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THE IMMIGRANT HISPANIC POPULATION: PERCEPTIONS ABOUT CULTURAL COMPETENCY IN THE HEALTHCARE SETTING

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
College of Nursing

Dr. Susan Yarbrough, Ph.D., Committee Chair

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THE IMMIGRANT HISPANIC POPULATION: PERCEPTIONS ABOUT CULTURAL COMPETENCY IN THE HEALTHCARE SETTING

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Cultural competence has been reported as a means of impacting health disparities in minority populations. The Hispanic population has grown exponentially in the United States accounting for over fifty million people on the latest census report. Continued immigration by persons of Hispanic origin occurs for many reasons offering a challenge to nurses and other healthcare workers to provide culturally competent care. Two endeavors were undertaken to determine what research has been done regarding cultural competence and the immigrant Hispanic patient and what perceptions regarding cultural competence immigrant Hispanic patients have had from their healthcare encounters. The first endeavor was a state of the science. Findings from this activity indicated that the majority of research on cultural competence and the immigrant Hispanic patient was conducted from the viewpoint of the healthcare provider. Additionally, most research that did take into account the perspective of the immigrant Hispanic patient focused on a single aspect of cultural competence rather than cultural competence as a whole. The second endeavor was a phenomenological study that used semi-structured interviews and included twelve immigrant Hispanic patients. Questions were aimed at eliciting information regarding the cultural competence of healthcare encounters. Data were analyzed according to van Manen's four existential themes of lived body, lived time, lived space, and human relations and according to characteristics of cultural competence as defined in the literature. Results indicated that cultural competence is lacking in healthcare encounters despite the emphasis placed on it by federal and state mandates.

Key Words: Hispanic, immigrant, experiences, health care, cultural competence

Chapter 1: Overview of the Research Study

The immigration of Hispanic persons has increased dramatically since the turn of the century and currently accounts for over fifty million people as reported in the 2010 United States Census (Passel, Cohn & Lopez, 2011). The Pew Hispanic Center reports that the top ten countries from which persons self-identifying as Hispanic come include Mexico, Puerto Rico, El Salvador, Cuba, Dominican Republic, Guatemala, Columbia, Honduras, Ecuador, and Peru (Lopez & Dockterman, 2011). The report further states that in the last decade immigrants from El Salvador have increased 152 percent while those from Guatemala have increased 180 percent. In spite of those staggering numbers, immigrants from Mexico still rank number one and now account for 31.8 million of the 50.5 million Hispanics reported as living in the United States (U.S.) (Lopez & Dockterman, 2011).

This influx poses a challenge for nurses and other healthcare workers as the immigrants come from a variety of countries and cultures adding to the amount of diversity faced. Each subgroup comes with its own history regarding place of origin, reasons for and methods of immigrating, and experiences in settling within the U.S. (Pares-Avila, Sobalske, & Katz, 2011). The immigration experience itself causes the Hispanic population to continually undergo change as those who have been in the U. S. reach varying levels of acculturation and assimilation and those newly arrived bring resurgences of the Spanish language and Latin American values and traditions (Brodie, Steffenson, Valdez, & Levin, 2002). These factors require that members of the healthcare team develop skills in cultural competence and practice in a culturally competent manner. An additional challenge facing nurses and other healthcare providers is that the Agency for Health Research and Quality (AHRQ) (2008) continues to report disparities for the Hispanic population regarding quality of care and access to care. Contributing factors to these disparities include language barriers, financial barriers, and level of poverty experienced by members of the immigrant Hispanic population (AHRQ, 2008). In spite of federal mandates to provide language services in healthcare settings, there are no standards in place to regulate effectiveness and quality of such services causing disparities to remain (Paris-Avila, Sobalske, & Katz, 2011).

Overall Purpose of the Study

The American Institute for Research (2002) defines cultural competence as, "…a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (p. 7). The challenge that continues to plague healthcare professionals is a consistent means of measuring levels of cultural competence and determining whether culturally competent care is provided. As demonstrated in a study by Gozu and colleagues (2007), the forty-five unique tools available for measuring cultural competence all focus on the healthcare provider perspective and up to sixty-seven percent of those lack available information on the validity and reliability of the tool. There were no tools found during the study that attempted to measure cultural competence from the immigrant Hispanic patient perspective.

With such issues in mind, this researcher embarked on a journey to determine what types of research have been done from the perspective of the immigrant Hispanic patient and to determine what the focus of such studies had been. Additionally, it was deemed imperative to ask members of the immigrant Hispanic population to describe the healthcare encounters they have experienced since coming to the U.S. The goal was to interpret whether culturally competent care had been received by members of this population. As a means of meeting those goals two separate, but related, activities were conducted.

Introduction of Articles

The first activity was a state of the science paper which synthesized information from current literature regarding cultural competence and the immigrant Hispanic patient. The manuscript, entitled *The Case for Studying Cultural Competence from the Perspective of the Hispanic Immigrant Patient: A State of the Science* (Swanson, 2012a), has been published with the *Online Journal of Cultural Competence in Nursing and Healthcare* and is included in its entirety in Chapter 2 of this portfolio. The focus of the question for this activity was whether the immigrant Hispanic patient considered the care received to have been culturally competent. The goal of the endeavor was to emphasize the need for evaluating the cultural competence of care from the patient perspective rather than from the perspective of the healthcare provider.

The second study was the actual dissertation research entitled *The Immigrant Hispanic Population: Perceptions about Cultural Competency in the Healthcare Setting* (Swanson, 2012b). The purpose of this study was to provide a description of experiences and perceptions immigrant Hispanic patients have had regarding the cultural competence of healthcare encounters. A phenomenological study was conducted in the style of van Manen (1990) using semi-structured interviews. The data were then analyzed according to the existential themes of lived body, lived time, lived space, and human relations as defined by van Manen (1990) and according to characteristics of culturally competent care as defined in the literature. A complete write-up of this study is contained in Chapter 3 of this portfolio. Funding for the study was graciously provided from the Tjelta Research Fund at Oral Roberts University Anna Vaughn College of Nursing.

Chapter 2: The Case for Studying Cultural Competence from the Perspective of the Hispanic Immigrant Patient: A State of the Science[1]

Abstract and manuscript prepared for the *Online Journal of Cultural Competence in Nursing and Healthcare*

Abstract

Hispanic immigrants have contributed to 56% of the nation's growth providing a challenge to nurses and other U.S. health providers in delivering culturally competent care. This state of the science paper examines representative research on the topic of cultural competence from the perspective of the Hispanic immigrant patient. Twenty-two articles were identified and summarized. It was found that the origins and cultures of the Hispanic population are often extremely varied further complicating the ability for Hispanic patients to receive culturally competent care. The research indicates that this population requires further study as to their needs and experiences with the U.S. healthcare system.

Keywords: Hispanic, Mexican, immigrant, cultural competence, perceptions of care, patient perspective, U.S. healthcare

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[1] *Note*. From "The Case for Studying Cultural Competence from the Perspective of the Hispanic Immigrant Patient: A State of the Science," by C. Swanson, 2012, Online Journal of Cultural Competence in Nursing and Healthcare, 2(1). Copyright 2012 by Cheryl Swanson, All Rights Reserved (Appendix A).

The Case for Studying Cultural Competence from the Perspective of the Hispanic Immigrant Patient: A State of the Science

Government agencies and health insurance companies have looked at cultural competence as a way to improve quality of health care and to decrease health disparities among minority populations (Betancourt, Green, Carillo, & Park, 2005; Burchum, 2002). In spite of efforts to increase providers' cultural competence and decrease disparities, the Agency for Health Research and Quality (AHRQ) reports that the Hispanic population continues to show little improvement in the core measures being monitored regarding disparities including effectiveness, patient safety, timeliness, patient centeredness, efficiency, and access to care (2010). Approximately 16.3% of the total U.S. population is made up of persons self-identifying as Hispanic and this ethnic group has contributed to 56% of the nation's total growth over the last decade (Pew Research Center, 2011). Hispanics as a group have been reported as having disparities regarding access to preventive health care for many common chronic diseases such as cardiovascular disease, diabetes, cancer, end stage renal disease, as well as maternal and pediatric health care services (Cristancho, Garces, Peters, & Mueller, 2008). With that being the case, it is important to determine, from the Hispanic immigrant's perspective, the degree to which they perceive that they are receiving culturally competent care. This state of the science paper examines current nursing and other health related literature pertaining to cultural competence from the perspective of the Hispanic immigrant patient to determine what is known regarding this topic and what gaps in the research still exist.

Scope of the Question

Do Hispanic immigrant patients consider the care they are receiving to be culturally competent? The U.S. Department of Health and Human Services Office of Minority Health (OMH) has defined cultural competence as, “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (OMH, 2005). Developing cultural competence is a process consisting of many stages including cultural desire, cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interactions or encounters, and cultural skill (Burchum, 2002; Campinha-Bacote, 2006). Research has shown that unless nurses and other healthcare providers develop some measure of cultural competence, the risks of clients being non-compliant with treatment regimens, having low satisfaction with the care provided, and ultimately having poor patient outcomes are intensified (Castro & Ruiz, 2009; Taylor, 2005).

Organizations such as the OMH and the American Nurses’ Association have published standards and continuing education courses designed to assist healthcare providers in becoming more culturally competent (Campinha-Bacote, 2006). The National Standards on Culturally and Linguistically Appropriate Services (CLAS standards) published by the OMH in 2001 focused on culturally and linguistically appropriate healthcare for every patient (OMH, 2007). Four of the fourteen standards are currently federal mandates for health care organizations that receive any type of federal funding. The remaining ten standards are being recommended as mandates (OMH, 2007). In response to these types of federal initiatives, state lawmakers from across the nation have begun to initiate legislation requiring cultural competence components to be integrated into healthcare education. Some states have even considered making cultural competence education a requirement for licensure (Graves, Like, Kelly, & Hohensee, 2007).

Current Knowledge

In spite of the amount of attention the topic of cultural competence has received in health care over the last two decades, the issues of measuring cultural competence and the perspective being studied are two areas of concern. First, a research review by Gozu et al. (2007) investigating cultural competence tools in the literature found 45 unique instruments for measuring cultural competence from the perspective of the health care provider. The authors reported that within the articles studied, they were unable to find information regarding the reliability and/or validity for 67 percent of the instruments (Gozu et al, 2007). In addition, the multitude of tools demonstrated a lack of consensus on how to measure the concept of cultural competence objectively (Barone, 2010).

Only recently has a tool been developed to measure cultural competence from the viewpoint of the patient regarding their interactions with physicians. The Consumer Assessment of Healthcare providers and Systems (CAHPS) Cultural Competence item set is a 44 item survey focusing on collecting information from the patient’s perspective over five areas dealing specifically with cultural competence. The five areas include language access (15 items), patient-provider communication and alternative medicine (16 items), shared decision-making (5 items), experiences of discrimination (2 items), and trust (6 items) (Hurtado, Weech-Maldonado & Weidmer, 2010). At this time, the tool is specifically focused on patient and physician interactions and does not take into account other health care providers leaving a large gap still to be covered.

A second area of concern is the perspective being studied. It has been common practice to focus on cultural competence ratings from the perspective of the health care provider rather than from the patient's perspective. In other words, instead of asking the patient if the care they received was culturally competent, researchers ask the practitioner if the care they gave was culturally competent. Additionally, models of cultural competence in health care are often associated with self-assessment tools for measuring some components of cultural competence and are used extensively in nursing and medical education as well as in practice (Burchum, 2002; Capell, Veenstra, & Dean, 2007; Fernandez, Schillinger, Grumbach, Rosenthal, Stewart, Wang, & Perez-Stable, 2004; Jirwe, Gerrish, & Emami, 2006; Ladson, Linn, Flores, & Magrane, 2006; Nokes, Nickitas, Keida, & Neville, 2005; Sargent, Sedlak, and Martsolf, 2005; Suarez-Balcazar, Balcazar, Taylor-Ritzler, Portillo, Rodakowsk, Garcia-Ramirez, & Willis, 2011; Starr & Wallace, 2009).

A search of nursing and other health care literature regarding cultural competence from the patient perspective was undertaken to determine the state of the science. The Cumulative Index for Nursing and Allied Health Literature (CINAHL) and Web of Science databases were searched using the terms Hispanic, Mexican, immigrant, cultural competence, perceptions of care, patient perspective, and U.S. healthcare individually and in combination. Articles were initially selected based on title and perusal of abstracts. Those that appeared to be about some aspect of cultural competence from the Hispanic patient perspective were then scanned for applicability. The search produced 31 promising articles of which nine were applicable to the query. A second search of Web of Science was further refined re-using the terms “Mexican immigrants” and “U.S. healthcare” which provided four articles, two of which were applicable. A further search using the terms “Hispanics” OR “Mexican immigrants” AND “cultural congruence” AND “health care” AND “perceptions” and further refined using the term “perceptions of care” revealed 86 results. Of those 86 articles, an additional six article were identified as applicable. Reference lists from the applicable articles were also searched for additional studies.

Twenty-two articles were finally selected and deemed representative of current research providing pertinent information about health care encounters from the Hispanic immigrant patient’s perspective related to cultural competence. The studies included two case studies (Barone, 2010; Derose, 2000), ten qualitative studies using interviews or focus groups (Bergmark, Barr, & Garcia, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Clark & Redman, 2007; Collins, Villagran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Keller, 2008; Nailon, 2004; Warda, 2000); a descriptive correlational study (Castro & Ruiz, 2009); three reviews of the literature (Cooper & Ballard, 2011; Mayo, Sherrill, Sundareswaran, & Crew, 2007; Padilla & Villalobos, 2007); five studies using survey data (Gonzalez, Vega, & Tarraf, 2010; Johnson, Saha, Arbelaez, Beach & Cooper, 2004; Riffe, Turner, & Rojas-Guyler, 2008; Sorkin, Ngo-Metzger, & DeAlba, 2010; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009), and a mixed methods study (Lassetter & Baldwin, 2004).

While the majority of the selected studies focused on the patient's perspective, only a few studied cultural competence as a whole (Barone, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Nailon, 2004). The majority of studies focused on investigating aspects affecting cultural competence including themes such as barriers to health care (Bergmark, Barr, & Garcia, 2010; Collins, Villagran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Lassetter & Baldwin, 2004), cultural sensitivity and congruence in health promotion and care (Cooper & Ballard, 2011; Keller, 2008; Padilla & Villalobos, 2007), language issues (Bergmark, Barr & Garcia, 2010; Cristancho, Garces, Peters, & Mueller, 2008; Gonzalez, Vega, & Tarraf, 2010; Harari, Davis, & Heisler, 2008), discrimination (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010), expectations (Clark & Redman, 2007), and patient satisfaction or quality of care (Castro & Ruiz, 2009; Gonzalez, Vega, & Tarraf, 2010; Sorkin, Ngo-Metzger, & DeAlba, 2010; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009).

Barone's (2010) case study identified four major themes found to contribute to the culturally competent care given at an outpatient health clinic in Omaha, Nebraska. The clinic was developed to meet the needs of Indian American and Hispanic populations in the area and both practitioners and patients were interviewed for the case study. The themes identified that contributed to culturally competent care included physical space, culture and language, community involvement, and the practicing of cultural medicine (Barone, 2010). Since these themes encompassed most of the themes listed previously, modifications of these categories were used to organize the information from the above research in determining the state of the science. The following sections summarize the information gained from these research studies.

Physical Environment

The environment that a patient walks into for health care can have a huge impact on their overall perception of the encounter. Barone (2010) found that when an environment is welcoming and facilitates interactions between patients and providers, patients have a better perception of the facility. Warda's (2000) qualitative study to determine important aspects of cultural competence from the Hispanic patient's perception reported that dissatisfaction by Hispanic patients was associated with the physical environment coupled with a perceived lack of caring evident in the attitudes of health care providers.

Wait times were also negatively associated with perceptions of health care by Hispanic immigrants. Having to wait up to 12 hours or more for an appointment has been shown to be a barrier to accessing care in this population (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Nailon, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010) as the expectation is often for timely care with treatments that provide rapid results (Clark & Redman, 2007). Castro and Ruiz (2009) in their study comparing nurse practitioner levels of cultural competence with Latina patient satisfaction scores found that longer wait times were associated with lower satisfaction scores. A primary reason cited by the authors was that the patients often have to bring their children with them to an environment not conducive to the energy and exuberance of children (Castro & Ruiz, 2009).

Communication

Communication is at the center of every health care encounter. Effective communication is important for the exchange of important information regarding wellness, illness, and treatment. Language discordance is often one of the greatest barriers to Hispanic patients receiving health care, culturally competent or otherwise, and many studies focused specifically on the communication aspect of care. Bergmark, Barr, and Garcia (2010) in their study to determine why Mexican immigrants return to Mexico for health care reported that many do so due to language barriers. Other studies have shown that a practitioner's ability to speak Spanish improves the perception of the care received while an inability to speak Spanish poses barriers to access and adequate care for the patient (Castro & Ruiz, 2009; Clark & Redman, 2007; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Gonzalez, Vega, & Tarraf, 2010; Harari, Davis, & Heisler, 2008; Keller, 2008; Mayo, Sherrill, Sundareswaran, & Crew, 2007; Nailon, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010). Keller (2008) found in studying Mexican parents' perceptions regarding their relationships with rural clinic nurses that the race and ethnicity of the practitioner is not as important as their ability to speak in the patient's language.

Another aspect of communication that has been found to be extremely important in a culturally competent encounter with Hispanic immigrant patients is the concept of *personalismo.* Warda (2000) described this concept as a "formal friendliness" where adequate time is taken to visit with patients openly and in a caring manner. The concept of *personalismo* has been repeatedly found as an important element in culturally competent encounters (Clark & Redman, 2007; Cooper & Ballard, 2011; Keller, 2008).

The idea of spending time visiting with a patient on a more personal level and making sure they understand what they need to during each visit often goes against the more time constrained clinical aspects of health care appointments in the U.S., but for the Hispanic immigrant, relationship building and fostering a respectful and sympathetic connection between provider and patient is at the heart of culturally competent health care (Bergmark, Barr, & Garcia, 2010; Castro & Ruiz, 2009; Clark & Redman, 2007; Cristancho, Garces, Peters, & Mueller, 2008; Keller, 2008; Lassetter & Baldwin, 2004; Nailon, 2004; Padilla & Villalobos, 2007; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009).

The use of interpreters has also received much attention in the literature. With language services being one of the governmental mandates associated with the CLAS standards (OMH, 2007), studying the use and effectiveness of interpretation services or other means of interpretation has abounded. Almost without fail, cultural competence is perceived as being greater when health care practitioners are able to speak Spanish or when there are adequate interpretation services available (Barone, 2010; Castro & Ruiz, 2009; Clark & Redman, 2007; Sorkin, Ngo-Metzger, & DeAlba, 2010). Often times, Hispanic immigrants consider interpretation services to be inadequate and they question the accuracy of the information being translated (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Harari, Davis, & Heisler, 2008; Nailon, 2004). This often leads to the use of family members or community members as translators (Barone, 2010; Derose, 2000) or becomes an additional barrier to health care access when such resources are not available (Cristancho, Garces, Peters, & Mueller, 2008; Harari, Davis, & Heisler, 2008; Johnson, Saha, Arbalaez, Beach, & Cooper, 2004).

Family and Community Involvement

The Hispanic culture has been said to be community oriented rather than being as individualistic as found in U.S. culture. With that being the case, it is reasonable that Hispanic patients value input from family and community into their health care, a recurring theme found in a literature review by Cooper and Ballard (2011) to determine best educational practices for osteoporosis in this population. Culturally competent health care for the Hispanic patient is often facilitated by community leaders or contacts working as cultural brokers (Barone, 2010; Harari, Davis, & Heisler, 2008; Padilla & Villalobos, 2007). It is also very important that family members be included in health care encounters as they provide a large measure of support to patients (Bergmark, Barr, & Garcia, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Lassetter & Baldwin, 2004; Mayo, Sherrill, & Sundareswaran, & Crew, 2007; Nailon, 2004; Riffe, Turner, & Rojas-Guyler, 2008; Warda, 2000). Derose (2000) found in a study to determine the barriers to access Latina patients face and what they do to overcome the obstacles, that English speaking family or community members are heavily relied upon for even gaining entry into the health care system.

Equally important to including family and community members in the care of the patient when needed or desired, is an appreciation of the gender roles within the family as this is often important when delivering health education. Women are often perceived as the care-givers, dispensing medicines to other family members and in control of the dietary intake of the family (Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Collins, Villagran, & Sparks, 2008). However, men are considered the leaders of the family and are often deferred to for decision-making (Collins, Villagran, & Sparks, 2008).

Practicing Cultural Medicine

The practice of cultural remedies or the use of traditional healers is another area where cultural competence in U.S. health providers appears to be lacking. Many Hispanic immigrants will use home remedies prior to accessing traditional care (Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Mayo, Sherrill, Sundareswaran, & Crew, 2007). If they are able, some will even return to Mexico (if that is where they are from) to get medicines stating that medicines from Mexico work better and are cheaper (Bergmark, Barr, & Garcia, 2010). Additionally, the services of *curanderos,* or lay healers, may be used in addition to more advanced medicine (Collins, Villagran, & Sparks, 2008; Cooper & Ballard, 2011; Padilla & Villalobos, 2007).

Cultural medicine in the Hispanic culture is also closely linked with spiritual beliefs and characterized by a fatalistic attitude known as *fatalism* (Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Cooper & Ballard, 2011; Warda, 2000). It must also be understood that there are often culturally based beliefs about what may be causing an illness, something that must be assessed during a health care encounter (Lassetter & Baldwin, 2004).

Other

In spite of the information found in the research on what can aid nurses and other health care providers in caring for Hispanic immigrant patients in a culturally competent manner, evidence of bias and discrimination toward this population continues to be reported (Bergmark, Barr, & Garcia, 2010; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010). Perceived discrimination has been negatively associated with perceptions of quality of care and level of cultural competence (Sorkin, Ngo-Metzger, & DeAlba, 2010). It becomes important to ask why the health disparities that exist within this population are not decreasing. The next section reporting the gaps that exist within the research may help to answer this question.

Gaps in Nursing Science

As was pointed out earlier, there is a major lack of consensus on how cultural competence is measured (Barone, 2010). There is also a lack of measuring cultural competence from the patient perspective as well as comparative measures between patients and providers (Johnson, Saha, Arbalaez, Beach, & Cooper, 2004; Nailon, 2004). There has been little research to date on the health literacy aspect of this population including learning preferences (Carbone, Rosal, Torres, Goins, & Bermudez, 2007). Having standardized measures that are well validated and proven reliable and that measure and compare practitioner and patient perspectives are needed. Measures for determining health literacy also need to be incorporated into research.

Due to the family-oriented nature of the Hispanic populations in these studies, further research should be aimed at determining the effectiveness of community-based interventions that meet health care prevention, promotion, and maintenance needs (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000). Further investigation into how to incorporate cultural beliefs of the population being served with biomedical care is also needed to enhance cultural competence (Nailon, 2004; Padilla & Villalobos, 2007; Warda, 2000).

The point that makes the case for studying cultural competence from the perspective of the Hispanic immigrant patient, however is that a problem faced by researchers originates from the multiple originations for people who self-identify as Hispanic. Even those from the same country of origin may have significant biological and cultural differences (Collins, Villagran, & Sparks, 2008; Cooper & Ballard, 2011). Furthermore, continuing waves of immigration often hinders progress toward cultural competence as cultural differences can abound, requiring further research for each subgroup (Collins, Villagran & Sparks, 2008; Harari, Davis, & Heisler, 2008; Padilla & Villalobos, 2007; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009). Continuing needs assessments with Hispanic communities and families is important to delivering culturally competent care (Lassetter & Baldwin, 2004; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009). Obtaining input from Hispanic immigrant patients on how health care is being or should be delivered is perhaps the only avenue for changes to take place and a measure of cultural competence to be achieved.

Conclusion

Providing culturally competent care continues to be a challenge for nurses and other health care workers as rates of migration and immigration continue to increase changing the demographic face of the United States. Lack of knowledge about cultures and lack of exposure to certain cultures often limit members of the health care team in providing culturally competent care. Lack of culturally competent care serves as a barrier for many immigrant patients to access and receive effective care. Developing relationships and opening communication with local Hispanic communities and individuals to determine needs, expectations, previous experiences, and areas that health care providers can improve upon can only improve the cultural competence of health care. From there, interventions and health promotion models can be implemented and evaluated for effectiveness. With this combination of research and practice, it is hoped that one day the health disparities present in the Hispanic immigrant population will decline.

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Chapter 3: The Immigrant Hispanic Population: Perceptions about Cultural Competency in the Healthcare Setting

Abstract

Problem: Persons self-identifying as Hispanic will increase dramatically between now and the year 2050. With health disparities already being reported for this population due to lack of access, low health literacy rates, and inadequate numbers of same-ethnicity practitioners, cultural competence will become increasingly significant. **Objectives:** To explore the experiences and perceptions about cultural competency of the immigrant Hispanic patient in the healthcare setting. **Methods:** A phenomenological qualitative research study using semi-structured interviews was used to gain pertinent information from members of the Hispanic community who had recently been patients at a healthcare facility, either inpatient or outpatient. **Analysis:** Transcripts from the interviews were analyzed for recurring themes and in accordance with van Manen's existentials of body, time, space, and human relations and characteristics of cultural competence including effectiveness of care, promotion and protection of human rights, communicating in patients' preferred language, and consideration of cultural aspects. The data were interpreted to answer the research question. **Findings:** Results of the study indicate that immigrant Hispanic patients do not often perceive they are receiving culturally competent care in most instances contributing to continuing health disparities and vulnerabilities in this population.

Key Words: Hispanic, immigrant, experiences, health care, cultural competence

The Immigrant Hispanic Population: Perceptions about Cultural Competency in the Healthcare Setting

Healthcare globalization has occurred with increased migration due to wars, disasters, and economic crises (Fortier, 2008). Immigration to the United States (U.S.) has resulted in an increasingly diverse population. As a result, cultural competence in healthcare has become a focal point for government agencies and insurance companies with a view toward decreasing health disparities and improving quality of healthcare among minority populations (Betancourt, Green, Carillo, & Park, 2005; Burchum, 2002; Flaskerud, 2007).

Significance

The Agency for Health Research and Quality (AHRQ) monitors six dimensions of healthcare related to disparities in minority populations including access to care, effectiveness, timeliness, patient safety, patient centeredness, and efficiency. Reports from this agency indicate little improvement in any of these dimensions as related to the Hispanic population (Agency for Health Research and Quality, 2010). These reports are of great concern to nurses and other healthcare providers since the Hispanic population has continued to increase over the last decade. The Pew Research Center (2011) reports that the Hispanic population has accounted for 56% of the nation’s growth during the last decade and currently makes up 16.3% of the total U.S. population. This statistic graphically illustrates the certainty that nurses and other healthcare professionals will more frequently come in contact with members of this population.

Research has shown that significant health issues are prevalent in the Hispanic population (Cristancho, Garces, Peters, & Mueller, 2008; Graves, Like, Kelly, &

Hohensee, 2007; Kao & Travis, 2005; Koskan, Friedman, & Messias, 2010). Compared to the non-Hispanic Caucasian majority, persons of Hispanic origin living in the United States are reported as having a fifty percent higher prevalence of diabetes as well as an increased incidence of cervical and stomach cancers, and increased obesity in women (Graves, Like, Kelly, & Hohensee, 2007). Because of a lack of access, Hispanics have not received preventive healthcare for other chronic diseases such as cardiovascular disease and end stage renal disease as well as maternal and pediatric healthcare services (Cristancho, Garces, Peters, & Mueller, 2008; Koskan, Friedman, & Messias, 2010). An increased rate of disability among the elderly in this population is also reported (Kao & Travis, 2005) as well as low health literacy rates (Koskan, Friedman, & Messias, 2010).

To mediate the consequences of health disparities among the Hispanic population in the United States, cultural competence of healthcare providers is a necessity. Research has shown that a major contributing factor to existing disparities within the Hispanic population is low levels of cultural competence on the part of healthcare providers (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Koskan, Friedman, & Messias, 2010; Mayo, Sherrill, Sundareswaran, & Crew, 2007). Research also shows the lack of linguistic ability by members of the healthcare team is a contributing factor to the continued disparities (Bergmark, Barr, & Garcia, 2010; Derose, 2000; Koskan, Friedman, & Messias, 2010; Mayo, Sherrill, Sundareswaran, & Crew, 2007).

Cultural competence is a concept composed of many facets beginning with cultural desire and including cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interactions or encounters, and cultural skill (Burchum, 2002; Campinha-Bacote, 2006). Cultural desire is defined as having an interest in learning more about another culture (Campinha-Bacote, 2006). Cultural awareness is a process by which an individual examines the personal biases and prejudices held regarding persons from other cultures (Campinha-Bacote, 2006). Cultural knowledge is a process during which one seeks out and obtains information about practices from other cultures (Campinha-Bacote, 2006). Cultural understanding is practiced when an individual ponders the meaning of culture in relation to personal beliefs, values, and practices (Burchum, 2002; Campinha-Bacote, 2006). Cultural sensitivity occurs when one begins to appreciate the differences in persons from other cultures (Burchum, 2002). Cultural interactions or encounters happen when one purposefully practices interacting with persons from other cultures (Burchum, 2002; Campinha-Bacote, 2006). And finally, cultural skill is demonstrated when a practitioner collects relevant cultural information including assessment data in a culturally sensitive manner when treating persons from other cultures (Burchum, 2002; Campinha-Bacote, 2006).

Providing culturally competent nursing care involves combining nursing knowledge with cultural knowledge resulting in the ability to care for culturally diverse patients (DeRosa & Kochurka, 2006). Unless nurses and other healthcare providers develop some measure of cultural competence, research has shown clients are at higher risk for being non-adherent to treatment regimens and report lower satisfaction with care provided, both of which ultimately contribute to poor patient outcomes (Castro & Ruiz, 2009; Taylor, 2005). Organizations such as the U.S. Department of Health and Human Services Office of Minority Health (OMH) have published standards intended to assist healthcare providers in becoming more culturally competent (Campinha-Bacote, 2006).

The standards published by the OMH in 2001 focused on culturally and linguistically appropriate healthcare for all patients and are known as the Culturally and Linguistically Appropriate Services (CLAS) standards (OMH, 2007). If a healthcare organization receives any type of federal funding, four of the fourteen standards must be met. The publication of *Healthy People 2010* goals furthered the commitment to equality in healthcare for all people across the nation. The goals have been expanded regarding public health services and access to care in light of the changing demographics with *Healthy People 2020* (U.S. Department of Health and Human Services, 2011). State lawmakers have responded to these federal initiatives by enacting legislation that requires cultural competence training to be integrated into nursing and other healthcare education (Graves, Like, Kelly, & Hohensee, 2007).

Most research on the topic of cultural competence has focused on self-assessments by practitioners as to their perception of their personal level of cultural competence (Burchum, 2002; Gozu, Beach, Price, Gary, Robinson, et al., 2007; Wells, 2000). Qualitative research that explores cultural competence from the viewpoint of the immigrant consumer is important to glean their perception of whether culturally competent care is being delivered. This important piece is missing and by gaining this knowledge specific cultural competence training for health care workers can be developed, especially in areas where immigrant populations are growing in number. Research is also needed to identify areas of concern that minority populations have regarding healthcare encounters in order to develop interventions that are more population specific and in keeping with the goals of *Healthy People 2020* and the CLAS standards.

Problem/Purpose

A complicating factor that makes this type of on-going research a necessity is the continuing waves of immigration. Such waves of immigration can challenge the progress being made toward cultural competence as each influx of immigrants brings with it cultural differences that require a heightened sensitivity to cultural differences and possibly further research for each subgroup (Collins, Villagran & Sparks, 2008; Harari, Davis, & Heisler, 2008; Padilla & Villalobos, 2007; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009). There are few studies that have examined aspects of cultural competence of the U.S. healthcare worker through an analysis of experiences and perceptions described by Hispanic patients. Those reported have focused on communication issues, perceptions, and barriers to health care (Cristancho, Garces, Peters, & Mueller, 2008; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Keating, Carlson, Jimenez, Estrada, Gastelum, Romero, & Riegal, 2009). One study in particular concluded that differences between groups of self-identified Hispanics are so vast that culturally competent care is essential to meet the needs of the individual and family (Clark & Redman, 2007). A review of the literature by Mayo, Sherrill, Sundareswaran, and Crew (2007) compared provider and Hispanic patient perceptions regarding health care encounters. Perceptions of the provider and those of the Hispanic patient varied greatly.

With these gaps in research in mind, and the continued disparities that are reported in the Hispanic population, the purpose of this study was to describe the experiences and perceptions of the immigrant Hispanic patient in the healthcare setting in relation to the cultural competence of the care provided. The study begins to fill a gap in knowledge within the central part of the U.S. as this population continues to expand and assists in providing a basis for reducing the disparities currently existing for this population. Obtaining input from the Hispanic immigrant patient regarding perceptions pertaining to healthcare received was important in order to provide an avenue for improving cultural competence.

Review of Literature

Cultural competence can be defined as the ability of healthcare workers and systems to effectively provide care to patients from other cultures while considering cultural aspects (Fernandez, Schillinger, Grumbach, Rosenthal, Stewart, Wang, & Perez-Stable, 2004; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). Culturally competent care focuses on reducing health risks and vulnerabilities while promoting and protecting each individual's human rights (Flaskerud, 2007). It also entails being able to communicate with patients in the manner to which they best relate (Ericksen, 2006; Fortier, 2008). Furthermore, understanding social and cultural dynamics involved in shaping the perceptions of healthcare, illness, and wellness in these populations is necessary to build effective relationships (Fortier, 2008).

The Cumulative Index for Nursing and Allied Health Literature (CINAHL) and Web of Science data-bases were searched using the search terms Hispanic or Mexican, immigrant, cultural competence, patient perspective, perceptions of care, and U.S. healthcare. Titles and abstracts were perused to determine if articles focused on the Hispanic patient perspective regarding cultural competence. Of the many articles identified by the searches, only three were found that focused on cultural competence as a whole from the perspective of the immigrant Hispanic patient (Barone, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Nailon, 2004).

Barone (2010) presented a case study conducted at a free urban clinic in the Omaha, Nebraska area. The author evaluated the effectiveness of the clinic's cultural competence structure as related to the CLAS standards. Healthcare providers, community members, and patients were interviewed for the study. Findings revealed that physical space was deemed as an important component of providing a culturally appropriate structure. As a result, the community and healthcare workers collaborated to make the clinic space open, warm, and welcoming without typical barriers such as walled in reception and waiting areas between the healthcare staff and the patients. The findings also identified the importance that the family be welcomed into the clinic area. Culture and language were primary foci resulting in the requirement by clinic administration that all paid staff must be bilingual. The administration was made up of a combination of community members and healthcare workers, a factor that was determined to figure prominently in the success of the facility. The integration of "cultural medicine", or remedies specific to the Hispanic culture, into care of the patient was promoted and supported through the clinic. The combination of all these aspects of culture worked to make this particular clinic a place where healthcare workers and patients alike deemed the care to be culturally competent and consistent with the CLAS standards.

A second study by Carbone, Rosal, Torres, Goines, and Bermudez (2007) described findings from focus groups with healthcare providers and Hispanic patients that were intended to refine self-management strategies for Hispanic patients with diabetes. The study identified differences between provider and patient perspectives of what would be considered an effective and manageable intervention. The findings revealed that providers often had biases or preconceived ideas of why the patient population was not responding well to prescribed interventions. Findings also revealed that patients in this study emphasized the importance for a greater understanding of cultural concepts and cultural competence on the part of the provider, including more family considerations with goal setting, the importance of religion, and recognition that there are differing ideas as to what constitutes quality of life.

The third study (Nailon, 2004) investigated cultural competence from the viewpoints of the emergency department nurse and the Hispanic patient. The study determined that culturally competent nursing care of Hispanic patients is affected by the nurse's ability to speak Spanish or the availability of an adequate number of experienced translators. Other factors affecting culturally competent nursing care included the availability of language appropriate materials, time spent with patients, cultural knowledge, and administrative support.

Other studies focused on specific aspects of cultural competence rather than cultural competence as a whole. Seven studies addressed barriers this population faces in obtaining health care (Bergmark, Barr, & Garcia, 2010; Collins, Villagran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Lassetter & Baldwin, 2004). Four others studied patient satisfaction and quality of care (Castro & Ruiz, 2009; Gonzalez, Vega, & Tarraf, 2010; Sorkin, Ngo-Metzger, & DeAlba, 2010; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009).

In summary, the available research related to experiences and perceptions of the immigrant Hispanic patient about cultural competency in healthcare settings is limited with most studies focusing on particular aspects of health care or cultural competence rather than on cultural competence as a whole. There is also a predisposition for research to focus on the healthcare provider rather than on the patient perspective of care. Further research is needed in areas where Hispanic populations have flourished in order to allow local healthcare facilities and organizations to implement the most effective measures to providing culturally competent care (Barone, 2010; Collins, Villagran, & Sparks, 2008; Harari, Davis, & Heisler, 2008).

Design Statement and Rationale

The design of this research was one of heuristic phenomenology. As described in Munhall (2007), phenomenology is used to give nurses an awareness of what persons in a given situation may be experiencing emotionally, physically, and spiritually. Since nurses are described as being concerned with processes that affect changes in a population's or individual's health status, using phenomenology to investigate such processes in order to provide a basis for bringing about positive changes was appropriate. This study used van Manen's (1990) approach to phenomenologically describe healthcare experiences and perceptions of Hispanic immigrant patients. Heuristics were used to interpret the meanings embedded within the expressions and narratives obtained from the participants in order to answer the research question.

Using a phenomenological approach allowed the nurse researcher to gain an understanding of the experiences and perceptions that Hispanic immigrants have had while seeking health care in U.S. healthcare facilities in regards to cultural competence.

Analyzing the reports of those experiences provided a basis from which to develop more adequate cultural competence training. It also contributed to the knowledge base needed for the development of culturally appropriate interventions that will assist in decreasing the reported disparities in this population (Graves, Like, Kelly, & Hohensee, 2007).

Philosophical Underpinnings

The research study had a philosophical basis in phenomenology, a human science that, according to van Manen (1990), "involves description, interpretation, and self-reflective or critical analysis" (p.4). Phenomenology evolved from the field of philosophy in 18th century Europe and was adopted as a method of researching the meaning of the conscious world by such notables as Husserl and Heidegger (Dowling, 2007). Husserl believed intentionality, or the principle that every mental action is related to an object and all perceptions mean something, as being fundamental to phenomenology (Lopez & Willis, 2004). He likewise believed that having an intuitive understanding of the meaning within a description was the basis for phenomenology, a process known as phenomenological reduction. Phenomenological reduction, also known as bracketing, involves the researcher setting aside all preconceptions in order to come to an understanding of the phenomenon as described by another (Dowling, 2007; van Manen, 1990). While Husserl focused on the descriptive element, Heidegger focused on the hermeneutic avenue of interpretation of descriptions as they related to one *being*, or having presence, in the world (Dowling, 2007).

van Manen (1990) describes phenomenology as a means of offering accounts of experiences in four existential realms including space, time, body, and human relations. He ascribes to a combination of the descriptive and interpretive aspects of phenomenology. The analysis involves reflective awareness which is used to describe a human experience, to process and interpret that experience, and to derive meanings from the experience (Munhall, 2007). The understanding of the experience is attained through a process of writing and re-writing that includes response and reflection (van Manen, 1990). Having had members of the Hispanic population describe their experiences and perceptions regarding culturally competent care has provided valuable information for nurses and other health professionals. The data that were gathered, studied, and interpreted may allow nurses and other healthcare providers to become more experienced themselves (van Manen, 1990). Identifying what was good and commendable and what was frustrating and inefficient may assist nurses and other members of the healthcare team to provide services that are more culturally competent and aid in decreasing health disparities in this population.

Methods Defined

Research Question

The study began with a research question for as van Manen (1990) states, "A research method is only a way of investigating certain kinds of questions. The questions themselves and the way one understands the questions are the important starting points…" (p. 1). Phenomenological questions are questions that search for meaning in order to more deeply understand an experience with the end result allowing for more thoughtfulness or tact in certain situations (van Manen, 1990). Therefore, with the significance of the problem and the identified gaps in research, a heuristic phenomenological qualitative research study was conducted to answer the question: In the immigrant Hispanic population, what are the perceptions pertaining to cultural competency in the healthcare setting? Data were collected through semi-structured interviews and the transcripts from the interviews were analyzed for common themes in relation to the four existential realms as described by van Manen (1990).

Sample

The population for the study was persons that classified themselves as being Hispanic in origin and had immigrated to the United States within the last ten years. The range of time corresponded with the burgeoning growth of the Hispanic population in Oklahoma which almost doubled between 2000 and 2010 causing it to rank thirteenth in the nation for Hispanic growth as of the 2010 census (Pew Research Center, 2011). The accessible population included those identifying themselves as Hispanic immigrants within the Tulsa, Oklahoma area. The target population included persons of Hispanic origin who had immigrated to the United States within the last ten years and had been seen as an outpatient at a Tulsa clinic or been an inpatient at a Tulsa hospital, and who agreed to be interviewed. Inclusion criteria for the target population consisted of adults who had been the patient or were parents of young children who had been seen in a healthcare facility, male or female, 18 years of age or older, self-identified as Hispanic, and immigrated within the last ten years. Exclusion criteria included patients seen for dementia or who were in active psychiatric care. The legality of each participant’s immigration status was not a determining factor nor was that information collected as demographic data for this study.

The type of sampling for the study was purposive as each participant had to meet the inclusion criteria to be eligible to participate in the study. Purposive sampling led to the identification of additional participants as once a person had participated, that individual often recommended others for the study (Roberts, 2009). This process is known as snowballing. Sampling continued until no further variations of themes were obtained indicating that data saturation had occurred (Munhall, 2007). The combination of sampling methods was beneficial in providing participants that reflected a broad spectrum of the population characteristics desired (Portney & Watkins, 2009).

Prior to approaching any potential participants, the University of Texas at Tyler Institutional Review Board (IRB) approval was obtained (Appendix B). The consent forms were translated to Spanish and back translated to English to check for accuracy in accordance with IRB requirements. Once IRB approval was obtained, recruitment began.

The sample was obtained through personal contacts of the principle investigator and the research assistants and through the use of the snowballing technique. Once an individual agreed to participate and an interview was conducted, that individual recommended others for the study. Recruitment fliers were given to each participant to share with others within the Hispanic community (Appendix C). Recruitment fliers were also handed out at business establishments frequented by members of the Hispanic community with agreement of the manager or proprietor. The recruitment fliers provided pertinent information regarding the study and contact information for the research assistants who then did the actual recruiting.

Sample demographics. Demographic information was collected for each participant (Appendix D). The final sample for the study consisted of 12 participants. Eighty-three percent of the sample was female (n = 10) and seventeen percent was male (n = 2). The mean age of all participants was 35.4 years. The education level of participants fell into three categories including sixty-eight percent with some grade school (*n* = 8, ranging from sixth grade to eleventh grade), twenty-five percent with a high school diploma (*n* = 3), and eight percent with some college education (*n* = 1). Occupations of the participants included homemakers (*n* = 4), food service workers (*n* = 2), cleaning service providers (*n* = 5), and laborers (*n* = 1). Average income for each household was $1500 per month. One participant did not know the household level of income and was excluded from that variable. Each household contained an average of 4.5 people living under one roof. All of the participants spoke Spanish in the home.

The average length of time since participants had immigrated to the United States was 7.3 years. The majority of the sample came from Mexico (*n* = 9) with the remaining individuals representing Argentina (*n* = 1), El Salvador (*n* = 1), and Uruguay (*n* = 1). Sixty-seven percent (*n* = 8) of the participants had originally lived in an urban setting in their home country while the rest came from rural settings. None of the participants carried health insurance, although some had Medicaid for their children who had been born in the U.S. Forty-two percent (*n* = 5) of the participants spoke about outpatient experiences, while twenty-five percent (*n* = 3) spoke of inpatient experiences and thirty-three percent (*n* = 4) spoke of both. Demographic information is summarized in Table 1.

Table 1

Demographic Data of Study Participants (N = 12)

Characteristic	*N*	*M (SD)*	Percent	Range
Gender				
Male	2	-	17%	-
Female	10	-	83%	-

Table 1 Continued

Characteristic	*N*	*M (SD)*	Percent	Range
Age	12	35.4 (11.6)	-	22-62
Education				
Some grade school	8	-	68%	6-11
High school diploma	3	-	25%	-
Some college	1	-	8%	-
Occupation				
Homemakers	4	-	33%	-
Food service workers	2	-	17%	-
Cleaning service providers	5	-	42%	-
Laborers	1	-	8%	-
Average income	11	$1500 ($803)	-	$0 - $3000
Number of people in household	12	4.5 (2.3)	-	2-7
Primary language spoken in home				
English	0	-	0%	-
Spanish	12	-	100%	-
Average length of time in US	12	7 years (2years)	-	4-10 yrs
Country of origin				
Mexico	9	-	75%	-
Argentina	1	-	8.3%	-
El Salvador	1	-	8.3%	-
Uruguay	1	-	8.3%	-
Area of origin				
Rural	4	-	33%	-
Urban	8	-	67%	-
Health insurance carriers	12	-	0%	-
Healthcare Experience				
Outpatient	5	-	42%	-
Inpatient	3	-	25%	-
Both	4	-	33%	-

Research Assistants

There were initially two research assistants who participated on the study team and were provided with cell phones designated for the research project. The research assistants were chosen from personal contacts of the principal researcher and were fluent in both the English and Spanish languages and had experience in translation between English and Spanish. Both a female and a male research assistant were initially employed so that participants would be more at ease by speaking directly to someone of the same gender. After approximately six weeks, however, the female research assistant was no longer able to assist with the study so the majority of the interviews were translated by the male research assistant.

Both research assistants had the ability to type and were computer literate. Each research assistant received a password protected USB device for storage of study documents. These devices were returned to the principal researcher at the conclusion of data collection. The research assistants were trained regarding the focus of the study and in the duties expected of them including assisting with recruitment, scheduling interview sessions, obtaining informed consent, translating during the interviews as the principal researcher conducted the interviews, transcribing the interview recordings, and back translating to Spanish the English translation portions of the transcripts. The principal researcher was responsible for directing the research assistants in what to say and in overseeing the entire informed consent process which took place prior to any data being collected (Appendix E). The research assistants completed IRB training through the University of Texas at Tyler regarding the protection of human subjects in research.

They also agreed to abide by all study protocols, and were compensated $10 per hour for their time.

Location of Data Collection

Participant interviews were scheduled at a time and place convenient to the participant. The interviews were conducted at either the participant's home (*n* = 8) or a neutral location such as an eating establishment in an easily accessible location (*n* = 4). Persons who agreed to participate in the study were given an incentive of $25 as reimbursement for time spent during the interview process including subsequent contacts for follow-up questions or to pay for child care or transportation as needed. A research assistant accompanied the principal researcher to all interviews to provide assistance with communication and translation, even with participants who spoke English.

Instruments

Once informed consent was obtained, a demographic questionnaire was completed (Appendix D). Following the collection of demographic information, the interview began with a general statement by the principal researcher, "I am interested in learning more about the experiences and perceptions of immigrant Hispanic patients in healthcare settings to determine the cultural competency of the care received. Tell me about your last experience going to a health clinic or hospital." An interview guide was used to stimulate further discussion in relation to cultural competence as the interview progressed (Appendix F). Many of the questions related to aspects of compliance to the CLAS standards and van Manen's four existential realms (OMH, 2007; van Manen, 1990). Questions were modified as necessary to enhance understandability. Occasionally, follow-up questions were asked to clarify events or comments by participants. The semi-structured interview format allowed the researcher to explore areas of concern voiced by the participants (Munhall, 2007; Roberts, 2009). Interviews took between thirty minutes and an hour and a half for each participant.

Procedures

Data collection and management. The principal method of data collection in a heuristic phenomenological study is that of semi-structured or unstructured interviews (Munhall, 2007). van Manen (1990) offers two specific purposes of the hermeneutic phenomenological research interview. The first purpose is to explore and gather narrative material about an experience that may provide a resource for the development of richer and deeper understandings of a phenomenon. The second purpose is to develop a conversational relationship with another about the meaning of a certain experience. The semi-structured interview as the primary data collection method facilitated the achievement of both purposes. Prior to the interviews the researcher spent time in critical reflection of her own beliefs, experiences, biases, and preconceptions regarding members of the Hispanic population. The use of a personal reflective journal was used to record these reflections as the writing process was a way of externalizing something that was internal and provided some distance from those reflections (van Manen, 1990). Unlike the traditional bracketing as described by Husserl, van Manen (1990) holds to this form of reduction that while we need to externalize such thoughts and preconceptions, they are a part of the process of understanding a phenomenon. Recordings within the reflective journal were then brought back into consideration throughout the data analysis process.

Preliminary interaction at the time of the interview allowed the researcher, the research assistant and the participant to build rapport. Informed consent forms and other study associated information were available in both English and Spanish. Translation of all documents and of the interview process was done by the research assistants. Participants were asked their language preference prior to being interviewed. Informed consent was obtained as well as permission to audio tape the conversation. Due to varying literacy levels of participants, the researcher asked participants to verbalize on the audio recording their understanding of the research goals, their role in the study and its voluntary nature, the risks and benefits of the project, and their understanding of who they could contact if they had questions. As the interview proceeded, assurance was given that anything shared would be kept confidential and that the participant could end the interview at any time.

Additional information was collected during the interview process as the principal researcher carefully observed all interactions and non-verbal communication. Immediately following the interview, the observations of both the principal researcher and the research assistant were discussed and then later recorded by the principle investigator in the reflective journal. These detailed field notes specifically included observations; perceptions obtained by the principle researcher and research assistants as to the overall climate of the interview; and details about surroundings, settings, expressions, and activities that occurred during the time the researcher was collecting information. While the principal researcher was conducting the interview and the research assistant was translating, observations were made by both which aided in rounding out the information obtained from the interview.

All interviews were digitally recorded and stored as an electronic file on a password protected computer as well as on the password protected USB devices in the possession of each research assistant. The research assistants transcribed the interview audio file and saved the document on the password protected USB device. No identifying information other than an assigned coded number was included on any audio file, transcript or field note to maintain confidentiality of the participant. Each informed consent form contained the coded number that was used on corresponding audio files, transcripts and field notes. The key to the coded numbers was kept in a separate log stored in a password protected computer file. The informed consent forms were kept in a locked file drawer. The transcripts contained the entire interview verbatim, both the English and the Spanish portions. Once the interview had been transcribed, the transcript was sent to the principal researcher and secured on a password protected computer. Any Spanish to English translation that was done during the actual interview was then pulled from each transcript, placed in a separate document and given to another research assistant or transcriber to back translate into Spanish. The back translation was then compared to the original transcript for accuracy. Any discrepancies between the two were addressed with the research assistant who translated at the interview.

Data analysis. The method of data analysis consistent with a heuristic phenomenological study included coding and thematic organization of field notes and interview transcripts (Jacelon & O'Dell, 2006; Munhall, 2007; van Manen, 1990). van Manen (1990) defines phenomenological themes as being the "structures of the experience" (p. 79). According to van Manen (1990), data analysis begins and runs concurrently with data collection with the purpose of the interview being to gather information and reflect on an experience with the participant. Inference and interpretation are also important in heuristic phenomenology and occur as data are collected, organized, and reviewed (Jacelon & O'Dell, 2006; van Manen, 1990).

Prior to each session of data analysis the research question was reviewed to assist in providing focus (van Manen, 1990). Transcribed interviews and field notes were analyzed through three approaches as outlined by van Manen (1990). The first was a wholistic approach where the researcher read through the transcripts and field notes to obtain an initial impression of what had been said or observed. The second was a selective approach where the researcher went back through the transcripts and field notes several more times and highlighted key words and phrases important toward answering the research question. The third was a detailed approach where the researcher analyzed line by line words, phrases, and observations. The results of the analyses were clustered together in an electronic document. The thematic clusters were then interpreted by the researcher in accordance with the definition of cultural competence provided earlier in this manuscript and with van Manen's (1990) four existential realms of body, time, space, and human relations. Narration of the themes in textual form was expected to provide insight into the experiences and perceptions as described by the participants and to answer the research question. As stated by van Manen (1990), "Creating a phenomenological text is the object of the research process" (p. 111). All aspects of this process were verified by an experienced qualitative research mentor to ensure accuracy of the research results.

Data analysis in phenomenological research contains a back and forth analysis where the researcher has an idea and compares it to the interviews and field notes already collected or, as the researcher reads the interview transcripts and field notes, formulates ideas (Roberts, 2009). van Manen states, “To be able to do justice to the fullness and ambiguity of the experience of the lifeworld, writing may turn into a complex process of re-writing (re-thinking, re-flecting, re-cognizing)” (p.131) emphasizing the importance of the back and forth analysis. A benefit associated with this type of analysis is that as themes emerged, questions for subsequent interviews could be modified or added to the interview guide. The minor changes that occurred in the interview questions were duly noted in the field notes that served as a step-by-step log of the research process. Detailed notes such as these served to enhance replicability of the study.

Scholarly Rigor

Validity of results in qualitative research is usually referred to as the trustworthiness of the findings (Creswell, 2009). Trustworthiness is enhanced in a qualitative research project when multiple methods are used to assess the accuracy of findings. This study achieved trustworthiness through the methods associated with credibility, dependability, and reflexivity.

Credibility

A heuristic phenomenological study achieves credibility when rigor of the methods used can be shown (Munhall, 2007). Credibility was achieved through the researcher having prolonged engagement with the data and the participants. The participants also had the opportunity to engage in a member check, or review of the written narrative of the results of the study, prior to publication or use to determine accuracy (Munhall, 2007; van Manen, 1990). Debriefing of research assistants occurred throughout the process as they had also spent prolonged amounts of time (several hours for each individual transcript) with portions of the data collected. It was important to note that the principal researcher had a limited working understanding of the Spanish language and was able to follow much of the translation as it occurred during interviews, enhancing the credibility of the process. Additionally, translated portions of the interviews were back translated into Spanish and checked for accuracy. Further verification was done by also having the Spanish portions of the transcripts re-translated into English long after the interviews so as to verify the expressiveness of the participants' language. As stated earlier, thematic analysis and results of the study were verified by an experienced qualitative research mentor.

Dependability

Dependability was established through a comprehensive audit trail. The audit trail consisted of organized and detailed field notes, personal notes and reflections of the entire process, and interview transcripts. Further dependability was achieved through the finished manuscript, results, and recommendations that came from the study (Munhall, 2007).

Reflexivity

Munhall (2007) and Roberts (2009) both speak about reflexivity in phenomenological research. Reflexivity is enhanced when the researcher is aware of the bias he or she brings to the study due to their role in the study as a participant observer. van Manen (1990) also encourages reflexivity as a means of accomplishing reduction which allows a researcher to accept a phenomenon or experience as it has been lived. Careful notes about biases, interactions, influences, and ideas that were generated as a result of the researcher being part of the study, as well as the observational field notes made from each interview served to accomplish reflexivity (Munhall, 2007).

Maintaining a personal journal with the reflective notes enhanced the process as according to van Manen (1990), “Writing is a reflexive activity that involves the totality of our physical and mental being” (p. 132).

Findings

Cultural competence was defined earlier in the manuscript as the ability of healthcare workers and systems to: effectively provide care to patients from other cultures (Fernandez, Schillinger, Grumbach, Rosenthal, Stewart, Wang, & Perez-Stable, 2004; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004), focus on reducing health risks and vulnerabilities while promoting and protecting human rights (Flaskerud, 2007), communicate with patients in the manner to which they best relate (Ericksen, 2006; Fortier, 2008) and understand social and cultural dynamics involved in shaping the perceptions of healthcare, illness, and wellness (Fortier, 2008). Characteristics of culturally competent healthcare identified from the definition of cultural competence included effective provision of care, reduction of health risks and vulnerabilities, promotion and protection of human rights, communicating in the patient’s preferred language, and consideration of cultural aspects. As data were analyzed, it was determined that the emerging themes related well to these five characteristics of cultural competence as well as to the four existentials of body, time, space, and human relations as defined by van Manen (1990). Consequently, the seventeen resulting themes were organized in that manner.

Existential of Lived Body

The existential of lived body or corporeality refers to one’s existence in the physical world (van Manen, 1990). In one’s physical body, one both reveals and conceals something about oneself, both intentionally and unintentionally (van Manen, 1990). One's physical body also reacts to the presence or essence of another's whether in a positive or negative way (van Manen, 1990). To elicit information about participants' perceptions during healthcare encounters regarding their physical body, a question such as, "How did the visit go?" was asked. Two major themes were revealed including a negative theme of feeling like an obligation and a theme of feeling cared for with both positive and negative reports.

Feeling like an obligation. At least half of the participants reported having felt like they were an obligation to clinic and hospital staff during healthcare encounters. One participant stated, "I felt only like an obligation, like I was there so they had to help but they just said your daughter is ok, it's ok, it's normal, now you can leave…So I said well I won't come back here because it's a bother for them when I come." Another said, "The nurses weren't really warm towards me and didn't try to connect with me. I felt like it was just their job and they just had to get done." Another participant also commented, "Really they just do their job and nothing else."

Feeling cared for. Four of the participants reported positive experiences in regards to feeling cared for. One participant spoke about her experience when giving birth to her child that, "I liked it there because they attended me well…and I think they treated us better here than in our own country." Another reported, "A good example was the night that I had surgery, my temperature went up and they [the nurses] saw it and made me go, go, go…made me keep walking and I felt better, and they gave me medicine and they were fantastic." Another stated:

> They were very nice and caring people. I have felt very welcomed. The nurse was a black guy, and there was a doctor, and they didn't portray like, 'ok she's Hispanic, let's just, you know, whatever.' They really took care of me and were attentive to what I needed.

In several instances, participants reported that their experiences were positive as the result of one person making a difference. As one participant reported, "Out of the whole bunch of employees just one to two people sincerely want to help you." One participant spoke in particular of a nurse that really impacted him during the hospitalization of his wife when one of their children was being born. He stated:

> I really saw in her a passion or compassion for Hispanics. Other nurses that had the opportunity to help didn't. In her shift she [the nurse] came and helped us out. She had a deep passion to help, particularly Hispanics. Even when we were discharged, she was so concerned about us that she got us an extra blanket, thermometer, and nipples for the bottle.

Another told the following story:

> An American nurse that spoke Spanish to me took interest in me and asked how I was doing, what was going on. I have never seen her again, but I would love to see her, because I want to tell her thank you. They [the doctors] were going to do emergency C-section. She [the nurse] was asking, 'Where is your family?', and I told her they are in Mexico. The nurse asked, 'Where is your momma then?' When she asked 'where is your momma,' I got real sentimental and started crying, and then plus the pain of the baby. So the nurse told me, 'Don't you worry. If you don't have your mother here I'll be your mother.' And then it

> wasn’t just me crying anymore it was the nurse crying for me and hugging me and being with me.

For all the positive stories about feeling cared for, there were an equal number of negative stories where the participants did not feel cared for at all. One participant said, “We were not treated well…They [clinic staff] just did an x-ray and sent us home.” Another stated, “I can’t count them [bad experiences] because there’s too many.” The same participant told a story about being with her daughter in the hospital reporting:

> When we are in the hospital, they [the hospital] have their pack of residents that come in, so we are confused as to who actually is the doctor taking care of our daughter, so, we start talking to one person and they’re like, ‘Well I’m not the doctor, I’m the resident.’ That was really confusing and aggravating at the same time. It also makes me feel like they treat my daughter like a little object, and not really a person.

Another participant also spoke of her frustration as a concerned parent when she didn’t feel as if healthcare facilities and workers cared when she said:

> In all the clinics I’ve gone to it’s been the same, all of them are the same. They all say “it’s ok, don’t worry” but I do worry because sometimes my daughter is truly sick but I go to the doctor and they tell me that everything is alright but I see her here in the house that she isn’t alright.

Frustrations were voiced by other young mothers as well. One spoke of a tragic story about one of her children when she said, “They [the hospital] told him [my husband] that the only thing the baby had was an infection and sent them home. So the baby wouldn’t eat, just fuss and one of the eyes was out of alignment.” Another spoke of a couple of years of frustration when she would take her son back to the clinic over and over without results when she said, “They would tell me that it was because of growth, that the pains he had were because he was growing. They sent me to draw blood and my child was small and he would cry a lot, and then they lost it all…Because of it I had to continue going because the little one was still having pains.”

Existential of Lived Time

Lived time according to van Manen (1990) is subjective rather than objective. He describes it as, “the time that appears to speed up when we enjoy ourselves, or slow down when we feel bored during an uninteresting lecture or when we are anxious, as in the dentist’s chair” (van Manen, 1990, p. 104). Questions that were asked of the participants were geared to elicit information regarding both objective and subjective time. Questions included, “How was the amount of time that was spent with you?”; “Were you able to get all your questions answered?”; and “What was the reason you were at the clinic or hospital…can you tell me about that time?” The major theme for this existential was that of respect for time. There were both positive and negative reports regarding this theme.

Respect for time – yes. Several of the participants reported that health care facilities helped them out with appointments by being flexible and accommodating. One participant stated:

> …the appointment was at three thirty and at three thirty I was still at the house and I had to call them and say look, I had a problem and I can’t come to the appointment and they said ‘can you come in half an hour?’…Then they said, ‘Go ahead and come’…and we went and everything was great.

Another participant reported:

> I called the clinic to make an appointment and they gave it to me the same day. The doctor was going into a meeting, but they told me come before so you can see her before the meeting. What impacted me that day was that she [the doctor] said she had important things to do, meetings, but she set them aside and perhaps even arrived late to visit with my little boy. The doctor wound up finding out through blood work that he had arthritis in his legs.

A third reported that clinic staff took the time to be sure questions were answered by stating, "Several people come and ask, 'Do you have any questions? How can we help you?' It's good."

Respect for time – no. Other participants reported episodes where time was not respected causing undue anxiety and discomfort. One participant reported, "…I had to wait in my seat for half an hour" while waiting to have her sick child seen at a clinic. Another was concerned about the length of time it took to get needed treatment when she stated, "It took them four days to get the suppository, actually." Dental clinics were also topics of discussion as one participant described an instance where she was left alone in a room "…and my mouth was still open and I couldn't handle it anymore." A third described an anxious period of waiting when she said:

> After they did the mammogram I got dressed but I didn't know what else they were going to do so I just sat there and waited for them to return, but no one returned. Finally, I peeked out and asked, 'Are you going to do anything else?' And they [hospital staff] said, 'Oh no you should have left here a long time ago.'

Existential of Lived Space

According to van Manen (1990), lived space is space that is felt or the space we are in that affects the way we feel. It is also the world in which one moves or feels comfortable (van Manen, 1990). The question posed to participants in order to elicit information regarding the adequacy of space for health care encounters was, “How did the doctor or nurse provide privacy for you during your time with them?” The two themes that emerged were respect for space and feelings of intimidation.

Respect for space. The majority of participants did not appear to think anything negative in regards to this existential stating that it was, “Muy bien [very good].” Several emphasized the fact that privacy was given to them when they stated, “…they put me in a private room” and “they give me a little cubicle” and “pues, sí, un cuartito, y la camilla [Yes, they put me in a room with a bed.]”

Feelings of intimidation. One participant, however, described a visit to a dental clinic her husband insisted she go to for care. She reported feeling intimidated just by walking into the clinic when she said, “…when I arrived it was luxurious and I did not want to go. I was saying [to my husband] I will not go.” Another reported the feelings of anxiety she experienced when being given a computed tomography (CT) scan. She stated, “Every time they would put me in and out of the machine I would cry thinking I was going to die.”

Existential of Human Relations

The existential of lived human relations refers to the shared space one has with others including physical contact and impressions (van Manen, 1990). In a larger sense it also encompasses the search for meaningfulness, purpose, and religious encounters (van

Manen, 1990). A question that probed this existential included, “What was done by nurses and doctors that made you feel they understood what it meant to come from a different country, not speak the language, and be in this place?” Two primary themes emerged for this existential including culture of hardship and finding support.

Culture of hardship. Many of the stories that were reported through the interview process gave a picture of hardship and suffering experienced by the immigrant Hispanic population. One participant summed this theme up succinctly when she said:

> The truth is, sometimes we Hispanics go through a lot that people don’t even think about. We are in our neighbor’s house [the United States] and we can’t change the laws of our neighbor’s house and nobody invited us to our neighbor’s house and nobody really knows what we go through.”

Another participant felt he was fortunate because his children were born here and had access to services such as Medicaid. His concern was for other Hispanic immigrants without those benefits. He said:

> The concern I might have is about immigrants who have come and they were born in Mexico and the kids that come now they don’t have the advantage that we have because our children were born here. So because they [our children] were born here they have access to the Medicaid, unlike the others, they don’t have that access.

Finding support. The theme of finding support was represented by stories that spoke of relationships with other people and with God. One participant spoke of how not even communication barriers affects the love she feels from an American lady she knows. She stated:

> Those Americans that give us an opportunity and know us, won't let us go. For example, we clean a house where we don't have any communication because we don't speak the same language, but the lady will not let us go because she loves us. She will even cry with us when things go wrong, so there are great connections once the opportunity arises.

Another participant spoke of taking matters into his own hands to help his wife get the care she needed. He stated:

> They did x-ray, CT and lab work. They [the hospital] said that she didn't have an infection, she didn't have anything, and that it was psychological. It turned into a three day stay. I think the doctors are stupid, so we went to [another clinic] because we wanted a second opinion. We wound up controlling the issue.

Others referred to their belief and faith in God and His ability to see them through. As one participant reported, "I go in there believing that God's hand is upon the doctors and nurses that are going to be working with my daughter and that everything's going to work out for the best" while another stated, "I confessed that the arthritis was cancelled and eliminated, and he's [my son] never had a treatment, never had anything. He's doing great."

Cultural Competence Characteristic of Effective Provision of Care

Effective provision of care was interpreted to mean experiences by participants that helped or hindered them getting the care they needed. Questions that initiated the probing into this topic area included, "How did your visit go?" and "What kind of input were you given in your care?" and "What did you think you needed or wanted…was that taken into consideration?" and "What could be done to make the care you receive better?" Common themes that emerged included continuity of care, congruency of care, and financial burden.

Continuity of care. Continuity of care refers to patients having a regular healthcare provider or consistency in who they see and where they go for healthcare encounters (Shreffler, McQuillan, Greil, Lacy, & Ngaruiya, 2007). Many of the participants in this study reported accessing care at multiple agencies. The reasons for changing facilities were varied and included having had bad experiences, needing to find someplace cheaper, wanting to find someone who would relate to them better, and others. Some participants reported that the clinics they would go to were good about referring them to other agencies when further care was needed and in helping them with follow-up appointments. As one stated, "The clinics they do referrals and they actually send us to the places they think we can get good care" and another reported, "…when I had to do follow up the actual doctor was no longer there, so I had to find another doctor. The clinic [staff] were the ones that helped get the next doctor that was going to help me." Follow up reminders were also appreciated as reported by one participant who said, "They asked me questions about how I took care of myself and about what I did to do things and they did even a year after the surgery, they followed up with a letter to make sure I did the mammogram."

Negative reports of continuity in care were also given. One participant referred to stories she had heard from friends of hers who had given birth to their children at a different hospital than the one to which she went. She said, "…they weren't treated well by the nurses. They left you there, they didn't clean you, they didn't bring you things.

I've heard of bad experiences but only at certain hospitals." Another participant referred to an instance where she was not notified of an abnormal test result when she stated,

> The thing that really surprised me was that they told me that the previous pap smear was irregular and I was supposed to have come back, but I never got any notification. I never received any notice, and then when they were doing this pap smear, they had my medical records and they [clinic staff] were saying, 'Why did you take so long to come back? You should have been here a lot sooner.'

Another participant reflected on the differences she saw between physicians giving her prenatal care when she stated, "…we changed from the clinic and are now going to the actual hospital where we will have the baby. So, it's been great now. The doctor we are seeing now is great, but before it was not so great." Differences regarding provision of care based on having insurance were also noted. One participant stated, "I think people who have health insurance may get better attention than we who don't have health insurance do."

Congruency of care. Congruency of care can be defined as a process characterized by effective interactions between healthcare providers and their patients (Schim & Doorenbos, 2010). Several of the participants voiced wishing to or actually going to a clinic that was staffed by nurses and physicians who were either Hispanic or spoke Spanish. Many felt congruency of at least language was important to improve care for the immigrant Hispanic population. As one participant stated, "If somebody could create a network of Hispanic care workers and advertise on the Hispanic television station, the Hispanics would all go there and be more comfortable." She further stated, "I wound up changing them [my kids] to a Hispanic doctor, and that doctor really connects with them, talks to them [parents] about the kids and things like that, and I feel comfortable." She also spoke about how she appreciates this physician making that extra effort to deal equally with all his patients. She said, "He [the doctor] has many years here and speaks English and Spanish but has always said if you speak Spanish he will speak Spanish, if you speak English he will speak English." Another participant spoke of his appreciation for a clinic staffed by mostly Hispanic healthcare workers. He stated, "La mayoria son Hispanos alli [The majority of the people there are Hispanic]."

Financial burden. Perhaps the most common issue faced by participants regarding obtaining adequate and effective health care was that of the financial burden. Many reported high costs such as, "For one child it was a hundred and five dollar check-up" and, "For three days it was six thousand dollars" as well as, "Si te hablamos del hospital este yo me quede de desmayar este son once mil dolares, dije que, Que! Que! No! No! [I spoke with the hospital and was faint because they told me the bill was eleven thousand dollars. I said WHAT! WHAT! NO! NO!]." Several participants reported that healthcare agencies had not been cooperative in working out any form of payment plan for them and voiced frustration at not being able to come to an agreement. One participant spoke of trying to explain her circumstances to a hospital cashier when she reported:

> They [the hospital] had been calling and calling and trying to get some kind of form of payment. At that time we didn't even have food and I was trying to explain to them we want to pay you, and I'm really grateful that you attended me, but then this is our situation now.

Another reported a similar experience when he stated:

> The business office called about the bill and I told them that I haven't been working but I'm willing to pay a hundred dollars every two weeks. They [the business office] didn't want to accept that. They wanted a thousand dollars at that moment. So at the end of the conversation I wound up hanging up on them because I wasn't getting anywhere.

The participants that had received some form of aid with healthcare costs for their children that have been born in the United States voice relief. One participant said, "…the copayments were very, very minimal for like sonograms and checkups, and so for the help like the Medicaid, I am grateful." Another participant put it this way, "We are lucky because our kids were born here, but there are a lot of Mexicans or Hispanics that are coming in with kids already and they don't have access to that healthcare, which makes it really difficult."

Cultural Competence Characteristic of Reduction of Health Risks and Vulnerabilities

In order to reduce health risks and vulnerabilities and decrease disparities in the immigrant Hispanic population, members of that population need to access health care when necessary and feel as if their needs are being met and that they are cared for. Health risk is the theme for this characteristic. For the most part the participants in this study had had such negative previous experiences that they instead tried to fend for themselves, and avoided having to seek care. By doing so, reduction of their health risks and vulnerabilities were not facilitated. As one participant commented, "Like I said I haven't gone back. So when my daughter has a fever I just buy Tylenol and give it to her so I don't have to go to the clinic… If we (the rest of the household) get sick, whatever happens happens here in the house." Another also dealt with such issues at home as indicated by her statement, "I was just trying to treat [the fever] at home with towels and wait until Monday to see our doctor." Still another participant avoided accessing care after an accident as she reported, "I had an accident where a cup of boiling water spilled on one of my ribs and burned me pretty bad, but I was not going to the hospital. I said no, no, no!"

Feelings of vulnerability often followed negative healthcare experiences. This served to diminish any trust participants had in the healthcare system and its workers to care for them. One particular story emphasized those feelings of distrust as the participant reported:

> When the baby was born we were on the same floor where our other baby had died and I had the same nurse. I was outraged at the doctor and the nurse as well because they hadn't been honest with me. It made me think, 'I'm the mother and you should tell me and be open with me. Why did you just take my son from me?' We did not leave the hospital. We were there the whole time…

Cultural Competence Characteristic of Promotion and Protection of Human Rights

Human rights should mean that people are treated equally and receive what they need to maintain their health and well-being (International Council of Nurses, 2009). The participants interviewed for this study, however, were very aware of issues such as racism, bias, and stereotyping, the theme for this characteristic of cultural competence. As one participant stated, "They [healthcare workers] don't really see our [Hispanics'] side, and they don't take us that serious because we are Hispanic." Putting it another way a participant said, "It's almost like a racist issue. Because we are Hispanics we get treated differently. They [healthcare providers] should be more attentive on what the actual problem is, and not really the fact that we are Hispanic." Cultural congruency of the healthcare worker was not an automatic fix for this issue either. As one participant reflected she said, "I don't understand how the Latin dentist was more racist than the American dentist." One participant further reflected on her feelings of being thought of as a burden when she mused, "If only they [medical professionals] could see that we are not a burden like they think we are and will not abuse medical services because we won't go unless it is a last resort."

Cultural Competence Characteristic of Communication in Patient's Preferred Language

Congruency in communication has long been cited in the literature as necessary for culturally competent care to take place (Ericksen, 2006; Fortier, 2008). Questions to address communication issues included, "How did you communicate?" and "In what language was written material?" Common themes that emerged included: provision of translation services, language preference for written materials, and effectiveness of communication.

Provision of translation services. The CLAS standards focus a lot on the need for healthcare organizations and providers to provide translation services for their clients that require such (OMH, 2007). The participants in this study reported both positive and negative instances regarding the provision of translation services within Tulsa area health care facilities. For some organizations and providers participants reported positive assistance such as, "I'm really happy with this medical clinic people 'cause always have somebody speak Spanish, always, always", "…it was just a basic checkup, but they did provide a translator", "…the class was in Spanish", "…some spoke only English but if they needed to say something in Spanish they called someone who spoke Spanish", "…when I went the first time they provided a telephone and machine that asked me in Spanish and translated the answer", and "…he [the doctor] makes sure that somebody's there that can communicate with me in Spanish."

Other instances were reported where translation services were lacking causing confusion and frustration. When a participant was asked if there was anyone who could explain to her what was going on regarding her mammogram exam she replied by saying, "No, no hablaban español." Another participant was concerned regarding the care her daughter was receiving in one of the local hospitals and stated, "I didn't understand what was going on because they [the hospital] didn't have a translator." Still another instance causing frustration was when a nurse chose to use her language of preference rather than that of the participant who reported, "She saw I was Hispanic and asked me, 'do you speak English?' I told her I spoke a tiny bit and she told me 'ok' but she never even spoke one word of Spanish to me."

As a result of the inconsistencies in healthcare organizations and providers offering translation services, many participants felt the burden of efforts to improve communication and understanding during clinic and hospital visits. Participants voiced concern over possibly not communicating important information correctly when as one stated, "…we wonder if we are saying what we need to say." Others spoke of family and friends who came to help when services weren't offered as in, "…they attended me well, but because they [hospital staff] only spoke English it created chaos. My niece didn't want to leave me alone because there was nobody to be with me, and if she were to leave there was no translator either" and "I understand a lot but I had to bring my own translator…if I had not taken my sister-in-law, I would not have understood and they would not have helped me" and "…after not knowing anything, I found somebody from church that could translate for me, and started telling them everything."

Language preference for written materials. Health education materials and medication instructions are very important for care to be effective and safe. The need for language appropriate written materials in providing culturally competent care is as important as the spoken language for each healthcare encounter. The majority of participants reported that "…I did receive information but it was in English" or "the paperwork they gave us was all in English" or "…the information for the medicine was in English." Use of a language line was helpful in one particular instance as the participant stated, "They told me all I had to do and how I had to prepare [for surgery] after I got it in writing…that was in English. The operator helped much." It was also reported that some more pertinent information was in Spanish as when a participant commented, "…the majority was in English but there was a certain part that [I] was supposed to do, and that was in Spanish…but the rest of it was in English." Two participants in particular were fortunate enough to get their choice of language for any written materials. One stated, "Tenemos el, el, la opcion [They give me the option]. Te dicen quieres llevar en Espanol o en Ingles [Do you want it in Spanish or in English]?" The other decided she liked the challenge of learning a new language so admitted, "I'm trying to learn how to read English, so when they ask me if I want it in English or Spanish, I request English…But, when I take the kids in to be seen, they do give me Spanish instructions."

Effectiveness of communication. Often participants reported confusion regarding healthcare encounters. In many instances they were able to understand what was being said to them, but key pieces of information were missing that did not allow for full comprehension of the situation. One example was when three participants went together to a dental clinic and reported, "…they told us there were too many people [to be seen], but we were the only ones there…In the end they didn't do anything for any of us and their excuse was that there were too many people, but we were the only ones there." Another of the participants in this situation added, "Nobody even spoke on the way back because we were so sad. We spent more on gas and time, got charged thirty-five dollars for an x-ray, and were given nothing and told nothing, just sent home." Another participant was confused by events related to her daughter's hospital stay. She reported:

> I finally went and talked to the doctor and asked, 'Why has she only received one suppository treatment and that was after four days?' The doctor said that the chart showed that she [the daughter] was already discharged so she was in the hospital several days…but we were really there for nothing.

Another participant reported feeling scared when she wasn't given enough information. She stated:

> When I went to get the mammogram, they didn't do the correct positioning and so they had to redo it. So, they called me back to get me to go in and redo it and that made me frantic because I didn't understand what was going on and thought something was wrong with me and I was scared.

Perhaps worst of all was the report of one participant of an instance that made her feel as if she had been lied to and as if something had been concealed from her and, to this day, causes her to feel anger and resentment. The report of the situation during the interview was confusing, but the anguish felt by the participant and her husband caused them not to pursue matters further even for clarification. She described:

> About four o'clock in the morning the next morning they [the hospital] called him [my husband] saying we need you to come in to sign some documents to do a transfusion. Something was not right with the brain [of the baby] so they were trying to do something…When we both went I asked the doctor was my son alive and well or what's going on? The doctor, three specific times after I questioned, 'Is he alive?' and told him, 'I need you to do whatever it takes to help him', the doctor adamantly said that he was alive. Not even two minutes after the doctor left, the nurse came and said that your son is no longer alive and he hasn't been alive since the last time you left. He has passed.

Instances such as these emphasize the need for appropriate and effective communication. The participants in this study voiced their opinions on this matter when they said, "I would like to see more medical people who can speak our language [Spanish] so we can better communicate when we have health problems" and "It would help if medical people could speak our language because the words are completely different and sometime we [Hispanics] say something but think we may have it wrong." As one participant summed up her concerns she stated, "My daughter has very special care. She actually has a pacemaker. So every time I have to explain to them about it and it's hard to communicate, so I try the best I can and hope for the best."

Cultural Competence Characteristic of Consideration of Cultural Aspects

Understanding cultural aspects of the immigrant Hispanic patient begins with understanding the importance placed on family and relationships. Questions that addressed such issues included, “What made you feel your culture was respected?” and “Who in your family is important in your medical care?” Two themes emerged from this line of questioning including respect for family and patient centered care.

Respect for family. Most reports regarding family members indicated that family was included and welcomed into the healthcare experiences. Statements such as, “Once the baby was born everything was good, my husband and children were with me” and “…they [my husband and son] were there the whole time” supported the importance of family and the need for family members to be present during healthcare encounters. However, one participant reported several instances where her husband was not welcomed for her prenatal visits. She reported:

> The doctor wouldn’t allow my husband to go in with me for the checkups. My husband would leave from work to come to be there and then the doctor would kick him out. My husband wanted to at least hear the baby’s heartbeat, but the doctor wouldn’t let him…We asked if we could go and see another doctor, and they [the clinic] did allow us to see someone else for one of the visits, but after that they [the clinic] brought us back to the original doctor.

This instance resulted in the participant interrupting her regular prenatal visits in order to find another physician who would welcome her husband in the exam room. Since making the change she states, “It’s been great now.”

Patient centered care. Relationships are considered very important to Hispanic populations. Many participants perceived their healthcare experiences as positive or negative based on how well providers related to them. Several instances were reported where no effort was made by providers to develop much of a relationship with the participants. One example, “They’ve never allowed me any kind [of input]. They don’t even ask” and “They just give me the treatment and then that’s it.” Healthcare providers also did not spend time educating or investigating cultural food differences as evidenced by the manner in which one participant received instructions related to a restricted diet. Her husband reported:

> They [the hospital] did give us a form in Spanish but it didn’t have anything as far as what the diagnosis was, what any kind of treatment was. It was just more like be cautious of not eating spicy foods, chilies or anything like that.”

Other participants, however, were pleased with the smallest gestures made by healthcare workers to understand their needs and desires and who showed even a modicum of respect for them as individuals and families. As some of the participants said, “They not only told me [how I should take care of my foot], but I was able to participate in the conversation,” and “He [the doctor] has actually taken time to really connect with me and help me out, and really make me feel like, ‘Don’t worry about anything,’ when I am worrying because this is my first pregnancy.” Another participant recognized respect when he stated:

> They [healthcare workers] have been very well, into trying to, to accommodate us with what we want or believe. Even with the doctor that delivered my son, when we found out that we were pregnant we didn’t want to know what the gender was so when he was born, the doctor immediately said, “nino” and he [the doctor] remembered it was a secret. We have been accommodated very, very well.

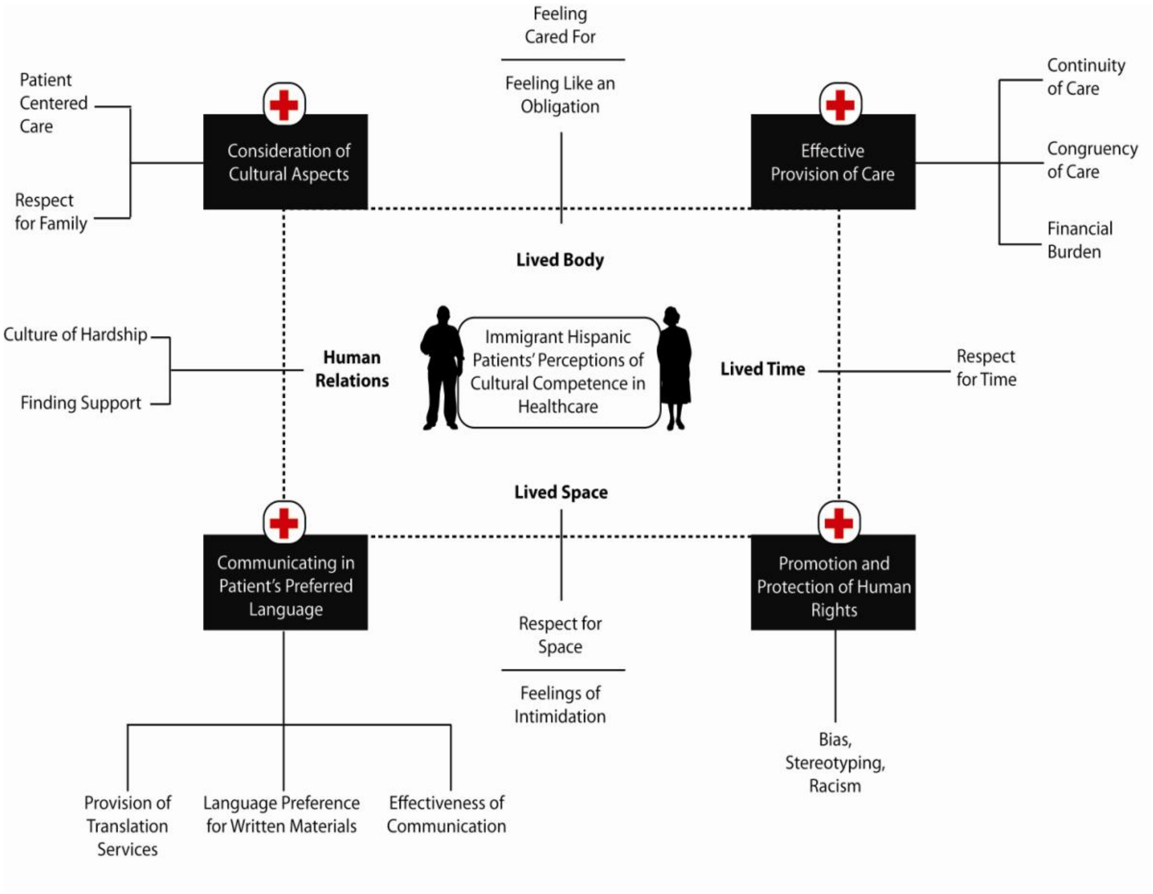
Such reports allowed those particular participants to look favorably upon healthcare especially when it pertained to certain providers.

Discussion

The primary purpose of this study was to answer the question, “In the immigrant Hispanic population, what are the perceptions pertaining to cultural competency in the healthcare setting?” The data were analyzed according to van Manen’s (1990) four existential themes of body, time, space, and human relations and characteristics of cultural competence including effective provision of care, reduction of health risks and vulnerabilities, promotion and protection of human rights, communication in patient’s preferred language, and consideration of cultural aspects. While a few of the experiences related by participants were viewed in a positive light and included many of the characteristics of cultural competence, the majority of encounters lacked any components of cultural competence. This indicates that health care encounters from the perspective of the Hispanic immigrant patient often lack essential elements that would qualify them as culturally competent. Figure 1 gives a graphic representation of the relationship of immigrant Hispanic patients’ perceptions regarding the cultural competence of healthcare encounters and the themes found in this study.

Figure 1

Factors Affecting Immigrant Hispanic Patients' Perceptions of Cultural Competence in Healthcare



In regards to van Manen's (1990) existential of lived body, many participants reported feeling like an obligation or duty rather than an individual. Such feelings gave the participants a general perception of not being cared for as an individual or human being. This was compounded by a reported lack of personal attention and information requiring repeated visits for the same problem. The accounts verbalized by participants in this study conveyed a lack of caring and humanness in healthcare encounters, elements that would have aided perceptions in being more positive (Guruge, Hunter, Barker, McNally, Magalhaus, 2010; Warda, 2000). Other studies in the literature report a need for healthcare providers to show interest and spend adequate time and attention developing a working relationship with immigrant Hispanic patients (Clark & Redman, 2007; Warda, 2000) as well as to display a welcoming attitude (Harari, Davis, & Heisler, 2008).

van Manen's (1990) existential of lived time was of most concern to participants when it was perceived that care was not received in a timely manner. Long wait times and not being able to get timely appointments or treatments were perceived negatively, a finding supported in the literature (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Sorkin, Ngo-Metzger, & DeAlba, 2009). Only three of the participants reported that some health care providers spent enough time with them to answer questions and assist them with healthcare needs resulting in positive perceptions that is supported in a previous study by Johnson, Saha, Arbelaez, Beach, and Cooper (2004).

Contrary to the study by Barone (2010), participants in this study were primarily unconcerned with the existential of lived space which van Manen (1990) described as the space we feel comfortable in. Participants perceived that the space provided was adequate and private enough for their needs. Most participants appeared surprised by the question regarding space and did not elaborate beyond simple answers. Of the two participants who did speak about space in a negative way, one could have been impacted positively if a healthcare provider had taken a little time and communicated with the participant about the computed tomography scan she was undergoing. Communication in that particular instance would have helped to alleviate the fears and anxiety that contributed to the negative experience.

The existential of human relations van Manen (1990) describes as including meaningfulness, purpose and religious encounters was characterized by themes of a culture of hardship and finding support. Warda (2000) referred to the need for healthcare providers to understand the life circumstances of their patients in order to provide culturally competent care. Participants in this study reported a lack of sensitivity and understanding by health care providers as to what their life entails as an immigrant Hispanic patient not speaking the language well and not having easy access to care for healthcare needs. Finding support was a theme that showed a contrast to Warda (2000) who emphasized fatalism as a primary attitude toward their relationship with God. In this study, participants who expressed a belief in God did not indicate a fatalistic attitude but rather an optimistic belief and assurance that God cared for them and would provide for them.

Effective provision of care has been addressed in the literature in regards to patients obtaining the care they need to maintain health (Fernandez, Schillinger, Grumbach, Rosenthal, Stewart, Wang, & Perez-Stable, 2004; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). Continuity of care, or consistency in obtaining care from a primary provider or organization, was not often seen in the participants of this study. Reasons for a lack of continuity in care were similar to findings in the literature such as lack of insurance (Harari, Davis, & Heisler, 2008), lack of knowledge of the healthcare system (Cristancho, Garces, Peters, & Mueller, 2008), and previous negative experiences with healthcare (Derose, 2000). Contrary to findings by Clark and Redman (2007), participants in this study desired a primary care relationship no matter their number of years living in the United States. The more important issues regarding continuity of care to study participants was supported in the literature including obtaining notification of needed follow-up care (Derose, 2000) and not being discriminated against based on health insurance status (Cristancho, Garces, Peters, & Mueller, 2008; Harari, Davis, & Heisler, 2008). The importance of congruency of care, or effectiveness of healthcare interactions due to same race or ethnicity or same language between provider and patient, was also a factor found to influence perceptions of effectiveness of care (Schim & Doorenbos, 2010). Study participants reported more positive experiences when care was received either by congruent (Hispanic) caregivers or by caregivers that spoke congruent (Spanish) language (Gonzalez, Vega, & Tarraf, 2010; Sorkin, Ngo-Metzger, & DeAlba, 2009). Finally, financial issues proved to be a barrier in most instances, a finding supported by many previous studies (Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Collins, Villafran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008). As in a study by Harari and colleagues (2008) and one by Cristancho and colleagues (2008), several participants expressed the need for healthcare facilities and providers to provide flexible payment plans that would work with the immigrant Hispanic person's income and allow for better consistency and trust in the healthcare system.

Reduction of health risks and vulnerabilities, as stated earlier, cannot be impacted when patients will not seek access to healthcare. Due to previous negative experiences and lack of trust in the healthcare system, participants in this study would try home remedies or self-medicating practices to avoid accessing care, a finding similar to that of Harari, Davis, and Heisler (2008). In addition, when patients perceive the presence of discrimination or bias, access to care is further hindered, again, not allowing for health risks and vulnerabilities to be reduced. The majority of participants in this study, similar to findings in other studies, have experienced discrimination or bias from healthcare providers and facilities causing them to avoid seeking care even when it was needed (Crsitancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2009). Contrary to other studies reporting a high incidence of immigrants returning to their country of origin for healthcare, none of the participants in this study reported such, although the issue was not formally addressed (Bergmark, Barr, & Garcia, 2010; Gonzalez-Block & Vega, 2011; Horton & Cole, 2011). Finally, although documentation status regarding residency was not addressed in this study, it is important to note that none of the participants had health insurance. In spite of recent healthcare reform initiatives and legislation to expand coverage to America's uninsured, many of the participants may remain ineligible for coverage due to legal status, length of time in the U.S., and whether they ever applied for citizenship (Diamond, 2011; Nandi, Loue, & Galea, 2009; Warner, 2011). This will further reduce the ability for healthcare to impact disparities and vulnerabilities in this population.

Communication issues and problems have been the focus of many studies and often serve as a barrier to accessing care (Clark & Redman, 2007; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Carces, Scarinci, & Marsh-Tootle, 2009; warda, 2000). Issues with communication also influence perceived quality of care (Gonzales, Vega, & Tarraf, 2010; Sorkin, Ngo-Metzger, & DeAlba, 2009). Participants in this study voiced concerns regarding communication issues and even those who looked more favorably on their healthcare experiences admitted that having more Spanish speaking providers or better and more abundant translation services would help healthcare encounters go even better. Many of the participants took the burden on themselves to be sure there was someone available to assist with translation, a finding also common to other studies (Cristancho, Garces, Peters, & Mueller, 2008; Harari, Davis, & Heisler, 2008). However, in accordance with the CLAS standards for provision of culturally competent care, healthcare organizations have the obligation to provide for the communication needs of the patient necessitating further modification of health systems as determined by Gonzalez, Vega, and Tarraf (2010). One additional finding similar to that of Clark and Redman (2007) was the confusion that resulted when participants failed to understand the sequence of events due to lack of effective and timely communication on the part of healthcare providers.

Finally, consideration of cultural aspects for this study focused on presence of family and patient-centered care. The literature reports that relationships are very important within the Hispanic culture (Clark & Redman, 2007; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Warda, 2000). In most instances, participants reported satisfaction with the opportunity to have family members with them during healthcare encounters. One significant exception resulted in a change of healthcare providers. The positive family involvement reported by participants supported findings by Carbone et al. (2007) who found that family members were relied on as the first line of assistance when help was needed. Participants also voiced frustration with care that was not patient-centered, a finding in this population also supported by Tandon, Parillo, and Keefer (2005).

Implications

The findings of this study have numerous implications for the fields of nursing education, nursing practice, and nursing research. The challenge for nurse educators is to teach students to care for and respect patients in a manner that will meet their needs and promote effective care. Unfortunately participants in this study were not receiving such care or respect as evidenced by statements such as, “Especially in the hospitals they [healthcare workers] don’t really respect Hispanics and downgrade us because we don’t have things like social security numbers.” Faculty are responsible for teaching students how to be aware of cultural differences and similarities and should be held accountable for that as well as for teaching students the importance of taking the time to provide language services, culturally congruent written materials, and patient-centered care. Emphasis on recruitment of minority population representatives into nursing and other healthcare programs could also impact the level of culturally competent care provided. In order for any of this to happen, however, nursing faculty must become more culturally competent themselves and learn to work through their own biases and tendencies toward discrimination.

The findings of this study reflect that few practicing nurses are providing culturally competent care from the perspective of the immigrant Hispanic patient. Implications for nursing practice include supporting initiatives that will allow for the time it takes to provide effective care to patients that are culturally diverse. Educating practicing nurses on available resources such as translation services and language congruent written materials may increase the perceived cultural competence of the care received by immigrant Hispanic patients. Increasing the awareness of how nurses can be advocates for their culturally diverse patients could also potentially impact the level of culturally competent care that is delivered. Health promotion teachings and information regarding culturally congruent healthcare providers that provide culturally competent care are also necessary and requested by many of the participants in this study. Finally, in spite of the intended contribution of the CLAS standards toward providing more culturally competent care, results of this study indicate that healthcare is falling far short of the standards. Greater measures of enforcement of the CLAS standards to provide culturally competent healthcare must be instituted if health disparities are going to be impacted.

Nursing research is still a wide open forum on the topic of cultural competence. Further development of tools that measure cultural competence from the perspective of the patient is greatly needed as are studies determining the effectiveness of educational interventions focused at improving cultural competence of nurses and other healthcare providers. Mixed methods studies that measure cultural competence from the patient perspective and then qualitatively describe areas that are done well and areas that are not would also be very invaluable. Investigation of business models that could provide more flexible payment options are also needed for as one participant stated, “If the doctors or dentist could have confidence in the Hispanics that they are going to pay, it would create a win-win situation for the doctor building cash flow, and for them [Hispanics] making it more feasible to seek the healthcare.”

Strengths and Limitations of the Study

This study had several strengths and limitations of note. Strengths included the amount of time the researcher spent immersed in the literature and data related to this study. The research assistants also added strength to the study with their ability to translate and transcribe. The researcher also possesses a limited working proficiency of the Spanish language and was able to understand much of the interviews, allowing verification of translations as they occurred. Having an experienced research mentor to guide and verify the credibility and efficacy of the research process was a major strength. Due to that factor, this study could be replicated for verification of results.

Limitations to this study include the small sample size and limited geographical location which limit the generalizability of findings. Another limitation was having a sample that primarily came from Mexico and was mostly female. Repeating this study with a larger, more diverse, and representative sample could add to the credibility of the results.

Conclusions

With the immigrant Hispanic population growing exponentially in many parts of the United States, the need for culturally competent care is also ever increasing. This study revealed that immigrant Hispanic patients in the Tulsa, Oklahoma area did not perceive many healthcare encounters as possessing essential characteristics of culturally competent care including effectiveness of care, reduction of health risks and vulnerabilities, promotion and protection of human rights, communication in the patient's preferred language, and consideration of cultural aspects. Participants related experiences of not being respected, not feeling cared for, and struggling to understand what was happening around them during healthcare encounters. Participants often did not even feel as if they were being treated as human beings. Positive experiences were often related to the efforts of one or two particular people who evidenced caring in their practice. The findings of this study emphasized the need for a holistic, patient-centered model of care. The health disparities and vulnerabilities existent in this population will never decrease unless such care is provided.

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Chapter 4: Summary and Conclusions

The purpose of this research was twofold. The first was to determine what had been done from the perspective of the immigrant Hispanic patient regarding the cultural competence of the care they had received during healthcare encounters. The second was to determine from interviews conducted with immigrant Hispanic patients whether the care they had received was culturally competent.

Evaluation of the Project

The research indicated that current literature is lacking as it pertains to evaluating cultural competence from the perspective of the immigrant Hispanic patient. There was also evidence that while many tools exist to measure cultural competence, the majority cannot be confirmed as valid and reliable nor do they measure cultural competence from the patient perspective (Gozu, Beach, Price, Gary, Robinson, et al., 2007). Conclusions based on the state of the science manuscript portrayed the need for development of tools that can measure cultural competence as perceived by the patient. The one tool developed for such use was for physician and patient interactions and did not cover other members of the healthcare team (Hurtado, Weech-Maldonado & Weidmer, 2010).

The dissertation research was also valuable in providing information from immigrant Hispanic patients as to their perceptions of cultural competency of the care they have received since immigrating to the Tulsa, Oklahoma area. Overall, it was determined that this population is rarely receiving culturally competent care. In spite of federal mandates to provide language access programs for those of limited English proficiency, most participants reported having to bring their own interpreters. Additionally, when translation services were available, rarely were they freely offered by nurses or other healthcare workers. Furthermore, an alarming picture of a lack of caring clearly came through the stories shared by participants, an issue that has great implications for nurses.

Strengths of the research included the comprehensive nature of the literature reviews. Additionally, the findings of the research provide a platform for continued research in this area and emphasize the need for further qualitative and quantitative studies. Limitations of the study included a small sample size and focus on one geographical area limiting the generalizability of findings. Also, not all hospitals and healthcare facilities in the Tulsa area were represented limiting the generalizability of findings even within the Tulsa area.

Recommendations Based on Findings

Perhaps the primary recommendation that can be made from this research is the development of a survey that would measure cultural competence from the perspective of the immigrant Hispanic patient. The tool should be generic enough to include all healthcare providers and specific enough to determine in which areas healthcare is falling short. Once such a tool is developed, in-depth mixed methods studies should be conducted in a variety of healthcare settings frequented by the immigrant Hispanic population. The survey would be used to quantify cultural competence ratings while the qualitative portion would continue to provide insight into what still needs to be improved. As that information is collected, implementation of cultural competence training based on the findings should be conducted. Since immigrant Hispanic patients come from a variety of countries and cultural backgrounds, training should reflect the population of the area in which nurses and other providers conduct their practice.

It could also prove useful to compare results of survey research between healthcare facilities and determine what models are in place contributing to higher levels of cultural competence. Such research could aid in providing better continuity of care between facilities in a geographical area as each revise procedures and protocols to model best practice for culturally competent care. Only then might we see a difference in the disparities that continue to be reported in this population.

Conclusion

On-going assessment may assist in improving the level of cultural competence in healthcare and eliminating the barrier a lack of cultural competence poses regarding access to care and effectiveness of care in this population. As immigrant Hispanic patients continue to voice the need for more and better translation services, better payment plan options, and a need to be respected as persons rather than treated as unwanted visitors, health disparities will fail to be impacted. Nurses stand in a pivotal position to impact this problem through research and through providing a higher quality of care.

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Appendix A: Copyright Agreement for Manuscript

Dear Cheryl,

On behalf of our Editor, Dr. Marge Andrews and Managing Editor, John Collins, I would like to congratulate you for being accepted as a contributing author in the *Online Journal of Cultural Competence in Nursing and Healthcare*.

Your manuscript, **The Case for Studying Cultural Competence from the Perspective of the Hispanic Immigrant Patient: A State of the Science**, will appear in our January 2012 issue.

I am attaching the publishing agreement. Please return it to us via email. An electronic signature is acceptable. Please note that you will retain full copyrights to your work, however you allow us to publish your work as stated in the agreement. For example, you have the right to re-publish this work or publish derivative works of your article on a non-profit or for-profit basis without our permission. In the event that you publish on a for-profit basis, you are entitled to all profits/royalties without our involvement whatsoever. In addition, you allow us to grant permission to others to use and reprint your article. A copy of those permissions will be sent to you. Authors find this is a valuable service.

A feature that is unique to our journal is a moderated online discussion board. Readers have an opportunity to interact with you electronically regarding your article. You will be notified when a question appears on your article's online discussion board.

I have provided the three peer reviews we received on your article. Most authors find this helpful to grow professionally.

If you have any questions, please don't hesitate to contact me. On behalf of the editorial board, I remain,

Cordially yours,

John S. Vanderlaan, RN, MSN, CEN, CTN-A
Web Editor
Online Journal of Cultural Competence in Nursing and Healthcare

Appendix B: Institutional Review Board Approval Letter

The University of Texas at Tyler
Institutional Review Board

October 21, 2011

Dear Ms. Swanson:

Your request to conduct the study entitled *The Immigrant Hispanic Population: Perceptions about Cultural Competency in the Healthcare Setting* is approved as an expedited study, IRB #F2011-21 by The University of Texas at Tyler Institutional Review Board. This approval includes the use of the written informed consent that is attached to this approval letter. Please use this attached form for all persons, and ensure that each participant is able to repeat the purpose of the study, the voluntary nature of it, any risks involved, and who to contact other than you as the PI. In addition, ensure that any research assistants or co-investigators have completed human protection training, and have forwarded their certificates to the IRB office (G. Duke).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- This approval is for one year, as of the date of the approval letter
- Request for Continuing Review must be completed for projects extending past one year
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others

Appendix B (Continued)

- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Gloria Duke, PhD, RN

Gloria Duke, PhD, RN

Chair, UT Tyler IRB

Appendix C: Recruitment Flyer

The Immigrant Hispanic Population:

Perceptions about Cultural Competency in the Healthcare Setting

Please share your story for an important research study.

- Are you 18 years of age or older?

- Do you identify yourself as Hispanic?

- Did you immigrate to the United States in the last 10 years?

- Have you received care at an outpatient clinic or hospital within the last 6 months?

If you answered **YES** to these questions, you may be eligible to participate in a research study. The purpose of the research study is to describe the experiences and perceptions of immigrant Hispanic patients about cultural competency in the healthcare setting. The results of the study will provide valuable information to Tulsa area healthcare facilities about the provision of care to members of the Hispanic community. Participants will receive a small incentive payment for their time. Both adults, 18 years of age and older, and parents of children who have been seen in a healthcare facility in the last 6 months are eligible to participate.

This study is being conducted by Cheryl Swanson, RN, PhD (c), a PhD in Nursing Student at The University of Texas at Tyler.

For more information and to schedule an interview, please contact:

Brittany at (918) 859-5925 if you are female

Jonathan at (918) 859-5908 if you are male

Appendix C (Continued)

Flyer de Reclutamiento

De La Población Inmigrante Hispana:

Percepciones sobre la competencia cultural en los entornos médicos

Por favor, comparta su historia para un importante estudio de investigación.

- ¿Tiene 18 años de edad o más?
- ¿Se identifica a sí mismo como hispano?
- ¿Ha emigrado a los Estados Unidos en los últimos 10 años?
- ¿Ha recibido atención médica en una clínica o hospital en los últimos 6 meses?

Si usted contestó **sí** a estas preguntas, usted puede ser elegible para participar en un estudio de investigación. El propósito del estudio es describir las experiencias y percepciones de los pacientes hispanos inmigrantes acerca de la competencia cultural en el entorno médico. Los resultados del estudio proporcionarán información valiosa a los servicios de salud en el area de Tulsa sobre la prestación de servicios a los miembros de la comunidad hispana. Los participantes recibirán un incentivo pequeño para su tiempo. Tanto los adultos, de 18 años de edad y mayores, y los padres de los niños que se han visto en un centro de salud en los últimos 6 meses son elegibles para participar.

Este estudio está siendo llevado a cabo por Cheryl Swanson, RN, PhD (c), un estudiante de doctorado en enfermería en la Universidad de Texas en Tyler.

Para más información y para concertar una entrevista, por favor contactar a:

Brittany at (918) 859-5925 if you are female

Jonathan at (918) 859-5908 if you are male

Appendix D: Demographic Interview Guide

Consent Code:____________

- Age in years: ____
- Gender: ______Male   _______Female

  Educational level: ______Some grade school   ______ High school diploma

  _____ Some college   _____ College degree   ______ Graduate school
- Occupation: ____
- Household level of income (monthly): ____________________________
- Primary language spoken in the home: _____ English   _____ Spanish

  _____ Other (specify)
- Number of people living in the home: __________
- Length of time in U.S.: ___________ (in years and months)
- Country/region of origin: ______________________________________
- Rural or Urban: ____
- Health insurance: _____ yes   _____no
- Were you last seen as an inpatient or an outpatient?

  _____ inpatient (specify hospital) _____________________

  _____ outpatient (specify clinic)_____________

Appendix E: Informed Consent Form

Original English Version

THE UNIVERSITY OF TEXAS AT TYLER

Informed Consent to Participate in Research

Institutional Review Board # F2011-21

Approval Date: October 21, 2011

Consent Code:___________

1. **Project Title**: The Immigrant Hispanic Population: Perceptions about Cultural Competence in the Healthcare Setting.
2. **Principal Investigator:** Cheryl Swanson
3. **Participant's Name: ____**

To the Participant:

You are being asked to take part in this study at The University of Texas at Tyler (UT Tyler). This consent form explains why this research study is being performed and what your role will be if you choose to participate. This form also describes the possible risks connected with being in this study. After reviewing this information with the person responsible for your enrollment, you should be able to understand and make an informed decision on whether you want to take part in this study.

4. Description of Project

The purpose of this study is to gather information on the experiences and perceptions you have had within a healthcare setting. This study will give you a chance to describe both the good and the bad experiences to help me understand what we are doing well and what we need to do better in serving members of the Hispanic community.

5. Research Procedures

If you agree to be in this study, we will ask you to do the following things:

- Sign this informed consent
- Participate in an audio-taped interview (about 1 hour to 1.5 hours in length)
- Agree to allow follow-up questions if needed at a time after the interview.
- Review results of the study and make comments.

6. Side Effects/Risks

There are very few risks anticipated with this study. All information will be kept locked and secured without identifying information on it so no one will be able to identify you individually.

7. Potential Benefits

The benefits of this study are that it will provide information for health care workers in Tulsa to be better able to serve you and those within your community. It will also provide documentation to request appropriate resources whether that be more Spanish speaking resources or written materials in Spanish or better translation services (just to name a few).

Understanding Of Participants

8. I have been given an opportunity to ask any questions concerning this research study and the researcher has been willing to answer my questions.

9. If I sign this consent form I know it means that:

- I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.

- I know that I am free to not participate in this study and that if I choose to not participate, then nothing will happen to me as a consequence.

- I know that I have been told that if I choose to participate, then I can stop being a part of this study at any time. I know that if I do stop being a part of the study, then nothing will happen to me.

- I will be told about any new information that may affect my willingness to continue participating in this study.

- The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.

- The researcher will gain my written consent for any changes that may affect me.

10. I have been assured that that my name will not be revealed in any reports or publications resulting from this study without my expressed written consent.

11. I also understand that any information collected during this study, including any health-related information, may be shared with the following <u>as long as no identifying information as to my name, address, or other contact information is provided</u>:

- Organization contributing money to be able to conduct this study

- Other researchers interested in combining your information with information from other studies

- Information shared through presentations or publications

12. I understand The UT Tyler Institutional Review Board (the group that ensures that research is done correctly and that measures are in place to protect the safety of research participants) may review documents that have my identifying information on them as part of their compliance and monitoring process. I also understand that any personal information revealed during this process will be kept strictly confidential.

13. I have been told of and I understand any possible expected risks that are associated with my participation in this research project.

14. I also understand that I will not be compensated for any patents or discoveries that may result from my participation in this research.

15. If I have any questions concerning my participation in this project, I shall contact the principal researcher: Cheryl Swanson, 918-605-6499, cswanson4@patriots.uttyler.edu.

You may also contact her Dissertation Committee Chair, Dr. Susan Yarbrough, at The University of Texas at Tyler at (903-566-7220) or syarbrough@uttyler.edu

16. If I have any questions concerning my rights as a research subject, I shall contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu, or the University's Office of Sponsored Research:

The University of Texas at Tyler
c/o Office of Sponsored Research
3900 University Blvd
Tyler, TX 75799

I understand that I may contact Dr. Duke with questions about research-related injuries.

17. CONSENT/PERMISSION FOR PARTICIPATION IN THIS RESEARCH STUDY

Based upon the above, I consent to taking part in this study as it is described to me. I give the study researcher permission to enroll me in this study. I have received a signed copy of this consent form.

Signature of Participant   Date

Witness to Signature

18. I have discussed this project with the participant, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks. I believe the participant understood this explanation.

Researcher/Principal Investigator   Date

Appendix E (Continued)

Spanish Translation

LA UNIVERSIDAD DE TEXAS EN TYLER

Consentimiento Informado para Participar en la Investigación

Junta de Revisión Institucional # F2011-21

Fecha de Aprobación: Octobre 21, 2011

Consent Code:___________

1. **Título del proyecto:** La población hispana inmigrante: Percepciones sobre la competencia cultural en los entornos médicos.
2. **Investigador principal:** Cheryl Swanson
3. **Nombre del participante: __________________________**

Para el Participante:

Usted está siendo invitado a participar en este estudio en la Universidad de Texas en Tyler (UT Tyler). Este formulario de consentimiento explica por qué este estudio de investigación se está realizando y cuál es su función será la de si decide participar. Este formulario también se describen los posibles riesgos relacionados con la participación en este estudio. Después de revisar esta información con la persona responsable de su inscripción, usted debería ser capaz de comprender y tomar una decisión informada sobre si desea tomar parte en este estudio.

4. **Descripción del Proyecto**

El propósito de este estudio es recopilar información sobre las experiencias y percepciones que ha tenido dentro del servicio sanitario. Este estudio le dará la oportunidad de describir lo bueno y las malas experiencias que me ayude a entender lo que estamos haciendo bien y lo que tenemos que hacer mejor en el servicio a los miembros de la comunidad hispana.

5. Procedimientos de Investigación

Si usted acepta participar en este estudio, se le pedirá que haga las siguientes cosas:

- Firmar este consentimiento informado
- Participar en una entrevista grabada en audio (de 1 a 1.5 horas de duración)
- Póngase de acuerdo para permitir que siga- a las preguntas si es necesario en un momento después de la entrevista.
- Revisar los resultados del estudio y hacer comentarios.

6. Efectos secundarios/Riesgos

Existen muy pocos riesgos previstos en este estudio. Toda la información se mantendrá cerrado y asegurado sin la identificación de información sobre lo que nadie podrá identificarle de forma individual.

7. Beneficios potenciales

Los beneficios de este estudio son que proporcionará información para los trabajadores de la salud en Tulsa para estar en mejores condiciones para servir a usted y a los de su comunidad. También proporcionará la documentación para solicitar los recursos necesarios ya sea recursos que hablan más español o materiales escritos en español o mejor servicios de traducción (sólo por nombrar algunos).

Comprensión de los participantes

8. Se me ha dado la oportunidad de hacer alguna pregunta sobre este estudio de investigación y el investigador ha estado dispuesto a responder a mis preguntas.

9. Si yo firme este formulario de consentimiento sé que significa que:

  - Yo estoy tomando parte en este estudio porque quiero. Decidí participar en este estudio después de haber sido informado acerca del estudio y cómo me afectará.

  - Sé que soy libre de no participar en este estudio y que si decido no participar, entonces nada me va a pasar como consecuencia.

- Yo sé que me han dicho que si decide participar, entonces puede dejar de ser parte de este estudio en cualquier momento. Yo sé que si me dejan de ser una parte del estudio, entonces nada va a pasar conmigo.

- Que se le informe sobre cualquier información nueva que pueda afectar mi disposición a seguir participando en este estudio.

- El estudio se puede cambiar o suspender en cualquier momento por el investigador o por la Universidad de Texas en Tyler.

- El investigador obtendrá mi consentimiento por escrito de cualquier cambio que pueda afectarme.

10. Me han asegurado que que mi nombre no será revelado en los informes o publicaciones resultantes de este estudio sin mi consentimiento expreso por escrito.

11. También entiendo que cualquier información obtenida durante este estudio, incluyendo cualquier información relacionada con la salud, puede ser compartida con los siguientes, siempre y cuando ninguna información de identificación en cuanto a mi nombre, dirección, o información de contacto se proporciona):

- Organización de contribuir con dinero a poder llevar a cabo este estudio

- Otros investigadores interesados en combinar su información con la información de otros estudios

- La información compartida a través de presentaciones o publicaciones

12. Entiendo que la UT Tyler Junta de Revisión Institucional (el grupo que asegura que la investigación se hace correctamente y que las medidas son para proteger la seguridad de los participantes en la investigación) puede revisar los documentos que tienen mis datos de identificación de ellos como parte de su cumplimiento y el proceso de monitoreo. También entiendo que cualquier información personal revelada durante este proceso se mantendrá estrictamente confidencial.

13. Me han dicho de mí y yo entiendo los posibles riesgos esperados que están asociados con mi participación en este proyecto de investigación.

14. También entiendo que no voy a ser compensados por las patentes o descubrimientos que puedan derivarse de mi participación en esta investigación.

15. Si tiene alguna pregunta con respecto a mi participación en este proyecto, me pondré en contacto el investigador principal: Cheryl Swanson, 918-605-6499, cswanson4@patriots.uttyler.edu.

Usted puede también ponerse en contacto con su disertación Comité president, Dr. Susan Yarbrough, en la Universidad de Texas en Tyler (903-566-7220) o syarbrough@uttyler.edu

16. Si tiene alguna pregunta sobre mis derechos como sujeto de investigación, me pondré en contacto Dra. Gloria Duke, Presidente de la IRB, en el (903) 566-7023, gduke@uttyler.edu, o la Oficina de la Universidad de Investigación patrocinados:

La Universidad de Texas en Tyler
c / o Oficina de investigación patrocinada
3900 University Blvd. Tyler, TX 75799

Yo entiendo que puedo comunicarme con el Dr. Duke con preguntas sobre la investigación relacionada con las lesiones.

17. <u>CONSENTIMIENTO/PERMISO PARA PARTICIPAR EN ESTE ESTUDIO DE INVESTIGACIÓN</u>

Con base en lo anterior, doy mi consentimiento para participar en este estudio como se describe a mí. Doy permiso al investigador principal del estudio para inscribirme en este estudio. He recibido una copia firmada de este formulario de consentimiento.

____________________________________ ____________________
Firma del Participante Fecha

18. He discutido este proyecto con el participante, utilizando un lenguaje que sea comprensible y apropiada. Yo creo que tengo pleno conocimiento de este participante de la naturaleza de este estudio y sus posibles beneficios y riesgos. Yo creo que el participante entendió esta explicación.

____________________________________ ____________

Investigador / Investigador Principal Fecha

Appendix F: Interview Guide

Consent Code: ______________

Primary Question:

I am interested in learning more about the experiences and perceptions of immigrant Hispanic patients in healthcare settings. Would you please tell me about your last experience going to a health clinic or hospital?

Interview Guide Questions:

1. What was the reason you were at the clinic or hospital?
2. How did you communicate? (language used, translation services-offered in a timely manner, did healthcare providers look at you or the translator when communicating?)
3. Were you provided with privacy for your care and consulta? (How was the amount of time that was spent? Were your questions answered?)
4. What language were written materials in? (Were you able to understand them?)
5. What was done by nurses and doctors that made you feel they understood you, your culture, and background? (What made you feel your culture was respected? What kind of input were you given in your care? What did you think you needed or wanted…was that taken into consideration? Who in your family is important in your medical care…were they included in decisions if they were there?)
6. Tell me about a nurse or doctor you felt took very good care of you…very poor care of you. (What did they do to make you feel that way?)
7. What could be done to make the care you receive better?

Biosketch

BIOGRAPHICAL SKETCH

NAME Cheryl Swanson	POSITION TITLE Doctoral Candidate, University of Texas at Tyler Assistant Professor of Nursing, Oral Roberts University Anna Vaughn College of Nursing, Tulsa, Oklahoma
eRA COMMONS USER NAME (credential, e.g., agency login) cswanson4	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	MM/YY	FIELD OF STUDY
Oral Roberts University, Tulsa, Oklahoma	BSN	05/87	Nursing
University of Oklahoma, Tulsa, Oklahoma	MS	08/07	Nursing
University of Texas at Tyler, Tyler, Texas	PhD	05/12	Nursing

A. Personal Statement

The goal of the proposed research is to investigate the perceptions held by the immigrant Hispanic patient regarding the cultural competence of healthcare encounters. Specifically, I plan to conduct a state of the science review and a qualitative phenomenological study that addresses this topic. I have the expertise, leadership and motivation necessary to successfully carry out the proposed work. I have a broad background in nursing and healthcare missions, with specific training and expertise in working with members of the immigrant Hispanic population. As a doctoral student in nursing at the University of Texas at Tyler, I investigated current research on this topic through extensive literature reviews and health disparity report projects. Such scholarly activities laid the groundwork for the proposed research. As a result of these previous experiences, I am aware of the importance of frequent communication among project members and of constructing a realistic research plan, timeline, and budget. The current application builds logically on my prior work. In summary, I have a demonstrated record of accomplished and productive research projects in an area of high relevance for our increasingly diverse population, and my expertise and experience have prepared me to conduct the proposed projects.

B. Positions and Honors

<u>Positions and Employment</u>

2007 - Present	Assistant Professor of Nursing, Oral Roberts University, Anna Vaughn College of Nursing, Tulsa,OK

2005-2007	Adjunct Clinical Instructor, Oral Roberts University, Anna Vaughn College of Nursing, Tulsa, OK
1991 - Present	Staff Nurse, Cancer Treatment Centers of America at Southwestern Regional Medical Center, Tulsa, OK
1992-1995	Staff Nurse, St. Francis Hospital, Tulsa, OK
1987-1991	Staff Nurse, Tulsa Regional Medical Center, Tulsa, OK

Other Experience and Professional Memberships

2011 – Present	Member, Transcultural Nursing Society
2011 – Present	Member, Oklahoma Nurses Association
2009 – Present	Member, Nurses Christian Fellowship
2006 – Present	Member, Sigma Theta Tau International Honor Society of Nursing
1995 – Present	Member, American Association of Critical Care Nurses

Honors

2008 & 2010	Outstanding Nursing Faculty of the Year Award, Oral Roberts University, Tulsa, OK
1990	Who's Who in American Nursing

C. Selected Peer-reviewed Publications

Most relevant to the current application

1. Swanson, C. (2012). The case for studying cultural competence from the perspective of the Hispanic immigrant patient: A state of the science. *Online Journal of Cultural Competence in Nursing and Healthcare*, In Press.

D. Research Support

Completed Research Support

Tjelta Research Fund	Swanson (PI)	10/01/2011 – 03/29/2012