AN EXAMINATION OF CULTURAL AND LINGUISTIC

COMPETENCE IN HEALTH CARE

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AN EXAMINATION OF CULTURAL AND LINGUISTIC COMPETENCE IN HEALTH CARE

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AN EXAMINATION OF CULTURAL AND LINGUISTIC

COMPETENCE IN HEALTH CARE

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DISSERTATION ABSTRACT

AN EXAMINATION OF CULTURAL AND LINGUISTIC

COMPETENCE IN HEALTH CARE

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The increasing number of foreign-born persons in the United States is creating significant cultural and linguistic challenges for health care providers. The Department of Health and Human Services, Office of Minority Health (OMH) has issued standards to guide hospitals in the provision of culturally and linguistically appropriate care to all patients. This research used a combination of mail and Internet surveys to examine whether Alabama's 101 general medical and surgical hospitals are meeting these standards. The surveys were directed to Chief Executive Officers (CEOs), Human Resource Directors (HRDs), and Registered Nurses (RNs).

The findings indicate that health care providers do believe that the increasing foreign-born population will pose future cultural and linguistic challenges for their hospitals and the overwhelming majority has witnessed an increase in the number of non-English speaking patients. HRDs indicated that their hospitals are actively recruiting persons from diverse cultural, religious, and linguistic backgrounds, yet the distribution of their hospitals' workforce by race indicates that hospitals are having difficulty finding qualified candidates from races other than White, non-Hispanic and Black or African American.

A greater percentage of CEOs and RNs indicated that their hospitals do have trained interpreters on staff; however, an overwhelming majority of RNs indicated that interpreters are not available on all shifts and they have not been trained on how to effectively use interpreters. Hospitals are having difficulty finding trained interpreters in their area and often rely on non-English speaking patients to bring a family member or friends to help translate, a practice discouraged by OMH and most research on competent care. In addition, a greater percentage of RNs agreed that they prefer to care for a patient that is of the same culture and speaks the same language because it is easier.

While some of the OMH standards are being met, many are not, and policies and procedures described by CEOs are often contrary to the perceptions of those held by the RNs, suggesting miscommunication. Overall, Alabama general medical and surgical hospitals appear to be taking the initial steps to prepare for the diversifying patient population. All respondents indicate a willingness to become more culturally and linguistically competent, but a great deal needs to be accomplished before Alabama hospitals meet the OMH standards.

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CHAPTER I

AN EXAMINATION OF CULTURAL AND LINGUISTIC COMPETENCE IN HEALTH CARE: AN INTRODUCTION AND RESEARCH OBJECTIVES

Statement of the Problem

The American health care system is currently faced with a myriad of challenges. Functionally fragmented, our health care system remains unstandardized, uncoordinated, and inclined to disparities. Due to the variety of financing, insurance, delivery, and payment mechanisms, the process is often complex, inconsistent, and inefficient (Shi & Singh, 2004). The struggle to address the unrelenting concerns of cost, access, and quality is magnified as operating costs increase, reimbursement decreases, and patients demand the latest and the best in medical care. In addition, the growing number of uninsured and underserved populations has posed significant financial and ethical challenges in health care delivery.

A far greater challenge to our nation's health care system, however, is quietly emerging. Since the 1990s, the U.S. has witnessed increasing numbers in documented and undocumented immigrants. Between 1990 and 2000, the foreign-born[1] population increased from 19.8 million, or 7.9% of the population to 31.1 million, or 11.1% of the population (U.S. Census Bureau, 2003b). In 2004, the foreign-born population swelled to

[1] Foreign-born, as defined by the U.S. Census Bureau, relates to a person currently living in the U.S., either documented or undocumented, who was not a U.S. citizen at birth (U.S. Census Bureau, 2003b).

an estimated 34.2 million, representing 12% of the nation's total population (U.S. Census Bureau, 2005a). Over one-half of this segment of the population are from Latin America (53.0%) and 25.0% are from Asia (U.S. Census Bureau, 2005a). More than 80% are between the ages of 18 and 64 (U.S. Census Bureau, 2004a).

In 2000, nearly 12 million people were said to be linguistically isolated or Limited English Proficiency (LEP)[2], up from 7.7 million in 1990 (U.S. Census Bureau, 2003a). In addition, 47.0 million people speak a language other than English in their homes (U.S. Census Bureau, 2003a). This rising number of foreign-born is reintroducing a diversity of cultures and languages, comparable only to the nation's immigration peak between 1880 and 1914, that fundamentally challenges Western medicine. How to provide access and maintain the efficacy of health care for this specific segment of the population will represent one of the industry's important tasks in the years to come.

The United States has long been regarded as the world's melting pot. The world's third most populated country, the U.S. boasts the single most culturally diverse populace. Historically, the foreign-born population tended to settle in largely diverse areas such as California, New York, Texas, and Florida. Although these states still have the highest percentages of foreign-born, states that were previously impervious to a diverse population are suddenly being introduced to new cultures and languages (U.S. Census Bureau, 2003b). These states include much of the South:

> Across a broad swath of the region stretching westward from North Carolina on the Atlantic seaboard to Arkansas across the Mississippi River and south to Alabama on the Gulf of Mexico, sizeable Hispanic populations have emerged

[2] LEP refers to "persons who, as a result of national origin, are limited in their English proficiency" (U.S. Department of Justice Online, 2001).

> suddenly in communities where Latinos were a sparse presence just a decade or two ago. (Kochhar, Suro, & Tafoya, 2005, p. i)

The southern region of the country has witnessed an increase in the number of foreign-born (not just Hispanics). In 2003, the U.S. Census Bureau (2004a) found that 29.2 percent of the foreign-born population lived in the South, second only to the West with 37.3 percent.

In Alabama, specifically, the recent shifting migration patterns and the increase in the foreign-born population have altered the state's demographics, introducing new cultures and languages to the traditionally biracial state. The foreign-born population has more than doubled over the last 15 years. In 1990, the foreign-born numbered nearly 44,000 and over 107,000 residents spoke a language other than English at home (U.S Census Bureau American FactFinder, n.d.). Today, Michael Ciamarra (2005), Vice President of the Alabama Policy Institute, a non-profit research and educational organization that describes itself as dedicated to providing objective analysis of key policy issues and influencing public policy, estimates the foreign-born population to be over 118,000. The 2004 U.S. Census Bureau (2005b) State and County QuickFacts estimates that nearly 177,000 Alabama residents speak a language other than English at home. Ciamarra (2005) argues that "while Alabama is not yet experiencing the severe growth problems that have plagued neighboring states, demographic indicators show that the state is headed in that direction" (para. 19).

As the foreign-born population continues to increase nationwide, Alabama accordingly will continue to experience a rapid diversification of its population. This influx of different cultures and languages may pose a problem for the state's health care

providers if they are not adequately prepared to handle issues or situations that may be culturally sensitive.

Recent literature discusses the need for health care professionals to be culturally and linguistically competent in order to ensure proper care (Leininger, 1995; Spector, 2004b; Purnell & Paulanka, 2003; Andrews & Boyle, 2003; Betancourt, Green, Carrillo, & Park, 2005; Giger & Davidhizar, 2004; Luckmann, 1999; Kao, Hsu, & Clark, 2004). A number of studies conclude that language barriers and cultural differences result in misunderstandings, incorrect diagnosis, a higher number of tests performed, lack of informed consent, failure to comply with physician directives, and malpractice suits (Hampers, Cha, Gutglass, Krug, & Binns, 1999; Chin, Cook, Jin, Drum, Harrison, Koppert, Thiel, Harrand, Schaefer, Takashima, & Chiu, 2001; Baker & Parker, 1996; Baker, Hayes, & Fortier, 1998; Carrasquillo, Orav, Brennan, & Burstin, 1999; Ku & Flores, 2005; Ferguson & Candib, 2002). The foreign born commonly bring diseases that are endemic to their native countries. They also acquire new diseases as a result of the changes in environment and are more vulnerable to acculturation-related stress. These individuals generally have different beliefs about health and medical practices and may have little to no exposure or understanding of Western medicine. “Today, more than ever, transcultural knowledge is critical to meeting health needs by understanding the cultural beliefs, values, and norms of individuals and groups” (Leininger, 1995, p. xi). Cultural and linguistic competence in health care is necessary to lessen the disparities in access to care and provide quality-based care in a more cost-effective manner.

This study examined the level of cultural and linguistic competence in Alabama hospitals. The findings of this study tested the application of the Department of Health

and Human Services Office of Minority Health's (OMH) National Standards for Culturally and Linguistically Appropriate Services in Health Care in Alabama hospitals. Executive Order 13166 Limited English Proficiency (LEP) signed by President Clinton in 2000, requires all agencies and organizations that receive federal monies to ensure that the growing number of individuals who are not proficient in the English language be provided with meaningful access to their proficient language. The standards developed by OMH are intended to guide health care providers in preparing for, and responding to, culturally and linguistically sensitive situations (U.S. Dept. of Justice, 2001; HHS-OMH, 2001a). Questionnaires were developed based on OMH's 14 standards to determine the level of compliance. Dillman's (2000) multiple contact strategy was used to contact respondents multiple times in order to increase participation. The follow-up reminders were sent by mail in the form of postcards.

Health care providers' level of compliance with the national standards has received little attention in the fields of health care administration and public administration. An analysis of the current level of cultural and linguistic competence in Alabama hospitals provides the opportunity to broaden our knowledge of the subject and identify areas that are in need of improvement. The findings of this study, therefore, will contribute significantly to the knowledge base of both fields and may encourage further research in the area.

Overview of Subject

American, or Western medicine, is governed by the medical model. This model emerged from America's belief in the advancement of science and the applicability of the

scientific method to the study of medicine. The medical model assumes the existence of illness or disease and charges the practice of medicine with the task of treating symptoms. It, therefore, defines health as the absence of illness or disease. The model positions the role of the physician at the center of patient care, believing that the patient should essentially put his or her life in the hands of their physician who knows best how to care for them (Shi & Singh, 2004). What happens, however, when the physician cannot communicate with the patient to learn what his or her symptoms are? How does the physician then obtain informed consent to conduct testing to determine what the problem is and subsequently carry out the necessary treatment? How will treatment options be communicated to the patient? What if the patient's cultural practices and beliefs are inconsistent with the treatment rendered and instructions for post-operative care are not followed?

Recent literature related to the proper treatment of foreign-born patients stresses the need for health care professionals' awareness and understanding of different cultures. The U.S. Department of Health and Human Services Office of Minority Health (OMH) notes the importance of the role that culture plays in how a patient "defines health, wellness, illness, youth and old age" (HHS-OMH, 2001a). Individuals adopt health practices and illness prevention beliefs from their culture. Cultural beliefs and practices have a significant impact on an individual's measure of well-being, his or her understanding of certain illnesses, his or her decision regarding types of treatment, his or her expectations on how they should be treated by others, and his or her comfort level when interacting with health care professionals that are not of the same gender, race, ethnicity, or age. Culture can also have an impact on how an individual's visit with a

physician or health care professional is perceived. A physician's mannerism can imply different things to different cultures. Some cultures prefer a physician who smiles, converses informally with the patient, and always prescribes medication. Others prefer that a physician maintain a stern, but professional demeanor during their visit and prescribe lifestyle or nutritional changes rather than medication. Cultural awareness and knowledge, therefore, are necessary for health care providers to offer greater accessibility, obtain proper informed consent, improve cooperation in treatment, and ensure confidentiality.

There is, however, widespread misunderstanding regarding culture and what the term actually means. Several authors have offered a definition for culture as it relates to health care. Kao, Hsu, and Clark (2004) argue that there are various ways of defining culture. Each discipline has chosen to define it for its own purpose. In the field of health care, culture has generally been conceptualized in a "simplistic and inadequate" manner (p. 269). The authors state that the concept of culture is often applied to certain population groups rather than to racial or ethnic typologies. Leininger (1995), a pioneer in the subfield of transcultural nursing, offers a definition of culture from a nursing anthropologist's perspective stating it is "the learned and shared beliefs, values, and life ways of a designated or particular group which are generally transmitted intergenerationally and influence one's thinking and action modes" (p. 9). In contrast, Lenburg, Lipson, Demi, Blaney, Stern, Schultz, and Gage (1995) provide a definition of culture that conceptualizes it as a dynamic process, one that adapts to an individual's changing environment. Luckmann (1999) also believes that culture is constantly evolving. She argues that culture shapes an individual's world view and "provides each

person with specific rules for dealing with the universal events of life – birth, mating, child-rearing, illness, pain, and death" (p. 22). Kao, Hsu, and Clark (2004) conclude that however culture is defined, one must be wary not to broaden the term too widely. By combining variables such as race, ethnicity, nationality, language, geographic location, values, beliefs, and practices under the guise of culture, its meaning essentially becomes nonspecific.

The concept of communication and its importance in health care is also often misunderstood and greatly understated. Title VI of the Civil Rights Act of 1964 states that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financing assistance" (U.S. Dept. of Justice Online, 2000). Until recently, the terms of this law with regard to the health care industry's responsibility to provide interpretive services remained vague. In 2000, President Clinton signed Executive Order 13166 Limited English Proficiency mandating all agencies and organizations that receive federal monies ensure that the growing number of individuals who are not proficient in the English language be provided with meaningful access to their proficient language (U.S. Dept. of Justice Online, 2001). The HHS Office of Minority Health quickly thereafter developed the first comprehensive nationally recognized standards to guide health care providers in preparing for, and responding to, culturally and linguistically sensitive situations. These standards include provisions detailing how health care providers are to achieve linguistic competency, stating that they must provide language assistance services in the form of bilingual staff or interpreters and make essential written material available in the patient's

preferred language (OMH, 2001b). Several states have followed suit requiring subcontractors such as managed care organizations that administer the Medicaid program to encourage cultural and linguistic competence among providers (Vandervort & Melkus, 2003). The terms for health care providers receiving Medicare and Medicaid monies are now clear and pressures to comply are quickly mounting as the number of limited English proficient patients is increasing.

Today, linguistic competency is not only mandated by the Federal government, but also by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA). JCAHO has issued a number of standards to ensure that treatment is provided in a manner that is conducive to a patient's culture and linguistic orientation maintaining that this is "an important quality and safety issue and a key element in individual-centered care" (JCAHO, 2005). The NCQA states in its 2001 Managed Behavioral Healthcare Organization (MBHO) Surveyor Guidelines that MBHO's should pay particular attention to the "fit" of the service, or the person who is providing the service, with the particular enrollee. It identifies linguistic competency as one of the areas that is still in need of improvement stating that organizations should work to expand "the provider networks to serve enrollees who have linguistic and cultural needs and preferences" (NCQA, 2001). Professional associations such as the American Nurses Association (ANA) and the American Medical Association (AMA) have also adopted standards and urge their members to increase cultural and linguistic competence for the purposes of eliminating the growing disparities in health care (ANA, 1991; AMA, 2005a).

The importance of verbal communication in a situation involving a person's health and well-being cannot be overemphasized. Language barriers can have profound negative consequences. Luckmann (1999) states that "language is the primary means used by humans to communicate with each other …. Humans use language to express ideas, feelings, and emotions; to communicate information, reactions, and directions to each other; and to negotiate with each other" (p. 13). Although individuals can use nonverbal forms of communication, such as pointing to the area that is ailing them, or demonstrating a symptom, it is often confusing and frustrating for the patient and the health care provider when the problem cannot be explained with the use of verbal communication.

Spector (2004b) states "language differences are possibly the most important obstacle to providing multicultural health care because they affect all stages of the patient-caregiver relationship" (p. 23). Language barriers have commonly been associated with limited accessibility, incorrect diagnoses, uninformed consent, excessive testing, improper patient education, failure to comply with physician directives or appear for a follow-up visit, poor patient satisfaction, and even malpractice lawsuits (Hampers et al., 1999; Chin et al., 2001; Baker et al., 1996; Carrasquillo et al., 1999; Ku & Flores, 2005). Ferguson and Candib (2002), in a review of doctor-patient communication and relationship, found that differences in race, ethnicity, and language adversely affect the quality of communication and the relationship between physician and patient. The authors conclude that:

> minority patients, especially those not proficient in English, are less likely to engender empathic responses from physicians, less likely to establish rapport with

> physicians, less likely to receive sufficient information, and less likely to be encouraged to participate in medical decision making. (p. 359)

Furthermore, the nurse-patient relationship is also vulnerable to the negative effects of language barriers. Andrews and Boyle (2003) add that an estimated "90% of all difficulties in nurse-client interactions have resulted from miscommunication" (p. 22).

Communication, however, is similar to culture in that it is a broad concept. Language, although the primary means of communication, is not the only method of communicating. Nonverbal communication can also determine how effectively information is transmitted. For example, "Experts estimate that as much as two-thirds of all communication is nonverbal, consisting of messages that are conveyed from one person to another via body language and facial expressions" (Luckmann, 1999, 57). Forms of nonverbal communication include facial expressions, gestures, eye contact, space, silence, touch, posture, and physical setting (Luckmann, 1999; Andrews & Boyle, 2003; Spector, 2004b; Giger & Davidhizar, 2004). In an article discussing the component of touch when providing treatment to a person of a different culture, Davidhizar and Giger (1997) note that although touch is almost unavoidable when providing medical care, it is important that health care providers learn the norms and taboos related to space and touch among cultures. For example, persons from England, Canada, and Germany generally do not like their personal space to be infringed upon. In contrast, Italian, Spanish, Latin, South American, and Jewish cultures tend to be much more comfortable with the concept of touch. By familiarizing themselves with the various components of nonverbal communication and how they differ among cultures, health care providers can ensure that the patient has a more positive and comfortable experience.

The growing literature in health care regarding cultural differences and the problems surrounding them has prompted recent discussions on the need for cultural competence. As the patient population continues to become more diversified, the need to eliminate racial/ethnic disparities in access to and utilization of health care services intensifies. Having culturally competent health care professionals decreases the likelihood of misunderstandings and, thus, diminishes the anxiety and frustration felt by both the patient and the provider. The definition of cultural competence is fairly analogous throughout the literature. In summary, cultural competence signifies:

> a respectful knowledge of and attitude toward people from different cultures that enables health professionals who work with people from another culture to develop and use standard policies and practices that will increase the quality and outcome of their health care. (McBride, 2005, p. 181)

It seeks to transform the traditional "one size fits all" system into one that more adequately responds to the health needs of an increasingly diverse patient population (Betancourt et al., 2005).

Some authors have also emphasized the importance of workforce diversity and diversity management in the development of cultural competence. Lockwood (2005) states that when workplace diversity is integrated into an organization's goals employees exhibit "…greater adaptability and flexibility in a rapidly changing marketplace" (p. 3). The traditional schools of thought regarding diversity have slowly evolved from assimilation and differentiation to the current paradigm of integration and learning. Spataro (2005) adds that the demographic composition of a workgroup shapes an organization's attitude and behaviors about diversity. She notes that "workers who are

more different in sex, race, and nationality from others in their organization are more responsive in adjusting their behaviors to fit different situations" (p. 24). Thus, the more diverse a workforce, the greater the awareness of, and response to the need for cultural competency.

The National Center for Cultural Competence (NCCC) describes cultural competence as a developmental process for both the individual and their organization that evolves over time and spans a continuum that includes awareness, knowledge, and skills. The NCCC (2004) offers a conceptual framework that encourages organizations to:

> -have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
>
> -have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
>
> -incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities. (para. 2)

The Center urges organizations to conduct regular self-assessments in order to strategically plan for the implementation of cultural competence programs or services. It argues that self-assessments can help organizations determine the fiscal and personnel resources, short and long-term goals, and areas of strength and weakness needed to launch a successful program.

A number of cultural competence models and assessment tools have been developed to assist health care providers. Cross, Bazron, Dennis, and Isaacs (1989) identify five essential elements that contribute to an organization's ability to become more culturally competent. A culturally competent organization would: "(1) value diversity; (2) have the capacity for cultural self-assessment; (3) be conscious of the dynamics inherent when cultures interact; (4) have institutionalized cultural knowledge; and (5) have developed adaptations to diversity" (p. v.). In addition, the authors state that these five elements must be present at every level of the organization. The practice of cultural competence should include impartial policies, true perceptions of behavior, and unbiased attitudes.

Leininger (1991, 1995) introduces the "theory of culture care diversity and universality," depicted as a sunrise model to emphasize the nursing field's hopeful goal in raising its cultural knowledge. The model is intended to show how multiple cultural and social aspects influence care and thus the health and well-being of individuals. "The whole model with the different components are studied to discover their culture care diversity and universality patterns and to provide information related to culturally congruent care" (Leininger, 1995, p. 109).

Wells (2000) offers a cultural development model for individuals and institutions that includes six developmental stages that occur throughout two phases. The first phase, cognitive, includes the stages of cultural incompetence, cultural knowledge, and cultural awareness. These stages represent the learning process in which individuals or institutions acquire knowledge and become aware of the differences that exist. The second phase, affective, includes the stages of cultural sensitivity, cultural competence,

and cultural proficiency. The affective phase requires a commitment from individuals or institutions. As cultural knowledge is applied, attitudes and behaviors begin to change. Burchum (2002) proposes a model that includes five components: cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, and cultural skill. These components are regarded as the primary attributes of cultural competence. Burchum argues that the process of becoming culturally competent is nonlinear and ongoing. Campinha-Bacote (1999, 2002, 2003) offers a model that includes cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. These components are interdependent and intersect one another. The first four components, however, are attainable only when cultural desire, or an individual's motivation to want to engage in the process of becoming culturally competent, is reached. Campinha-Bacote argues that cultural competence is achieved when an individual progresses through all five components and effectively integrates them to achieve a balance.

Purnell and Paulanka (2003) introduce the Purnell Model of Cultural Competence. This model is depicted as a set of circles. Working from the outer circle inwards, the domains consist of global society, community, family, person, and unknown phenomena. Within the circle representing the individual person there are 12 interconnected domains that clinicians should familiarize themselves with to better understand the patient's unique ethnocultural beliefs, values, intentionality, and environment. Purnell and Paulanka, like many others, argue that cultural competence is an ongoing process that develops with each cultural encounter.

Several cultural competency assessment models and guides have also been developed over the past few years. Authors including Luckmann (1999), Spector (2004a,

2004b), Andrews and Boyle (2003), and Giger and Davidhizar (2004) have formulated check-lists or questionnaires designed to aid individuals and organizations in determining their level of cultural competency. Self-assessments generally focus on the practitioner's knowledge, attitude, and skills regarding the interaction with and care of culturally diverse patients. Assessments, however, can also be patient-focused and inquire about such things as their beliefs, preferences, special rituals, and diet.

The need for cultural and linguistic competence in health care is intensifying as the number of foreign-born continues to rise. Misunderstandings stemming from cultural differences and language barriers can result in costly medical mistakes, patient noncompliance, and even malpractice suits. By becoming aware of differences in cultures, providing interpretive services, and making vital documents available in a patient's preferred language, health care providers can offer greater accessibility, obtain proper informed consent, and improve cooperation in treatment.

Research Questions

The following questions initially guided this study:

1. Do Alabama general hospitals believe that the rising foreign-born population poses significant cultural and linguistic problems for their respective organizations in the future?
2. Are Alabama general hospitals preparing for the new diversity? Do they support and encourage the development of a culturally diverse staff? Have they written policies and procedures to guide the provision of culturally and

linguistically appropriate services? Do hospitals have a specific person or department assigned to promoting cultural competence?

3. Do Alabama general hospitals make interpretive services available to limited English proficient patients? If interpretive services are not regularly made available, what do hospitals cite as barriers to providing the service? Do they give hiring preferences to bilingual candidates? Do they provide vital forms and information such as HIPAA, Patient's Rights, Consent to Treat, Authorization for Use or Disclosure of Information, registration, billing statements, and customer satisfaction surveys to limited English proficient patients in their respective language?
4. Are Alabama general hospitals located in urban areas more culturally and linguistically competent than Alabama general hospitals located in rural areas?
5. Are Alabama hospitals which have a more diversified workforce more culturally and linguistically competent than hospitals with a less diversified workforce?

Purpose and Significance of the Research Questions

The purpose of this study was to determine whether Alabama general hospitals are preparing for the diversification, both culturally and linguistically, of their patient population. The southern region of the country now boasts the second highest percentage of foreign-born persons. As this sector of the population continues to rise, so too does the opportunity for misunderstandings and errors during patient-provider encounters. Since

Alabama general hospitals are not immune to the widespread cost, access, and quality paradox that plagues health care providers, they too must consider cultural and linguistic competence as a means of lessening the disparities concerning access to care, obtaining adequate information for diagnostic and treatment purposes, and providing high quality care to all its patients. The need for health care providers to be culturally competent and make interpretive services available will be critical in their efforts to provide appropriate care in a cost-effective manner.

A study regarding the awareness of and preparedness for a diversified patient population within Alabama general hospitals is absent from the literature of cultural and linguistic competence in health care. Findings from this study will provide insight as to whether hospitals consider the diversification of the patient population a problem for their organizations. The findings will also help to determine the response to federal requirements to provide care that is culturally and linguistically appropriate and identify areas that are in need of improvement. Finally, the findings will add to the knowledge base and provide insight on the barriers that Alabama general hospitals face in providing culturally and linguistically appropriate care to the foreign-born.

Theoretical Focus for the Study

The above literature served as the theoretical discussion base for the research with the federal standards and guidelines issued by the Department of Health and Human Services Office of Minority Health used as the foundation for empirical analysis.

In March 2001, following President Clinton's Executive Order 13166 Limited English Proficiency, the Department of Health and Human Services Office of Minority

Health (OMH) developed the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). This report recommends 14 standards for health care providers to adopt in their efforts to comply with LEP. The standards are divided into three themes. Standards 1-3 relate to Culturally Competent Care.

> Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
>
> Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
>
> Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standards 4-7 apply to Language Access Services.

> Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
>
> Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
>
> Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
>
> Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standards 8-14 deal with Organizational Supports for Cultural Competence.

> Standard 8. Health care organizations should develop, implement, and promote a

written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Standards 4, 5, 6 and 7 are federal requirements for those agencies and organizations that receive federal monies. Standards 1, 2, 3, 8, 9, 10, 11, 12 and 13 are guidelines "recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies" (p. 3). Standard 14 is offered as a recommendation by the OMH to health care providers.

Examining the use, or lack thereof, of CLAS standards in Alabama general hospitals provides insight on their level of preparedness for the increasing diversification of the patient population and their willingness and ability to provide culturally and linguistically appropriate care. If compliance levels are wanting, identifying the barriers or challenges that hospitals face in meeting government requirements may help encourage further research on methods to eliminate these obstacles and encourage discussion among hospital personnel and between hospitals. It is also possible that those who participated in the survey research portion of this study may use the questions raised by the survey questionnaire to generate on-the-job discussions of the issues raised in this study.

Methodology and Approach

The units of analyses for this study are Alabama general hospitals and registered nurses. The sample consists of the whole theoretical population of Alabama general hospitals obtained from the *American Hospital Association (AHA) Guide 2005,* the Alabama Hospital Association's online hospital directory,[3] and the Alabama Department of Public Health's Provider Services Directory.[4] The AHA Guide identifies hospital control using four categories: government nonfederal, government federal, nongovernment not-for-profit, and investor-owned (for-profit). Each category is divided into subcategories that provide specific details about the facility's control. All four categories are included in the sample. The Guide also identifies four types of hospitals:

[3] Retrieved March 14, 2006, from *http://www.alaha.org/dir_name.cfm*
[4] Retrieved March 14, 2006, from *http://www.adph.org/providers/Hospitals.pdf*

general, special, rehabilitation and chronic disease, and psychiatric. Hospitals identified as general were selected. According the AHA, the primary function of a general hospital is:

> to provide patient services, diagnostic and therapeutic, for a variety of medical conditions. A general hospital also shall provide: diagnostic x-ray services with facilities and staff for a variety of procedures; clinical laboratory service with facilities and staff for a variety of procedures and with anatomical pathology services regularly and conveniently available; [and] operating room service with facilities and staff. (p. A3)

There are 28 subcategories that further describe the types of hospitals. The subcategory of "general medical and surgical" (service code 10) was selected. There are currently 101 facilities that meet this definition. This includes proprietary (n=31), private nonprofit (n=32), and public facilities (n=38).

Data were collected using three questionnaires developed by the author. The first questionnaire was directed toward all Registered Nurses (including Advanced Practice Nurses) working in acute-care settings, and was distributed through the use of the Internet. The second questionnaire was directed toward all Chief Executive Officers (CEO) and was distributed through the mail. The third questionnaire was directed toward all Human Resources Directors, and was also distributed through the mail. The author employed Dillman's (2000) multiple contact strategy and used follow-up reminders. These follow-ups were conducted by mail. The three questionnaires consisted of questions developed based on the responders' positions.

The three questionnaires sought to gather the following data:

I. Registered Nurses' questionnaire sought to collect data on nurses' perceptions on whether the increase in the foreign-born population poses future cultural and linguistic problems for their hospital; their training on how to care for a diversified patient population; whether medical errors or problems have occurred as a result of a language barrier between the patient and the provider; the resources made available to them to care for foreign-born patients; assessment practices; the availability of trained interpreters and translated documents; their experience and level of comfort when caring for foreign-born patients; and, their interest in learning a foreign language.

II. Chief Executive Officers' questionnaire sought to collect data on hospital leaderships' view on whether the increase in the foreign-born population poses future cultural and linguistic problems for their hospital; whether developing a culturally and linguistically diverse workforce is a priority; the effort to periodically collect data on the demographic changes in their service area; recruiting a diverse workforce; use of trained interpreters; if no trained interpreters, the barriers to hiring them; community outreach efforts; and, whether medical errors or problems have occurred as a result of a language barrier between the patient and the provider.

III. Human Resources Directors' questionnaire sought to collect data on the hospitals' workforce demographics; recruitment efforts; community outreach efforts; cultural and linguistic competence training of employees;

use of trained interpreters; if no trained interpreters, the barriers to hiring them; and, general hospital demographics.

This research study was approved by the Office of Human Subjects Research at Auburn University (see Appendix M). The author collaborated with the Alabama Board of Nursing to collect data from the respondents. The Registered Nurses' questionnaire was recreated and distributed using Internet programming services provided by the Alabama Board of Nursing (ABN). The Chief Executive Officers' and Human Resources Directors' questionnaires were mailed to each respondent and included a letter of endorsement from the ABN and a separate letter from the author. Mailing labels were provided to the author by the ABN. The level of measurement included interval, ordinal, and nominal variables. Frequencies and crosstabulations were used.

Limitations of the Study

1. This study is limited to general medical and surgical hospitals in one state. The findings, therefore, cannot be generalized to all the states but may be suggestive for states similar to Alabama culturally.
2. The information received by the author from participants who completed the questionnaires is assumed to be based on their personal knowledge of cultural and linguistic competence, and it is assumed that this information is representative of their respective organizations.
3. The information received by the author from follow-up contacts may be subject to the author's biased interpretation.

4. This study is limited to the population of hospitals whose service category is general medical and surgical. Other health care provider organizations such as physician practices, outpatient diagnostic and surgical centers, urgent care centers, emergency medical transport services, and mental health facilities are not included; the findings, therefore, cannot be generalized beyond the general medical and surgical hospital setting.

Overview of Chapters

This opening chapter has presented the basic research questions and presented the research approach taken. Chapter Two presents an extensive review of the literature. Topics and concepts covered include culture, communication, cultural competence, and linguistic competence. The major authors reviewed include Leininger (1991, 1995), Leininger and McFarland (2002), Campinha-Bacote (1999, 2002, 2003), Purnell (2000, 2002), Purnell and Paulanka (2003), Andrews and Boyle (2003), Spector (2004a, 2004b), Giger and Davidhizar (2004), and Luckmann (1999).

Chapter Three incorporates an extensive review of the changing demographics in Alabama, and the role of the federal government, Alabama state government, accrediting bodies, and professional associations in ensuring cultural and linguistic competence in health care. Topics covered include Alabama demographics, federal mandates, state regulations, Department of Health and Human Services Office of Minority Health's national standards, Joint Commission on Accreditation of Hospitals, National Committee for Quality Assurance, American Medical Association, American Hospital Association, and Alabama Nursing Association, to name a few.

Chapter Four discusses methodology and the basic analytic approaches utilized. This discussion includes details explaining the study's design, the structure of the questionnaires and methods of delivery, and the use of frequencies and crosstabulations. A summary of the characteristics of Alabama general medical and surgical hospital and registered nurse populations follows along with a summary of the characteristics of the CEO, HRD, and RN samples.

Chapter Five presents the major findings. A descriptive summary of the data collected from the three questionnaires is provided.

Chapter Six discusses of the findings from crosstabular analysis of the CEO, HRD, and RN samples. This discussion focuses on hospital characteristics most likely to have an impact on the appropriateness of the cultural and linguistic care or services being delivered, or not delivered. The findings are then related to the original research questions.

Chapter Seven concludes the study by considering the implications of the findings for the operation of health care facilities within Alabama. Suggestions for future research and the significance of the study are also included. A reference section follows along with appendices that include the instruments used for data collection (cover letters from the author and the Alabama Board of Nursing, questionnaires, and second contact letters).

CHAPTER II

LITERATURE REVIEW

The recent resurgence in the number of foreign-born has resulted in increased awareness of the need for health care professionals to provide services that are sensitive to patients' beliefs and practices. The literature surrounding cultural and linguistic competence, still in its infancy, has made significant strides in capturing the industry's attention. Although there is consensus among researchers that cultural and linguistic competence in health care is vital to providing care that is equitable and cost-effective, there are differences in the various conceptual frameworks and assessment models and guides regarding how to achieve cultural competence. This chapter reviews the origins of cultural competence, the prominent conceptual frameworks in the literature, various cultural assessment models and guides, the importance of linguistic competence in health care, the need for cultural diversity in the health care workforce, and the role of organizational culture in facilitating workplace efforts to become culturally and linguistically competent.

Origins of Cultural Competence

In the 1950s, Madeliene M. Leininger (1967, 1970, 1978) identified the need for health care practitioners to become aware of and provide culturally congruent care to

culturally diverse patients. As a pioneer in the belief that culture had a significant influence on a person's beliefs and practices about his or her health and medical care, she introduced the idea of cultural care. Leininger (1995), the first professional nurse anthropologist and founder of transcultural nursing, believed that the field of nursing was too uniculturally focused in a nation that was rapidly becoming more multicultural. "Providing health care to immigrants, refugees, minorities (or underrepresented groups) from virtually every place in the world" would prove a daunting challenge to health care personnel (p. 3). She argued that cultural differences among the broadening patient population could no longer be ignored. Cultural biases and prejudices were increasingly being linked to frustration, poor nursing practices, and serious problems. In addition, Leininger strongly believed that every individual had a "human right and expectation to have their cultural values, beliefs, and needs met by nurses as professional caregivers" (p. 4). She claimed that an individual's culture influenced his or her acceptance or rejection of the care offered to them, stating that "cultural beliefs, values, norms, and patterns of caring had a powerful influence on human survival, growth, illness states, health, and well-being" (p. 36).

Leininger (1967, 1970) was among the first to suggest that the study of nursing include the study of health and medical care practices of other cultures. She believed that anthropological knowledge was equally important for nurses as anatomy and chemistry. Being aware of and understanding the differences and similarities of other cultures allows health care professionals to tailor the care provided to fit the cultural values, beliefs, and practices of the patient. According to Leininger (1967, p. 36), "the cultural norms, the specific patterns of living and the technologies, and the many beliefs and values of the

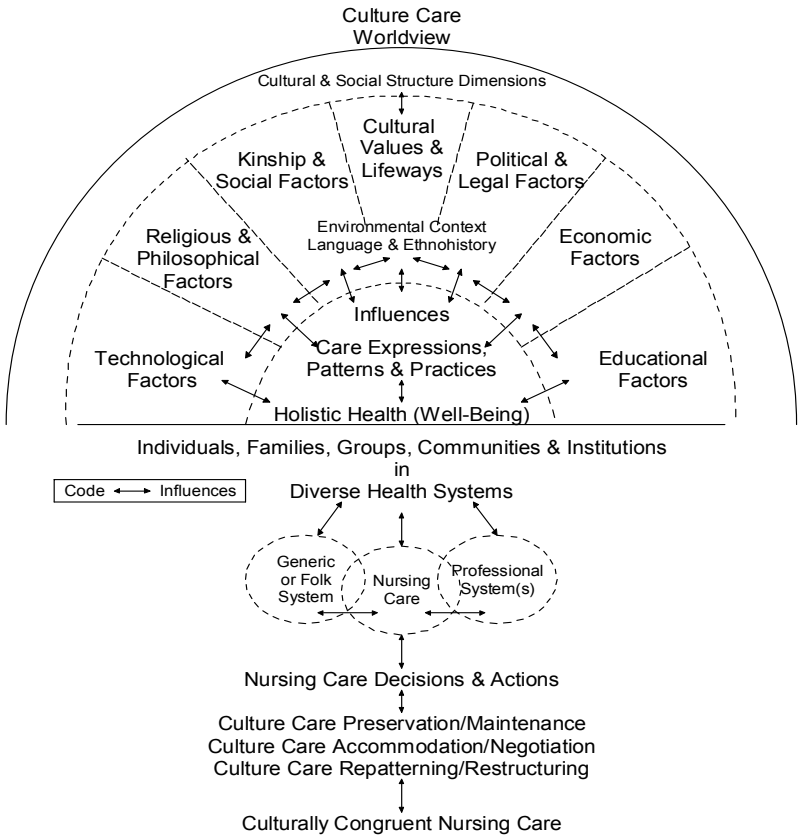
people are all dynamic forces that influence the health status of a cultural group." By receiving cultural-specific care, the patient is also more likely to comply with directives and recover in a timely manner. Leininger (1995), therefore, founded the subfield of transcultural nursing in hope of expanding nursing's view of the world and broadening its focus from medical values and practices to that of human beings. She urged nurses:

> to move away from the dominant and traditional medical model emphases that had long been held by nursing to a different cultural health maintenance, illness prevention, and to draw upon the caring modes of different cultures in order to practice nursing in culturally specific ways. (p. 27)

Leininger added that nurses would advance through three phases: cultural awareness, discovery and explanation, and application of knowledge to practice. During the first phase, nurses become aware of the differences and similarities in cultures. Awareness generally spawns sensitivity and a desire to understand the meaning behind the differences. In phase two, nurses attempt to explain what they have experienced through theory and research. Leininger developed the theory of Culture Care Diversity and Universality, discussed in detail below, to help guide nurses in this discovery and explanation phase. Lastly, nurses apply the knowledge acquired through research to improve patient care. In this phase, nurses are able to overcome previous biases and prejudices and provide culturally-specific care. Leininger maintains that the journey through the three phases is an ongoing process. As nurses encounter new cultural and health beliefs and practices, they reenter the cycle of awareness, research, and application.

Leininger (1978) initially developed the Transcultural Conceptual Model to Study and Analyze Health Care Systems to help health care providers "obtain a transcultural health care perspective of health-illness systems" (p. 68). The model consisted of four levels of analysis: social structure features, cultural values and health care, health care systems and typologies, and roles and functions of health professionals. The model serves as a baseline for providers to systematically study and analyze cultural characteristics in order to "develop sound health care plans and determine ways for outsiders and insiders to participate in meaningful health services" (p. 72).

Figure 2.1 Leininger's Sunrise Model



Source: Royal College of Nursing Online. (n.d.). Chapter Three: Transcultural Nursing Care of Adults. Retrieved February 21, 2006, from http://www.rcn.org.uk/resources/transcultural/adulthealth/sectiontwo.php

Continuous research led Leininger (1995) to expand upon her original model and develop the theory of Culture Care Diversity and Universality. She proposed this theory in an effort to encourage nurses to become aware of, respect, and respond to the different practices and expectations of various cultures in order to provide culturally appropriate care to the increasingly diversifying patient population. She uses the Sunrise model to depict this theory. The model is pictured in Figure 2.1.

Leininger (1995) begins by defining culture as "the learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways" (p. 60). She notes that culture is a dynamic process that serves as an individual's "blueprint for living, remaining healthy, or for dying" (Leininger, 2001, p. 36). The theory, therefore, challenges nurses to probe the various dimensions of culture that may shape an individual's expectations of care. These dimensions include cultural values and lifeways, kinship and social factors, religious and philosophical factors, political and legal factors, economic factors, educational factors, and technological factors. Before transcultural care decisions are made regarding the appropriate care to give, Leininger's theory calls for the nurse to obtain knowledge about the individual's experience with medical care. The theory assumes that all cultures have a culturally constituted concept of care deriving from their experiences with indigenous (folk) care or professional care. It is important that nurses obtain emic, or indigenous cultural knowledge from the individual. This insider knowledge is considered to be the most valuable knowledge base from which to gauge differences and similarities in the beliefs and practices for health. Combining an individual's expectations stemming from indigenous and professional care experiences

essentially allows nurses to provide care that is congruent with the individual's values, beliefs, and experiences.

After learning about an individual's worldview, the various dimensions of culture, and indigenous and professional care, nurses must then determine which of the three modalities used to guide judgments, decisions, and actions best fits the situation. The three modalities are: (1) cultural care preservation and/or maintenance; (2) cultural care accommodation and/or negotiation; and, (3) cultural care repatterning or restructuring (Leininger, 2001). The modalities can be used in conjunction with one another or separately depending on the nurse's assessment. Leininger (2001, p.42) provides the example of a Chinese-American individual who requests herbal tea to calm their nervous stomach. The nurse, aware of the culture's preference for herbal remedies, would make a special accommodation for tea to be included in the individual's diet. This situation called for the nurse, after obtaining the necessary cultural knowledge, to accommodate and/or negotiate with the individual in order to meet his or her expectations.

Leininger (2001) notes that the Sunrise model has undergone ten revisions over the past three decades in efforts to more clearly and fully depict the different dimensions and their relation and influence on each other. She warns that the model should be used as a cognitive map rather than a conceptual model. Its theoretical goal is "to discover inductively and explain, interpret, and predict culture care knowledge and its influencers in order to understand and develop ways to provide culturally congruent nursing care" (p. 49). She warns that the dimensions of culture should never be considered as unrelated to one another. Instead, influencers should be considered in totality. Nurses, or researchers, depending on their interests, can begin the discovery process at any point in the Sunrise

model, but are always encouraged to study the specific culture beforehand to help guide the exploration.

Leininger was not alone in her efforts to raise awareness of and sensitivity to cultural beliefs and practices and their influence on a patient's health and wellness. Frances C. MacGregor (1960), a social science professor at Cornell University's School of Nursing, also explored the need to include the study of anthropology and sociology in the nursing curriculum. She conducted a three year study on the effects of a social science course on nurses' awareness of and responses to cultural differences at New York Hospital–Cornell Medical Center. MacGregor cited cases involving culturally diverse patients and noted that the physicians and nurses presiding over these cases "had not been sensitized to the cultural determinants of behavior. This resulted in inaccurate diagnoses and in the loss of time and money" (p. 25). The importance of social science knowledge in the medical and nursing fields, she argued, was slowly gaining awareness and acceptance. She cited Johns Hopkins School of Medicine's then recent announcement that "modern health problems require a knowledge of sociology, psychology, and anthropology," and its plan to incorporate behavioral sciences into the medical curriculum (p. 27). MacGregor attributed the slow advancement of these ideas to the relative newness of social science as a discipline and the fact that social scientists, in efforts to establish themselves as a credible field, concentrated on pure research rather than practical, or applied, research. She also noted that attempts to incorporate social sciences in the medical and nursing fields had met some resistance from professionals and educators. She quoted Herman G. Weiskotten (1957) who in an article in the *Journal of the American Medical Association* stated, "this new trend of focusing on the patient as

an individual is reducing the scientific training and stringent discipline formerly required of doctors" (p. 28).

Despite opposition, MacGregor (1960) partnered with Cornell University and the Russell Sage Foundation to introduce a social science course at the University's School of Nursing. She was hired as the nursing school's first social scientist and developed a course to raise students' awareness not only of the cultural differences within the patient population but of their own personal biases. She argued that knowledge of the cultural, social, and psychological factors that influence patients' beliefs and practices would greatly improve the treatment and care that nurses provided. MacGregor urged her students to inquire about patients' backgrounds to better understand their individual needs and expectations. She admitted that many students were at first reluctant to learn about cultural differences. Most of these students were accustomed to lumping people of different cultures into one group and did not realize that significant variations existed between them. Soon, however, students began to exhibit an eagerness and willingness to learn more about culture differences after having the opportunity to apply their new knowledge and improve patient care. Rather than labeling patients whose beliefs and practices regarding health care were unfamiliar as crazy or uncooperative, nursing students were able to first identify and understand the differences and, subsequently, tailor their care techniques to accommodate them.

Lyle Saunders (1954) similarly argued "medicine is a part of culture" (p. 7). In his book, *Cultural Difference and Medical Care*, he examined the Spanish-speaking population of the Southwest to provide information regarding its distinctive culture to medical and related health professionals. Saunders believed that when it came to the

practice of medicine, all cultures had their own defined roles, behaviors, and expectations. Problems arose when the behaviors and expectations of one culture were applied to a person of a different culture who did not understand or accurately evaluate the unfamiliar practices. He, therefore, stressed the need for medical personnel in the Southwest to understand the cultural differences associated with the region's Spanish-speaking population.

Saunders also attempted to raise awareness of the existence of various subcultures within a culture. He claimed that "Anglos" in the Southwest often mistakenly grouped all Spanish-speaking people in the category of Mexicans. He illustrated the differences found within this population and concluded that knowledge about an individual's origin, education, social class, and religion:

> might help to explain such behavior as nonattendance at clinics, failure to have children immunized, the use of laymen or marginal professionals in the treatment of illness, reluctance to enter or remain in a tuberculosis sanitarium, leaving a hospital against medical advice, the use of folk remedies – for example, the wearing of amulets or copper bracelets to ward off disease – even during hospital confinement, and similar actions and attitudes that are puzzling from an Anglo point of view. If such behavior can be seen and interpreted as an expression of cultural conditioning rather than as simply the whimsical result of individual deviance, it becomes possible to anticipate it and to devise effective ways of changing it or of adapting to it. (p. 99)

Saunders urged medical personnel to make themselves aware of the cultural differences that exist among the Spanish-speaking population in order to remain objective when

providing care. He warned professionals to refrain from assuming that a patient is unintelligent or ignorant if he or she is unfamiliar with Western medical practices. This unfamiliarity does not necessarily indicate that the patient has no knowledge of medicine. The patient may simply be more accustomed to practicing folk medicine. The lack of knowledge or experience with Western medical practices should not imply that the individual's beliefs and practices are wrong or substandard, just different. Practitioners who can adapt their approach and procedures to better meet the needs and expectations of culturally diverse patients will be more versatile and perhaps more effective than those who expect "all the adjusting to be done by the patient" (p. 224).

Henderson and Primeaux (1981) similarly argued that an individual's practice of folk medicine did not imply that he or she lacked knowledge or experience with a medical system. Folk medicine, or "Third World medical beliefs and practices" as the authors define it, is a medical system (p. 59). Like Western medicine, groups who practice folk medicine adopt a philosophy of health and illness, delineate roles for the practitioner and the patient, establish hierarchies of competency and authority, and use medicines to cure or alleviate symptoms. Folk medicine takes a more holistic, or comprehensive, approach in caring for the patient. Unlike the traditional Western medical model, folk medicine considers the patient's physical, mental, social, and spiritual well-being. It often includes the patient's family or community in the treatment process.

Spector (1991) adds that there are two types of folk medicine, natural and magico-religious, or occult. Natural folk medicine is based on the premise that remedies are present in nature in the form of herbs. This form of folk medicine has recently gained widespread popularity in the United States (Giger & Davidhizar, 2004). More and more

Americans are turning to herbal treatments such as Ginseng, Echinacea, St. Johns Wart, and Garlic to fight fatigue, boost the immune system, relieve pain, and lower cholesterol. Magico-religious folk medicine, on the other hand, is based on spiritual or religious rituals and practices. This type of medicine is used to ward off evil spirits, remove the taboo, and escape pain or death inflicted by a higher power. Often used in these rituals and practices are charms or amulets, holy actions (such as sacrifices and exorcisms), and holy words.

Spector (1991) argues that practitioners routinely use Western medicine and its practices in a one-size-fits-all manner and fail to consider the patient's preference for treatment. Practitioners are distanced from the patient as a result of their education and training. Misunderstandings often occur when the practitioner and the patient are of different belief systems. Spector insists "that it is entirely appropriate for them [practitioners] to explore alternative ideas regarding health and illness and to adjust their approach to coincide with the needs of the specific client" (p. 60).

Several earlier writers also discuss the influence that religion has on an individual's beliefs about health and healing. Henderson and Primeaux (1981) state that as one of the most primitive institutions known to man, "religion is both a catalyst to understanding basic elements of health and a philosophic border within which to give at least a semblance of order to these conditions" (p. 186). Spector (1991) contends that religion, like culture, is strongly pervasive. It influences a person's belief, interpretation, and response (or in some cases lack thereof) to all aspects of life and its environment. She claims that religion is such a strong determinant in an individual's health beliefs and practices that "it is often difficult to distinguish between those aspects of a person's belief

system arising from a religious background and those that stem from an ethnic and cultural heritage" (p. 119). She cautions practitioners from the common mistake of considering culture, ethnicity, and religion to be interconnected. A group of people may share the same culture, yet vary in their ethnicity and religion. Likewise, a group that shares the same religion may have different cultural and ethnic backgrounds. "Each of these threads – religion, ethnicity, and culture – weave the fabric of each response of a particular person to treatment and healing" (p. 119). Similarly, Schreiber (1991) states that "a patient's belief in an afterlife, in the eternality of the soul, in reincarnation, or in the sanctity of the body will weigh heavily in some medical decisions" (p. 3066). If physicians are aware and understand the importance of these beliefs to their patients, they are better equipped to help their patients through these difficult times.

Cultural Competence Defined

The importance of understanding cultural, ethnic, and religious differences in the delivery of health care slowly gained attention as racial and ethnic disparities in health care increased and the focus of educators, policymakers, insurers, and providers turned towards ensuring efficacy and quality care to the diversifying patient population (Betancourt, Green, Carrillo, & Park, 2005). It was not until 1989 when the *Journal of Transcultural Nursing* was launched that research began to advance in the field and the term "cultural competence" emerged. Some definitions of cultural competence distinguish it as a complex integration of cultural awareness, knowledge, attitudes, skills, and encounters. Others describe it "as a distinct concept of transcultural nursing care,

which incorporates cultural sensitivity and knowledge, and requires a variety of abilities and cultural skills" (Kim-Godwin, Clarke, & Barton, 2001, p. 920).

Despite its broad usage and applicability, there are a few components that are constant in nearly all of the definitions of cultural competence. Most authors include awareness of the similarities and differences in cultures, knowledge of cultural values, beliefs, and practices, respect of patients and their differences, and modification of care practices to fit the patient's health care beliefs and practices (Meleis, 1999; Burchum, 2002; Campinha-Bacote, 2002; Giger & Davidhizar, 2002, 2004; Mays, Siantz, & Viehweg, 2002; Purnell & Paulanka, 2003). Purnell and Paulanka's (2003) definition of cultural competence, however, is considered by this author to be the most comprehensive. According to them, cultural competence means:

1. Developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds.
2. Demonstrating knowledge and understanding of the client's culture, health-related needs, and meanings of health and illness.
3. Accepting and respecting cultural differences.
4. Not assuming that the health-care provider's beliefs and values are the same as the client's.
5. Resisting judgmental attitudes such as "different is not as good."
6. Being open to cultural encounters.
7. Adapting care to be congruent with the client's culture. Cultural competence is a conscious process and not necessarily linear. (pp. 3-4)

A number of authors add that cultural competence is an ongoing process (Cross, Bazron, Dennis, & Isaacs, 1989; Campinha-Bacote, 2002; Burchum, 2002; Andrews in Andrews & Boyle, 2003; Giger & Davidhizar, 2004). Campinha-Bacote (2002) argues that health care providers should continuously strive "to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (p. 181).

Although slight variations appear in the definition of cultural competence, there is unwavering agreement among researchers in the field of nursing on its necessity in today's changing world (Leininger, 1978, 1995; Dobson, 1991; Andresen, 2001; Campinha-Bacote, 2002; Purnell, 2003; Andrews & Boyle, 2003; Giger & Davidhizar, 2002, 2004; Spector, 2004b; Betancourt, Green, Carrillo, & Park, 2005). Leininger (1995) states:

> as the world becomes smaller through rapid transportation and communication and increasingly depersonalized through high technology, human beings have come to cherish their cultural identities and cultural differences, and the importance of transcultural nursing has increased. (p. xi)

Likewise, Purnell (2003) maintains that "cultural competence in today's borderless societies is not a luxury; it is a necessity" (p. 45). Spector (2004b) states that individuals learn how to be healthy, as well as how to be ill, from their cultural and ethnic conditioning. Consequently, "cultural diversity and pluralism are a core part of the social and economic engines that drive the country, and their impact at this time has significant implications for health care delivery and policymaking throughout the United States" (p. 4). Furthermore, Betancourt, Green, Carrillo, and Park (2005) contend that "cultural

competence aims to change a 'one size fits all' health care system to one that is more responsive to the needs of an increasingly diverse patient population" (pp. 502-503).

The increasing awareness of the need for health care providers to be culturally competent and provide care that is culturally appropriate has encouraged researchers to develop a number of conceptual and practical models and guides to assist health care providers in becoming culturally competent and providing culturally competent care. A review of the various cultural competence frameworks, cultural assessment models, and cultural assessment guides follows.

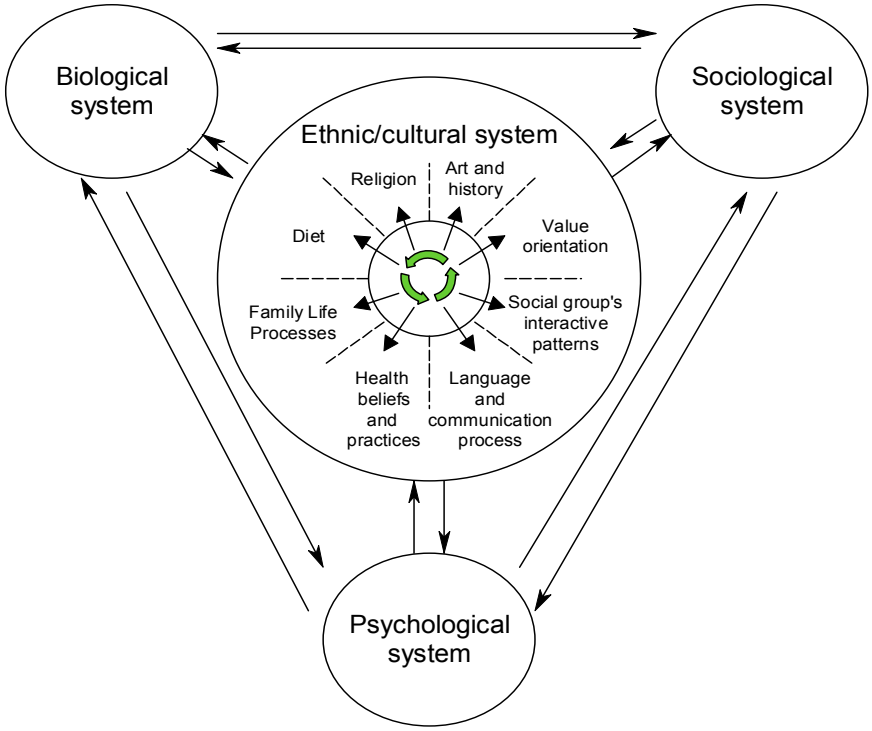
Cultural Competence Frameworks

Following Leininger's (1971) Sunrise model, Orque (1983) proposed an ethnic/cultural system framework to improve culturally relevant care in response to the increasing health disparities at the time. The author defines ethnic nursing care as "the nurse's effective integration of the patient's ethnic cultural background into her nursing process-based patient care" (p. 7). Since culture is believed to influence all aspects of human life, Orque argues that nurses must gain knowledge of the various cultures and incorporate that knowledge into developing culturally appropriate care. The model, shown in Figure 2.2, is depicted as segments of a wheel.

The center of the wheel represents Maslow's (1954) universal basic human needs. Surrounding the center circle are eight cultural components that Orque identifies as having an impact on a person's beliefs and practices. These components surround the center circle and include religion, diet, family life processes, health beliefs and practices, language and communication process, social groups' interactive patterns, value

orientation, and art and history. The eight components are separated by dotted lines representing their interrelationships and interdependence on one another. Arrows drawn from the basic human needs circle out toward each of the eight cultural components indicate "that solutions to basic human needs lead to these cultural elements" (p. 10). Orque notes that basic human needs are cyclical and individuals are continuously adapting to their changing environment, "therefore, for any ethnic/cultural system, the degree to which basic human needs are reflected in each of these cultural components determines to a great extent the ethnic/cultural system's impact on how these needs are met" (p. 11).

Figure 2.2. Orque's Ethnic/Cultural System Framework



Source: Orque, Modesta S. (1983). Orque's Ethnic/Cultural System: a framework for ethnic nursing care. In M. S. Orque, B. Bloch, & L. S. A. Monrroy (Eds.), *Ethnic Nursing Care: A multicultural approach* (pp. 5-48). St. Louis: C.V. Mosby Co.

Orque (1983) also encourages nurses to consider how the ethnic/cultural system is influenced by the biological, psychological, and sociological systems. These three additional systems form a triangle that surrounds the ethnic/cultural system wheel. Factors such as a patient's physiology, mental and behavioral processes, and the groups to which the patient belongs significantly influence his or her beliefs and practices and cause variations in the eight cultural components. Orque, thus, warns nurses not to assume that all individuals of the same culture have the same beliefs and practices. Differences within cultures, if not identified, could result in nurses' failure to provide holistic and culturally appropriate care.

Cross, Bazron, Dennis, and Isaacs (1989), in their study of how to improve service delivery to minority children who are emotionally disturbed, were the first to use the term "cultural competence." The authors defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Cultural competence is a developmental process that is based on a continuum. This continuum includes cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency. As knowledge of different cultural beliefs and practices is acquired, professionals and agencies progress from ethnocentrism and bigotry, or cultural destructiveness, to respecting cultural differences and holding them in high esteem, or cultural proficiency.

The authors claimed that in order for professionals or organizations to become culturally competent they must: "(1) value diversity; (2) have the capacity for cultural

self-assessment; (3) be conscious of the dynamics inherent when cultures interact; (4) have institutionalized cultural knowledge; and, (5) have developed adaptations to diversity" (p. v). The authors note that the five elements must be functioning within all levels of the system and policies, practices, and attitudes must consistently reflect these elements. Attitudes that embrace cultural differences can be developed with the use of "training, modeling, and experience" (p. 25). To develop a culturally competent system, organizations must carefully plan for it. Strategic planning must include assessing the organization's internal and external environment, generating a support base to help facilitate action and change, allocating the appropriate resources needed to aid in the implementation effort, maintaining leadership involvement, and creating a mission statement to establish direction. The authors conclude that a culturally competent system of care, or a system that "acknowledges and incorporates-at all levels-the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs," is vital to providing appropriate services to the growing number of minority children and their families (p. 13).

Campinha-Bacote (1999, 2002) claims that the rapidly changing demographics and increasing disparities in the health care have challenged health care providers to place greater emphasis on the need for cultural competency. She proposes The Process of Cultural Competence in the Delivery of Healthcare Services as a model to guide nursing actions. The author expands upon her earlier model that describes cultural competence as a process involving four stages: cultural awareness, cultural knowledge, cultural skill, and

cultural encounters (see Campinha-Bacote, 1994; Campinha-Bacote, Yahle, & Langenkamp, 1996).

The first stage, cultural awareness, requires nurses to examine their own personal biases and prejudices towards different cultures and examine their own cultural background. This process seeks to eliminate ethnocentrism and prevent nurses from imposing their personal values, beliefs, and practices on others. Campinha-Bacote, Yahle, and Langenkamp (1996) cite Pedersen's (1988) proposed techniques to encourage cultural awareness. His techniques include role plays, field trips, critical incidents, audiovisual presentations, panel discussions, and bicultural observations. The authors also suggest the use of Borkan and Neher's (1991) Developmental Model of Ethnosensitivity as an assessment tool to measure cultural awareness levels. In this model, ethnosensitivity is viewed on a personal growth continuum ranging from ethnocentrism to ethnorelativity. Ethnocentrism represents fear and mistrust. Ethnorelativity represents "an ethnosensitive attitude of integration" (para. 9). The nurse advances through several phases including overgeneralization and cultural blindness, negative stereotyping, reductionism, acceptance, and empathy.

During the second stage, the nurse begins to inquire about the values, beliefs, and practices of diverse groups. Cultural knowledge aims to build a foundation from which nurses can understand differences and develop problem-solving techniques to appropriately address them.

The process of cultural skill educates nurses on how to conduct cultural assessments. The authors caution nurses not to depend solely on the general information gathered from the cultural knowledge process. In conducting cultural assessments, nurses

can obtain specific information regarding the patient's values, beliefs, practices, and experiences of health care.

The last stage, cultural encounter, urges nurses to interact with culturally diverse patients to revise and improve existing knowledge. The authors stress the importance of cultural encounters to minimize the likelihood of stereotyping. As nurses increasingly interact with patients of diverse cultures, they realize that differences are prevalent within cultures as well. Campinha-Bacote, Yahle, and Langenkamp (1996) conclude "effective educational programs on cultural diversity have the potential to yield culturally responsive nursing assessments which can in turn produce culturally relevant nursing interventions" (para.28).

Campinha-Bacote (1999) adds an additional stage to the model – cultural desire. She argues that as health care providers progress through the first four stages of cultural awareness, cultural knowledge, cultural skill, and cultural encounters, they must also have a genuine enthusiasm and desire to work with patients who are culturally different. She refers to Rogers' (1951) belief "that genuineness, or congruence, is the very basic ability of individuals to read their own inner experiencing and allow the quality of this inner experiencing to be apparent in relationships" (p. 205). Campinha-Bacote contends that health care providers' goal should not be to ensure that their comments are politically correct, rather their comments should reflect genuine care and concern. Campinha-Bacote (2002) notes that this expanded model is widely applicable and has been suggested as a framework for a number of different areas including: (1) providing culturally competent care in specialty areas such as psychiatric and mental health services, case management, home care, and rehabilitation nursing; (2) guiding nurse educators, management, and

administration; (3) guiding policy development; and, (4) conducting culturally sensitive research.

Wells (2000) argues that in order for health care providers to meet the challenges posed by the increasingly diversifying patient population, both individual and organizational change is necessary. She claims that "cultural awareness, cultural sensitivity, and cultural competence do not go far enough to achieve the level of cultural development required by health care professionals and institutions to effectively meet the health care needs of a diverse population" (p. 191). Wells, therefore, offers the Cultural Development Model (CDM). The model consists of two phases, the cognitive and the affective. Each phase consists of three stages, all of which reside on a continuum. Change occurs as practitioners and organizations progress through the six stages on the continuum. During the cognitive phase, the stages of cultural incompetence, cultural knowledge, and cultural awareness help practitioners and organizations to gradually advance from having little to no knowledge of how culture influences a patient's beliefs and practices regarding health, to learning about the various elements of culture and understanding its effect on behavior. During the affective phase, the stages of cultural sensitivity, cultural competence, and cultural proficiency allow practitioners and organizations to apply their newly acquired knowledge of culture and its behavioral outcomes to practical use.

Wells (2000) also urges practitioners and organizations to follow Leininger's (1978) "two guiding principles for promoting cultural development" (p. 194). First, it is important for health care providers to maintain an objective and tolerant view of different cultures. One must remain open and accepting of the differences in cultural values,

beliefs, and practices to avoid ethnocentrism, or the view that one's own culture is superior to that of others. Second, practitioners and organizations must "avoid seeing all individuals alike" (p. 194). Assuming that individuals of the same ethnicity also share the same culture can result in stereotyping. Individual or group variations should always be taken into consideration when determining the appropriate care to provide. Similarly, Campinha-Bacote, Yahle, and Langenkamp (1996) suggest conducting a cultural assessment on each patient "for every client has values, beliefs and practices that must be considered when rendering health care services" (para. 13). They argue that in addition to ethnicity, factors such as geographical location, socioeconomic status, gender, sexual orientation, occupation, and religious affiliation also shape a cultural group.

Wells (2000) concludes that in order for practitioners and organizations to successfully progress through the stages of the Cultural Development Model, they must first assess their own cultural development. A cultural audit should be performed to help identify and examine the preexisting cultural biases. Failure to change cultural assumptions that have been entrenched over the years will result in anecdotal changes rather than the inherent changes that are necessary to sustain over time.

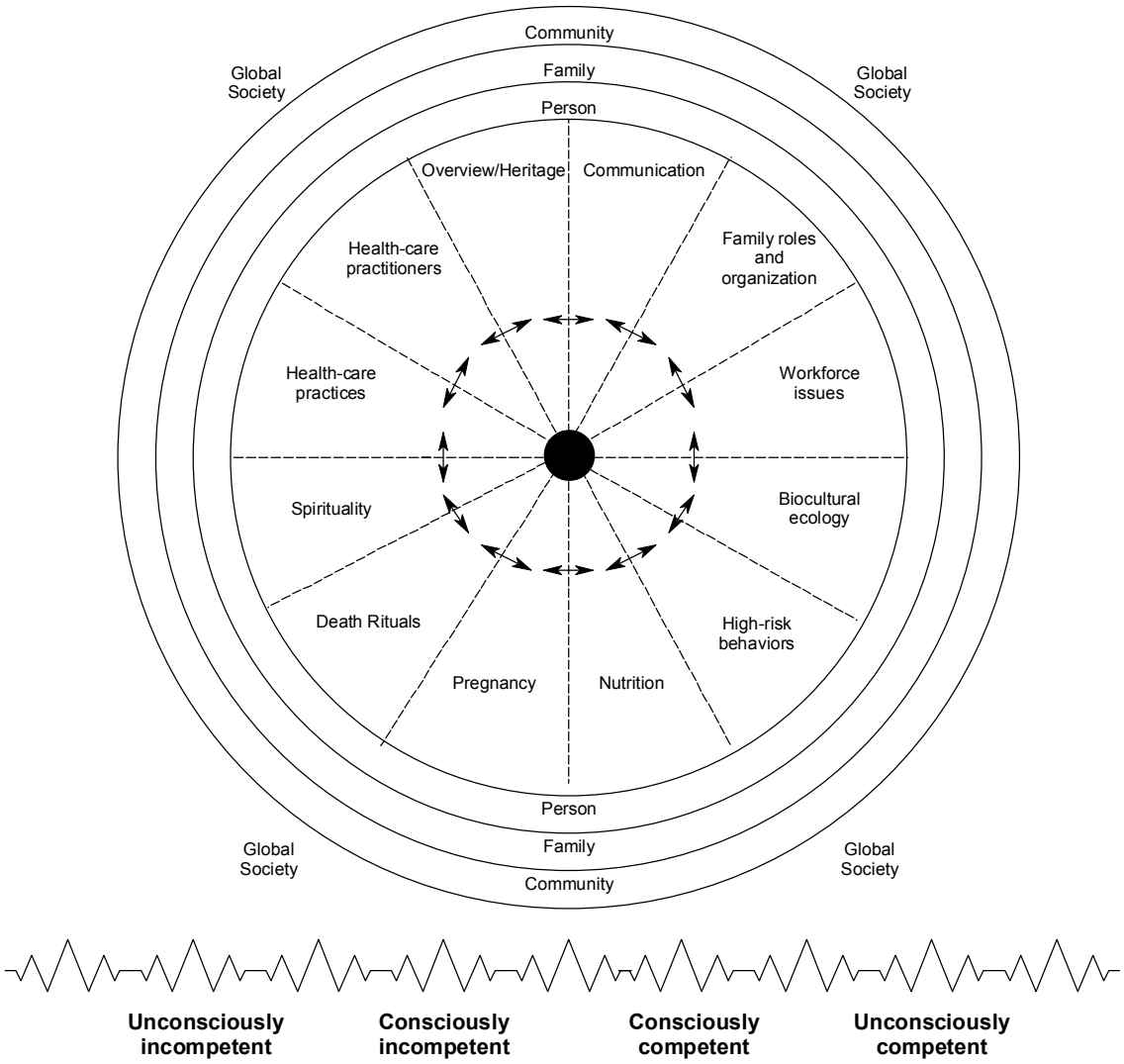
Likewise, Purnell (2005) argues that the complex and often exhausting concept of culture and cultural diversity requires "providers to look at themselves, their patients, their communities, their colleagues, and their employment settings from multiple perspectives" (p. 7). He adds that cultural competence is a nonlinear process that requires a conscious commitment from health care providers in a variety of disciplines. Purnell, therefore, developed the Purnell Model for Cultural Competence as "an organizing

framework to guide cultural competence among multidisciplinary members of the healthcare team in a variety of primary, secondary, and tertiary settings" (p. 7).

Conceptualized from a number of fields and theories, Purnell's (2000, 2002, 2005) model is highly complex and comprehensive. He begins by emphasizing that cultural competence is not an endpoint, but an ongoing process in which individuals progress from lack of awareness and knowledge (unconscious incompetence), to knowing that they lack cultural knowledge (conscious incompetence), then familiarizing themselves with cultural norms and adapting care to be culturally congruent with that of the patient's (conscious competence), and finally, providing culturally competent care automatically (unconscious competence). Purnell warns that unconscious competence can be dangerous when differences within cultures and individuals are not considered. He stresses the need for practitioners to consider both the emic view, or the insider's knowledge and perspective, and the etic view, or the outsider's knowledge and perspective, given that beliefs and practices are constantly changing. Expanding upon Hage's (1972) variable and nonvariable concepts of culture, Purnell (2005) identifies primary and secondary characteristics of culture that shape an individual's worldview and level of acculturation. Primary characteristics include "nationality, race, color, gender, age, and religious affilitation" (p. 14). Secondary characteristics include "educational status, socioeconomic status, occupation, military experience, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, reasons for migration, and length of time away from the country of origin" (p. 14). Examining the primary and secondary

characteristics of culture assists practitioners in determining how the individual's beliefs and practices vary from those of the dominant culture.

Figure 2.3. Purnell's Model for Cultural Competence



Source: Purnell, Larry D. (2005). The Purnell Model for Cultural Competence [Electronic version]. *Journal of Multicultural Nursing and Health, 11*(2), 7-15.

The model, depicted in Figure 2.3, is illustrated as a series of concentric circles. These circles, beginning with the outermost one, represent the global society, the community, the family, the person, and unknown phenomena. Purnell claims that individuals' world view, lifeways, and level of acculturation are constantly changing due to events or experiences within each of the four realms. The circle representing the person contains 12 interrelated cultural domains, or constructs, and their concepts. These domains are vital for evaluating the specific cultural attributes of an individual or a group. The 12 domains and their respective concepts include:

Overview/heritage – origins, residence, topography, economics, politics, education, and occupation.

Communication – dominant language, dialects, contextual use, volume/tone, spatial distancing, eye contact, facial expressions, greetings, temporality, time, names, and touch.

Family roles and organization – head of household, gender roles, goals and priorities, developmental tasks, roles of aged, extended family, social status, and alternative lifestyles.

Workforce issues – acculturation, autonomy, and language barriers.

Biocultural ecology – biological variations, skin color, heredity, genetics, ecology, and drug metabolism.

High-risk behaviors – tobacco, alcohol, recreational drugs, physical activity, and safety.

Nutrition – meaning of food, common foods, rituals, deficiencies, limitations, and health promotion.

Pregnancy and childbearing – fertility practices, views toward pregnancy, pregnancy beliefs, birthing, and postpartum.

Death rituals – death rituals and bereavement.

Spirituality – religious practices, use of prayer, meaning of life, individual strength, and spirituality and health.

Health care practices – focus on health care, traditional practices, magicoreligious religious beliefs, responsibility for health, organ transplantation and donation, rehabilitation/chronicity, self-medication, pain and sick roles, and mental health barriers.

Health care practitioners – perceptions of practitioners, folk practitioners, and gender and health care. (Purnell, 2005, p. 11).

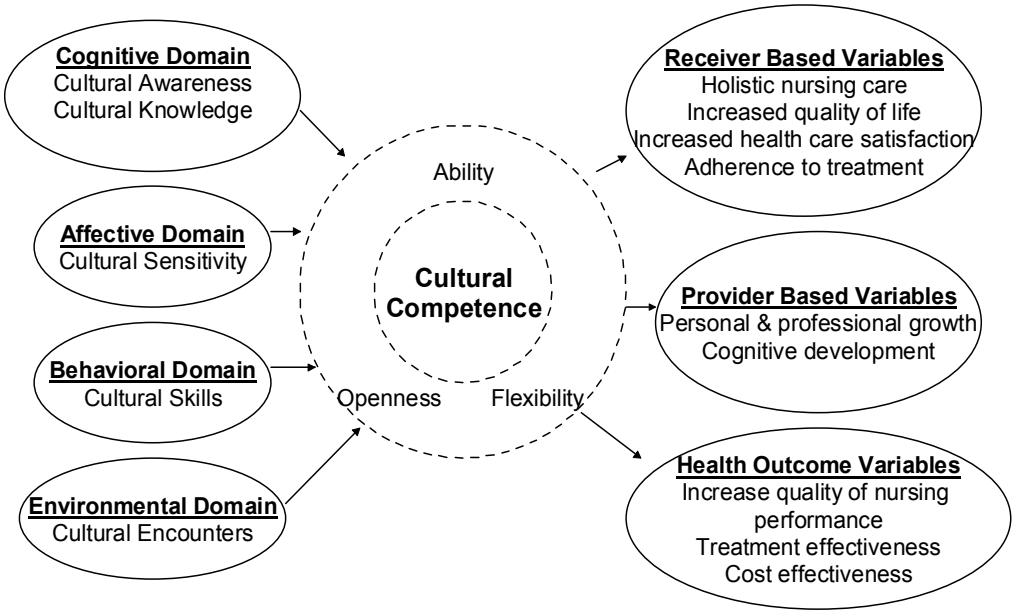
By gathering data on an individual's beliefs and practices regarding the 12 domains, practitioners can more easily identify the "differences within, between, and among cultures (Purnell & Paulanka, 2003, p. 9).

Suh (2004) conducts an evolutionary concept analysis of cultural competence, and based on her findings, proposes a theoretical model. She notes that the growing disparity between the minority population, estimated to comprise nearly 50% of the U.S. population by 2050, and the nurse workforce, comprised of almost 90% non-Hispanic Caucasians, has fueled the demand for culturally competent nurses and health care professionals. Using Rodgers' (1989) evolutionary concept analysis as a guide, Suh's review of the literature results in the identification of three common attributes of cultural competence. These attributes include: ability, or providers' aptitude in appropriately dealing with culturally sensitive situations; openness, or providers' acceptance and

respect of cultural differences; and flexibility, or providers' ability to adapt and tailor care to fit the patient's needs and expectations.

Continuing her literature review, Suh (2004) then identifies the antecedents, or prerequisites, of cultural competence and organizes them into four domains. She identifies cultural knowledge and cultural awareness as antecedents associated with the cognitive domain, cultural sensitivity associated with the affective domain, cultural skills with the behavioral domain, and cultural encounters with the environmental domain.

Figure 2.4. Suh's Model of Cultural Competence



Source: Suh, Eunyoung E. (2004). The Model of Cultural Competence Through an Evolutionary Concept Analysis [Electronic version]. *Journal of Transcultural Nursing, 15*(2), 93-102.

Suh (2004) also identifies the most commonly noted consequences of providing culturally competent care in the literature reviewed and groups them into three categories: receiver-based variables, provider-based variables, and health outcome variables.

Receiver-based variables include outcomes such as receiving holistic care which may be more familiar and more effective for culturally diverse patients who may not understand or accept Western medical practices, increased patient satisfaction and quality of life as a result of receiving care that more closely meets patients' expectations, perceiving health care providers more positively, and improved adherence to medical directives. Provider-based variables refer to the benefits obtained by health care providers as a result of providing care to patients who are culturally diverse. These benefits include advanced personal and cognitive development, enhanced international perspective, and improvements in communication and nursing practice. Finally, health outcome variables include improvements in the quality of nursing performance, development of positive patient-provider relationships, increases in treatment effectiveness and cost effectiveness, and an overall decrease in health disparities among cultural and ethnic groups.

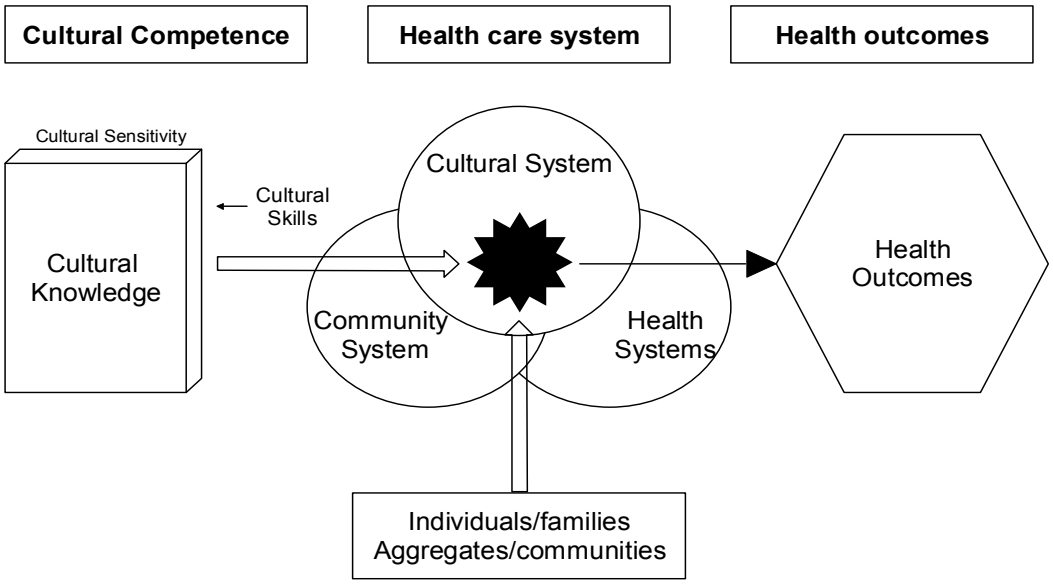
Suh's (2004) model illustrates cultural competence as a process that requires "specific ability, openness to cultural attributes, and flexibility to adjust to those attributes, both differences and similarities" (p. 99). One cannot become culturally competent without first fulfilling the prerequisites of cultural awareness, knowledge, sensitivity, skills, and encounters. In conclusion, Suh urges health care providers to consider cultural competence as a continuous process, one that requires a lifelong "commitment to a new way of thinking" (p. 100). Providers should not struggle to achieve cultural competence, rather they should strive to become culturally competent.

Many frameworks and models have been developed for health care providers, but Kim-Godwin, Clarke, and Barton (2001) argue "none attempt to explain the effects of culturally competent care on populations in community settings" (p. 919). Health care is

quickly shifting from a hospital-based focus to a community-based focus and community and public health nurses are facing the challenge of providing community health services that are culturally competent. Kim-Godwin, Clarke, and Barton (2001), therefore, present a model for community and public health nurses to consider when faced with the challenge of delivering culturally competent services to an individual or a community.

The Culturally Competent Community Care model (CCCC) is based on three constructs, cultural competence, the health care system, and health outcomes (see Figure 2.5). Cultural competence consists of four interdependent dimensions, care, cultural sensitivity, cultural knowledge, and cultural skill. Selection of the four dimensions was based upon the authors' analysis of the various definitions of cultural competence. These dimensions were identified as common staples in the definitions examined.

Figure 2.5. The Culturally Competent Community Care Model



Source: Kim-Godwin, Y.S., Clarke, P.N., & Barton, L. (2001). A model for the delivery of culturally competent community care [Electronic version]. *Journal of Advanced Nursing, 35*(6), 918-925.

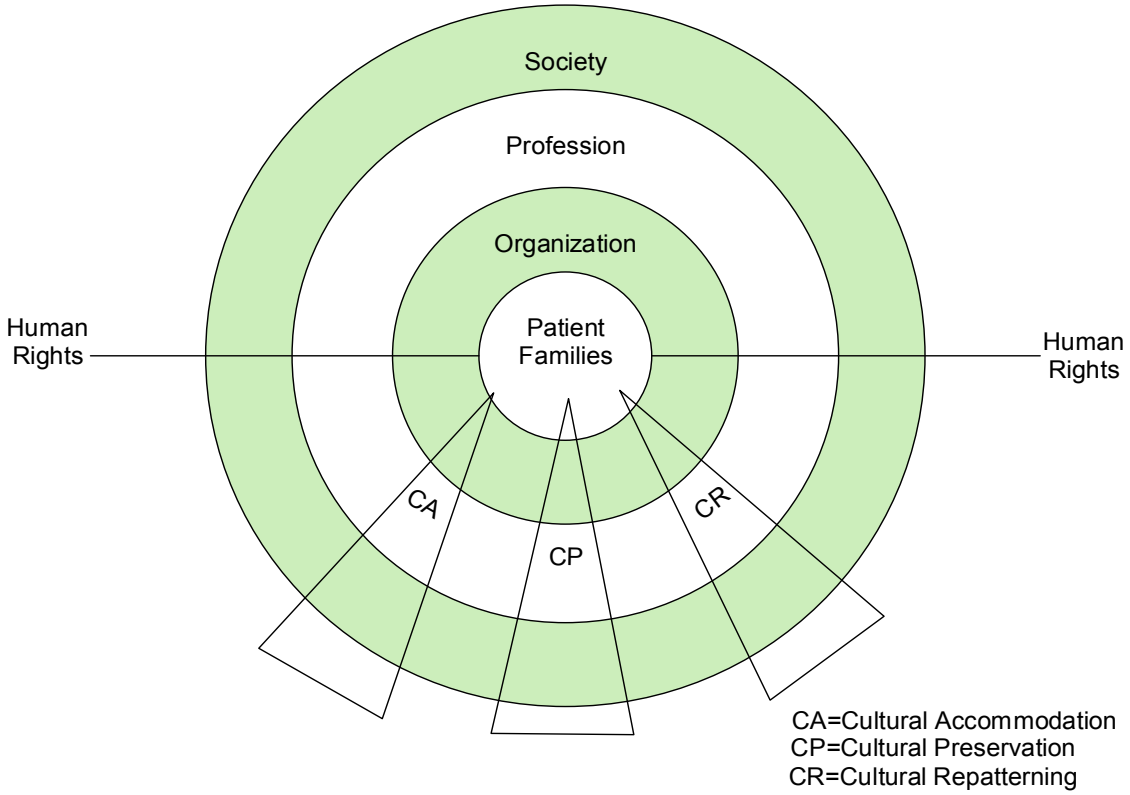
The second construct, the health care system, represents the "place for community health care" (p. 919). The model assumes that the development and design of these health care systems is led by community health nurses whose goal is to meet the community's health needs. Problems often occur when the cultural system, the community system, and the health system intersect. These issues are resolved when culturally competent community nurses integrate the three systems. For example, nurses can demonstrate knowledge and understanding of a client's native culture to alleviate their fears of the unfamiliar community health system. "Culturally competent nurses can incorporate aspects of the client's cultural system in their care of the client, leading to client satisfaction and increased utilization of health care services" (p. 920). Clients are then motivated to participate in the community system.

The third construct, health outcomes, represents the effects on the community's population based on providing culturally competent care. Kim-Godwin, Clarke, and Barton cite a number of researchers who have examined the positive outcomes on community health care as a result of culturally competent care. In addition, the authors conducted a study of 13 community health nurses and nurse experts who provided culturally competent care to migrant farm workers. All 13 nurses reported experiencing positive health outcomes. Some of the outcomes they identified included increased trust in health care professionals, increase in the number of individuals obtaining the necessary and appropriate health care, more expectant mothers seeking prenatal care, increase in the rate of immunization, decrease in morbidity and mortality rates, increased compliance, and greater interest among individuals in the community in health maintenance and disease prevention. The authors argue that because "communities have significant

barriers for receiving quality health care, such as lack of health insurance, inaccessible 'free' clinics, language differences, cultural conflicts with health care providers, and lack of trust" it is vital that community health nurses recognize cultural differences and offer culturally competent services and care in order to improve health outcomes for those groups who are disadvantaged (p. 923).

Recent cases involving ethical decisions such as the Terry Schiavo case and Oregon's physician-assisted suicide law have created new challenges for health care providers. As the patient population continues to diversify and different views regarding such issues as artificial life support, organ transplants, and organ donation are introduced, the need for practitioners to be culturally competent will increase. Pacquiao (2003) presents the Culturally Competent Model of Ethical Decision-Making to help guide health care professionals in providing culturally appropriate care to patients of various cultural groups that may have to make ethical decisions regarding their health or that of a family member. The model combines Leininger's (1991) action strategies and Mann's (in Mann & Burris, 1998) human rights framework. Pacquiao argues that "promoting and protecting human rights is inextricably linked with promoting and protecting health. Human rights must be respected, not only for their instrumental value in contributing to public health goals but as a societal good of preeminent importance" (p. 521). The model calls for practitioners to familiarize themselves with a patient's ethnohistory, concept of life and death, beliefs about the human body and soul, family roles, family and community support structures, and experience with Western medicine, to name but a few.

Figure 2.6. Culturally Competent Model of Ethical Decision-Making



Source: Pacquiao, Dula F. (2003). Cultural Competence in Ethical Decision-Making. In M. M. Andrews & Joyceen S. Boyle (Eds.), *Transcultural Concepts in Nursing Care* (4th ed., pp.503-532). Philadelphia: Lippincott Williams & Wilkins.

The model then calls for an assessment of the organization, its staff members, and key professional and society norms. Conflict tends to arise when the organization or its staff is unaware and insensitive to the beliefs and practices of a different culture. Continuous monitoring and redevelopment of the organization's willingness and ability to appropriately handle culturally sensitive situations will ensure that "ethical decisions preserve a patient's human rights to meaningful and satisfying care that is grounded in the patient's culturally constituted values and lifeways" (p. 524). The organization and its staff members must also comply with professional and societal norms. Identifying the

parameters imposed by legal mandates, regulatory requirements, and professional codes of ethics "[facilitates] realistic collaboration between care providers and consumers that protects the human rights of consumers, other patients, and staff" (p. 524).

After assessing the patient, the organization and its staff, and professional and societal norms, health care providers then move on to the planning and outcome identification phase. During this phase, the provider develops an understanding of the patient's world view and lifeways and seeks to define the situation from the patient's viewpoint. The health care provider is then able to establish a respectful and trusting relationship with the patient, the patient's family, and their community.

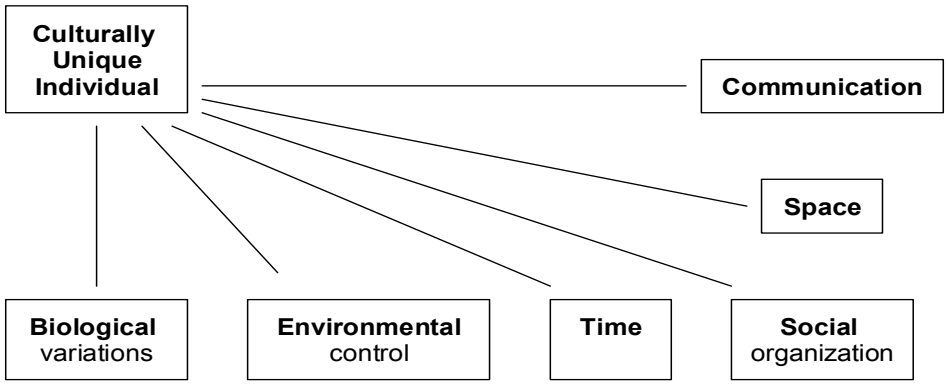
The intervention phase calls for the application of Leininger's (1991) three action strategies: (1) cultural care preservation or maintenance; (2) cultural care accommodation or negotiation; and, (3) cultural care repatterning or restructuring. Pacquiao (2003) notes that the three action strategies may be implemented simultaneously. These action strategies allow practitioners to integrate a patient's specific cultural values, beliefs, and practices into the care given.

Lastly, the evaluation phase examines the outcomes of care. Pacquiao (2003) warns that outcomes should not be limited to biomedical results. Health care providers should measure outcomes based on the patient's indices of health and illness. Different cultures value different positive outcomes: "Biomedical outcomes of care that define the effectiveness of professional health care may be secondary to other outcomes, such as the observance of religious and spiritual beliefs" (p. 526). Practitioners must consider the patient's expectations when identifying outcome goals and work collaboratively to achieve outcomes that are meaningful to the patient.

Cultural Assessment Models and Guides

Giger and Davidhizar (1991, 2004) argue that earlier cultural assessment models were either not designed for health care providers (Murdock et al., 1971) or too complex and difficult to follow (Brownlee, 1978). The authors offer the Giger and Davidhizar Transcultural Assessment Model as a practical and concise framework to guide health care providers in conducting comprehensive cultural assessments (see Figure 2.7). The authors identify six cultural phenomena that affect health care and vary among cultural groups. These are environmental control, biological variations, social organization, communication, space, and time orientation. Giger and Davidhizar (2004) maintain that "every individual is culturally unique… and a product of past experiences, beliefs, and values that have been learned and passed down from one generation to the next" (p. 6). Cultural competence requires health care professionals to identify an individual's cultural uniqueness in order to better meet his or her needs and expectations and provide the most effective care.

Figure 2.7. Giger and Davidhizar Transcultural Assessment Model



Source: Giger, Joyce N. & Davidhizar, Ruth E. (2002). The Giger and Davidhizar Transcultural Assessment Model [Electronic version]. *Journal of Transcultural Nursing, 13*(3), 185-188.

The model illustrates the nursing assessment process. First, practitioners need to learn about the patient's cultural and racial identification, place of birth, and the amount of time they have lived in the host country. It is also strongly recommended that practitioners have a general knowledge of the specific cultural group to provide a baseline for assessment. The practitioner then assesses the six cultural phenomena that will help design appropriate care for the patient. Communication includes the assessment of verbal and nonverbal communication variables such as language spoken, voice qualities (such as tone of voice), pronounciation, use of silence and touch, facial expression, eye movement, and body posture. Practitioners, however, should also consider factors including the patient's physical health and emotional well-being, the meaning and knowledge of a particular topic and the patient's level of comfort in discussing it, the patient's cultural beliefs and practices, the patient's communication skills, the patient's attitude toward the health care provider, and the patient's past experience to name a few.

Space describes the context in which all communication occurs. Perceptions of space and rules governing personal distance vary among cultures. Giger and Davidhizar (2004), however, argue that "personal space is an individual matter and varies with the situation" (p.45). An assessment of a patient's view of personal space should include the degree of comfort observed, proximity to others, and body movement.

Social organization refers to a patient's family and social structure. It is important to identify the roles of family, church or religion, work, friends, and leisure in the life of a patient as they often have significant influence on health care decisions.

The concept of time varies by culture. Giger and Davidhizar (2002) claim "cultural groups can be past, present, or future oriented" (p. 185). It is necessary to assess a patient's definition, measure, and use of time when designing care regimens. For example, some cultures place little emphasis on clock time. In caring for such a patient, the practitioner should avoid rigid treatment and medication schedules and use broader time frames such as morning and afternoon.

Environmental control is a significant factor in health-seeking behavior. Beliefs regarding the amount of control an individual has over his or her health and illness vary among cultures. Some cultures believe that illness is a form of divine punishment and thus, do not seek medical attention. Other cultures believe that illness can be manipulated with the use of folk medicine practices. Assessing a patient's beliefs of health and illness, as well as his or her cultural health practices, can help practitioners design care that is congruent with the patient's beliefs and practices. Finally, it is important for practitioners to assess biological variations. Differences between racial groups have been identified in drug metabolization and susceptibility to disease.

Spector (2004b) combines Giger and Davidhizar's (2004) Transcultural Assessment Model along with Estes and Zitzow's (1980) model of heritage consistency, and her own HEALTH traditions assessment model to guide health care providers in conducting a comprehensive assessment of culturally diverse patients. Spector's (2002) fundamental argument is based on the distinct "provider culture" that is deep-seated in health care providers: "This culture instills in its members its own norms regarding health and illness beliefs and practices. When a member of the provider culture interacts with a person from a culture with differing health/illness norms, there may often be a conflict"

(p. 197). The three concepts are interwoven, inspired by the saying "all things are related." Their commingling signifies an effort to equip health care providers with a better understanding of the significant issues that culturally diverse groups face when exposed to our health care system.

Spector (2004b) expands upon Estes and Zitzow's (1980) model of heritage consistency "in an attempt to study the degree to which a person's lifestyle reflects his or her traditional culture" (p. 8). A person's cultural, ethnic, and religious background must be considered when identifying the values associated with consistent, or traditional, heritage and inconsistent, or acculturation, heritage. These values reside on a continuum and an individual can have both consistent and inconsistent characteristics. "The notion is that the deeper a person identifies with a traditional heritage, the greater the chance they will follow traditional health and illness beliefs and practices derived from their ethnocultural heritage" (Spector, 2002, p. 197). Spector (2004b) provides a heritage assessment tool in the form of a questionnaire that health care providers can use to assess a patient. The higher the number of "yes" responses from the patient, the deeper the identification with their traditional heritage.

The HEALTH traditions model takes a holistic approach in exploring the health beliefs and practices of different cultures. HEALTH has three dimensions that vary among cultures: maintaining health, protecting health, and restoring health. Each dimension contains its own physical, mental, and spiritual aspects. Spector (2002) defines HEALTH "as the balance of the person, both within one's being – physical, mental, spiritual – and in the outside world – natural, familial and communal, metaphysical" (p. 199). Spector (2004b) also clarifies the use of capital letters as a way to "differentiate

holistic and traditional definitions of HEALTH, ILLNESS, and HEALING from contemporary definitions" (p. 69). She discusses the concept of HEALTH as encompassing a person's mind, body, and spirit. It is a complex phenomenon that considers the constant fluctuating physical aspects, cognitive processes, and spiritual facets of an individual. These factors are interrelated and influence the overall milieu of the individual. It is important that the health care provider identify HEALTH beliefs and practices in order to design care that is appropriate to culturally diverse individuals and ensure positive health outcomes, efficiency, and patient satisfaction.

A number of cultural assessment guides have been offered to help health care providers learn about the traditions, beliefs, and practices of different cultures and guide them in their data collection efforts. Bloch (1983) offered Bloch's Assessment Guide for ethnic/cultural variations as a tool to aide nurses in their assessment of ethnically/culturally diverse patients. This guide is based on Orque's (1983) Ethnic/Cultural System framework and utilizes the four systems identified in the model (cultural, sociological, psychological, and biological/physiological) as major categories for data collection. Bloch identifies a number of subcategories and provides a list of questions to guide the nurse in gathering the correct information for each one. She cautions nurses not to consider the guide as an all-inclusive method of data collection and encourages them to consult additional guides to determine the combination of tools that fits them best. Finally, Bloch urges nurses to exercise their own good judgment in determining which subcategories need further examination.

Rundle, Carvalho, and Robinson (1999) developed a guide to acquaint health care providers with the general characteristics and traditions of various cultural and religious

groups. The authors provide information on 22 cultural groups, two nationality-independent groups (deaf or hard-of-hearing and families with gay or lesbian parents), and 11 religions. Templates for collecting cultural and religious information are included. They also include a tools section intended to guide health care providers in resource utilization. They provide information regarding interpreter services, including how to find the appropriate interpreter and using them effectively.

Andrews and Boyle (2003) offer a cultural self-assessment for health care providers. This self-assessment is intended to help providers gain insight into their own biases and prejudices of other cultures. The assessment asks providers to rate their level of response to various ethnic/racial groups, social issues or problems, religions, physical and mental handicaps, and political beliefs and associations. The authors urge practitioners to conduct a self-assessment first to identify their level of ethnocentrism or their tendency to negatively stereotype a group. The authors also provide the Andrews/Boyle Transcultural Assessment Guide as a tool to help practitioners conduct an assessment interview. The main categories include:

> cultural affiliation, values orientation, health-related beliefs and practices, nutrition, socioeconomic considerations, organizations providing cultural support, education, religion, cultural aspects of disease incidence, biocultural variations, and developmental considerations across the life span. (p. 37)

The authors list a number of questions within each category aimed at helping the health care provider identify the cultural differences and similarities of the group or individual.

Purnell and Paulanka (2003) discuss the common characteristics of 19 cultural groups. A CD-ROM included with their text contains discussions on eight additional

cultural groups. The authors consider the general characteristics of each culture based on the 12 domains of culture as described in the Purnell Model for Cultural Competence. These include overview/heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health-care practices, and health-care practitioners.

Giger and Davidhizar (2004) provide cultural assessment guides for 17 cultural groups. They recently have included an additional six groups on their website. These guides include current demographic information and provide general information regarding the groups' beliefs and practices associated with the six cultural phenomena: environmental control, biological variations, social organization, communication, space, and time orientation. They also review the common religious beliefs and practices within each group. The authors urge practitioners to consider the guides as a baseline. Each patient should be assessed to determine his or her unique cultural values, beliefs, and practices.

Hill, Lipson, and Meleis (2003) have compiled a comprehensive assessment guide to help health care providers understand the cultural implications of caring for immigrant and minority women of 19 cultural groups. Similar to other authors, they urge practitioners to use the information as a starting point, emphasizing that individuals are culturally unique. Each chapter reviews the different developmental stages of a woman's life including infancy, pubescence, adulthood, middle age, and old age. The issues and expectations relevant to each stage are addressed including rituals, education, sexuality, marriage and divorce, pregnancy, infant care, menopause, and death to name a few.

Throughout the chapters, the authors include "notes to the health care provider" to alert practitioners about potential problems or difficulties they may encounter in regards to a specific topic or developmental stage and offer suggestions on how to manage them appropriately.

Communication and Health Care

Communication is a fundamental, yet hugely complex facet of human life. It is through the various methods of communication that messages and emotions are transmitted between individuals. Andrews and Boyle (2003) state, "communication is an organized, patterned system of behavior that regulates and makes possible all nurse-client interactions. It is the exchange of messages and the creation of meaning" (p. 21). Communication is integrally linked with culture. It is through culture that an individual learns how to communicate verbally and nonverbally with others. Culture shapes how an individual interprets the meaning of words, gestures, and feelings. Culture also shapes an individual's beliefs and reactions towards health and illness and "influences how feelings are expressed and what verbal and nonverbal expressions are appropriate" (Giger & Davidhizar, 2004, p. 22). The rapid diversification of the patient population calls for health care providers to be knowledgeable about the similarities and differences in the communication patterns of the various cultural groups they serve.

Luckmann (1999) argues that clear communication between patient and provider is vital to ensure mutual understanding, quality, and effective care. The increasing diversification of the patient population introducing various health behaviors and expectations, the rising number of patients who speak a language other than English, and

professional mandates requiring providers to offer care that is culturally appropriate have contributed to the need for transcultural communication. Giger and Davidhizar (2004) state that "nurses need to have not only a working knowledge of communication with clients of the same culture but also a thorough awareness of racial, cultural, and social factors that may affect communication with persons from other cultures" (p. 22). Kavanagh and Kennedy (1992) argue that cross-cultural communication, similar to cultural competence, requires "awareness that communication is possible and that mistakes will occur, sensitivity to the communication process, knowledge of expectable patterns of communication styles that are appropriate to the client, and a set of practiced skills" (p. 42). Knowledge of the different communication styles and patterns can avoid feelings of anger and helplessness for both provider and patient, and encourage the patient's cooperation and motivation in the health process.

Information, ideas, and emotions are transmitted using both verbal and nonverbal communication styles and patterns. Verbal communication includes language, word choice, intonation, inflection, volume, speed, and silence (Purnell & Paulanka, 2003; Luckmann, 1999; Giger & Davidhizar, 2004). As the number of individuals who speak a language other than English continues to rise, language, as the dominant means of communicating with one another, will pose a greater challenge for health care providers in providing appropriate and effective care to non-English speaking patients. These challenges will be discussed further in the *Linguistic Competency* section below.

Luckmann (1999) argues that Americans are accustomed to using informal verbal communication such as slang, abbreviations, or jargon in everyday language. Word choice, intonation, and inflection must be carefully considered when speaking to

culturally diverse patients. Providers should beware that certain words or phrases, as well as their intonation, or the rise and fall in the pitch of the voice, and inflection, or the emphasis placed on specific words, mean or imply different things to different people. Providers should regularly use clear and formal words and refrain from using sarcasm or inflection to avoid insult or misunderstandings.

Giger and Davidhizar (2004) note that health care providers should consider cultural differences when interpreting a patient's behavior based on voice volume and speed. For instance, a patient who speaks softly and slowly may be viewed as shy or indecisive, whereas a patient who speaks loudly and quickly may be considered rude or insubordinate. The authors argue that cultural values determine the appropriateness of voice volume and speed. Luckmann (1999) claims "white American middle-class culture values a controlled tone of voice and some emotional restraint … [while] black Americans are more verbal and value emotional expressiveness in a conversation or discussion" (p. 56). Asians and Native Americans, however, typically speak softly and show great emotional restraint. Providers must be aware of the differences in voice volume and speed among cultures to avoid misjudging a patient's mood or intent.

Cultures vary in their perception and comfort with silence during conversation. Some cultures, such as Native Americans and some Asian groups, believe that silence exhibits respect and understanding. Other cultures use silence to signify agreement, show concern for privacy, or as a sign of reverence. Some cultures, on the other hand, are uncomfortable with silence and immediately try to fill the quiet gaps with words. Giger and Davidhizar (2004) stress "nurses need to be aware of possible meanings of silence so that personal anxiety does not promote the silence to be interrupted prematurely or to be

nontherapeutic" (p. 30). Awareness of the various levels of comfort with silence among cultural groups can help nurses determine if silence is considered therapeutic or unfavorable and design care accordingly.

Information, ideas, and emotions, however, can also be transmitted with the use of nonverbal communication. Luckmann (1999) argues that "two-thirds of all communication is nonverbal" (p. 57). Nonverbal communication includes eye contact, facial expressions, posture, touch, and space (Purnell & Paulanka, 2003; Leininger & McFarland, 2002; Luckmann, 1999; Giger & Davidhizar, 2004). Leininger and McFarland (2002) note that nurses should pay close attention to "head, face, and hand movements" (p. 127). They argue that not all cultures share the same meanings for head movements. For example, in some cultures nodding the head, as Americans do to imply a yes answer, means the opposite. In America, hand shaking is considered a formal greeting; however, in some Asian cultures, touching another person's hand is considered taboo. In addition, Americans generally consider eye contact as a sign of respect, attentiveness, and honesty. Other cultures may consider eye contact to be rude, inappropriate (depending on the person's socioeconomic class or their gender), or altogether unimportant (Giger & Davidhizar, 2004).

A person's posture often indicates his or her feelings toward another person or feelings about the topic being discussed. Giger and Davidhizar (2004) note that among some Western cultures, matching posture or body movements to that of the speaker indicates receptivity and solidarity. Receptivity can also be demonstrated by leaning towards the person who is speaking. Other cultures, however, believe that the dominant person should demonstrate a more attentive or erect posture than the submissive or

compliant person. Luckmann (1999) states "posture can also communicate a tense or relaxed state" (p. 59). A person with crossed arms implies distance and difference, whereas someone with arms to their side suggests closeness and cooperation. Flexed muscles often indicate tension or physical pain. Giger and Davidhizar (2004) urge health care providers to familiarize themselves with the common practices of various cultures regarding posture to avoid sending the wrong message, as certain gestures or body movements mean different things to different people.

Comfort zones also vary among cultures. Gardenswartz and Rowe (1998) state that "how close we stand to others, how or whether we touch, the level of formality we prefer, and the degree of openness we show are all parts of how we manage our sense of self and our physical space" (p. 42). Some cultures require very little personal space and are accustomed to being in dense crowds and thus touched by strangers, while others prefer to have several feet of distance from another person and are uncomfortable with touch. Leininger and McFarland (2002) warn "personal space has major implications in doing an assessment and of where one stands or sits to talk to a client" (p. 127). Orque (1983) describes a study conducted by Hall (1963) in which a Chinese subject was being interviewed. Hall, sitting in front of the subject, noticed that the patient seemed "tongue-tied." Hall soon determined that the subject was accustomed to having conversations sitting beside another individual. After repositioning the chairs side-by-side, the subject became more talkative. Orque adds that by learning what is culturally appropriate in terms of touch and space, the nurse can avoid common communication problems and reduce the patient's tension and fear.

Linguistic Competence

Language is the most commonly used form of communication. Saunders (1954) states that "language itself both embodies and determines the thought and perception patterns of a cultural group" (p. 116). Individuals use language as a means of expressing ideas and emotions, communicating data and directions, and negotiating with one another (Luckmann, 1999). It is not surprising, therefore, that language differences are one of the most frequently cited problems encountered when delivering health care to culturally diverse patients (Gardenswartz & Rowe, 1998).

A number of authors have discussed the issues associated with language differences in health care. Saunders (1954), in his examination of the Spanish-speaking population of the Southwest, noted that communication barriers prevented Anglos and Spanish-speaking people from establishing good relationships and often resulted in feelings of anger and resentment. Henderson and Primeaux (1981) conducted a study on Spanish-American schizophrenic patients to examine the effect that language had on their behavior and responses when interviewed separately in English and Spanish. The interviews used the same questions, in the same order, and were conducted in similar environments to minimize the impact of other variables. The subjects selected were of the same cultural group and identified Spanish as their native language, yet they were also fluent in English. Half of the group was interviewed using the English version of the interview first, followed by the Spanish version of the interview a few hours later. The other half of the group began with the Spanish version of the interview first and was later interviewed with the English version. The authors noticed "there was a striking tendency in our Spanish-American patients to answer the English questions with a short sentence, a

word, or even silence" (p. 43). The patients appeared to be more emotionally withdrawn during the English interview. The authors state that this could be a result of the patient's lack of ease with an interviewer who is of another culture, or their lack of confidence in their capability to express themselves in English. They note: "speaking across the language barrier arouses a complex group of socially learned perceptions which color the patient's behavior" (p. 47). The authors argue that, if feasible, care should be provided in the patient's native language to optimize results, or at the very least, clinicians should be aware of the language barrier and the cultural differences in beliefs and attitudes of the specific group and take the necessary steps to eliminate misunderstandings.

Orque (1983) states "failure to communicate effectively with the patient may not only cause unnecessary and costly delays in diagnosis and treatment but also may lead to potentially tragic incidents" (p. 21). She recalls an incident where a nurse failed to assess a non-English speaking patient's level of understanding regarding preoperative instructions. The nurse told the patient to wash the area that was to be operated on with Betadine, a chemical disinfectant. The patient nodded and smiled when asked by the nurse if she understood. As the nurse left the room, the patient drank the Betadine. Fortunately, the error was discovered quickly and the patient's life was saved. Orque adds:

> the need for nurses to be able to adeptly communicate with non-English-speaking and limited-English-speaking patients is urgent, for when deprived of their most common medium of interaction with patients – the spoken word – nurses often become frustrated and ineffective in their interventions. (p. 21)

She, therefore, emphasizes the importance in assessing a patient's language proficiency before administering treatment or giving medical instructions. Orque suggests bridging language barriers with the use of bilingual family members or staff members.

Today, the growing numbers of foreign-born who are limited English proficient is creating significant problems in the delivery of health care. The limited availability or improper use of bilingual health professionals or trained medical interpreters is resulting in little to no use of primary care services, poor patient-provider relationships, incorrect diagnosis, lack of informed consent, a higher number of tests performed, decreased patient compliance with physician directives and follow-up care, increased costs, lower patient satisfaction, and even malpractice suits (Baker, Hayes, & Fortier, 1998; Hampers, Cha, Gutlass, Krug, & Bennis, 1999; Carrasquillo, Orav, Brennan, & Burstin, 1999; Sarver & Baker, 2001; Ferguson & Candib, 2002; Herndon & Joyce, 2004; Ku & Flores, 2005). In addition, Vandervort and Melkus (2003), in a study of eight ambulatory care centers' provision of linguistically appropriate care, concluded that "although most of the clinics provided informal mechanisms of interpreter services, few directly addressed linguistic services as a component of culturally competent care" (p. 358). As the demand for high quality, low cost health care intensifies, the need to provide the same level of access and care to this growing segment of the population will be crucial to the future survival of providers.

The need to offer linguistically appropriate services to ensure quality and efficacy in health care delivery has recently gained widespread attention. More and more studies are focusing on the impact that language barriers have on cost and medical care. Linguistic competence is defined as:

> the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literary skills or are not literate, and individuals with disabilities. (NCCC, 2004, p. 5)

This can be achieved with the use of professionally trained medical interpreters, bilingual staff members, telephone interpretive services, translated medical documents, and media material such as television, newspaper, radio, and internet offered in different languages.

Several authors offer suggestions on how to overcome language barriers. Luckmann (1999) states that when a professional medical interpreter is not available, a provider may resort to using a bilingual family member or staff member (see also Orque, 1983; Gardenswartz & Rowe, 1998). A provider may also use a telephone interpretation service, such as AT&T Language Line, if the health care facility subscribes to one. These telephone services are generally available 24 hours a day and provide interpretive services for various languages (see also Rivero-Kempf, 1999; Gardenswartz & Rowe, 1998). Herndon and Joyce (2004) note that these telephone services generally average between $2 to $3 per minute and warn that it "usually requires two separate phone calls [per visit]: one to take the patient's history and another following the physical exam to discuss findings, diagnosis, and treatment" (p. 39). In the event that an interpreter or a telephone service is unavailable, Andrews and Boyle (2003) suggest trying a third language. Europeans, for example, often speak three or four languages. They also advise using a phrase book or flash cards.

A number of studies, however, reveal that the use of bilingual family members or staff or the use of telephone interpreter services often results in errors such as

substituting, adding, or omitting vital information (Orque, 1983; Carrasquillo, Orav, Brennan, & Burstin, 1999; Purnell & Paulanka, 2003). Bilingual family or staff members who are not proficient with medical terminology may not be able to properly explain a problem or the proposed treatment. Telephone interpreter services, on the other hand, provide trained professionals to accurately interpret information but are impaired by their inability to assess the patient's nonverbal behavior. In addition, Carrasquillo, Orav, Brennan, and Burstin (1999) state that "aside from violating a patient's right to privacy, such interpreters usually only translate and cannot place the message into the appropriate social and cultural context as a professional interpreter is trained to do" (p. 86).

Leininger and McFarland (2002) argue that nurses should, at the very least, speak two languages and consider learning more in the future. They state that "nurse educators need to require language skills to care for clients of diverse cultures and to meet a critical need today for education, research, and consultation" (p. 126). Likewise, Boyle (2000) argues that all health care providers should learn Spanish based on estimates that by 2020 "one fourth of the U.S. population will be native Spanish speakers" (p. 11). She also advocates the use of interpreters and educational programs aimed at helping student nurses learn how to work with and use interpreters effectively. Ferguson and Candib (2002), in their review of the literature regarding the influence of cultural and linguistic differences on doctor-patient communication and relationship, find a valid call for "a more diverse physician workforce, since minority patients are more likely to choose minority physicians, be more satisfied by language-concordant relationships, and feel more connected and involved in decision making with racially concordant physicians"

(p. 359). Brach, Fraser, and Paez (2005) add that a study of Spanish-speaking patients who were cared for by native Spanish-speaking physicians found these patients to be in better health, have greater compliance with medical directives, and have lower visits to emergency departments than those who were not cared for by bilingual physicians.

Hampers, Cha, Gutglass, and Binns (1999) studied the differences in resource utilization in a pediatric emergency department when language barriers are present. The authors found "significant differences in test ordering behavior and lengths of stay when physicians believed that they were confronted by LB [language barrier]" (p. 1255). Patients with a perceived language barrier average a lengthier stay (20 minutes) and test charges average $38 higher than patients who are English proficient.

In a similar study, Hampers and McNulty (2002) examine the impact of bilingual physicians and interpreters on decision-making and resource utilization in a pediatric emergency department. The authors confirm "the presence of a 'language-barrier premium,' i.e., more conservative medical decision making and increased resource utilization associated with physician-family language discordance" (para. 31). They find that using bilingual physicians or professional medical interpreters significantly lessens this premium due to the decrease in diagnostic testing and less use of precautionary procedures.

Jacobs, Shepard, Suaya, and Stone (2004), in a two year study of the costs and benefits of implementing comprehensive interpreter services at four health centers, conclude that the expenses associated with providing interpreter services ($279 per person per year) is reasonable given that "interpretation improved patients' utilization of preventative and primary care services, such as follow-up visits and medications, that

potentially may reduce costly complications of these and other conditions" (p. 868). Senator Edward Kennedy (2005) notes that the Office of Management and Budget (OMB) estimates that interpretive services "would add only 0.5 percent to the cost of the average health care visit" (p. 454). He argues that the federal government, as the leader in the struggle to eliminate health disparities, should increase reimbursement to cover the minor cost of providing an interpreter. Ku and Flores (2005) add that "we can either pay a small amount up front to ensure that all patients receive equitable, high-quality care, or pay a lot more later for unnecessary tests and procedures, preventable hospitalizations, medical errors and injuries, and expensive lawsuits" (p. 442).

Cultural Diversity in the Health Care Workforce

More recently, discussion regarding the need for a culturally diverse workforce and the use of diversity management to promote the development of cultural competence in health care is slowly emerging in the literature. Several studies have shown the lack of implementation of diversity management programs despite leadership's awareness of the rapidly diversifying workforce and the importance of diversity management (see Muller & Haase, 1994; Motwani, Hodge, & Crampton, 1995; Wallace, Ermer, & Motshabi, 1996). Muller and Haase (1994), in their study of diversity management practices in six large health institutions in the Southwest, conclude that many of the diversity management policies adopted are compliance-oriented. The policies and programs aimed at diversity management are largely reactive rather than proactive. The authors state that "the homogenous power structure of health organizations and the conventional managerial approaches that assume employees must assimilate the norms of the top

managerial structure may be a deterrent to adopting and practicing proactive diversity management practices" (p. 428). Weech-Maldonado, Dreaschlin, Dansky, De Souza, and Gatto (2002), in their assessment of diversity management practices in 203 Pennsylvania hospitals, argue that healthcare organizations must focus on becoming culturally competent to respond to the diversifying workforce and patient population. The authors note that:

> while cultural competence is the goal, diversity management is the process leading to culturally competent organizations. Diversity management is 'a strategically driven process' whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations. (p. 112)

Health care organizations will need to focus on developing policies and practices "aimed at recruiting, retaining, and managing a more diverse workforce and developing culturally appropriate systems of care" to manage diversity more effectively (p. 123). The authors argue that those organizations that respond to their changing environments will perform better "as their organizational strategy aligns with the requirements of their business environment" (p. 123).

Dreachslin (1996) reviews what she believes are two important trends in health care today: "leadership and diversity in the organization" (p. ix). She claims that as the health care workforce continues to diversify, leaders will be challenged to understand, encourage, and manage a culturally diverse labor pool.

Dreachslin defines diversity leadership as an "exciting and essential process of showing management, staff, clinicians, patients, and other organizational stakeholders the

way to discover the common ground and shared purpose that always exists in human communities, even in the context of diversity" (p. xiii). She warns that leaders, like most people, are often constrained by their own biases and prejudices. Dreachslin urges leaders to first assess their individual experiences in order to overcome the "isms" that may preclude their efforts to appropriately manage diversity. This initial assessment should be followed by a cultural audit of the organization in which its values, beliefs, attitudes, and practices are reviewed. This audit can be performed with the use of interviews, surveys, checklists, or focus groups. A diversity training program can then be designed based on the organization's needs. Dreachslin argues that diversity leadership must be a transformational process rather than a mere change in systems and procedures. The organization must transform its vision and adopt a new paradigm. Only when this transformation is achieved will the organization witness the benefits of diversity leadership including improved customer base, improved quality of care, increased in the labor pool despite a scarce labor market, labor cost savings, reduction in turnover, and more effective teams. In addition, "when clinicians have an enhanced understanding of patients' diverse cultural backgrounds and beliefs, they can better serve patients, and compliance with prescribed treatment can be improved" (p. 15).

Shaw-Taylor and Benesch (1998) argue that "valuing employees' differences is intrinsically important, not only in the delivery of healthcare, but in the retention of quality healthcare providers who can best serve the growing diversity of the patient pool" (p. 139). The authors warn that implementing affirmative action hiring practices is not necessarily the best way to promote cultural diversity. Organizations must go beyond

surface changes and allocate the necessary time and resources to sustain long-term initiatives.

Andrews and Boyle (2003) state that since 1996 there has been a 13.4% increase in the number of registered nurses in the United States who identify themselves as a racial/ethnic minority. They cite a Bureau of Labor Statistics report that estimates that the net rate of growth of minorities in the workforce will outpace that of non-Hispanic White women and men. Over the last two decades, "women and members of racially and ethnically diverse groups have made significant inroads into health professions that were once overwhelmingly the province of White men" (p. 363). The increasing diversification of the health care workforce presents challenges for nursing managers and leaders to understand the different values, beliefs, and perceptions that cultural groups may have regarding the meaning of work, communication patterns, interpersonal relationships, moral and religious beliefs, clothing, and hygiene.

In contrast, the Sullivan Commission on Diversity in the Healthcare Workforce (2004) found that "today's physicians, nurses, and dentists have too little resemblance to the diverse population they serve" (p. 1). Convened at Duke University School of Medicine and directed by former U.S. Health and Human Services Secretary Dr. Louis W. Sullivan, this commission sought to identify, examine, and find solutions to the barriers to increasing diversity in health care. The Commission claimed that as the U.S. population continues to diversify, diversity in the workforce will be a key component to the industry's excellence. Workforce diversity can improve cultural competence as providers and organizations begin to recognize the "intrinsic value of all human and of health beliefs and practices that may not align with the dominant Western model" (p. 20).

In addition, Spataro (2005) argues that as the composition of a workgroup becomes more diversified, attitudes regarding diversity will change. She notes that "workers who are more different in sex, race, and nationality from others in their organization are more responsive in adjusting their behaviors to fit different situations" (p. 24). Increasing workforce diversity, therefore, can result in greater access to care, improved patient-physician communication and relationship, compliance with treatment and follow-up, larger market share, and increased patient and provider satisfaction.

The American Academy of Pediatrics (AAP) (2000) issued a statement to raise awareness of the importance of workforce diversity in providing culturally competent health care to the pediatric patient population. According to the *Statistical Abstract of the United States: 1997*, nearly 40% of school-aged children by the year 2020 will be non-white. The AAP warns that disparities between the increasingly diversifying pediatric patient population and their pediatricians will widen substantially. They argue that in order to meet the health care needs of this changing patient population, the pediatric workforce must recruit a greater number of racially and ethnically diverse candidates and must begin to educate medical and nursing students on the importance of recognizing and valuing cultural differences. The AAP claims that:

> racial and ethnic diversity among pediatricians enhances opportunities to improve quality of care for these children. Diversity in the pediatric workforce, in pediatric educational systems, and in the leadership of our pediatric organizations promotes the cultural effectiveness of pediatricians. (p. 129)

The physician's race and ethnicity are also of great significance. Racial, ethnic, and social barriers often deter parents from seeking necessary health care for their

children. The AAP suggests that increasing the number of culturally diverse physicians may help remove barriers to access and increase quality of care. "Patient and parent satisfaction with care may be higher when the physician is of the same racial or ethnic group as the patient" (p. 130).

Maxwell (2005) argues that the present health care workforce does not reflect the demographic mix of the overall country. According to Maxwell, "African Americans, Hispanic Americans, and Native Americans compose almost 25% of the total U.S. population, yet account for only 6% of the nation's physicians, 9% of its nurses, and 5% of its dentists" (p. 139). Encouraging and maintaining a diverse workforce, however, is not as simple as hiring culturally diverse individuals. This method produced high turnover rates due to a lack of implementing the appropriate organization-wide training and communication programs. Diversity requires a spirit of inclusion and the belief that differences are valuable. "Employees with different opinions who work in an environment that is open and honest lead to a better product, process, or service" (p. 139).

Maxwell (2005) offers steps for successfully implementing and maintaining a diversity program. She claims that health care can benefit from some of the measures employed in corporate America. These include adopting a long-term approach for the development and implementation of a diversity program, having measurable goals, enlisting the support of senior management and stakeholders, developing targeted recruitment programs, providing ongoing training programs, and incorporating a feedback system such as focus groups. Maxwell concludes that "in the health care industry diversity ultimately leads to higher productivity, improved access and quality of care, and a higher level of consumer satisfaction" (p. 139).

Organizational Culture and Cultural and Linguistic Competency

A discussion regarding the influence that organizational culture may or may not have on an institution's awareness of and willingness to become culturally and linguistically competent is considerably lacking in the literature. Although many authors discuss how culture shapes an individual's perception of health and illness and their expectations of care, very few authors discuss the role of organizational culture in facilitating the provision of culturally and linguistically competent care. The culture of an organization, similar to that of an individual or group, embodies its unique characteristics. Carney (2006) states "the culture of the organization is viewed as a critical driver of norms and the 'way we do things around here'" (p. 24). It embodies formal and informal customs, rituals, and practices. Leininger (1996) refers to organizational culture as the norms, values, goals, and practices that are shared by all members. Andrews and Boyle (2003) add that:

> organizational culture encompasses an organization's preferred ways of accomplishing goals, determining priorities, and making decisions. These shared norms and expectations guide the thinking and behavior of the group members, and the shared values provide a sense of common direction and behavior. (pp. 252-253)

Schein (1985) argues that some common definitions of organizational culture, such as language, rituals, behaviors, norms, espoused values, mission, rules, and climate, are mere reflections of the concept; they do not define what the essence of organizational culture really is. He defines the term as:

> a pattern of basic assumptions-invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration-that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 9)

Schein (1992) later adds that there are various levels of organizational culture. The most observable level, artifacts and creations, include work processes and procedures, symbols and logos, and behavioral patterns such as the use of formal or informal communication, ceremonies, and rituals. The second level, basic values, is less observable to those outside of the organization. These values include shared beliefs about how things generally ought to be and acceptable behavior and responses. The least observable level, basic assumptions, describes the often unconscious beliefs about how the organization operates. It includes the beliefs about how the organization relates to its environment, how members relate to one another, and how activities are carried out.

Ciccocioppo and Ciccocioppo (2002) argue that Weech-Maldonado et al.'s (2002) study of diversity management practices in Pennsylvania hospitals shows that organizational culture change cannot be accomplished by using affirmative action policies alone. They claim "hospital cultures must come to value diversity as intrinsically good for the hospital and for the community. Internal champions who understand the critical need for change lead successful organizational change efforts" (p. 125). Executives must move from managing diversity for compliance purposes to valuing diversity and regarding it as a significant strategy issue.

Andrews and Boyle (2003) note that the organizational cultures of health care institutions not only affect staff members within the organization, but also affect patients and physicians. The social organization of health care facilities "has a profound effect on patients, both directly through the care provided and indirectly through organizational policies and philosophy" (p. 253). The American Nurses Association (1991) argues that nurses must be aware of the three cultural systems that influence nurse-patient encounters: "the culture of the nurse, the culture of the client, and the culture of the setting" (para. 6). According the Andrews and Boyle (2003), the interplay of the three cultural systems "may create barriers, result in cultural conflicts, and even lead to a client's lack of trust or reluctance to access services" (p. 249).

Carney (2006), in a study of how organizational culture influences the middle manager's strategic involvement in the delivery of health care, argues "it could reasonably be inferred … that strategic involvement and strong organizational culture is related to effectiveness in health care delivery" (pp. 29-30). Strong organizational culture was characterized by the study's respondents as encompassing a high level of professionalism and a commitment to providing high quality care. Organizational culture influenced strategic involvement in both clinical and non-clinical middle managers, with non-clinical managers showing a greater extent of involvement overall. Carney concludes that clinical and non-clinical middle managers "have the potential to influence health care delivery through involvement in strategy development and through an understanding of the power of organizational culture and its impact on strategic involvement" (p. 30).

Fortenberry (1995), in his examination of the role that hospital control plays in the development and maintenance of organizational culture, finds that the organizational

cultures of hospitals differ based on control, or ownership. The author analyzed Schein's (1992) levels of organizational culture in 18 general hospitals in the South. Data collected from telephone interviews with various respondents from each hospital, including the executive, nursing, personnel, public relations, medical staff, food service, and maintenance departments, revealed that non-profit, religiously affiliated hospitals developed and maintained organizational cultures that were largely altruistic based on analyses of artifacts, values, and assumptions. The altruistic artifacts identified in government, non-federal hospitals exhibited the highest mean of business concern, while for-profit hospitals exhibited the highest mean of business concern based on basic values and assumptions. This study marks the first attempt to provide systematic empirical verification that hospital control influences a hospital's organizational culture. The author states that beliefs about organizational culture are largely assumptive and, therefore, remain untested.

An examination of the extent to which organizational culture influences members' awareness of and acceptance of diversification is warranted. If a culture of professionalism and commitment to high quality care positively influences middle managers' involvement in strategic planning, could a culture that strongly and positively values diversity influence the level of collaboration among its members to provide culturally and linguistically appropriate services? If hospital ownership influences organizational culture, would non-government not-for-profit hospitals (church operated and secular, or other), identified by Fortenberry (1995) to have the highest level of altruistic concern, exhibit the highest level of awareness of the need for, and provision of culturally and linguistically competent services of all general hospitals? Would cultural

diversity be more accepted in an organization that displays culturally diverse artifacts, embraces rather than stifles cultural differences among members of various racial and ethnic origins, and embodies a basic assumption that the beliefs and practices of all members and customers should be regarded with respect? Several authors offer guides to assess organizational culture (see Leininger, 1991; Roizner, 1996; Andrew, 1998), but no examination on the impact of an organization's culture on the awareness of the need for, and provision of, culturally and linguistically competent care was found by this author.

Summary

The importance of providing culturally and linguistically competent care is increasingly capturing the attention of health care professionals and organizations. The growing number of studies relating costly errors and frustrating patient-provider encounters to the lack of cultural knowledge and language barriers has prompted mandates from the federal government, accrediting bodies, and professional associations requiring providers to take reasonable measures to ensure that care is congruent with a patient's cultural beliefs and practices, and that services are provided in the patient's proficient language. The following chapter will discuss the increasing number of foreign-born and the mandates that have been issued to ensure accessibility, appropriateness, and efficacy in health care.

CHAPTER III

GOVERNMENTAL AND PROFESSIONAL RESPONSIBILITY FOR CULTURAL AND LINGUISTIC COMPETENCE IN HEALTH CARE

The U.S. population is rapidly diversifying. In 2005, the land of opportunity witnessed a record number of foreign-born residing within its borders. As the number of foreign-born continues to increase, patient populations accordingly will represent new cultures and languages to a predominately non-Hispanic White health care industry. This chapter reviews the evolution of the Melting Pot concept, details regarding the nation's rising foreign born population and its subsequent rise in Alabama, the history of the Federal government's role in combating health disparities, accrediting bodies' and professional associations' support for cultural and linguistic competence in health care, and assessments of cultural and linguistic competence in U.S. hospitals.

Beyond the Melting Pot

The United States has traditionally been considered the world's melting pot. Originally the title of a 1908 play by Israel Zangwill that gives a cultural twist to Shakespeare's *Romeo and Juliet*, *The Melting Pot* sought to emphasize the uselessness and evil associated with American immigrants clinging to their prejudices and hatred (Hirschman, 1999). The story's main character David Quixano, a Russian Jewish

immigrant who loses his mother and sister in a pogrom in Russia and migrates to the U.S., "believes that the divisions of nationality and ethnicity will soon disappear in the promised land of America" (Hirschman, 1991, p. 103). The story reaffirmed the popular assumption held by many Americans at the time that immigrants should learn English and shed their cultural and ethnic heritage. Gardenswartz and Rowe (1998) state that "becoming 'Americanized' was valued to the exclusion of maintaining the traditions and language of one's root culture" (p. 64). Zangwill, nonetheless, believed that "God … was using America as 'a crucible' to melt the 'fifty' barbarian tribes of Europe into a metal from which He can cast Americans" (PBS Online, n.d., para. 2). This concept later became the central platform "in the development of the assimilation school of race and ethnic studies in American sociology" (Hirschman, 1991, p. 104).

In the early 20th century, the Chicago School of Sociology, led by Robert Park, developed a "sociological theory of race and ethnic change" (Hirschman, 1991, p. 105). According to the theory, assimilation was the inevitable result of contact, competition, and accommodation. Contact led to ethnocentrism and the competitive nature of modern society. To reduce conflict stemming from ethnocentrism and to control competition, cultural and ethnic groups would adjust their attitudes and social relations, or assimilate. Park and Burgess (1969), as quoted by Hirschman (1991), define assimilation as "a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons or groups, and by sharing their experience and history, are incorporated with them in a common cultural life" (p. 106). The Chicago School also proposed what later became known as the contact hypothesis. It claimed that assimilation would be the final perfect product as a result of interaction through social

contact. Primary contacts, those that consist of intense and intimate interactions, would rapidly accelerate assimilation. Secondary contacts, those that are external and isolated, stimulate accommodations but do not necessarily promote assimilation. Nevertheless, it was believed that the rate of assimilation could be decelerated, but never reversed. Assimilation was inevitable.

The Chicago School's theory, however, has endured relentless criticism. Some authors argue that the theory is untestable (see Lyman, 1968), while others suggest that assimilation has various levels (see Gordon, 1964). Moreover, in the 1960s, the idea of cultural pluralism began to challenge that of assimilation (Mohl, 1991; Pryor, 1992; Griffin, 1998). Griffin (1998) argues:

> violence, not the avoidance of conflict; discord, not consensus and agreement; and dismal of the very notion of a unified national character, rule the day … To many young citizens, the Melting Pot signaled enforced enrollment in a system for which they felt no allegiance. (p. 138)

Pozzetta (1991) adds that scholars are no longer "captivated by images of a vast 'Melting Pot' at work that has thoroughly erased differences," rather they now imagine a synthesized outcome in which not only the immigrants have been changed, but mainstream society as well (p. vii). The process of immigration has not been one of sheer integration. Immigrants have generally tried to preserve their languages, traditions, and values, yet these attempts have not resulted in the precise replication of these features. Instead, immigrants have relied on a process of negotiation and invention to adapt their ethnic and cultural identities "to meet changing historical circumstances and to resolve

the problems of duality inherent in their straddling of Old and New Worlds" (Pozzetta, 1991, p. vii).

Higham (1991) argues that "in some degree a multi-ethnic melting pot indubitably has worked – but so imperfectly, so inconsistently, so incompletely! It worked, bit it did not prevail" (p. 85). Higham states that although nearly all of the tribal identities that immigrants brought with them have been obliterated, the "racial and national groupings that [were] created in America have stubbornly persisted" (p. 85). In the aft of the Civil Rights movement, cultural and ethnic groups began questioning the long held belief that newcomers should simply blend in by adopting America's language, ideology, and practices. These groups challenged assimilation with that of pluralism, arguing that shedding their customs should not be a precursor to achieving the American dream. The struggle to resist Americanization and maintain one's cultural identity led to the concepts of the salad bowl, vegetable soup, and the flower pot, to name a few, as well as the birth of the hyphenated American (Pryor, 1992; Griffin 1998; Dreachslin, 1996).

Today, the capacity to maintain one's cultural and ethnic identity is increasing. Many American businesses are adapting their marketing techniques to capture this growing segment of the population. Companies such as Lowe's, Target, General Motors, and America Online (AOL), to name a few, now provide websites and services in Spanish. In some metropolitan areas, ATM machines give customers the option to select from up to seven different languages (Orum, 2005). Even a number of federal and state government websites offer foreign language translation including the Internal Revenue Service, the Official State of Iowa, Florida's Department of Elder Affairs, and California's Department of Motor Vehicles. Orum (2005) argues that this increased

capacity, along with the emergence of migrant communities that "move easily back and forth among nations while maintaining a separate transnational community," has resulted in a large number of cultural and ethnic groups retaining a great deal of power and independence over their daily lives (p. 924). These groups are no longer melting into the American mainstream culture. On the contrary, they are influencing America's way of life.

The Rising Number of Foreign-Born

The United States boasts a long history of immigration. Before 1800, immigration was moderately free and unrestricted for most Europeans. The nation's population totaled approximately 5.3 million, including nearly 1 million African slaves, and the large majority of the immigrants came from Northern and Western Europe (Wepman, 2002). Nearly three quarters of the population were of English or Irish descent (U.S. Information Agency, 1999). They spoke related languages and were predominately Protestant (Wepman, 2002). In 1880, the great wave of immigration began. These immigrants were predominantly Southern and Eastern Europeans from Italy, Russia, Greece, and Turkey (Wepman, 2002). The number of Asian immigrants, although pale in comparison to those from Southern and Eastern Europe, also reached significant proportions (Wepman, 2002). Resentment from Americans, some immigrants themselves, grew as this new wave of immigrants introduced different languages, radical political beliefs, and religions such as Catholicism, Eastern Orthodoxy, and Judaism. Trade unions argued that the new immigrants had a negative impact on the job market since many of them were willing to work for low wages (Wepman, 2002). Subsequently, an anti-alien sentiment flourished as

many Americans considered immigrants to pose a threat to the national character of the new world (Wepman, 2002).

As the number of Southern and Eastern European and Asian immigrants continued to increase, Congress, after the Supreme Court declared the federal government responsible for the regulation of immigration in 1875, enacted strict controls that banned or sanctioned immigrants from certain countries (e.g., the Chinese Exclusion Act of 1882) and levied a head tax in the Immigration Act of 1882 (Smith, 1998). The number of foreign-born, however, continued to increase steadily from 6.6 million in 1880 to 13.9 million in 1920 (Gibson & Lennon, 1999). It was not until after World War I that the number of foreign-born began to decline. Wepman (2002) states that "the Red Scare, the threat of racial pollution, and the wave of renewed anti-Semitism had set the stage for profound changes in U.S. immigration law" (p. 226). After several unsuccessful attempts to control immigration numbers, Congress passed the Immigration Act of 1921 which limited the number of European immigrants that could enter the U.S. to 357,000 and established national quotas "based on previous immigration statistics" for all other nations (Wepman, 2002, p. 242).

Between 1921 and 1970, the number of foreign-born decreased significantly. In 1970, the foreign-born population reached a record low of 9.6 million, or 4.7 percent of the population (Gibson & Lennon, 1999). Since then, however, the foreign-born population has been slowly rising. This resurgence may be partly attributed to the replacement in 1965 of the "national origins system with preference system designed to unite immigrant families and attract skilled immigrants to the United States" (Center for Immigration Studies, n.d., para. 4). The preference system resulted in larger numbers of

Asian and Hispanic applicants, groups whose numbers were, up to this time, insignificant compared to those of European origin. Wepman (2002) attributes the recent increases to the large number of refugees seeking asylum in the U.S., such as those from Vietnam, Laos, Cambodia, Cuba, and Uganda, and the rising incidence of illegal entry.

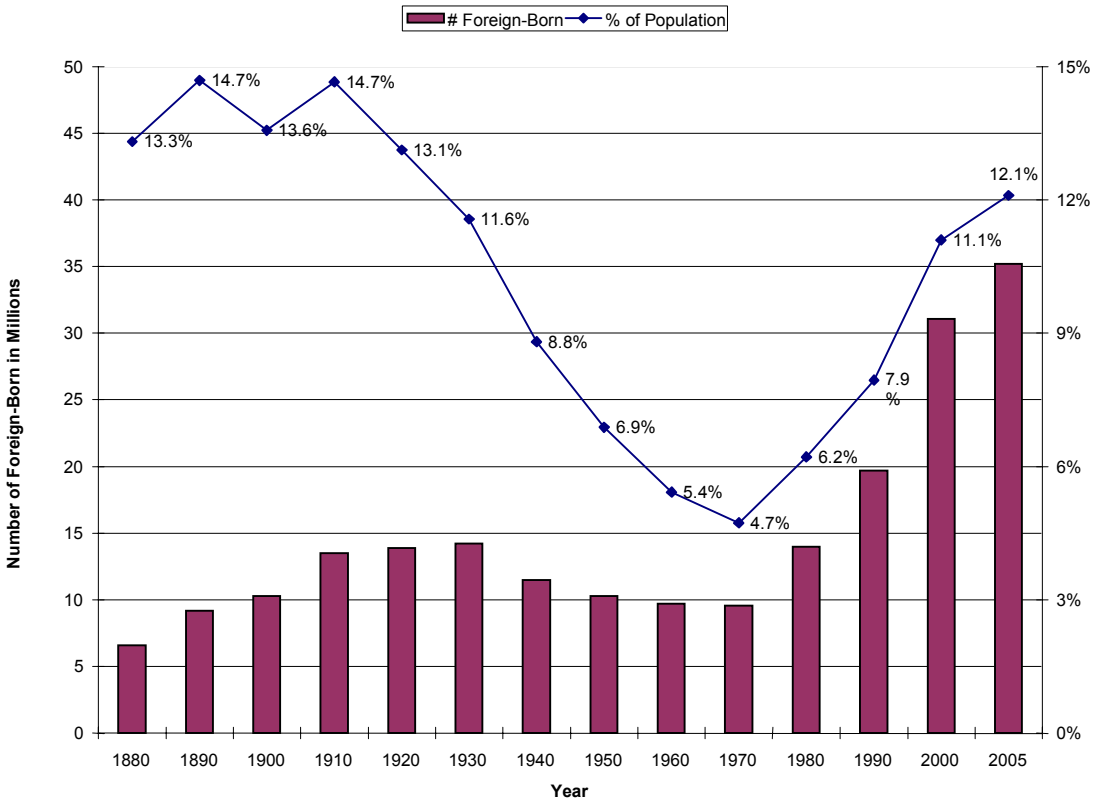
The number of foreign-born has steadily grown from 14.1 million in 1980 and 19.8 million in 1990, to 31.1 million in 2000 (U.S. Census Bureau, 2003b). The Census Bureau (2005a) estimates that in 2004 the foreign-born population represented 12 percent of the nation's population, or 34.2 million. Moreover, nearly 12 million people were said to be linguistically isolated or Limited English Proficiency (LEP) in 2000, up from 7.7 million in 1990 (U.S. Census Bureau, 2003a), and 47.0 million people speak a language other than English in their homes (U.S. Census Bureau, 2003a).

The most recent estimates show that the foreign-born population has reached a record 35.2 million (Camarota, 2005). Analyzing the Census Bureau's March 2005 Current Population Survey, Camarota (2005) argues that "between January 2000 and March 2005, 7.9 million new immigrants (legal and illegal) settled in the country, making it the highest five-year period of immigration in American history" (p. 1). This represents two and a half times the number of immigrants during the great wave of immigration between 1880 and 1914. The foreign-born now account for 12.1 percent of the total population. Figure 3.1 illustrates the number and percentage of foreign-born population in the United States since 1880.

Camarota (2005) states that between 2000 and 2005, the largest percentage of foreign-born came from Mexico, over 2.8 million, or 35.9 percent. When combined, the foreign-born from "Mexico, Central and South America, and the Caribbean account for

the majority of immigrants, with 54 percent of the foreign-born coming from these areas" (p. 8). East Asia accounts for the second largest percentage of foreign-born, or 18 percent. The mean age of the foreign-born population is 33, and 34.1 percent have less than a high school education. Within the illegal foreign-born population alone, those who have less than a high school education rises sharply to 61 percent. Large numbers of foreign-born are employed in the construction and production industries. In 2005, the foreign-born comprised 14.7 percent of the U.S. workforce, 18.4 percent lived below the poverty level, 29 percent utilized "at least one major welfare program," and one-third lacked health insurance (p. 1). In addition, nearly one-half of the new arrivals since 2000 are presumed to have entered the country illegally.

Figure 3.1. Number and Percent of Foreign-Born in the U.S., 1880 to 2005



Source: Statistical information gathered from Gibson, Campbell J., and Lennon, Emily. (1999). Historical Census Statistics on the Foreign-born Population of the United States: 1850-1990. Retrieved October 14, 2005, from the Bureau of the Census Web site: *http://www.census.gov/population/www/documentation/twps0029/twps0029.html*

Camarota (2005) also notes that during the five year period between 2000 and 2005, Mississippi, Tennessee, and Georgia had the largest percentage increases in foreign-born population. Mississippi showed the largest increase with a growth of 43,000, representing an increase of 148.7 percent. Tennessee's foreign-born population increased by 154,000, or 140.0 percent. Georgia gained 384,000 foreign-born, or 101.5 percent. The South, traditionally a biracial region, is now home to nearly 30 percent of the nation's total foreign-born population (U.S. Census Bureau, 2004a). Kocchar, Suro, and

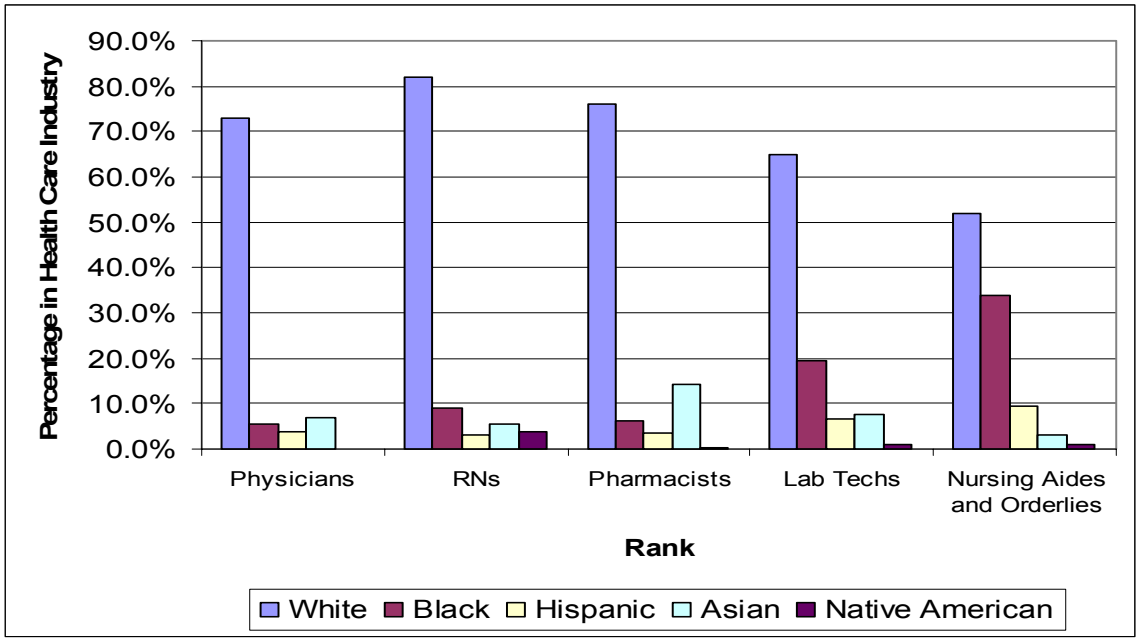
Tafoya (2005), in a study of the rise of Hispanic foreign-born in the South, attribute the increase in the South's foreign-born population to the region's booming economy. They argue that "not only is the region's economy one of the most robust in the country, but its evolution and diversification created job opportunities that Hispanics were eager and willing to fill" (p. 18). The growth in industries such as manufacturing and construction became a magnet for foreign-born seeking employment.

Despite the increasing diversity in the nation's population, the demographic profile of the health care industry's professionals, specifically higher level professions, does not follow suit. The American Hospital Association (AHA) (2005) states that "the ranks of physicians, pharmacists, laboratory technicians, and especially nurses are far less diverse than the general population; in some states, the mismatch is of major proportions" (p.36). Figure 3.2 illustrates the demographics of the health care industry's professionals.

The percentage of Non-Hispanic Whites in high level ranks such as physicians, registered nurses (RNs), pharmacists, and lab technicians far exceed that of non-Hispanic Blacks, Hispanics, Asians, and Native Americans. The percentages of Hispanics and non-Hispanic Blacks in the ranks of physicians, nurses, pharmacists, and lab technicians do not mirror the percentages they represent in the total population. For example, Hispanics account for 14.1 percent of the U.S. population, but only 3.0 percent of RNs, and non-Hispanic Blacks account for 13.4 percent of the total population, but only 9.2 percent of RNs. The rank of nursing aides and orderlies, however, shows a larger percentage of non-Hispanic Blacks (33.9 percent) and Hispanics (9.3 percent). The AHA argues that the poor representation of minorities in higher level ranks may be a result of a lack of mentors or role models of the same race. The AHA states that "a failure on the part of

health care professions and health care employers to reach out to potential employees who are members of minority groups is one of the primary factors" behind the low percentage of minorities in higher level ranks (p. 38). AHA urges leaders in the health care industry to increase the efforts in their organizations to recruit a more diversified workforce.

Figure 3.2. Demographics of U.S. Health Care Professionals



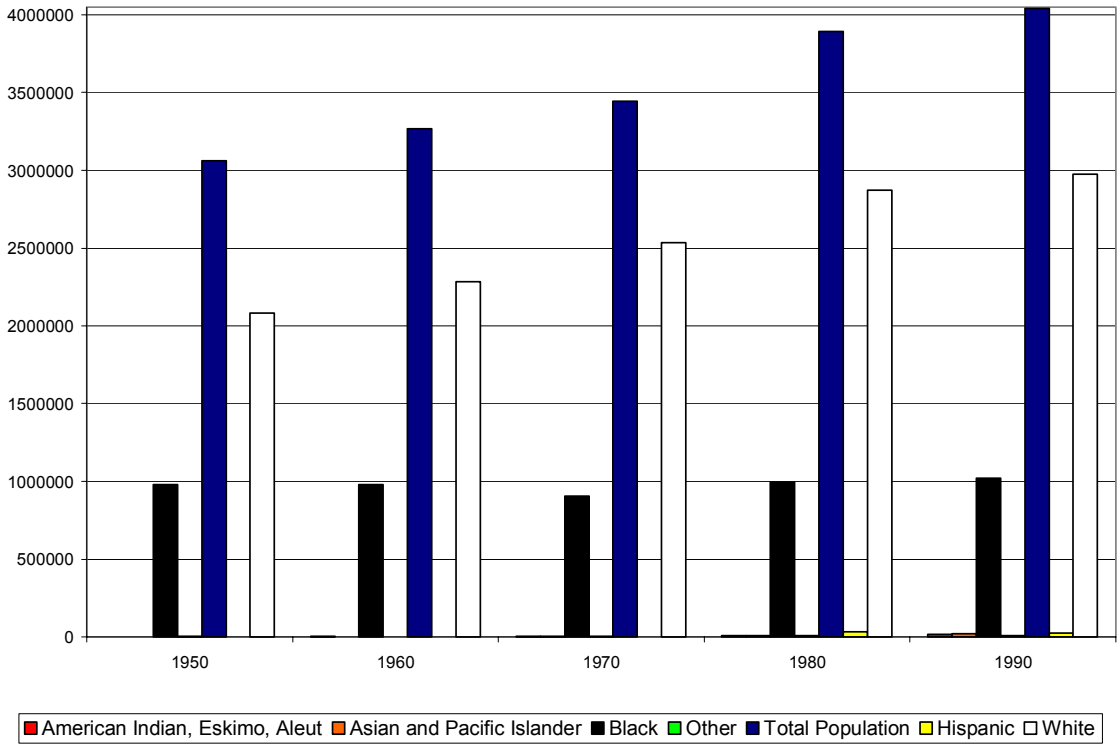
Source: American Hospital Association. (2005). White Coats and Many Colors: Population Diversity and Its Implications for Health Care. Retrieved October 14, 2005, from *http://www.aha.org/aha/key_issues/disparity/content/WhiteCoatsManyColors.pdf*

Alabama's Changing Demographics

Alabama's political, economic, and social history has, as Key (1949) argues, revolved around cotton, agrarian poverty, planters versus plutocrats, and intense racial conflict. The "Heart of Dixie," as the state is commonly nicknamed for its role as the capital of the Confederacy, struggled prominently with debilitating racial issues well into

the 1960s. Due to its long history of antebellum politics and the very nature of its former dominant industry, cotton, Alabama has traditionally been a biracial state. Admitted to the Union in 1819, the first federal census taken the following year estimated the state's population to be 127,901, with 42,450 representing the number of slaves (Griffith, 1968, p. 154). It was not until the 1860 census that a population of 160 American Indian, Eskimo, and Aleut appeared as the first non-White, non-Black race in the state, representing .02 percent of the total population (Gibson & Jung, 2002, Table 1). In 1880, the census showed a second race, Asian and Pacific Islander, of which four residents were estimated to live in Alabama (Gibson & Jung, 2002, Table 1). In 1950, the category of other race was added to the census and 1,269, or .04 percent of Alabama residents considered themselves to be of a race other than White, Black, American Indian, Eskimo, Aleut, Asian and Pacific Islander (Gibson & Jung, 2002, Table 1). It was not until 1980 that significant numbers of races other than White and Black, although still in the single digit percentages, were estimated in Alabama. Figure 3.2 shows the population of Alabama by race from 1950 to 1990.

Figure 3.3. Alabama Population by Race, 1820 to 1990

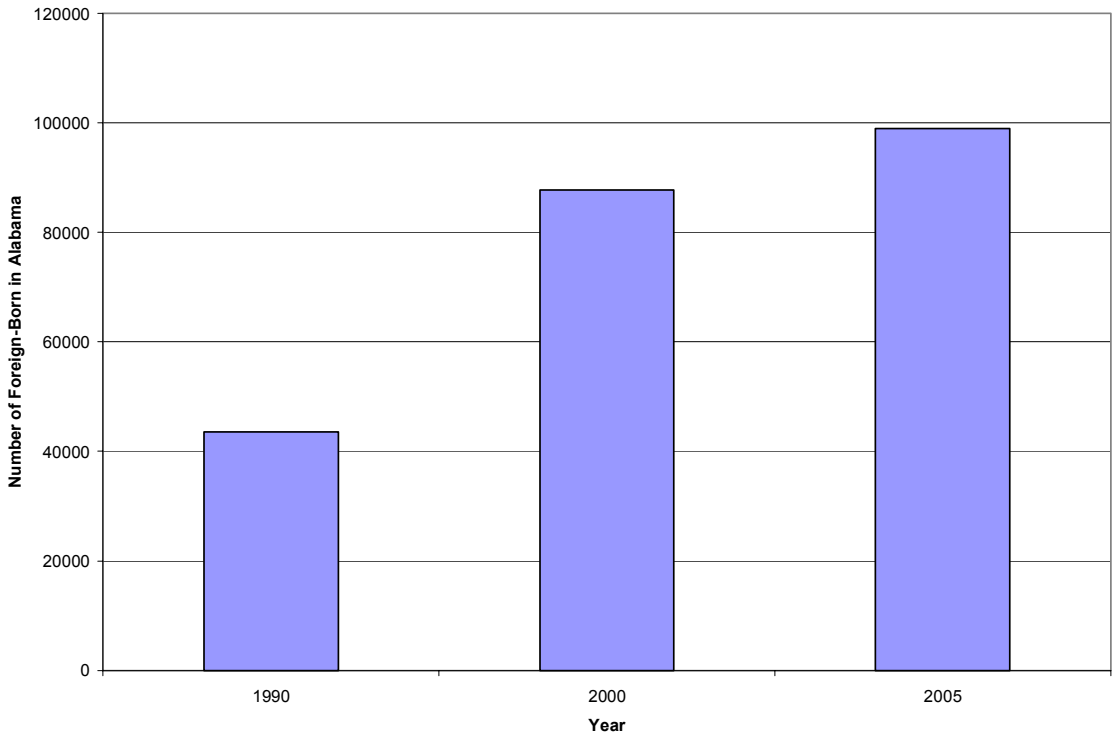


Source: Statistical information gathered from Gibson, Campbell J. & Jung, Kay. (2002). Historical Census Statistics on Population Totals by Race, 1790 to 1990, and By Hispanic Origin, 1970 to 1990, For the United States, Regions, Divisions, and States. Retrieved January 28, 2006, from *http://ww.census.gov/population/www/documentation/twps0056.html*

Over the last 15 years, Alabama's demographics have notably changed. Recent shifting migration patterns, as well as the increase in the foreign-born population, have introduced new cultures and languages to this historically biracial state. According to the 2000 census, the South is now the most populated region in the country (Census Bureau, 2001). Black and Black (2002) add that population growth and economic expansion have resulted in a diversification of political and social ideologies. The end of the agrarian-like economy gave way to a modern and industry diverse one that has attracted individuals of all races. From 1990 to 2000 the number of foreign-born in

Alabama increased by 44,239, more than doubling the state's total foreign-born population to 87,772 (Census Bureau, n.d.a; Census Bureau, n.d.b). Camarota (2005) notes that between 2000 and 2005 nearly 12,000 additional foreign-born entered the state, raising the total population to approximately 99,000 (p. 6). Ciamarra (2005), however, estimates that the current foreign-born population in Alabama exceeds 118,000 (para. 20). Figure 3.3 illustrates the growth in Alabama's foreign-born population since 1990.

Figure 3.4. Foreign-Born Population in Alabama, 1990 to 2005



Source: Statistical information gathered from http://census.cba.ua.edu/SocReport.php?/subtop=S11&area=S&check=1 and http://www.census.gov/population/www/documentation/twps0029/tabl3.html

Kocchar, Suro, and Tafoya (2005) argue that it is not the number of foreign born in the South, specifically Hispanics, that is of great concern, rather the rapid pace at

which the number is increasing. The authors note that between 1990 and 2000, there was a 208% change in Alabama's Hispanic foreign-born population (p. ii). In addition, The University of Alabama News (2003) claims 16 counties in the state gained between 100 to 500 Hispanic foreign-born between 2000 and 2002. Jefferson and Marshall Counties each gained over 1,000, DeKalb County followed closely with a gain of 975, and Shelby, Madison, and Baldwin Counties gained over 500 each. The UA News adds that "some counties believe their Census 2000 count of Hispanics was artificially low, making comparisons of change within the decade a little problematic" (para. 10). The Alabama Department of Public Health (ADPH) (2005) states that the 2000 Census showed Franklin County to have the highest percentage of Hispanics, representing 7.4% of the county's total population. These numbers clearly show that the increases in the foreign-born population are impacting both rural and urban Alabama.

Kocchar, Suro, and Tafoya (2005) also state that while the growth in the overall population, the foreign-born population, and the economy "are not unique to the South, they are playing out in that region with a greater intensity and across a larger variety of communities – rural, small towns, suburbs and big cities – than any other part of the country" (p. i). Ciamarra (2005) adds that although the foreign-born population in Alabama may not be consistent with the growth witnessed in neighboring states such as Florida, Georgia, and Tennessee, "demographic indicators show that the state is headed in that direction" (para. 19).

In its report, *Hispanic Health Profile Alabama 2003*, the ADPH (2005) stated that although the percentage of persons of Hispanic origin in the state is still low, this segment of the population is growing rapidly. The ADPH examined this group's demographic and

health conditions compared to the state's non-Hispanic White and non-Hispanic Black populations, and in some areas to the national Hispanic population. The ADPH notes that the median age of Hispanics in Alabama is 25.1, which is younger than the median age of non-Hispanic Whites and non-Hispanic Blacks. Hispanics in Alabama in all age groups are more likely than non-Hispanic Whites and non-Hispanic Blacks to live below poverty level. The majority of Hispanic males in the state work in the production, transportation, moving, construction, and maintenance industries. Hispanics have more than twice the birth rate (33.3 per 1,000) than that of non-Hispanic Whites (12.1 per 1,000) and non-Hispanic Blacks (15.1 per 1,000), and the Alabama Hispanic birth rate is higher than the national Hispanic birth rate (22.9 per 1,000) (p. 10). The ADPH also noted that there is a higher rate of tuberculosis cases in Alabama among Hispanics (21.3 per 100,000) than non-Hispanic Whites (2.7 per 100,000) and non-Hispanic Blacks (10.0 per 100,000) (p. 29).

Moreover, the increase in Alabama's foreign-born population has resulted in an increase in the number of residents who speak a language other than English at home. In 1990, an estimated 107,866 residents, or 2.9% of Alabama's total population, fell in this category (Census Bureau, 2003a). This number rose to 162,483, or 3.9%, in 2000 (Census Bureau, 2003a). The 2000 U.S. Census also asked those residents who stated that they spoke a non-English language at home to rate how well they could speak English. Nearly 64,000 residents in Alabama stated that they spoke English less than "very well" (Census Bureau, 2003a).

As the number of foreign-born continues to increase throughout the nation, Alabama accordingly will experience a greater diversification of its population. The

state's growing economy and recent prosperity in the manufacturing, production, and construction industries, at a time when these industries are declining elsewhere in the country, will continue to lure the foreign-born and residents from other regions seeking employment. The introduction of different cultures and languages into a state that has historically contended with only two races, White and Black, may pose a problem for Alabama's health care providers if they are not adequately prepared to provide culturally and linguistically appropriate services. As previously mentioned, failure to provide care that is culturally congruent with a patient's beliefs and practices, and failure to effectively communicate due to a language barrier, can lead to serious and costly errors. Becoming aware of and preparing for the inevitable diversification will not only help providers comply with federal regulations, but will also allow providers to ensure quality, equity, and efficacy in the services they provide.

History of Federal Efforts to Combat Growing Health Disparities

In 1985, the growing health disparities between White and minority Americans captured national attention with the release of the Department of Health and Human Services (HHS) *Report of the Secretary's Task Force on Black and Minority Health*. The task force reviewed data on national mortality based on disease categories and minority health factors such as demographics, health information, number of visits to a physician, hospital admissions, and self-perceived health, to name a few. A number of factors such as "etiology; associated physiologic, cultural, and societal factors; means for improving treatment; and possible intervention strategies to prevent excess deaths in minority groups" were considered for each disease category, or cause of death identified (Centers

for Disease Control and Prevention, 1986, para. 3). The task force found that the minority population had 60,000 excess deaths per year compared to Whites. Eighty percent of the excess deaths were caused by six illnesses or diseases including cancer, cardiovascular disease, cirrhosis of the liver as a result of chemical dependency, diabetes, homicides and unintentional injuries, and infant mortality. The task force also found that the data available on minority mortality was lacking in quality. The data on Hispanics largely focused on the foreign-born population, and the data on Asians focused on established populations and did not equally consider recent immigrants. As a result of these findings, the task force offered a number of recommendations to lessen the health disparities faced by minorities. These recommendations included improving health education for minorities; improving "the access, delivery, and financing of health services to minority populations through increased efficiency and acceptability"; coordinating with federal and nonfederal agencies to increase the availability of health professionals in minority communities; encouraging and providing assistance to community agencies in their efforts to meet the needs of the minority population; and, supporting further research to identify risk factors and develop prevention measures and treatment services (Centers for Disease Control and Prevention, 1986, para. 8).

The HHS report generated considerable attention. In response, the Office of Minority Health (OMH) was created the following year by the Secretary of Health and Human Services to implement the recommendations made by the Task Force to lessen health disparities among minority populations. In 1990, the Disadvantaged Minority Health Improvement Act, signed by President George H. Bush, reemphasized the need to lessen the widening health disparities among disadvantaged and minority populations. In

1994, Congress further "encouraged the OMH to carry out activities to improve the ability of health care providers to deliver health services in the native languages of limited English proficient populations" (HHS-OMH, n.d., para. 2). The OMH responded to Congress' request by establishing the Center for Linguistic and Cultural Competence in Health Care (CLCCHC) in 1995. This center's goals included increasing accessibility to and encouraging the exchange of information on how to remove cultural and language barriers in the health care system; collaborating with various federal agencies, public and private health care entities, research institutions, and community-based organizations to promote programs and research aimed at reducing the barriers that the limited English-speaking populations face; developing demonstration projects on how to remove cultural and language barriers and determining their effectiveness and feasibility; and providing technical assistance to health care providers in their efforts to enhance their capabilities of providing linguistically congruent health care to the various minority populations they serve.

A number of federal initiatives were also launched to combat health disparities. In 1990, the second national health objectives program, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, considered a few of the HHS Task Force's recommendation. Developed by a group of national and state organizations and led by the U.S. Surgeon General, the goals of *Healthy People 2000* included decreasing deaths from cancer, coronary heart disease, tobacco use, and violent deaths; reducing the incidence rates of syphilis, AIDS, and infant mortality; increasing the number of mammography exams; and, lessening the health disparities among minority populations (Shi & Singh, 2004). The following initiative, *Healthy People 2010: Healthy People in*

Healthy Communities, released in 2000, focuses greater attention on eliminating health disparities and identifies it as one of its overarching goals (the other goal being to increase life expectancy and improve the quality of life for all individuals) (Shi & Singh, 2004). *Healthy People 2010* defines a new relationship between health care providers and public health departments, emphasizing the important role of community agents in improving the overall health of their communities.

Racial and Ethnic Approaches to Community Health (REACH), similar to *Healthy People 2010*, seeks to eliminate health disparities among minority populations by 2010. The program identified six priority areas that are known to have increased incidence, or are significantly lacking among minority populations. The areas include infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, HIV infections/AIDS, and child and adult immunizations (HHS-CDC, 2005). REACH "supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities" (HHS-CDC, 2005, para. 5). These coalitions each consist of a community-based organization, a research organization or university, and a state or local health department. The coalitions strive to implement measures to lessen disparities by conducting continuing education for health care providers on disease prevention, community-wide campaigns to promote health communications, and community health education programs led by lay health workers.

In 1999, as studies continued to show widening health disparities among minority populations, the HHS Agency for Healthcare Research and Quality (AHRQ) solicited applications from Centers of Excellence proposing studies in the areas that had been identified in previous research as having a disproportionate affect on minority

populations. Nine Centers of Excellence, or "hospitals that specialize in treating particular illnesses, or performing particular treatments, such as cancer or organ transplants," were awarded grants by the AHRQ in 2000 (Health Insurance Coverage Online, n.d., para, 3). The program, named the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED), brings teams of investigators together "to analyze underlying causes and contributing factors for racial and ethnic disparities in health care and to identify and implement strategies for reducing and eliminating them" (HHS-AHRQ, 2001, p. 2). The nine projects aim to understand why health disparities among minority populations exist and, based on these findings, develop measures to improve communication and delivery. EXCEED seeks to increase the knowledge base on minority health disparities and improve "the health and health care of priority populations and [eliminate] racial and ethnic disparities in health outcomes and in health access and service delivery" (HHS-AHRQ, 2001, p. 2).

In the midst of increasing efforts to eliminate the barriers that minority populations face in regard to health care, President William J. Clinton signed Executive Order 13166 Limited English Proficiency (LEP) in 2000. LEP required all agencies and organizations that receive federal monies to ensure that the growing number of individuals who are not proficient in the English language be provided with meaningful access to their proficient language. It argued that by not providing language appropriate services to individuals who did not speak English, agencies and organizations were discriminating "on the basis of national origin" and were, therefore, "in violation of Title VI of the Civil Rights Act of 1964" (U.S. Department of Justice, 2001, para. 2). LEP required each Federal agency to:

> develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. (U.S. Department of Justice, 2001, para. 2).

Executive Order 13166 helped clarify the role that Title VI played in the health care industry. Title VI stated that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financing assistance" (U.S. Dept. of Justice Online, 2000). Until the executive order, the terms of this law with regard to the health care industry's responsibility to provide interpretive services had remained vague and, thus, disregarded.

The Department of Justice (DOJ) was charged with the responsibility of "providing LEP Guidance to other Federal agencies and for ensuring consistency among each agency" (HHS, 2003, para. 23). On the same day the President Clinton signed the Executive Order, the DOJ released a policy guidance document urging all Federal agencies to examine their services and develop measures to ensure that limited English proficient individuals are not being discriminated upon. In 2001, the HHS Office of Minority Health (OMH) developed the first comprehensive nationally recognized standards to guide health care providers in complying with Executive Order 13166. The OMH (2001b) stated that the nation's increasing diversification "brings with it a host of

opportunities and challenges that are experienced with increasing frequency and immediacy in health care facilities, from small rural clinics to large urban medical centers" (p. vi). The 14 standards for cultural and linguistic appropriate services (CLAS) were offered as a practical framework to guide health care providers in implementing services and structuring their organizations to respond to the cultural and linguistic needs of all patients or consumers. These standards are listed in full on pages 18-20.

In 2003, HHS offered a revised policy document guidance on LEP to provide clarification pursuant to the Department of Justice's 2002 recommendation that all Federal agencies adopt a uniform guidance "with flexibility to permit tailoring to each agency's specific recipients" (HHS, 2003, para. 8). The revised policy stated that Title VI would not be violated as long as health care providers "take reasonable steps to ensure meaningful access to their programs and activities by LEP persons" (para. 41). Providers are urged to assess the following four factors to determine meaningful access:

> 1.) the number of eligible LEP individuals that are likely to seek the services provided; 2.) the frequency that LEP individuals seek the services provided; 3.) the importance of the services provided to the lives of LEP individuals; and, 4.) the organization's resources and the costs associated with providing services to LEP individuals. (para. 41)

The four factors are intended to guide providers in maintaining a balance "that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits" (para. 41).

HHS also revised its position on using patients' family members or friends as interpreters stating that they may be used if the patient, after having been offered medical

interpretation services at the expense of the provider, insists on using a family member or friend. HHS advises that providers should not consider the use of family members and friends as their primary language interpretation resource, rather they should consider it only when the patient prefers them to the providers' qualified personnel (professional medical interpreter or telephone interpretation service).

Professional Support for Cultural and Linguistic Competence

Various accrediting bodies and professional organizations have also recognized the need for cultural and linguistic competence in health care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an independent nonprofit organization that accredits over 15,000 health care programs and organizations in the U.S., considers cultural and linguistic appropriate services to be "an important quality and safety issue and a key element in individual-centered care" (JCAHO, 2005a, p. 1). JCAHO has issued 20 standards related to cultural and linguistic competence to ensure that health care treatments and services are provided "in a manner that is conducive to the cultural, language, literacy, and learning needs of an individual" (p. 1). The standards include provisions in the following areas: values, beliefs respected; appropriate communication including interpreter and translation services; patient involvement in care; informed consent; thorough patient assessment; patient education on organizations' policies and procedures and available treatments and services; respect for food preferences; observance of end of life care beliefs and practices; provision of care, treatment, and services in accordance with all applicable laws and regulations; continuous revision of services to meet patients' needs; equal standards of care for all patients;

provision of staffing-appropriate mix, adequate staff training, and continuous competence assessment; ongoing staff education and addressing the changing needs of patient populations; ensuring external and internal environments that are appropriate to all patients; data collection on patients' perception of care, treatment, and services for purposes of improvement; proactively seeking to prevent adverse events; use of Clinical Practice Guidelines; and, including language and communications needs of patients in medical records (JCAHO, 2005a; JCAHO, 2005b).

The JCAHO standards, although not directly reflective of the CLAS standards offered by the OMH, do require health care programs and organizations that seek accreditation to provide services that are "conducive to the cultural, language, literacy, and learning needs of individuals" (JCAHO, 2005b, p. 2). JCAHO adds that all patients have the right to participate in decisions regarding their care and treatment. In addition, patient involvement leads to accurate assessments, appropriate treatment, and higher satisfaction and compliance.

The National Committee for Quality Assurance (NCQA), considered a watchdog for health care consumers, is an independent nonprofit organization that accredits managed care organizations and seeks to improve the quality of health care. NCQA accreditation is recognized by 30 states as a proxy for meeting the necessary regulatory provisions for health plans. Accreditation is based on compliance with 60 standards that evaluate such factors as access and service, qualified providers, health maintenance, care, and management of chronic illnesses (NCQA, n.d.; NCQA Public Policy, n.d.). This ongoing measurement of performance among health plans promotes industry-wide commitment to improving the quality of care and services provided.

In 2001, in a study examining the rate of cervical cancer screenings among Managed Care Organizations (MCO), the NCQA concluded that MCOs must remove barriers to access to increase the number of screenings. Quality improvement measures should "address cultural competence, patient education about the importance of screening and early detection, and treatment services" (NCQA, 2002, para. 7). That same year, in its Managed Behavioral Healthcare Organization (MBHO) Surveyor Guidelines, the NCQA stated that particular emphasis should be placed on the appropriateness of the services provided or the person who is providing the service with the particular enrollee. This refers to member satisfaction in regard to accessibility. The appropriateness "reflects the MBHO's 'cultural competence,' or its capability to assess and meet the special, cultural, ethnic and communicative needs and preferences expressed by its members (NCQA, 2001, p. 86). Linguistic competency, however, is still in need of improvement. The NCQA states that organizations should aim to expand their services to include members who have linguistic needs and preferences (NCQA, 2001).

A number of professional associations have also urged the adoption of cultural and linguistic competence standards to eliminate the growing health disparities. The American Medical Association (AMA) issued H-295.897 Enhancing the Cultural Competence of Physicians, a policy statement declaring that the organization will embark on the following activities: continue to provide information to medical schools and residency programs about resources and programs regarding the provision of culturally competent care; urge medical schools to include cultural competence in their curricula; continue to examine the need for cultural competence training; create a national advisory panel to advise physicians on cultural competence and develop and maintain a database

of cultural competence resources; and obtain external funding to create a collaborative program that will seek to modify medical education to emphasize the importance of cultural competence in medical practice (AMA, 2005b).

The American Nurses Association (ANA) issued a position statement arguing that "knowledge of cultural diversity is vital at all levels or nursing practice" (ANA, 1991, para. 2). The ANA urges nurses to become aware of their own cultural biases and understand the life processes, meanings of health and illness, wellness practices, beliefs surrounding illness, and folk medicine practices of the various cultural groups they serve. The ANA adds that nursing educators and administrators must emphasize the importance of cultural beliefs and practices and their influence on a patient's health and acceptance of care, and modify their curricula and policies accordingly.

The American Hospital Association (AHA), in its report *White Coats and Many Colors: Population Diversity and Its Implications for Health Care* (2003), states that it is imperative that health care leaders "understand how their communities are changing, what new needs for care are emerging, and what kind of potential there is for employing members of these new and growing populations" (p. 3). AHA argues that the health care industry's ability to adapt to the rapid diversification of their patient population will be a key factor to their future success. Health care providers are urged to develop community outreach programs designed to target those diverse populations that would otherwise not feel welcomed due to cultural or language barriers. In addition, the AHA contends that although many providers are embracing the concept of cultural competence, minority populations overall continue to report feeling that health care professionals are not

familiar with their cultural beliefs and practices and continue to cite difficulties communicating.

Assessment of Cultural and Linguistic Competence

A study by Regenstein and Sickler (2006) of the National Public Health and Hospital Institute (NPHHI) surveyed 500 non-federal acute care hospitals in the U.S. to inquire about their data collection practices regarding race, ethnicity, and language information. The authors found that 78.4% of the hospitals surveyed collected information regarding patients' race, 50.4% collected information regarding patients' ethnicity, and 50.2% collected information regarding patients' language. Yet, when asked if the race, ethnicity, and language information collected was used to "assess and compare quality of care, utilization of health services, health outcomes, or patient satisfaction across their different patient populations," the study found that "fewer than one in five hospitals that collects this information uses it for any of these purposes" (p. viii). The most commonly cited barrier to collecting the information was the tendency of staff to consider it unnecessary or unimportant or to fear that the patient would be reluctant to answer. The report argues that collecting and analyzing this data is the first step in the industry's efforts to eliminate health disparities. By not using the data collected to assess the quality of services provided across different patient populations and improve patient care, hospitals are overlooking valuable opportunities to enhance marketing, quality, and patient satisfaction efforts.

An examination of hospitals' compliance with the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) standards is absent from the

literature. Many authors have discussed the importance of patient cultural and linguistic assessments in providing effective care (Block, 1983; Leininger, 2001; Campinha-Bacote, Yahle, & Langenkamp, 1996; Hill, Lipson, & Meleis, 2003; Giger & Davidhizar, 1991, 2004; Spector, 2004b). Others have emphasized the need for providers to conduct cultural self-assessment and organizations to conduct cultural audits (Dreachslin, 1996; Wells, 2000; Pacquiao, 2003; Andrews & Boyle, 2003). Moreover, there is unwavering agreement among researchers on the importance of cultural and linguistic competence in health care (Leininger, 1978, 1995; Dobson, 1991; Andresen, 2001; Campinha-Bacote, 2002; Purnell, 2003; Andrews & Boyle, 2003; Giger & Davidhizar, 2002, 2004; Spector, 2004b; Betancourt, Green, Carrillo, & Park, 2005). Yet, little to no attention has been given to hospital compliance with the cultural and linguistic mandates imposed by the federal government, accrediting bodies, and professional associations. Furthermore, no study has examined the levels of acceptance or rejection of policies and practices requiring the provision of culturally and linguistically appropriate services to diverse patients in terms of: (1) health care providers who are of different racial, ethnic, or religious backgrounds; (2) urban versus rural hospitals; (3) hospitals that have different ownership - public, private, or nonprofit; (4) hospitals that have a diverse patient population versus those with a patient population that is still homogenous; and (5) hospitals with an organizational culture that values differences and reflects those values in the three levels of organizational culture as identified by Schein (1992) – artifacts and creations, basic values, and basic assumption. This study will attempt to fill the gap.

Summary

As the nation's foreign-born population continues to increase, health care organizations accordingly will witness a diversification of their workforce and patient population. This diversification will inevitably pose significant challenges to an industry that up to now has been dominated by a predominately non-Hispanic White labor force. The growth of a modern and industry-diverse economy in the South has recently begun to attract a larger number of foreign-born seeking employment. In Alabama, specifically, the introduction of new cultures and languages to a traditionally biracial state may pose considerable challenges for health care providers if they are not adequately prepared to provide care that is culturally and linguistically appropriate. This study, therefore, will examine Alabama hospitals' awareness of the diversifying patient population and their efforts to comply with CLAS standards as required by the federal government, accrediting bodies, and professional associations.

CHAPTER IV

METHODOLOGY AND APPROACH

This chapter discusses the methods used to collect data on Alabama general hospitals' awareness of and preparedness for diversity in their patient populations. The unit of analysis and method of sample selection, respondent selection, survey method, and the questionnaires used are reviewed. The method of analysis used is discussed and details regarding the characteristics of the sample are also provided.

Units of Analyses and Method of Sample Selection

The units of analyses for this study are Alabama general hospitals and registered nurses, including advanced practice nurses who work in acute-care settings within general hospitals. The hospital sample consists of the entire theoretical population of Alabama hospitals whose service category is general. *The AHA Guide 2005* registers hospitals as one of four types: general, special, rehabilitation and chronic disease, and psychiatric. For the purpose of this study, only hospitals registered as general were considered. The AHA Guide defines general as any hospital whose primary function "is to provide patient services, diagnostic and therapeutic, for a variety of medical conditions" (p. A3). A general hospital may provide additional services such as diagnostic x-ray, clinical laboratory including anatomical pathology, and surgical. The AHA Guide offers 28 subcategories that give broad classifications on the service

provided at the hospitals listed. The subcategory of "general medical and surgical" (service code 10) was selected.

Research on the foreign-born population's use of health care services shows that over half of those who recently entered the U.S. are uninsured (Henry J. Kaiser Family Foundation, 2004, p. 1). This is attributed to the low-wage jobs that many foreign-born are employed in that "are less likely to offer health benefits" (p. 1). The lack of coverage is considered one of the main factors in the growing health disparities in access to care among minorities and results in the lack of primary and preventative care (KFF, 2004). Shi and Singh (2004) argue that the growing numbers of uninsured individuals are turning to Emergency Departments (ED) for their basic health care needs. Those who lack coverage make disproportionately more visits to the ED than individuals who have health insurance. Shi and Singh state that "for many of the uninsured lacking access to routine, or primary care, the ED has become the family physician, especially at night and on weekends" (p. 256). The authors argue that today less than half of all ED visits require emergency or urgent attention. The majority of these cases could have been addressed through routine, or primary care. This increase in the number of nonurgent cases utilizing ED services has resulted in overcrowding and the misuse of vital resources. Shi and Singh conclude that EDs are now beginning to "function as a public safety net," acting as primary care providers to those who lack access to it or the financial means to pay for it (p. 256).

In 2004, a Census Bureau report on the fertility of American women stated that the national birth rate of the foreign-born was higher than that of natives. Natives had 56.7 births per 1,000 women while the foreign-born had 83.7 births per 1, 000 women

(Census Bureau, 2004b). In Alabama, the ADPH (2005) reported that in 2003 Hispanics had twice the birth rate (33.3 per 1,000) than that of non-Hispanic Whites (12.1 per 1,000) and non-Hispanic Blacks (15.1 per 1,000) (p.10). The Alabama Hispanic birth rate was also higher than the national Hispanic birth rate (22.9 per 1,000) (p. 10).

Considering the research on the misuse of emergency departments for primary care services by the uninsured and the higher number of births among foreign-born women, this author assumes that the foreign-born are more likely to visit general hospitals seeking emergency and obstetrics services. The population of general hospitals offering "general medical and surgical" services, therefore, was chosen.

In addition to classifying the types of services provided, the AHA Guide classifies hospitals according to type of ownership. There are four main categories: government nonfederal, government federal, nongovernment not-for-profit, and investor-owned (for-profit). The population of Alabama general hospitals selected represents all four types of ownership categories.

Sources used to identify all general hospitals in Alabama included the *AHA Guide 2005*, the Alabama Hospital Association's online member directory[5], and the Alabama Department of Public Health's (ADPH) Provider Services Directory[6]. The *AHA Guide* and the Alabama Hospital Association's online member directory list only those hospitals that are members of their organization. The ADPH directory did have the most comprehensive list of facilities in the state, however, when compared to the previous two lists, two facilities were not listed in the ADPH directory. The reason for consulting all three sources was to ensure that all general hospitals in the state were identified.

[1] Retrieved March 14, 2006, from *http://www.alaha.org/dir_name.cfm*
[6] Retrieved March 14, 2006, from *http://www.adph.org/providers/Hospitals.pdf*

There are 101 facilities that meet this definition. A spreadsheet was created listing the hospitals' names, mailing address, county in which they reside, telephone number, type of control, and type of service. The *AHA Guide* also lists the number of beds and number of personnel for those hospitals that provided the information, however, a large number of hospitals did not provide this information. Human Resources Directors were asked to report the number of beds and personnel at their respective hospitals in the questionnaire sent to them. The population includes proprietary (n=31), private nonprofit (n=32), and public facilities (n=38).

The registered nurse (RN) sample consists of all RNs, including advanced practice nurses[7], who work in acute-care[8] settings within Alabama general hospitals. Data on the sample were provided by the Alabama Board of Nursing (ABN), a state government regulatory body that seeks "to safeguard the public's health, safety and welfare by adopting and enforcing legal standards for nursing education and nursing practice" (ABN, 2006, para. 2). The ABN is charged with:

> establishing the standards for safe nursing care and issuing licenses to practice nursing. Once a license is issued, the board's job continues by monitoring licensees' compliance to state laws and taking action against the licenses of those nurses who have exhibited unsafe nursing practice. (National Council on State Boards of Nursing, 2006, para. 1)

[7] Advanced Practice Nurse (APN) is a general term referring to nurses "who have education and clinic experience beyond that required of an RN. APNs include four areas of specialization in nursing: clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), and certified nurse midwives (CNMs)" (Shi & Singh, 2004, p. 595-596).

[8] Acute care refers to "short-term, intense medical care for an illness or injury usually requiring hospitalization" (Shi & Singh, 2004, p. 595).

According to the ABN, there are currently 26,136 registered nurses, including advanced practice nurses, that identify working in hospitals. Out of the total number, there are 1,154 Certified Registered Nurse Anesthetists, 430 Nurse Practitioners, 74 Clinical Nurse Specialists, and 8 Certified Nurse Midwives.

Method of Respondent Selection

Three major categories of respondents are used in this study: Chief Executive Officers, Human Resource Directors, and Registered Nurses. The reasons these three were selected are described below.

Chief Executive Officers

Gardenswartz and Rowe (1998) argue that in order for organizations to effectively embrace and manage diversity, they must first overcome barriers to change. One of the key factors to facilitating change is to secure commitment from top leadership and have them "walk the talk" (p. 177). The authors contend that it is not enough for health care leaders to go through the motions, rather their efforts must be sincere. It must be a long-term strategy that leaders commit to and consider a priority for their organization. If leaders do not believe in the importance of promoting and managing diversity, neither will the employees.

Similarly, Dreaschlin (1996) states that Chief Executive Officers (CEOs) must be actively involved in managing diversity. She writes, "Visible personal support and involvement in diversity leadership by the CEO, coupled with employee-driven diversity agendas, are key to the change process" (p. 199). Dreaschlin interviews a number of

CEOs in the health care industry and finds that many of them believe that their role in diversity leadership and management is that of modeling and facilitating. Most of the CEOs also discussed the role of champion of diversity, or one who celebrates and values differences. They conclude that it is not enough to create a strategic plan for diversity, rather they must lead by example.

The role of the CEO in promoting and managing diversity within an organization involves establishing "the moral tone and business objectives as well as [setting] the pace and energy required to implement the action plan" (Dreaschlin, 1996, p. 217). It can, therefore, be assumed that in an organization's efforts to achieve cultural and linguistic competence, the CEO also plays a role in establishing objectives and "setting the pace and energy required to implement the action plan" (p. 217). The CEOs of the 101 Alabama general hospitals are questioned about their awareness of and preparation for the diversification of the patient population.

Human Resource Directors

In an assessment of diversity management practices in Pennsylvania hospitals, Weech-Maldonado, Dreaschlin, Dansky, De Souza, and Gatto (2002) argue that effective diversity management is necessary for organizations to achieve cultural and linguistic competence. Health care organizations must develop policies and practices to address the changing workforce and patient demographics. There must be considerable focus on "recruiting, retaining, and managing a more diverse workforce and developing culturally appropriate systems of care" to ensure that the organization continues to meet the needs of its changing environment (p. 123). In addition, Spataro (2005) contends that the more

diverse an organization's workforce is, the likelier that workforce is to understand and value differences resulting in greater flexibility and responsiveness towards others who are of different cultures.

Dreaschlin (1996) states that although those in leadership roles must take ownership of managing diversity, "human resource's task is to facilitate [the] transition" (p. 197). The Human Resource Directors of the 101 Alabama general hospitals were, therefore, sent a questionnaire to inquire about the demographics of their current workforce and their efforts to recruit employees of diverse cultural and linguistic backgrounds.

Registered Nurses

Shi and Singh (2004) contend that registered nurses "are the major caregivers of sick and injured patients, addressing their physical, mental, and emotional needs" (p. 138). According to the U.S. Department of Labor (2005), registered nurses comprise the largest occupation in the health care industry. Nursing is an essential component of health care and has proven to be effective in the patient care setting (Shi and Singh, 2004). RNs work in a variety of health care settings and perform numerous different nursing functions. RNs work in hospitals, physician practices, skilled nursing facilities, nursing homes, hospice facilities, schools, community health centers, and managed care organizations to name a few. RNs provide the necessary skilled care to patients that are faced with the challenge of regaining their health or learning to cope with chronic symptoms or limitations due to illness or disease. Leininger (1995) defines nursing as:

> a learned humanistic and scientific profession and discipline focused on human care phenomena and caring activities in order to assist, support, facilitate, or enable individuals or groups to maintain or regain their health or well-being in culturally meaningful and beneficial ways, or to help individuals face handicaps or death. (p. 59)

The nursing process, as described by Luckmann (1997), includes: (1) assessment, or the collection of data through patient consultation, physical examination, and observation; (2) diagnosis; (3) planning for the appropriate intervention or treatment and discussing it with the patient and family; (4) implementation of the intervention or treatment plan; and, (5) evaluation, including a review of outcomes, a reassessment of the patient, and a determination of the next course of action.

RNs are licensed in every state and are guided by the Code of Ethics for Nurses With Interpretive Statements. This code, developed by the American Nurses' Association, summarizes the primary duties and responsibilities of a nurse:

> Provision 1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
>
> Provision 2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
>
> Provision 3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
>
> Provision 4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

> Provision 5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
>
> Provision 6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
>
> Provision 7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
>
> Provision 8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
>
> Provision 9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy. (ANA, 2005, para. 1).

Although the Code of Ethics does not address the provision of cultural and linguistic appropriate services, a decade earlier, the ANA issued a position statement on cultural diversity in nursing practice. The ANA (1991) stated that ethnocentrism prevents nurses from meeting the needs of those patients that are culturally and linguistically diverse. Nurses, therefore, must familiarize themselves with the different cultural beliefs and practices of health, wellness, and illness. The ANA argued that "culture is one of the organizing concepts upon which nursing is based and defined" (para. 3). Nurses must understand:

> how cultural groups understand life processes; how cultural groups define health and illness; what cultural groups do to maintain wellness; what cultural groups believe to be the causes of illness; how healers cure and care for members of cultural groups; and how the cultural background of the nurse influences the way in which care is delivered. (para. 4)

Nurses must also understand that beliefs and practices vary among individuals who are of the same cultural group, therefore, each patient should be assessed to identify variations.

All registered nurses, including advanced practice nurses, working in acute-care settings within the 101 Alabama general hospitals were asked to complete an online questionnaire to inquire about their beliefs about caring for foreign-born patients, their previous experience with patients who are of different cultures and religions, and standard nursing practices at their hospital regarding the provision of care to foreign-born patients.

Survey Method

The three questionnaires were distributed using Dillman's (2000) Tailored Design Method. He describes this method as:

> a set of procedures for conducting successful self-administered surveys that produce both high quality information and high response rates … it is the development of survey procedures that create respondent trust and perceptions of increased rewards and reduced costs for being a respondent, that take into account features of the survey situation, and that have as their goal the overall reduction of survey error. Its distinguishing feature is that rather than relying on one basic procedure for all survey situations, it builds effective social exchange through knowledge of the population to be surveyed, respondent burden, and sponsorship. Its goal is to reduce overall survey error, with particular emphasis on nonresponse and measurement. (p. 29)

The survey method, therefore, consisted of a mixed-mode format using Internet and mail questionnaires. This dual format allowed the author to reduce the burden of completing a questionnaire for each group of respondents. The survey method also utilized a multiple-contact strategy to reduce nonresponse rates. The author collaborated with the Alabama Board of Nursing (ABN) which administered the registered nurse (RN) questionnaire to acute-care RNs including advanced practice nurses working in the 101 general medical and surgical hospitals. The initial contact included an information letter from the author stating the purpose of the study, how their responses would be used, the deadline for submission, and a pledge of confidentiality. The initial contact also included an information letter from the ABN stating its support, information on how to access the online questionnaire, and information on the continuing education credits offered. These materials and copies of the questionnaires used are found in the Appendices.

The RN questionnaire was Internet-based. The ABN had previously used an Internet-based questionnaire to collect data from RNs and achieved a high response rate. The flexibility provided by the use of the Internet allowing RNs to go online at their convenience (reduced burden), along with Continuing Education (CE) credits that were awarded to those RNs who completed the questionnaire (reward), attributed to the high response rate. Given their success in collecting data using an Internet-based questionnaire, it was agreed upon by the author and the Alabama Board of Nursing that the registered nurse questionnaire would be administered using the Internet and CE credits would be offered as an incentive to participate. To obtain CE credits, RNs had to provide their nursing license number when submitting their responses.

The ABN collects demographic information on all RNs. The license numbers provided by RNs who completed the questionnaire can be used to query the sample's demographics. The questionnaire, however, also included questions regarding the respondents' gender, age, highest level of education, and race/ethnicity to ensure that demographic data are captured on all respondents. Respondents were also asked to identify the department or unit that they currently work in and the name of their respective hospital to ensure that responses from the same department or unit and hospital could be grouped together. This information could only be viewed by the author and the ABN. Respondents were not asked to provide their name and, thus, were unknown to the author. The RNs had five weeks to complete the online questionnaire.

The Chief Executive Officer (CEO) and Human Resources (HR) Director questionnaires were administered through the mail using multiple-contact strategy. According to Dillman (2000), the mail survey method, once unfavorable because of its poor response rate, has been greatly improved upon. The CEOs and the HR Directors were contacted directly by mail using a cover letter from the author that provided a brief explanation of the research study and one from the ABN endorsing the study, a confidentiality pledge, and instructions on completing the enclosed questionnaire. A separate sheet asking the respondent to identify their hospital by name and the county where it resides was included at the end of the questionnaire. This identifier page also included a confidentiality pledge informing respondents that the information provided on the page would only be viewed by the author. Respondents were also informed that as the information is entered into the database, the hospital name would be removed from the mailing list, and the identifier page would be destroyed. Hospital names are not used in

the study to ensure confidentiality. The initial contact letter also included a self-addressed, stamped envelope for the respondent to return the completed questionnaire to the author. A second contact letter was mailed within two weeks of the initial mailing. The second contact consisted of a reminder to those respondents who had not completed the questionnaire. A copy of the questionnaire accompanyed the reminder, as well as a self-addressed, stamped envelope. A final reminder was sent within two weeks of the second contact. This final reminder took the form of a mailed postcard to those respondents that had not returned a questionnaire. A copy of the second contact letter and the wording of the final reminder is included in the Appendices.

Discussion of Questionnaires

The three questionnaires contain both open format and closed format questions. All questionnaires included brief statements regarding the purpose of the study, a pledge of confidentiality, and instructions on how to complete them. At the end of the questionnaires the respondents were provided with a space for comments they wished to share, as well as a space to include their email address if they would like to receive a copy of the questionnaire results when they become available.

The CEO questionnaire examined Chief Executive Officers' awareness of, and preparation for, the increasing diversification of the patient population. CEOs were asked to indicate their level of agreement or disagreement on questions concerning the increase in the foreign-born population posing future cultural and linguistic problems for their hospital, the increase in foreign-born patients within the last year, the provision of culturally and linguistically competent care as part of their hospital's mission statement,

the designation of a person or department assigned to promote cultural competence within their hospital, written policies and procedures ensuring the provision of culturally and linguistically appropriate services, efforts to maintain current information regarding new cultural groups that are moving into their service areas and the representation of these cultural groups within their workforce, efforts to maintain current epidemiological profiles of their service area, and collaborative efforts with community groups regarding the forms of care and services that should be made available to these groups' members. The CEOs were asked if their hospital have a trained interpreter(s) on staff. If they do have a trained interpreter(s), CEOs were asked to provide the hours that they are available and what language(s) they speak. If there is no interpreter(s) on staff, CEOs were asked to answer yes or no to a list of possible reasons. CEOs were asked if their hospital subscribes to a telephone interpreter service. If they do, the CEOs were asked about the availability of the service.

The CEO questionnaire also asked if pictures and decorations that are representative of the various cultures and religions present in their service area are displayed in their hospital. They were asked if signs are posted in a language other than English. If so, CEOs were asked to indicate what language(s). The questionnaire asked if free foreign language classes are offered to interested employees. If so, CEOs were asked to indicate what language(s) are taught. The questionnaire also asked if the hospital gives hiring preference to bilingual candidates. If so, what language(s).

CEOs were asked to indicate their agreement or disagreement on whether the increase in foreign-born patients has resulted in a number of medical errors that have been cited in the literature, such as incorrect diagnosis due to language barriers, excessive

diagnostic testing, lack of informed consent, improper patient education, patient failure to comply with physician directives, poor patient satisfaction scores, increased patient loads in the Emergency Room, increases in uncollectible billings, and malpractice suits. CEOs were also asked whether they consider developing a culturally and linguistically competent workforce a priority for their hospital, do they see the need for more health care practitioners to learn a language other than English, and do they speak a language other than English.

The Human Resource Director questionnaire examined Human Resource Directors' (HRD) awareness of, and preparation for, the increasing diversification of the patient population. The questionnaire inquired about their respective hospital's recruitment efforts, employee training, and workforce diversity. HRDs were asked to indicate their level of agreement or disagreement on questions concerning recruitment efforts to develop a culturally, linguistically, and religiously diverse workforce. The questionnaire also asked if pictures and decorations that are representative of the various cultures and religions present in their service area are displayed in their hospital, if signs are posted in a language other than English and what language, if free foreign language classes are offered to interested employees and for what language(s), and if customer satisfaction surveys are made available in other languages and what languages.

The questionnaire also inquired if admissions desk staff, office personnel, clerical personnel in patient care areas, and nurses are trained to identify and deal with patients are from different cultural, religious, racial, and linguistic backgrounds. HRDs were asked if their hospital has a trained interpreter(s) on staff. If they do have a trained interpreter(s), HRDs were asked to provide the hours that they are available and what

language(s) they speak. If there is no interpreter(s) on staff, they were asked to answer yes or no to a list of possible reasons. HRDs were asked if their hospital subscribes to a telephone interpreter service. If they do, the HRDs were asked about the availability of the service.

The questionnaire also asked HRDs to provide hospital demographic information such as service area population, bed size, personnel size, racial/ethnic demographics of their employees, and racial/ethnic demographics of those in management.

The Registered Nurse questionnaire examined registered nurses' (RN) perception of, and experience with, caring for foreign-born patients. RNs were asked if they believe that a patient's culture influences his or her perception of health, illness, and death. RNs were asked to indicate their level of agreement or disagreement on questions concerning the increase in the foreign-born population posing future cultural and linguistic problems for their hospital, the increase in foreign-born patients within the last year, the availability of trained interpreters, the training received on how to effectively use interpreters, and the training received on the beliefs and practices of different cultural and religious groups.

RNs were asked to indicate their agreement or disagreement on whether the increase in foreign-born patients has resulted in medical errors such as incorrect diagnosis due to language barriers, excessive diagnostic testing, lack of informed consent, improper patient education, patient failure to comply with physician directives, poor patient satisfaction scores, increased patient loads in the Emergency Room, increases in uncollectible billings, and malpractice suits.

The questionnaire inquired about the availability and recent use of cultural reference guides. If these guides are available, RNs were asked to identify the major

cultural and religious groups that are listed. RNs were asked if certain factors such as country of origin, beliefs about health, religious practices and beliefs, family roles, preference in care provider, use of alternative therapies, and nutrition practices and food limitations due to cultural and/or religious beliefs were considered when assessing a patient. The availability of certain written materials in other languages and literacy assessment of patients, including non-English or limited English speaking patients, was inquired about. The questionnaire also asked if signs are posted in a language other than English and what language, if free foreign language classes are offered to interested employees and for what language(s).

RNs were asked about their personal experience in caring for a foreign-born patient. They were asked to indicate if they have provided nursing care to patients of certain racial/ethnic and religious backgrounds. RNs indicated their level of agreement or disagreement with statements concerning their knowledge of other cultures and their level of comfort in providing care for patients from different cultural and linguistic groups. The questionnaire also inquired if RNs speak a language other than English, if they would take a foreign language class if offered free of charge, if they see a need for more health care providers to learn a language other than English, and if so what language(s).

RNs were asked to provide information such as nursing license number, gender, age, highest level of education attained, race/ethnicity, department or unit they currently work in, hospital name, and the county in which it resides.

Internal and External Validity

All subjects possess unique inherent and acquired characteristics. Variables such as gender, age, highest level of education attained, race/ethnicity, urban or rural workplace, and profession or job title were controlled for to reduce selection bias, as well as the likelihood of having unequal distributions of subject-related variables. The author, however, could not control the testing environment to ensure that all respondents complete the questionnaire under the same environmental conditions and during the exact time period. External events or situations may have influenced the respondents during the course of data collection, therefore, maturation due to permanent or temporary changes that respondents may have undergone could not be controlled.

To increase external validity, the whole population of Alabama general hospitals and registered nurses working in acute care settings in these hospitals was selected. The findings of this study, however, are limited to: (1) general hospitals in one state and, therefore, cannot be generalized to all states; and, (2) registered nurses working in acute care settings within these general hospitals and, therefore, cannot be generalized to all registered nurses. The findings are also limited to hospitals that are categorized as offering "general medical and surgical" services. This prevents the findings from being generalized beyond this setting to other health care provider organizations such as physician practices, outpatient diagnostic and surgical centers, urgent care centers, emergency medical transport services, and mental health facilities. The hospitals within the sample, however, represent those hospitals most likely to be visited by the foreign-born population seeking emergency and labor and delivery services. The findings may be suggestive for general hospitals in states that are similar to Alabama in size and culture.

The data collected from the three questionnaires are assumed by the author to be based on the respondents' knowledge of cultural and linguistic competence policies and practices of their respective hospital and the information is representative of their respective hospital. The author also assumes that all respondents answered questions regarding their beliefs or perceptions honestly. The information received by the author from follow-up contacts, however, may have been subject to the author's biased interpretation.

Methods of Analysis

Variables were measured using interval, ordinal, and nominal classifications. Frequency distribution were used to summarize the data for each variable. This method of analysis provides a "summary of the pattern of variation of a variable," showing the number of respondents that answered each value for all questions (Fox, 1995, p. 26). Percentage tables are also used to standardize each frequency for easy comparisons. Fox (1995) notes that "percentaging reduces the magnitudes of large frequencies to manageable numbers that range from 0 to 100" (p. 29). The frequency and percentage tables facilitate the examination of the characteristics of hospital operations as they are currently being carried out. This will help in determining whether hospitals are prepared for the linguistic and cultural challenges that come with a growing non-English speaking patient population.

In addition, crosstabulation was used to combine two or more frequency tables in order to "examine frequencies of observation that belong to specific categories on more than one variable" and "identify relations between crosstabulated variables" (StatSoft,

2003, para. 56). Bivariate analysis techniques were used in order to examine the impact of hospital characteristics on whether or not linguistic and cultural competence support mechanism have been implemented.

Characteristics of Hospital Population

Shi and Singh (2004) state that hospitals can be classified in a number of ways. The most common classification arrangements are hospital ownership, type of service, location, and bed size. The theoretical population was selected based on type of service classification as noted in the *AHA 2005 Guide* and the Alabama Department of Public Health's Provider Services Directory[9]. All respondents, in each of the three positions surveyed, work in hospitals that are classified as offering general medical and surgical services in Alabama.

Table 4.1 presents the distribution of hospitals targeted by ownership. This information was obtained from the *AHA 2005 Guide*. Out of the 101 hospitals targeted, 31 were for-profit proprietary (also known as investor-owned), 32 were private non-profit (also known as voluntary hospitals), and 38 were public hospitals including federal, state, county, city and hospital district or authority classifications.

[9] Retrieved March 14, 2006, from *http://www.adph.org/providers/Hospitals.pdf*

Table 4.1 Distribution of Alabama Hospitals Offering General Medical and Surgical Services by Ownership

Hospital Ownership	Frequency	Percent
For-Profit Proprietary or Investor-Owned	31	30.7
Private, Non-Profit or Voluntary Hospital	32	31.7
Public Hospital (including Federal, non-Federal, State, City, County, and Hospital District or Authority)	38	37.6
Total	101	100.0

Source: *AHA 2005 Guide*

Hospitals are also commonly classified according to location, that is, whether they are located in urban or rural areas. The designation of Alabama counties as urban or rural was obtained by the U.S. Census Bureau. Table 4.2 presents the distribution of the targeted population by location. The majority of general medical and surgical hospitals in Alabama are located in rural areas, 59.4 percent. Hospitals located in urban areas account for 40.6 percent.

Table 4.2 Distribution of Hospitals by Location

Hospital Location	Frequency	Percent
Urban County	41	40.6
Rural County	60	59.4
Total	101	100.0

Table 4.3 presents the distribution of hospitals by bed size. This information was obtained from Human Resource Director responses and from the *AHA 2005 Guide*. Shi and Singh (2004) state that although there is no standardized classification, hospital bed size is generally arranged into three categories: 1) small, fewer than 100 beds; 2) medium, 100 to 500 beds; and, 3) large, over 500 beds (p. 304). In Alabama 47.5 percent of general medical and surgical hospitals are small. Medium hospitals account for 48.5 percent. Large hospitals represent 4.0 percent. The author, however, divided bed size into six categories to obtain a more detailed distribution (see Table 4.3).

Table 4.3 Distribution of Hospitals by Bed Size

Hospital Bed Size	Frequency	Percent
100 or less	48	47.5
101-200	29	28.7
201-300	11	10.9
301-400	7	6.9
401-500	2	2.0
501 or more	4	4.0
Total	101	100.0

Characteristics of Respondents:

Chief Executive Officers and Human Resource Directors

Data collection for the Chief Executive Officer and Human Resource Director positions was conducted between June 28, 2006 and August 18, 2006. The first contact letter and questionnaire were mailed June 28, 2006. The second contact letter and copy of questionnaire were mailed on July 17, 2006. A final reminder was mailed on July 24, 2006 and included a copy of the questionnaire. The data collection was closed on August 18, 2006.

Chief Executive Officer Sample

Chief Executives Officers (CEO) from 59 of the 101 Alabama hospitals identified as offering general medical and surgical services responded to the survey, representing 57.4 percent of the total population. Table 4.4 presents the comparison of the CEO sample to the total population by hospital ownership, location, and bed size.

Table 4.4 Comparison of CEO Sample and Population by Classification

Classification	CEO Sample Frequency	CEO Sample Percent	Hospital Population Frequency	Hospital Population Percent
For-Profit Proprietary or Investor-Owned	14	23.7	31	30.7
Private, Non-Profit or Voluntary Hospital	19	32.2	32	31.7
Public Hospital	24	40.7	38	37.6
No Response	2	3.4	0	0.0
Total	59	100.0	101	100.0
Urban County	18	30.5	41	40.59
Rural County	40	67.8	60	59.41
No Response	1	1.7	0	0.0
Total	59	100.0	101	100.0
100 or less beds	26	44.1	48	47.5
101-200 beds	18	30.5	29	28.7
201-300 beds	8	13.6	11	10.9
301-400 beds	2	3.4	7	6.9
401-500 beds	1	1.7	2	2.0
501 or more beds	2	3.4	4	4.0
No Response	2	3.4	0	0.0
Total	59	100.0	101	100.0

The largest group of respondents, or 40.7 percent, represent public hospitals. Nineteen respondents, or 32.2 percent, represent private non-profit hospitals. Fourteen respondents, or 23.7 percent, represent for-profit proprietary hospitals. Two respondents did not identify their hospital.

The majority of respondents identified their location in rural counties, 67.8 percent. Those who identified their location in urban counties accounted for 30.5 percent. One respondent did not identify his or her location.

Twenty-six respondents, or 44.1 percent, represent hospitals that have 100 beds or less, 30.5 percent represent hospitals that have between 101 and 200 beds, 13.6 percent represent hospitals that have between 201 and 300 beds, 3.4 percent represent hospitals that have between 301 and 400 beds, 1.7 percent represent hospitals that have between 401 and 500 beds, 3.4 percent represent hospitals that have 501 beds or more, and 3.4 percent did not provide the name of their respective hospital.

Human Resource Director Sample

The Human Resource Directors (HRD) of the 101 Alabama hospitals identified as offering general medical and surgical services were solicited by mail to participate in this research study. A sample of 61 responses was collected, representing 60.4 percent of the total population. Table 4.5 presents the comparison of the HRD sample to the total population by hospital ownership, location, and bed size.

Table 4.5 Comparison of HRD Sample and Population by Classification

Classification	HRD Sample Frequency	HRD Sample Percent	Hospital Population Frequency	Hospital Population Percent
For-Profit Proprietary or Investor-Owned	17	27.9	31	30.7
Private, Non-Profit or Voluntary Hospital	18	29.5	32	31.7
Public Hospital	23	37.7	38	37.6
No Response	3	4.9	0	0.0
Total	61	100.0	101	100.0
Urban County	23	37.7	41	40.6
Rural County	35	57.4	60	59.4
No Response	3	4.9	0	0.0
Total	61	100.0	101	100.0
100 or less beds	26	42.6	48	47.5
101-200 beds	18	29.5	29	28.7
201-300 beds	8	13.1	11	10.9
301-400 beds	3	4.9	7	6.9
401-500 beds	1	1.6	2	2.0
501 or more beds	2	3.3	4	4.0
No Response	3	4.9	0	0.0
Total	61	100.0	101	100.0

The largest group of respondents, or 37.7 percent, represent public hospitals. Eighteen respondents, or 29.5 percent, represent private non-profit hospitals. Seventeen respondents, or 27.9 percent, represent for-profit proprietary hospitals. Three respondents did not identify their hospital.

The majority of respondents identified their location in rural counties, 57.4 percent. Those who identified their location in urban counties accounted for 37.7 percent. Three respondents did not identify their location.

Twenty-six respondents, or 42.6 percent, represent hospitals that have 100 beds or less, 29.5 percent represent hospitals that have between 101 and 200 beds, 13.1 percent represent hospitals that have between 201 and 300 beds, 4.9 percent represent hospitals that have between 301 and 400 beds, 1.6 percent represents hospitals that have between 401 and 500 beds, 3.3 percent represent hospitals that have 501 beds or more, and 4.9 percent did not provide the name of their respective hospital.

Characteristics of Registered Nurse Population

The Alabama Board of Nursing (ABN), a state agency responsible for the development and enforcement of "legal standards for nursing education and nursing practice," maintains current data on registered nurses (ABN Website, para. 2). The total number of registered nurses working in hospitals when the data collection process began in June 2006 was 26,136. The ABN also collects demographic information from registered nurses at the time of licensure. This information includes gender, age, education, and race. Table 4.6 presents the distribution of registered nurses by gender. Nearly 89 percent of registered nurses (88.9 percent) identify themselves as female.

Table 4.6 Distribution of Registered Nurses by Gender

Gender	Frequency	Percent
Male	2,899	11.1
Female	23,237	88.9
Total	26,136	100.0

Table 4.7 presents the distribution of registered nurses by age. Nurses who identified being between the ages of 41 and 50 are the largest group at 32.4 percent. The second largest age group is 31 to 40, representing 25.8 percent. Nurses age 51 to 60 accounted for 23.8 percent. Nurses age 21 to 30 represent 11.9 percent. The smallest age group, 61 or above, accounted for 6.0 percent.

Table 4.7 Distribution of Registered Nurses by Age

Age	Frequency	Percent
21 to 30	3,116	11.9
31 to 40	6,742	25.8
41 to 50	8,477	32.4
51 to 60	6,225	23.8
61 or above	1,576	6.0
Total	26,136	100.0

The distribution of registered nurses by highest level of education achieved is presented in Table 4.8. The largest group of registered nurses, or 48.6 percent, have an Associate Degree. Registered nurses who have earned a Bachelor Degree account for

35.4percent. Those with a Master Degree represent 8.1 percent. Registered nurses that have earned a Doctoral Degree account for 0.3 percent. Those with a High School Diploma or Nursing Certificate represent 7.4 percent. Seventy nurses, or 0.3 percent, did not identify their level of education.

Table 4.8 Distribution of Registered Nurses by Highest Level of Education

Highest Level of Education	Frequency	Percent
High School Diploma or Nursing Certificate	1,934	7.4
Associate Degree	12,713	48.6
Bachelor Degree	9,239	35.4
Master Degree	2,112	8.1
Doctoral Degree	68	0.3
No Response	70	0.3
Total	26,136	100.1

The ABN also collects information on race. Table 4.9 presents the distribution of registered nurses by race. The majority of registered nurses identify themselves as White, Non-Hispanic, accounting for 81.5 percent. Those registered nurses that identified themselves as Black or African American represent 13.8 percent. A total of 2.4 percent identified themselves as Asian, Hispanic, Native American, Multiracial, or Other with Asian the largest category at 0.9 percent. Registered nurses that did not respond represent 2.3 percent of licensees.

Table 4.9 Distribution of Registered Nurses by Race

Race	Frequency	Percent
White, Non-Hispanic	21,305	81.5
Black or African American	3,605	13.8
Asian	240	0.9
Hispanic	117	0.5
Native American	127	0.5
Multiracial	26	0.1
Other	121	0.5
No Response	595	2.3
Total	26,136	100.1

Characteristics of Registered Nurse Respondents

All registered nurses practicing in Alabama hospitals were solicited by mail to participate in this research study. A letter of endorsement from the ABN providing instructions on how to access the questionnaire online and information on earning the one continuing education credit offered, along with a cover letter from the author discussing the objective of the research study and providing contact information, was sent to 26,136 registered nurses. Data collection was conducted between June 28, 2006 and August 7, 2006. The questionnaire could be accessed through the ABN website and was available 24 hours a day, seven days a week during the collection period. Approximately 1,000 letters were returned to the ABN due to incorrect mailing addresses (nurses are responsible for providing the ABN with their current contact information). The author

received three telephone calls and two E-mails from registered nurses who said they were licensed in the state of Alabama, but were currently practicing in another state. These nurses were asked not to complete the questionnaire since the study focused only on Alabama general hospitals.

A sample of 1,979 registered nurses responded representing 7.6 percent of the total population. Table 4.10 presents the comparison of the RN sample to the total population by gender, age, highest level of education, and race.

Table 4.10 Comparison of RN Sample and Population by Demographic Indicator

Demographic Indicator	RN Sample Frequency	RN Sample Percent	RN Population Frequency	RN Population Percent
Male	171	8.6	2,899	11.1
Female	1,585	80.1	23,237	88.9
No Response	223	11.3	-	-
Total	1,979	100.0	26,136	100.0
Age 21 to 30	193	9.8	3,116	11.9
Age 31 to 40	409	20.7	6,742	25.8
Age 41 to 50	650	32.8	8,477	32.4
Age 51 to 60	434	21.9	6,225	23.8
Age 61 or above	70	3.5	1,576	6.0
No Response	223	11.3	-	-
Total	1,979	100.0	26,136	99.9
High School Diploma or Certificate	14	0.7	1,934	7.4
Associate Degree	852	43.1	12,713	48.6
Bachelor Degree	705	35.6	9,239	35.3
Master Degree	174	8.8	2,112	8.1
Doctoral Degree	11	0.6	68	0.3
No Response	223	11.3	70	0.3
Total	1,979	100.0	26,136	100.0

Demographic Indicator	RN Sample Frequency	RN RN Sample Percent	RN Population Frequency	Population Percent
White, Non-Hispanic	1,549	78.3	21,305	81.5
Black or African American	149	7.5	3,605	13.8
Asian	15	0.8	240	0.9
Native Hawaiian or Other Pacific Islander	5	0.2	-	-
Hispanic	5	0.2	117	0.5
Native American	16	0.8	127	0.5
Multiracial	14	0.7	26	0.1
Other	3	0.2	121	0.5
No Response	223	11.3	595	2.3
Total	1,979	100.0	26,136	100.1

The majority of respondents identified themselves as female, 80.1 percent. Male respondents accounted for 8.6 percent. Those respondents that did not provide the information accounted for 11.3 percent.

The largest age group, 41 to 50, account for 32.8 percent. Nurses age 51 to 60 were the second largest age group, representing 21.9 percent, followed by those age 31 to 40, or 20.7 percent. Nurses between the ages of 21 and 30 accounted for 9.8 percent, and those 61 or above represent the smallest group, or 3.5 percent. Two hundred and twenty-three respondents, or 11.3 percent, did not provide the information.

A greater percentage of registered nurses, or 43.1 percent, have an Associate Degree. Registered nurses who have earned a Bachelor Degree account for 35.6 percent. Those with a Master Degree represent 8.8 percent. Registered nurses that have earned a Doctoral Degree account for 0.5 percent. Those with a High School Diploma represent 0.7 percent. Two hundred twenty-three nurses, or 11.3 percent, did not identify their level of education.

The majority of registered nurses (78.3 percent) identify themselves as White, Non-Hispanic. Those registered nurses that identified themselves as Black or African American represent 7.5 percent. Less than one percent identified themselves as Asian, Native Hawaiian or Other Pacific Islander, Hispanic or Latin American, Native American, Multiracial, and Other. Registered nurses that did not respond account for 11.3 percent.

The data collected from the questionnaires are presented in the following chapter. Analysis of the data on each variable using frequency tables and percentage tables is included. This analysis identifies what measures hospitals are taking, if any, to ensure the provision of culturally and linguistically appropriate services as recommended by the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services.

CHAPTER V

FINDINGS

This chapter begins the discussion of the major findings of the study. A descriptive summary of the data collected from the Chief Executive Officer (CEO), Human Resource Director (HRD), and Registered Nurse (RN) questionnaires is provided using frequency and percentage tables. These findings help to determine whether Alabama general hospitals have developed and employed mechanisms to ensure the provision of care and services that are culturally and linguistically appropriate.

CEO Sample Findings

The CEOs were asked to agree or disagree with two statements related to future problems for their hospital as a result of the increasing numbers of foreign-born. Their responses are summarized in Table 5.1. Over 59 percent of the CEOs believe that the increasing number of foreign-born poses future cultural problems for their hospitals and over 84 percent believe there are future linguistic problems posed by the foreign-born. The more definite position on linguistic problems is reflected in lower percentages of both Neither Agree or Disagree responses.

Table 5.1 CEO Sample Responses to Future Problems Due to Increase in Foreign-Born (Percentages)

The increasing number of foreign-born (both documented and undocumented immigrants):	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
poses future cultural problems for my hospital	13.6	45.8	27.1	11.9	1.7	59
poses future linguistic problems for my hospital	20.3	64.4	6.8	8.5	0.0	59

When asked to indicate their level of agreement or disagreement with the statement "my hospital has witnessed an increase in non-English speaking patients within the last year," 20.3 percent of CEOs indicated that they strongly agree, 50.8 percent that they agree, 11.9 percent neither agree or disagree, 15.3 percent that they disagree, and only 1.7 percent indicated that they strongly disagree. This means over 70 percent indicate an increase in foreign-born patients in their hospital during the last year.

CEOs were then asked to indicate their level of agreement or disagreement with a series of statements related to the provision of culturally and linguistically appropriate services at their hospital and their hospital's commitment to delivery of such services. Their responses are summarized in Table 5.2.

Table 5.2 CEOs Responses to the Provision of and Their Commitment to Culturally and Linguistically Appropriate Care (Percentages)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
The provision of culturally appropriate care is part of my hospital's mission statement	10.2	44.1	16.9	27.1	1.7	59
The provision of linguistically appropriate care is part of my hospital's mission statement	3.5	36.8	17.5	35.1	7.0	59
My hospital has written policies and procedures that ensure the provision of culturally appropriate services	5.3	54.4	10.5	24.6	5.3	57
My hospital has written policies and procedures that ensure the provision of linguistically appropriate services	12.1	67.2	10.3	10.3	0.0	58
My hospital has a specific person or department assigned to promoting cultural competence	1.7	20.7	15.5	51.7	10.3	58
My hospital maintains current information regarding new cultural groups that are moving into our service area	3.4	32.8	22.4	36.2	5.2	58
The cultural demographics of my hospital's workforce mirrors the cultural demographics of our service area	15.5	48.3	12.1	20.7	3.4	58
My hospital maintains current epidemiological profiles (information on the causes, distribution, and control of diseases in the population) of our service area	8.6	50.0	20.7	15.5	5.2	58
My hospital regularly works with or consults our community's cultural, ethnic and religious groups regarding the forms of care and services which should be made available to their members	6.9	32.8	32.8	24.1	3.4	58

The majority of CEOs, or 54.3 percent, indicated that they agree or strongly agree that the provision of culturally appropriate care is part of their hospital's mission statement. The provision of linguistically appropriate care, however, is not part of a number of hospital's mission statements, as 42.1 percent of respondents indicated that they disagree or strongly disagree with the statement.

The overwhelming majority of CEOs indicated that their hospital has written policies and procedures that ensure the provision of culturally and linguistically appropriate services and agreed that the demographics of their hospital's workforce mirrors the cultural demographics of their service area. Over 41 percent of respondents, however, disagreed that their hospital maintains current information regarding new cultural groups that are moving into their service area raising. This raises the question of whether hospitals' workforce demographics are truly representative of their service areas' cultural demographics if an evaluation of new cultural groups moving into their service area is not being conducted on a regular basis.

Over 58 percent (58.6) of CEOs indicated agreement that their hospital maintains current epidemiological profiles of their service area and a smaller percent, or 39.7, indicated that their hospital regularly works with or consults their community's cultural, ethnic, and religious groups regarding the forms of care and services which should be made available to their members. Nearly one-third of respondents indicated that they Neither Agree or Disagree with this statement suggesting that perhaps they are unsure or unaware if certain departments work with or consult community groups, or there are no community groups of this nature in their service area.

CEOs were also asked if they have trained interpreters on staff and if so, what hours or shifts are they available and for what languages. Table 5.3 presents the distribution of hospitals by the availability of trained interpreters on staff. Over half of the respondents, or 52.6 percent, indicated that they did not have trained interpreters on staff.

Of those respondents that indicated that they did have trained interpreters on staff, 34.6 percent stated that these interpreters are available during all hours and/or shifts, 23.1 percent stated these interpreters are on call, 26.9 percent stated that interpreters are available during the first shift, 11.5 percent stated that availability varies (further detail was not provided), and 3.8 percent stated that interpreters were available Monday thru Friday. The most often cited language that respondents indicated was made available was Spanish, representing 84.6 percent. Respondents also listed German, Korean, Mandarin, Chinese, and Swahili.

Table 5.3 CEO Sample Responses Regarding Trained Interpreters on Staff

Does your hospital have trained interpreters on staff?	Frequency	Percent
Yes	27	47.4
No	30	52.6
Total	57	100.0

Respondents who indicated that their hospital did not have trained interpreters on staffed were asked to select closed ended options that might explain why there were no trained interpreters on staff. Table 5.4 summarizes the findings.

Table 5.4 CEO Sample Responses for Reasons Why There Are No Trained Interpreters on Staff (Percentages)

	Yes	No	N
Your hospital is witnessing few encounters with non-English speaking patients	69.2	30.8	26
It is too expensive to hire a trained interpreter	76.2	23.8	21
It is difficult to find trained interpreters in your area	95.8	4.2	24
Non-English speaking patients generally bring a family member or friend who can help translate	81.0	19.0	21

The major reason given for not having trained interpreters on staff was the difficulty in finding such a person in the area. The fact that 81.0 percent of CEOs indicated their hospital relies on the patient's family and friends for interpretation should raise concern over the quality of communication between the patient and staff and therefore the quality of care being received. The literature discusses the problems associated with having the patient's family or friends serve as interpreters citing miscommunication due to their unfamiliarity with medical terms, omission of information if the family member or friend decides not to worry the patient with the news of a certain test result or the potential side effects of a procedure, and the possibility of

being put in an uncomfortable situation having to discuss problems of a serious or personal nature.

When asked if their hospital subscribed to a telephone interpreter service a large majority of CEO respondents, 80.4 percent, indicated that they did subscribe, compared to 19.6 percent who indicated that they did not subscribe (see Table 5.5). Respondents who indicated their hospital subscribed to a telephone interpreter service were asked if this service is available 24 hours a day, during weekends, and during holidays. All respondents indicated that the service is available 24 hours a day, 73.3 percent indicated that it is available during weekends, and 73.3 percent indicated that it is available during holidays.

Table 5.5 CEO Sample Responses on Telephone Interpreter Service

Does your hospital subscribe to a telephone interpreter service?	Frequency	Percent
Yes	45	80.4
No	11	19.6
Total	56	100.0

CEOs were asked to indicate if their hospitals post signs in a language other than English. Respondents that indicated that their hospitals did post signs in a language other than English accounted for 81.4 percent, compared to 18.6 percent that indicated they did not. Of those respondents that indicated that they did post signs in other languages, 72.9 percent specified that they had signs posted in Spanish, 2.1 percent specified that they had signs posted in Korean, 25.0 percent did not specify a language.

Asked if their hospital provides free foreign language classes to interested employees 86.4 percent of the CEOs indicated that their hospital does *not* provide free foreign language classes to interested employees, compared to 13.6 percent that indicated they did. Of those 13.6 percent that offer free foreign language classes, 75.0 percent specified that their hospital offers classes in Spanish to interested employees, and the other 25.0 percent did not specify a language.

CEOs were also asked if hiring preferences are being given to bilingual candidates. The majority of respondents, 82.5 percent, indicated that they do *not* give bilingual candidates hiring preferences, compared to 17.5 percent who indicated that bilingual candidates were being given preference. Of those respondents that indicated that their hospital was giving hiring preferences to bilingual candidates, 70.0 percent indicated they preferred Spanish speaking candidates, and 30.0 percent did not specify a preferred language. See Table 5.6.

Table 5.6 CEO Sample Responses to Signage, Providing Foreign Language Classes, and Giving Hiring Preference to Bilingual Candidates (Percentages)

Does your hospital:	Yes	No	N
Post signs in a language other than English	81.4	18.6	59
Provide free foreign language classes to interested employees	13.6	86.4	59
Give hiring preference to bilingual candidates	17.5	82.5	57

A review of the literature found numerous studies arguing that cultural and language barriers have commonly been associated with misunderstandings, medical

errors, poor outcomes, and in some cases legal action (Hampers et al., 1999; Chin et al., 2001; Andrews & Boyle, 2003; Baker et al., 1996; Carrasquillo et al., 1999; Ku & Flores, 2005). CEOs were asked to indicate their level of agreement or disagreement that their hospital had experienced some of the most common problems cited in the literature. Table 5.7 summarizes the responses.

Table 5.7 CEO Sample Responses to Common Problems Due to Increase in Foreign-Born (Percentages)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does Not Apply	N
Incorrect diagnosis as a result of a language barrier between the patient and a service provider	0.0	3.4	22.0	37.3	16.9	20.3	59
Excessive diagnostic testing	0.0	6.8	20.3	39.0	15.3	18.6	59
Lack of informed consent	0.0	13.6	22.0	39.0	8.5	16.9	59
Improper patient education	0.0	23.7	30.5	25.4	3.4	16.9	59
Patient's failure to comply with physician directives	0.0	23.7	33.9	22.0	3.4	16.9	59
Poor patient satisfaction scores on hospital surveys	0.0	6.8	39.0	32.2	5.1	16.9	59
Increase patient loads in the Emergency Room	6.8	30.5	16.9	25.4	1.7	18.6	59
Increases in uncollectible billings	18.6	39.0	15.3	8.5	1.7	16.9	59
Malpractice suits	1.7	1.7	30.5	44.1	3.4	18.6	59

Over 54 percent of CEOs disagreed that cases involving incorrect diagnosis and excessive diagnostic testing had occurred in their hospital as a result of the increase in

foreign-born patients. Slightly less, 47.5 percent, disagreed that cases involving lack of informed consent or malpractice suits had occurred. The largest percentage of respondents indicated that they Neither Agreed or Disagreed that poor patient satisfaction scores on hospital surveys had resulted from the increase in foreign-born patients. Those hospitals that do utilize surveys to measure quality and identify areas that are in need of improvement may not ask patients to identify if they are foreign-born, making it difficult to indicate if lower scores are a direct result of an increase in these patients. Also, the majority of hospitals, as indicated by 65.5 percent of HRD respondents, do not make customer satisfaction surveys available in other languages. Foreign-born patients that speak little or no English are likely not to participate in surveys if they are not made available in their preferred language.

With regard to having witnessed cases involving improper patient education and patient's failure to comply with physician directives, the largest percent of respondents indicated that they Neither Agree or Disagree. CEOs may not have the necessary information to provide a more definitive answer to these statements due to not having direct contacts with patients or experiencing the day-to-day workings of the various nursing units.

There were two statements in the section relating to problems encountered due to the increase foreign-born patient population that respondents agreed their hospitals have experienced. When asked if their hospital has witnessed increased patient loads in the Emergency Rooms, 37.3 percent indicated that they agreed. A large number of foreign-born persons are employed by businesses that do not offer health insurance, or are not eligible because they are undocumented. Lack of insurance often results in poor, or no

primary care, causing these persons to rely on Emergency Rooms for their basic health care needs. Subsequently, when asked if their hospital has experienced increases in uncollectible billings due to the increasing number of foreign-born patients, 57.6 percent indicated that they agreed that their hospital had witnessed this problem.

Table 5.8 presents the responses of CEOs when asked if they consider developing a culturally and linguistically competent workforce to be a priority for their hospital at this time and if they believe more health practitioners should learn another language.

Table 5.8 CEO Sample Responses on the Development of Culturally and Linguistically Competent Workforce and Need for More Bilingual Health Practitioners (Percentages)

Do you:	Yes	No	N
Consider developing a culturally and linguistically competent workforce as a priority for your hospital at this time?	42.4	57.6	59
See a need for more health practitioners to learn a language other than English?	79.3	20.7	58

A greater percent of respondents (57.6) indicated that developing a culturally and linguistically competent workforce is *not* a priority for their hospital at this time, compared to 42.4 percent who indicated that they did consider this a priority. When asked if they see a need for more health practitioners to learn a language other than English, the majority of respondents, or 79.3 percent, indicated that they did see a need, compared to 20.7 percent who indicated they did not see a need at this time. Of those respondents that

indicated that they did see a need, 78.3 percent specified that more health practitioners should learn Spanish, 2.2 percent specified Korean, 2.2 percent specified Asian, and 17.4 did not specify a language.

HRD Sample Findings

HRDs were asked to indicate their level of agreement or disagreement on a number of questions relating to current recruitment efforts and workforce demographics. Table 5.9 summarizes their responses.

Table 5.9 HRD Sample Responses to Current Recruitment Efforts and Workforce Demographics (Percentages)

My hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Actively recruits employees from various ethnic backgrounds	45.9	31.1	11.5	8.2	3.3	61
Actively recruits employees from various religious backgrounds	39.3	26.2	21.3	9.8	3.3	61
Actively recruits employees who speak a language other than English	18.3	26.7	36.7	15.0	3.3	60
Gives hiring preference to bilingual candidates	4.9	9.8	65.6	18.0	1.6	61
Has persons from different ethnic backgrounds in leadership positions	27.9	45.9	19.7	6.6	0.0	61
Has persons from different religious backgrounds in leadership positions	34.4	36.1	21.3	4.9	3.3	61
Has persons who speak a language other than English in leadership positions	6.7	25.0	38.3	28.3	1.7	60

Over three quarters, or 77.0 percent of HRD respondents, indicated that their hospital actively recruits employees from various ethnic backgrounds. A large percentage (65.5) also agreed that their hospital actively recruits employees from various religious backgrounds. Slight less than half of HRDs (45.0) agreed that their hospital actively recruits employees who speak a language other than English.

When asked to indicate their level of agreement or disagreement that their hospital gives hiring preferences to bilingual candidates, well over half of the respondents, or 65.6 percent, indicated that they Neither Agree or Disagree with the statement.

Over 70 percent of HRDs agreed that their hospital has persons from different ethnic backgrounds (73.8) and different religious backgrounds (70.5) in leadership positions. The response to their hospital having persons who speak a language other than English in leadership positions was almost equally divided between Agree (31.7) and Disagree (30.0).

The HRD responses to the series of statements regarding current recruitment efforts and workforce demographics suggests that hospitals are attempting to diversify their workforce. The data collected on the distribution of their current workforce, both employees and management, however, suggests that although hospitals are actively recruiting a diverse workforce, the distribution of employees is still largely White, non-Hispanic, and Black or African American, and the distribution of those in management is overwhelmingly White. Current employee and management demographics by race is summarized in Table 5.10.

Table 5.10 HRD Sample Responses to Employee and Management Distribution by Race (Percentages)

Employees	White	Black or African American	Asian	Native Hawaiian or Pacific Islander	Hispanic	Native American	Multi Racial	Other
1% or less	0.0	10.3	79.3	91.4	87.9	96.6	89.7	98.3
2 to 10%	0.0	15.5	19.0	8.6	12.1	3.4	10.3	0.0
11 to 20%	3.4	20.7	0.0	0.0	0.0	0.0	0.0	1.7
21 to 30%	0.0	15.5	0.0	0.0	0.0	0.0	0.0	0.0
31 to 40%	1.7	20.7	1.7	0.0	0.0	0.0	0.0	0.0
41 to 50%	5.2	10.3	0.0	0.0	0.0	0.0	0.0	0.0
51 to 60%	20.7	1.7	0.0	0.0	0.0	0.0	0.0	0.0
61 to 70%	13.8	1.7	0.0	0.0	0.0	0.0	0.0	0.0
71 to 80%	20.7	3.4	0.0	0.0	0.0	0.0	0.0	0.0
81 to 90%	17.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
91 to 100%	15.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Management	White	Black or African American	Asian	Native Hawaiian or Pacific Islander	Hispanic	Native American	Multi Racial	Other
1% or less	0.0	31.1	88.5	93.4	91.8	93.4	95.1	95.1
2 to 10%	0.0	34.4	4.9	1.6	3.3	1.6	0.0	0.0
11 to 20%	0.0	14.8	1.6	0.0	0.0	0.0	0.0	0.0
21 to 30%	0.0	6.6	0.0	0.0	0.0	0.0	0.0	0.0
31 to 40%	4.9	3.3	0.0	0.0	0.0	0.0	0.0	0.0
41 to 50%	1.6	1.6	0.0	0.0	0.0	0.0	0.0	0.0
51 to 60%	1.6	1.6	0.0	0.0	0.0	0.0	0.0	0.0
61 to 70%	3.3	1.6	0.0	0.0	0.0	0.0	0.0	0.0
71 to 80%	11.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0
81 to 90%	16.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
91 to 100%	54.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

HRDs identified having larger percentages of White, Non-Hispanic and Black or African American employees and managers than any other race. Nearly 88 percent (87.9) of respondents identified having White, non-Hispanic employees constituting between 51 and 100 percent of their workforce. Ninety-three percent of respondents identified having Black or African American employees constituting between 1 and 50 percent of their workforce. Only 19 percent of HRDs reported having Asian employees constituting between 2 and 10 percent of their workforce, and 1.7 percent of respondents stated that Asian employees constituted between 31 and 40 percent. The large percentage of Native Hawaiian or Pacific Islander, Hispanic, Native American, Multiracial, and Other employees reported by HRDs fall into the 1 percent or less category. Of these races, a larger percentage of respondents (12.1) reported having between 2 and 10 percent Hispanic employees.

HRDs were asked to indicate their level of agreement or disagreement regarding their hospital's collaboration with organizations that provide support to the foreign-born. Over 50 percent of respondents (50.8) indicated that they Neither Agree or Disagree suggesting that perhaps they are unsure or unaware if certain departments work with or consult community groups, or there are no community groups of this nature in their service area. Table 5.11 summarizes the data.

Table 5.11 HRD Sample Responses to Collaborating With Community Groups

My hospital works closely with one Or more organizations that provide Support to the foreign-born	Frequency	Percent
Strongly Agree	4	6.6
Agree	13	21.3
Neither Agree or Disagree	31	50.8
Disagree	13	21.3
Total	61	100.0

HRDs were then asked to indicate their level of agreement or disagreement to a series of statements relating to the training of admissions desk staff, office personnel, clerical personnel, and nurses to identify and deal with patients from different cultural, religious, and ethnic backgrounds as well as patients who speak little or no English. Table 5.12 summarizes the results.

Table 5.12 HRD Sample Response to Training of Admissions Desk Staff, Office Personnel, Clerical Personnel, and Nurses (Percentages)

In my hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Admissions desk staff are trained to identify and deal with patients from:						
Different cultural backgrounds	31.1	55.7	9.8	1.6	1.6	61
Different religious backgrounds	28.3	53.3	16.6	1.7	0.0	60
Different racial backgrounds	33.3	55.0	10.0	1.7	0.0	60
Who speak little or no English	26.7	51.7	15.0	5.0	1.7	60
Office personnel are trained to identify and deal with patients from:						
Different cultural backgrounds	32.8	49.2	16.4	0.0	1.6	61
Different religious backgrounds	29.5	50.8	19.7	0.0	0.0	61
Different racial backgrounds	32.8	50.8	16.4	0.0	0.0	61
Who speak little or no English	27.9	49.2	16.4	4.9	1.6	61
Clerical personnel are trained to identify and deal with patients from:						
Different cultural backgrounds	29.5	57.4	11.5	0.0	1.6	61
Different religious backgrounds	27.9	54.1	18.0	0.0	0.0	61
Different racial backgrounds	31.1	55.7	13.1	0.0	0.0	61
Who speak little or no English	26.2	50.8	16.4	4.9	1.6	61
Nurses are trained to identify and deal with patients from:						
Different cultural backgrounds	36.1	57.4	4.9	0.0	1.6	61
Different religious backgrounds	36.1	55.7	6.6	1.6	0.0	61
Different racial backgrounds	37.7	55.7	4.9	1.6	0.0	61
Who speak little or no English	31.1	55.7	9.8	1.6	1.6	61

Well over three quarters of respondents agreed that admissions desk staff, office personnel, clerical personnel, and nurses are all trained to identify and deal with patients that are from different cultural backgrounds, different religious backgrounds, different racial backgrounds, and who speak a language other than English. The agreement levels are at their highest when the HRDs are describing the training of their nurses.

HRDs were also asked to indicate if their hospitals post signs in a language other than English, provide free foreign language classes to interested employees, and make customer satisfaction surveys available in other languages. The summary of responses is presented in Table 5.13 below.

Table 5.13 HRD Sample Responses to Their Hospital Having Signs Posted in a Language Other Than English (Percentages)

Does your hospital:	Yes	No	N
Post signs in a language other than English	73.3	26.7	60
Provide free foreign language classes to interested employees	24.6	75.4	61
Make customer satisfaction surveys available in other languages	34.5	65.5	58

The majority of respondents, or 73.3 percent, indicated that their hospitals did post signs in a language other than English. Just over 95 percent of these indicated that they post signs in Spanish, 2.3 percent specified that they post signs in French, and 2.3 percent specified that they post signs in Braille.

The majority of HRDs, or 75.4 percent, indicated that their hospital does *not* provide free foreign language classes to interested employees. Of those 24.6 percent that indicated that their hospital does offer free foreign language classes, 86.7 percent specified Spanish as the language, and 13.3 percent did not specify a language.

When asked if their hospital makes customer satisfaction surveys available in other languages, 65.5 percent indicated that surveys were *not* made available in other languages, compared to 34.5 percent that said they did. Of those respondents that indicated that surveys were available in other languages, 85.0 percent specified Spanish, 5.0 percent specified French, and 10.0 did not specify a language.

HRDs were asked if their hospitals have trained interpreters on staff and if so, what hours or shifts are they available and for what languages. Table 5.14 presents a summary of HRD responses on the distribution of hospitals by the availability of trained interpreters on staff. The percentage of respondents that indicated that they did have trained interpreters on staff is equal to the percentage of respondents that indicated that their hospitals do not have trained interpreters on staff, or 50.0 percent. Of those respondents that indicated that they did have trained interpreters on staff, 43.3 percent stated that these interpreters are available during all hours and/or shifts, 16.7 percent stated these interpreters are on call, 20.0 percent stated that interpreters are available during the first shift, 10.0 percent stated that interpreters are available as needed, 3.3 percent stated that interpreters are available from 7 a.m. to 7 p.m., and 6.7 percent stated that interpreters are available on employee's scheduled shift (further detail was not provided). The most often cited language that respondents indicated was made available was Spanish, representing 90.0 percent.

Table 5.14 HRD Sample Response Regarding Trained Interpreters on Staff

Does your hospital have trained interpreters on staff?	Frequency	Percent
Yes	30	50.0
No	30	50.0
Total	60	100.0

Respondents who indicated that their hospital did not have trained interpreters on staffed were asked to select closed ended options that might explain why there are no trained interpreters. Table 5.15 summarizes the findings.

Table 5.15 HRD Sample Response for Reasons Why There Are No Trained Interpreters on Staff (Percentages)

	Yes	No	No Response
Your hospital is witnessing few encounters with non-English speaking patients	50.0	13.3	36.7
It is too expensive to hire a trained interpreter	13.3	30.0	56.7
It is difficult to find trained interpreters in your area	33.3	16.7	50.0
Non-English speaking patients generally bring a family member or friend who can help translate	56.7	10.0	33.3

The major reason given for not having trained interpreters on staff, similar to CEO responses, is that non-English speaking patients generally bring a family member or friend who can help translate. This raises serious concerns regarding equity and quality of care, as discussed in the CEO Sample Findings section. The lack of increases in non-English speaking patients is the second most frequently given response. One problem here is the items in this section receive unusually high nonresponses.

Table 5.16 presents the responses provided by HRDs when asked if their hospital subscribed to a telephone interpreter service. The majority of respondents, 65.0 percent, indicated that they did subscribe, compared to 35.0 percent who indicated that they did not subscribe. Respondents that indicated their hospital subscribed to a telephone interpreter service, were asked if this service is available 24 hours a day, during weekends, and during holidays. All respondents indicated that the services are available 24 hours a day, while 71.8 percent indicated that it is available during weekends and during holidays.

Table 5.16 HRD Sample Response to Telephone Interpreter Service Subscription

Does your hospital subscribe to a telephone interpreter service?	Frequency	Percent
Yes	39	63.9
No	21	34.4
Total	60	100.0

Lastly, HRDs were asked to identify the size of their hospital's service population and size of workforce. Table 5.17 summarizes the responses. HRDs were given six closed ended responses from which to select the size of service population. The majority of respondents, or 63.9 percent, indicated that the size of their hospital's service population is 99,999 or less, 13.1 percent indicated between 100,000 and 199,999, 8.2 percent indicated between 200,000 and 299,999, 4.9 percent indicated 300,000 and 399,999, 4.9 percent indicated 500,000 or more, and 4.9 percent did not respond. Respondents were

then asked to select the size of their workforce from seven closed ended responses. The majority of respondents (52.5) indicated that their hospital's workforce consists of 500 or fewer employees, 14.8 percent that indicated between 501 and 1000 employees, and 19.7 percent indicated 1001 and 1500 employees.

Table 5.17 HRD Sample Response to Size of Service Population and Workforce

Size of Service Population	Frequency	Percent
99,999 or less	39	63.9
100,000 to 199,999	8	13.1
200,000 to 299,999	5	8.2
300,000 to 399,999	3	4.9
400,000 to 499,999	0	0.0
500,000 or more	3	4.9
No Response	3	4.9
Total	58	100.0
Number of Employees		
500 or less	32	52.5
501 to 1000	9	14.8
1001 to 1500	12	19.7
1501 to 2000	2	3.3
2001 to 2500	1	1.6
2501 to 3000	2	3.3
3001 or more	3	4.9
Total	61	100.0

RN Sample Findings

RNs were asked if they believed that a patient's culture, or his or her unique beliefs, values, and practices, can influence the patient's perception of health, illness, and death. Table 5.18 summarizes the responses. Nearly all respondents indicated that they believed that a patient's culture can influence his or her perception of health (99.5 percent), illness (99.4 percent), and death (99.4 percent).

Table 5.18 RN Sample Responses to Cultures Influence on a Patient's Perception of Health, Illness, and Death (Percentages)

Do you believe that a patient's culture (their unique beliefs, values, and practices) can influence the patient's:	Yes	No	N
Perception of health	99.5	0.5	1979
Perception of Illness	99.4	0.6	1978
Perception of Death	99.4	0.6	1978

RNs were then asked to agree or disagree with two statements related to future problems for their hospital as a result of the increasing number of foreign-born. Their responses are summarized in Table 5.19. Over 70 percent of RNs believe that the increasing number of foreign-born poses future cultural problems for their hospital and over 88 percent believe there are future linguistic problems posed by the foreign-born. The more definite position on linguistic problems is reflected in lower percentages of both Neither Agree or Disagree responses.

Table 5.19 RN Sample Response to Future Problems Due to Increase in Foreign-Born (Percentages)

The increasing number of foreign-born (both documented and undocumented immigrants):	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
poses future cultural problems for my hospital	22.4	47.9	17.9	10.9	0.9	1976
poses future linguistic problems for my hospital	37.5	50.8	5.4	6.0	0.3	1976

When asked to indicate their level of agreement or disagreement with the statement "my hospital has witnessed an increase in non-English (or limited English) speaking patients within the last year," 80.9 percent of RNs indicated that they Strongly Agree or Agree, 10.8 percent indicated that they Neither Agree or Disagree, and only 8.2 percent indicated that they Disagree or Strongly Disagree.

RNs were then asked to indicate their level of agreement or disagreement with a series of statements related to the provision of culturally and linguistically appropriate services at their hospital and resources or guidelines made available to them. Their responses -- which are summarized in Table 5.20 -- present a very different image of the training received than the HRDs presented.

Table 5.20 RN Sample Responses to the Provision of Culturally and Linguistically Appropriate Services and Resources Available (Percentages)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
My hospital has trained interpreters on its staff	11.6	40.3	13.9	25.7	8.4	1976
My department or unit has a list of interpreters or bilingual staff for me to contact when caring for a non-English (or limited English) speaking patient	19.0	52.8	8.1	15.9	4.2	1976
Trained interpreters are available on all shifts to assist medical and nursing staff in communicating with non-English speaking patients	11.0	30.0	18.0	37.1	9.2	1976
Non-English speaking patients are provided with verbal or written notice (in the patient's preferred language) informing them of their right to receive language assistance services	6.7	29.9	33.2	24.3	5.8	1976
Nurses and Staff:						
Have been trained on how to effectively use interpreters	5.7	30.0	18.0	37.1	9.2	1976
Receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases	2.3	17.0	19.7	50.4	10.7	1976
Are made aware of the different life-styles and dietary habits of various cultural groups which might impact health or interfere with patients' adherence to treatment plans	3.0	27.5	17.8	42.7	9.1	1976
Receive written guidelines regarding how to work with patients:						
From different cultures	2.9	23.9	19.3	46.3	7.6	1976
From different religions	3.5	27.5	19.4	42.1	7.4	1975
That speak a language other than English	3.1	28.7	19.3	41.8	7.1	1975

The majority of RNs, or 51.9 percent, indicated that they Agree or Strongly Agree that their hospital has trained interpreters on staff. Over 70 percent of RNs indicated that they agreed that their department or unit has a list of interpreters or bilingual staff for them to contact when caring for a non-English (or limited English) speaking patient. When asked to indicate if trained interpreters are available on all shifts to assist medical and nursing staff, a greater percentage of RNs (46.3) indicated that interpreters are *not* available on all shifts. This raises serious concerns as language barriers in health care have been associated with profound negative consequences. The inability of patients and health care providers to communicate may result in barriers to accessibility, improper diagnosis, lack of informed consent, lack of cooperation in treatment, lack of confidentiality, and poor quality of care. The use of interpreters decreases the likelihood of misunderstandings and diminishes the anxiety and frustration felt by both the patient and provider.

In addition, when asked to indicate if nurses and staff have been trained on how to effectively use interpreters, a greater percentage of RNs (46.3) indicated that they disagree. Herndon and Joyce (2004) state "communicating with patients who have limited English proficiency requires more than simply 'finding someone who speaks their language'" (para. 1). Learning how to effectively use interpreters can help maximize communication and, thus, enhance the quality of care. A few of the main points that Herndon and Joyce stress in the proper use of interpreters include: providing the interpreter with the necessary background information before meeting with the patient, having the interpreter sit next to the patient if possible, maintaining eye contact with the

patient, speaking directly to the patient not the interpreter, avoiding jargon that may be difficult for the interpreter to translate, and allowing for extra time.

When asked if nurses and staff receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases or are made aware of the different lifestyles and dietary habits of various cultural groups which might impact health or interfere with patients' adherence to treatment plans, the majority of RNs indicated that they were *not* provided with this information. RNs also disagreed that their hospital provides written guidelines regarding how to work with patients that are of different cultures, religions, or that speak a language other than English.

RN respondents appear to be more evenly divided when asked if non-English speaking patients are provided with verbal or written notice (in the patient's preferred language) informing them of their right to receive language assistance services. Slightly over a third of respondents indicated that they agree, one third indicated that they Neither Agree or Disagree, and 30.1 percent indicated that they disagree. The larger percentage of Neither Agree or Disagree responses suggests that RNs are unaware or unsure if non-English speaking patients are provided with verbal or written notice. In some hospitals, this notice may be provided during registration.

RNs were then asked to indicate their level of agreement or disagreement that their hospital had experienced some of the most common problems cited in the literature. Table 5.21 summarizes their responses.

Table 5.21 RN Sample Responses to Common Problems Due to Increase in Foreign-Born (Percentages)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does Not Apply	N
Incorrect diagnosis as a result of a language barrier between the patient and a service provider	1.8	9.3	32.3	35.3	8.7	12.7	1960
Excessive diagnostic testing	1.7	13.9	31.9	33.1	7.2	12.1	1960
Lack of informed consent	3.4	23.1	25.2	30.8	6.6	11.0	1960
Improper patient education	7.8	38.1	19.8	21.5	3.0	9.7	1960
Patient's failure to comply with physician directives	7.9	37.8	28.8	13.4	1.8	10.4	1960
Poor patient satisfaction scores on hospital surveys	2.2	12.2	49.0	21.3	3.2	12.0	1960
Increase patient loads in the Emergency Room	15.8	35.0	28.0	8.4	1.3	11.6	1960
Increases in uncollectible billings	18.8	26.8	38.2	3.7	0.6	11.9	1960
Malpractice suits	0.9	3.5	60.3	17.7	4.4	13.2	1960

Over 40 percent of RNs disagreed that cases involving incorrect diagnosis and excessive diagnostic testing had occurred in their hospital as a result of the increase in foreign-born patients. Slightly less, 37.4 percent, disagreed that cases involving lack of informed consent had occurred.

With regard to having experienced cases with improper patient education and patient's failure to comply with physician directives, over 45 percent of RNs agreed that their hospital had witnessed these problems. This differs from CEO responses in which

only 24.1 percent agreed that cases involving improper patient education and patient's failure to comply with physician directives had occurred. Over 45 percent of RNs also indicated having experienced increases in uncollectible billings.

There were two statements in the section relating to problems encountered due to the increase in the foreign-born patient population that the majority of RNs indicated they Neither Agree or Disagree. When asked if their hospital had experienced poor patient satisfaction scores on hospital surveys, 49.0 percent of respondents appeared to be unsure or unwilling to select a more definitive response. Over 60 percent of RNs also appeared to be unsure or unwilling to provide a more definitive response when asked if their hospital has experienced malpractice suits. The higher percentages of Neither Agree or Disagree responses to these two statements may be attributed to the lack of exposure RNs have to this information in their hospital. RNs may only receive aggregate scores of patient satisfaction surveys relating to their specific areas and may not be provided with specific information. Likewise, RNs may not be informed of legal issues unless directly involved in the case.

RNs were asked if their department or unit has easy-to-access cultural reference guides for use by medical and nursing staff, and if so, have they used this guide in the past year and what are the major groups listed. Table 5.22 presents a summary of the responses.

Table 5.22 RN Sample Responses to Cultural Reference Guides (Percentages)

	Yes	No	N
Does your department or unit have easy-to-access cultural reference guides for use by medical and nursing staff?	22.0	78.0	1937
If yes, have you used the guide in the past year?	50.2	49.8	426

Seventy-eight percent of respondents indicated that cultural reference guides are *not* made readily available in their department or unit. Of those that indicated that cultural reference guides are available, the use of these guides was close to evenly divided between those who indicated they had used the guide within the last year and those that had not. Respondents were then asked to list the major cultural and/or religious groups listed in the guide. Hispanic or Latin culture was the most frequently cited cultural group, followed by Asian, Indian, Black or African American, Korean, and Arabic. Jehovah's Witness was the most frequently cited religious group, followed by Muslim, Jewish, Catholic, Hindu, and Islamic. Seven respondents, or 3.3 percent of those that indicated they had used the guide in the past year, stated that their department or unit could access information on all cultures and religions on the computer and/or Internet.

RNs were asked to estimate the percentage of patients they had cared for in the last year that spoke little or no English and indicate the language(s) of these patients. The median response is 1.0 and the mean is 4.38. The findings are summarized in Table 5.23.

Table 5.23 RN Sample Responses to Percentage of Non-English Speaking Patients in the Last Year

What is your best estimate of the percentage of patients that you as a nurse have cared for in the last year that speak little or no English?	Frequency	Percent	N
Less than 1%	164	8.5	1931
2 to 10%	1248	64.6	1931
11 to 20%	238	12.3	1931
21 to 30%	184	9.5	1931
31 to 40%	56	2.9	1931
41 to 50%	21	1.1	1931
51% or more	20	1.0	1931

The majority of respondents, or 64.6 percent, estimated the percentage of patients that spoke little or no English to be between 2 and 10 percent, followed by 12.3 percent that estimated between 11 and 20 percent. This means over 75 percent of RNs have provided care to patients that speak little or no English in the past year. Respondents were then asked to identify the language or languages spoken by these patients. Spanish was the most frequently cited language, followed by Vietnamese, Chinese, Korean, Guatemalan (or Central American) dialects, Indian, German, Russian, Japanese, and Arabic.

RNs were asked to indicate their level of agreement or disagreement with a number of statements regarding assessment practices. Table 5.24 summarizes their responses.

Table 5.24 RN Sample Responses to Patient Assessment Practices (Percentages)

When assessing a patient, the following factors are considered:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Country of origin	11.8	53.3	18.1	14.5	2.1	1935
Beliefs about health	14.2	58.8	14.9	10.9	1.1	1935
Religious practices and beliefs	16.7	63.2	12.0	7.4	0.6	1935
Family roles	16.5	61.6	12.6	8.7	0.6	1935
Preference in care provider (do they prefer a provider of the same sex or age)	10.5	43.2	29.5	15.5	1.3	1935
Use of alternative therapies	6.0	34.3	38.3	19.2	2.2	1935
Nutrition practices and food limitations due to cultural and/or religious beliefs	13.3	56.3	19.4	9.7	1.3	1935

A greater percent of respondents agreed that a patient's country of origin, beliefs about health, religious practices and beliefs, family roles, preference in care provider, and nutrition practices and food limitations were considered during assessment. A lesser percentage of respondents (40.3) agreed that a patient's use of alternative therapies was considered during assessment while 38.3 percent indicated that they Neither Agree or Disagree that this was done.

RNs were then asked to indicate whether certain forms were available in a language other than English. The forms listed on the questionnaire included: Health Insurance Portability and Accountability Act (HIPAA) Privacy form, Patient's Rights form, Consent to Treat form, Authorization for Use or Disclosure of Information form, registration forms, billing statements, Customer Satisfaction Surveys. These forms were

selected based on their importance in collecting patient information, informing patients of their rights, providing information on charges and payment, and collecting patient feedback. Table 5.25 presents the summary of responses. Because of the legal importance of many of these forms, the no response category is included in the table.

Table 5.25 RN Sample Responses to the Availability of Translated Forms (Percentages)

My hospital makes the following written material available in a language other than English:	Yes	No	No Response
HIPAA Privacy Form	48.7	46.0	5.3
Patient's Rights	50.6	44.1	5.3
Consent to Treat	43.4	51.3	5.3
Authorization for Use or Disclosure of Information	38.6	56.0	5.3
Registration Forms	34.7	60.0	5.3
Billing Statements	27.5	67.2	5.3
Customer Satisfaction Survey	26.6	68.1	5.3

Only one form, the Patient's Rights form, was identified by a majority of respondents as available in their hospital in a language other than English. A near majority indicated that their hospital does provide HIPAA Privacy forms in a language other than English. A number of respondents (38 for HIPAA, 33 for Patient's Rights) stated that although they selected "Yes," they were unsure if this form was available in

another language. For the other forms listed, a majority of respondents indicated the forms were *not* made available in another language.

If respondents indicated that one or more forms were made available in a language other than English, they were asked to identify what language(s) were available. Spanish was the most frequently cited language for all seven forms. "All languages" was the second most frequently cited. German, Chinese, French, Vietnamese, Indian, Russian, Korean, "Asian," Indian, Japanese, Braille, Italian, and "Others" were also cited.

Table 5.26 summarizes the findings on RN responses to their hospitals posting signs in other languages, providing free foreign language classes, the likelihood that they would take a foreign language class if offered, and if they speak another language. Over half of the respondents indicated that there are signs posted in a language other than English in their hospital. Of those that answered "Yes," seven respondents noted that their hospitals had bilingual "wet floor" signs. When asked what languages were posted, Spanish was the most frequently cited language, followed by Braille, German, Sign Language, Vietnamese, and French.

Over 70 percent of RNs indicated that their hospital does *not* provide free foreign language classes to interested employees. Those that indicated that their hospital did provide classes were asked to identify what language(s) is being offered. The most frequently cited language was Spanish, followed by German, French, Chinese, and Sign Language. Nineteen respondents, or 3.5 percent, stated that classes had been offered in the past. Four respondents, or 0.7 percent, stated that their hospital provided tuition reimbursement and a number of different language classes were available at a nearby college or university. When asked if they would take a foreign language class if offered

free of charge by their employer or a community organization, over 80 percent of respondents indicated that they would take a class. Just over 95 percent of respondents identified Spanish as the language they would like to learn. Other languages commonly mentioned included French, German, Sign Language, Chinese, Korean, Vietnamese, Italian, Arabic, and Japanese. Eleven respondents stated that they would take any foreign language class that was made available.

Only 11.7 percent of RNs stated that they did speak a language other than English. When asked to identify what language, the most frequently cited response was "basic or little Spanish" (49.0), followed by Spanish, French, German, "basic or little French," Sign Language, "basic or little German," and Tagalog. Although nearly 12 percent stated that they did speak another language, the answers provided by nurses regarding what language suggest that nearly half are *not* fluent in another language.

Table 5.26 RN Sample Responses to Signage, Availability and Preference of Foreign Language Classes, and Second Language (Percentages)

	Yes	No	N
Does your hospital post signs in a language other than English?	55.1	44.9	1860
Does your hospital provide free foreign language classes to interested employees?	29.2	70.8	1860
If offered free of charge by your employer or a community organization, would you take a foreign language class?	81.4	18.6	1762
Do you speak a language other than English?	11.7	88.3	1762

RNs were asked to indicate if they had delivered nursing care to patients of various ethnic or racial backgrounds within the past year. The ethnic or racial backgrounds listed included those groups commonly referred to by the U.S. Census Bureau: Black or African American, American Indian or Alaskan Native, Native Hawaiian and Other Pacific Islander, Asian, Hispanic or Latin American, Middle Eastern or Western Asian, African, and Other. Table 5.27 summarizes the results.

Table 5.27 RN Sample Responses to Caring for Patients of Various Ethnic or Racial Backgrounds in the Past Year (Percentages)

Please indicate if you have delivered nursing care to a patient of the following ethnic or racial background within the last year:	Yes	No	N
Black or African American	99.1	0.9	1860
American Indian or Alaskan Native	37.2	62.8	1860
Native Hawaiian and Other Pacific Islander	16.0	84.0	1860
Asian	76.5	23.5	1860
Hispanic or Latin American	95.1	4.9	1860
Middle Eastern or Western Asian	52.2	47.8	1860
African	34.8	65.2	1860

Nearly all respondents indicated that they had provided care for Black or African American patients within the last year. Over 95 percent indicated that they had provided care to Hispanic or Latin American patients, 76.5 percent indicated that they had provided care to Asian patients, and 52.2 percent indicated Middle Eastern or Western

Asian patients. Those respondents that indicated they had delivered nursing care to patients of a different ethnic or racial background not listed were asked to identify the patient(s) race or ethnicity. German was the most frequently cited ethnicity, followed by Russian, French, Greek, British, European, and Ukranian. These responses indicate that Alabama's patient population is diversifying and nurses are being exposed to new cultures and languages.

RNs were asked to indicate if they had delivered nursing care to patients of various religious backgrounds within the past year. The religious backgrounds listed included Protestant, Catholic, Jewish, Muslim, Jehovah's Witness, Hindu, Atheist, and Other. Table 5.28 summarizes their responses.

Table 5.28 RN Sample Responses to Caring for Patients of Various Religious Backgrounds in the Past Year (Percentages)

	Yes	No	Do Not Know	N
Protestant	85.5	2.3	12.2	1858
Catholic	89.9	1.8	8.2	1850
Jewish	57.3	12.5	30.2	1850
Muslim	41.3	22.4	36.3	1850
Jehovah's Witness	78.9	7.0	14.1	1849
Hindu	15.6	32.0	52.4	1851
Atheist	25.6	11.5	62.9	1851

A greater percentage of RNs indicate that they have provided care to patients that are Protestant, Catholic, Jehovah's Witness, and Jewish. Over 41 percent indicate that they have provided care to Muslim patients. Twenty-three respondents indicated that they have provided care to patients of other religions. Fourteen respondents specified Buddhist, five specified Wicca or Witchcraft, four specified Agnostic, and one specified Bahai.

Significantly smaller percentages of RNs indicate that they have provided care for Hindu and Atheist patients, and a greater percentage of RNs indicated that they do not know if they have provided care to patients with these beliefs. This and the relatively high no response rate suggests that some nurses may not inquire about a patient's religion. As discussed in Chapter 2, religion, like culture, is strongly pervasive and is a strong determinant in an individual's health beliefs and practices. Spector (1991) warns against the dangers of considering culture, ethnicity, and religion to be interconnected. Assuming that because a person is of a specific ethnicity or culture does not necessarily ensure that he or she will be of a specific religion, and vice-versa. By becoming aware of and understanding the importance of religious beliefs and practices to their patients, providers can be better equipped to help their patients with treatment and ensure compliance with directives.

RNs were asked to indicate their level of agreement or disagreement with a number of statements regarding their perceived capability and level of comfort when providing care to patients that are of different cultural backgrounds or speak a language other than English. This series of statements was adopted from Luckmann's (1999) self-assessment. Table 5.29 summarizes the findings.

Table 5.29 RN Sample Responses to Perceived Capability and Level of Comfort When Providing Care to Diverse Patients (Percentages)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
I feel comfortable caring for patients who are of a different culture	22.3	57.2	11.2	8.8	0.5	1856
I feel I have the knowledge necessary to care for patients who are of a different culture	9.6	42.7	24.9	21.8	1.0	1856
I do not behave differently toward people who are of a different culture than mine	26.2	55.5	10.2	7.9	0.2	1856
I always know what to say to someone from a different cultural background	1.6	11.6	32.8	50.9	3.1	1856
I look forward to caring for a patient from a different cultural background	7.0	33.5	43.1	14.8	1.6	1856
I can learn something when I care for patients from diverse cultural backgrounds	21.7	71.3	6.3	0.6	0.0	1856
I always introduce myself to the patient's family	38.7	55.2	4.3	1.8	0.0	1856
I know how to care for a patient who does not speak any English	8.2	54.5	23.4	12. 8	1.1	1856
I prefer to care for a patient from my own cultural group who speaks my language because it is easier	13.5	39.6	29.0	13.4	4.5	1856

The overwhelming majority of respondents agreed that they always introduce themselves to a patient's family and they can learn something when caring for patients from diverse cultural backgrounds. Around 70 percent of RNs agreed that they feel

comfortable caring for diverse patients and do not behave differently toward them. Over 52 percent agreed that they feel they have the knowledge necessary to care for diverse patients and over 62 percent agreed that they know how to care for a patient that does not speak English. Fifty-four percent of respondents disagreed that they always know what to say to patients from a different cultural background, and over 43 percent indicated that they Neither Agree or Disagree that they look forward to caring for a patient from of different culture. Over 53 percent of RNs agreed that they prefer to care for a patient of the same culture and who speaks their language because it is easier. These results indicate that RNs appear to feel comfortable with their capacity to deliver nursing care to diverse patients, but do not necessarily look forward to caring for these patients or always know what to say to them.

Table 5.30 RN Sample Responses to the Need for More Health Practitioners to Learn A Second Language (Percentages)

	Yes	No	N
Do you see a need for more health practitioners to learn a language other than English?	89.9	10.2	1762

Lastly, RNs were asked if they see a need for more health practitioners to learn a language other than English. Table 5.30 above summarizes the responses. Nearly 90 percent of respondents indicated that they *did* see a need, and 97.1 percent of this group stated that health practitioners should learn Spanish. The remaining respondents specified that health practitioners should learn all the languages that are necessary to care for

patients in their respective area, or they indicated they should learn Korean, Sign Language, Chinese, and French. German, Arabic, Japanese, Russian, and Vietnamese received one mention each. The overwhelming percentage of nurses that believe more health practitioners should learn another language, specifically Spanish, suggests that they believe the foreign-born patient population will continue to increase in their area.

Summary of Findings

The data collected indicates that Alabama general hospitals are aware of the challenges that the increasing foreign-born population pose in terms of cultural and linguistic competence for their hospitals in the future. Over fifty-nine percent (59.4) of CEOs and 70.3 percent of RNs indicated that the increasing number of foreign-born poses future cultural problems for their hospitals. Nearly eighty-five percent (84.7) of CEOs and 88.3 percent of RNs indicated that the increasing number of foreign-born poses future linguistic problems.

The data collected from HRDs indicates that Alabama hospitals are actively recruiting persons from diverse cultures. Larger percentages of HRDs indicated that their hospital actively recruits person from various ethnic (77.0), religious (65.5), and linguistic (45.0) backgrounds. The distribution of their current workforce by race, however, suggests that hospitals are having difficulty finding qualified persons of diverse cultures to fill vacancies. The 2005 Census Bureau State and County QuickFacts estimates that persons of races other than White, non-Hispanic and Black constitute only 4.4 percent of the state's total population, with Hispanic being the largest at 2.2 percent. Both CEOs and HRDs indicated having difficulty in finding trained interpreters in their

area. This suggests that qualified persons of diverse cultures, specifically Hispanic, may be difficult to find for other positions as well. One HRD commented that due to the significant nursing shortage, emphasis is placed on recruitment of candidates that are licensed rather than those of different ethnicities. This respondent indicated "if a cultural diversity publication made a difference in the number of applicants (qualified applicants) received I would capitalize on it … unfortunately emphasis in those publications are not in attracting licensed staff." Another HRD commented "all hiring and positions filled are based on qualifications, not race." This suggests that as the foreign-born population is increasing, the number of qualified persons within these cultural groups is not.

Over 59 percent of CEOs indicated that their hospital has written policies and procedures that ensure the provision of culturally appropriate services. A larger percentage of CEOs, or 79.3 percent, indicated their hospital has written policies and procedures on linguistically appropriate services. The overwhelming majority of HRDs, over 91 percent, indicated that RNs in their respective hospitals are trained to identify and deal with patients from different cultural and religious backgrounds and those that speak little or no English. When RNs were asked to indicate if they receive written guidelines regarding how to work with culturally and linguistically diverse patients, larger percentages of RNs indicated that they do *not*. Over 60 percent of RNs also indicated that they do *not* receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases, and over 51 percent indicated they are *not* made aware of the different lifestyles and dietary habits of various cultural groups which might impact health or interfere with patients' adherence to treatment plans.

These findings suggest that although hospitals may have written policies and procedures outlining the provision of culturally and linguistically appropriate care, RNs are not readily being informed of these policies and procedures. Without the necessary knowledge of the various cultural and religious beliefs and practices that may influence a patient's perception of health and wellness, RNs may not be providing the most appropriate care to those patients that are of different cultures, religions, and those that speak little or no English. This is evident in RN responses to the increase in foreign-born patients resulting in cases involving improper patient education (46.5) and patient's failure to comply with physician directives (45.7).

The data collected with regard to hospitals having trained interpreters on staff varied among CEO, HRD, and RN responses. The majority of CEOs, or 52.6 percent, indicated that their hospital did *not* have trained interpreters. HRD responses were equally divided between those that indicated their hospital did have trained interpreters (50.0) and those that indicated they did not (50.0). A larger percentage of RNs, or 51.9 percent, agreed that their hospital had trained interpreters. It is uncertain if those RNs that indicated their hospital did have trained interpreters on staff are referring to community volunteers or bilingual staff that are called upon when an interpreter is needed.

Over 46 percent of RNs indicated that interpreters are *not* available on all shifts to assist medical and nursing staff in communicating with non-English speaking patients. The same percent of RNs indicated that they have *not* been trained on how to effectively use interpreters. As previously discussed, the availability of interpreters, and their effective use, is vital when caring for a patient that speaks little or no English. Knowing

how to effectively utilize trained interpreters can aide health providers to ensure that the care being rendered to the patient is accurate, appropriate, and considerate.

A larger percentage of CEOs, or 95.8 percent, indicated that their hospital does not have trained interpreters on staff because it is too difficult to find trained interpreters in their area, followed by 81.0 percent that indicated non-English speaking patients generally bring a family member or friend who can help translate, 76.2 percent that indicated it is too expense to hire a trained interpreters, and 69.2 percent that indicated their hospital is witnessing few encounters with non-English speaking patients. A larger percentage of HRDs, or 56.7 percent, however, indicated non-English speaking patients bring a family member or friend who can help translate as the primary reason, followed by their hospital witnessing few encounters (50.0), difficulty finding trained interpreters (33.3), and too expensive to hire one (13.3). Although the Office of Minority Health (2001) states that family members and friends may be used as translators per the patient's request, their use raises serious concerns regarding the accuracy and completeness of the information being interpreted. A discussion of the problems associated with using family members and friends as interpreters is included in Chapter VII.

CEOs and HRDs were asked to indicate if their hospital subscribes to a telephone interpreter service. Over 80 percent of CEOs and 63.9 percent of HRDs indicated that they *did* subscribe to a telephone interpreter service.

The overwhelming majority of CEOs, or 82.5 percent, indicated that their hospitals do *not* give hiring preferences to bilingual candidates. The majority of HRDs, or 65.6 percent, indicated that they Neither Agree or Disagree. Yet, when asked if they are actively recruiting employees who speak a language other than English, a larger

percentage of HRDs, or 45.0 percent, indicated that they agree. Due to concerns over Equal Employment Opportunity regulations, HRDs may not have provided a more definitive response to this question.

RNs were asked to indicate if their hospital made the above forms available in a language other than English. Over 48 percent indicated that HIPAA Privacy form is available in another language(s). A slightly larger percentage, or 50.6, indicated that Patient's Rights form is available in another language(s). The majority of respondents indicated that the other forms listed are *not* made available in another language(s). This raises concern regarding whether Alabama general hospitals are presently obtaining true informed consent for procedures and treatments rendered to limited English proficient patients. Not providing patients with materials in their proficient language also creates barriers to information. Patients may not receive information regarding alternative procedures or treatments, post-operative care, prescription directives, follow-up appointments, and payment options. Making the same information that English proficient patients receive in limited English proficient patients' preferred language reduces barriers to access and ensures that all patients are treated equally.

The data collected from CEO and RN responses indicates that the number of non-English speaking patients has increased over the last year. Over 71 percent of CEOs and 80.9 percent of RNs agreed that their hospital has witnessed an increase. When asked to estimate the percentage of patients that they cared for in the last year that speak little or no English, over 76 percent of RNs estimated between 2 and 20 percent and 93.8 percent cited Spanish as the language spoken by these patients. In addition, 95 percent of RNs indicated that they have provided care to Hispanic or Latin American patients. These

findings suggest that the number of Spanish speaking patients is increasing. Although the percentage of Hispanics in Alabama is still relatively low at 2.2 percent, hospitals may consider making materials such as those in question available in Spanish to address the rising numbers.

The data collected from HRDs regarding the racial/ethnic demographics of their current employees and managers reveals a largely biracial workforce with White, non-Hispanic and Black or African American constituting the majority. Nearly 88 percent of HRDs identified having White, non-Hispanic employees constitute over 51 percent of their workforce. Over 82 percent identified having Black or African American employees constitute 40 percent or less of their workforce. In addition, 88.2 percent of RN respondents identified themselves as White, non-Hispanic and 8.5 percent identified themselves as Black or African American. A total of 3.3 percent of RNs identified themselves as Asian, Native Hawaiian and Other Pacific Islander, Hispanic or Latin American, Native American, Multiracial, and Other. Due to the very low percentages of RNs that identified themselves as a race other than White, non-Hispanic or Black or African American, very little analysis was possible other than White-Black comparisons. This analysis revealed that a lower percentage of Black or African American RNs (56.4) agree that the increasing number of foreign-born poses future cultural problems for their hospital compared to White, non-Hispanic RNs (72.5). When asked if they look forward to caring for a patient from a different cultural background, 44.9 percent of Black or African American RNs indicated they agree, while 42.8 percent of White, non-Hispanic RNs indicated they Neither Agree or Disagree.

Overall, the analysis of the research questions indicates that although Alabama general medical and surgical hospitals are aware of the future challenges that the rising foreign-born population poses, many of the resources necessary to develop, implement, and maintain cultural and linguistic competence are not readily available. The following chapter will present a summary of the findings of bivariate analysis.

CHAPTER VI

ANALYSIS

This chapter focuses on hospital characteristics most likely to have an impact on the culturally and linguistically appropriateness of care or services being delivered, or not delivered. A discussion of the findings from crosstabular analysis of the CEO, HRD, and RN samples is included. The chapter ends by relating the findings to the original research questions.

Crosstabulations

The crosstabulation analyses focused on the independent variables most likely to have an impact on hospital responses to the growing foreign-born population such as location, type of ownership, and bed size. The major findings from these analyses are presented below beginning with results from the CEO sample.

CEO Sample

CEO responses broken down by hospital location revealed a number of variations in responses between urban and rural hospitals. Table 6.1 summarizes the responses of CEOs when asked to indicate their level of agreement or disagreement that the increasing

foreign-born population poses future cultural and linguistic problems for their hospital by location.

Table 6.1 CEO Sample Responses to Future Problems Due to Increase in Foreign-Born by Location (Percentages)

The increasing number of foreign-born poses future:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
cultural problems for my hospital						
Urban	1.7	38.9	22.2	1.7	5.6	18
Rural	12.5	47.5	30.0	10.0	0.0	40
linguistic problems for my hospital						
Urban	11.1	66.7	11.1	11.1	0.0	18
Rural	25.0	62.5	5.0	7.5	0.0	40

Slightly more CEOs from rural hospitals (60.0) agreed that the increasing number of foreign-born poses future cultural problems for their hospitals, compared to 55.6 percent of respondents from urban hospital. The relationship between these variables was not significant, X_2 (2, N=58) = 1.658. A larger percent of CEOs from rural hospitals (87.5) indicated that they agree that the increasing number poses future linguistic problems, compared to 77.8 percent of respondents from urban hospitals. The Chi-Square test between these variables revealed no significance, X_2 (2, N=58) = .999.

When asked if their hospital has trained interpreters on staff, 61.1 percent of CEOs from urban hospitals stated that they *did*, while 60.5 percent of respondents from rural hospitals stated they did *not*. The relationship between these variables was not significant, X_2 (1, N=56) = 2.299. All of the rural hospitals that did not have trained

interpreters on staff cited the dominant reason they did not was due to the difficulty in finding trained interpreters in their area. Other reasons cited included non-English speaking patients bring a family member or friend to translate (86.7), and it is too expensive to hire trained interpreters (78.6). Over two thirds of CEO respondents from rural hospitals (71.5) indicated that they subscribe to a telephone interpreter service, compared to 100.0 percent of urban respondents.

A greater percentage of rural hospitals (66.7) indicated that they did *not* have a specific person or department assigned to promoting cultural competence, compared to 50.0 percent of urban hospitals. The Chi-Square test of the relationship between these variables revealed no significance, X_2 (2, N=57) = 1.532. A smaller percentage of rural hospitals (35.9) agreed that they regularly work with or consult community cultural, ethnic, and religious groups regarding the forms of care and services which should be made available to their members, compared to 50.0 percent of urban hospitals that agreed. A Chi-Square of independence was conducted to examine the relationship between these two variables. The test revealed no significance, X_2 (2, N=57) = 3.292.

These findings suggest that rural hospitals may have fewer resources available to them. The difficulty in finding qualified interpreters and the expense associated with hiring them or subscribing to a telephone interpreter service creates financial burdens for rural hospitals. In addition, community groups aimed at providing support for foreign-born persons or those of diverse cultural groups may not exist in rural areas, leaving rural hospitals without the guidance that these groups can provide in terms of how to provide the most appropriate care to these persons.

CEO respondents from both urban and rural hospitals indicated that they agree that their hospitals' mission statements include the provision of linguistically appropriate services (Chi-Square just missed being significant at the .05 level (X_2 (2, N=56) = .054). Asked about the provision of culturally appropriate services being part of their mission statement, 83.3 percent of CEOs from urban hospitals agreed while only 42.5 percent from rural hospitals agreed. A Chi-Square of independence revealed a significant relationship, X_2 (2, N=58) = 9.225, p<.01.

CEO responses to whether they consider developing a culturally and linguistically competent workforce as a priority for their hospital at this time differed by location. Over 61 percent of respondents from urban hospitals indicated that it *is* a priority, while 69.2 percent of those from rural hospitals indicated that it was *not*. A Chi-Square test of independence revealed a significant relationship, X_2 (1, N=58) = 5.909, p<.02. Rural hospitals were less likely to consider developing a culturally competent workforce as a priority than urban hospitals.

When asked if they see a need for more health practitioners to learn a language other than English, however, both urban and rural hospitals indicated that they did see a need. Respondents from urban hospitals represented 88.9 percent, while a slightly lesser percent of respondents from rural hospitals, or 75.0 percent, indicated they see a need. The relation between hospital location and CEOs response on the need for more health practitioners to learn another language was not statistically significant, X_2 (2, N=58) = 1.601. Table 6.2 summarizes the findings.

Table 6.2 CEO Sample Responses to Developing a Culturally and Linguistically Competent Workforce and a Need for More Health Practitioners to Learn Another Language by Location (Percentages)

Do you:	Yes	No	N
Consider developing a culturally and linguistically competent workforce as a priority for your hospital at this time?			
Urban	66.7	33.3	18
Rural	32.5	67.5	40
See a need for more health practitioners to learn a language other than English?			
Urban	88.9	11.1	18
Rural	75.0	25.0	40

Crosstabular analysis conducted on CEO responses by ownership revealed a few variations in responses between investor owned, private non-profit, and public hospitals. When asked if their hospital had witnessed an increase in non-English speaking patients within the last year, a larger percentage of respondents representing publicly owned hospitals (79.2) indicated that they had witnessed an increase, compared to 64.3 percent of respondents from investor owned hospitals, and 63.2 percent from private non-profit hospitals. Chi-Square was not statistically significant, X_2 (4, N=57) = 6.546.

The majority of respondents, regardless of ownership, indicated that their hospital's mission statement did include the provision of culturally appropriate care. When asked if the provision of linguistically appropriate services was part of their

mission statement, however, a larger percentage of respondents from private non-profit and public hospitals disagreed, while a larger percentage of respondents from investor owned hospitals agreed. A Chi-Square test of independence revealed no significant relationship between these variables, X_2 (4, N=56) = .934. Table 6.3 summarizes the findings below.

Table 6.3 CEO Sample Responses to the Provision of Linguistically Appropriate Services Included in Their Mission Statement by Hospital Ownership (Percentages)

The provision of linguistically appropriate care is part of my hospital's mission statement	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Investor Owned Hospitals	0.0	42.9	21.4	21.4	14.3	14
Private Non-Profit Hospitals	0.0	42.1	10.5	36.8	10.5	19
Public Hospitals	8.7	30.4	17.4	43.4	0.0	23

When asked to indicate their level of agreement or disagreement that their hospital has a specific person or department assigned to promoting cultural competence, the majority of respondents from private non-profit (68.4) and public (73.9) hospitals disagreed, while 42.9 percent of respondents from investor owned hospitals indicated that they Neither Agree or Disagree. A Chi-Square test revealed a significant relationship between hospital ownership and assignment of promotion of cultural competence, X_2 (4, N=56) = 10.989, $p<.05$. CEOs may not have provided a more directive response due to their uncertainty about whether a specific person or department was charged with this

responsibility, or the implementation and maintenance of cultural competencies may be divided among various persons or departments, not centralized.

A greater percent of respondents from investor owned hospitals indicated that they *do* maintain current information regarding new cultural groups that are moving into their service area, while a greater percent of respondents from both private non-profit (52.6) and public (39.1) indicated that they did *not*. A Chi-Square test examining the relationship between these variables indicated no significance, X_2 (4, N=56) = 5.238. The majority of respondents from both investor owned (71.4) and public (69.6) hospitals indicated that they agree that their hospital maintains current epidemiological profiles of their service area, while respondents from private non-profit hospitals were equally divided among those that indicated they agree (42.1) and disagree (42.1). Chi-Square test of independence revealed a statistically significant relationship between hospital ownership and maintenance of current epidemiological profiles, X_2 (4, N=56) = 10.304, $p<.05$. Table 6.4 summarizes the findings.

Table 6.4 CEO Sample Responses to Specific Person or Department Assigned to Promoting Cultural Competence and Maintaining Current Information on New Cultural Groups and Epidemiological Profiles by Hospital Ownership (Percentages)

My hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Has a specific person or department assigned to promoting cultural competence						
Investor Owned Hospitals	0.0	21.4	42.9	21.4	14.3	14
Private Non-Profit Hospitals	0.0	26.3	5.3	52.6	15.8	19
Public Hospitals	4.3	13.0	8.7	69.6	4.3	23
Maintains current information regarding new cultural groups that are moving into our service area						
Investor Owned Hospitals	7.1	42.9	21.4	28.6	0.0	14
Private Non-Profit Hospitals	0.0	36.8	10.5	42.1	0.0	19
Public Hospitals	4.3	21.7	34.8	34.8	4.3	23
Maintains current epidemiological profiles of our service area						
Investor Owned Hospitals	7.1	64.3	14.3	14.3	0.0	14
Private Non-Profit Hospitals	0.0	42.1	15.8	26.3	15.8	19
Public Hospitals	17.4	52.2	26.1	4.3	0.0	23

When asked if their hospital has trained interpreters on staff, 52.2 percent of respondents from public hospitals indicated they did, 66.7 percent of respondents from private non-profit hospitals indicated that they did *not*, and respondents from investor owned hospitals were equally divided among those that indicated they did (50.0) and those that did not (50.0). A Chi-Square test examining the relationship between these variables indicated no significance, X_2 (2, N=55) = 1.602. Of those respondents from

investor owned and private non-profit hospitals that indicated they did not have trained interpreters on staff, 100.0 percent of both groups of respondents indicated that it is too difficult to find trained interpreters in their area, followed by 100.0 of respondents from investor owned hospitals stating that non-English speaking patients bring family members or friends that can translate, and private non-profit hospitals stating equally that non-English speaking patients bring family members or friends that can translate (75.0) and it is too expensive to hire a trained interpreter (75.0).

Table 6.5 presents the findings of CEO responses by hospital ownership when asked if they consider developing a culturally and linguistically competent workforce as a priority for their hospital at this time. A larger percentage of respondents from both investor owned (64.3) and public (58.3) hospitals indicated that it is *not* a priority at this time, while 52.6 percent of private non-profit hospitals indicated that it is a priority. Chi-Square was not statistically significant, X_2 (2, N=57) = 1.018.

Table 6.5 CEO Sample Responses to Developing a Culturally and Linguistically Competent Workforce by Hospital Ownership (Percentages)

Do you consider developing a culturally And linguistically competent workforce As a priority for your hospital at this time?	Yes	No	N
Investor Owned Hospitals	35.7	64.3	14
Private Non-Profit Hospitals	52.6	47.4	19
Public Hospitals	41.7	58.3	24

An analysis of CEO responses from hospitals within counties that had experienced a 30 percent or larger increase in their Hispanic population between 2000

and 2005 and those that had experienced a 29.9 percent or smaller increase in their Hispanic population was conducted using the "Hispanic Population Estimates by County" released by the Alabama State Data Center (2004). Detailed data on the percent increase in individual counties was only found for the Hispanic category. Since the large majority of RNs identified that the non-English speaking patients they have provided care for speak Spanish, the increase in Hispanic persons in each county was considered by this author to be representative of the overall increase in the foreign-born population that the state has experienced. Of the 67 counties total in Alabama, 29 counties experienced a 30 percent or greater percent increase between 2000 and 2005, and 38 counties experienced a 29.9 percent or lesser percent increase. Of the 29 counties, 18 counties, or 62.1 percent, have responses from CEOs. Of the 38 counties that experienced smaller percent increases, 22 counties, or 57.9 percent, have responses from CEOs.

A larger percent of respondents (78.6) from those counties that witnessed a higher percent increase in the Hispanic population indicated that they agreed that their hospital had witnessed an increase in non-English speaking patients within the last year, compared to 62.1 percent representing counties with a lower percent increase.

Slightly less than 50 percent of respondents from those counties that have a higher percent increase agreed that their workforce demographics mirror that of their service area, compared to 79.3 percent of respondents from counties that have a smaller percent increase that agreed. These findings suggest that those hospitals in counties with a higher percent increase in their Hispanic population may be experiencing difficulty in finding qualified Hispanic candidates to fill vacant positions.

A greater percent of respondents from hospitals in counties that have witnessed a higher percent increase in their Hispanic population indicated that they have experienced increased patient loads in the Emergency Room (46.4), compared to 31.0 percent of respondents from counties that have witnessed a smaller percent increase that disagreed. The larger percentage of respondents from both groups of counties, however, indicated that they have experienced an increase in uncollectible billings.

A greater percent of respondents from counties with a higher percent increase (59.3) indicated that they do *not* have trained interpreters on staff, compared to those respondents in counties with lower percent increases that were equally divided among those that indicated they do have trained interpreters (50.0) and those that do not (50.0). Of those respondents in both groups of counties that indicated they do not have trained interpreters, the dominant reason why they do not have interpreters is the difficulty in finding trained interpreters in their area.

Respondents from hospitals in counties that have witnessed a higher percent increase in their Hispanic population indicated that they do consider developing a culturally and linguistically competent workforce a priority for their hospital at this time (57.1), compared to 69.0 percent of respondents from hospitals in counties that have witnessed a smaller percent increase that do *not* consider it a priority at this time.

HRD Sample

Crosstabular analysis conducted on HRD responses by location revealed a number of variations in responses between urban and rural hospitals. Table 6.6 summarizes the responses of HRD respondents when asked to indicate their level of agreement or

disagreement for a number of statements regarding the characteristics of their current workforce and their recruitment practices by location.

Table 6.6 HRD Sample Responses to Characteristics of Their Current Workforce and Recruitment Practices (Percentages)

My hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	N
Actively recruits employees from various ethnic backgrounds						
Urban Hospitals	39.1	26.1	17.4	13.0	4.3	23
Rural Hospitals	48.6	34.3	8.6	5.7	2.9	35
Actively recruits employees from various religious backgrounds						
Urban Hospitals	26.1	26.1	26.1	17.4	4.3	23
Rural Hospitals	45.7	25.7	20.0	5.7	2.9	35
Actively recruits employees who speak a language other than English						
Urban Hospitals	13.6	13.6	54.5	13.6	4.5	22
Rural Hospitals	20.0	37.1	22.9	17.1	2.9	35
Has persons from different ethnic backgrounds in leadership positions						
Urban Hospitals	34.8	52.2	8.7	4.3	0.0	23
Rural Hospitals	20.0	42.9	28.6	8.6	0.0	35
Has persons who speak a language other than English in leadership positions						
Urban Hospitals	4.3	39.1	26.1	30.4	0.0	23
Rural Hospitals	5.9	17.6	44.1	29.4	0.0	34

A greater percentage of respondents from rural hospitals agreed that they actively recruit employees from various ethnic backgrounds (82.9), religious backgrounds (71.4), and those who speak a language other than English (57.1). Chi-Square revealed no

significance between hospital location and recruitment of persons from various ethnic backgrounds, X_2 (2, N=58) = 2.358, or recruitment of persons from various religious backgrounds, X_2 (2, N=58) = 2.781. A statistically significant relationship was found between hospital location and recruitment of persons that speak a language other than English, X_2 (2, N=57) = 6.531, $p<.05$.

A greater percentage of respondents from urban hospitals agreed that they have persons from different ethnic backgrounds (87.0) and persons who speak a language other than English (43.4) in leadership positions, compared to 62.9 percent of respondents from rural hospitals that agree they have persons from different ethnic backgrounds, and 44.1 that indicated they Neither Agree or Disagree that they have persons who speak a language other than English in leadership positions. A Chi-Square test revealed no statistical significance between hospital location and having persons from various ethnic backgrounds in leadership positions, X_2 (2, N=58) = 4.122, or having persons who speak a language other than English in leadership positions, X_2 (2, N=57) = 2.956.

When asked if their hospitals post signs in a language other than English, a larger percentage of HRDs from rural hospitals, or 85.7 percent, indicated that they did, compared to 54.5 percent of HRDs from urban hospitals that indicated they did. A Chi-Square test of independence conducted revealed a statistically significant relationship between hospital location and signage in another language, X_2 (1, N=57) = 6.768, $p<.01$.

A greater percentage of respondents (73.9) from urban hospitals indicated that their hospital did subscribe to a telephone interpreter service, compared to 60.0 percent of

respondents from rural hospitals that indicated they did. A Chi-Square test revealed no statistical significance, X_2 (1, N=57) = .011.

Analysis conducted on HRD responses by size of hospital service population revealed a number of variations in responses. Hospitals with a service population between 400,000 and 499,999 were not represented in the sample. When asked if their hospital actively recruits employees from various religious backgrounds, over 66 percent of HRDs from hospitals whose service population is 500,000 or more indicated that they disagree. A Chi-Square test revealed a statistically significant relationship between the variables, X_2 (8, N=58) = 16.856, $p<.05$. When asked if they are actively recruiting employees that speak a language other than English, 53.8 percent of HRDs representing hospitals with a service population of 99,999 or less indicated they agree, compared to the majority of other respondents that indicated they Neither Agree or Disagree. Those HRDs representing hospitals with service populations of 200,000 to 299,999 were equally divided between agree (40.0) and Neither Agree or Disagree (40.0). An analysis of the relationship between the variables using Chi-Square revealed no significance, X_2 (8, N=58) = 6.362.

Table 6.7 summarizes the findings of HRD responses when asked to identify if their hospital posts signs in a language other than English, provide foreign language classes, and make customer satisfaction surveys available in other languages by size of service population.

Table 6.7 HRD Sample Responses to Hospital Signage, Foreign Language Classes, and Customer Satisfaction Surveys by Size of Service Population (Percentage)

Does your hospital:	Yes	No	N
Post signs in a language other than English			
99,999 or less	82.1	17.9	39
100,000 to 199,999	75.0	25.0	8
200,000 to 299,999	60.0	40.0	5
300,000 to 399,999	33.3	66.7	3
500,000 or more	66.7	33.3	3
Provide free foreign language classes to interested employees			
99,999 or less	20.5	79.5	39
100,000 to 199,999	25.0	75.0	8
200,000 to 299,999	20.0	80.0	5
300,000 to 399,999	33.3	66.7	3
500,000 or more	66.7	33.3	3
Make customer satisfaction surveys available in other languages			
99,999 or less	31.6	68.4	38
100,000 to 199,999	28.6	71.4	7
200,000 to 299,999	60.0	40.0	5
300,000 to 399,999	0.0	100.0	3
500,000 or more	50.0	50.0	2

The majority of HRDs indicated that their hospitals post signs in a language other than English with the exception of those representing hospitals with a service population of 300,000 to 399,999 who indicated that that their hospitals do not. A Chi-Square test revealed no significance, X_2 (4, N=57) = 4.022. When asked if their hospital provided foreign language classes to interested employees, the large majority of respondents

indicated that they did *not*. Only those respondents representing hospitals with a service population of 500,000 or more indicated that they did. Analysis of the relationship between these variables using Chi-Square revealed no significance, X_2 (4, N=58) = 3.432. When asked if their hospital makes customer satisfaction surveys available in a language other than English, HRDs representing hospitals with a service population of 199,999 or less and 300,000 to 399,999 indicated that they did *not*. The majority of HRDs from hospitals with a service population of 200,000 to 299,999 indicated that they did. Equal percentages of HRDs representing 500,000 or more indicated that their hospital did (50.0) and did not (50.0). A Chi-Square test indicated no significance, X_2 (4, N=55) = 3.497.

HRDs were asked to indicate if their hospital has trained interpreters on staff. Table 6.8 summarizes the findings.

Table 6.8 HRD Sample Responses to Having Trained Interpreters on Staff by Size of Service Population (Percentages)

Does your hospital have trained interpreters on staff?	Yes	No	N
99,999 or less	51.3	49.7	39
100,000 to 199,999	25.0	75.0	8
200,000 to 299,999	60.0	40.0	5
300,000 to 399,999	50.0	50.0	2
500,000 or more	66.7	33.3	3

A greater percentage of HRDs representing hospitals with a service population of 100,000 to 199,999 indicated that their hospitals do *not* have trained interpreters on staff.

Those representing populations between 300,000 and 399,999 were equally divided among those that indicated they did (50.0) and those that did not (50.0). A Chi-Square test revealed no significance, X_2 (4, N=57) = 2.542.

Analysis conducted on HRD responses by size of hospital workforce revealed a number of variations in responses. When asked to indicate their level of agreement or disagreement that their hospital actively recruits employees from various ethnic backgrounds, only those respondents whose hospitals employ 2501 to 3000 persons disagreed (100.0). A Chi-Square test of independence examining the relationship between the variables revealed statistical significance, X_2 (12, N=61) = 22.203, p<.05. When asked if their hospital actively recruited employees from various religious backgrounds, those respondents whose hospitals employ 2501 to 3000 persons disagreed (100.0), and those with 1001 to 1500 employees indicated that they Neither Agree or Disagree (50.0). An analysis of the relation between the variables using Chi-Square revealed a statistically significant relationship, X_2 (12, N=61) = 26.702, p<.01. When asked if they actively recruit employees that speak a language other than English, HRDs representing hospitals with 1000 employees or less indicated that they do. Those whose workforce is 2501 to 3000 were equally divided between agree (50.0) and disagree (50.0). Respondents from hospitals that employ between 1001 and 2500 employees indicated that they Neither Agree or Disagree. Chi-Square revealed no significance, X_2 (12, N=60) = 16.498.

When asked to indicate if their hospital has persons who speak a language other than English in leadership positions, HRDs representing hospitals that employ larger numbers (2501 and above) indicated that they agree. HRDs representing hospitals that employ the smallest number -- 500 or less -- indicated that they disagree. Those who have

between 1001 and 2000 employees indicated that they Neither Agree or Disagree, and those with 501 to 1000 employees were equally divided between agree (33.3), Neither Agree or Disagree (33.3), and disagree (33.3). A Chi-Square test revealed no significance, X_2 (12, N=60) =14.380.

When asked if their hospitals post signs in a language other than English, both HRDs from hospitals with smaller workforces, 1000 or less, and those with larger workforces, 3001 or more, indicated that their hospitals do. Of those hospitals with workforces between 1001 and 3000, only those respondents presenting hospitals with 1501 to 2000 employees indicated that they do post signs in another language. Analysis of the relationship between the two variables using Chi-Square revealed statistical significance, X_2 (6, N=60) =16.526, p<.02.

When asked if their hospital provides foreign language classes to interested employees, a larger percentage of HRDs from hospitals with the largest workforce, 3001 or more, indicated that they did (Chi-Square revealed no significance, X_2 (6, N=61) =8.795). Asked if their hospital makes customer satisfaction surveys available in a language other than English, HRDs from hospitals with smaller workforces, or 2500 employees or less, indicated they did not, with the exception of those with 1501 to 2000 employees that were equally divided between yes (50.0) and no (50.0). HRDs representing hospitals that employ between 2501 and 3000 employees indicated that they did make surveys available in another language (100.0). Hospitals with the largest workforce, or 3000 or more, indicated that they did not. Analysis of the relationship between these variables using Chi-Square revealed no significance, X_2 (6, N=58) =6.306.

HRDs were asked to indicate if their hospital has trained interpreters on staff by size of workforce. Table 6.9 summarizes the findings.

Table 6.9 HRD Sample Responses to Trained Interpreters on Staff by Size of Workforce (Percentages)

Does your hospital have trained interpreters on staff?	Yes	No	N
500 or Less Employees	43.8	56.2	32
501 to 1000 Employees	55.6	44.4	9
1001 to 1500 Employees	66.7	33.3	12
1501 to 2000 Employees	0.0	100.0	2
2001 to 2500 Employees	0.0	100.0	2
2501 to 3000 Employees	50.0	50.0	2
3001 or More Employees	66.7	33.3	3

Respondents representing hospitals with the small workforces -- 500 or less -- indicated that they did *not* have trained interpreters on staff. Those with 3001 or more employees indicated they did. This would suggest that hospitals with larger workforces are more likely to have interpreters than those with smaller workforces. The findings, however, reveal an inconsistent pattern. Respondents representing hospitals that have 501 to 1500 employees indicated in larger percentages that they *did* have trained interpreters, while those with 1501 to 2500 employees indicated they did *not*. HRDs from hospitals with 2501 to 3000 employees were equally divided between those that did (50.0) and those that did not (50.0) have trained interpreters. A Chi-Square test revealed no significance, X_2 (6, N=60) =6.944.

Analysis conducted on HRD responses by race distribution of their employees and managers revealed no variations in responses due to the very low percentages of persons from races other than White, non-Hispanic and Black or African American.

An analysis of HRD responses from hospitals within counties that had experienced a 30 percent or larger increase in their Hispanic population between 2000 and 2005 and those that experience a 29.9 percent or smaller increase in their Hispanic population was conducted. Of the 29 counties that experienced a 30 percent or greater increase in their Hispanic population, 12 counties, or 41.4 percent, have responses from HRDs. Of the 38 counties that experienced smaller percent increases, 25 counties, or 65.8 percent, have responses from HRDs.

A larger percent of HRDs (78.4) representing counties that experienced lower percent change in their Hispanic population indicated that they agreed that their hospital actively recruits employees from various religious backgrounds, compared to 38.1 percent of HRDs from counties with higher percent change. A larger percentage of HRDs from counties with lower pecent change indicated that they have persons from different ethnic (81.1) and religious (81.1) backgrounds in leadership positions, compared to those from counties with higher percent change that indicated they have persons from different ethnic (57.1) and religious (47.6) backgrounds.

A larger percent of HRDs representing counties that witnessed a higher percent change in their Hispanic population indicated that they *do* have trained interpreters on staff (66.7), compared to 58.3 percent of respondents from counties with lower percent change who indicated they did *not*. Likewise, a larger percent of HRDs from counties with a higher percent change indicated their hospital did subscribe to a telephone

interpreter service (81.0), compared to 56.8 percent from counties with a lower percent change that indicated they did not.

Analysis of CEO and HRD Responses from the Same Hospital

An analysis conducted on the responses of CEOs and HRDs from the same hospital revealed several variations. Of the 59 CEO respondents and 61 HRD respondents, 32 were from the same hospital. Table 6.10 presents the findings, indicating the frequency that responses varied between the two positions on those questions that were asked of both.

Table 6.10 Numbers of Differing CEO and HRD Responses from the Same Hospital*

Does your hospital:	Frequency	Percent
Give hiring preference to bilingual candidates	4	12.5
Work with community or organizations regarding the provision of care to foreign-born	5	15.6
Post signs in a language other than English	4	12.5
Provide free foreign language classes to interested employees	6	18.8
Have trained interpreters on staff	12	37.5
Subscribe to a telephone interpreter service	3	9.4

*Total N=32

The variations presented identify cases in which the CEO of a specific hospital indicated agreement with a statement and the HRD of the same hospital indicated disagreement, or vice-versa. The largest number of varied responses occurred when CEO

and HRD respondents were asked if their hospital has trained interpreters on staff, followed by whether they provide free foreign language classes. The larger percentage of variation in responses indicates a lack of communication.

RN Sample

Crosstabular analysis of RN responses by location revealed very few differences. The most significant variation found between RNs working in urban versus rural counties was that over 55 percent of RNs in urban counties indicated that they did have trained interpreters on staff, while 45.6 percent of those in rural counties indicated that they did *not* (X_2 (2, N=1755) =33.885, p<.001). Of those respondents that indicated interpreters were available, 43.9 percent of RNs in rural counties indicated that they disagree that these interpreters are available on all shifts, compared to 43.3 percent of RNs in urban counties that agreed. A Chi-Square test revealed no significance, X_2 (2, N=919) =1.978. The majority of RNs in urban counties (53.2) indicated that they have provided care to patients that are Middle Eastern or Western Asian, compared to 51.5 percent of RNs in rural counties who indicated they have *not.* Chi-Square revealed no significance, X_2 (1, N=1684) =2.603.

Analysis conducted on RN responses by age revealed that over 53 percent of RNs in each of the age categories between 21 and 50 indicate that they have provided care to a Middle Eastern or Western Asian patient, compared to a larger percentage of RNs 51 or above (51.0 percent of RNs age 51-60 and 54.7 percent 61 or above) that indicate they have not. Analysis of the relationship between the two variables using Chi-Square revealed no significance, X_2 (4, N=1684) =3.667.

When asked if they have provided care to a Middle Eastern or Western Asian patient, larger percentages of RNs with Master and Doctoral degrees indicated they had not. Analysis examining the relationship between these variables using Chi-Square revealed no significance, X_2 (4, N=1684) =2.023. The responses of RNs with Doctoral degrees were divided equally among those who indicated they have and have not provided care for a Jewish (36.4), Muslim (36.4), or Atheist (27.3) patient. A Chi-Square test of the relationship between education and each of these variables revealed no significance. Larger percentages of RNs with Bachelor (43.5), Master (45.4), and Doctoral (54.5) degrees indicated that they Neither Agree or Disagree that they look forward to caring for a patient that is of a different culture. Chi-Square revealed no significance, X_2 (8, N=1681) =11.777. These findings suggest that RNs with advanced degrees may be in administrative or supervisory positions and, therefore, not providing patient care.

Analysis conducted on RNs by the department in which they work focused on RNs that identified working in acute care units or departments. These units included general inpatient, maternal child, pediatric, general intensive care, surgery, cardiac care, psychiatric, emergency room departments, general ambulatory care, and other specialty units. Non-acute care units or departments were not considered due to the lesser amount of time RNs in these units spend providing direct patient care.

When asked to indicate their level of agreement or disagreement that their hospital has trained interpreters on staff, a greater percentage of RNs, or 49.7 percent, working in Emergency Room department indicated that they disagree. A Chi-Square test of independence examining the relationship between the variable department and trained

interpreters on staff revealed statistical significance, X_2 (32, N=1743) =65.670, p<.001. Of those that indicated that trained interpreters are on staff, when asked if they are available on all shifts, a larger percentage of RNs working in maternal child units (47.3), general intensive care (50.8), surgery (42.9), cardiac care (41.9), psychiatric (45.5), and emergency room departments (46.5) indicated that they disagree. An equal percent of RNs working in general ambulatory care indicated that they agree (31.8) and disagree (31.8). A Chi-Square test revealed no significance, X_2 (32, N=915) =45.387.

RNs were asked to indicate their level of agreement or disagreement that non-English speaking patients are provided with verbal or written notice informing them of their right to receive language assistance services. A larger percentage of RNs working in maternal child units (41.9) and emergency room departments (40.0) indicated that they disagree. A larger percentage of respondents working in pediatric (45.5) and general ambulatory care units (45.5) indicated that they Neither Agree or Disagree. Analysis of the relationship between these variables using Chi-Square revealed statistical significance, X_2 (32, N=1743) =64.608, p<.001.

When asked if nurses and staff are made aware of the different lifestyles and dietary habits of various cultural groups, only RNs that work in psychiatric units agreed that this information is provided (52.3). A larger percentage of RNs that work in the other departments indicated they disagree. A Chi-Square test revealed a significant relationship between the variables, X_2 (32, N=1743) =69.549, p<.001.

When asked if nurses and staff receive written guidelines on how to work with patients that speak a language other than English, the responses of RNs that work in psychiatric units were equally divided between agree (36.4) and disagree (36.4). A larger

percentage of RNs that work in the other departments indicated they disagree. Chi-Square revealed a statistically significant relationship, X_2 (48, N=1742) =84.697, p<.001.

RNs were asked to estimate the percentage of patients that they have provided care for over the last year that speak little or no English. The units or departments that reported witnessing the largest percentages of these patients include maternal child unit (28.3), emergency room department (26.5), general inpatient unit (12.4), and surgery unit (12.4). Chi-Square revealed a significant relationship between department and estimated percentage of patients cared for that speak little or no English, X_2 (96, N=1740) =230.999, p<.001.

Analysis was conducted on RN responses by race. Due to the very low percentages of all categories except White, non-Hispanic and Black or African American, analysis was conducted comparing just these two groups. A slight variation in responses was identified when respondents were asked if the increasing number of foreign-born poses future cultural problems for their hospital. Over 72 percent of White, Non-Hispanic RNs indicated they agree, compared to 56.4 percent of Black or African American RNs that indicated they agree. When asked if they look forward to caring for a patient from a different cultural background, 44.9 percent of Black or African American RNs indicated they agree, while 42.8 percent of White, non-Hispanic RNs indicated they Neither Agree or Disagree.

Analysis on RN responses by gender also revealed very little variation between male and female nurses on any of the major variables under consideration.

An analysis of RN responses from hospitals within counties that had experienced a 30 percent or larger increase in their Hispanic population between 2000 and 2005 and

those that experience a 29.9 percent or smaller increase in their Hispanic population was conducted. Of the 29 counties that experiences a 30 percent or greater increase in their Hispanic population, 24 counties, or 82.8 percent, have responses from RNs. Of the 38 counties that experienced smaller percent increases, 28 counties, or 73.7 percent, have responses from HRDs.

There was virtually no difference between RNs from counties with greater increases in Hispanic population and counties with lower levels of change when it came to reporting that trained interpreters are on staff (46.1 percent compared to 47.2 percent).

When asked if non-English speaking patients are provided with verbal or written notice informing them of their right to receive language assistance services, 40.9 percent of RNs from counties with a higher percent change indicated they agree, while the largest percentage of RNs (35.6) from counties with a lower percent change indicated they disagree.

Analysis of CEO, HRD, and RN Responses from the Same Hospital

An analysis conducted on the responses of CEOs, HRDs, and RNs from the same hospital revealed several variations. Five hospitals received 50 or more RN responses. Of these 5 hospitals, 3 have corresponding CEO and HRD responses, 1 has a corresponding HRD response, and 1 has a corresponding CEO response. Table 6.11 presents the findings, indicating the number of hospitals that have varied responses between the RN, CEO, and/or HRD positions on those questions asked of all three. While the numbers presented represent disagreement within a small starting base, they may be used as a

suggestive indicator of whether direct caregivers and front office personnel have the same image of how their hospital is dealing with cultural and linguistic problems.

Table 6.11 Differences in Responses from CEOs, HRDs, and RNs from the Same Hospital*

CEO and RN	Frequency
My hospital has written policies and procedures that ensure the provision of culturally appropriate services	4
My hospital has written policies and procedures that ensure the provision of linguistically appropriate services	2
What hours are trained interpreters available	1
Does your hospital post signs in a language other than English	1
Does your hospital provide free foreign language classes to interested employees	2
Incorrect diagnosis as a result of a language barrier between the patient and service provider	1
Excessive diagnostic testing	1
Lack of informed consent	1
Improper patient education	1
Patient's failure to comply with physician directives	1

HRD and RN	Frequency
In my hospital, RNs are trained to identify and deal with patients from different cultural backgrounds	3
In my hospital, RNs are trained to identify and deal with patients from different religious backgrounds	3
In my hospital, RNs are trained to identify and deal with patients who speak little or no English	2
Does your hospital post signs in a language other than English	2
Does your hospital provide free foreign language classes to interested employees	3
Does your hospital have trained interpreters on staff	2

*Total N = 5 based on responses from the CEO, HRD, and 50 RNs from the same facility

Asked to indicate their level of agreement or disagreement that their hospital has written policies and procedures that ensure the provision of culturally appropriate services, three CEOs indicated that they agree, while over 52 percent of RN respondents in each of these hospitals indicated that they disagree. One CEO respondent disagreed, while over 46 percent of the RN respondents from that hospital indicated they agree. When asked if their hospital has written policies and procedures that ensure the provision of linguistically appropriate services, two CEOs indicated that they agree, while over 42 percent of RNs from those same hospitals indicated that they disagree.

When CEOs indicated that their hospital has trained interpreters on staff, they were asked to indicate what hours they are available. One CEO respondent indicated that trained interpreters were available on all shifts, or all hours, while the RN respondents from the same hospital indicated that they disagree.

One CEO indicated that his or her hospital posts signs in a language other than English, while over 50 percent of RNs from the same hospital indicated they do not. Two CEOs stated that their hospital does offer free foreign language classes to interested employees, while over 64 percent of RNs in each of these hospitals indicated they did not.

When asked to indicate if the increase in foreign-born patients has resulted in problems or errors, one CEO indicated that he or she agrees having witnessed errors such as incorrect diagnosis, excessive diagnostic testing, and lack of informed consent, while over 55 percent of RNs from the same hospital indicated that they disagree these problems or errors have occurred. One CEO disagreed that his or her hospital has

witnessed improper patient education and failure to comply with physician directives, though 40 percent of RNs from the same hospital agree these problems have occurred.

Asked to indicate their level of agreement or disagreement that RNs in their hospital are trained to identify and deal with patients from different cultural backgrounds, 3 HRDs indicated they agree, while over 54 percent of RNs in each of the hospitals disagree that nurses and staff receive written guidelines regarding how to work with patients from different cultures. The same HRDs indicated they agree that RNs are trained to identify and deal with patients from different religious backgrounds, while over 46 percent of RNs in each hospital disagree that they receive written guidelines regarding how to work with patients from different religions. Two HRDs indicated they agree that RNs are trained to identify and deal with patients who speak little or no English, while over 51 percent of RNs from the same hospital indicated that they disagree.

Two HRDs indicated their hospital did not post signs in a language other than English, while over 50 percent of RNs from the same hospitals indicated they did. Three HRDs indicated that their hospital provides free foreign language classes to interested employees, while over 61 percent of RNs from each hospital indicated they did not. Two HRDs indicated that their hospital does not have trained interpreters on staff, yet over 44 percent of RNs from those hospitals indicated they did.

The variations in responses point to the need for greater communication within Alabama general medical and surgical hospitals regarding the provision of culturally and linguistically appropriate care and the resources that are readily available in their respective hospitals. Although the majority of CEOs indicate that their hospital has written policies and procedures regarding the provision of culturally and linguistically

appropriate services, and the majority of HRDs indicate that RNs in their respective hospitals are trained to identify and deal with patients from different cultural backgrounds and those that speak little or no English, larger percentages of RNs indicate that they do *not* receive written guidelines regarding how to work with these patients. Additionally, the large majority of CEOs and HRDs (over 75 percent) indicated that their hospital does *not* offer free foreign language classes to interested employees, yet when RNs were asked if they would take a foreign language class, over 80 percent indicated they would.

Cultural and Linguistic Competency in Urban v. Rural Hospitals

To determine whether urban hospitals are more culturally and linguistically competent, the variables relating to Standards 1 thru 7 of the National Standards for Culturally and Linguistically Appropriate Services in Health Care were analyzed. Standards 1 thru 3 are associated with culturally competent care and Standards 4 thru 7 are associated with language access services. Table 6.12 summarizes the findings of variables associated with culturally competent care by location. Response categories have been collapsed to Agree (includes Strongly Agree and Agree responses), Neither Agree or Disagree, and Disagree (includes Strongly Disagree and Disagree responses). For the following discussion, the three samples were combined into one file.

Table 6.12 Combined CEO, HRD, and RN Sample Responses to Variables Associated With Culturally Competent Care Standards by Location (Percentages)

	Agree	Neither Agree or Disagree	Disagree	N
Actively recruits employees from various:				
Ethnic backgrounds				
Urban Hospitals	65.2	17.4	17.4	23
Rural Hospitals	82.9	8.6	8.6	35
Religious backgrounds				
Urban Hospitals	52.2	26.1	21.7	23
Rural Hospitals	71.4	20.0	8.6	35
Who speak a language other than English				
Urban Hospitals	27.3	54.5	18.2	22
Rural Hospitals	57.1	22.9	20.0	35
My hospital has persons:				
From different ethnic backgrounds in leadership positions				
Urban Hospital	87.0	8.7	4.3	23
Rural Hospital	62.9	28.6	8.6	35
From different religious backgrounds in leadership positions				
Urban Hospital	73.9	21.7	4.3	23
Rural Hospital	65.7	22.9	4.3	23
Who speak a language other than English in leadership positions				
Urban Hospital	43.5	26.1	30.4	23
Rural Hospital	23.5	44.1	32.3	34

	Agree	Neither Agree or Disagree	Disagree	N
The cultural demographics of my hospital's workforce mirrors that of our service area				
Urban Hospital	55.6	22.2	22.2	18
Rural Hospital	69.2	7.7	23.1	39
Nurses and staff are made aware of the different lifestyles and dietary habits of various cultural groups which might impact their health or interfere with patients' adherence to treatment plans				
Urban Hospital	31.3	16.9	51.9	1334
Rural Hospital	25.2	19.7	55.1	421
Nurses and staff receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases				
Urban Hospital	18.9	19.0	62.1	1334
Rural Hospital	19.5	19.7	60.8	421
Nurses and staff in my hospital receive written guidelines regarding how to work with patients:				
From different cultures				
Urban Hospital	26.5	20.2	53.3	1334
Rural Hospital	25.4	17.1	57.5	421
From different religions				
Urban Hospital	30.8	20.4	48.8	1333
Rural Hospital	27.3	17.6	55.1	421
That speak a language other than English				
Urban Hospital	32.1	19.4	48.5	1333
Rural Hospital	28.7	19.2	52.0	421

	Yes	No	N
Does your department or unit have easy-to-access cultural reference guides for use by medical and nursing staff			
Urban Hospital	21.3	78.7	1335
Rural Hospital	22.8	77.2	421
Does your hospital provide free foreign language classes to interested employees			
Urban Hospital	29.4	70.6	1325
Rural Hospital	28.0	72.0	475
Does your hospital give hiring preference to bilingual candidates			
Urban Hospital	24.0	76.0	25
Rural Hospital	26.0	74.0	50

Of the 15 variables selected to identify the provision of culturally competent care, urban hospitals indicated higher percentages of compliance on 8 variables, while rural hospitals indicated higher percentages of compliance on 7 variables. A larger percentage of urban hospitals currently have persons of different ethnic, religious, and language backgrounds in leadership positions. No relationship was found between hospital location and having persons from various ethnic backgrounds in leadership positions, X_2 (2, N=58) = 4.122, having persons from various religious backgrounds in leadership positions, X_2 (2, N=58) = .950, or having persons who speak a language other than English in leadership positions, X_2 (2, N=57) = 2.956.

A greater percentage of rural hospitals, however, indicate that they are actively recruiting employees from various ethnic, religious, and language backgrounds.

Chi-Square revealed no significance between hospital location and recruitment of persons from various ethnic backgrounds, X_2 (2, N=58) = 2.358, or recruitment of persons from various religious backgrounds, X_2 (2, N=58) = 2.781. A statistically significant relationship was found between hospital location and recruitment of persons that speak a language other than English, X_2 (2, N=57) = 6.531, $p<.05$.

Analysis of workforce demographics by location revealed that urban hospitals have a slightly more diversified workforce than rural hospitals. Rural hospitals did, however, indicate that they have a larger percentage of Multiracial employees than urban hospitals. Rural hospitals also indicated that they have Native Americans in management positions, compared to zero identified in urban hospitals.

A greater percentage of rural hospitals agreed that the cultural demographics of their hospital mirror that of their service area. A Chi-Square test revealed no significance, X_2 (2, N=57) = 2.476. Although greater percentages of CEOs and HRDs from both urban and rural hospitals indicated that they do *not* give hiring preferences to bilingual candidates, a slightly larger percentage of those respondents from rural hospitals indicated that they do. Analysis of the relationship between hospital location and hiring preferences using Chi-Square revealed no significance, X_2 (1, N=75) = .035.

When questioned about the ongoing education and training of their staff on cultural competence, although the majority of RNs from both urban and rural hospitals indicated that they do *not* receive education or training, a larger percent of RNs from urban hospitals indicated that they are made aware of the different lifestyles and dietary habits of various cultural groups and they receive written guidelines regarding how to work with patients from different cultures, religions, and those that speak a language

other than English. A Chi-Square test revealed no significance between hospital location and receiving guidelines on how to work with patients from different cultures, X_2 (2, N=1755) = 2.730, different religions, X_2 (2, N=1754) = 5.178, and that speak a language other than English, X_2 (3, N=1754) = 1.998.

Analysis of the relationship between location and being made aware of the different lifestyles and dietary habits revealed statistical significance, X_2 (2, N=1755) = 6.086, $p<.05$. A larger percentage of RNs from rural hospitals indicated that they receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases and have easy-to-access cultural reference guides in their department or unit. No significance was found between hospital location and receiving written information regarding tendency of groups, X_2 (2, N=1755) = .216, and easy-to-access guides, X_2 (1, N=1756) = .399. The majority of respondents from both urban and rural hospitals indicated that they do *not* provide free foreign language classes to interested employees, yet a slightly larger percentage of respondents from urban hospitals indicated that they did. Chi-Square revealed no significance, X_2 (1, N=1800) = .313.

Table 6.13 presents the findings variables associated with the language access services standards by location. Response categories have been collapsed to Agree (includes Strongly Agree and Agree responses), Neither Agree or Disagree, and Disagree (includes Strongly Disagree and Disagree responses).

Table 6.13 CEO, HRD, and RN Sample Responses to Variables Associated With Language Access Services Standards by Location (Percentages)

	Yes	No	N
Does your hospital:			
Have trained interpreters on staff			
Urban	64.3	35.7	1191
Rural	47.3	52.7	440
Subscribe to a telephone interpreter service			
Urban	85.0	15.0	40
Rural	65.8	34.2	73
Post signs in a language other than English			
Urban	55.1	44.9	1324
Rural	59.4	40.6	475
Make the following forms available in a language other than English:			
HIPAA Privacy			
Urban	51.5	48.5	1294
Rural	50.6	49.4	403
Patients' Rights			
Urban	54.0	46.0	1294
Rural	50.4	49.6	403
Consent to Treat			
Urban	46.1	53.9	1294
Rural	43.4	56.6	403
Authorization for Use or Disclosure of Information			
Urban	40.6	59.4	1294
Rural	41.4	58.6	403

	Yes	No	N
Registration Forms			
Urban	36.2	63.8	1294
Rural	36.5	63.5	403
Billing Statements			
Urban	29.0	71.0	1294
Rural	27.3	72.7	403
Customer Satisfaction Surveys			
Urban	28.2	71.8	1315
Rural	27.2	72.8	437

	Agree	Neither Agree or Disagree	Disagree	N
Trained interpreters are available on shifts				
Urban	43.3	15.1	41.7	1334
Rural	40.1	15.9	43.9	421
Nurses and staff have been trained on how to effectively use interpreters				
Urban	35.4	17.4	47.2	1334
Rural	34.9	19.7	45.4	421
Non-English (or limited English) speaking patients are provided with verbal or written notice (in the patient's preferred language) informing them of their right to receive language assistance services				
Urban	36.7	32.9	30.4	1334
Rural	35.1	34.0	30.9	421

Of the 7 variables selected to identify the provision of language access services, urban hospitals indicated higher percentages of compliance on 6 variables, while rural hospitals indicated higher percentages of compliance on only 1 variable. The percentage differences on 4 variables, however, are less than 5 percent. A larger percentage of CEOs, HRDs, and RNs from urban hospitals indicated that they do have trained interpreters on staff and subscribe to a telephone interpreter service. Analysis of the relationship between hospital location and having trained interpreters using Chi-Square revealed statistical significance, X_2 (1, N=1629) = 39.502, p<.001. Statistical significance was also revealed between hospital location and subscribing to a telephone interpreter, X_2 (1, N=114) = 4.808, p<.05.

When asked if trained interpreters are available on all shifts, a larger percentage of RNs (43.3) from urban hospitals agree, while 43.9 percent of RNs from rural hospitals disagree. Chi-Square revealed no significance, X_2 (2, N=1755) = 1.267. Although greater percentages of RNs from both urban and rural hospitals disagree that they have received training on how to effectively use interpreters, 35.5 percent of RNs from urban hospitals indicated they did, compared to 34.9 percent from rural hospitals who indicated they did. No significance was found between these variables, X_2 (2, N=1755) = 1.219. Slightly larger percentages of respondents from urban hospitals indicated that they have 5 out of the 7 documents and forms listed available in a language other than English. A greater percentage of respondents from rural hospitals indicated that they have Authorization for Use or Disclosure of Information and registration forms available in another language(s). A Chi-Square test examining hospital location and the various forms revealed no significance.

Nearly 60 percent of respondents from rural hospitals indicated that their hospital posts signs in a language other than English, compared to 55.1 percent of urban hospitals. Chi-Square revealed no significance, X_2 (1, N=1765) = 1.845. When asked if non-English (or limited English) speaking patients are provided with verbal or written notice (in the patient's preferred language) informing them of their right to receive language assistance services, over 36 percent of RNs from urban hospitals indicated they do, compared to a slightly less percentage of RNs from rural hospitals, or 35.1 percent, that indicated they do. No significance was found between these variables, X_2 (2, N=1755) = .328.

Although urban hospitals have indicated larger percentages of compliance with culturally competent care and language access services standards, very small percentage differences exist in a number of variables. Significant variations in responses are evident in only three variables. Over 43 percent of HRDs from urban areas indicated that their hospital has persons who speak a language other than English in leadership positions, compared to 32.3 percent of HRDs from rural hospitals that indicated they disagree and 44.1 percent that indicated they Neither Agree or Disagree. A Chi-Square test examining the relationship between these variables revealed no significance, X_2 (2, N=57) = 2.956.

The majority of respondents from urban hospitals, or 64.3 percent, indicated that they did have trained interpreters, while 52.7 percent of respondents from rural hospitals indicated they did not. Over 43 percent of RNs from urban hospitals indicated that trained interpreters are available on all shifts, compared to 43.9 percent of RNs from rural hospitals that indicated they were not. Chi-Square revealed no significance, X_2 (2, N=919) = 1.978.

Overall, the analysis of the research questions indicates that although Alabama general medical and surgical hospitals are aware of the future challenges that the rising foreign-born population poses, many of the resources necessary to develop, implement, and maintain cultural and linguistic competence are not readily available. The implications of the findings, along with recommendations, will be discussed in the following chapter.

CHAPTER VII

CONCLUSION

This chapter discusses the implications of the findings and offers recommendations to ensure the provision of culturally and linguistically appropriate care in Alabama general hospitals. A discussion on future directions aimed at further broadening the knowledge base follows. The chapter concludes with a recap of the study's significance.

Implications of Findings and Recommendations

The findings presented in Chapter 5 suggest that although the overwhelming majority of Alabama general medical and surgical hospitals indicate that they are aware of the future cultural and linguistic challenges that the rising foreign-born population poses, many of the resources necessary to promote and monitor the provision of culturally and linguistically appropriate care are not readily available. As the foreign-born population continues to increase nationwide, Alabama general hospitals accordingly will continue to experience a rapid diversification of their patient population. The need for health care providers to be culturally competent and make interpretive services available will be critical in their efforts to provide appropriate care in a cost-effective manner.

Alabama general hospitals indicate that they are actively recruiting persons from diverse cultures and have persons of diverse ethnic and religious backgrounds in

leadership positions. The distribution of their current workforce by race, however, suggests that hospitals are having difficulty finding qualified candidates that are of diverse cultures, those other than White, non-Hispanic and Black or African American, to fill vacant positions. As the number of patients of diverse cultures and languages increases, the findings indicate that the number of persons within these cultural groups with the necessary qualifications to fill vacancies is stagnant.

The Office of Minority Health's (OMH) (2001) final report of the "National Standards for Culturally and Linguistically Appropriate Services in Health Care" suggests a number of ways that health care providers can address the challenges associated with developing a more culturally and linguistically diverse workforce. First, OMH stresses the need for health care providers to periodically collect information regarding new cultural groups that are moving into their service area. Being aware of these new cultural groups not only gives hospitals the opportunity to learn about the appropriate forms of care and services that should be made available to better serve these groups and subsequently train their staff, it allows hospitals to ensure that these cultural and linguistic groups are adequately represented in their workforce and throughout all levels of the organization.

Alabama hospitals indicated that there are few to no qualified candidates of diverse cultures to fill vacancies. To combat this problem, the OMH suggests that hospitals consider working with local colleges and/or universities to recruit diverse students enrolled in the medical, nursing, and allied health fields. Hospitals may also consider partnering with statewide or community-based organizations that support the

foreign-born to aide in recruitment efforts. These organizations may help target specific candidates that were missed through standard advertising channels.

The OMH (2001) also suggests that hospitals "grow [their] own" staff. These programs "hire individuals from the community and provide them with training to act as interpreters and cultural brokers. These liaison staff members are encouraged to pursue formal training for a health profession or other important roles in the organization" (p. 57). These individuals are generally very involved and strongly committed to their communities. They can serve as a bridge between the hospital and the diverse cultural groups, helping newcomers learn about our nation's health care system and helping the hospital learn about the groups' cultural values, beliefs, and practices. Several communities throughout the nation with larger populations of Hispanics have successfully employed health promoters, or "promotores de salud" (Migrant Health Promotion, 2005). This model, similar to the "grow your own" staff model, works with the community leaders of those cultural groups, to distribute information related to the various health resources available and how to access them, immunization and well-baby care, and promoting a healthy lifestyle with tips on not smoking, exercising, and having regular medical check-ups.

Although having a diverse workforce does not ensure a culturally competent workforce, Spataro (2005) argues that a diverse workforce is more accepting and responsive of the need to adapt their practices and behaviors to fit those who are of different cultures. Thus, an organization’s attitude about diversity is largely shaped by the demographic composition of their workforce. This assumes that the more diverse a

workforce, the greater the awareness of, and response to the need for cultural competency.

A diverse workforce, however, requires a strong commitment from organizational leaders to promote and maintain diversity. Weech-Maldonado et al. (2002) stress that only through effective diversity management can cultural competence be achieved. They refer to diversity management as "'a strategically driven process' whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations" (p. 112). Moreover, Ciccocioppo and Ciccocioppo (2002) claim that managing diversity solely for compliance purposes will never result in the organization becoming culturally competent. Hospital administrators must adopt the role of internal champions to successfully lead the organization in its efforts to change the culture from one that sees diversity as a necessary evil, to one that "values diversity as intrinsically good for the hospital and for the community" (p. 125).

The majority of Alabama general hospitals indicated that they do have written policies and procedures that ensure the provision of culturally and linguistically appropriate services; however, when RNs were asked if they receive written guidelines regarding how to work with diverse patients, receive information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases, or are made aware of the different lifestyles of the dietary habits of various cultural groups which might impact health or interfere with patients' adherence to treatment plans, a greater percentage indicated they do not. Ongoing training of RNs and staff is crucial to ensuring that all information related to the provision of appropriate care is distributed throughout the organization. The OMH (2001) argues that "staff education and training may be the

single most important element of assuring the cultural and linguistic competence of an organization and is closely related to improving clinical care and outcomes" (p. 60). Presently, however, there are no standard or universally accepted curricula to educate health care providers, nor are there "standardized measures for evaluating the effectiveness of cultural competence trainings" (p. 60).

Although the lack of uniformity in training makes it difficult to ensure that all health care providers are receiving the same information, it provides hospitals with the flexibility to tailor training to areas that are specific to their current needs. Due to the changing patient population, the small amount of course hours devoted to cultural competence in nursing curricula, and the high turnover rates in nursing staff, Alabama hospitals may consider offering their own continuing education courses. These courses can be customized to include the specific cultural group(s) whose numbers are increasing in the service area, issues encountered in specific departments or units, and the specific responsibilities of the nurses or staff being trained. During these sessions, nurses and staff should be taught about the various beliefs and practices of the cultural groups present in their service area, provided with written guidelines on how to care for patients of different cultures, and be informed of the various cultural and language resources available and how to access them.

In addition to offering ongoing training sessions, hospitals should make cultural reference guides available to all nurses and staff in the form of quick reference books, pocket-size booklets, or a website. These reference guides can aide nurses and staff, when caring for a foreign-born patient, to familiarize themselves with the common characteristics and traditions of that patient's cultural and religious group. Although

nurses should be encouraged to assess each patient individually and not assume that their beliefs and practices are synonymous with the cultural or religious group they belong to, cultural reference guides can provide nurses with a baseline of common characteristics from which to build upon.

The findings indicate that Alabama hospitals do not have a specific person or department charged with promoting cultural and linguistic competence. The OMH (2001) argues that designating a specific person or department to develop, implement, and maintain cultural and linguistic competencies ensures that these competencies are executed throughout the organization and are continuously monitored for improvement opportunities. "For example, having qualified interpreters and translated materials available at the time of need is nearly impossible without designated staff who are responsible for organizing and dispatching the services" (p. 84). Not designating a specific person or department with the responsibility of overseeing the implementation and maintenance of cultural and linguistic competencies may suggest to others in the organization that the initiatives are not important. Lack of accountability may also result in poor or improper implementation, training, and evaluation.

Hospitals may consider assembling a committee or task force composed of a mix of employees and managers representing different departments and units to develop a comprehensive strategy for their organization. This committee can collaborate with existing departments to devise training programs, care competencies, and evaluation processes. Initially, the committee can play a more active role in guiding departments through the implementation process. Once employed, the committee can then simply monitor progress and periodically evaluate outcomes and make changes where necessary.

The committee, however, must have strong management support for the purposes of legitimacy and longevity. Raso (2006) argues that "the glue that ties [cultural competence] all together is leadership" (p. 56). It is a transformational process that requires leaders to transform their vision and adopt a new paradigm for their organization. Achieving cultural competence requires a spirit of inclusion and the belief that differences are valuable. Dreachslin (1996) adds that leaders are essential to fostering an environment of acceptance and understanding. Only when this acceptance and understanding is achieved will patients benefit from the provision of culturally appropriate care.

Over two-thirds of Alabama general hospital respondents indicated that they do subscribe to a telephone interpreter service. The literature argues that although telephone interpreter services provide trained professionals to accurately interpret information, they are largely impaired by their inability to assess the patient's nonverbal behavior. The OMH (2001) states that telephone interpreter services may be appropriate in cases of emergency, nonclinical situations, and instances in which a patient's preferred language is not one common to the area. For all other cases, the OMH states that the telephone interpreter service should not be the primary source used. Luckmann (1999) argues that "two-thirds of all communication is nonverbal" (p. 57). It is important to assess a patient's facial expressions and body language. In some cases, gestures and expressions may convey more information to health care providers than words. In addition, Carrasquillo, Orav, Brennan, and Burstin (1999) state that "aside from violating a patient's right to privacy, such interpreters usually only translate and cannot place the

message into the appropriate social and cultural context as a professional interpreter is trained to do" (p. 86).

Responses regarding having a trained interpreter on staff varied among CEOs, HRDs, and RNs. As previously mentioned, some RNs may have considered volunteer interpreters or bilingual staff as trained interpreters. A larger percentage of CEOs indicated they did not have trained interpreters due to the difficulty in finding individuals qualified to serve as interpreters in their area, followed by non-English speaking patients generally bringing a family member or friend that can help translate. These findings raise serious concerns regarding equity and the quality of care provided to non-English speaking patients.

The difficulty in finding trained interpreters may be a direct result of the challenges faced by HRDs in recruiting qualified individuals from various ethnic and linguistic backgrounds. A number of authors discuss the trend of hiring foreign nurses to alleviate the current nursing shortage (Brush, Sochalski, & Berger, 2004; Pacquiao, 2002; Daum, 2001). In addition to other recruitment efforts such as working with community groups and growing their own staff, hospitals may consider hiring foreign nurses to increase the number of bilingual employees that can serve as interpreters when needed. This option, however, presents significant challenges. First, recruiting nurses from other countries can be costly. Recruitment firms charge between $5,000 and $10,000 per nurse (Chandra & Willis, 2005; Brush, Sochalski, & Berger, 2004). This may be cost prohibitive to many small rural hospitals. Second, prior to the attacks on September 11, 2001, obtaining visas for these recruits took an average of 12 to 18 months (Daum, 2001). As a result of post 9/11 immigration restrictions, the length of time to obtain a visa is now

several years (Chandra & Willis, 2005). Third, once here, foreign nurses must pass licensing exams before they are allowed to practice. Lastly, foreign nurses require extensive clinical, cultural, and linguistic training. Even after extensive language training, however, issues with enunciation, pronunciation, improper translation, and improper written-word selection may still occur resulting in miscommunication and documentation errors (Bola, Driggers, Dunlap & Ebersole, 2003). Given the challenges associated with recruiting and training foreign nurses to increase the number of bilingual employees, Alabama general hospitals might find working with state or local community groups and developing programs such as "grow your own" staff more fitting.

The literature discusses the problems associated with having the patient's family or friends serve as interpreters. Flores (2006) argues that "such interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences" (p. 231). Family members or friends may not be familiar with certain medical terms or procedures resulting in improper translation of information. In some cases, the family member or friend may decide not to worry the patient with the news of a certain test result or the potential side effects of a procedure, resulting in a lack of true informed consent. Family members or friends may also be put in an uncomfortable situation having to discuss a problem that is of a serious or personal nature, resulting in the lack of privacy. The OMH (2001) states that family members or friends should only be used when the patient specifically requests them, refusing the trained interpreter provided by the hospital. Family members or friends should not be relied upon as one of the primary sources for interpretive services.

The majority of RNs indicated that they do not receive training on how to effectively use interpreters. The U.S. Department of Justice maintains a website (www.lep.gov) dedicated to providing agencies and organizations with information on practical tools and measures for the provision of linguistically appropriate care. The website offers a video that illustrates the correct way to identify a patient's preferred language, locate an interpreter, and communicate with the patient using the interpreter. The video suggests that health providers brief interpreters prior to meeting with patients and inquire about significant cultural or religious factors that may affect the encounter. Interpreters should be seated beside the patient if possible and health providers should speak directly to the patient, not the interpreter. Health providers should avoid using phrases or jargon that may be difficult to translate. Finally, health providers should allow for extra time when using interpreters to communicate with patients. The LEP video can be downloaded free of charge and may prove to be an inexpensive, yet helpful approach to ensuring that nurses and staff are communicating appropriately with non-English speaking patients through the use of interpreters.

When asked if they prefer to care for a patient from their own cultural group who speaks their language because it is easier, the majority of RNs indicated they did. Although a greater percentage of nurses responded favorably to statements regarding feeling comfortable and having the knowledge necessary to care for patients of a different culture, not behaving differently and always knowing what to say, and looking forward to caring for patients of different cultural backgrounds, their preference in caring for patients of the same culture raises serious concerns. This preference implies that RNs do not consider the provision of care to foreign-born patients to be easy. Perhaps the

irregularity of encounters with patients of different cultures contributes to their partiality. In a study examining Latino immigrants' views of black Americans in Durham, North Carolina, McClain, Carter, Soto, Lyle, Grynaviski, Nunnally, Scotto, Kendrick, Lackey, and Cotton (2006) found that Latino immigrants that had greater social interactions with blacks had more positive views. The authors argue that "contact theory, as defined as social contact, seems to bring about a positive change in attitudes" (p. 581). Contact, or propinquity, theory asserts that "increased contact between two groups with negative attitudes toward each other will result in a decrease in negative attitudes" (p. 574). Although the findings in no way indicate that RNs have negative attitudes toward foreign-born patients, increased exposure to patients that are of a different culture and speak a language other than English may change RNs beliefs that caring for these patients is more difficult. As nurses learn more about the cultural beliefs and practices of those groups present in their service area and become more familiar with requesting and effectively using interpreters, the difficulty and perhaps frustration associated with caring for foreign-born patients may diminish.

A number of findings indicate that CEOs and RNs are aware of their changing patient population and are taking certain measures to ensure the provision of culturally and linguistically appropriate care. The majority of respondents agree that the increasing number of foreign-born poses future cultural and linguistic challenges to their respective organization. A greater percentage of CEOs indicate that they do have written policies and procedures related to the provision of culturally and linguistically appropriate services and that the provision of culturally appropriate care is part of their mission statement. Over two-thirds of CEOs, and slightly less HRDs, stated that they do subscribe

to a telephone interpreter service and do post signs in a language other than English. Nearly all RNs believe that a patient's culture can influence their perception of health, illness, and death, and agree that they do take a patient's cultural and religious beliefs and practices into consideration during assessment. All respondents recognize the need for more health care practitioners to learn another language, and nearly all RNs stated they would take a foreign language class if offered free of charge. Overall, CEOs, HRDs, and RNs indicate a willingness to become more culturally and linguistically competent and appear to be taking some initial steps to manage the imminent challenges.

Future Directions

An obvious expansion to this research would be to inquire about Alabama general hospitals' efforts to collect and periodically review information related to patients' country of origin and preferred language. Presently, hospitals are not required to collect this information. Those hospitals that do collect this information could be further questioned to determine if this information is used to improve the care and services offered to foreign-born patients.

A complement to this study would be a similar analysis examining the three levels of Alabama general hospitals' organizational culture: (1) artifacts and creations; (2) basic values; and, (3) basic assumptions. This study could seek to determine if organizational culture influences perceptions on the need for cultural and linguistic competence. Efforts to develop, implement, and maintain competencies could also be examined. Additionally, this study could examine if CEOs who adopted the role of internal champions for

diversity, or simply cultivated a culture of tolerance and inclusion, were more successful in their efforts to develop a culturally and linguistically competent organization.

An additional complement to this study would be to conduct a similar investigation on general medical and surgical hospitals located in various other states to determine if hospitals located in states that have a higher percentage of foreign-born are more culturally and linguistically competent.

Significance of the Study

Few studies have examined health care providers' level of compliance with OMH's National Standards for Culturally and Linguistically Appropriate Services in Health Care. This analysis of Alabama general medical and surgical hospitals' level of cultural and linguistic competence has afforded the opportunity to broaden our knowledge of the subject and identify areas that are in need of improvement.

The southern region of the country is now home to the second highest percentage of foreign-born persons. Subsequently, the number of non-English, or limited English, proficient patients is rising, as is the likelihood of misunderstandings and errors during patient-provider encounters. As this segment of the population continues to grow, Alabama general hospitals will be forced to become culturally and linguistically competent in order to lessen barriers to access, obtain adequate information for diagnostic and treatment purposes, and provide high quality care to all its patients. The need for hospitals to develop a culturally competent workforce and make interpretive services available will intensify as hospitals struggle to provide appropriate care in a cost-effective manner.

Although this study has added to the knowledge base, considerable gaps remain. Given the significance of cultural and linguistic competence in health care, this study should serve as a foundation for additional research into the development, implementation, and maintenance of culturally and linguistically appropriate care to foreign-born persons. In addition, the results of this study should help to initiate a dialogue within and among hospitals to evaluate the areas that are in need of improvement and find more effective ways to care for culturally and linguistically diverse patients.

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June 19, 2006

Dear Chief Executive Officer,

The Alabama Board of Nursing is cooperating with Marilyn V. Whitman, MPA, Doctoral Candidate in the Public Administration program at Auburn University, in her dissertation research. The changing demographics of Alabama's population is creating challenges for all health care delivery systems.

Ms. Whitman's letter explains the details of the research and how the data will be reported. The Board is assisting with the data collection from registered nurses, including advanced practice nurses, who work in Alabama hospitals. Approximately 26,000 registered nurses identified in the last renewal that they work in hospitals. As I have discussed with many of you, the nursing population does not reflect the general population and the Board hopes to use the aggregate data from this study to identify target areas for recruitment of minorities into nursing.

The Board will not have access to your response other than through Ms. Whitman's reporting of aggregate data. The Board is hopeful that the information collected will provide state-wide data on the issues surrounding linguistic and cultural competence at all levels of patient care in Alabama hospitals.

Sincerely,

N. Genell Lee, MSN, RN, JD
Executive Officer

APPENDIX B

Auburn University Montgomery
School of Sciences
Department of Political Science and Public Administration

June 19, 2006

INFORMATION SHEET
for Research Study Entitled
An Examination of Cultural and Linguistic Competence in Health Care

To: Chief Executive Officer

My name is Marilyn Whitman, a doctoral candidate in the joint Auburn University/ Auburn University Montgomery Ph.D. Program in Public Administration and Public Policy. For my dissertation, I am working under the supervision of Dr. Anne Permaloff, Professor, and in collaboration with the Alabama Board of Nursing (ABN) to examine whether the patient population in Alabama general hospitals is diversifying and what measures hospitals may be taking in response to diversification. You are invited to participate in this research study.

We are contacting all Chief Executive Officers of Alabama general hospitals whose service category is general medical and surgical. Your responses to the enclosed questionnaire will help us to measure Alabama general hospitals' awareness of and preparation for a diversifying patient population. The questionnaire includes instructions on how to navigate through each section of questions and how to mark your responses. Completing the questionnaire will only take a few minutes.

Please be assured that your responses will remain **completely confidential**. Information collected through your participation will be used to fulfill the doctoral degree requirements. You may withdraw from participating in this study at any time, without penalty, however, after the information you provide is anonymously entered into the database, I will be unable to withdraw your data since there is no way to identify your individual information. Results will be presented only as summaries and individual respondents and their hospitals will not be able to be identified.

The last page of the questionnaire asks for your hospital's name and county in which it resides. This information will be used for contact and analysis purposes only. When you return your questionnaire, your hospital will be deleted from the mailing list and the page will be destroyed.

A self-addressed, stamped envelope is enclosed for your convenience. Please return the completed questionnaire by **July 31, 2006**. When the research is complete, survey results will be sent to all respondents who provided their email address.

This survey is voluntary. I know your time is valuable; however, the ABN and I do appreciate you taking the time to fill in the questionnaire. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, the Department of Political Science and Public Administration, or the Alabama Board of Nursing.

P.O. Box 244023 Montgomery, Alabama 36124-4023 • 334.244.3698 Fax 334.244.3826 ATTNet

If you have any questions regarding the questionnaire, or the study itself, we invite you to ask them now. Please feel free to contact me by phone at (205) 826-4620 or e-mail valpuma@auburn.edu. My dissertation advisor, Dr. Anne Permaloff, is also available at (334) 270-0539 or e-mail apermalo@mail.aum.edu.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THIS INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

I thank you for your time. Your participation is greatly valued and appreciated.

M J Whitman 6-19-06

Investigator's Signature Date
Marilyn Whitman
Doctoral Candidate, Auburn University

Enclosure: Chief Executive Officer Questionnaire

APPENDIX C

ALABAMA HOSPITALS' RESPONSES TO THE CHANGING PATIENT POPULATION: A RESEARCH STUDY
To Be Completed By Chief Executive Officer (CEO)

This survey examines whether the patient population in Alabama general hospitals is diversifying and what measures hospitals may be taking in response to diversification. All responses will remain confidential.

Most items may be answered by placing a "✓" or "**x**" in the box that best describes your hospital. A few items will require a short answer that should be placed in the space provided.

Your participation is greatly appreciated. Thank you for your time.

What do you consider to be your <u>primary</u> role as Chief Executive Officer?

- □ Facilitator – empowering employees
- □ Setting the agenda for your organization
- □ Carrying out the strategic plan of your organization
- □ Change agent
- □ Visionary – keeper of the organization's mission
- □ Cultivator of the organization's culture

Please indicate your level of agreement or disagreement with the following statements.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The increasing number of foreign-born (both documented and undocumented immigrants) poses future cultural problems for my hospital	□	□	□	□	□
The increasing number of foreign-born (both documented and undocumented immigrants) poses future linguistic problems (or language barriers) for my hospital	□	□	□	□	□
My hospital has witnessed an increase in non-English (or limited English) speaking patients within the last year	□	□	□	□	□
The provision of culturally appropriate care is part of my hospital's mission statement	□	□	□	□	□

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The provision of linguistically appropriate care is part of my hospital's mission statement	□	□	□	□	□
My hospital has a specific person or department assigned to promoting cultural competence	□	□	□	□	□
My hospital has written policies and procedures that ensure the provision of culturally appropriate services	□	□	□	□	□
My hospital has written policies and procedures that ensure the provision of linguistically appropriate services	□	□	□	□	□
My hospital maintains current information regarding new cultural groups that are moving into our service area	□	□	□	□	□
The cultural demographics of my hospital's workforce mirrors the cultural demographics of our service area	□	□	□	□	□
My hospital maintains current epidemiological profiles (information on the causes, distribution, and control of diseases in the population) of our service area	□	□	□	□	□
My hospital regularly works with or consults our community's cultural, ethnic and religious groups regarding the forms of care and services which should be made available to their members	□	□	□	□	□

Does your hospital have trained interpreters on staff?

□ Yes → If Yes, during what hours (or shifts) are they available? _____

What language(s) are available? _____

□ No → If No, please indicate if any of the following reasons explain why there are no trained interpreters on staff:

	Yes	No
Your hospital is witnessing few encounters with non-English speaking patients	□	□
It is too expensive to hire a trained interpreter . . .	□	□
It is difficult to find trained interpreters in your area	□	□
Non-English speaking patients generally bring a family member or friend who can help translate . .	□	□

Does your hospital subscribe to a telephone interpreter service?

□ Yes → If Yes, is the service available …

	Yes	No	
24 hours a day?	□	□	If No, during what hours? _____
During weekends?	□	□	
During holidays?	□	□	

□ No

Does your hospital:			
	Yes	No	
Display pictures and decorations that are representative of all the cultures present in your service area	□	□	
Display pictures and decorations that are representative of the major religions present in your service area	□	□	
Post signs in a language other than English	□	□	If Yes, in what language(s)? _____
Provide free foreign language classes to interested employees	□	□	If Yes, for what language(s)? _____
Give hiring preference to bilingual candidates	□	□	If Yes, what language(s)? _____

Foreign-born patients (both documented and undocumented immigrants) may create problems for hospitals, especially when the numbers of these patients begin to increase.

Please indicate whether you agree or disagree that any of the following have occurred in your hospital due to an increase in foreign-born patients. ***Check "Does Not Apply" if your hospital has seen no increase in foreign-born patients in the past year.***

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does Not Apply
Incorrect diagnosis as a result of a language barrier between the patient and a service provider	□	□	□	□	□	□
Excessive diagnostic testing	□	□	□	□	□	□
Lack of informed consent	□	□	□	□	□	□

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does Not Apply
Improper patient education	☐	☐	☐	☐	☐	☐
Patient's failure to comply with physician directives	☐	☐	☐	☐	☐	☐
Poor patient satisfaction scores on hospital surveys	☐	☐	☐	☐	☐	☐
Increased patient loads in the Emergency Room	☐	☐	☐	☐	☐	☐
Increases in uncollectible billings	☐	☐	☐	☐	☐	☐
Malpractice suits	☐	☐	☐	☐	☐	☐

Do you:			
	Yes	No	
Consider developing a culturally and linguistically competent workforce as a priority for your hospital at this time?	☐	☐	
See a need for more health practitioners to learn a language other than English?	☐	☐	If Yes, what language(s)? _____
Speak a language other than English?	☐	☐	If Yes, what language(s)? _____

The following information will remain confidential. It will only be used for analysis purposes.

Hospital Name: _____

County in which hospital resides: _____

Please use the space below for any comments you wish to share.

Thank you again for your assistance. It is greatly appreciated.

Please write your email address on the line below if you would like to receive a copy of the survey results when they become available.

Email address: _____

CEO Questionnaire

APPENDIX D

Auburn University Montgomery
School of Sciences
Department of Political Science and Public Administration

July 5, 2006

To: Chief Executive Officer

A few weeks ago, I sent you a questionnaire asking about the diversifying patient population in Alabama general hospitals. The responses received thus far have been quite valuable in examining the measures hospitals have been taking in response to diversification. I am writing to you again due to the importance of your responses to these questions. Receiving responses from everyone who is selected will ensure that the results are representative of all Alabama general hospitals.

Please be assured that your responses will remain **completely confidential**. Results will be presented only as summaries and individual respondents and their hospitals will not be able to be identified. The last page of the questionnaire asks for your hospital's name and county in which it resides. This information will be used for contact and analysis purposes only. When you return your questionnaire, your hospital will be deleted from the mailing list and the page will be destroyed.

This survey is voluntary. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, the Department of Political Science and Public Administration, or the Alabama Board of Nursing. I have enclosed a copy of the questionnaire and a self-addressed, stamped envelop for your convenience. Please return the completed questionnaire by **July 31, 2006**.

If you have any questions regarding the questionnaire, or the study itself, please do not hesitate to contact me by phone at (205) 826-4620 or e-mail valpuma@auburn.edu. My dissertation advisor, Dr. Anne Permaloff, is also available at (334) 270-0539 or e-mail apermalo@mail.aum.edu.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THIS INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

I thank you for your time. Your participation is greatly valued and appreciated.

M J Whitman 7-5-06

Investigator's Signature Date
Marilyn Whitman
Doctoral Candidate, Auburn University

Enclosure: Chief Executive Officer Questionnaire

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June 19, 2006

Dear Director of Human Resources,

The Alabama Board of Nursing is cooperating with Marilyn V. Whitman, MPA, Doctoral Candidate in the Public Administration program at Auburn University, in her dissertation research. The changing demographics of Alabama's population is creating challenges for all health care delivery systems.

Ms. Whitman's letter explains the details of the research and how the data will be reported. The Board is assisting with the data collection from registered nurses, including advanced practice nurses, who work in Alabama hospitals. Approximately 26,000 registered nurses identified in the last renewal that they work in hospitals.

The Board will not have access to your response other than through Ms. Whitman's reporting of aggregate data. The Board is hopeful that the information collected will provide state-wide data on the issues surrounding linguistic and cultural competence at all levels of patient care in Alabama hospitals.

Sincerely,

N. Genell Lee, MSN, RN, JD
Executive Officer

APPENDIX F

Auburn University Montgomery
School of Sciences
Department of Political Science and Public Administration

June 19, 2006

INFORMATION SHEET
for Research Study Entitled
An Examination of Cultural and Linguistic Competence in Health Care

To: Human Resource Director

My name is Marilyn Whitman, a doctoral candidate in the joint Auburn University/ Auburn University Montgomery Ph.D. Program in Public Administration and Public Policy. For my dissertation, I am working under the supervision of Dr. Anne Permaloff, Professor, and in collaboration with the Alabama Board of Nursing (ABN) to examine whether the patient population in Alabama general hospitals is diversifying and what measures hospitals may be taking in response to diversification. You are invited to participate in this research study.

We are contacting all Human Resource Directors of Alabama general hospitals whose service category is general medical and surgical. Enclosed is a short questionnaire about your hospital's policies and practices concerning workforce diversity and training. The questionnaire includes instructions on how to navigate through each section of questions and how to mark your responses. Completing the questionnaire will only take a few minutes. Your responses will help us to measure Alabama general hospitals' awareness of and preparation for a diversifying patient population.

Please be assured that your responses will remain **completely confidential**. Information collected through your participation will be used to fulfill the doctoral degree requirements. You may withdraw from participating in this study at any time, without penalty, however, after the information you provide is anonymously entered into the database, I will be unable to withdraw your data since there is no way to identify your individual information. Results will be presented only as summaries and individual respondents and their hospitals will not be able to be identified.

The last page of the questionnaire asks for your hospital's name and county in which it resides. This information will be used for contact and analysis purposes only. When you return your questionnaire, your hospital will be deleted from the mailing list and the page will be destroyed.

A self-addressed, stamped envelope is enclosed for your convenience. Please return the completed questionnaire by **July 31, 2006**. When the research is complete, survey results will be sent to all respondents who provided their email address.

P.O. Box 244023 Montgomery, Alabama 36124-4023 • 334.244.3698 Fax 334.244.3826 ATTNet 240.3698

This survey is voluntary. I know your time is valuable; however, the ABN and I do appreciate you taking the time to fill in the questionnaire. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, the Department of Political Science and Public Administration, or the Alabama Board of Nursing.

If you have any questions regarding the questionnaire, or the study itself, we invite you to ask them now. Please feel free to contact me by phone at (205) 826-4620 or e-mail valpuma@auburn.edu. My dissertation advisor, Dr. Anne Permaloff, is also available at (334) 270-0539 or e-mail apermalo@mail.aum.edu.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THIS INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

I thank you for your time. Your participation is greatly valued and appreciated.

M L Whitman 6-19-06

Investigator's Signature Date

Marilyn Whitman
Doctoral Candidate, Auburn University

Enclosure: Human Resource Director Questionnaire

APPENDIX G

ALABAMA HOSPITALS' RESPONSES TO THE CHANGING PATIENT POPULATION: A RESEARCH STUDY
To Be Completed By Human Resources Director

This survey examines whether the patient population in Alabama general hospitals is diversifying and what measures hospitals may be taking in response to diversification. All responses will remain confidential.

Most items may be answered by placing a "✓" or "**x**" in the box that best describes your hospital. A few items will require a short answer that should be placed in the space provided.

Your participation is greatly appreciated. Thank you for your time.

Please indicate your level of agreement or disagreement with the following statements.

My hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Actively recruits employees from various ethnic backgrounds	☐	☐	☐	☐	☐
Actively recruits employees from various religious backgrounds	☐	☐	☐	☐	☐
Actively recruits employees who speak a language other than English	☐	☐	☐	☐	☐
Gives hiring preferences to bilingual candidates	☐	☐	☐	☐	☐
Has persons from different ethnic backgrounds in leadership positions	☐	☐	☐	☐	☐
Has persons from different religious backgrounds in leadership positions	☐	☐	☐	☐	☐
Has persons who speak a language other than English in leadership positions	☐	☐	☐	☐	☐
Works closely with one or more organizations (community support group or church) that provide support to the foreign-born	☐	☐	☐	☐	☐
Displays pictures and decorations that are representative of all the cultures present in the service area	☐	☐	☐	☐	☐

My hospital:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Displays pictures and decorations that are representative of the major religions present in the service area	□	□	□	□	□

Please indicate your level of agreement or disagreement with the following statements.

In my hospital, admissions desk staff are trained to identify and deal with patients:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
From different cultural backgrounds	□	□	□	□	□
From different religious backgrounds	□	□	□	□	□
From different racial backgrounds	□	□	□	□	□
Who speak little or no English	□	□	□	□	□

In my hospital, office personnel are trained to identify and deal with patients:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
From different cultural backgrounds	□	□	□	□	□
From different religious backgrounds	□	□	□	□	□
From different racial backgrounds	□	□	□	□	□
Who speak little or no English	□	□	□	□	□

In my hospital, clerical personnel in patient care areas are trained to identify and deal with patients:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
From different cultural backgrounds	□	□	□	□	□
From different religious backgrounds	□	□	□	□	□
From different racial backgrounds	□	□	□	□	□
Who speak little or no English	□	□	□	□	□

In my hospital, nurses are trained to identify and deal with patients:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
From different cultural backgrounds	□	□	□	□	□
From different religious backgrounds	□	□	□	□	□
From different racial backgrounds	□	□	□	□	□
Who speak little or no English	□	□	□	□	□

Does your hospital:			
	Yes	No	
Post signs in a language other than English	□	□	If Yes, in what language(s)? _____
Provide free foreign language classes to interested employees	□	□	If Yes, for what language(s)? _____
Make customer satisfaction surveys available in other languages	□	□	If Yes, in what language(s)? _____

Does your hospital have trained interpreters on staff?

□ Yes → If Yes, during what hours (or shifts) are they available? _____

What language(s) are available? _____

□ No → If No, please indicate if any of the following reasons explain why there are no trained interpreters on staff:

	Yes	No
Your hospital is witnessing few encounters with non-English speaking patients	□	□
It is too expensive to hire a trained interpreter . . .	□	□
It is difficult to find trained interpreters in your area	□	□
Non-English speaking patients generally bring a family member or friend who can help translate . .	□	□

Does your hospital subscribe to a telephone interpreter service?

□ Yes → If Yes, is the service available …

	Yes	No	
24 hours a day?	□	□	If No, during what hours? _____
During weekends?	□	□	
During holidays?	□	□	

□ No

What is the approximate size of your hospital's service population?

□ 99,999 or less
□ 100,000-199,999
□ 200,000-299,999
□ 300,000-399,999
□ 400,000-499,999
□ 500,000 or more

What is your hospital's bed size?

- □ 100 or less
- □ 101-200
- □ 201-300
- □ 301-400
- □ 401-500
- □ 501 or more

What is the size of your hospital's workforce?

- □ 500 or less
- □ 501-1000
- □1001-1500
- □1501-2000
- □2001-2500
- □2501-3000
- □3001 or more

What percentage of your hospital's employees identify themselves as:

White (Non Hispanic)	_____%
Black or African American	_____%
Asian	_____%
Native Hawaiian or Other Pacific Islander	_____%
Hispanic or Latin American	_____%
Native American	_____%
Multiracial (two or more races)	_____%
Other: _____	_____%

What percentage of your employees in *management* positions identify themselves as:

White (Non Hispanic)	_____%
Black or African American	_____%
Asian	_____%
Native Hawaiian or Other Pacific Islander	_____%
Hispanic or Latin American	_____%
Native American	_____%
Multiracial (two or more races)	_____%
Other: _____	_____%

The following information will remain confidential. It will only be used for analysis purposes.

Hospital Name: _____

County in which hospital resides: _____

Please use the space below for any comments you wish to share.

Thank you again for your assistance. It is greatly appreciated.

Please write your email address on the line below if you would like to receive a copy of the survey results when they become available.

Email address: _____

APPENDIX H

Auburn University Montgomery
School of Sciences
Department of Political Science and Public Administration

July 5, 2006

To: Human Resource Director

A few weeks ago, I sent you a questionnaire asking about the diversifying patient population in Alabama general hospitals. The responses received thus far have been quite valuable in examining the measures hospitals have been taking in response to diversification. I am writing to you again due to the importance of your responses to these questions. Receiving responses from everyone who is selected will ensure that the results are representative of all Alabama general hospitals.

Please be assured that your responses will remain **completely confidential**. Results will be presented only as summaries and individual respondents and their hospitals will not be able to be identified. The last page of the questionnaire asks for your hospital's name and county in which it resides. This information will be used for contact and analysis purposes only. When you return your questionnaire, your hospital will be deleted from the mailing list and the page will be destroyed.

This survey is voluntary. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, the Department of Political Science and Public Administration, or the Alabama Board of Nursing. I have enclosed a copy of the questionnaire and a self-addressed, stamped envelop for your convenience. Please return the completed questionnaire by **July 31, 2006**.

If you have any questions regarding the questionnaire, or the study itself, please do not hesitate to contact me by phone at (205) 826-4620 or e-mail valpuma@auburn.edu. My dissertation advisor, Dr. Anne Permaloff, is also available at (334) 270-0539 or e-mail apermalo@mail.aum.edu.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THIS INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

I thank you for your time. Your participation is greatly valued and appreciated.

M J Whitman 7-5-06

Investigator's Signature Date
Marilyn Whitman
Doctoral Candidate, Auburn University

Enclosure: Human Resource Director Questionnaire

P.O. Box 244023 Montgomery, Alabama 36124-4023 • 334.244.3698 Fax 334.244.3826 ATTNet 2

ABN

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N. GENELL LEE, MSN, RN, JD
EXECUTIVE OFFICER

(334) 242-4060
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FAX (334) 242-4360

WWW.ABN.STATE.AL.US

June 19, 2006

TO: Registered Nurses, CRNAs, CRNPs, CNMs, and CNSs

FROM: N. Genell Lee, MSN, RN, JD
Executive Officer

RE: Online Survey Related to Language and Cultural Competence

The Alabama Board of Nursing is cooperating with Marilyn V. Whitman, MPA, Doctoral Candidate in Public Administration at Auburn University, in completing her doctoral research. Ms. Whitman's letter explaining the research is enclosed.

You are receiving this information because you identified a hospital was your primary place of employment at the time of the last renewal. If you are no longer working in the hospital setting, please do not respond to the survey.

The survey is available online and should not require more than 15 minutes to complete. Go to the Board's web site, www.abn.state.al.us, click on "Online Services" and then select "Hospital Language Survey." You will need to input your license number and last four digits of your social security number to access the survey. The Board of Nursing is offering one (1) continuing education contact hour for participation in the research so your license number is required to award the contact hour to the appropriate participants.

Participation in the research is not required by the Board but is encouraged. Your identity and that of your hospital will not be released individually but will only be reported as a group.

Should you have any questions about the Board's involvement, do not hesitate to contact me at 334-242-4184 or via electronic mail at Genell.Lee@abn.alabama.gov. If you have technical difficulty with the survey, please contact Richard Boyette at 334-353-8539,

APPENDIX J

Auburn University Montgomery
School of Sciences
Department of Political Science and Public Administration

June 19, 2006

INFORMATION SHEET
for Research Study Entitled
An Examination of Cultural and Linguistic Competence in Health Care

To: Registered Nurse

My name is Marilyn Whitman, a doctoral candidate in the joint Auburn University/ Auburn University Montgomery Ph.D. Program in Public Administration and Public Policy. For my dissertation, I am working under the supervision of Dr. Anne Permaloff, Professor, and in collaboration with the Alabama Board of Nursing (ABN) to examine whether the patient population in Alabama general hospitals is diversifying and what measures hospitals may be taking in response to diversification. You are invited to participate in this research study.

We would like to welcome all registered nurses, including advanced practice nurses, that work in acute care settings to complete an online questionnaire. Your responses will help us to measure Alabama general hospitals' awareness of and preparation for a diversifying patient population. The online questionnaire includes instructions on how to navigate through each section of questions and how to mark your responses. Completing the questionnaire will only take a few minutes.

Please be assured that your responses will remain **completely confidential**. Information collected through your participation will be used to fulfill the doctoral degree requirements. You may withdraw from participating in this study at any time, without penalty, however, after the information you provide is anonymously entered into the database, I will be unable to withdraw your data since there is no way to identify your individual information. The personal information you provide, including nursing license number, hospital name, and department or unit name will be used for analysis purposes only. Results will be presented only as summaries and individual respondents and their hospitals will not be able to be identified.

This survey is voluntary. I know your time is valuable; however, the ABN and I do appreciate you taking the time to fill in the online questionnaire by **July 31, 2006**. Your decision whether or not to participate will not jeopardize your future relations with Auburn University, the Department of Political Science and Public Administration, or the Alabama Board of Nursing.

If you have any questions regarding the questionnaire, or the study itself, we invite you to ask them now. Please feel free to contact me by phone at (205) 826-4620 or e-mail valpuma@auburn.edu. My dissertation advisor, Dr. Anne Permaloff, is also available at (334) 270-0539 or e-mail apermalo@mail.aum.edu.

P.O. Box 244023 Montgomery, Alabama 36124-4023 • 334.244.3698 Fax 334.244.3826 ATTNet

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THIS INFORMATION PROVIDED, YOU MUST DECIDE WHETHER TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

I thank you for your time. Your participation is greatly valued and appreciated.

M J Whitman 6-19-06

Investigator's Signature Date

Marilyn Whitman
Doctoral Candidate, Auburn University

APPENDIX K

ALABAMA HOSPITALS' RESPONSES TO THE CHANGING PATIENT POPULATION: A RESEARCH STUDY
To Be Completed By Acute Care RNs (including Advanced Practice Nurses)

This survey examines the perception of nurses regarding the diversifying patient population in Alabama general hospitals. All responses will remain confidential.

Most items may be answered by placing a "✓" or "**x**" in the box that best describes your belief or your hospital's practice. A few items will require a short answer that should be placed in the space provided.

Your participation is greatly appreciated. Thank you for your time.

What do you consider to be the <u>central</u> focus of nursing?

- □ Promoting health and wellness
- □ Providing compassionate care
- □ Improving patients' quality of life
- □ Assisting in the diagnosis and treatment of patients

Do you believe that a patient's culture (their unique beliefs, values, and practices) can influence the patient's:		
	Yes	No
Perception of health	□	□
Perception of illness	□	□
Perception of death	□	□

Please indicate your level of agreement or disagreement with the following statements.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The increasing number of foreign-born (both documented and undocumented immigrants) poses future cultural problems for my hospital	□	□	□	□	□
The increasing number of foreign-born (both documented and undocumented immigrants) poses future linguistic problems (or language barriers) for my hospital	□	□	□	□	□

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
My hospital has witnessed an increase in non-English (or limited English) speaking patients within the last year	□	□	□	□	□
My hospital has trained interpreters on its staff	□	□	□	□	□
My department or unit has a list of interpreters or bilingual staff for me to contact when caring for a non-English (or limited English) speaking patient	□	□	□	□	□
Trained interpreters are available on all shifts to assist medical and nursing staff in communicating with non-English (or limited English) speaking patients	□	□	□	□	□
Nurses and staff have been trained on how to effectively use interpreters	□	□	□	□	□
Non-English (or limited English) speaking patients are provided with verbal or written notice (in the patient's preferred language) informing them of their right to receive language assistance services	□	□	□	□	□
Nurses and staff receive written information regarding the tendency of particular ethnic/cultural groups to have or develop certain diseases	□	□	□	□	□
Nurses and staff are made aware of the different lifestyles and dietary habits of various cultural groups which might impact health or interfere with patients' adherence to treatment plans	□	□	□	□	□
Nurses and staff in my hospital receive written guidelines regarding how to work with patients:					
From different cultures	□	□	□	□	□
From different religions	□	□	□	□	□
That speak a language other than English	□	□	□	□	□

Foreign-born patients (both documented and undocumented immigrants) may create problems for hospitals, especially when the numbers of these patients begin to increase.

Please indicate whether you agree or disagree that any of the following have occurred in your hospital because of an increase in foreign-born patients. ***Check "Does Not Apply" if your hospital has seen no increase in foreign-born patients in the past year.***

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does Not Apply
Incorrect diagnosis as a result of a language barrier between the patient and a service provider	□	□	□	□	□	□
Excessive diagnostic testing	□	□	□	□	□	□
Lack of informed consent	□	□	□	□	□	□
Improper patient education	□	□	□	□	□	□
Patient's failure to comply with physician directives	□	□	□	□	□	□
Poor patient satisfaction scores on hospital surveys	□	□	□	□	□	□
Increased patient loads in the Emergency Room	□	□	□	□	□	□
Increases in uncollectible billings	□	□	□	□	□	□
Malpractice suits	□	□	□	□	□	□

Cultural reference guides list the common characteristics and traditions of various cultural and religious groups. Guides can be in the form of quick reference books, pocket-sized booklets, or as a website.

Does your department or unit have easy-to-access cultural reference guides for use by medical and nursing staff?

□ Yes → If Yes, have you used the guide in the past year? □ Yes □ No

Please list what major cultural and/or religious groups are listed in the guide.

_____

_____

□ No

What is your best estimate of the percentage of patients that you as a nurse have cared for in the last year that speak little or no English? _____%

What language(s) were spoken by these patients? _____Language(s)

Please indicate your level of agreement or disagreement with the following statements.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
When assessing a patient, the following factors are considered:					
Country of origin	□	□	□	□	□
Beliefs about health	□	□	□	□	□
Religious practices and beliefs	□	□	□	□	□
Family roles	□	□	□	□	□
Preference in care provider (do they prefer a provider of the same sex or age)	□	□	□	□	□
Use of alternative therapies	□	□	□	□	□
Nutrition practices and food limitations due to cultural and/or religious beliefs	□	□	□	□	□

My hospital makes the following written material available in a language other than English:		
HIPAA Privacy Form	Yes □ No □	If yes, in what language(s)? _____
Patient's Rights	Yes □ No □	If yes, in what language(s)? _____
Consent to Treat	Yes □ No □	If yes, in what language(s)? _____
Authorization for Use or Disclosure of Information	Yes □ No □	If yes, in what language(s)? _____
Registration Forms	Yes □ No □	If yes, in what language(s)? _____
Billing Statements	Yes □ No □	If yes, in what language(s)? _____
Customer Satisfaction Survey	Yes □ No □	If yes, in what language(s)? _____

If you checked "Yes" for any of the above, is a patient's ability to read, regardless of their preferred language, assessed when providing them with these documents?

□ Yes →
- If Yes, are non-English (or limited English) speaking patients assessed for their ability to read in their preferred language? □ Yes □ No
  - If Yes, is an interpreter asked to assist the patient in reviewing the documents/forms? □ Yes □ No

□ No

Does your hospital:			
	Yes	No	
Post signs in a language other than English	□	□	If Yes, in what language(s)? _____
Provide free foreign language classes to interested employees	□	□	If Yes, in what language(s)? _____

Please indicate if you have delivered nursing care to a patient of the following ethnic or racial background within the past year (check all that apply):					
	Yes	No		Yes	No
Black or African American	□	□	**Hispanic or Latin American (Mexico, Guatemala, Cuba, Columbia, Venzuela, Argentina, etc.)**	□	□
American Indian or Alaskan Native	□	□	**Middle Eastern or Western Asian (Iraq, Saudi Arabia, Syria, Turkey, Lebanon, Israel, etc.)**	□	□
Native Hawaiian and Other Pacific Islander (Guam, Samoa)	□	□	**African (Nigeria, Kenya, Chad, Egypt, Libya, Sudan, Morocco, Namibia, Ghana, etc.)**	□	□
Asian (China, Taiwan, Japan, North and South Korea, Vietnam, India, etc.)	□	□	**Other: _____**		

Please indicate if you have delivered nursing care to a patient of the following religious background within the last year (check all that apply):							
	Yes	**No**	**Do Not Know**		**Yes**	**No**	**Do Not Know**
Protestant	□	□	□	**Jehovah's Witness**	□	□	□
Catholic	□	□	□	**Hindu**	□	□	□
Jewish	□	□	□	**Atheist**	□	□	□
Muslim	□	□	□	**Other: _____**			

Please indicate your level of agreement or disagreement with the following statements.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I feel comfortable caring for patients who are of a different culture (having different beliefs, values, and practices)	□	□	□	□	□
I feel I have the knowledge necessary to care for patients who are of a different culture	□	□	□	□	□
I do not behave differently toward people who are of a different culture than mine	□	□	□	□	□
I always know what to say to someone from a different cultural background	□	□	□	□	□
I look forward to caring for a patient from a different cultural background	□	□	□	□	□
I can learn something when I care for patients from diverse cultural backgrounds	□	□	□	□	□
I always introduce myself to the patient's family	□	□	□	□	□
I know how to care for a patient who does not speak any English	□	□	□	□	□
I prefer to care for a patient from my own cultural group who speaks my language because it is easier	□	□	□	□	□

Do you speak a language other than English?	Yes □ No □	If Yes, what language(s)? _____
If offered free of charge by your employer or a community organization, would you take a foreign language class?	Yes □ No □	If Yes, what language(s) would you like to learn? _____
Do you see a need for more health practitioners to learn a language other than English?	Yes □ No □	If Yes, what language(s)? _____

The following information will remain confidential. It will only be used for analysis purposes.

Nursing License ID #: _____ (Must provide to obtain CE credits)

What is your gender? □ Male □ Female

What is your current age?

□ 20 or below
□ 21-30
□ 31-40
□ 41-50
□ 51-60
□ 61 or above

What is your highest level of education?

□ High School Diploma
□ Associate Degree (2 yr)
□ Bachelor Degree (4 yr)
□ Master Degree
□ Doctoral Degree

What race do you identify yourself as?

□White, non-Hispanic
□Black or African American
□Asian
□Native Hawaiian or Other Pacific Islander
□Hispanic or Latin American
□Native American
□Mulitracial (two or more races)
□Other: _____

Your Department or Unit: _____

Hospital Name: _____

County in which hospital resides: _____

Please use the space below for any comments you wish to share.

Thank you again for your assistance. It is greatly appreciated.

Please write your email address on the line below if you would like to receive a copy of the survey results when they become available.

Email address: _____

APPENDIX L

ALABAMA BOARD OF NURSING

ABN

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WWW.ABN.STATE.AL.US

May 18, 2006

Office of Human Subjects Research
307 Samford Hall
Auburn University, AL 36849

TO WHOM IT MAY CONCERN:

The Alabama Board of Nursing voted today to cooperate with Marilyn V. Whitman, MPA, Doctoral Candidate in Public Administration, in her dissertation research. The Board's legal mandate is protection of the public health, safety, and welfare. Issues related to potential cultural and linguistic barriers to adequate health care are pertinent with today's changing demographics. Ms. Whitman's research into the linguistic and cultural competence of Alabama hospitals is of vital interest to the Board of Nursing.

The Board will assist with data collection from registered nurses, including advanced practice nurses, in acute care hospitals. The analysis of the data is solely within the purview of Ms. Whitman. The identity of the nurses selected for participation in the survey will be known only to the Board of Nursing. In addition, the Board agreed to offer continuing education for registered nurses who participate in the survey.

Should you have any questions, do not hesitate to contact me at 334-242-4184 or via electronic mail at Genell.Lee@abn.alabama.gov.

Sincerely,

N. Genell Lee, MSN, RN, JD
Executive Officer

APPENDIX M

Auburn University

Auburn University, Alabama 36849

Office of Human Subjects Research
307 Samford Hall

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

June 14, 2006

MEMORANDUM TO: Marilyn Whitman
Public Administration

PROTOCOL TITLE: "An Examination of Cultural and Linguistic Competence in Health Care"

IRB File: #06-099 EX 0606

APPROVAL DATE: June 10, 2006
EXPIRATION DATE: June 9, 2007

The referenced protocol was approved "Exempt" from further review under 45 CFR 46.101 (b)(2) by IRB procedure on June 10, 2006. You should retain this letter in your files, along with a copy of the revised protocol and other pertinent information concerning your study. If you should anticipate a change in any of the procedures authorized in this protocol, you must request and receive IRB approval prior to implementation of any revision. Please reference the above IRB File in any correspondence regarding this project.

If you will be unable to file a Final Report on your project before June 9, 2007, you must submit a request for an extension of approval to the IRB no later than May 20, 2007. If your IRB authorization expires and/or you have not received written notice that a request for an extension has been approved prior to June 9, 2007, you must suspend the project immediately and contact the Office of Human Subjects Research for assistance.

A Final Report will be required to close your IRB project file.

If you have any questions concerning this Board action, please contact the Office of Human Subjects Research at 844-5966.

Sincerely,

Niki L. Johnson, JD, MBA, Director
Office of Human Subjects Research
Research Compliance Auburn University

cc: Carl Grafton
Anne Permaloff