, entitled “Health Care Plan Progress Report”, summarized the goals of the clinic, and the extent to which the goals were achieved in 2001-2002. The report highlighted areas that needed improvement, such as 1<sup>st</sup> trimester enrollment of pregnant women, and suggested ways to achieve the set goal. Some goals focused on segments of the clinic population, such as pediatrics and geriatrics. However, there was

no emphasis on setting goals for improving the health care of migrant workers or Hispanic patients specifically.

Administrative documents related to policy were reviewed in order to determine what policy-related steps the clinic is taking to be culturally sensitive. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) is the accrediting organization for all health care centers. The JCAHO manual discusses the issue of cultural sensitivity in one chapter. The chapter “Patient Rights and Organization Ethics”, standard RI.1.2.1. enforces that “patients’ cultural, psychosocial, spiritual, and personal values are respected.” The manual suggests an example that shows compliance with the standard is to “prepare printed materials that demonstrate sensitivity to the culture of these patient groups.” At the time of data collection, the HC was undergoing the reaccreditation process. It was not possible to obtain specific evidence of how the clinic intended to comply with this standard. However, in the section below, I discuss the results of the evaluation of the health education materials offered at the clinic.

### **Health Education Materials**

A total of twenty-two handouts or booklets written in Spanish were evaluated based on readability, quality, and presence of graphics. The SMOG readability formula was used to determine the reading level in which each health education material was written. The SMOG Readability Formula is a method used to determine the reading level of written materials. The formula includes counting sentences in the beginning of the material, ten sentences in the middle, and ten sentences near the end of the written material. In each group of sentences, one is to count every word that has three or more syllables. The total number of words with more than three syllables is counted and a

SMOG Conversion Table provides the reading level for the written material. As previously mentioned, this formula is used only as an estimate so that one can have an idea of the reading level at which the materials are written. The SMOG formula was developed for the English language. However, because there is no readability formula available for the Spanish language, the SMOG formula was used. Contreras et al (1999) found that SMOG can be used to assess readability in Spanish. Therefore, the SMOG formula was used as an estimate to get an idea of the readability of the handouts.

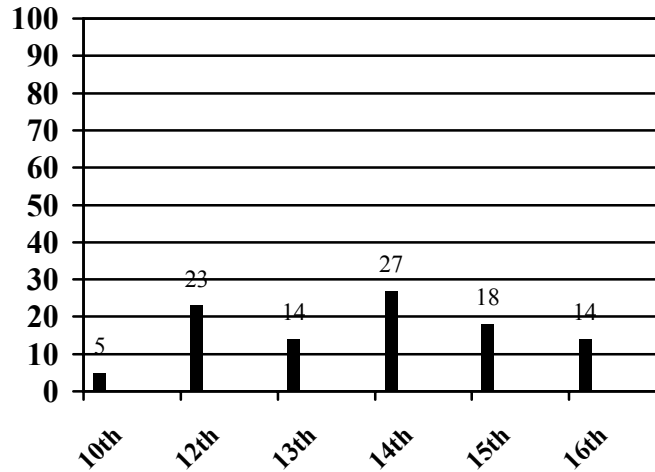
Most materials should have been written at most a 6<sup>th</sup> grade reading level, given that a large percentage of Spanish-speaking patients have low educational levels. However, with the exception of one handout written on a 10<sup>th</sup> grade level, all of the handouts surveyed were written in at least a 12<sup>th</sup> grade reading level. Some were actually written as high as a 16<sup>th</sup> grade reading level, which would require most people to have a dictionary to help them understand what they were reading. For example, one handout on Hyperthyroidism was written on a 13<sup>th</sup> grade reading level. The first two sentences read in Spanish: *“Exceso de actividad de la glándula tiroides, glándula endocrina que regula todas las funciones del cuerpo. El resultado es la superproducción de la hormona tiroidea”*. Translated in English, the text reads: *“Excessive activity of the thyroid gland, an endocrine gland that regulates all of the bodily functions. The result is the overproduction of the thyroid hormone”*. The handout included a picture of the throat area that was not labeled at all. A patient who has very limited reading ability and low educational level would more than likely not understand the concept that was explained in the first two sentences.



The quality of all the materials sampled was good, with the exception of one handout which was illegible. The quality of the handouts was determined by whether or not the text could be read. Fifteen out twenty-two (68%) of the handouts did not have any graphics on them. This is significant because pictures assist persons with low literacy to understand the material they are reading. Although it was hard to determine when each handout was published, the majority of them had been published more than five years ago. The clinic should make an effort to update the materials. Some pharmaceutical companies have made the effort to publish their health education materials in low literacy levels. Furthermore, there is a heightened awareness of the importance of literacy in the health field. Efforts should be taken to acquire new materials that are written in at least a 6<sup>th</sup> grade reading level, if not lower.

Although health literacy is also a major concern with the Hispanic population, it was beyond the scope of this study to determine the health literacy levels of the patients interviewed. It was evident, however, that patients with low health literacy would not be able to understand the materials that were sampled. For instance, according to Doak & Doak (2004), one of the “words to watch” when creating health education materials is oral, they suggest using by mouth instead. Just as an example, there were several of the handouts that used the term oral. Of all the patients that were surveyed, 77% felt that they understood the health education information that was given to them. Some of them added that it is because they are in Spanish that they understood them. However, these results are not consistent with the results from the evaluation of the handouts. See the table below for a summary of the results of evaluation of the health education materials.

**Figure 11: % Readability of Health Education Materials**



Based on the results of the interviews, participant observation, and analysis of archival data, a model of cultural sensitivity specifically for rural health centers with a large Hispanic patient population was developed (Figure 12).

**Figure 12: Model of Cultural Sensitivity for Rural Health Centers**

1. Mandatory Medical Interpretation Training
2. Properly translated health education materials at low literacy levels
3. Holistic health care, with all services offered in one location (medical, dental, acute care, OBGYN, laboratory, X-ray, referrals, health education, and outreach)
4. Transportation
5. Flexible clinic hours – open late and on Saturdays
6. Financial Assistance for patients
7. Regular cultural competence training
8. Culturally diverse staff and administration – representative of the community
9. Culturally appropriate messages available throughout the clinic
10. Participation in cultural competence research and dissemination
11. Constant assessment of patient satisfaction using qualitative methods such as face-to-face interviews and focus groups

## **Summary**

This chapter presented the results of the patient interviews, staff interviews, observations, and archival records. The results were discussed by answering the research questions that guided this inquiry. The conclusions for this project and recommendations for the clinic are offered in chapter five.

## **Chapter Five**

### **Conclusions and Recommendations**

#### **Introduction**

The following chapter presents the conclusions from this study, as well as the recommendations offered to the HC studied. The eleven recommendations are based on the patients' interviews, staff suggestions, and results from the study. In addition to conclusions and recommendations, this chapter also discusses the difference that anthropology made to this study, as well as the contributions that this study made to the fields of public health, anthropology, and applied anthropology.

#### **Conclusions**

There is not much anthropological literature available on the topic of cultural competence. Indeed, there is much that the area of anthropology can contribute to cultural competence. As an anthropological and public health contribution, this project aimed at advocating the patients' voice, and offers meaningful descriptions of what cultural sensitivity means to patients, providers, and health care agencies.

The purpose of this study was to explore the definition of cultural sensitivity from both the staff and the patients' perspective. The methodology used to complete this inquiry included open-ended semi-structured interviews, observations, and analysis of archival data. The review of literature discussed the cultural values among Hispanics and biomedical professionals. This study is distinct in that it takes into account the emic

perspective, which provides an insider's, or participant's, view of what is important in the health care situation.

The first research question that guided this study was "What does cultural sensitivity mean to patients?" Unlike the staff interviews, patients were not specifically asked whether or not they feel the clinic is culturally sensitive because of a lack of understanding and awareness of the term. The patient interviews aimed at determining a starting point for what Hispanic patients perceive to be qualities that a favorable rural health clinic should have. Essentially, the patient interviews gave the HC patients a voice. The attributes that Hispanic patients look for in a clinic are that they receive attention from staff, services in Spanish, financial assistance, a solution to their health problem, and Hispanics should be everywhere in the clinic. The majority of patients felt that the clinic does understand the Hispanic culture, mostly because the staff speaks Spanish and are Hispanic.

The second research question was "What does cultural sensitivity mean to HC staff? Although half of the respondents had not been trained in cultural competence, all of them defined cultural sensitivity as either using appropriate language, and knowing and understanding a person's culture.

The third research question was "Does cultural sensitivity mean different things to patients and staff? As previously stated, patients were not directly asked what cultural sensitivity means. However, based on the results of this study, it can be determined that at the HC, the patients and staff have a concordant view of favorable qualities that a rural health center that caters to a large percentage of Hispanics should have. Both groups

view language, attention, presence of Hispanics, and solution to health problems as factors of culturally sensitive health care.

Finally, the fourth research question aimed at determining “what makes a clinic culturally sensitive”. The evaluation of this project was determined using a combination of the two most widely cited cultural competence models, the Cultural Competence Continuum Model and the Cultural Development Model. The HC is in between the “cultural pre-competence” and “cultural competence” levels of the Cultural Competence Continuum, and the “cultural competence” level of the Cultural Development Model. Based on the staff interviews, it can be determined that a significantly high percentage (90%) of staff show acceptance and respect of patients’ health beliefs and practices. However, because, according to staff members, employees are not actively trained in cultural competence, the HC has not yet progressed into the “cultural competence” level. The final level, cultural proficiency, involves serving as role models and actively participating in cultural competence research and disseminating that information. It is at this level that the clinic should soon be in with a few improvements.

The literature suggests that some Hispanic cultural values that may be of importance in the medical encounter are *fatalismo*, *respeto*, *simpatía*, and *personalismo* (Flores 2000, National Council of La Raza 1998, and Zoucha 2000,). This study confirmed that these cultural concepts are indeed important to Hispanic patients, as evident in some of the staff’s responses to how they themselves are sensitive to Hispanic patients. Patients also named attention from staff as one of the reasons that made them feel comfortable when they came to the clinic, which is a value that research shows many Hispanics share (personalism).

A review of the literature also showed that some of the barriers to health care that affect migrant workers are language, affordability, and transportation (Betancourt et al. 2003, Carrasquillo et al. 1999, Chávez 1984, Morales et al. 1999, Napolitano & Goldberg 1998, National Center for Farmworker Health 2005, and Singleton 2002). Findings from this study serve as evidence that the patients at the rural health center, many of whom were migrants, believed that language, affordability, and transportation were some of the reasons that kept them coming to the clinic. Only three patients named transportation as a reason for why they like this clinic. Transportation is one of the main factors that makes HC a culturally sensitive clinic. The fact that patients have a reliable source of transportation, even though they may not have a vehicle, is outstanding. It is not possible to determine why such few patients discussed transportation during the interview. However, based on prior observations and staff responses to interviews, there could be a lack of communication to patients about the availability of transportation. Other reasons for why patients like the clinic include the existence of Hispanics in the clinic, and getting a solution to their problem.

If the mission of the HC is to provide culturally sensitive health care, they have accomplished their mission because a large percentage of the staff, mainly medical assistants, is Hispanic. Many of them live in the community and were raised in the culture that is similar to the patients' culture. Language is a key component of any culturally sensitive program. The HC has succeeded in making Spanish available throughout the clinic. However, it is not the only component of a cultural sensitivity model. There should be an equally strong emphasis on other components, such as

transportation availability, flexible clinic hours, and financial assistance, all of which the clinic succeeds in accomplishing.

Based on the evaluation of the administrative documents that were made available for this study, the HC does an excellent job assessing Hispanic patient satisfaction levels. The clinic should be commended for their diligence in maintaining the satisfaction of their patients. However, as the clinic itself recognizes, there is always room for improvement. The survey should continue to be utilized using face-to-face methods on a regular basis. Patients should be given a voice to express their feelings about the clinic, and their voices should be presented to employees during staff meetings as a way to reinforce and promote the idea of cultural sensitivity. While the clinic does recognize the need to train nursing staff to interpret properly, they should also be required to complete a formal medical interpretation class, in which they can receive a certification. Thereafter, the clinic should offer continuing education classes in medical interpretation and cultural sensitivity training either at the clinic or in other facilities.

The services that the HC offers are without a doubt an excellent example of how a rural health center should operate. The HC accomplishes many exemplary activities, and definitely serves as a model for other rural health centers to follow. While there are many models of cultural competency available, many of them are more abstract than practical, and are not specific to rural health centers that cater to a large Hispanic population. Based on this study, a model for cultural sensitivity in rural health centers with large Hispanic populations was developed. The model is shown in Figure 13.

A condensed version of this study will be provided to the HC. The written report will summarize the methods, results, and conclusions of this study. In addition,



recommendations will be provided in the condensed report, as well as an appendix that lists further resources in cultural competence.

The HC studied in this project offers the rest of the health care community much evidence on how to provide excellent health care in a culturally competent manner. The clinic is indeed a model for cultural competence, despite the few improvements that need to be made. The clinic should engage in sharing their experience with other clinics and health care agencies, as well as researchers, and be advocates for cultural competence and cultural sensitivity. The HC should be actively participating in the community, outside of the free health fairs that they offer. Indeed, the clinic needs to reinforce the idea of cultural competence and culturally sensitive health care as **necessary** and prove to the rest of the world that it **does** make a difference.

### **Anthropological Difference**

The discipline of anthropology enriched this study with qualitative methodology. Anthropological methodology, which included participant observation and open-ended interviews, introduced another dimension to evaluation of programs by presenting the emic perspective. Readers were able to understand the patients perspective of what they do and do not like about the clinic, as well as the staff member's own perspective of what their views are on cultural sensitivity. Through participant observation, I was better able to understand the intricacies of the clinic, such as patient-provider interactions and employee relations, and consequently situate the reader to give him/her the most accurate portrayal of what goes on in a rural health center. Working at the clinic allowed me to understand the perspective of being a staff member at the HC, as well as gain an entrée to the world of patients.

Because they are culturally relative, anthropologists who work in the health care industry play an important role in advocating for cultural competence and cultural sensitivity. They can encourage health care providers, who have a tendency to stay focused on the medical issues surrounding health problems, to also focus on other sociocultural issues surrounding the problem, such as a patient's cultural values. Anthropologists can assist health care providers to assess patients' worldviews, engage in a more ethnographic approach during the patient/provider interaction, and evaluate their own biases. This will prevent health care providers from using stereotypes to guide their knowledge of culture.

### **Contributions to Anthropology**

This study contributes to general anthropological research in several ways. The field of anthropology, which is the study of cultures, suggests that there are certain cultural values that some Hispanics share, such as personalismo, familismo, and respeto. Results from this study confirmed that some Hispanics still share those values. A confirmation that anthropological methods are an excellent way to explore human problems from the holistic perspective is another contribution made to anthropology. This study also advanced general anthropological research on the topic of cultural sensitivity because there is little information available in the anthropological literature about cultural competence and cultural sensitivity. The idea that culture has a very strong impact on health is also reinforced from the project findings.

Another anthropological core value, cultural relativity, was reinforced and utilized throughout the internship and thesis. Unless health care providers are underlying cultural sensitivity, they will not be able to provide the best health care that patients deserve. At

the same time, this study confirmed that culture is important in any human relationship, including the relationship between patient, provider, and health care agency.

### **Contributions to Applied Anthropology**

Applied anthropology, which has often been called the fifth subdiscipline, bridges theory and practice (Ervin 2000). If the goal of applied anthropology is to focus on policy and practice, this study has indeed made several contributions to applied anthropology. For instance, this study put into practice many of the anthropological methods, such as participant observation, unstructured interviews, and analysis of archival data to reinforce that qualitative methods are indeed ideal for research on social issues. Furthermore, this study focused on making improvements in the clinic's policy as it relates to cultural competence/cultural sensitivity. In addition, this study also emphasizes the emic perspective of both providers and patients. The common anthropological terms and methods, such as ethnocentrism, holism, culture, cultural relativity, and participant observation were applied in the field and put into practice. This study shows that applied anthropology is a subdiscipline that is necessary in order to truly represent and advocate for the human condition. Furthermore, the goal of the project went beyond merely interpreting what cultural competence/cultural sensitivity should be, to defining what it actually means to those who function in the health care industry: the patients, the providers, and the health care agency. From the results of this study, the contribution to applied anthropology also includes a model of cultural sensitivity that other clinics can utilize. Finally, this project has contributed many valuable lessons to other applied anthropologists working in the field of public health, who are engaged in the evaluation of a health care organization, especially in the area of cultural competence.

## **Contributions to Public Health**

This study made several contributions to public health by underscoring the value and necessity of cultural competence, which is a well known concept in public health. This study confirmed the relevance of cultural competence and reinforced the need for culturally competent health care in order to decrease the health care disparities gap, which is the goal of Healthy People 2010. The problem of low health literacy is also well known. Archival analysis examined the readability level of a small sample of health education materials and showed that a significantly high percentage of the educational handouts given to patients is written above the twelfth grade reading level. The findings confirm that this is still a problem and at the same time highlights the need for public health practitioners to continue scrutinizing health education materials and questioning the quality of educational handouts.

Another major contribution to public health is the emphasis that this study placed on cultural values. Public health, in particular, health education, has previously been criticized for “blaming the victim” (McLeroy et al. 1993). Many of the theories that guide public health education presuppose that individuals are responsible for their illness. For instance, the Health Belief Model, which is a widely used theory in health education, is based on the assumptions that the individual must believe that his/her health is in jeopardy, perceive the symptoms of that illness, and believe that the benefits of changing his/her behavior outweigh the barriers of the illness (Rosenstock 1974). This theory fails to consider other factors that may influence the individual’s behavior, such as cultural environment, as well as the policy and political environment. Directly related to the “blaming the victim” issue is the issue of changing an individual’s behavior “rather than

changing the environment that supports and maintains unhealthy lifestyles” (McLeroy et al. 1993). This study challenges the tendency towards “blaming the victim” by focusing on patients’ and staff’s perspective and the cultural dynamics associated with their situation, as well as policy analysis and provides a deeper understanding of the interrelationships in improving health outcomes.

Finally, this study contributed to the field of public health education by showing how an evaluation of a rural health center should take place. One of the responsibilities of a public health educator is to evaluate the effectiveness of the health education program. Publishing the evaluation results serve as a way of improving the health education field by disseminating the successes and failures, and making future recommendations to other health care professionals (Cotrell et al. 1999). This study emphasizes the use of qualitative methods to give the health care recipients a voice in the health care organization. In addition, cultural competence is an issue that exists throughout all public health settings, and should be emphasized in all public health programs. Finally, public health professionals can use the research design of this project to conduct their own organization’s evaluation of cultural competence, and either apply the Model of Cultural Sensitivity for Rural Centers (Figure 13) or develop their own model of cultural sensitivity.

## **Recommendations**

The following recommendations for the clinic are based on results from the data collection, as well as recommendations from the patients and staff.

1. The first and foremost important recommendation for this clinic is to form a cultural sensitivity/competence committee. The committee should be composed of members from the patient population, the community itself, the staff, providers, and administration. Once the committee is established, the following recommendations can take place. There are many resources available, as seen in Appendix G, which can assist the committee in undertaking the major efforts of enforcing and reinforcing cultural sensitivity and cultural competence at the HC.
2. Assess the cultural competence level of all staff members, providers, and administrators as a starting point for cultural competence training. Based on the study results, cultural competence training should emphasize that equal treatment does not mean cultural sensitivity.
3. Conduct ongoing cultural competence training on a regular basis, such as during staff meetings and in the newsletter. Cultural sensitivity should be reinforced constantly. Training can include role modeling, problem solving, and case studies, and basically any type of educational strategy that actively engages the person, rather than listening to a lecture.
4. Make transportation services more available to patients by placing signs throughout the building, or asking providers to let their patients know about it. If the clinic has logistical problems of not having enough drivers, then the clinic

should consider finding a way to hire more drivers to make the services more available to patients.

5. Offer mandatory medical interpretation training to all medical assistants and front desk personnel. There are agencies, such as AHEC (Area Health Education Center) that offer medical interpretation training at affordable rates for community health centers.
6. Decrease the long wait time. While the problem of a long wait is well known at the clinic, it is a major barrier to patients who do not have the time to spend away from work at the clinic. Efforts should be made to address the barrier, by increasing funding, hiring more doctors, or developing an alternative system of intake for fast-track patients. For instance, some patients suggested that it would be helpful to them if they were given an approximate wait time so that they could leave the clinic and either eat or run errands, and return at the suggested time.
7. The clinic's hours of operation should include Saturdays to accommodate the schedules of migrant workers, who tend to work long days.
8. Members from the community should be hired to work in administration, as well as the board of trustees to give the patients a voice in the decision-making process of the HC.
9. Efforts should be made to obtain up-to-date health education materials that are written at low literacy levels, and properly translated into Spanish, as well as representative of the Hispanic culture. There are many agencies and websites that offer health education materials at inexpensive, if not free, rates to community health centers. There are many websites listed on Appendix G that offer

appropriate health education materials. If there are certain materials that can not be found in Spanish, the clinic should make an effort to translate the health education information into Spanish, and consider making the handouts available to other clinics.

10. The clinic should continue to conduct Patient Satisfaction Surveys and use the results in an action plan for cultural competency.
11. The clinic should seek a grant to establish itself as a model center for cultural competency. Not only will others be able to learn first hand how cultural competence works in a clinic, but it provides the clinic with more ways to obtain funding resources.
12. The committee should publish the results from cultural competence evaluations so that other health care organizations can learn from their experience in cultural sensitivity and cultural competence.

### **Summary**

In summary, this chapter presented the conclusions of a study that aimed at defining cultural sensitivity in a rural health center from the perspective of the patient, staff, and provider. The conclusions were based on the literature review described in Chapter Two and the findings presented in Chapter Four. In addition, recommendations for improving the HC were given, based on the results of the evaluation.



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## **Appendix A: Patient Oral Consent Guide - English**

Hi, my name is Nadine and I'm doing a research project for my school, the University of South Florida. I would like to ask you some questions while you wait for the doctor about what you think of the HC.

I'm not going to use your name. Nothing you say will affect the care that you get here at [the] . Your decision to participate in this research study is completely voluntary. You are free to participate in this research study or to withdraw at any time.

You can stop answering the questions when you want.

If you have any questions about this project, I can give you the phone number of my teacher at the University. Do you want her phone number?

Will you help me by answering some questions?

## **Appendix B: Patient Oral Consent Guide – Spanish**

Hola mi nombre es Nadine y estoy llevando a cabo un proyecto para mi escuela, la Universidad del Sur de la Florida. Me gustaria hacerle preguntas mientras espera al doctor. Yo quiero entender como los pacientes de HC se sienten con la a de HC.

Yo no voy a usar su nombre ni le voy a decir a nadie lo que usted me dice. Nada de lo que usted me diga afectará el cuidado de salud que usted recibe. Su decisión en participar en este estudio es voluntaria. Usted esta libre de participar en este estudio o de retirarse del estudio en cualquier momento.

Usted se puede negar a contestar cualquiera pregunta que no quiera contestar.

Si usted tiene preguntas sobre este proyecto, le puedo dar el numero de telefono de mi profesora en la Universidad. Quiere ese numero de telefono?

Me puede ayudar a contestar unas preguntas?



## Appendix C: Patient Interview Questions - English

Hello. My name is Nadine and I'm a health educator here at the HC. Right now I'm working on a project for the HC and the university. We want to find out how our patients feel about the HC. Do you have some time to answer a few of my questions? Your opinions are very important to us to assure that we are giving you the best quality of services that you deserve and that you should be receiving.

1. What languages do you speak?
2. How old are you?
3. What is your nationality?
4. What health insurance do you have?
5. How long have you been coming to the HC?
6. What services do you use here at the clinic? (ie – mental health, dental, medical, lab, x-ray, referrals, health education, obgyn, pediatrics, transportation, pharmacy)
7. In what ways does the clinic make you feel good when you are here? (probes – environment & surroundings, staff, doctors, assistants)
8. How do you feel about the written information that the doctors and nurses give you sometimes? (probes – understand the materials, helpful)
9. Have you or your family ever experienced difficulty getting health care here at the ? (probe – b/c of \$, transportation, language)
10. How do you think that other patients feel about the HC?
11. How is your communication between yourself and the doctor? (probe – language, etc)
12. How is your communication between yourself and the medical assistants? (probe – language)
13. How is your communication between yourself and the front desk personnel? (probe – language)
14. What are some things that you like and don't like about HC?
15. What are some things that you think we need to improve?

**Appendix C: (Continued)**

16. What are some of the reasons that make you think that the HC understands or doesn't understand your customs as a hispanic person?

## Appendix D: Patient Interview Questions - Spanish

Hola. Mi nombre es Nadine y yo soy una educadora de salud aqui en la a y tambien una estudiante de la Universidad del Sur de la Florida. Ahora estoy trabajando en un proyecto para la a, y la Universidad. Nosotros queremos saber como la a lo trata a usted. Tiene usted tiempo para contestar unas preguntas? Sus opiniones son muy importante para nosotros, para segurar que estamos dando la mayor calidad de servicios que merece y que debe de estar recibiendo.

1. Que idioma habla usted?
2. Cuantos años tiene usted?
3. De que pais es usted?
4. Que clase de seguro medico tiene usted?
5. Cuanto tiempo hace que usted viene a la a?
6. Cuales son los servicios que usted usa aqui en la a. Por ejemplo – el dentista, medico, laboratorio, referidos, educacion de salud, la partera, pediastra, transportacion, farmacia, o psicologo)
7. En que manera la a de HC le hace sentir bien cuando usted esta aqui? (el ambiente, los doctores, asistentes, o la gente en general)
8. Como se siente con la informacion sobre salud que le dan los doctores y las enfermeras de vez en cuando? Por ejemplo, pamphletos, papelitos) (probe – understand the materials, helpful)
9. Usted o su familia ha tenido problemas recibiendo atencion medica aqui en la a? (probe – porque no tienen dinero, transportacion, o idioma)
10. Como piensa usted que los otros pacientes se siente con la a de HC?
11. Como esta la comunicacion entre usted y su doctor? (probe – lenguaje)
12. Como esta la comunicacion entre usted y las asistentas medicas? (probe – lenguaje)
13. Como esta la comunicacion entre usted y las trabajadoras de la ventanilla?
14. Cuales son las cosas que a usted le gustan y no le gustan de la a en HC?

**Appendix D: (Continued)**

15. Cuales son las cosas que usted cree que se deben mejorar en la a en HC?
16. Cuales son las razones que le hacen pensar que la a de HC conoce o no conoce sus costumbres como persona hispana?

## **Appendix E: Staff/Provider Interview Questions**

1. Please tell me about what your job here at the HC.
2. How long have you been working at this clinic?
3. Please tell me about your cultural or ethnic background.
4. How would you define cultural sensitivity?
5. How is it relevant to the clinic (or why do you think HC should or should not be culturally sensitive)?
6. What kind of training have you had in being culturally sensitive?
7. How often do you receive training?
8. In what ways do you practice cultural sensitivity?
9. In what ways do you think that HC does or does not practice cultural sensitivity?
10. In what ways do you think that culturally sensitive health care affects health?
11. How would you measure the impact of cultural sensitivity on health outcomes?
12. In what ways do you think HC tries to overcome patients' barriers to health care?
13. Are there barriers that keep HC from being culturally sensitive? If so, what are they?
14. What ideas do you have for how the HC can become more culturally competent?
15. What kind of changes should be made in the health care system to better meet the needs of migrant workers?

## **Appendix F: Recommended Standards for Culturally and Linguistically Appropriate Health Care Services**

Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these proposed standards were developed with input from a national advisory committee of policymakers, providers, and researchers. In the [full report], each standard is accompanied by commentary that addresses its relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

### Preamble:

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, and training and, as appropriate, treatment planning.
4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, al, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, al, and support staff in culturally and linguistically competent service delivery.
6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to al or non-al encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

## Appendix F: (Continued)

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and al outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

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## Appendix G: Cultural Competence Resources

The Center for Cross Cultural Health

[www.crosshealth.com](http://www.crosshealth.com)

The Cross Cultural Health Care Program

[www.xculture.org](http://www.xculture.org)

[www.diversityrx.org](http://www.diversityrx.org) – A website sponsored by The National Conference of State Legislatures, Resources for Cross Cultural Health Care, and the Henry J. Kaiser Family Foundation of Menlo Park, CA.

A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials

[http://gucchd.georgetown.edu/nccc/documents/Materials\\_Guide.pdf](http://gucchd.georgetown.edu/nccc/documents/Materials_Guide.pdf)

The Henry J. Kaiser Family Foundation

Compendium of Cultural Competence Initiatives in Health Care

<http://www.kff.org/uninsured/6067-index.cfm>

Migrant Clinician Network

[www.migrantian.org](http://www.migrantian.org)

National Alliance for Hispanic Health

[www.hispanichealth.org](http://www.hispanichealth.org)

National Association of Community Health Centers

[www.nachc.com](http://www.nachc.com)

National Center for Cultural Competence

<http://gucchd.georgetown.edu/nccc/>

National Center for Farmworker Health

Has bilingual teaching materials

[www.ncfh.org](http://www.ncfh.org)

Pfizer Principles for Clear Health Communication: A Handbook for Creating Patient Education Materials That Enhance Understanding and Promote Health Outcomes

[http://www.pfizerhealthliteracy.com/pdfs/Pfizers\\_Principles\\_for\\_Clear\\_Health\\_Communication.pdf](http://www.pfizerhealthliteracy.com/pdfs/Pfizers_Principles_for_Clear_Health_Communication.pdf)

US Department of Health and Human Services

Office of Minority Health

<http://www.omhHC.gov/clas/index.htm>



**Appendix G: (Continued)**

University of Washington  
Harborview Medical Center  
[www.ethnomed.org](http://www.ethnomed.org)