

**IMPROVING ACCESS TO CARE BY DETERMINING KEY ELEMENTS
OF CULTURALLY AND LINGUISTICALLY APPROPRIATE
HEALTHCARE INTERVENTIONS FOR HISPANIC POPULATIONS
IN TEXAS USING A DELPHI TECHNIQUE**

A Dissertation

by

LINDA MILAM PONDER

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2005

Major Subject: Health Education

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Approved by:

Co-Chairs of Committee,	B. E. Pruitt B. Lee Green
Committee Members,	Danny Ballard Craig Blakely Jeffrey Guidry
Head of Department,	Steve Dorman

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ABSTRACT

Improving Access to Care by Determining Key Elements
of Culturally and Linguistically Appropriate Healthcare Interventions
for Hispanic Populations in Texas

Using a Delphi Technique. (December 2005)

Linda Milam Ponder, B.A, Texas Tech University;

M.A., Texas Tech University

Co-Chairs of Advisory Committee: Dr. B. E. Pruitt
Dr. B. Lee Green

Cultural competence, mandated by Federal law since 1964, has not been appropriately addressed due to its lack of specifics and the lack of specifics within subsequent mandates. This study was designed to determine specific key elements of cultural and linguistic appropriateness which would “operationalize” cultural competence in the provision of healthcare services. Knowing the elements of cultural and linguistic appropriateness will assist non-Hispanic healthcare providers to remove personal barriers of cultural and linguistic differences for Texas’ Hispanic population.

The problem of cultural competence gained national focus during the Civil Rights movement of the ‘60s. Current research revealed that Hispanics continue to have the worst healthcare outcomes of any minority population. Census data reflecting that Hispanics are the fastest growing segment of the population, with Texas having the nation’s second largest Hispanic population, make it imperative for healthcare providers to determine methods to improve healthcare for Texas’ Hispanic population.

A Delphi Technique was used to extract expert opinions from 26 highly qualified, Texas Hispanic healthcare providers regarding the key elements of cultural and linguistic appropriateness for Texas' Hispanic population. The ultimate goal of the research was to determine essential information which would assist non-Hispanic healthcare providers in removing personal barriers of cultural and linguistic appropriateness to the delivery of healthcare services for Texas' Hispanics.

Through the approximately 16-month process of the Delphi Technique, the Panel produced 249 distinct elements in 11 groups of cultural appropriateness and 8 groups of linguistic appropriateness. Members of the Panel ranked the groups for importance, indicated the level of agreement/disagreement with each element, and rated each element for its individual importance.

This study is important because it is the first time an expert panel of solely Hispanic healthcare providers has spoken collectively about what constitutes cultural and linguistic appropriateness. This research can provide a framework for professional practices, grant providing organizations, or evaluation teams to assess professionals and programs to determine their degree of cultural and linguistic appropriateness. The work can also form the basis for curricula to be used in Texas' healthcare professions preparatory schools or continuing education for practicing healthcare professionals.

DEDICATION

To my family who always believed in the student in me.

To my daughter Leigh without whom I would still be a language arts teacher somewhere
in West Texas.

To my beloved Len whom I met at the water fountain shortly after coming to Aggieland
and who married me in spite of my being a graduate student.

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My deepest gratitude goes to the members of my Delphi Panel without whom the study could not have happened:

<p>Hector Balcazar, PhD Regional Dean and Professor of Health Promotion and Behavioral Sciences UT School of Public Health , El Paso Regional Campus El Paso</p>	<p>Cristina M González-Boles, BS, MA Assistant Professor & Content Expert UT Southwestern Medical Center at Dallas, Department of Physician Assistant Studies Dallas</p>
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<p>Yvonne Carillo-Brown, RN Faculty Associate, Texas Tech Orthopaedics (Retired), and Director of the West Texas Case Management Project for Children with Special Health Care Needs (Retired) El Paso</p>	<p>Jacobo Kupersztoch, PhD, MSc, BSc Executive Director, Centro Comunitario Mexicano DFW Secretaria, Comisión de Salud, Consejo Consultivo del Instituto de los Mexicanos en el Exterior IME/Secretaria de Relaciones Exteriores Dallas</p>
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<p>Miguel A. Escobedo, MD, MPH Medical Officer CDC El Paso Quarantine Station Centers for Disease Control and Prevention El Paso</p>	<p>Ciro V. Sumaya, MD, MPHTM Cox Endowed Chair in Medicine Dean, School of Rural Public Health Texas A&M Health Science Center College Station</p>
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<p>Pema B. Garcia, MA Texas A&M Colonias Regional Director, Western Region Texas A&M Colonias Project El Paso</p>	<p>Adolfo M. Valadez, MD, MPH Health Authority and Medical Director Austin /Travis County Health and Human Services Department Austin</p>
<p>Rebecca Garza, PhD Associate Director, Migrant Health Promotion REACH 2010 Principal Investigator REACH Promotora Community Coalition Progresso</p>	<p>Leonel Vela, MD, MPH Dean, Regional Academic Health Center (RAHC) of the University of Texas Health Science Center at San Antonio Harlingen</p>
<p>Paula S. Gomez Executive Director Brownsville Community Health Center Brownsville</p>	<p>Javier (Santos) Zelaya, MD ProSalud Physician Houston</p>

and my Review Panel:

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<p>Nellie Jimenez Clinical Supervisor Texas Ear, Nose, Throat and Allergy Associates Bryan/College Station</p>	<p>Nancy E. Vivas-Valdez, PhD Research Scientist Center for the Study of Health Disparities Texas A&M University College Station</p>
<p>Ricardo S. Lemos, MD Private practice physician in Infectious Diseases and Internal Medicine Bryan/College Station</p>	

I am grateful to all of them for their dedication to complete this study and encouragement throughout the rounds. These very busy Hispanic healthcare professionals, many of whom did not know me at the outset of the study, from around the state agreed with me that the health of Texas in general is directly tied to the health of its Hispanic population, and they were willing to give freely of their time to provide the best insight possible for this study.

I am grateful to Dr. P. J. Miller for her ongoing support and for sharing her technological expertise throughout my studies. I am especially grateful for her technological expertise on this project in formatting the hard copy version of Round III.

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In saying thanks to folks by name, one always runs the risk of leaving out someone who should have been named specifically. There are so many others who helped and encouraged me. You know who you are, and I am grateful to you, too!

NOMENCLATURE

CLAS	Culturally and Linguistically Appropriate Services
HDTF	Health Disparities Task Force
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IOM	Institutes of Medicine
NHLBI	US Department of Health and Human Services' National Institutes of Health's, National Heart, Lung, and Blood Institute
OMH	US Department of Health and Human Services' Office of Minority Health
SCBHI	Starr County Border Health Initiative
TDH	Texas Department of Health (Before 9-1-2004)
TDSHS	Texas Department of State Health Services (After 9-1-2004)
THHSC	Texas Health and Human Services Commission
THQA	Texas Health Quality Alliance
US	United States
USDHHS	US Department of Health and Human Services
UTMB	University of Texas Medical Branch

TABLE OF CONTENTS

	Page
ABSTRACT	iii
DEDICATION	v
ACKNOWLEDGMENTS.....	vi
NOMENCLATURE.....	x
TABLE OF CONTENTS	xi
LIST OF TABLES	xiii
 CHAPTER	
I INTRODUCTION.....	1
Statement of the Problem	6
Purpose of the Study	8
Definition of the Terms	8
Research Questions	10
Delimitations of the Study.....	10
Limitations of the Study	10
Value of the Study.....	11
II REVIEW OF THE LITERATURE.....	12
Health Disparities.....	12
Mounting Crisis of Population Increase and Provider Undersupply.....	19
Cultural Competency to Cultural and Linguistic Appropriateness	23
Attempting Compliance	27
Major National Research Projects with Hispanic Populations.....	36
Summary	40
III IMPROVING ACCESS TO CARE BY DETERMINING KEY ELEMENTS OF CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTHCARE INTERVENTIONS FOR HISPANIC POPULATIONS IN TEXAS USING A DELPHI TECHNIQUE	42

LIST OF TABLES

TABLE		Page
3.1	Delphi Panel	49
3.2	Review Panel.....	51
3.3	Delphi Process Table.....	52
3.4	Groups Summation Table.....	58
4.1	Delphi Panel Acknowledgment.....	73
4.2	Respect and Trust Framework.....	78
4.3	Respect and Trust User Card.....	82

CHAPTER I

INTRODUCTION

“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” With the passage of that simple sentence in the Civil Rights Act of 1964 (Title VI, Section 601), all people in the United States were assured access to healthcare services, as well as other services, appropriate to their race, color, or national origin. Providing those services in a manner deemed to be culturally competent by the language of Federal grants and applications, proved to be anything but simple, yet failure to provide such services became illegal (Tervalon, 2003).

Minority populations in the United States continued to lag behind whites on many of the Nation’s health indicators, including access to care, while surpassing whites in most acute and chronic disease rates (Kagawa-Singer & Kassim-Lakha, 2003; Smedley, Stith, & Nelson, 2003; The Sullivan Commission, 2004). Improving access to quality healthcare services, however, continued as a part of the Nation’s attempt to eliminate health disparities with *Healthy People 2010* making it the Nation’s overarching national priority. Access to quality healthcare services was described by the United States Department of Health and Human Services as occurring along a continuum with four major components: clinical preventive care services, primary care

This dissertation follows the style and format of *Health Promotion Practice*.

services, emergency care services, and long-term and rehabilitative care services (USDHHS, *Healthy People 2010*, 2000), see Figure 1.1.

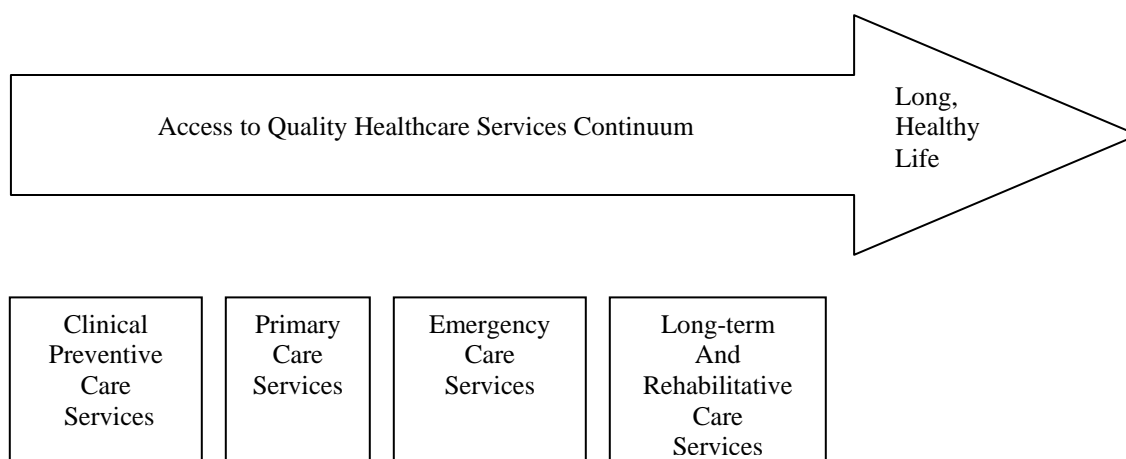


FIGURE 1.1 Access Continuum

Public health plays an important role in each of the components because of its role in educating people about prevention, addressing the need to remove preventive care access barriers, ensuring the availability of primary care, coordinating emergency services, and overseeing long-term and rehabilitative services. For the United States to realize the full potential of prevention, access to high-quality health services across the continuum must be improved (USDHHS, *Healthy People 2010*, 2000).

At the time that two agencies within the US Department of Health and Human Services (USDHHS) were developing *Healthy People 2010*, (2000) the Office of Minority Health (OMH), also in USDHHS, was developing National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Fourteen national standards were published in final form in the *Federal Register* on December 22,

2000. The standards had four mandates that became Federal requirements, nine guidelines that OMH recommended for adoption as mandates by Federal, state, and national accrediting agencies, and one standard that was recommended for voluntary adoption by practitioners. The standards were directed primarily at healthcare organizations, but individual healthcare providers were encouraged to use the standards to achieve more culturally and linguistically accessible services (OMH, 2000).

Texas leaders also recognized the need to improve access to healthcare services in order to eliminate health disparities, and the 77th Texas Legislature created a statewide Health Disparities Task Force in 2001. In their February 2003 *Health Disparities Task Force: Executive Summary for the 78th Legislature*, the Task Force made eliminating healthcare access disparities the number one goal. The Task Force recognized that people were Texas' most important resource and also acknowledged that public health was a key component in assuring a strong healthcare system.

According to the USDHHS, culturally diverse populations had a persistent disparity in health status compared to the United States population in general. This agency projected that over the next decade, the United States population would become even more culturally diverse with a lack of culturally and linguistically appropriate healthcare services as serious access issues requiring attention (*Healthy People 2010*, 2000). Purnell and Paulanka (2003) and the Pew Hispanic Center (2002) reported that Hispanics were the largest and fastest growing ethnic population in the United States, representing 12.5% of the population at the 2000 US Census accounting. Approximately one-half of this population resided in California and Texas.

Growth of the Hispanic population in Texas was significantly above the national average. The 2003 update of the US Census Bureau's 2000 data revealed that Texas had a total population of 21,547,821 and 35.34% of that total were Hispanic (US Census Bureau, 2004). That percentage more than doubled the national percentage of Hispanic presence. In addition 27% of the Texas Hispanic population over the age of 5 reported that Spanish was the language spoken at home (US Census Bureau, 2002). With release of the updated 2003 Census data, non-whites became the majority in Texas' population, but whites still maintained the plurality (Babineck, 2004). Analysis of the 2000 Census data by the Hispanic Research Center at the University of Texas at San Antonio revealed that a trend toward an increasingly Hispanic population in Texas should be expected because the Hispanic population of Texas was much younger than the non-Hispanic population, and the size of the Hispanic family was generally larger than that of non-Hispanic families. The data also showed that the number of Hispanic children under the age of five increased by 52% from 1990 to 2000 while the number of non-Hispanic children decreased by one percent. The Hispanic population growth makes it imperative that healthcare planners address their needs (Hispanic Research Center, 2002).

The problem of access to healthcare services was compounded in Texas because much of the state suffered health professional shortages sufficient to receive Federal designation as Health Professional Shortage Areas (HPSA). Of Texas' 254 counties, 131 were designated as whole county HPSAs and 48 were designated as partial county HPSAs. Sixty-seven of the 131 counties had a minority population of twenty percent or more and are also designated as HPSAs. Likewise, 33 of the 48 partial county HPSAs

had a minority population of twenty percent or more (Rural Health Unit, 2004). Since designation of HPSAs came in response to community requests or in response to the Federal requirement to update designations every three years, it was possible that there were areas where shortages of providers existed but no designation was made. Clearly in Texas, geographic areas with minority concentrations were suffering from shortages of practicing health professionals (Texas Department of Health, 2002).

In an attempt to address healthcare access issues for minorities, Objective 1.8 of *Healthy People 2010* targeted increasing the proportion of all health professional degrees awarded to underrepresented groups. The National target percentage for Hispanics was 12%, up from 4% for the combined health professions of medicine, dentistry, pharmacy and public health (USDHHS, 2000). Logic would suggest that since Texas had large areas designated as HPSAs and a population that was already about 35% Hispanic and projected to increase, getting to the national target of twelve percent, while laudable, would not significantly help Hispanic Texans with the access barriers of cultural and linguistic differences.

Both the governments of the United States in *Healthy People 2010* (USDHHS, 2000) and Texas in *Health Disparities in Texas: An Epidemiologic Review of Priority Health Outcomes* (Texas Department of Health, 2002) cited “personal barriers” as a major cause for disparities in access to quality healthcare services. Cultural and linguistic differences were two personal barriers impacting access to quality healthcare services.

Healthy People 2010 (USDHHS, 2000) explained that the term “culturally appropriate” refers to an unbiased attitude and organizational policy that values cultural diversity in the population served and reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age gender, sexual orientation, or generational and acculturation status. It includes awareness that cultural differences may affect health and the effectiveness of health care delivery while also including knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits. *Healthy People 2010* went on to explain that the term “linguistically competent” refers to skills for communicating effectively in the native language or dialect of the targeted population, taking into account general educational levels, literacy, and language preferences. These two terms seemed to be supplanting the previously used expression of “cultural competence” which the Texas Health Disparities Task Force defined as “the ability of a healthcare system to provide culturally appropriate care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and language needs (2003, p. 8).”

Statement of the Problem

Healthcare services, to be effectively accessible and to successfully maintain or improve health status, must be provided in a culturally and linguistically appropriate manner. The National Standards on Culturally and Linguistically Appropriate Services

in Health Care mandated linguistic access and recommended the requirement of cultural appropriateness while recognizing that simply hiring bilingual, bicultural healthcare professionals would not guarantee culturally competent care (OMH, 2000). Yet, most would agree that cultural and linguistic appropriateness best occurs when patients and providers are from the same ethnic group. In Texas, however, state census numbers projected that the Hispanic population would increase while the Texas Department of Health (now the Department of State Health Services) projected that the Hispanic provider population would remain constant. Only a fraction of the professionals in healthcare were Hispanic and most of the non-Hispanic professionals had limited knowledge of the Hispanic culture. Consequently, while well intentioned, much if not most of the healthcare services were neither culturally nor linguistically appropriate (Flores et al., 2002).

State contractors for health maintenance organizations (HMO) providing Medicaid services in Texas were required to provide the state with a cultural competency plan, but there was no such requirement for primary care case management models or traditional Medicaid beyond what was in Federal law. Random inspections by both the Texas Health Quality Alliance (THQA) and the Texas Department of Health (TDH) during 2000 showed that only 5 of 13 HMOs met the access standards for Spanish interpretation (Texas Health and Human Services Commission, 2000) stipulated by state requirements and Federal law on accessibility. *Healthy People 2010* stressed the need for special efforts to develop culturally appropriate and linguistically competent health

information to overcome the cultural differences of the expanding diverse populations (USDHHS, 2000).

A careful review of the literature revealed very little information properly gleaned from the Hispanic population about Hispanic cultural and linguistic appropriateness. Consequently, most efforts toward teaching and achieving cultural appropriateness and linguistic competence were too general to be of much value (Kumanyika, 2003). Texas demographics suggested a great need for better education and in-service training of this nature. Clearly, however, little could be accomplished without a careful delineation of the key elements of Hispanic cultural and linguistic appropriateness that would be respected by the Hispanic community.

Purpose of the Study

This study was designed to determine key elements of cultural and linguistic appropriateness in the provision of healthcare services to Hispanic patients. The product of this work was intended to assist non-Hispanic providers in removing personal barriers to healthcare delivery that result from cultural and linguistic differences for Hispanic populations in Texas. The ultimate goal of this study was to improve access to healthcare for Hispanics in Texas.

Definition of the Terms

The following terminology is defined for clarification and is used throughout this study:

Competence: having the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs of the consumers in their communities (OMH, 2000).

Culture: integrated patterns of human behavior including the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (OMH, 2000).

Cultural appropriateness: the healthcare services are respectful of and responsive to the cultural needs (OMH, 2000) of Texas' growing Hispanic population. Furthermore, it is an unbiased attitude and organizational policy that values cultural diversity in the population served and reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age gender, sexual orientation, or generational and acculturation status. It includes awareness that cultural differences may affect health and the effectiveness of health care delivery while also including knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits (USDHHS, *Healthy People 2010*, 2000).

Cultural competence: “the ability of a health care system to provide culturally appropriate care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and language needs (Texas Health Disparities Task Force 2003, p. 8).”

Linguistic appropriateness: the healthcare services are respectful of and responsive to the linguistic needs (OMH, 2000) of Texas' growing Hispanic population.

Linguistic competence: skills for communicating effectively in the native language or dialect of the targeted population, taking into account general educational levels, literacy, and language preferences (USDHHS, *Healthy People 2010*, 2000) .

Personal barriers: difficulties beyond the usual limitations in accessing healthcare such as shortages of healthcare providers and includes cultural differences and language differences between providers and patients (USDHHS, *Healthy People 2010*, 2000).

Research Questions

1. What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to eliminate personal barriers for accessing and receiving quality healthcare services?
2. What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to eliminate personal barriers for accessing and receiving quality healthcare services?

Delimitations of the Study

This study was delimited to a panel of 26 Hispanic experts who are bilingual, bicultural healthcare professionals working in a variety of healthcare-related fields in Texas.

Limitations of the Study

1. This study was limited by the commitment of the panel of experts.

2. The Delphi Technique employed in this study may not lend itself to a generalization of the results beyond Texas.

Value of the Study

This study determined key elements of cultural and linguistic appropriateness in the provision of healthcare services to assist non-Hispanic providers in removing personal barriers of cultural and linguistic differences for Hispanic populations in Texas. The Delphi Panel provided 249 elements, broken into 11 groups of cultural appropriateness and 8 groups of linguistic appropriateness, which formed a composite of cultural competence for non-Hispanic healthcare providers in Texas.

In an effort to break the overwhelming mass of information from the Delphi Panel into workable amounts, a framework was created for practical steps that healthcare professionals or organizations can take to make their services more culturally and linguistically appropriate for the Hispanic population of Texas. The work was begun within the area of “Respect and Trust” which the Panel ranked as their number one group of elements for both cultural and linguistic appropriateness. The framework was developed from the work of the Panel. The hope is that this framework will lead to a reduction of the personal barriers of cultural and linguistic differences which currently impede access to quality healthcare services and move Texas’ healthcare providers toward the goal of eliminating health disparities. These practical steps are of particular significance because they were provided by bilingual, bicultural Hispanic healthcare services professionals practicing in Texas at the time of the study.

CHAPTER II

REVIEW OF THE LITERATURE

Since the US Congress passed the Civil Rights Act in 1964, guaranteeing access to healthcare services appropriate to a person's race, color, or national origin, there has been a wealth of books, articles, and governmental reports written on cultural competency in the delivery of healthcare services. As recently as September 2004's release of The Sullivan Commission Report, *Missing Persons: Minorities in the Health Professions*, healthcare is, however, still beyond the reach of many Americans, especially those who are of racial and ethnic minorities. This chapter will present an overview of recent literature on the current state of health disparities, the mounting crisis of Hispanic population increase and provider undersupply, the need for cultural competence in healthcare services broken down into cultural and linguistic appropriateness, and major national research projects with Hispanic populations. Most of the literature reviewed was published in the last five years, but earlier important works are also included.

Health Disparities

Changing demographics have refocused the national spotlight on the old debates about cultural competence in healthcare (Howard, Andrade, & Byrd, 2001) because it is believed that cultural competence is a key element for improving access to care and eliminating disparities (Ramirez, 2003, The Sullivan Commission, 2004). The debates began in healthcare circles and Hispanic communities back in the 1970s (Howard et al.,

2001). Even though the US Congress passed the Civil Rights Act in 1964 guaranteeing culturally competent care (Title VI, Section 601), a large body of research revealed that racial and ethnic minorities were still experiencing a lower quality of care, prompting the US Congress in 1999 to request that the Institutes of Medicine (IOM) conduct a study to assess differences in the kinds and quality of healthcare experienced by racial and ethnic minorities. Taking into account factors known to impact access to care such as insurance coverage, income, age, co-morbid conditions, and symptom expression, the study revealed that racial and ethnic minorities were still less likely to receive routine and appropriate medical procedures than white Americans (Smedley, Stith, & Nelson, 2003).

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, the IOM report published in 2003 (Smedley et al.), presented the current status of disparities for racial and ethnic minorities in the US. A study committee of 15 members from around the US with expertise in clinical medicine, economics, healthcare services research, health policy, health professions education, minority health, psychology, anthropology and related fields reviewed data from recent scientific literature; commissioned papers; and held public forums with professional societies and organizations, technical liaison panels, and minority consumers in focus groups and roundtables. The study committee found some 600 articles, deemed to be primarily seminal works, published in the last 10 years that assessed racial and ethnic disparities in healthcare while controlling for differences in access to healthcare and socioeconomic levels. This body of literature was only a small sample of the published studies

investigating differences for racial and ethnic minorities in access to and use of healthcare services. The study committee commissioned seven papers, hosted four public workshops, and assembled four technical liaison panels. Focus groups were conducted for the committee by the Westat Corporation with six groups of 8 to 10 healthcare consumers: two groups of African Americans, one in Los Angeles, CA, and one in Rockville, MD; two groups of Hispanics, one in Los Angeles with individuals who self-identified as primarily English-speaking and one in Washington, DC, with individuals who self-identified as primarily Spanish-speaking; one group in Albuquerque, NM, of American Indians; and one group in Los Angeles of Chinese Americans who self-identified as primarily Mandarin-speaking. The study committee published four findings with one finding having two parts:

Finding 1-1: Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.

Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.

Finding 3-1: Many sources—including health systems, healthcare providers, patients, and utilization managers—may contribute to racial and ethnic disparities in healthcare.

Finding 4-1: Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.

Finding 4-2: A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse

treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain healthcare disparities (p. 19).

Of course, the study committee made recommendations for alleviating their findings. These recommendations fell into seven broad categories: general recommendations; legal, regulatory, and policy interventions; health system interventions; cross-cultural education in the health professions; data collection and monitoring; and research needs (Smedley et al., 2003).

At about the same time that the US Congress was requesting study of disparities faced by minority populations nationally, the Texas Legislature also began to request similar information specific to Texas. The Texas Legislature had established the Office of Minority Health inside the Texas Department of Health in 1993 to assume a leadership role in minority health issues including bilingual communication, maximal use of existing resources without duplication, and reports on the status of minority health in Texas to the legislature (TDH, 2001, February). In 2001, the concern over health disparities prompted the 77th Texas Legislature to create and Governor Perry to sign into law a statewide Health Disparities Task Force (HDTF). The HDTF consisted of nine members appointed three each by the Governor, Lieutenant Governor, and Speaker of the House with staggered two-year terms. Members had to represent at least one of the following areas: business, labor, government, charitable or community organizations, racial or ethnic populations, or community-based health organizations. In conjunction with the efforts of the HDTF, eight community forums were held around Texas seeking comments and recommendations appropriate for Texas (TDH, 2001, September). Their

findings were published in an Executive Summary in February 2003 with five recommendations in the areas of prevention; public/private insurance and access to care; cultural competency; tort reform; and specific actions for TDH programmatic areas. If implemented, the HDTF stated that the recommendations would make significant strides toward reducing health disparities in Texas. The overall recommendation was that “the Texas Legislature should commit to making health care a priority (p. 4).” Culturally competent and linguistically appropriate health care was an overriding and essential theme of all the recommendations (p. 4).

On September 1, 2004, the Texas Department of Health became the Texas Department of State Health Services (TDSHS) (Texas Department of State Health Services, 2004a, *Office of Minority Health*). In a document entitled *Transition Information*, the Commissioner of Health wrote that the Office of Minority Health would be in the Office of Public Health Practice, organized along a model similar to that of the federal Health Resources and Services Administration. Emphasis was placed on the fact that staff would continue to integrate minority health strategies, including multi-lingual communications, into all TDSHS programs and other health and human services programs as well. While the language of *Transition Information* said that future work would continue to reduce or lessen racial and ethnic health disparities, language supporting the continuation of cultural competency improvement or cultural and linguistic appropriateness was not included. According to *Transition Information*, the newly structured Office of Minority Health would focus on the six areas of health status for Texas by promoting childhood immunization and increased immunization rates

among minority populations; increased regular physical activity and fitness for racial and ethnic minorities; responsible sexual behavior among minority youth and adults; adequate prenatal care among minority women; decreasing obesity among racial and ethnic minorities; and discouraging tobacco use among minority youth. To carry out these activities, a background note explained that, the Texas Legislature budgeted \$2,000,000 for the Office of Minority Health in Fiscal Year 02-03, and \$700,000 for Fiscal Year 04-05. Since the document stated that TDSHS staff would continue to support the Health Disparities Task Force (TDSHS, 2004b), one logically could assume that the Health Disparities Task Force would continue to report to the Texas Legislature.

As the Texas Department of State Health Services faced a decreased budget and a reduced capacity for addressing health disparities, Texas was experiencing an increase in activities by its academic institutions to address health disparities. In March of 2003, the Texas A&M University Board of Regents approved the Center for the Study of Health Disparities in the Department of Health and Kinesiology (Watkins, 2004). In March of 2003, the Hispanic Research Center at the University of Texas San Antonio merged with the Metropolitan Research and Policy Institute to form the Culture and Policy Institute. The Hispanic Research Center was established in 1989 to conduct a broad spectrum of research on social, historical, political, and cultural issues for the nation's fastest growing population. The work of the Hispanic Research Center would continue and expand in the Culture and Policy Institute (Hispanic Research Center, 2003). In April of 2003, a \$7.5 million grant from the National Institutes of Health (NIH) was announced allowing the University of Texas School of Public Health at

Houston and the University of Texas Brownsville/Texas Southmost College to create the Hispanic Health Research Center in the lower Rio Grande Valley (\$7.5 million NIH grant creates U.T. center for studying Hispanic health issues, 2003). In July of 2004, the University of Texas at El Paso and the University of Texas at Houston Health Science Center announced the receipt of a \$4.1 million NIH grant to open the Hispanic Health Disparities Research Center (Center to explore health disparities among Hispanics, 2004).

Additionally, Texas has Centers of Excellence specifically funded by the federal government to train underrepresented minority students in the health professions (HRSA, 2003). Baylor College of Medicine and the University of Texas-Pan American has received financial support from the USDHHS to begin the Center of Hispanic Excellence in South Texas designed to increase the number of Hispanic physicians working in Hispanic communities (Hispanic Center of Excellence, n.d.a). The Medical Hispanic Center of Excellence at the University of Texas at San Antonio Health Science Center is made possible with support from the Division of Health Careers Diversity and Development, Bureau of Health Professions, HRSA, USDHHS to provide information on areas related to Hispanic health (Hispanic Research Center, 2003). Texas Tech University Health Sciences Center-El Paso has an Hispanic Center of Excellence to address the under-representation of minorities in the field of medicine and lack of access to culturally competent care for underserved individuals along the US-Mexico border (Hispanic Center of Excellence, n.d.b). The University of Texas College of Pharmacy recently received \$2 million from HRSA for the inclusion and development of Hispanic

students and faculty to better serve underserved minorities (Pharmacy Hispanic Center of Excellence, 2004). Building on the fact that the University of Texas Medical Branch (UTMB) ranks first in the state in minority recruiting and first nationally in the number of Hispanic physicians graduated, HRSA awarded them \$4.5 million to continue the efforts of their Hispanic Center of Excellence (News briefs: Dollars for diversity, n.d.).

Mounting Crisis of Population Increase and Provider Undersupply

2000 Census data documented that Hispanics are the largest yet most diverse of the minority populations in the United States, reaching this milestone several years before demographers had predicted. While two-thirds of the Hispanics are of Mexican origin, the remaining one-third come from at least 20 other national origin groups. Historically, Hispanic population growth was fueled by immigration, but future growth will be due to large numbers of the population being of child-bearing age with larger family expectations than non-Hispanic groups while other populations are growing older and having fewer children (Pew Hispanic Center, 2002).

Discussions of Hispanics in the US is complicated by the fact that the collection of information on Hispanics by US Census demographers was not begun until 1970 when the first question of Hispanic origin was included for a 5% sample of the population. The term “Latino” appeared on Census forms for the first time in 2000, and “Spanish/Hispanic/Latino” origin is about ethnicity, not about race. People self-selecting to identify as of Spanish/Hispanic/Latino origin may be of any race. That being said, US Census data reflects a 58% increase in the Hispanic population from 1990 to 2000 while the US population only increased by 13%. Half of all US Hispanics live

in either California or Texas with Texas having the second largest population of 6.7 million or 19% of all Hispanics (US Census Bureau, 2001). Texas, however, has the most homogeneous Hispanic population with 87.9% of them self-identifying as of Mexican origin rather than Puerto Rican, Cuban, or Other Hispanic or Latino (US Census Bureau, 2004).

A second complicating factor in the discussion of Hispanics in the US is in deciding what term to use since it is about ethnicity and not about race as is seen in the previous paragraph. Celestino Fernandez, a professor of sociology at the University of Arizona in Tucson said that the term Hispanic has been used for at least the last two censuses and is now ingrained in daily usage. He objected to the term, as do a number of prominent, outspoken leaders, but said that the debate is really about who is doing the naming. “It’s like the difference between African American, Colored, or Negro. That’s the issue: Who is naming you? (Granados, 2000).” President of Hispanic Trends, Sergio Bendixen had his company poll Hispanic/Latino registered voters because the question of calling someone Hispanic or Latino had been debated within the Hispanic/Latino community for years. Bendixen and his company could not find that the question of what the people preferred to be called had ever been asked. With his experience conducting polls and working for *Univision* and *Telemundo* where he was forbidden to use Hispanic on the air, Bendixen thought the term Latino would win overwhelmingly, but 65% of those polled preferred Hispanic while only 30% chose Latino. The sample in Texas showed that 67% preferred the term Hispanic (Granados, 2000, p. 2). Documents from the Texas Department of Health, Texas Health and Human

Services Commission, and University of Texas at San Antonio's Hispanic Resource Center use the term "Hispanic" (Hispanic Research Center, 2002, February; TDH, 2003, September; TDH, 2002, March; Texas Health Disparities Task Force, 2003; THHSC, 2000, November).

In September 2004, The Sullivan Commission published its report, *Missing Persons: Minorities in the Health Professions*. The Commission was an outgrowth of a grant from the W. K. Kellogg Foundation to Duke University School of Medicine to examine the stagnating enrollment of racial and ethnic minorities in nursing, medicine, and dentistry in spite of the growing diversity of the American population. Named for and headed by Louis W. Sullivan, M.D., former US Secretary of Health and Human Services, the Commission consisted of 16 expert members from health, business, higher education, and law while former US Senate Majority Leader Bob Dole and Congressional Health Subcommittee Chairman Paul Rogers served as Honorary Co-Chairs. Unencumbered by the constraints that often exist for governmental and quasi-governmental panels, the Commission held six field hearings and one nationally broadcast town hall meeting, examined existing research, and commissioned studies. The Commission found that while minorities make up about 25% of the population, they comprise only nine percent of the nation's nurses, 6% of its doctors, and 5% of its dentists. The Commission made 37 recommendations designed to achieve their new vision of well-trained, qualified, and culturally competent healthcare professionals who would reflect the diversity of the populations they served. Believing that the lack of minority health professionals compounds health disparities for the racial and ethnic

minorities and believing that the consequences of health disparities are grave, they developed three overarching principles to fulfill their vision of sustained national effort and commitment: “1) To increase diversity in the health professions, the culture of health professions schools must change. 2) New and nontraditional paths to the health professions should be explored. 3) Commitments must be at the highest levels (p. 3).”

Ten years of healthcare provider supply data collected by the Health Professions Resource Center at TDH revealed that Texas had large numbers of areas with a chronic undersupply of providers in general (2002, March). Logically one could assume that when access to healthcare in general is diminished because of broad-based undersupply, then access to culturally and linguistically appropriate care is further diminished because in the Texas healthcare professions, the numbers of minority professionals do not match the minority percentages in the general population. This seems problematic because language and cultural barriers deter individuals from seeking appropriate and timely healthcare services from providers who are unable to communicate with the patients or are unfamiliar with important cultural beliefs and customs (TDH, 2004). The most recent data on seventeen health professions shows that, in Texas, ratios of healthcare professionals in general are lower than for the US as a whole (TDH, 2003). In a 2004 professional development workshop, the Dean of the Texas A&M University Health Science Center School of Rural Public Health, emphasized that Hispanics are disproportionately underrepresented in virtually all of the health professions. He reported that in Texas, the population is about 30% Hispanic while only about 10 % of physicians, 6% of registered nurses, 12% of physician assistants, 11% of pharmacists,

and 6% of psychologists are Hispanic (Sumaya, 2004). Dr. Steve Murdock of the Texas State Data Center says,

While it is not imperative that the racial/ethnic status of health care personnel mirror that of the patient population, there will be an increasing demand for the diversification of the health workforce in Texas. The broad ethnic diversity of Texas calls for a workforce that is, at best, an ethnic/cultural reflection of the population, and at least, well educated in the cultures, customs, and health beliefs of the major population segments it serves. (TDH, 2001-2002, p. 245)

Simple arithmetic would indicate that while the national target of increasing Hispanic health professions graduates to 12%, up from 4% (USDHHS, *Healthy People, 2010*, 2000) is laudable, Texas would still be far from having the ideal that Murdock described and with the general dearth of healthcare providers, perhaps even far from having the least acceptable circumstance he described.

Cultural Competency to Cultural and Linguistic Appropriateness

Since the passage of the Civil Rights act of 1964, there has been an increasing amount of federal, with subsequent trickle down to state level, rules and regulations in response to the negative consequences of cultural and linguistic disparities (Brach & Fraser, 2000; OMH, 2000; Smedley et al., 2003; USDHHS, *Healthy People 2010*, 2000). In Texas, state level rules and regulations are found in such places as Medicaid (THHSC, 2000) and programs administered or assessed by the Texas Department of State Health Services (TDSHS), like those using monies from Title V, X, and XX. TDSHS uses a generic assessment form that it calls a Core Tool with every program it evaluates. (There are also some program specific assessment tools that can be additionally applied.) The elements of the Core Tool apply to all of its contractors, and

it begins with assessing a program's Civil Rights Act compliance as interpreted for Texas programs (TDSHS, n.d.). In 2003, the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care reported that, in spite of rules, regulations, and mandates, evidence still pointed to remarkably consistent evidence that racial and ethnic disparities existed in healthcare across a wide range of illness and healthcare services (Smedley et al., 2003). This supported earlier data from the 2002, Texas Department of Health report entitled, *Health Disparities in Texas: An Epidemiologic Review of Priority Health Outcomes*, which revealed that health disparities still existed and were identified within the numerous programs devoted to disease surveillance, risk reduction, and community education but were not necessarily the primary focus of program activities (TDH, 2002, March).

Betancourt et al., (2002) stated that cultural competence has emerged in the last few years as part of the strategy, suggested in such documents as *Healthy People 2010*, for reducing health disparities and improving access to and quality of care for minority populations; however, efforts to determine what culturally competent care looks like are still needed for many minority populations. Simultaneously, Flores et al. (2002) recommended more research specifically with Latino populations. They cited three common errors in academic study design that renders the data less useful for these populations: arbitrarily excluding non-English speakers from studies, assuming a study is ethnically and racially diverse when only black and white subjects are enrolled, and relegating Latinos to the "other" category in analysis of the data when they are now the largest minority group in the US. Failure to consider cultural and linguistic differences

can lead to a variety of adverse outcomes including medical errors, difficulty obtaining truly informed consent, inadequate analgesia, fewer prescriptions, use of harmful remedies, and decreased satisfaction with care. In a study of pediatric primary care, Latino parents cited language barriers as the single greatest impediment to accessing care with research documenting an average of 18 interpreter errors of clinical consequence per pediatric encounter when untrained interpreters were used. Flores et al. (2002) concluded that more research is needed on course content and structure for teaching cultural competence, medical errors in Latino populations, and cost effective ways to provide comprehensive interpreter services, especially since Latinos represent the largest racial/ethnic minority but are underrepresented at every level of the health care professions (2002).

The Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care found in its literature review that there was very little research on non-African-American minority populations (Smedley et al., 2003). The Sullivan Commission (2004) concurred that while health disparities existed for a broad number of minority populations, “the history is best documented for African-Americans (p. 32).” The Commission went on to postulate that the history of exclusion and inequality for African-Americans applies in many ways to all the minority populations in their encounters with a predominantly Anglo healthcare system. The Committee’s focus group data and other information, however, suggested that non-African-American minorities populations suffer greater challenges posed by the cultural and linguistic mismatches with healthcare providers. The Committee also made note of the wide

cultural and linguistic variation within subgroups of the various minority populations and concluded that more study on non-African-American populations and their subgroups was badly needed (Smedley et al., 2003).

In the 2003 report of the National Heart, Lung, and Blood Institute's (NHLBI) working group on epidemiologic research in Hispanic populations, it was noted that for use with Hispanic populations, data collection methodologies in general and with appropriate cultural contexts specifically are only minimally developed. They recommended that research be done to develop instruments relevant to Hispanic populations with particular attention to incorrect stereotypes and misconceptions in connection with cultural beliefs and acculturation which are not solely dependent on language differences.

Just as there was debate about whether the term should be Hispanic or Latino, there was differing in the literature on the use of the terms cultural competence, linguistic competence, cultural appropriateness, and linguistic appropriateness. *Healthy People 2010* (USDHHS, 2000) used the term, culturally appropriate, but paralleled it with the term, linguistically competent. Within the Culturally and Linguistically Appropriate Services (CLAS) standards, however, there was the use of the older terminology of cultural and linguistic competence, but there also emerged the newer terms of cultural and linguistic appropriateness. In response to public comments, Office of Minority Health (OMH) staff addressed the need for continuing the use of the mainstream term, cultural competence, while reasserting the need for the newer terms of

cultural and linguistic appropriateness for use with the package of activities described by the standards being set forth (OMH, 2000).

The OMH defined cultural and linguistic 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. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (2000, p. 80873).

The OMH then distinguished culturally and linguistically appropriate services as those “health care services that are respectful of and responsive to cultural and linguistic needs (2000, p. 80873).

Attempting Compliance

A healthcare professional attempting compliance with the CLAS standards would find a wealth of written material including the publication entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* with its extensive 10 year retrospective literature review (Smedley et al., 2003); various general books on cultural competence with their population specific chapters or sections (Bonder, Martin, & Miracle, 2002; Huff & Kline, 1999; Lassiter, 1995; Purnell & Paulanka, 2003; Spector, 2004); various books on cultural competence for specific populations (Aguirre-Molina, Molina, & Zambrana, 2001; de la Torre & Estrada, 2001; Power & Byrd, 1998); and a myriad of journal articles in various healthcare fields (Brach & Fraser, 2000; Brach & Fraser, 2002; Carrillo, Green, & Bettancourt, 1999; Flores, 2000; Howard et al., 2001;

Kagawa-Singer & Kassim-Lakha, 2003; Kleinman, Eisenberg, & Good, 1978; Koo & Koo, 2002; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Kumanyika, 2003; Ramirez, 2003; Tervalon, 2003). Many cross-cultural curricula have been developed to address the existing health disparities for minority populations, but they are not much used in medical education and have a serious potential for stereotyping because their categorical nature tends to tie a set of specific characteristics to all patients of a particular culture (Carrillo et al., 1999).

Examination of a small sample selection of various recent general books on cultural competence revealed that *Promoting Health in Multicultural Populations: A Handbook for Practitioners* (1999) by Huff and Kline is the longest book at 554 pages and attempted, as its title says, to be a “handbook” for healthcare practitioners. It was divided into seven parts with Part I containing general information about cross-cultural practice and Part VII containing conclusions about cross-cultural assessment and moving into the 21st century. Part II had four chapters across 75 pages devoted to working with Hispanic/Latino populations. The first chapter was an overview and brief history of Hispanic/Latino populations in the US. The second chapter was a guide for health promotion activities with the Hispanic/Latino populations. The third chapter was a case study with diabetes patients in a Texas barrio. The fourth chapter contained “tips” for working with Hispanic/Latino populations. Together, the four chapters provided an overview of Hispanic/Latino populations with many caveats that the information would not apply to all Hispanic/Latino patients/consumers.

Transcultural Health Care: A Culturally Competent Approach (2003), 2nd Edition, by Purnell and Paulanka was 376 pages long, divided into 21 chapters. Chapter I addressed diversity in general and the healthcare system. Chapter II described the Purnell Model for Cultural Competence. The remaining 19 chapters were devoted to different populations. People of Cuban, Mexican, and Puerto Rican heritage each had a chapter covering a total of 51 pages. Each chapter had the same format, providing information on the population in general, communication patterns, family structure, workplace issues, “biocultural” factors, high-risk behaviors, nutrition, pregnancy and childbirth practices, death and dying rituals, spirituality, healthcare practices, healthcare practitioners, and a cultural case study.

Rachel E. Spector’s *Cultural Diversity in Health and Illness* (2004), 6th Edition, spanned 375 pages. The contents were divided into three units. Unit I covered “Cultural Foundations” beginning with a discussion of National Standards for CLAS in Health Care, moving on to a discussion of the shifting demographics of the United States as reflected in the 2000 Census, and closing with a discussion of the dichotomy that is “Health and Illness.” Unit II looked at the variety of traditions that impact healthcare in this country. Unit III addressed health among the various US populations and devoted one chapter of 26 pages to “Health and Illness in the Hispanic Population.” The Hispanic populations addressed specifically were the Mexicans and the Puerto Ricans.

Multicultural Clients: A Professional Handbook for Health Care Providers and Social Workers (Lassiter, 1995) was a shorter work at 197 pages. The text included an introduction but was actually divided into 15 chapters, each dealing with a different

population. There were chapters on Cuban Americans and Mexican Americans, with a combined total of 25 pages. The chapters were all organized along the same pattern. First, there was a geographical introduction. Then, there followed sections of one to several paragraphs describing briefly the population in the United States, immigration, communication, socioeconomic status, chief complaint, family, elderly, child rearing, socialization patterns, religious beliefs and practices, culturally based health beliefs and practices, cultural dietary patterns, morbidity and mortality, beliefs about death and dying, and physical assessment. The source material dates ranged from 1974 to 1992.

Bonder, Martin, and Miracle (2002) took a very different approach from the previous general texts on cultural competence in *Culture in Clinical Care*. Their approach was based on disciplines of field-based research like anthropology and ethnography and focused on “learning how to ask (p. 9).” They referred to this as an inquiry-centered approach, and they emphasized that culture is constantly changing and contextual. They continued by saying that the provider-patient relationship stands to be damaged by presentations of rules and lists for understanding culture. This approach shaped the text into eight chapters dealing with culture in general ways it would present in healthcare settings or impact patients coming to healthcare settings. Specific examples were given from the viewpoint of a variety of populations such as the story of Lia Lee summarized from *The Spirit Catches You and You Fall Down* and the story of an Indiantown Mayan from *Maya in Exile: Guatemalans in Florida*.

The three texts surveyed that were totally devoted to the Hispanic population allowed 156 pages (de la Torre & Estrada, 2001), 278 pages (Power & Byrd, 1998), and

492 pages (Aguirre-Molina et al., 2001) respectively to address the healthcare needs of Hispanics and trying to explain Hispanic culture to non-Hispanic providers. Raul Yzaguirre reminded the reader in the foreword to *Health Issues in the Latino Community* that Latinos will soon be the largest minority group in the United States and that they have to “navigate a health care system that is often unfamiliar with—and sometimes hostile to—their culture, language, and beliefs (Aguirre-Molina et al., 2001, p. xvi).” Yzaguirre went on to note that there was still an incomplete picture of Latino health, even though more research is being done, and that the knowledge gained from studying one group will usually benefit other groups, improving the health of all Americans.

A sample of journal articles was also reviewed for this study and ranged from what Brach and Fraser (2000) referred to as the “seminal article (p. 182)” by Kleinman, Eisenberg, and Good (1978) on the importance of culture in healthcare to a variety of 2003 articles which also stressed the importance of culture in healthcare (Flores, et al., 2003; Kagawa-Singer & Kassim-Lakha, 2003; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Kumanyika, 2003; Ramirez, 2003; Tervalon, 2003). The articles logically seemed to indicate what The Sullivan Commission plainly stated in 2004, “cultural competence is systemically inadequate, compromising the delivery of high-quality care (p. 17).” The articles and The Sullivan Commission report concluded that enhancing cultural competence within the healthcare system will go a long way toward reducing health disparities for minority populations.

With regard specifically to Hispanic populations, Dr. Glenn Flores attempted to provide guidance for non-Hispanic providers in his 2000 article, “Culture and the

patient-physician-relationship: Achieving cultural competency in health care.” Flores examined five components of a culture’s effect on clinical care: normative cultural values, language, folk illnesses, parent/patient beliefs, and provider practices. He then suggested solutions to “ensure culturally sensitive care (p. 14).” In his section on normative cultural values, he briefly described five important Latino concepts: *simpatia*, politeness and pleasantness in the face of stress; *personalismo*, warmth and close personal contact; *respeto*, appropriate deferential behavior; *familismo*, loyalty to family outranking individual need; and *fatalismo*, unalterable, individual fate. Flores suggested honoring these values with simple alterations in the provider approach like taking a few minutes at the beginning of a patient visit to discuss family, friends, and school, maintaining a positive attitude, courtesy and social amenities throughout the visit, allowing time for family consultation on medical decisions, using formal language not familiar language, and rewording a patient’s fatalistic views. Flores also noted the seriousness of language problems impacting healthcare access, health status, use of health services, and health outcomes since 31 million Americans do not speak the same language as their healthcare providers. He provided a chart on the advantages and disadvantages of the four interpreter provider types, but stressed the importance of using trained interpreters in medical settings. In the section on folk illness, Flores used the examples of *empacho*, food stuck in the stomach or intestines from dietary indiscretions; *mal ojo*, evil eye or bad eye from too much admiration; and *mollera caida*, fallen fontanel from removing the breast or bottle too quickly from the infant’s mouth. Flores stated that most folk remedies are harmless and that the providers should stress the use

of biomedical interventions in addition to the folk remedies, but in the cases where the folk remedies are harmful, he suggested a similar treatment substitution like herbal tea for the harmful wormwood tea. In dealing with parent/patient beliefs, Flores first described the serious potential for delayed care and suggested using strategies similar to those for honoring cultural beliefs and folk illnesses. In the examination of provider practices, Flores stated that clinicians sometimes provide a lower quality of care to patients of a different culture. For example, in one study, Latinos were seven times less likely than whites to receive analgesia, and in another study of hospitalized, asthmatic, preschool children, Latino children were 17 times less likely to be prescribed a nebulizer for home use. To improve provider practices, Flores proposed a model to achieve cultural competency based on the five components (Latino concepts) of the article. He stated that the culturally competent provider would be familiar with the normative cultural values, use interpreter services, recognize and accommodate for folk illnesses, identify beliefs that might impede clinical care, and maintain vigilance for ethnic disparities. Flores noted that to do what he suggested would require outside resources such as consulting with colleagues from other ethnic groups, using published references, speaking with interpreters and community members from other ethnic groups, working to increase their own language skills, and outside monitoring for improvements in cultural competence. In conclusion, Flores warned, “. . . the culturally competent clinician needs to beware of the dangers of stereotyping (p. 21).”

Carrillo, Green, and Betancourt (1999) had also warned that cultural competence curricula structured categorically is potentially a stereotypic approach to cultural

competence training fraught with oversimplification. They gave an example of a black Cuban immigrant seeking healthcare in Harlem and posed the question of his being categorized as African American or Hispanic. The case can be further confused if there is consideration of socioeconomic factors. They described a cross-cultural approach that is patient-based. In their model, the cultural competence training required five units taught in four two-hour sessions. Module 1 is directed at general discussion of cultures and included a discussion of medical culture and the importance of the triad of empathy, curiosity, and respect. Module 2 emphasized sociocultural differences and the adverse medical affects which can arise from such misunderstandings. This module stressed the importance of asking about patient preferences. Module 3 discussed the meaning of illness from the patient's perspective, teaching the use of the patient's explanatory model. Module 4 urged the learners to explore the patient's social context for the illness, such as migration history, social networks, literacy, and class barriers between clinician and patient. Module 5 provided a framework for negotiating expectations, agenda, concerns, meanings, and values across cultures and socioeconomic levels. Each module had case studies for discussion and practice among the participants.

Betancourt, Green, and Carrillo (2002) revisited cultural competence in a field report prepared for The Commonwealth Fund. They acknowledged the emergence of cultural competence as a strategy to reduce health disparities in both access and quality of care, but they also recognized that it was an emerging field with much work still needed to determine key components of cultural competence. They found that while cultural competence is widely recognized as an integral part of eliminating disparities,

questions remain. Legislators ask what policies are needed to foster cultural competence. Administrators ask how to make managed care organizations more culturally competent. Academicians ask what to teach students in the healthcare professions about cultural competence. Providers ask how to deliver more culturally competent care. They also found that current systems of care are complicated for all users, and more so for those of limited English proficiency, and these same systems are poorly designed and not responsive to diverse patient populations. They visited four programs which experts had identified as being models of cultural competence: one academic, one governmental, one managed care and one community healthcare. They concluded that cultural competence occurs on three levels: organizational, systemic, and clinical. As in their previous work, they continued to stress the need to avoid stereotypes and to consider the relevance of socioeconomic factors. They did not provide a list of key components of cultural competence by which others could determine how to recognize a culturally competent program. Instead, they stated that cultural competence in healthcare requires an understanding of the communities being served and the sociocultural influences of the individuals seeking care. From their literature review, interviews, and site visits, they provided a discussion of a framework for defining cultural competence in healthcare.

Brach and Fraser (2002) made four business arguments or interrelated financial incentives for culturally competent healthcare: 1) appeal to minority consumers, 2) compete for private purchases business, 3) respond to public purchases demands, and 4) improve cost effectiveness. One in five Americans experience communication problems

while receiving healthcare. People with limited English proficiency have fewer provider visits, receive fewer preventive services, and have lower satisfaction with the healthcare encounter. While Brach and Fraser acknowledged that quality issues arise in homogeneous environments, the growing diversity between providers and patients increases the likelihood of diagnostic errors; missed opportunities for screening; failure to account for different differing medication responses; harmful drug interactions with prescribed medications and folk remedies; and patient non-compliance with prescriptions, self-care, and follow-up visits. Increasing cultural and linguistic competence provides a way to address flaws in the delivery system for the largest growing market segment of the population, thus increasing market share. There are financial incentives from private purchasers for doing well on quality measures of interest to minority groups. Culturally competent care is being required by public purchasers of healthcare like Medicare and Medicaid. It has proven to be more cost effective to provide culturally competent care because patients will more likely use routine screenings and immunizations, adopt healthier lifestyles, and receive appropriate and timely treatment.

Major National Research Projects with Hispanic Populations

“Few culturally competent health programs have been designed for Mexican Americans (Brown & Hanis, 1999, p. 226).” In a search for research projects with Hispanic populations, three seminal examples emerged: the San Antonio Heart Study, Project Dulce, and the Starr County Border Health Initiative. Extensive data base

searches of Cambridge Scientific Abstracts and Medline/EBSCO were made in search of how these projects insured that they were culturally competent.

The San Antonio Heart Study is a longitudinal project, conducted from 1979 to 1996 with the addition of the Mexico City Diabetes Study, conducted from 1990 to 1999 extending some of the work from the original study (Williams, Stern, & Gonzalez-Villalpando, 2004). A Medline/EBSCO search using the term “San Antonio Heart Study” found 135 journal articles from 1980 to 2004. In an abstract review of all 135 articles, the term “cultural competence” did not appear and provided no insight. A reading of three complete articles selected because the titles contained sociocultural implications (Hunt et al., 2002; Wei et al., 1996; Williams et al., 2004) failed to reveal any discussion of cultural competence in the study. Four attempts to contact Dr. Helen Hazuda, who was an author on all three articles, by email and phone to inquire about cultural competence in the San Antonio Heart Study produced no response.

Project Dulce began in 1998 in San Diego County, California to test a team approach to diabetic care with an added peer education component. The team consisted of a registered nurse/certified diabetic educator, bilingual/bicultural medical assistant, and bilingual/bicultural dietician. Peer educators were selected from patients with diabetes who appeared to be natural leaders. They were trained to use the Latino Health Access Program developed in Orange County, California, and later completed the Project Dulce training curriculum (Philis-Tsimikas et al., 2004). With 2 of the 3 professionals on the team being bilingual/bicultural, it was obvious that their presence was a key to the cultural competence of the program, but a Medline/EBSCO search

using the term “Project Dulce” produced no journal articles actually discussing the project’s cultural competence. A phone call to Leticia Lleva, MPH, program development specialist for Project Dulce, confirmed that the project team had not yet published the information on Project Dulce’s components of cultural competence. She did say that San Diego State University’s School of Public Health worked with Project Dulce staff on designing the components of cultural competence for the project with a Latino focus for the Latino population served in San Diego County. There was cultural competency and sensitivity training for all staff involved in the project, and the translators had to be certified as medical translators, even if they were bilingual/bicultural (Leticia Lleva, MPH, personal communication, March 10, 2004). The researchers noted that “there is a lack of culturally appropriate diabetes programs designed for the racial and ethnic groups at greatest risk (Philis-Tsimikas et al., 2004, p. 114).” They acknowledged that at the outset, implementation of this program was cost-incurring but projected that ultimately it would save money by keeping the patients healthier. They also acknowledged that a cost-effectiveness evaluation of the project was needed (Philis-Tsimikas et al., 2004).

The Starr County Border Health Initiative (SCBHI) conducted from 1994 to 1998 in Starr County, Texas, on the Texas-Mexico Border halfway between Brownsville and Laredo. The county’s residents are 97% Mexican American (Brown, Garcia, Kouzekanani, & Hanis, 2002). To begin the project, several systematic literature reviews of diabetes education literature since 1988 were completed. The search revealed a serious lack of research with the minority groups who bear a disproportionate share of

the burden of Type 2 diabetes. The reviews further revealed that culturally appropriate approaches for minority groups had rarely been investigated although it was noted that conventional interventions were ineffective. Hispanic groups in some areas were labeled noncompliant, although they were treated more often with insulin than other racial and ethnic groups. The SCBHI began Phase 1 with focus groups in the community to assess the unique needs of Starr County residents. In the focus groups, individuals directly and forcefully said, “If you plan to come down here and tell us not to eat our favorite Mexican American food, you might as well stay home (Brown & Hanis, 1999, p. 228)!”

The researchers knew that to be successful, the intervention needed to be carefully developed with input from potential participants. To that end, the researchers planned to:

- 1) employ bilingual Mexican American nurses and dieticians from the community;
- 2) use videotapes made in Starr County with local people;
- 3) focus on realistic recommendations consistent with Mexican American preferences; and
- 4) offer the instruction in Spanish.

To begin Phase 2, researchers reviewed available materials searching for pamphlets, videotapes, and other materials in Spanish and found few. Researchers, using Starr County local people, developed seven 15-minute videotapes in Spanish based on priorities from the literature review, national diabetes education standards, and focus group input. At the same time, intervention teams were trained. The standard team was a nurse, dietician, physician, psychologist, and perhaps pharmacist and podiatrist; however, in rural settings the general lack of healthcare professionals precluded the use of such teams. In Starr County, there were four teams each with a bilingual, Mexican American area resident nurse and dietician with training

in diabetes education and management from courses at the Texas Medical Center in Houston. There were also eight community workers chosen as peer educators who had to be bilingual high school graduates, residents of Starr County, licensed to drive, and diagnosed with Type 2 diabetes. They were given eight weeks of training on diabetes self-management. Phase 3 involved measures of intervention effectiveness. The researchers development of a Spanish-language evaluation instrument in 1989 specifically for the lower level reading skills of the Starr County population (Brown & Hanis, 1999) was sufficiently complex to warrant a separate article detailing its development (Garcia, Villagomez, Brown, Kouzekanani, & Hanis, 2001). Phase 4 was the pilot testing of the intervention with an eight week version of the program. In Phase 5, thirty-two groups received the year long intervention and baseline data was gathered (Brown & Hanis, 1999).

Summary

This chapter is a review of recent research at both the national and state (Texas) levels on health disparities experienced by racial and ethnic minorities, the mounting crisis posed by the increasing Hispanic population and their under-representation in the healthcare professions, the status of cultural competency within the healthcare system, and major national research projects with Hispanic populations. Health disparities exist because the healthcare system was designed to care for a dominant white majority. Even though the Civil Rights Act of 1964 made it illegal to discriminate in the provision of healthcare services, disparities in healthcare and health status still exist today due to entrenched patterns of inequality in the healthcare system and forms of unconscious bias.

Much research has been done with African American populations, and there is a wealth of researchers recommending more research for other minority populations, especially Hispanics since they are the fastest growing minority group. With the under-representation of Hispanics in the healthcare professions, initial research will have to be done by non-Hispanics. This need for research with Hispanic populations by non-Hispanics brings cultural and linguistic differences into play. Current research seemed to suggest that cultural competence or at least cultural and linguistic appropriateness would go a long way toward lessening health disparities for all minority populations, but to date there are only recommendations for improvement and a few programs moving toward fulfillment of the recommendations. Those few programs achieve their levels of cultural competence by employing bilingual/bicultural staff. In Texas, the growing gap between the percentage of total Hispanic population and percentage of Hispanic healthcare professionals will not make that a practical solution in the foreseeable future. In this second area, there will be a need for the gap to be filled in the near term by non-Hispanics and again cultural and linguistic differences come into play.

CHAPTER III

**IMPROVING ACCESS TO CARE BY DETERMINING KEY ELEMENTS
OF CULTURALLY AND LINGUISTICALLY APPROPRIATE
HEALTHCARE INTERVENTIONS FOR HISPANIC POPULATIONS
IN TEXAS USING A DELPHI TECHNIQUE**

“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” With the passage of that simple sentence in the Civil Rights Act of 1964 (Title VI, Section 601), all people in the United States were to have access to healthcare services, as well as other services, appropriate to their race, color, or national origin. Providing those services in a culturally competent manner has proven to be anything but simple, yet it is against the law to fail to provide such services (Tervalon, 2003). One then should logically ask if providing culturally competent healthcare services is the law of the land, why isn't it happening.

Problem

To be accessible, healthcare services need to be provided in a culturally and linguistically appropriate manner. Such cultural competence might be assumed if healthcare providers were from the same cultural background as their patients. Such is not the case with Hispanic consumers of healthcare in Texas. Most providers of healthcare services are not Hispanic, and that is expected to be the norm for the

foreseeable future. Thus, many, if not most, of the services provided to Hispanic patients are neither culturally nor linguistically appropriate (Flores et al., 2002). One cannot conceive that healthcare service providers willingly choose to be culturally incompetent. The next logical question should then be with all the mandates and requirements, what are the elements of cultural and linguistic appropriateness that would take healthcare organizations or individual providers along a path toward cultural competence?

Context/Background

The overarching goal for both the Nation and Texas is to achieve systemic cultural competence. Such competence would be demonstrated by a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables effective work in cross-cultural situations. The term culture refers to integrated patterns of human behavior including the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (OMH, 2000). The term competence refers to having the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs of the consumers in their communities (OMH, 2000).

Healthy People 2010 stressed the need for special efforts to develop culturally appropriate and linguistically competent health information to overcome the cultural differences of the expanding diverse populations (USDHHS, 2000). The National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS)

mandated linguistic access and recommended the requirement of cultural appropriateness while recognizing that simply hiring bilingual/bicultural individuals does not guarantee culturally competent care (OMH, 2000).

Texas leaders also recognized the need to improve access to health services in order to eliminate health disparities, and the 77th Texas Legislature created a statewide Health Disparities Task Force in 2001. In their February 2003 *Health Disparities Task Force: Executive Summary for the 78th Legislature*, the Task Force made eliminating healthcare access disparities its number one goal because it recognized people as Texas' most precious resource. The Task Force also acknowledged that public health is a key component in assuring a strong health system.

Ten years of healthcare provider supply data collected by the Health Professions Resource Center at the Texas Department of Health (TDH) revealed that Texas had large numbers of areas with a chronic undersupply of providers in general (2002, March). Logically one could assume that when access to healthcare in general is diminished because of broad-based undersupply, then access to culturally and linguistically appropriate care is further diminished because in the Texas healthcare professions, the numbers of minority professionals do not match the minority percentages in the general population. This seems problematic because language and cultural barriers deter individuals from seeking appropriate and timely health services from providers who are unable to communicate with the patients or are unfamiliar with important cultural beliefs and customs (TDH, 2004). The most recent data on seventeen health professions shows that, in Texas, ratios of healthcare professionals in general are lower than for the US as a

whole (TDH, 2003). In a 2004 professional development workshop, the Dean of the Texas A&M University Health Science Center School of Rural Public Health emphasized that Hispanics are disproportionately underrepresented in virtually all of the health professions. He reported that in Texas, the population is about 30% Hispanic while only about 10% of physicians, 6% of registered nurses, 12% of physician assistants, 11% of pharmacists, and 6% of psychologists are Hispanic (Sumaya, 2004). Murdock of the Texas State Data Center says,

While it is not imperative that the racial/ethnic status of health care personnel mirror that of the patient population, there will be an increasing demand for the diversification of the health workforce in Texas. The broad ethnic diversity of Texas calls for a workforce that is, at best, an ethnic/cultural reflection of the population, and at least, well educated in the cultures, customs, and health beliefs of the major population segments it serves (TDH, 2001-2002, p. 245).

Simple arithmetic would indicate that while the national target of increasing Hispanic health professions graduates to 12%, up from 4% (USDHHS, *Healthy People, 2010*, 2000) is laudable, Texas would still be far from having the ideal that Murdock described and with the general dearth of healthcare providers, perhaps even far from having the least acceptable circumstance he described.

Since the census numbers projected that the Hispanic population in Texas is going to continue to increase while the TDH provider numbers projected an Hispanic provider population that will remain constant around 9%, it seemed practical to begin by addressing a part, cultural and linguistic appropriateness, of the whole, cultural competence, that Flores (2000) suggested is a cause of poorer outcomes for Hispanic populations. Cultural and linguistic appropriateness would mean that the health services

are respectful of and responsive to the cultural and linguistic needs (OMH, 2000) of Texas' growing Hispanic population.

Most efforts toward teaching and achieving cultural appropriateness and linguistic competence are too general to be of much value (Kumanyika, 2003). A healthcare professional attempting compliance with the CLAS standards would find a wealth of written material including the publication entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* with its extensive 10 year retrospective literature review (Smedley et al., 2003); various general books on cultural competence with their population specific chapters or sections (Bonder, Martin, & Miracle, 2002; Huff & Kline, 1999; Lassiter, 1995; Purnell & Paulanka, 2003; Spector, 2004); various books on cultural competence for specific populations (Aguirre-Molina, Molina, & Zambrana, 2001; de la Torre & Estrada, 2001; Power & Byrd, 1998); and a myriad of journal articles in various healthcare fields (Brach & Fraser, 2000; Brach & Fraser, 2002; Carrillo, Green, & Bettancourt, 1999; Flores, 2000; Howard et al., 2001; Kagawa-Singer & Kassim-Lakha, 2003; Kleinman, Eisenberg, & Good, 1978; Koo & Koo, 2002; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Kumanyika, 2003; Ramirez, 2003; Tervalon, 2003). Many cross-cultural curricula have been developed to address the existing health disparities for minority populations, but they are not much used in medical education and have a serious potential for stereotyping because their categorical nature tends to tie a set of specific characteristics to all patients of a particular culture (Carrillo et al., 1999).

Purpose

This study was designed to determine key elements of cultural and linguistic appropriateness in the provision of healthcare services to assist non-Hispanic providers in serving Hispanic populations in Texas.

Methodology

Nowhere in the literature was there an elemental breakdown of what constituted culturally and linguistically appropriate healthcare services, either nationally or in Texas. Additionally, nowhere in the literature could it be found that a group of solely Hispanic healthcare professionals had ever been asked to help delineate these elements. From the literature review, it was apparent that this work was much needed for bettering access to healthcare for Hispanics in Texas until such time as the provider base matches the diversity of the population.

Various types of information can be represented as points on a continuum with one extreme being labeled “knowledge” and the opposite extreme being labeled “speculation.” In the field of public health “knowledge” is often very hard to achieve, but the grey area between the extreme points that can be called “wisdom,” “insight,” or “informed judgment” is present if one only seeks it out. The Delphi Technique is a good tool to use in public health and social services when there is more known than mere speculation, but knowledge has not yet been achieved, and there is a complex problem at hand which needs addressing by a geographically dispersed group of experts in a structured communication process (Adler & Ziglio, 1996).

A Delphi Technique based on the work of Delbecq, Van de Ven, and Gustafson (1975) was chosen for this study. Two research questions began this study: 1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? 2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

Since the researcher was not a bilingual (possessing competent language skills in both English and Spanish), bicultural (functioning comfortably in both Hispanic and Anglo healthcare settings) Hispanic, three key bilingual, bicultural Hispanic healthcare professionals in the state of Texas assisted in the nomination process to obtain the panel of respondents: Dr. Eduardo Sanchez, Commissioner of the Texas Department of State Health Services, Dr. Ciro Sumaya, Cox Endowed Chair in Medicine and Dean of the School of Rural Public Health in the Texas A&M Health Science Center, and Dr. Amelie Ramirez, Professor in the Department of Medicine, Deputy Director of the Chronic Disease Prevention and Control Research Center, and Associate Director for Community Research at the San Antonio Cancer Institute in the Baylor College of Medicine.

Because Texas is such a large state, and there are numerous fields in healthcare services, the panel consisted of three members from each of Texas' eight "functional" public health regions. The professionals were selected from a variety of healthcare services providers. The panel began with 26 members, see Table 3.1, instead of 24

because of two delayed affirmative responses. (All 26 Panel members participated in Rounds I and II; however, one Panel member was unable to participate in Round III. As a result, the percentage of agreement and importance rating are based on 25 responses.)

TABLE 3.1
Delphi Panel

<p>Hector Balcazar, PhD Regional Dean and Professor of Health Promotion and Behavioral Sciences UT School of Public Health , El Paso Regional Campus El Paso</p>	<p>Cristina M González-Boles, BS, MA Assistant Professor & Content Expert UT Southwestern Medical Center at Dallas, Department of Physician Assistant Studies Dallas</p>
<p>Jaime Barceau, MSSW Executive Director El Paso Rehabilitation Center El Paso</p>	<p>David Gonzalez Admissions Counselor Tyler Junior College (At the beginning of the study, Women & Children's Program Coordinator Northeast Texas Public Health District) Tyler</p>
<p>Judith F. Blevins, RN ADN, Tyler Junior College Public Health Nurse, North East Texas Public Health District Tyler</p>	<p>Norma Gutierrez, RN, BSN Performance Improvement/Health Disparities Coordinator South Plains Health Provider Org., Inc. Plainview</p>
<p>*Maria Montes-Boydston Health Initiatives Program Coordinator American Cancer Society Houston</p>	<p>Alfonso Holguin, Jr., MD, MPH Professor of Public Health and Epidemiology - UT School of Public Health, San Antonio Regional Campus (Retired) Program Director, Health Education Training Center Alliance of Texas (Retired) United States Public Health Service Commissioned Officer, Medical Director, CDC, 1959-1974 (Retired) San Antonio</p>
<p>Yvonne Carillo-Brown, RN Faculty Associate, Texas Tech Orthopaedics (Retired), and Director of the West Texas Case Management Project for Children with Special Health Care Needs (Retired) El Paso</p>	<p>Jacobo Kupersztoch, PhD, MSc, BSc Executive Director, Centro Comunitario Mexicano DFW Secretaria, Comisión de Salud, Consejo Consultivo del Instituto de los Mexicanos en el Exterior IME/Secretaria de Relaciones Exteriores Dallas</p>
<p>Vicky Contreras, MSW, LCSW Director of Social Work Services Texas Department of State Health Services (DSHS) San Antonio</p>	<p>Guadalupe Palos, RN, LMSW, DrPH Instructor, Clinical Research Faculty Division of Internal Medicine Department of Symptom Research M.D. Anderson Cancer Research Center Houston</p>

TABLE 3.1 Continued

Leslie L. Cortes, MD Director, Medical Quality Assurance Department of Aging and Disability Services Austin	Amelie G. Ramirez, DrPH Professor, Department of Medicine Deputy Director, Chronic Disease Prevention and Control Research Center Associate Director for Community Research, San Antonio Cancer Institute Baylor College of Medicine, San Antonio Cancer Institute San Antonio and Houston
Jessica De La Cruz Dental Assistant Hart School-based Health Clinic Hart	Eduardo J. Sanchez, MD, MPH Commissioner, Texas Department of State Health Services Chief Health Officer of Texas Austin
Miguel A. Escobedo, MD, MPH Medical Officer CDC El Paso Quarantine Station Centers for Disease Control and Prevention El Paso	Ciro V. Sumaya, MD, MPHTM Cox Endowed Chair in Medicine Dean, School of Rural Public Health Texas A&M Health Science Center College Station
Maria Garcia, MEd Program Director, Uniting Parents Coalition of Health Services, Inc. Amarillo	Mary Thrasher Parents Anonymous Tyler
Pema B. Garcia, MA Texas A&M Colonias Regional Director, Western Region Texas A&M Colonias Project El Paso	Adolfo M. Valadez, MD, MPH Health Authority and Medical Director Austin /Travis County Health and Human Services Department Austin
Rebecca Garza, PhD Associate Director, Migrant Health Promotion REACH 2010 Principal Investigator REACH Promotora Community Coalition Progreso	Leonel Vela, MD, MPH Dean, Regional Academic Health Center (RAHC) of the University of Texas Health Science Center at San Antonio Harlingen
Paula S. Gomez Executive Director Brownsville Community Health Center Brownsville	Javier (Santos) Zelaya, MD ProSalud Physician Houston

*Indicates the inability to contribute responses in Round III.

Additionally, a group of five local bilingual, bicultural Hispanic healthcare professionals, see Table 3.2, who were not an actual part of the Delphi Panel were selected by the researcher to review the two blank questions and the beginning round of communication prior to its use with the expert panel.

TABLE 3.2
Review Panel

<p>Alma M. Fonseca, EdD County Extension Agent-Family and Consumer Sciences Texas Cooperative Extension, Texas A&M University System Bryan</p>	<p>Alejandra Mejia, MA Counselor Illinois School of Professional Psychology now operating under Argosy University, Chicago Campus College Station</p>
<p>Nellie Jimenez Clinical Supervisor Texas Ear, Nose, Throat and Allergy Associates Bryan/College Station</p>	<p>Nancy E. Vivas-Valdez, PhD Research Scientist Center for the Study of Health Disparities Texas A&M University College Station</p>
<p>Ricardo S. Lemos, MD Private practice physician in Infectious Diseases and Internal Medicine Bryan/College Station</p>	

While there was the three person nominating panel who was known to the potential panel members, it was possible that the Panel members could have assumed that the nominators were also Panel members. The Panel members, however, were not told specifically that the nominating panel members were members of the actual Delphi Panel. During this Delphi Technique, the identity of the Panel members was kept anonymous throughout the process. The Panel members' identities were revealed in the Preliminary Report of Results sent out by email on August 31, 2005.

This study was a three round format Delphi Technique that was computerized to be an e-Delphi Technique; however, because some members needed to use phone and mail responses in Rounds II and III to accommodate their schedules and the timelines of the study, it did not conclude as a true e-Delphi Technique. The study began with the Round I blank questionnaire which was composed of the two research questions and the one page cover letter. After review by the group of five local bilingual, bicultural

Hispanic healthcare professionals, the blank questionnaire and cover letter were emailed to the Delphi Panel of experts. Since maintaining the original composition of the Panel was important, each round had many “dunning” (polite prompting/reminding/pleading) emails and phone calls with some letters needed in Round III to obtain responses. The Panel was composed of busy Hispanic healthcare professionals who agreed to participate without compensation; therefore, in every round, timelines had to slip in order to accommodate their professional circumstances. From the beginning of the study and the soliciting of nominators, through assembling the actual Delphi Panel, to completing all three rounds of the study, this study took approximately 16 months, from May 2004 to August 2005, see Table 3.3.

TABLE 3.3
Delphi Process Table

Rounds	Number of Respondents	Type of communication	Time	Task for Respondents	Task for Researcher
Nominating	3	Face to face, email	5-1-04 to 8-31-04	Provide a list of qualified (healthcare professional practicing in Texas) prospective Panel members with phone numbers and email addresses	Compile the list of nominees, divide the pool into their 8 respective “functional” public health regions, contact multiple nominees first, contact other nominees striving for diversity of healthcare professions, secure commitment of participation from 24 nominees dispersed throughout Texas
I	26	Email	9-1-04 to 10-31-04	Answer the two research questions however it was easiest for each respondent	Aggregate the responses into some logical order while reducing any redundancies

TABLE 3.3 Continued

Rounds	Number of Respondents	Type of communication	Time	Task for Respondents	Task for Researcher
II	26	Email, phone	11-2-04 to 1-27-05	Review the list of elements with the researcher imposed groupings to see if 1) the respondent's particular elements had been included accurately; 2) there were missing elements that needed to be added; 3) the groupings seemed appropriate; 4) there were other comments to be made	Make the Panel's recommended corrections, reduce any redundant responses, solicit further clarification from specific Panel members regarding his/her particular element causing confusion for other Panel members, incorporate Panel member's comments where appropriate, format the list of elements so that the Panel could agree/disagree with each element, rate it for importance, and rank the groups of elements
III	25	Email, phone, electronic portal, mail	4-12-05 to 8-31-05	Agree/disagree with each of the 249 elements, rate each element for importance, rank the groups of elements in order of importance, make any additional comments desired	Tally the percentage of agreement for each element, formulate an importance rating for each element, rank the groups of elements based on the Panel's cumulative ranking, coordinate comments, prepare a summative report for the Panel

Round I responses came in as lists of elements, narrative stories of Panel members' experiences, and a previously published journal article by one panel member. The elements were extracted, aggregated, made grammatically parallel, and like responses reduced to a single response forming a single-spaced, 32-page document with no numbering system so as not to appear to give numeric importance to any element. So many responses, more than the researcher anticipated, came in to both questions that it

seemed logical to break related responses into named groups, 12 for cultural appropriateness and 10 for linguistic appropriateness. Many elements were as one would expect and represented by single statements such as, “For some providers, cultural appropriateness is very narrow and lacks specificity.” (100% agreement; 3.08 importance rating) Many other elements, however, were individually quite lengthy and detailed such as:

All translations need to have a 6 step process: 1. First translation from English to Spanish should be done by a trained translator fluent in both languages. 2. The translation should be reviewed by a group of people representing different Hispanic sub-groups (or if the instrument is going to be used with only 1 group, representatives from that group). The members should have different educational backgrounds as well as different countries or regions of origin. 3. Have the group back-translate the “translated instrument.” 4. Discuss any differences, and test the differences with people from the community. For example, it was found out that “excruciating” was a word that could be translated into Spanish linguistically; however, Hispanic people had a hard time conceptualizing the difference between “excruciating” pain and “very severe” pain. Pain that bad was pain that bad, so in the mind of an Hispanic why was another word like “excruciating” needed? 5. Repeat the process until consensus is reached on the translation. 6. The goal is to make the tool as “generic Spanish “as possible. (Then begin the usual validation and reliability processes. Lastly, publish the results and share, so the tool will not have to be re-invented.) (88% agreement; 3.12 importance rating), or

Providers need to approach all patients (English speaking, foreign, non-foreign, etc.) with a general framework for the patient-provider interaction that is respectful and shares power with the patient. This requires a huge paradigm shift that most providers find threatening. It requires providers to “let go” in order to “get back.” What they let go is the power of their provider title, the power of knowledge, the power of expert. What they gain is patient trust, confidence, improved compliance, and ultimately, better outcomes, and hence a stronger patient-provider bond. This framework involves the following and is based on the visionary work of Arthur Kleinman, and carried on by others like J. Emilio Carrillo, Alexander Green, and Joseph Betancourt. The framework is based on the explanatory model of disease for patients that has been used successfully with patients of any culture to bridge cultural gaps. The paradigm shift moves away from one of cultural stereotypes (what do I do for Hispanics?) to a broader line of questions that are applicable to all patients. The first question to ask the patient

is, "What do you think causes what you have, or what do you think you have?" This simple question serves several purposes beyond what is on the surface. First, it shares power with the patient by saying "I respect you and I want to know what you are thinking." Secondly, it reveals that the provider is willing to share power by making the patient the expert. It also signals to the patient that it is acceptable to talk about his worldview and provides insight into how he views illness and disease. Follow up questions include asking: How long the illness has lasted? How does one treat it? What is its usual course, etc.? These questions again strengthen the provider-patient relationship by building trust, sharing power, and enabling the patient to begin to discuss culture-bound syndromes (susto, empacho, etc.) as well as culturally acceptable home remedies and alternative therapies. Knowledge or lack of knowledge about disease and prevention is also important to assess. Thus a simple line of questioning does much to move away from cultural stereotypes, power imbalance, and provider/patient dissatisfaction towards respect for differences, power sharing, and improved satisfaction, all working toward better outcomes. (96% agreement; 3.52 importance rating)

These elements, of the many generated, are offered only as an example of how much thought and effort the Panel put into its work.

Round II was sent out by email with the request to the Panel to check all responses for accuracy and clarity, add any forgotten or additional responses desired, and provide comments arguing for or against items of special interest. Already, after Round I, the list of elements had become quite lengthy making the Panel's work in Round II quite time consuming. Again, in Round II, like responses were reduced to single statements, groups were reorganized based on Panel comments, and additions and corrections were made. As an example, it was suggested that under cultural appropriateness the separation of respect and trust into different groups was unnecessary, so that pair of groups was condensed into one. The groups in linguistic appropriateness had two changes with respect and trust again collapsing to form one group, and time and

patience also collapsing to form one group. For linguistic appropriateness it was suggested that a companion element be formed for the cultural appropriateness element:

Depending on how well the concepts are developed by the provider, there could be a cultural competence continuum that may be operating. The continuum can affect positively or negatively the practice of the providers with regards to their cultural competence or cultural appropriateness. The negative side of the continuum explains levels of cultural incompetence while the positive side of the continuum explains levels of cultural competence. In this competence continuum one can find: -3 would be at the lowest end of the continuum. It represents the provider with the most barriers; one who expresses cultural destructiveness. The provider would profess cultural superiority of the dominant culture and inferiority of the Hispanic culture. One would hear comments like, "Oh here we come again, these Mexicans who are all so poor and incapable of taking care of themselves, always taking advantage of the system." -2 would be next. It represents cultural incapacity; one who professes separate but equal treatment. -1 would be next. It represents cultural blindness; one who professes that all cultures and people are alike and equal. +1 would be next. It represents sensitivity or a basic understanding of and appreciation for the importance of sociocultural factors in work with Hispanics. +2 would be next. It represents competence or the capacity to work with more complex issues and cultural nuances and is more sophisticated than sensitivity. +3 would be next. It represents proficiency or the highest capacity for work with Hispanics marked by a commitment to excellence and proactive effort. (88% agreement; 3.24 importance rating)

Work was done with the author of the cultural appropriateness element to develop the linguistic element:

It would be important to develop a competence of language continuum similar to that for culture. It would be useful to evaluate how well the elements of language (proficiency, preference, skills, etc) are taken into consideration for building competence and appropriateness as far as reaching Hispanics effectively with key messages and communication pieces that will help them with different provider encounters and interactions within the healthcare system. Depending on how well the language skills are developed by the provider, there could be a linguistic competence continuum that may be operating. The continuum can affect positively or negatively the practice of the providers with regards to their linguistic competence or linguistic appropriateness. The negative side of the continuum explains levels of linguistic incompetence while the positive side of the continuum explains levels of linguistic competence. In this competence continuum one can find: -3 would be

at the lowest end of the continuum. It represents the provider with the most barriers; one who expresses linguistic destructiveness. The provider would profess linguistic superiority of his dominant language and inferiority of the Spanish language. One would hear comments like, "If these Mexicans insist on coming here, why won't they learn the language. They can't expect me to find time to learn Spanish, and I won't pay for those interpreter services." -2 would be next. It represents linguistic incapacity; one who professes separate but equal treatment. One would hear comments like, "I can't communicate with this patient, but I will give him the number of a provider who speaks his language." -1 would be next. It represents linguistic deafness; one who professes that all languages and people are alike and equal. It might be represented by the philosophy of practice that reflects, "I know how the body and disease process work; all people are alike; even though I don't understand what this person is saying, I can still successfully diagnose and treat this person; in turn, the person will know that I mean well and be able to intuit what I mean with the prescribed treatment." +1 would be next. It represents sensitivity or a basic understanding of and appreciation for the importance of sociocultural factors in work with Hispanics. The provider would at least make provision for some kind of translation even if the translation had to be done by a friend, neighbor, ad hoc staff person, or in the worst case scenario, a child. The provider would have to be aware that the translation may not be optimal in these circumstances, and work diligently to avoid using a child as a translator. +2 would be next. It represents competence or the capacity to work successfully with the complex issues of the language differences and is more sophisticated than sensitivity. The provider would understand the difference in translation and interpretation, have some rudimentary Spanish communication skills, and know how to work well with an interpreter. +3 would be next. It represents proficiency or the highest capacity for work with Hispanics marked by a commitment to excellence and proactive effort. The provider would be equally comfortable in his native language and Spanish and be able to successfully work with Spanish-speaking patients without the aid of an interpreter. (88% agreement; 3.00 importance rating)

At this stage, the Panel had produced 249 distinct elements with 11 groups for cultural appropriateness, 8 groups for linguistic appropriateness, and a separate group of what seemed to be 9 important elements that did not answer either of the two research questions.

Due to the length and complexity of the responses, Round III was done both as a hard copy by mail and as an electronic response through a portal, whichever was most

convenient for the Panel members. They were asked to agree or disagree with the elements and rank them as very important (4), important (3), somewhat important (2), or unimportant (1), and examples of those agreement percentages and importance ratings appear when an element is quoted in this text. They also had another opportunity to make any additional comments in response to each element. For example with regard to the above cited continuums developed for a provider to assess his/her own cultural and linguistic appropriateness, it was said “that this linear continuum, regardless of its intuitive appeal, is something that needs validation and testing. So rendering an opinion regarding its utility is not possible at this time.” Then they were asked to rank the groups of elements, but the ranking of the groups of elements was not necessarily based on the agreement on importance of the elements within each group, see Table 3.4.

TABLE 3.4
Groups Summation Table

Group	Number of Elements	Ranking Totals	Ranking
Question: Cultural Appropriateness			
General Assumptions	18	156	9
Provider Acculturation	36	119	4
Hispanic Views of Healthcare System	11	140	5
Hispanic Acculturation	4	149	6
Office Environments and Activities	18	177	10
Influence of Family	6	112	3
Age and Gender	8	150	7 (Tie)
Respect and Trust	9	84	1
Faith and Religion	5	150	7 (Tie)
Folk Ailments, Remedies and Beliefs	19	178	11
Economic and Social Influences	13	110	2
Question: Linguistic Appropriateness			
General Assumptions	20	118	6
Translators and Interpreters	13	84	2
Accessibility of Spanish Speaking Personnel	3	103	4
Provider Language Skills	7	114	5

TABLE 3.4 Continued

Group	Number of Elements	Ranking Totals	Ranking
Dialectical Concerns	12	136	8
Literacy	21	100	3
Respect and Trust	12	73	1
Time and Patience	5	119	7
Pertinent statements that do not directly answer the questions.			
	9		
The groups were ranked with one being the most important concept, two being second most important, etc. The lower the number is the more important the group of elements.			

Results

Responses to cultural appropriateness broke into 11 groups: General Assumptions (18 elements); Provider Acculturation (36 elements); Hispanic Views of the Healthcare System (11 elements); Hispanic Acculturation (4 elements); Office Environments and Activities (18 elements); Influence of the Family (6 elements); Age and Gender (8 elements); Respect and Trust (9 elements); Faith and Religion (5 elements); Folk Ailments, Remedies and Beliefs (19 elements); and Economic and Social Influences (13 elements). Responses to linguistic appropriateness broke into 8 groups: General Assumptions (20 elements); Translators and Interpreters (12 elements); Accessibility of Spanish Speaking Personnel (3 elements); Provider Language Skills (7 elements); Dialectical Concerns (12 elements); Literacy (21 elements); Respect and Trust (12 elements); and Time and Patience (5 elements).

“Respect and Trust” was by far the number one group of elements for both questions of cultural and linguistic appropriateness. For cultural appropriateness, the second and third most important groups with only a two point separation were “Economic and Social Influences” and “Influence of Family,” respectively. For

linguistic appropriateness, the second most important group was “Translators and Interpreters.” The third and fourth most important groups with only a three point separation were “Literacy” and “Accessibility of Spanish Speaking Personnel,” respectively.

The highest importance rating with 100% agreement was a 3.84 given to one element: “One should not make cultural judgments based on skin color.” The highest importance rating of 3.88 had 96% agreement or only one person disagreeing with the statement: “The interpreters should be respectful and courteous.”

In both Rounds II and III, in numerous comments, the Panel reiterated that any single element taken from its context or applied universally to all Hispanic patients could lead to stereotyping. That sentiment is captured in the element:

The Hispanic population is so diverse in Texas. Given the complexities related to cultural determinants and cultural influences, any element should be interpreted as general in nature and not applicable to all Hispanics in all circumstances so as not to continue to promote stereotypes. Providers must remember to individualize health care to Hispanics as they would with other populations by committing to applying two principles: 1) There is more variation within cultures than between cultures or within-ethnic group variability for culture, acculturation, language, etc.; and 2) Hispanics are not all the same. They do not all come from the same place. They are not all of the same economic class. They are not all of the same generation of immigrants, in fact, some may trace their ancestry to before Texas was a Republic. They have many different and unique perspectives. The economic class can make as much difference as the geography. In Mexico, there are really two classes, upper and lower, but within the lower class there is a very low class comprised of the native Indians. These groups retain their native languages, rather than Spanish, and many of their traditional practices. Every patient is an individual, and therefore by definition, providers should not generalize or stereotype, but instead develop a unique solution for every patient problem. (96% agreement; 3.44 importance rating)

After reviewing the Round I responses, one Panel member made what seemed at the time to be a pertinent statement that was not a direct answer to either of the questions. The statement went verbatim from the Panel member's submission to one of the highest importance ratings of 3.72 with 100% agreement. No Panel member felt compelled to further illuminate the comment. By the conclusion of Round III, it seemed to be the study's summative statement: "Hispanics need and want what everyone else needs and wants: 1) a trusting relationship with the healthcare provider; 2) friendly, respectful treatment by the healthcare provider and his staff; 3) an assurance that care will be provided free of assumptions based on appearances."

Importance of Findings

Twenty-six very busy Texas Hispanic healthcare professionals devoted much time and thought to painting an expansive picture of what non-Hispanic healthcare professionals need to know to improve access to healthcare by delineating key elements of culturally and linguistically appropriate health interventions for Hispanic populations in Texas by participating in a Delphi Technique. The Panel did not, however, stop with just delineating the elements. They went on to agree/disagree with each element, give it an importance rating, provide further illuminating and instructive comments, and rank the groups of elements for overall importance. From the Panel's work, tools can be developed for assisting professional practices, grant providing organizations, or evaluation teams to look at professionals and programs to determine their degree of cultural and linguistic appropriateness. This work could also form the basis for curricula to be constructed for use in Texas' healthcare professions preparatory schools or for use

in continuing education curricula for healthcare professionals already in the workforce. Lastly, as seen in some of the examples in this paper, this would also provide some tools which will need testing and validation in their own right. Collectively, the Panel's work offers a starting point for improvement, and perhaps, a tool for assessing "Respect and Trust" should be first.

CHAPTER IV

**DEVELOPMENT OF A FRAMEWORK FOR ASSESSING THE “RESPECT
AND TRUST” COMPONENT OF CULTURAL COMPETENCY IN
HEALTHCARE SETTINGS FOR HISPANICS IN TEXAS**

“One should not make cultural judgments based on skin color.” (Delphi Panel with 100% agreement, 3.84 importance rating) How would a healthcare provider or provider organization then go about becoming culturally competent in its care of the growing Hispanic population? This is an important question, especially when one Delphi Panel member admitted,

Cultural misconceptions can have an adverse effect in the healthcare setting. Seeing a patient who is, and appears Hispanic, might prompt a provider to attempt to engage the patient in Spanish. However, not all Hispanics speak Spanish. I have seen customers in retail establishments get downright nasty in such situations. This can become quite ugly in a retail environment, but in a clinical setting, it can be disastrous. The misconception in this case is that the Hispanic-looking patient speaks Spanish. The same effect can be seen with any other cultural norm. For example, assuming that the Hispanic patient is Catholic, or a Democrat, I have expressed myself in Catholic terms with an Hispanic who turned out to be Jewish. He was offended, and I was embarrassed. My misconception was that all Hispanics are Catholic?

Cultural competence would then seem to be important enough that there should be an enumeration of specific elements that could form the basis of teaching curricula and aid those healthcare providers and organizations that want or need to become more culturally competent.

In the last few years, such documents as *Healthy People 2010* have suggested that cultural competence be a part of the strategy for reducing health disparities and improving access to and quality of care for minority populations. Efforts to determine

what culturally competent care looks like, however, are still needed for many minority populations (Betancourt, Green, & Carillo, 2002). To aid in the development of courses, more research, specifically with Latino (This is the term of choice for Flores et al. while this paper will use the term Hispanic.) populations, is needed on course content and structure for teaching cultural competence regarding Latino populations, especially since Latinos represent one of the largest racial/ethnic groups but are underrepresented at every level of the healthcare professions (Flores et al., 2002). The National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care mandated linguistic access and recommended the requirement of cultural appropriateness while recognizing that simply hiring bilingual/bicultural individuals does not guarantee culturally competent care (OMH, 2000). After an extensive but fruitless literature search for elements of cultural competency, it was apparent that a framework was needed to “operationalize” the lofty ideals of such documents as *Healthy People 2010* and the CLAS Standards.

Purpose

The purpose of this paper is to provide a framework for assessing the elements of respect and trust, both culturally and linguistically, that could be used by a provider, an organization, or a review team to determine if indeed respect and trust exist. “Respect and Trust” for both cultural and linguistic appropriateness received the highest ranking by an expert panel of 26 Texas Hispanic healthcare professionals during a recently completed Delphi study.

Background

Culturally diverse populations have a persistent disparity in health status compared to the United States population in general. Over the next decade, the United States population is projected to become even more culturally diverse; therefore, providing culturally and linguistically appropriate healthcare services must be addressed (USDHHS, *Healthy People 2010*, 2000). Hispanics are the largest and fastest growing ethnic population in the United States, representing 12.5% of the population in the 2000 US Census, and one-half of this population reside in California and Texas (Pew Hispanic Center, 2002; Purnell & Paulanka, 2003).

The state of Texas is becoming a “majority-minority” state as Hispanics become the majority population in this state. As a result, providing culturally and linguistically appropriate healthcare services is of particular importance (Caldwell, 2005). The 2003 update of the US Census Bureau’s 2000 Census data reveals that Texas has a total population of 21,547,821 and 35.34% of that total are Hispanic (US Census Bureau, 2004) which is more than double the national percentage of Hispanic presence, with 27% of the Texas Hispanic population over the age of 5 reporting that Spanish is the language spoken at home (US Census Bureau, 2002). With the release of the updated 2003 Census data, non-whites became the majority in Texas’ population, but whites still maintained the plurality (Babineck, 2004). Analysis of the 2000 Census data by the Hispanic Research Center at the University of Texas at San Antonio demonstrated that the trend toward an increasingly Hispanic population in Texas is to be expected because the Hispanic population of Texas is much younger than the non-Hispanic population

with the size of the Hispanic family generally being larger than that of non-Hispanic families. The data also reveals that the number of Hispanic children under the age of five increased by 52% from 1990 to 2000 while the number of non-Hispanic children decreased by one percent. Healthcare services planners must prepare to address the needs of the increasing Hispanic population (Hispanic Research Center, 2002).

The Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care found in its literature review that there was very little research on non-African-American minority populations (Smedley et al., 2003). The Sullivan Commission (2004) concurred that while health disparities existed for a broad number of minority populations, “the history is best documented for African-Americans (p. 32).” The Commission postulated that the history of exclusion and inequality for African-Americans applies in many ways to all the minority populations in their encounters with a predominantly Anglo healthcare system. The Committee’s focus group data and other information, however, suggested that non-African-American minority populations suffer greater challenges posed by the cultural and linguistic mismatches with healthcare providers. The Committee also noted the wide cultural and linguistic variation within subgroups of the various minority populations and concluded that more study on non-African-American populations and their subgroups was badly needed (Smedley et al., 2003).

The 2003 report of the National Heart, Lung, and Blood Institute’s working group on epidemiologic research in Hispanic populations made an effort to single out the nation’s largest non-African-American minority population. The group noted that for

use with Hispanic populations, data collection methodologies in general, and with appropriate cultural contexts specifically, are only minimally developed. They recommended that research be done to develop instruments relevant to Hispanic populations with particular attention to incorrect stereotypes and misconceptions in connection with cultural beliefs and acculturation which are not solely dependent on language differences.

The OMH defined cultural and linguistic 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. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (2000, p. 80873)

The OMH then distinguished culturally and linguistically appropriate services as those “health care services that are respectful of and responsive to cultural and linguistic needs (2000, p. 80873).

With regard specifically to Hispanic populations, Flores attempted to provide guidance for non-Hispanic providers in his 2000 article, “Culture and the patient-physician-relationship: Achieving cultural competency in health care.” Flores suggested solutions to “ensure culturally sensitive care (p. 14)” and briefly described five important Latino concepts: *simpatia*, politeness and pleasantness in the face of stress; *personalismo*, warmth and close personal contact; *respeto*, appropriate deferential behavior; *familismo*, loyalty to family outranking individual need; and *fatalismo*,

unalterable, individual fate. Flores stated that clinicians sometimes provide a lower quality of care to patients of a different culture. For example, in one study, Latinos were seven times less likely than whites to receive analgesia, and in another study of hospitalized, asthmatic, preschool children, Latino children were 17 times less likely to be prescribed a nebulizer for home use. To improve provider practices, Flores proposed a model to achieve cultural competency based on the five components (Latino concepts) of the article. He stated that the culturally competent provider would be familiar with the normative cultural values, use interpreter services, recognize and accommodate for folk illnesses, identify beliefs that might impede clinical care, and maintain vigilance for ethnic disparities. Flores noted that to do what he suggested would require outside resources such as consulting with colleagues from other ethnic groups, using published references, speaking with interpreters and community members from other ethnic groups, working to increase their own language skills, and outside monitoring for improvements in cultural competence. In conclusion, Flores warned, “. . . the culturally competent clinician needs to beware of the dangers of stereotyping (p. 21).” While Flores made sound recommendations, the article lacked the specificity of delineated elements for each of his five components which one could assume should come from the outside resources.

Major National Research Projects with Hispanic Populations

“Few culturally competent health programs have been designed for Mexican Americans (Brown & Hanis, 1999, p. 226). In a search for research projects with Hispanic populations, three seminal examples emerged: the San Antonio Heart Study,

Project Dulce, and the Starr County Border Health Initiative. Extensive data base searches of Cambridge Scientific Abstracts and Medline/EBSCO were made in search of how these projects insured that they were culturally competent.

The San Antonio Heart Study was a longitudinal project, conducted from 1979 to 1996 with the addition of the Mexico City Diabetes Study, conducted from 1990 to 1999 extending some of the work from the original study (Williams, Stern, & Gonzalez-Villalpando, 2004). A Medline/EBSCO search using the term “San Antonio Heart Study” found 135 journal articles from 1980 to 2004. In an abstract review of all 135 articles, the term “cultural competence” did not appear and provided no insight. A reading of three complete articles selected because the titles contained sociocultural implications (Hunt et al., 2002; and Wei et al., 1996; Williams et al., 2004) failed to reveal any discussion of cultural competence in the study.

Project Dulce began in 1998 in San Diego County, California to test a team approach to diabetic care with an added peer education component. The team consisted of a registered nurse/certified diabetic educator, bilingual/bicultural medical assistant, and bilingual/bicultural dietician. Peer educators were selected from patients with diabetes who appeared to be natural leaders. They were trained to use the Latino Health Access Program developed in Orange County, California, and later completed the Project Dulce training curriculum (Philis-Tsimikas et al., 2004). With two of the three professionals on the team being bilingual/bicultural, it was obvious that their presence was a key to the cultural competence of the program, but a Medline/EBSCO search using the term “Project Dulce” produced no journal articles actually discussing the

project's cultural competence. The researchers noted that "there is a lack of culturally appropriate diabetes programs designed for the racial and ethnic groups at greatest risk (Philis-Tsimikas et al., 2004, p. 114)."

The Starr County Border Health Initiative (SCBHI) conducted from 1994 to 1998 in Starr County, Texas, on the Texas-Mexico Border halfway between Brownsville and Laredo. The county's residents are 97% Mexican American (Brown, Garcia, Kouzekanani, & Hanis, 2002). To begin the project, several systematic literature reviews of diabetes education literature since 1988 were completed. The search revealed a serious lack of research with the minority groups who bear a disproportionate share of the burden of Type 2 diabetes. The reviews further revealed that culturally appropriate approaches for minority groups had rarely been investigated although it was noted that conventional interventions were ineffective. Hispanic groups in some areas were labeled noncompliant, although they were treated more often with insulin than other racial and ethnic groups. The SCBHI began with focus groups in the community to assess the unique needs of Starr County residents. In the focus groups, individuals directly and forcefully said, "If you plan to come down here and tell us not to eat our favorite Mexican American food, you might as well stay home (Brown & Hanis, 1999, p. 228)!" The researchers knew that to be successful, the intervention needed to be carefully developed with input from potential participants. To that end, the researchers planned to: 1) employ bilingual Mexican American nurses and dieticians from the community; 2) use videotapes made in Starr County with local people; 3) focus on realistic recommendations consistent with Mexican American preferences; and 4) offer the

instruction in Spanish. Researchers reviewed available materials searching for pamphlets, videotapes, and other materials in Spanish and found few. Researchers, using Starr County local people, developed seven 15-minute videotapes in Spanish based on priorities from the literature review, national diabetes education standards, and focus group input. At the same time, intervention teams were trained. The standard team was a nurse, dietician, physician, psychologist, and perhaps pharmacist and podiatrist; however, in rural settings the general lack of healthcare professionals precluded the use of such teams. In Starr County, there were four teams each with a bilingual, Mexican American area resident nurse and dietician with training in diabetes education and management from courses at the Texas Medical Center in Houston. There were also eight community workers chosen as peer educators who had to be bilingual high school graduates, residents of Starr County, licensed to drive, and diagnosed with Type 2 diabetes.

None of the three projects delineated elements of cultural and linguistic appropriateness that would help a healthcare provider or healthcare organization to assess its own cultural competence. Furthermore, these three projects depended heavily on bilingual, bicultural staff to affect their cultural competence. Since Texas has a serious lack of Hispanic healthcare professionals, something must be done to help non-Hispanic healthcare providers deliver more culturally competent care.

Methodology

Various types of information can be represented as points on a continuum with one extreme being labeled “knowledge” and the opposite extreme being labeled

“speculation.” In the field of public health “knowledge” is often very hard to achieve, but the grey area between the extreme points that can be called “wisdom,” “insight,” or “informed judgment” is present if one only seeks it out. The Delphi Technique is a good tool to use in public health and social services for seeking “wisdom,” “insight,” or “informed judgment.” The Delphi Technique is especially effective when there is more known than mere speculation, but knowledge has not yet been achieved, and there is a complex problem at hand which needs addressing by a geographically dispersed group of experts in a structured communication process (Adler & Ziglio, 1996).

Since the literature did not provide an elemental breakdown of what constituted culturally and linguistically appropriate healthcare services, either nationally or in Texas, it was apparent that this work was much needed for bettering access to healthcare for Hispanics in Texas until such time as the provider base matches the diversity of the population. A Delphi Technique seemed exactly the right tool to draw on the wisdom of the experts who could delineate the elements of culturally and linguistically appropriate healthcare services.

Nowhere in the literature could it be found that a group of solely Hispanic healthcare professionals had ever been asked to help delineate the elements of cultural and linguistic appropriateness for non-Hispanic healthcare providers working with Hispanic populations. In an effort to address the needs of Texas’ Hispanic population in overcoming the health disparities, 26 expert Hispanic healthcare professionals, see Table 4.1, from academia, government, and field practices in Texas participated in a three round format Delphi Technique.

TABLE 4.1
Delphi Panel Acknowledgment

<p>Hector Balcazar, PhD Regional Dean and Professor of Health Promotion and Behavioral Sciences UT School of Public Health , El Paso Regional Campus El Paso</p>	<p>Cristina M González-Boles, BS, MA Assistant Professor & Content Expert UT Southwestern Medical Center at Dallas, Department of Physician Assistant Studies Dallas</p>
<p>Jaime Barceau, MSSW Executive Director El Paso Rehabilitation Center El Paso</p>	<p>David Gonzalez Admissions Counselor Tyler Junior College (At the beginning of the study, Women & Children's Program Coordinator Northeast Texas Public Health District) Tyler</p>
<p>Judith F. Blevins, RN ADN, Tyler Junior College Public Health Nurse, North East Texas Public Health District Tyler</p>	<p>Norma Gutierrez, RN, BSN Performance Improvement/Health Disparities Coordinator South Plains Health Provider Org., Inc. Plainview</p>
<p>*Maria Montes-Boydston Health Initiatives Program Coordinator American Cancer Society Houston</p>	<p>Alfonso Holguin, Jr., MD, MPH Professor of Public Health and Epidemiology - UT School of Public Health, San Antonio Regional Campus (Retired) Program Director, Health Education Training Center Alliance of Texas (Retired) United States Public Health Service Commissioned Officer, Medical Director, CDC, 1959-1974 (Retired) San Antonio</p>
<p>Yvonne Carillo-Brown, RN Faculty Associate, Texas Tech Orthopaedics (Retired), and Director of the West Texas Case Management Project for Children with Special Health Care Needs (Retired) El Paso</p>	<p>Jacobo Kupersztoch, PhD, MSc, BSc Executive Director, Centro Comunitario Mexicano DFW Secretaria, Comisión de Salud, Consejo Consultivo del Instituto de los Mexicanos en el Exterior IME/Secretaria de Relaciones Exteriores Dallas</p>
<p>Vicky Contreras, MSW, LCSW Director of Social Work Services Texas Department of State Health Services (DSHS) San Antonio</p>	<p>Guadalupe Palos, RN, LMSW, DrPH Instructor, Clinical Research Faculty Division of Internal Medicine Department of Symptom Research M.D. Anderson Cancer Research Center Houston</p>

TABLE 4.1 Continued

<p>Leslie L. Cortes, MD Director, Medical Quality Assurance Department of Aging and Disability Services Austin</p>	<p>Amelie G. Ramirez, DrPH Professor, Department of Medicine Deputy Director, Chronic Disease Prevention and Control Research Center Associate Director for Community Research, San Antonio Cancer Institute Baylor College of Medicine, San Antonio Cancer Institute San Antonio and Houston</p>
<p>Jessica De La Cruz Dental Assistant Hart School-based Health Clinic Hart</p>	<p>Eduardo J. Sanchez, MD, MPH Commissioner, Texas Department of State Health Services Chief Health Officer of Texas Austin</p>
<p>Miguel A. Escobedo, MD MPH Medical Officer CDC El Paso Quarantine Station Centers for Disease Control and Prevention El Paso</p>	<p>Ciro V. Sumaya, MD, MPHTM Cox Endowed Chair in Medicine Dean, School of Rural Public Health Texas A&M Health Science Center College Station</p>
<p>Maria Garcia, MEd Program Director, Uniting Parents Coalition of Health Services, Inc. Amarillo</p>	<p>Mary Thrasher Parents Anonymous Tyler</p>
<p>Pema B. Garcia, MA Texas A&M Colonias Regional Director, Western Region Texas A&M Colonias Project El Paso</p>	<p>Adolfo M. Valadez, MD, MPH Health Authority and Medical Director Austin /Travis County Health and Human Services Department Austin</p>
<p>Rebecca Garza, PhD Associate Director, Migrant Health Promotion REACH 2010 Principal Investigator REACH Promotora Community Coalition Progreso</p>	<p>Leonel Vela, MD, MPH Dean, Regional Academic Health Center (RAHC) of the University of Texas Health Science Center at San Antonio Harlingen</p>
<p>Paula S. Gomez Executive Director Brownsville Community Health Center Brownsville</p>	<p>Javier (Santos) Zelaya, MD ProSalud Physician Houston</p>

*Indicates the inability to contribute responses in Round III.

The Panel was asked to answer the questions: 1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? 2) What are key elements of linguistic appropriateness for Hispanic

populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? The Panel members were chosen from Texas' eight functional public health regions and from a diversity of healthcare professions. The study was conducted for 16 months from May 2004 through August 2005.

Results

During the course of the Delphi Technique, the Panel first sent in lists of elements, narratives, and one journal article to begin the process. In Round II, the Panel refined the wording of the elements and added additional elements along with illuminating comments. In Round III, the Panel agreed or disagreed with the elements and rated them very important (4), important (3), somewhat important (2), or unimportant (1). In Round III, the Panel continued to provide illuminating comments. This work produced 249 distinct elements that were broken into 11 groups for cultural appropriateness (General Assumptions; Provider Acculturation; Hispanic Views of the Healthcare System; Hispanic Acculturation; Office Environments and Activities; Influence of the Family; Age and Gender; Respect and Trust; Faith and Religion; Folk Ailments, Remedies and Beliefs; and Economic and Social Influences) and 8 groups for linguistic appropriateness (General Assumptions; Translators and Interpreters; Accessibility of Spanish Speaking Personnel; Provider Language Skills; Dialectical Concerns; Literacy; Respect and Trust; Time and Patience). There was also one group of nine elements that seemed important but which did not appear to answer either of the two research questions.

The Panel strongly ranked “Respect and Trust” as the number one group of elements for both questions of cultural and linguistic appropriateness. This result seemed to affirm the Office of Minority Health’s statement that simply hiring bilingual/bicultural staff was not sufficient to guarantee culturally competent care (2000). With regard to “Respect and Trust,” the Panel produced 9 elements for cultural appropriateness and 12 elements for linguistic appropriateness.

After reviewing all the elements from Round I, one panel member made what seemed at the time to be a pertinent statement, yet was not a direct answer to the questions. At the end of Round III, however, it seemed to be the study’s summative statement: “Hispanics need and want what everyone else needs and wants: 1) a trusting relationship with the healthcare provider; 2) friendly, respectful treatment by the healthcare provider and his staff; 3) an assurance that care will be provided free of assumptions based on appearances.” This statement garnered 100% agreement and an importance rating of 3.72.

While “Respect and Trust” had its own groups in both cultural and linguistic appropriateness, it also played a part in elements that ultimately were placed in other groups such as this element from cultural appropriateness:

Providers need to approach all patients (English speaking, foreign, non-foreign, etc.) with a general framework for the patient-provider interaction that is respectful and shares power with the patient. This requires a huge paradigm shift that most providers find threatening. It requires providers to “let go” in order to “get back.” What they let go is the power of their provider title, the power of knowledge, the power of expert. What they gain is patient trust, confidence, improved compliance, and ultimately, better outcomes, and hence a stronger patient-provider bond. This framework involves the following and is based on the visionary work of Arthur Kleinman, and carried on by others like J. Emilio Carrillo, Alexander Green, and Joseph Betancourt. The framework

is based on the explanatory model of disease for patients that has been used successfully with patients of any culture to bridge cultural gaps. The paradigm shift moves away from one of cultural stereotypes (what do I do for Hispanics?) to a broader line of questions that are applicable to all patients. The first question to ask the patient is, "What do you think causes what you have, or what do you think you have?" This simple question serves several purposes beyond what is on the surface. First, it shares power with the patient by saying "I respect you and I want to know what you are thinking." Secondly, it reveals that the provider is willing to share power by making the patient the expert. It also signals to the patient that it is acceptable to talk about his worldview and provides insight into how he views illness and disease. Follow up questions include asking: How long the illness has lasted? How does one treat it? What is its usual course, etc.? These questions again strengthen the provider-patient relationship by building trust, sharing power, and enabling the patient to begin to discuss culture-bound syndromes (susto, empacho, etc.) as well as culturally acceptable home remedies and alternative therapies. Knowledge or lack of knowledge about disease and prevention is also important to assess. Thus a simple line of questioning does much to move away from cultural stereotypes, power imbalance, and provider/patient dissatisfaction towards respect for differences, power sharing, and improved satisfaction, all working toward better outcomes. (96% agreement; 3.52 importance rating)

This element was grouped into "Provider Acculturation," but the reader can find heavy emphasis within the element on giving respect and building trust. Another example was an element from linguistic appropriateness that wound up in the group of "Accessibility of Spanish Speaking Personnel:"

Twenty-five years of experience in a medical school setting, working side by side with the same non-Hispanic physician, afforded one provider the opportunity for a great learning experience in the area of needing accessible Spanish-speaking personnel. It is all about having one contact person with a solid medical background, who is Hispanic, who is easily accessible to answer any questions or concerns, and who can translate appropriately at the patient's level using layman's words and avoiding medical terminology during the detailed explanation. The diagnosis should, however, be given in its proper terminology and be written down on paper. The translator should be sure that the patient can pronounce it successfully. As providers, it is important to always remember the adage about fear of the unknown and strive to provide accurate, complete and understandable information during the translation. Building this sense of security for the patient will lessen numerous phone calls to the physician and will alleviate a lot of stress for the patients. In essence, this contact person is

an extension of the physician to a degree that tends to create a comfort zone for the patient and assists in the formation of a trusting relationship between provider and patient. (96% agreement; 3.2 importance rating)

With such emphasis placed on respect and trust by the Panel, it seemed the logical first choice from the groups for developing a framework to begin work on what might constitute culturally competent care in Texas. The framework is built around business operations. It sets the elements of “trust and respect” into categories of 1) structure or the staff, training, facilities, and business operations; 2) processes or the quality of activities going on with the patients; 3) outputs or evaluations of the immediate experience of the patients; and 4) outcomes or evaluations of the long-term effects of the care received. Each category of the framework has examples developed by, agreed or disagreed with, and rated for importance by the Delphi Panel. The supporting elements appear verbatim with their percentage of agreement and importance rating, see Table 4.2.

TABLE 4.2
Respect and Trust Framework

Respect and Trust Framework	
Cultural Appropriateness	
I. Business Structures—staff, training, facilities, and business operations	
a. Use local outreach workers	
	Providers need to respect culture and beliefs, need to work with the patients not just do to the patients, share education by using outreach workers and promotoras who speak the same language and live in the same neighborhoods. (100%; 3.6)
II. Processes—quality of activities going on with patients	
a. Engage the patient in warm, friendly, purposeful conversation	
	Once the culture is understood, one must try to gain the trust of the person. The use of common sense tactics such as developing a friendly, warm compassionate manner, asking questions about the patient’s beliefs when the patient sees something unusual, explaining that it is important that information be shared to avoid counteracting other treatments. One must learn to maintain professionalism at all times. (100%; 3.4)
b. Respect the patient no matter what his/her socioeconomic status, race, age, sex, or ethnicity by listening actively and observing their customs of touch, eye contact, and address	

TABLE 4.2 Continued

	<p>Respect is universal, and providers could begin there by being respectful regardless of socioeconomic status, race, or ethnicity. This includes respect for the person as a person including the manner in which they present themselves even if maybe they are not so clean because of their work or because they lack the resources to bathe frequently, and respect for their faith and beliefs that include faith healing and the use of medicinal herbs and faith healers. It also includes their customs of touching, active listening and looking them in the eye when listening and speaking with them. It is really important to know that everything that will end up in a successful outcome will be dependent on how respect is shown toward the patient. One provider reports as an example, "I have had the best of both worlds, being Hispanic, living in a large border city and working in a medical school setting. The exposure to all of the problems has been first hand. Time and time again, I have explained to the medical students and residents the importance of respect, dignity, and no condemnation. We do not have to accept traditions, but we can be tactful. All of us, without a shadow of a doubt, have at one time been exposed to a grandmother who has offered some type of home remedy, and we tried it." (100%; 3.44)</p>
	<p>Providers must learn to listen to the patient and family while respecting their beliefs and traditions. People from all cultures wish to maintain their dignity and respect, especially when in a health crisis. For Hispanics in the healthcare setting there is a conflict of familiarity vs. detachment. Often healthcare professionals maintain an air of "professionalism," which is often interpreted as detachment or rudeness. On the other hand, some healthcare professionals do not introduce themselves or call the patient or family members by their first names or use no names at all. (100%; 3.4)</p>
	<p>There is a distinct need and level of respect for the older population. The older population tends to be more reserved and a lot less willing to discuss health-related issues with their providers. (100%; 3.08)</p>
	<p>With many Hispanics there is a hard and fast rule, "respect your elders." One example is the story of an Hispanic CEO in a mid-sized organization who recounts, "To this day, I address all persons whom I think are older than I with a degree of formality and respect that is reserved for my elders. As a CEO in a mid-sized organization, I have many older Mexicans who work for me, including housekeepers, nonetheless, I am culturally obligated, and expected, to give them their due. Social and economic status, momentarily, takes a back seat to respecting my elders. While I am an authority figure, I am not exempted from observing this rule. Providers must likewise give older persons that level of respect and formality. I am nearly 50, and have come to be called "Don Pedro" as in The Godfather's Don Vito Corleone. I am not seen as a mobster, in our culture, rather it refers to a respected land owner. I am given a certain amount of respect and formality for my age AND my social status. A young provider who does not afford me that formality is likely to be dismissed as immature and, therefore, not a good healthcare provider." This may be more acute for first generation Mexican-Americans who still have strong cultural ties to the old ways. They might not return to a disrespectful provider for a follow-up visit simply because he is too casual in the interpersonal exchange. The Spanish language even has two distinctive conjugations for verbs, each with its own pronouns for "you" (usted/ustedes) to designate respect or familiarity. Using the more intimate conjugation of verbs with its pronoun (tu) is a sign of disrespect in formal situations. This distinction is further heightened by knowing that there is a verb (tutearse) which literally means "to use tu with each other" for use in discussing how familiar two people wish to be. (96%; 3.00)</p>
	<p>c. Establish that your goal is treatment in order to allay possible fears</p>

TABLE 4.2 Continued

	Hispanics have a sense of being strangers in a foreign land. They have a cautious demeanor with individuals in authority from a sense of lesser status or from fear of reprisal in circumstances such as deportation. Most of this population are immigrants or have been raised with the mind set that “they” can send you back to the country which you came from. Most of these people are afraid of everyone and have a fear and distrust of anything associated with the system, especially any procedures involving showing or sharing of personal records (fear of immigration, reprisal from government, imprisonment). The fear of deportation may lead to lack of trust in the medical system. (84%; 3.16)
III. Outputs—evaluations of the immediate experience of the patients	
a. Value the patient’s cultural perspective	
	In general, it is important that every encounter with the patient convey the understanding that the patient brings an important cultural perspective to the health care setting and to the provider/patient interaction. The Hispanic patient needs to appreciate that her/his cultural perspective is important and valued. (96%; 3.24)
IV. Outcomes—evaluations of the long-term effects of the care received	
a. Get compliance	
	Hispanics have to really trust their medical providers to follow directions. (84%; 3.32)
Linguistic Appropriateness	
I. Business Structures—staff, training, facilities, and business operations	
a. Monitor all verbal communications	
	For the most part all patients just want to be treated with respect and courtesy. Be careful what you say. (100%; 3.72)
b. Practice courtesy at every opportunity	
	Courtesy is important. Some providers report observing often that the people at the front desk, Hispanic or Anglo, treat many poor Hispanic patients very rudely. (100%; 3.48)
c. Learn non-verbal communication differences	
	Body language, soft-spokenness, and maintaining distance on the part of Hispanic patients are not signs of disrespect toward the provider. (96%; 3.12)
	Eye contact is tricky. One must judge the other person when making direct eye contact. Maintaining extended eye contact can be construed as a challenge or as anger. Should providers notice that Mexican patients are not making eye contact, it could be that they do not want to appear that they are challenging or disrespectful. In the American tradition, one looks a person straight in the eye, not so among Mexicans. (88%; 2.96)
d. Use people, not machines, as often as possible for patient interactions	
	Mexicans prefer face to face communications. One provider gives as examples, “My mother and my in-laws to this day will not leave voice mail messages. They prefer not to communicate than to communicate in such an impersonal way. In the office, I prefer to go to other peoples’ offices to talk directly rather than to call them on the intercom or send an email. Communication in person is best.” (88%; 2.8)
II. Processes—quality of activities going on with patients	
a. Practice patience with Hispanic patients attempting to communicate in English.	
	Providers should not be exasperated with Hispanic patients who stumble or falter in their use of English. (100%; 3.48)
b. Use terms of respect, not familiarity	
	In the older generation, it is still considered respectful to address the patient with terms that convey respect. Terms that convey too much familiarity, especially if early in building a provider-patient relationship, are not considered appropriate. (100%; 3.36)

TABLE 4.2 Continued

	Referring to authority figures, respected persons, or elderly people may be done through the use of Mister or Senor; Mistress or Senora; Miss or Seniorita; or Don and Dona which do not have a good English equivalent. Another way to show respect is by using usted(es) for you and not the less formal tu with the appropriate usted(es) conjugation of verbs. (100%; 3.32)
	Providers should maintain formal communication, demonstrating respect and using a vernacular appropriate to age, gender and social status. Some examples of these formalities in conversation are: “Whenever I speak with someone in Spanish who is in authority, or someone older than I, or someone with whom I have a formal relationship, I speak more formally. In the Mexican culture the pronoun “you” is stratified. In a formal setting we use the translation “usted” and with a more casual setting we use “tu.” Both are interchangeable and there is no difference in meaning, it is simply a reflection of the esteem and respect we have for the other person. My wife and children are “tu,” while my mother and in-laws are “usted.” My children would be rude if they used “tu” when talking with me or my mother.” Providers would generally be better served using the more formal “usted” with their patients. A provider never loses by being more formal; however, providers stand to lose an important key to the relationship by being too informal. (92%; 3.28)
	c. Learn some Spanish or use the appropriate Spanish you do know
	Language is a very important aspect of culture and communication in Spanish adds a strong feeling of trust, even for bilingual Hispanic patients. (100%; 3.32)
	d. Allow speaker to finish thoughts uninterrupted
	Do not interrupt the speaker. This is generally a good idea in any culture, but a surprising number of clinicians forget this when dealing with someone who is not from their own culture—particularly the young and inexperienced. (92%; 3.28)
	III. Outputs—evaluations of the immediate experience of the patients
	a. Greet patients with added descriptor of intent to be “serviceable”
	In conversations with Mexicans, it is always good to introduce one’s self with the added descriptor, “su servidor” or your servant rather than giving some official sounding title. In Mexico, anyone with a college degree is “licenciado” or licensed, that is a given. Mexicans value one who is “serviceable” or service-minded. During introductions, it is highly regarded to say, “I am Fulano de Tal, para servirle,” or “I am John Doe, at your service.” This linguistically appropriate nuance goes a long way to establishing a positive relationship. (88%; 2.76) [It should be noted here that some Panel members added that stating your title is very important and there are other ways to say this. One is to say, I am Dr. Fulano de Tal, a sus ordenes (at your orders), or para servirle (to serve you). There are other variations.]
	IV. Outcomes—evaluations of the long-term effects of the care received
	a. (none)
	In the percentage of agreement, all elements of respect and trust had at least 21 of the 25 Panel members agreeing with the statement. The point values assigned to importance ratings were: 4=very important, 3=important, 2=somewhat important, 1=unimportant.

In an effort to provide an example of how the Respect and Trust Framework might be used, a “Respect and Trust User Card” was developed. It had the verbatim elements removed with a checklist added. It can be copied and used as a small card to observe and note whether the elements in their condensed, action-verb form can be

observed or not. Anyone using the card should then refer back to the Panel's examples to see what actions would help a provider to begin to exhibit a missing element of respect and trust or improve on an element only marginally present, see Table 4.3.

TABLE 4.3
Respect and Trust User Card

Respect and Trust User Card			
	Yes	No	Some
Cultural Appropriateness			
I. Business Structures—staff, training, facilities, and business operations			
a.	Use local outreach workers		
II. Processes—quality of activities going on with patients			
a.	Engage the patient in warm, friendly, purposeful conversation		
b.	Respect the patient no matter what his/her socioeconomic status, race, age, sex, or ethnicity by listening actively and observing their customs of touch, eye contact, and address		
c.	Establish that your goal is treatment in order to allay possible fears		
III. Outputs—evaluations of the immediate experience of the patients			
a.	Value the patient's cultural perspective		
IV. Outcomes—evaluations of the long-term effects of the care received			
a.	Get compliance		
Linguistic Appropriateness			
I. Business Structures—staff, training, facilities, and business operations			
a.	Monitor all verbal communications		
b.	Practice courtesy at every opportunity		
c.	Learn non-verbal communication differences		
d.	Use people, not machines, as often as possible for patient interactions		
II. Processes—quality of activities going on with patients			
a.	Practice patience with Hispanic patients attempting to communicate in English.		
b.	Use terms of respect, not familiarity		
c.	Learn some Spanish or use the appropriate Spanish you do know		
d.	Allow speaker to finish thoughts uninterrupted		
III. Outputs—evaluations of the immediate experience of the patients			
a.	Greet patients with added descriptor of intent to be "serviceable"		
IV. Outcomes—evaluations of the long-term effects of the care received			
a.	(none)		

Discussion

From the literature review, it was apparent that new tools were needed to begin the work toward better access to healthcare for Hispanics in Texas. Nowhere in the

literature was there an elemental breakdown of what constituted culturally and linguistically appropriate healthcare services. Additionally, nowhere in the literature could it be found that a group of solely Hispanic healthcare professionals had ever been asked to help delineate these elements. Logically, it would seem that the first tool developed from the Delphi Panel's extensive work would be a framework of the elements of respect and trust, both culturally and linguistically, that could be used by a provider, an organization, or a review team to see if indeed respect and trust do exist. Conversely, this framework could form part of the curriculum for teaching the next generation of healthcare providers or for continuing education for the current generation of healthcare providers. The framework has enough specificity and examples to allow someone using it to observe if those elements are present or not in a healthcare setting. Conversely, the specificity and examples allow a provider or healthcare organization to know what needs work when an element is only somewhat present or not present at all.

Conclusions/Recommendations

The Delphi Panel provided a starting point of specific elements to formulate a framework on Respect and Trust, but it has not been tested for validity and reliability with different groups of Hispanics around Texas. If used as more than a framework, testing needs to be done. Then, other frameworks need to be developed based on the other groups of elements from the Panel's work. At some point, academicians might find it helpful to have the results of the entire study with the complete comments from the Panel members.

Although the group of general assumptions for both cultural and linguistic appropriateness was included in the rankings of the groups of elements, those elements would provide a good introduction to the use of the Respect and Trust Framework, other frameworks or tools to be developed, and any curricula to be developed. While the group of elements ranked toward the bottom of the groups, they still contain much information that sets the context for any use of the rest of the elements. The Panel was keen on not having any use of the elements out of context which might lead to further stereotyping.

CHAPTER V

CONCLUSION

With the increasing Hispanic population and static number of Hispanic healthcare providers, it seems imperative at this time that non-Hispanics undertake research to help improve healthcare outcomes for Hispanics. Numerous Federal and state documents continue to cite the need for healthcare to be delivered in a culturally competent manner; however, an extensive literature review failed to provide specific elements that a healthcare provider or organization could use as a framework for providing culturally competent care to Hispanics. Furthermore, the literature review revealed that Hispanic healthcare providers have never been asked what culturally competent care, in its two components of cultural and linguistic appropriateness, for Hispanic populations should look like in a comprehensive fashion. Journal articles and textbooks alike provide brief guides for cultural competency, but those brief guides are rarely written by Hispanic healthcare providers and feature the caveat that any healthcare provider must beware of stereotyping.

This research study undertook to assemble a Delphi Panel of solely Hispanic healthcare providers throughout the state of Texas for the purpose of asking them to list the elements of cultural and linguistic appropriateness. These 26 Hispanic healthcare professionals were then asked to agree or disagree with each element and rate it for its importance. When it became apparent that the lists of elements were far longer than the researcher imagined, the lists were broken into groupings. The Panel was additionally asked to rank the groups in order of importance to provide a hierarchy for building

frameworks or tools from the information. The Panel's work took approximately 16 months and produced 249 distinct elements broken into 11 groups for cultural appropriateness, 8 groups for linguistic appropriateness, and one group of 9 elements that were important but did not appear to fit into either of the two categories.

This research provided important insight from Hispanic healthcare providers to non-Hispanic healthcare providers. There was, however, an interesting development for the researcher, a non-Hispanic health educator. Nothing was found in the literature about difficulties experienced by individuals doing cross-cultural research, non-Hispanic/Hispanic.

In the beginning, the researcher was surprised at her nervousness in approaching the three members of the nominating panel. The researcher wanted to be respectful and helpful, and all three of the nominating panel members were encouraging of the research project. The researcher's nervousness continued, however, as approximately 75 Hispanic healthcare professionals around Texas were contacted to participate in the study. It was difficult to ask the key question, "Are you an Hispanic healthcare professional?" One prospective panel member laughed, explained he was African-American, and continued that he did see many Hispanics in his practice. Another prospective panel member responded tersely that she was Anglo but had lived and worked with Hispanics all her life and should be considered for inclusion on the Delphi Panel. Yet another prospective panel member laughed and explained that only her last name was Hispanic by virtue of her ex-husband, but that she was not. She, too, admitted to having many Hispanics in her practice. Another prospective panel member, who did

go on to serve on the Delphi Panel, explained that he was Hispanic but identified more with Anglos. He added that he could only respond to the work from the viewpoints of his family who were culturally more Hispanic than he.

A comment from one Panel member after reviewing the aggregated remarks from Round I confirmed the researcher's stand that this study should invite only Hispanic healthcare providers to serve on the Panel. The Panel member commented as an aside at the end of the elements' listing, "Please disregard my first comments. Some comments I read over just 'pushed my buttons' so I had to make comments. Change Hispanic to Anglo, and you'll see what I mean." Had any Panel member been non-Hispanic, there would have been an opening for elements to be legitimately viewed as racist, but with the entire Panel being Hispanic, every element represents the experience of at least one Panel member with the opportunity of all other Panel members to comment, agree or disagree with the statement, and rate it for its importance.

As the responses came in to the two "blank" questions that began the study, the researcher was touched by the profound honesty of the responses. Responses came in as simple lists, extended narratives, and one journal article. Upon reading all the responses to Round I, the researcher was surprised to find herself becoming "protective" of the information being so freely shared. The responses were aggregated into groups that seemed to make sense and like responses reduced to a single response. In the Round I, three respondents made it clear that allowing an Hispanic to "tell his story" was important. Ultimately, this concept is embodied in two elements from the research.

Do not interrupt the speaker. This is generally a good idea in any culture, but a surprising number of clinicians forget this when dealing with someone who is not

from their own culture—particularly the young and inexperienced. (92% agreement; 3.28 importance rating)

Providers should wait for a complete response from the individual(s) to whom they have posed a question. American culture seems to be obsessed with efficiency, and Hispanic culture is more focused on deliberation. The clash can manifest itself as impatience on the part of the clinician who poses what he believes to be a simple “yes/no” question (e.g. Does anyone in your family have diabetes?) and cannot wait for the less-than-simple answer that the patient will elaborate. (100% agreement; 3.08 importance rating)

In Round II, the Delphi Panel was asked to review all the elements in their groupings. They were to check to be sure that their thoughts had been captured accurately. They were asked to elaborate on any element they so chose and to add any elements that they felt were missing. They were also asked if the groupings made sense and were acceptable since they had been inserted by the researcher. Some Panel members additionally asked for clarification on elements which the researcher sought from the original authors of those elements in question.

The Delphi Panel painstakingly reviewed the elements, corrected elements, edited elements and groupings, and provided insightful commentary on numerous elements. The researcher again reduced like elements, but at the conclusion of Round II found it difficult to combine some elements. Since the researcher does speak Spanish and had some idea of the elevated concept of respect among Hispanics, some elements, while written in English, would hold slightly different meanings that could be interpreted as important differences to a Spanish speaker. Those seemingly similar elements were not reduced to a single element out of respect for the Panel member originating the element.

That operating decision created a “cultural clash.” Several Panel members noted the length of the document with two commenting specifically on it being “too long to be of much use.” Furthering the difference of opinion was the determination of the audience for the research findings. The Hispanic Delphi Panel was asked to list elements of cultural and linguistic appropriateness for non-Hispanic healthcare providers, but the consumers of the information are non-Hispanic healthcare providers. One Panel member provided this illuminating comment on a situation such as this, “This item captures what I was saying about Americans being more ruled by the clock than Hispanics (on average).” Non-Hispanic consumers of this research would probably prefer it to be condensed into a bulleted format. The researcher chose to preserve and use the Panel’s verbiage out of respect and in an effort to lessen the possibility of stereotyping.

The Panel expressed repeated concerns that any element lifted from context or used inappropriately could contribute to stereotyping. This was eloquently expressed in the following elements.

While every patient is an individual, and providers should not generalize or stereotype, it is appropriate to make common, general cultural observations, as long as the aim is not to stereotype or discriminate. (88% agreement; 3.04 importance rating)

There is an operating premise that Hispanics in Texas are of Mexican descent, not Cuban, Puerto Rican, Central American, etc., and most of these responses are based on this inference. Hispanics, however, are a very broad, non-homogenous group. There are common cultural elements among all Hispanics from Iberia and Iberia-America, but in some there are also unique aspects; thus, one cannot use a framework for healthcare providers who assume most Hispanics are of Mexican descent. One must stick to general principles of cultural models and move away from specific examples for Mexicans, Puerto Ricans, etc. (In other words, one needs to stay away from examples that start

with, “my Mexican patients always do this” or “Puerto Ricans always say this to mean that.” Obviously, there are times when providers have to specify, such as specific linguistic patterns and idioms that are specific to the different Hispanic groups: different meanings for similar words like *coger* (to seize, hold, catch, pick, gather, surprise, [slang variation, have sex] or *ahora* (now, very soon, just now, a short while a go) and completely different words for similar concepts. Lastly, having statistics for the various Hispanic group populations by number and percent for Texas as a whole and the large metropolitan areas would be helpful since different Hispanic groups may have settled in different communities due to immigration and emigration patterns. This will help healthcare providers to become aware of their specific Hispanic population within their specific area. (100% agreement; 3.04 importance rating)

Comments from Panel members further elucidate the problem.

1 - Groupings by nationality have some use, as long as one realizes that aggregating people by nationality or even other elements may/may not be totally accurate. There may be a need to look across Hispanics by other elements such as income, level of education, level of acculturation, to get more precise information. Data may need to be disaggregated to smaller units to gain precision.

2 - I would state that much like genes, cultural norms may have variable expression, and that the expression of a cultural norm may be more a function of a specific individual than a group. Again, pointing to individual differences vary more than group differences. For example, a 1st generation immigrant may be closer to that norm and express it (worshipping a saint), whereas a 3rd generation immigrant may be familiar with this norm (from their grandparents or other family members) but chose not to worship a saint but instead go to a pediatrician. Another 3rd generation person may go to the doctor and worship a saint (maybe go to church and say a prayer)--these are individual choices/preferences, and not representative of a group (1st generation v. 3rd generation immigrants) and it is what we must be aware of and familiar with this phenomenon.

3 - The more the provider knows about his/her patient, the better care he/she can provide. This includes gender roles, health care beliefs, customs and so much more.

Even though the Panel was very diligent in painting the whole picture, they were equally cognizant that the whole picture could be overwhelming to a non-Hispanic

provider. They reflected on the complexity of the problem in the following element and its illuminating comments.

Cultural competence requires the provision of services, education and training in the language and cultural context that is most appropriate for the individuals for whom the services are intended. (100% agreement; 3.36 importance rating)

1 - I do agree with this statement, but I think that we will never meet the language context--unless everyone learns every language. Perhaps it is more appropriate to say that cultural competence requires the "understanding of the importance of language and cultural context," whereas cultural proficiency may have the stricter requirement of the language requirement.

2 - I think that if the patient is comfortable with the provider, that the patient can accept language barriers. A warm smile, from a black or Anglo doctor, is still a warm smile.

3 - Not always a reality.

4 - Community clinics will service underprivileged people of many different backgrounds, and the providers need to be sensitive to the fact that not everyone is trying to take advantage of the government.

In the proposed framework for "Respect and Trust" the compromise resolution for the "cultural clash" was to present the framework in a manner consistent with current business operations. Then, each element was briefly summarized as an action step for the provider or healthcare organization followed by its supporting element directly from the Panel's work. This methodology for creating additional frameworks would accommodate respect for the Panel's work and a bulleted outline for non-Hispanics. Those providers seeking an in depth explanation of what constitutes cultural and linguistic appropriateness should find the examples and explanations of the Panel most helpful. (The framework has not been tested for validity and reliability. Anyone seeking to use it as other than a framework would need to do that testing.)

The framework for “Respect and Trust” was but the first of several that should be developed from the work of the Delphi Panel. It is hoped that their work will further the dialogue on how non-Hispanic providers serve Hispanic populations achieving more successful outcomes by providing the first listing of specific elements for non-Hispanic providers to be able to determine if those elements of cultural and linguistic appropriateness exist in their practices and organizations. If the providers and organizations find that the elements of cultural and linguistic appropriateness are lacking in their workplace, the Delphi Panel has provided sufficient examples and specificity for providers and organizations to take the necessary steps toward improvement.

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APPENDICES

APPENDIX A
CHRONOLOGY OF RESEARCH

Chronology of Research

1-14-04: Met with Dr. Lee Green about him working with the dissertation research in exchange for helping with his need for someone who spoke Spanish. Dr. B.E. Pruitt joined the meeting and was in agreement. It was agreed to add Dr. Green as co-chair of the graduate committee. Dr. Green agreed to call Lori Buhi and the Community Health Clinic and have her arrange for a meeting regarding work at the Clinic.

1-16-04: Met with Ms. Buhi at the Clinic. First, she had the Director of Nurses, Linda Vivar, conduct a conversational interview for Spanish proficiency acceptable for work in the clinic.

1-20-04: Met with Ms. Buhi at the Clinic to look at hours for work and direction of that work. Ms. Buhi wanted a learning model/chronic care model/improvement model for working with Hispanics diagnosed with diabetes that would come from a literature review and be based on best practices.

1-23-04: Met with Dr. Green and other members of his coalition who hold a grant looking at health disparities.

1-27-04: Met with Dr. Green to discuss questions worthy of dissertation research.

1-29-04: Met with Dr. Green and Ms. Buhi regarding work and work hours at the clinic. Ms. Buhi needed evidence-based information on self-management, optimizing self-management, and evaluation of self-management programs for the Hispanic population.

2-16-04: Met with Dr. Green regarding discontinuing work at clinic and thoughts on a direction for dissertation. No good information for Ms. Buhi was being discovered in literature searches. Perhaps this was an indication of the need for a meta-analysis of what did exist to find what the key elements of cultural competency actually are. Dr. Green wanted Dr. Pruitt's thoughts on the matter. In an immediate conversation with Dr. Pruitt, he said the dilemma sounded like a Delphi study would be a better way to go. Dr. Pruitt wanted close attention to rigor for the dissertation, directing the need to look at the Delphi procedure, seek out the key Hispanic leaders in the field, define cultural competency for use with Hispanics, find indicators of cultural competency, and look at Katie Pruitt's dissertation from 1994. Upon hearing Dr. Pruitt's recommendation, Dr. Green concurred that the Delphi study seemed most appropriate. He directed that verbal agreement should be obtained from the others on the committee. Dr. Danny Ballard agreed with the general idea of the study.

2-20-04: Drafted first statement of the problem: Hispanic people need good diabetic health information. Many/most of the providers of the information are not Hispanic. This information needs to be culturally competent. Much of the health information is

not culturally competent. Many efforts toward culturally competent guidelines are too general (from too many ethnicities). Not all Hispanics are created equal. Drafted first purpose of the study: This study will be designed to identify key elements of a culturally competent health education intervention.

2-25-04: Met with Dr. Jeffrey Guidry, and he very much liked the general idea for the study. Dr. Guidry suggested Dr. Amelie Ramirez as a panel member.

3-5-04: Met with Dr. Craig Blakely, and he was okay with the general idea for the study. Dr. Blakely suggested Miguel Zuniga from Honduras but current faculty member at SRPH, Isadora Flores and Nelda Mier, SRPH faculty in McAllen, Ann Millard, a medical anthropologist, Rogelio Saenz, Chair of Sociology at TAMU, and Cruz Torres in Sociology as potential panel members.

3-9-04: Met with Dr. Green regarding thoughts on organizing the panel for the study. The literature led to a feeling that the study should be limited to Hispanics in Texas since Texas has the 2nd largest Hispanic population in the nation, and it is the most homogeneous Hispanic population with approximately 80% tracing their heritage to Mexico. The literature also led to a feeling that it would be best to follow Delbecq's recommendation of using a nominating panel to get to the Texas experts. From the outset, Dr. Eduardo Sanchez, Texas' Commissioner of Health, and Dr. Ciro Sumaya, Dean of the School of Rural Public Health, seemed to be top choices for both the nominating panel and the actual Delphi panel, but a third panel member was needed, and it seemed important that the third member be an Hispanic woman who is prominent in Texas' healthcare. Dr. Guidry's suggestion of Dr. Amelie Ramirez seemed to be exactly right. It seemed tacitly very important that the panel should be comprised of only Hispanics, without the inclusion of non-Hispanics, even those who are very familiar with and work extensively with Hispanics.

3-23-04: Met with Dr. Green on the first draft of dissertation proposal.

4-6-04: Met with Drs. Pruitt and Green to refine the proposal and the process of the study. Dr. Pruitt wanted a chart or figure of the study. The proposal defense was planned for sometime after the week of April 19. There was discussion of where to publish the study when it was completed and which term to use for the population: Hispanic, Latino, or something else. More research was needed to decide the most appropriate term. There was also discussion of the actual proposal presentation.

4-26-04: Had the actual proposal defense. The committee signed the proposal with a couple of slight modifications.

5-12-04: Met with Dr. Sanchez in Austin. He agreed to be on the Nominating Panel as well as the actual Delphi Study Panel. He expressed the need for the study and enthusiasm for what the study might yield.

5-20-05: Filed Institutional Review Board request for approval for study with exemption from full IRB review and with a waiver of signed consent.

5-25-04: Met with Dr. Ramirez in San Antonio. She agreed to be on the Nominating Panel as well as the actual Delphi Study Panel. She also expressed the need for the study and enthusiasm for what the study might yield.

5-26-04: Received Institutional Review Board approval for study with exemption from full IRB review and with a waiver of signed consent.

6-2-04: Met with Dr. Sumaya in Bryan. He agreed to be on the Nominating Panel as well as the actual Delphi Study Panel. He also expressed the need for the study and enthusiasm for what the study might yield.

6-7-04: Sent email to Drs. Ramirez, Sumaya, and Sanchez requesting nominees for the Delphi Panel asking that those be in by the end of June/first of July.

7-5-04: Sent follow-up email requesting names of nominees.

8-2-04: Began soliciting Delphi Panel members from lists of nominees with priority to those who were double nominees. (There were 3, but Paula Gomez was the only double nominee to actually serve on the Delphi Panel.) Also began soliciting local Hispanic healthcare professionals to serve on the 5 person Review Panel.

8-16-04: Called Dr. Green requesting that the Delphi Panel number be cut from 33 to 24 after discovering in the Texas Department of Health documents that Texas really only has 8 “functional” public health regions instead of 11 and that finding Panel members in the East Texas areas was especially difficult with no nominations from that area coming in from the Nominating Panel. He asked that I email the whole committee seeking their input on the change and explaining the reason for the request.

8-17-04: Emailed committee requesting that the Delphi Panel number be reduced from 33 to 24 and explaining why. All committee members agreed to the reduction.

8-23-04: Completed Review Panel and sent out information and request for brief responses to the 2 research questions and evaluation of the cultural competency of the beginning documents.

9-1-04: Completed Delphi Panel and sent first email to assure electronic communication with entire Panel was established.

9-2-04: Received two more acceptances for the Delphi Panel bringing the number to 26.

9-9-04: Spoke with last Review Panel member on responses to the 2 research questions and cultural competency of the beginning documents.

9-10-04: Aggregated Review Panel information and made minor changes to accommodate their suggestions. Sent emails to Review Panel thanking them for their work.

9-13-04: Sent email with information to actually begin Round I with a deadline of 9-22-04 for response to Round I blank questions.

9-27-04: Sent dunning email for missing responses with deadline of 10-06-04.

9-28-04: Began aggregating responses into one list.

9-29-04: Called all Panel members who had not yet responded.

10-4-04: Sent another “personalized” email to those who had not yet responded.

10-18-04: Called all Panel members who had not yet responded.

10-19-04: Began trying to make responses grammatically parallel and to group similar responses.

10-31-04: Sent email to Panel members informing them that all Round I responses were in and that Round II would begin within a week or so. Sent update email to Drs. Pruitt and Green on study’s progress since the original deadlines were not working.

11-01-04: Finished aggregating like responses, making statements parallel, and grouping elements into like categories.

11-02-04: Sent email with attached file to begin Round II with 11-22-04 deadline for response to Round II reviews and edits of Round I information.

11-29-04: Sent first dunning email for response to Round II with vague deadline of as soon as possible given the coming holiday season and expressing the vague hope that the study might be concluded prior to the New Year.

12-6-04: Sent second dunning email for Round II responses requesting responses before the holiday vacation. Sent email to Drs. Pruitt and Green on study’s progress and lack of responses. They encouraged continued dunning efforts.

12-19-04: Sent third dunning email for Round II responses requesting responses as soon as possible after the New Year.

1-10-05: Called all Panel members who had not responded to Round II.

1-17-05: Sent fourth, individualized dunning email for Round II responses with deadline before scheduled meeting with Drs. Pruitt and Green on 1-20-05.

1-20-05: Met with Drs. Pruitt and Green to discuss the one missing response to Round II and how to proceed. They asked for one more attempt to solicit the missing response and then directed that Round III should begin. Dr. Pruitt brought up the idea of doing the dissertation as several publishable articles with Dr. Green saying he could see at least four article concepts: the literature review, the process of the study, the findings, and the recommendations. Dr. Pruitt added that the methodology becomes a chronology attached as an appendix. Dr. Pruitt said there is information on the Thesis Office website.

1-21-05: Sent one last email and made a phone call for the one outstanding response to Round II.

1-24-05: Emailed an update to Panel on the slow progress of Round II and the permission to now move forward with the one missing response.

1-27-05: Received the last outstanding response to Round II.

3-1-05: Met with Dr. Green for determination of most appropriate journal for publication of study and to obtain signature for Institutional Review Board Continuing Review Application. Filed paperwork to apply for Continuing Review Application for extension of study with exemption from full IRB review and with a waiver of signed consent.

3-7-05: Talked with Panel member for clarification of statement of element.

3-2-05: Sent explanation of delay for start of Round III.

3-27-05: Began work with Dr. P. J. Miller to set work from Round II into an electronic format for Round III that would allow Panel to agree or disagree with each element, rate each element for importance, and rank order each group of elements.

4-6-05: Tested emailing Round III to see if it would go and how long it would take to open and respond.

4-12-05: Sent email announcing the arrival later in the day of two emails to begin Round III. Received word that some Panel members could not open files and that others had the files "crash" their computers. Sought help from Dr. Miller to "zip" files, and then resent the files.

- 4-13-05: Received word that some Panel members could still not open files.
- 4-14-05: Received word that some servers would not allow receipt of the emails with the files attached . Sent email to Dr. Green for advice on how to proceed and received the name of Dr. Rod Ham at the Center for Distance Learning Research at TAMU.
- 4-15-05: Sent “cease and desist” email for Round III asking Panel members to delete the files and correspondence with the files attached since it was causing so much difficulty.
- 4-18-05: Called Dr. Ham, explained the problem, set up appointment for 4-19-05.
- 4-19-05: Met with Dr. Ham, Darryl Bassile, and Sudhakar Ramasamy at the Center for Distance Learning Research, and they were certain that they could create a portal and allow the Panel to respond electronically through the portal with the added benefit of the computer doing the tabulation of results. Sent the names and email addresses of all Panel members to Mr. Bassile.
- 4-20-05: Sent Mr. Bassile Round II edited files for posting into the portal.
- 4-26-05: Met with Mr. Bassile and Mr. Ramasamy to review Round III functioning through the portal.
- 4-27-05: Began testing portal access and function with several individuals not on the Panel.
- 4-28-05: Wrote new letter of explanation for restarting Round III, and instructions for opening page of portal. Sent both to Mr. Bassile for review and correction.
- 4-29-05: Made correction to both restart email and portal instructions based on feedback from testing. Sent those to Mr. Bassile with request to do more testing when instructions were pasted into the portal.
- 4-30-05: Tested Round III through the portal following the instructions that had been pasted into the beginning.
- 5-1-05: Checked with other individuals testing the portal to make last minute corrections.
- 5-2-05: Made last corrections to portal instructions with Mr. Bassile. Sent email to restart Round III through the electronic portal at the Center for Distance Learning with a deadline of 5-27-05. Sent email to Drs. Pruitt and Green to let them know that Round III had finally begun in earnest.

5-24-05: Sent out “hard” copy by mail with a return postage paid envelope for a Panel member who requested it.

5-27-05: Received Institutional Review Board approval of Continuing Review Application for extension of the study with exemption from full IRB review and with a waiver of signed consent.

5-31-05: Sent dunning email to Panel members who had not responded with a deadline of 6-6-05. Sent out “hard” copy by overnight mail with a return postage paid envelope for a Panel member who requested it.

6-12-05: Sent dunning email to Panel members who show to be “in progress” on the report from the Center for Distance Learning Research without a stated deadline. Sent email to Drs. Pruitt and Green on study’s progress and lack of responses. They encouraged more dunning efforts.

6-13-05: Called all Panel members who had not begun work on Round III through the portal, and seven members asked for “hard” copies of the round. Sent those seven and two additional members “hard” copies to allow for them choosing which method was best for them and included a return postage paid envelope with a deadline of 6-24-05.

6-29-05: Sent a letter by mail to those Panel members who had not responded with a deadline of 7-8-05 explaining that the study and the dissertation were in danger of failing without their responses.

7-18-05: Scheduled a meeting with Drs. Pruitt and Green.

7-19-05: Sent a letter by mail to the remaining three Panel members who had not responded with a 7-27-05 deadline explaining the importance of 100% participation in all rounds in a Delphi Technique.

7-20-05: Met with Drs. Pruitt and Green to update the progress on Round III and ask permission, which was granted, to conclude the study with the three missing responses. Decided on two publishable articles for the dissertation with one being the explanation of the study culminating in the development of the groupings of the elements which define cultural competence and the second being the development of a framework for “respect and trust.”

7-28-05: Worked with one Panel member by phone to complete the response using the electronic portal.

7-29-05: Met with Mr. Bassile at the Center for Distance Learning Research to run all the data from the study even though two responses were missing and asked that the portal access be closed for those two Panel members.

8-5-05: Met with Drs. Pruitt and Green to review first draft of first journal article and ask about scheduling defense.

8-8-05: Sent email to committee asking to schedule defense.

8-11-05: Met with Drs. Pruitt and Green (by phone) to review second draft of first journal article and set date for defense. Sent email to all committee members confirming defense for October 10 at 10:00am.

8-13-05: Received by mail one of remaining two outstanding responses.

8-15-05: Called Mr. Bassile to reopen portal for two Panel members who had not responded and entered the "hard" copy responses received on 8-13-05. Called the one remaining Panel member who had not responded and left a voice message. Sent an email plea explaining that it was the only response still outstanding and stressing the importance of 100% participation.

8-17-05: Met with Drs. Pruitt and Green to review first draft of second journal article.

8-18-05: Sent unsolicited "hard" copy of Round III to the last Panel member by overnight mail with return overnight mail postage paid envelope since observing that the Panel member had worked on a few of the responses.

8-31-05: Sent Preliminary Report of Results to all Delphi Panel members with the complete Panel roster, the rankings of the groups of elements, and the Delphi process table.

9-7-05: Met with Dr. Pruitt to review first draft of complete dissertation.

10-10-05: Had dissertation defense and work met with the approval of the committee.

APPENDIX B
COMMUNICATIONS WITH REVIEW PANEL

First Communication with Review Panel

Dear Review Panel Members,

I am grateful to you for agreeing to review communications with the Delphi Panel for my dissertation study. As you know from our earlier communications, a Delphi technique seeks to gain the wisdom, insight, or informed judgment from an anonymous panel of experts that is refined through rounds of anonymous interaction to gain consensus. You are already aware of the two questions I want my Delphi Panel, Hispanic health professionals from around Texas, to answer: 1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? 2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

I am attaching the first formal communication with the Delphi Panel which I hope will collect profile information from the panel members for acknowledgments when the study is complete, and I would like you to fill it out as well for those same acknowledgment purposes. It is also to verify that I am in “electronic” communication with both panels. I am at this time also attaching the second formal communication with the Delphi Panel which actually begins the formal part of the study. I am asking that you review panel members check the communication to see if it makes sense and that I have not breached some cultural barriers inadvertently. I am also asking that you give me what your answers to the two questions would be. Your responses do not have to be exhaustive. It is my way of “field testing” the questions to get an idea of what kind of responses may come back. Your answers will not be a part of the study, but will help guide me with my planning for the next phase of the study.

If you could get your responses back to me by the end of Labor Day Weekend, then I can send the communication out to the Delphi Panel to begin the process early in the second week of September. I will let you know with a quick email that I have your responses, then there will be what looks to be a three week period before I am back in touch with you for the second part of your review.

Again, I cannot thank you enough for your generosity in participating in my dissertation study.

Sincerely,
Linda Ponder

Acknowledgement Information for Delphi Study Participants

Please fill in the requested information and return to me as quickly as possible.

Name:

Degrees and Certifications with proper abbreviations:

Title:

Institution, Affiliation, Agency, or Company:

Health care profession:

City:

Brief statement of what your current work entails or recent accomplishments you wish to share:

Information Sheet for Review Panel

As a part of my methodology for the research on my dissertation topic, I need a 5 person review panel of local Hispanic health providers. I am asking that they review and make suggestions on all information I will be sending out to the Delphi Panel who agreed to participate in this study. I am attaching the Information Sheet for Delphi Panel members so that you see what they are given at the outset of the study explaining what we will be doing. Each time they are to receive information, you will see it first and make comments on its understandability. I will then make changes based on your suggestions before sending out the documents to the Delphi Panel. While your input will not show up in the final data analysis, your input is vital to making the whole process work smoothly in order to achieve the best results possible. I'm in hopes that we will begin this work the first part of September and be finished by mid-October. Your time commitment will be about the same as that for the Delphi Panel except that you will not have to provide the answers nor ranking and rating information. You will not see the raw answers from the panel, but only the information after I have compiled it. Again, I am asking that you help me have what the Delphi Panel sees make sense.

This study stems from my work in delivering health and human services to Texans and coming to realize that while our Hispanic population is growing, our numbers of Hispanic health providers is staying constant at around 3-4 %. Health outcomes for Hispanics are worse than for non-Hispanics. In the short term, I hope the information from this study will help to improve those outcomes while others in our state seek to find ways to increase Hispanic providers.

Information Sheet for Delphi Panel Members

About 32% of Texas' population is Hispanic, but only about 4% of Texas' health services providers are Hispanic. Research suggests that a lack of culturally and linguistically appropriate health services is a cause of poorer health outcomes for Hispanics. While Texas' institutions preparing health services providers try to recruit and train more Hispanic providers, something must be done to increase the cultural and linguistic appropriateness of non-Hispanic providers. Toward that end, I want to work on determining key elements of culturally and linguistically appropriate health interventions for the Hispanic population in Texas.

A man named N. C. Dalkey at the Rand Corporation believed that various types of information occurred on a continuum with "knowledge" being on one end and the opposite extreme being "speculation." He also believed that often in the field of public health "knowledge" was very hard to achieve, but in the middle of the continuum was a grey area of "wisdom," "insight," or "informed judgment." To seek that "wisdom, insight, or informed judgment" he and his colleagues developed what has come to be

known as a Delphi technique. I have chosen this method as having the best potential for determining key elements of cultural and linguistic appropriateness.

Since I am not bicultural and only bilingual in certain circumstances, I am asking that you participate in this Delphi study to be conducted by email. I asked Dr. Eduardo Sanchez, Dr. Ciro Sumaya, and Dr. Amelie Ramirez to help me find 33 qualified health services providers around the state of Texas to serve on this Delphi panel. Your name was given to me by them. I hope you will agree that this study is worth your time to participate.

This study is proposed as a three round Delphi technique by email. In Round I, you will receive what are called “blank” questions. There are two: 1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? 2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? You will list as many answers to both questions as you can think of or that you think are appropriate. This should take 30 minutes to an hour. You will have a week to get your responses back to me. I will spend a week or so organizing your responses, reducing duplications, and creating categories if appropriate. Your responses will be unidentifiable to the other panel members. You will then get Round II.

In Round II, you will be asked to look at everyone’s responses being sure that I accurately captured your original responses, adding anything additional you may have thought of since Round I, and writing arguments for or against items you feel strongly about. This should take about an hour. You will have 10 days to respond to Round II. I will then spend another week or so organizing your responses, reducing duplications, refining categories as needed, and incorporating the arguments. Your responses and arguments will be unidentifiable to the other panel members. You will then get Round III.

In Round III, you will be asked to read the responses and arguments for and against. Then you will be asked to rank the responses and rate them as very important, important, or unimportant. You may make summative comments at this time if you so choose. This should take an hour to an hour and a half. You will have 10 days to respond to Round III. I will spend about 2 weeks tabulating the results, and if there is general consensus, your work is finished. If there isn’t a general consensus, a fourth round may be needed patterned after Round III. As in the other rounds, your answers will still be kept confidential. You will receive the summative report approximately two weeks after the conclusion of the final round.

All of your responses during the rounds will be confidential and handled only by me so as to allow you to express yourself freely and completely. There will be none of your identifying information attached to your responses as the rounds progress, and in the summative report, you will not be identified by name. Your name will appear in my acknowledgements as a participant, but there will be no way for anyone to attach your name to your statements.

I am hopeful that we can begin the actual study in late July and that we will be finished by early October. Since one of the critical elements of a Delphi technique is the stability of the panel, please give serious consideration to your ability to complete this process if you agree to begin. While there isn't a great deal of "labor" being asked of your participation, there can be a fair amount of "think time" involved. I very much want this study to produce information useful to improving health services access for Hispanic Texans. Only if you share your wisdom, insight, and informed judgment will this study have a chance at succeeding, but please be aware that there will be no tangible benefit to you for your participation. Likewise, there is no risk of harm to you for participating either. Your participation is voluntary and you may withdraw from the Delphi panel at any time should the need arise.

Should you have questions or concerns, please feel free to contact me:

Linda Ponder

979-776-1880

LMPONDER@tamu.edu

or

Co-chairman of my graduate committee:

Dr. B. Lee Green

979-862-4403

lgreen@tamu.edu

"I understand that this research study has been reviewed and approved by the Institutional Review Board-Human Subjects in Research, Texas A&M University. For research-related problems or questions regarding subjects' rights, I can contact the Institutional Review Board through Dr. Michael W. Buckley, Director of Research Compliance, Office of Vice President for Research at (979)458-4067 or (mwbuckley@tamu.edu)."

Blank Questions to Begin the Delphi Technique

1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

APPENDIX C
COMMUNICATIONS WITH DELPHI PANEL

Sample Email Soliciting for Delphi Panel Members

Dear _____,

I am a PhD candidate in the Department of Health and Kinesiology at Texas A&M. My dissertation study is a Delphi process regarding cultural and linguistic appropriateness for non-Hispanic health professionals serving Texas' growing Hispanic population. My nominating panel is Dr. Eduardo Sanchez, Dr. Ciro Sumaya, and Dr. Amelie Ramirez. You have been nominated as one of the state's experts who should serve on this panel. I would be happy to visit with you about this study if you have questions that are not answered in the attached information sheet for panel members. You may call me at 979-776-1880 or send me an email and let me know when it would be convenient to call you.

At this time, it looks like the actual Delphi process will occur from early September through October, but it is dependent on how quickly I have the entire panel in place.

Thank you for your consideration.

Sincerely,
Linda Ponder

Information Sheet for Delphi Panel Members

About 32% of Texas' population is Hispanic, but only about 4% of Texas' health services providers are Hispanic. Research suggests that a lack of culturally and linguistically appropriate health services is a cause of poorer health outcomes for Hispanics. While Texas' institutions preparing health services providers try to recruit and train more Hispanic providers, something must be done to increase the cultural and linguistic appropriateness of non-Hispanic providers. Toward that end, I want to work on determining key elements of culturally and linguistically appropriate health interventions for the Hispanic population in Texas.

A man named N. C. Dalkey at the Rand Corporation believed that various types of information occurred on a continuum with "knowledge" being on one end and the opposite extreme being "speculation." He also believed that often in the field of public health "knowledge" was very hard to achieve, but in the middle of the continuum was a grey area of "wisdom," "insight," or "informed judgment." To seek that "wisdom, insight, or informed judgment" he and his colleagues developed what has come to be known as a Delphi technique. I have chosen this method as having the best potential for determining key elements of cultural and linguistic appropriateness.

Since I am not bicultural and only bilingual in certain circumstances, I am asking that you participate in this Delphi study to be conducted by email. I asked Dr. Eduardo Sanchez, Dr. Ciro Sumaya, and Dr. Amelie Ramirez to help me find 33 qualified health services providers around the state of Texas to serve on this Delphi panel. Your name was given to me by them. I hope you will agree that this study is worth your time to participate.

This study is proposed as a three round Delphi technique by email. In Round I, you will receive what are called "blank" questions. There are two: 1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? 2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services? You will list as many answers to both questions as you can think of or that you think are appropriate. This should take 30 minutes to an hour. You will have a week to get your responses back to me. I will spend a week or so organizing your responses, reducing duplications, and creating categories if appropriate. Your responses will be unidentifiable to the other panel members. You will then get Round II.

In Round II, you will be asked to look at everyone's responses being sure that I accurately captured your original responses, adding anything additional you may have thought of since Round I, and writing arguments for or against items you feel strongly about. This should take about an hour. You will have 10 days to respond to Round II. I will then spend another week or so organizing your responses, reducing duplications, refining categories as needed, and incorporating the arguments. Your responses and

arguments will be unidentifiable to the other panel members. You will then get Round III.

In Round III, you will be asked to read the responses and arguments for and against. Then you will be asked to rank the responses and rate them as very important, important, or unimportant. You may make summative comments at this time if you so choose. This should take an hour to an hour and a half. You will have 10 days to respond to Round III. I will spend about 2 weeks tabulating the results, and if there is general consensus, your work is finished. If there isn't a general consensus, a fourth round may be needed patterned after Round III. As in the other rounds, your answers will still be kept confidential. You will receive the summative report approximately two weeks after the conclusion of the final round.

All of your responses during the rounds will be confidential and handled only by me so as to allow you to express yourself freely and completely. There will be none of your identifying information attached to your responses as the rounds progress, and in the summative report, you will not be identified by name. Your name will appear in my acknowledgements as a participant, but there will be no way for anyone to attach your name to your statements.

I am hopeful that we can begin the actual study in late July and that we will be finished by early October. Since one of the critical elements of a Delphi technique is the stability of the panel, please give serious consideration to your ability to complete this process if you agree to begin. While there isn't a great deal of "labor" being asked of your participation, there can be a fair amount of "think time" involved. I very much want this study to produce information useful to improving health services access for Hispanic Texans. Only if you share your wisdom, insight, and informed judgment will this study have a chance at succeeding, but please be aware that there will be no tangible benefit to you for your participation. Likewise, there is no risk of harm to you for participating either. Your participation is voluntary and you may withdraw from the Delphi panel at any time should the need arise.

Should you have questions or concerns, please feel free to contact me:

Linda Ponder

979-776-1880

LMPONDER@tamu.edu

or

Co-chairman of my graduate committee:

Dr. B. Lee Green

979-862-4403

lgreen@tamu.edu

"I understand that this research study has been reviewed and approved by the Institutional Review Board-Human Subjects in Research, Texas A&M University. For research-related problems or questions regarding subjects' rights, I can contact the Institutional Review Board through Dr. Michael W. Buckley, Director of Research Compliance, Office of Vice President for Research at (979)458-4067 or (mwbuckley@tamu.edu)."

Blank Questions to Begin the Delphi Technique

1) What are key elements of cultural appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

2) What are key elements of linguistic appropriateness for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

First Communication with Delphi Panel

Dear Panel Members,

Thank you again for agreeing to participate in my dissertation study as a member of the Delphi Panel of Hispanic health care professionals in Texas. I want to acknowledge each of you fully and appropriately at the conclusion of the study, so I am asking that you fill in and return the following information for me. This brief form also serves as a way for me to verify that we are in “electronic” communication as a panel. You should be anonymous to everyone but me in these exchanges. In the unlikely event that you are “seeing” other panel members on this communication, please let me know so I can correct the problem before we begin the actual Delphi process. We will begin the actual Delphi process by the end of the week. And again, thank you so much for participating.

Sincerely,
Linda Ponder

Acknowledgement Information for Delphi Study Participants

Please fill in the requested information and return to me as quickly as possible.

Name:

Degrees and Certifications with proper abbreviations:

Title:

Institution, Affiliation, Agency, or Company:

Health care profession:

City:

Brief statement of what your current work entails or recent accomplishments you wish to share:

Communication to Begin the Delphi Process

Dear Panel Members,

At long last, we are ready to begin the actual Delphi Process we have been discussing for some time now. The study as proposed and explained in your “Information Sheet for Delphi Panel Members” is to be three rounds (with a possible fourth round if consensus is not obtained). The following two questions begin the Delphi Process and are Round I:

3. What are key elements of **cultural appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?
4. What are key elements of **linguistic appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

It is my belief that we are all culturally and linguistically competent in our own native culture, and some of us are fortunate enough to have more than one native culture and language. While I have studied Spanish and the culture of Mexico all my adult life, I do not feel culturally and linguistically competent, but the studies have given me some levels of appropriateness in given situations. I have often been asked about culturally and linguistically competent health services for Hispanics and have never truly been comfortable answering those questions. I am grateful to you for giving voice to what those elements of cultural and linguistic appropriateness are in the hope that it will assist non-Hispanics like myself.

In our “getting acquainted” conversations, some of you asked for examples of the elements. I am still not comfortable in providing Hispanic examples. My native language and culture are that of West Texas. If I substitute “West Texan” and “non-West Texan” for “Hispanic” and non-Hispanic” in the questions, I can give you examples of the elements.

1. In the culture of West Texas, the folk medicine relies heavily on the treatments used for livestock. It would be important for a non-West Texan to know to inquire *carefully* about the use of veterinary supplies like bag balm, udder cream, DMSO, or even cambiotic. This practice seems less unusual with the appearance of mane and tail shampoos and conditioners in the local Wal-Mart. Many of our older West Texans wear copper in the belief that it helps with arthritis. It is usually fashioned from copper tubing into bracelets or rings. Another important cultural element is the suspicion of outsiders, even helping professionals like teachers and health care professionals. It will require a building of trust to persuade us to talk openly and honestly such as in revealing that we self-medicate with veterinary supplies or old-fashioned home remedies. We often don't view this as “medicine” when asked to list the medications we currently use.
2. In the language of West Texas, we routinely use the verb “reckon.” It is archaic in all places where English is spoken except West Texas where it is still used in a grammatically correct fashion meaning “think about seriously or intensely.” In

West Texas we also still speak of the body part called “leaders.” That would be a tendon or large muscle which can be easily felt usually across the neck or top of the shoulder area or the back of the knee. In West Texas, we frequently get our “leaders all balled up.” In a slightly different linguistic area, West Texans often need to tell you something three times to be sure you understand. An outsider who stops the second and/or third telling would be considered rude.

You may list your elements any way you choose. They do not have to be parallels to the examples I gave you. You have no restrictions as to how many or how few you list. I do recognize that sometimes it is hard to determine if an element is cultural or linguistic. List those elements, and we’ll see where the process leads us. The Delphi process, unlike many other academic studies, does not begin with the testing of a hypothesis. It truly is the collecting of current wisdom, insight, and informed judgment on a given topic. This is the beginning step in collecting your wisdom, insight and informed judgment on the two questions at hand.

Please send back your list of responses to the two questions by September 22. Don’t hesitate to contact me if you have questions.

Sincerely,
Linda Ponder

PS—I appreciate the acknowledgement information that many of you returned, but I still need that information from more than half of you. I don’t want to be remiss in the formal thank you when the study is complete.

Round I Dunning Email # 1

Dear Panel Members,

The suggested deadline for Round I has passed without me receiving your input. The power of the Delphi comes from its members, and I value what you can contribute. The responses that are in are most intriguing, and I am hopeful that your response will arrive in the next day or two since I am already refining the responses to begin Round II. It cannot go out, however, until all the Round I responses are in. If there is something I can do to facilitate your response, please let me know what that is. I look forward to hearing from you shortly.

Sincerely,

Linda Ponder

5. What are key elements of **cultural appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?
6. What are key elements of **linguistic appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

Round I Dunning Email #2

Dear Panel Members,

I know you are very busy professionals and that I am asking one more, non-essential task of you. I am, however, to the “pleading stage” for your Round I responses. In the rigid structure of a Delphi process, I cannot move the study forward without responses from all the panel members. Round I is the most difficult because you are being asked to come up with the lists of elements from thin air.

The good news is that your responses need not be exhaustive. You will have a chance in Round II to add anything you may think of after reviewing the compilation of all responses. **Right now, if you could send me even one response to each question or at least a note saying you can't think of anything, it will allow the process to move forward.**

Sincerely,

Linda Ponder

7. What are key elements of **cultural appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?
8. What are key elements of **linguistic appropriateness** for Hispanic populations in Texas that would assist non-Hispanic providers to help eliminate personal barriers for accessing and receiving quality health services?

Acknowledgement of Receipt of All Round I Responses

Dear Panel Members,

This is just a quick note to let you know that I have now received **all** the Round I responses. I can't begin to describe the depth of my gratitude to each of you.

The responses present for me, and I am hopeful for other non-Hispanics, the first in-depth listing of cultural and linguistic elements. I have been engaged for several weeks in compiling those responses. I hope you are going to find that I have faithfully rendered your responses into one document. While the document will appear much lengthier than in Round I, it should be a much easier round for you. Round II should be ready at the end of this week or early next week.

Again, many thanks for your participation. I will be in touch again soon.

Sincerely,
Linda Ponder

Communication to Begin Round II of the Delphi Process

Dear Panel Members,

I am deeply grateful for your work on Round I. The picture created by your listing of elements is indeed profound. I know of no place where such a complete listing occurs, and I believe that is what makes your work so important for Texas' Hispanic population.

As you look at the compiled list of elements, please keep in mind that I tried to render your thoughts faithfully into a cohesive, single document but may have inadvertently altered your intent. I condensed like thoughts into a single element and grouped elements under broad topic heads. The elements you submitted are divided among those broad topic heads and not listed together by individual panel members. Within a broad topic head, there seemed to be some elements that were similar although not sufficiently so to combine into a single element. Those are placed together. Elements appear in the list in no particular order of importance. I want you to be prepared for a lengthy document when you open the attached file, but I think the work of this round is fairly straight forward and not as difficult as in Round I.

The purpose of Round II is to have the panel check all responses for accuracy and clarity, and add any forgotten or additional responses desired. If you wish you may provide comments arguing for or against items of special interest or importance. This, however, is essentially a round for editing the pool of elements.

Instructions for Round II:

1. Open the attached Word file saving it to your own hard drive or a disc so you may make comments, corrections, and additions, then resend it to me; **or** if it is easier for you with the size of the file, simply respond to this email with your comments, corrections, and additions by referencing elements on particular page numbers; **or** you (or your assistant) may call me (979-776-1880) and go over your comments, corrections, and additions verbally. I have no preference, and I want your response method to be what is most convenient for you.
2. Check to be sure that all your elements are listed. Tell me what I omitted.
3. Check to see that I did not alter the intent of your elements. Rephrase the element to restore you intent.
4. Check to see if your elements need further explanation since they are no longer in the context in which you submitted them. Add any needed clarification.
5. After reading through the elements, please provide any additional elements that occur to you.

Please respond by November 22, so we may all enjoy the Thanksgiving holiday later that week. If the deadline presents a problem for you or you have questions of any kind, please let me know since it is critical to the success of the Delphi Process that the panel remains totally intact. Again, thank you for your work on what I believe is a process to provide critical, needed information for Hispanics in Texas.

Sincerely,
Linda Ponder

Round II Dunning Email #1

Dear Panel Members,

The suggested deadline for Round II has passed without me receiving your input. Again I remind you that the power of the Delphi comes from its members and keeping the Panel intact, and I value your contribution to this work. The responses that are in are helping to refine and clarify the elements. I do recognize that the compiled document is lengthy, but I am hopeful that your response will arrive in the next day or two. At this time, I am hopeful that we can finish Round II soon, and perhaps still finish the rounds of the study before the New Year, but I know that is a long shot. Round III cannot go out, however, until all the Round II responses are in. I am attaching below the original Round II email with instructions and the file of the Round I compiled document. If there is something else I can do to facilitate your response, please let me know what that is. I look forward to hearing from you shortly.

Sincerely,

Linda Ponder

Round II Dunning Email #2

Dear Panel Members,

I know this is an exceptionally busy time of the year, and I hate continuing to pester you for your Round II response. I am, however, terribly anxious to have your Round II input. I think you can see from Round I that there is already a great deal of work from the Panel, and I am hopeful that you will not stop your participation in this project. I value your contribution to this work and remind you that the power of the Delphi comes from its Panel members and keeping the Panel intact. I do recognize that the compiled document is lengthy, but Round III cannot go out until all the Round II responses are in. I am attaching the original Round II email with its instructions and the file of the Round I compiled document. If there is something else I can do to facilitate your response, please let me know what that is. I look forward to hearing from you very soon so we can all enjoy the upcoming holidays.

Sincerely,

Linda Ponder

Round II Dunning Email #3

Dear _____,

Please forgive my persistence on getting your Round II response. I know this is a particularly hectic time of year, but your response is important to me and to the future value of this study. I would welcome extensive comments and edits if you feel you can devote the time to it. If however, you have only a few moments and you find your original responses are satisfactory in the compiled document, all I need is a quick email saying that you are fine with me moving the process forward.

I will be out of town and unable to check emails from Thursday, December 23 to Thursday, December 30. If you have questions, I would be happy to answer them the first part of this week. I would very much like to prepare Round III as quickly as possible after the New Year, but I do not wish to proceed with the study without your response. I am attaching the original information from the start of Round II in hopes that it will make your response as easy as possible

During this holiday season as I reflect on my blessings, I continue to be grateful that you agreed to participate in this Delphi study. I ask forgiveness for believing in the study so much that I continue to bother an already overworked professional.

Happy Holidays,
Linda Ponder

Letter on Conclusion of Round II

Dear Panel Members,

Since the original deadline for finishing Round II is long past, I wanted to provide you with an update. A number of panel members had work and personal circumstances that made the fall deadline impossible. I met with my dissertation committee co-chairs last Thursday, and they have given permission to move the study to Round III even though there is still one missing response* to Round II. They are also quite impressed with the make-up of the panel, your diligence in this project, and the information you are providing. For that I am deeply grateful. Thank you for participating and being so tolerant of my persistent requests for your input.

I am finishing the edits on your Round II responses. Then I will meet with my computer support person to help make the application of the Likert scale to the elements as easy for you as possible. Then we will begin Round III. Even as raw as the Round I material was, many of you were excited about the shape the information is taking. Your enthusiasm helps energize me as well. Thank you, thank you.

I anticipate beginning Round III in mid-February, but I will be in touch if there is a significant change in the schedule.

Sincerely,

Linda Ponder

(*This missing response came in after this email was sent out making for 100% participation in Round II.)

Explanation of Round III Delay

Dear Panel Members,

I apologize for the delay in getting Round III started, but I have now suffered my own setback. The entire month of February was consumed for me dealing with migraine headaches. My doctor seems to be onto treatments that are going to allow me to resume the editing of your Round II work. I tried to do a better job of explaining the delay, but decided the bare truth stated plain out was best. I am sorry because I find the work quite satisfying, but I found I could not do it justice with the headaches raging or on the medication for the headaches. I will be back in touch when Round III is ready. Again, please accept my apologies. I just wanted you all to know what is going on here.

Sincerely,

Linda Ponder

Round III Beginning Letter of Explanation

Dear Panel Members

At long last, I have Round III ready for you, and it will be arriving later today in two emails entitled Delphi Part I and Delphi Part II. With the ratings scales attached to each element, the files are quite large. The emails may take a while to download with an additional amount of time required to open the attached files. I tested the files, and my computer expert has ironed out the bugs we discovered, but you may encounter problems we could not foresee. That is the reason for this advance email. I am pleading with you in advance to let me know quickly if you have problems with the electronic version. I will send you a hardcopy by “snail” mail if the electronic copy is problematic for you in any way. I just need you to send me an email with the mailing address where you want the copy sent, and I will include a return envelope with postage attached.

Given the comments some of you made in Round II, I need to reiterate that all of you are Hispanics, and since I am not that governs a great deal of what I did and didn't do with the edits. It was important to me that in this first attempt to formulate lists of cultural and linguistic elements relevant to Hispanics in healthcare settings that only Hispanics be allowed to participate as Panel members. The elements come strictly from your submissions. Based on the comments you submitted in Round II, I feel compelled to explain my choices on the edits to Round II:

- 1) I incorporated the edits that you made to each other's elements, but only if those edits did not seem to me to alter the intent of the element.
- 2) Some elements generated a number of questions, and I contacted the original authors of those elements for clarification.
- 3) A few of you commented on the lack of published research supporting some of the elements. I agree that the elements would be strengthened or weakened by research, but the two open-ended questions that began this study did not require research-based responses only. The questions allow for experience-based responses. Some of you have extensive research backgrounds while others of you do not, but all of you have a lifetime of experience to share, and that is what I set out to gather.
- 4) It was suggested that some elements be eliminated, but I felt that would dishonor the experience of those who submitted the elements. Consequently, I did not remove any elements. The ratings of each element in a Delphi process sorts for importance.
- 5) Some of you observed that there are contradictory elements in the lists. Those contradictions remain and should be sorted out by your ratings of each element.
- 6) Many elements elicited comments of agreement or disagreement, sufficient enough in my mind to warrant the addition of “agree/disagree” as a part of the rating of each element.
- 7) A few of you commented on the length of the document and suggested further editing and consolidation of the elements while others of you commented on the importance of allowing for “elaboration.” After much deliberation, I consolidated, edited, and rearranged only to the extent that was suggested by Panel members.

This study is a beginning, but it already is generating interest among you and here at TAMU with my graduate committee. I am hopeful that once completed, it will stimulate much needed discussion and further research. I am grateful to each of you for your participation, and I am delighted to report that, so far, the Panel continues to have a 100% response rate which is critical to the power of a Delphi study. My anticipation and excitement grow as I look forward to your responses to Round III. Please don't hesitate to contact me if you have questions since we are now at the critical stage of completing the study.

Sincerely,
Linda Ponder
979-776-1880

Round III Directions

Dear Panel Members,

Here are the instructions for working with the two files containing parts I and II of the elements you have submitted in the Delphi study. Part I contains the cultural elements while Part II contains the linguistic elements.

- 1) Open the attached file. Be patient, it takes at least several minutes.
- 2) Save the file to your hard drive.
- 3) Work from the saved file.
- 4) You must “turn off” the design icon to be able to click on the choices in each box. If you work on the file in sessions, you will have to “turn off” the design icon each time you reopen the file. Be sure to save your work each time you close the file. The icon on my files appears on the lower right hand side of the screen.
- 5) In front of each element are two boxes, one for you to select that you agree or disagree with the element. The other is for you to select (rate) how important you think the element is. Sometimes a double click is required to get the selection to appear, but sometimes a single click makes the selection. (I have no idea why that is.) It would seem to me that if you disagree with the element then you would find it unimportant, but that may not be the case. I hope if it isn't the case, you will comment for me in the actual element box. (See next step.)
- 6) In the box containing each element, you may elect to open the format section and select a different font to make your comments stand out. Change the font and color so that I can see your comments and feel free to add whatever you choose.
- 7) At the end of the cultural section and again at the end of the linguistic section are listings of the sub-topics from each section. I ask that you rank/number them for their order of importance with “1” being the most important, “2” being next most important, etc.
- 8) Once you finish your responses, save the file and attach it to this email as a response which will take several minutes. Then send it back to me.
- 9) If you have questions, please email or call as soon as possible. 979-776-1880

I would like to have these back by Tuesday, May 3. I am hopeful that 3 weeks is sufficient for you to complete this round. If, however, that is problematic for you, please let me know since I am planning an August defense of the dissertation.

Sincerely,
Linda Ponder

Cease and Desist on Round III

Dear Panel Members,

You all have my most prolific and sincere apologies for the troubles being created with the Round III emails and their attached files! Several of you have reported major difficulties, and I do not want to have this round cause more computer problems for you. No one has reported being able to use the files to reply, so I'm asking at this time that you please delete the files and emails on Round III if they cause you any difficulty. I'm trying to check with other computer experts here at TAMU for a solution. We may have to resort to "snail" mail and hard copies. Again, my humble apologies for any difficulties this has caused you, and I will be back in touch when I have the best solution to the problem that I can find.

Linda

Round III Restart Directions

Dear Panel Members,

I'm sorry for the long delay to the restart of Round III, but with the help of some very nice gentlemen at the TAMU Center for Distance Learning Research, we have what I think is an easy way to respond to Round III electronically without fear of it "crashing" your Word program. If after looking at this format, you should find the electronic method more difficult than you wish to deal with, please let me know as quickly as possible, and I will be happy to mail you a hard copy with a postage paid return envelope. With a 100% participation rate so far, I very much want responses from all of you at this most critical juncture of the study. I'd like to end this round by Friday, May 27 in the hope that we can then all enjoy a long Memorial Day weekend. Please let me know if that presents a problem for you.

To access Round III over the internet, you can click on the following web address: <http://ponder.tamu.edu> If for some reason, clicking doesn't take you there, you can type in the address or copy and paste it into the address spot on your general internet screen.

The Ponder Portal Welcome page will ask for your Login name (use your first name), and password (use "delphi"). Then you must click on "sign in" because I have found that hitting "enter" will not allow access to the portal. Specifically for login problems, please contact Darryl Bassile at the Center for Distance Learning Research by phone (979-862-8051) or by email dbassile@cldr.tamu.edu since that will eliminate a step for you and provide you directly with a prompt response.

Once you enter the portal, the first screen has the general instructions for the round.

Your patience and notes of sympathy have been greatly appreciated.
Linda

Portal Directions (Read carefully before beginning the survey.)

This round is designed for you to be able to work in as many sessions as you need without losing your responses. Each element comes up one at a time, and I am asking you to agree or disagree with each element. Then rate the element for importance. There is also a box for you to add any comment you wish about that element. When you are finished with the element, there is a "save & next" icon for you to click on. If you move to another element without that step, the program will delete your responses and show that you have not responded to that element; however, should you change your mind even after you save your response, the program will allow you to change your response.

If you need to leave the document for some time, then log out of the site and close the screen. The document left open, but with no work being done on it, will eventually "time you out." Either way, you just return to the web address and log back in, returning to the unfinished elements.

You will find each screen labeled with "Question" and the designation of "cultural appropriateness," "linguistic appropriateness," or "pertinent but not direct answers to the two questions." That is followed with the label "Group" which pertains to the subdivisions we worked with in Round II. The elements had to be numbered to accommodate the computer program, but the numbers in no way are meant to convey any degree of importance to the element; however, they do make it easier to move within the document.

In the upper right hand of the survey screen are three choices: "Submit Survey," "View Status," and "Rank Groups." The "Submit Survey" icon will not allow you to submit the survey until all items are marked for both agreement and rating. Should you hit it when you think you are finished, but it still won't submit the information, the "View Status" icon will help you find an item that perhaps through multiple work sessions, you overlooked. The "Rank Groups" icon takes you to the last portion of the study which allows you to rank the groups of elements from 1 to 11 for cultural competence and 1 to 8 for linguistic importance. Use 1 for the most important group, 2 for the second most important group, 3 for the third most important group, etc.

I would like to have these back by Friday, May 27. If, however, that is problematic for you, please let me know since I am planning an August defense of the dissertation.

Should you have any problem, please call me (979-776-1880) or email me (LMPONDER@tamu.edu). I am happy to help you get your responses done as efficiently as possible.

Scroll back to the beginning of the Portal Directions and to proceed, click on "Survey" in the upper left hand corner of the screen under "Home."

Round III Dunning Email #1

Dear Panel Members,

I hope this note finds you just back from an enjoyable Memorial Day weekend. I know that the May 27 deadline on Round III was probably inconvenient for many of you, but now with the Legislative Session and spring semester completed, I urgently need you to please take time and respond to Round III. Without all your responses our work will be so much less valuable, and my graduate committee will not let me continue with the dissertation. **Please get your results in by June 6.** I have heard from some panel members that the comment windows do not allow for the use of apostrophes. I don't know why, but I do welcome your comments in this round. If you do not wish to do Round III electronically, I will be happy to send you a paper copy with a return, postage-paid envelope.

To access Round III over the internet, you can click on the following web address: <http://ponder.tamu.edu> If for some reason, clicking doesn't take you there, you can type in the address or copy and paste it into the address spot on your general internet screen.

The Ponder Portal Welcome page will ask for your Login name (use your first name), and password (use "delphi"). Then you must click on "sign in" because I have found that hitting "enter" will not allow access to the portal. Specifically for login problems, please contact Darryl Bassile at the Center for Distance Learning Research by phone (979-862-8051) or by email dbassile@cldr.tamu.edu since that will eliminate a step for you and provide you directly with a prompt response. It is not necessary for you to do the whole round in one session. Your saved responses will remain until you complete the round and submit it as final.

If you have questions, please give me a call (979-776-1880) or send me an email.

Sincerely,
Linda Ponder

Round III Dunning Email #2 for “In Progress” Members

Dear Panel Members,

I see in looking at my reporting document from the computer support folks at the Center for Distance Learning Research that you are in the process of completing Round III. I am checking in with you to be sure that the portal is working for you. If you have questions, please don't hesitate to contact me. As you can imagine, I am most anxious to have all the responses, so that I can begin compiling results. Thanks again for helping with this study. As I look at the preliminary results, I am convinced that your work will produce profound information for all health professionals in Texas.

Sincerely,

Linda

Round III Instructions for Hard Copy

Thank you so much for your patience and agreeing to submit your responses by paper—the old fashioned way is sometimes still the best!

Please clearly mark whether you agree or disagree with each element. Some panel members have asked about “disagreeing just a little” with an element since some of them are quite long. If you mostly agree, please mark “agree.” If you mostly disagree, please mark “disagree.” Feel free to write on the survey with comments about the element. You may write on the back with arrows to explain if you wish. The comments in earlier rounds have been most helpful. I can use your comments also in the narrative portions of the report.

Then, please clearly mark what level of importance you think the element has.

At the end of the responses to Questions 1 and 2, there are ranking sections for the categories we have worked with in each question. Please rank the one you consider most important with a 1, the second most important with a 2, etc. There are more sections for Question 1 than Question 2.

Again, if you have questions, please feel free to call me. 979-776-1880. If at all possible, please get these back to me by June 24. I hate to be a bother, but I think your work is very important to the delivery of healthcare for Hispanics in Texas. The study is weakened if all panel members do not complete the final round. Additionally, my graduate committee will not allow me to proceed with my dissertation defense without completed surveys from every panel member.

Sincerely,
Linda

Final Round Plea—letter

Linda Ponder

2513 Memorial Drive
Bryan, Texas 77802979-776-1880
LMPONDER@tamu.edu

June 29, 2005

Dear ,

I know you are very busy, but this is an impassioned plea for your response to the last round of the study. The deadline of May 27 is long passed, and I am beginning to have two large concerns.

My first concern is a very selfish one: I am in danger of not receiving my degree. Because the data collection phase has taken so long, I am already operating on an extension from the graduate office here at Texas A&M. That extension expires in December, but to meet the deadline I have to defend this dissertation study before the first part of October. I have written all I can without the final results of the survey, so I am now beginning to fear that if I don't have your results by **July 8**, it will be physically impossible to complete the study and defend the results.

My second concern is for the loss of your guidance to non-Hispanic healthcare professionals around the state. The entire panel has expressed the need for this information, but since it is a Delphi study, I must have responses back from the entire panel. You were chosen for your area of special expertise and geographic location. The loss of even one response weakens the study dramatically, but the reality is that my graduate committee will probably not allow for the reporting of an incomplete set of responses. From my research, I believe this is the first comprehensive study involving Hispanic healthcare providers speaking with one voice to their non-Hispanic colleagues about helping improve healthcare outcomes. I firmly believe that the future health of Texas is directly tied to the future health of its Hispanic population, and current census data and demographic information paints a bleak future picture.

Please finish your electronic portal response, or call me and let me know how to help you get your final response finished. We are so close to concluding this important study, but I am equally close to failing as a researcher and a caring Texan. I know I am asking a lot. Please forgive me for being a pest, and know that I will forever be grateful for your vital assistance.

Sincerely,
Linda Ponder

Final Round Last Plea—letter

Linda Ponder

2513 Memorial Drive
Bryan, Texas 77802

979-776-1880
LMPONDER@tamu.edu

July 19, 2005

Dear ,

First, let me thank you heartily for participating in the first two rounds of the Delphi study. Your participation was invaluable. I am very sorry you could not respond to the last round of the study because you were chosen for your particular area of expertise and geographic location. Yours is one of only three missing responses which would have made for the 100% response rate so important to a Delphi study.

I know you are very busy, but this is a last fervent plea for your response to the final round of the study. While I have some hope of salvaging the study without your response, I still believe your guidance to non-Hispanic healthcare professionals around the state is vitally important. If you can find the time, between now and **July 27** to get me your responses, I can still include them.

Please finish your electronic portal response, or call me and let me know how to help you get your final response finished. We are so close to a perfect conclusion to what I believe may well be a landmark study in Texas. I know I am asking a lot. Please forgive me for being a pest, and know that I am forever grateful for your participation to this point.

Sincerely,

Linda Ponder

Preliminary Report of Results

Dear Panel Members,

It's now been a year since we began the Delphi study. I wanted to provide you with a preliminary report on the findings and give you my most heartfelt appreciation for your participation. On July 20, my co-chairs granted permission to begin work on the dissertation even though several responses were still missing. Of those several responses all, but one have come in, and I am still hopeful that Round III will ultimately have the 100% response rate that we had in Rounds I and II.

First, I must confess that I was overwhelmed by the depth and sincerity of your responses as well as your dedication to seeing the study through. The results were comprehensive and far more detailed than I could have hoped at the outset. I will be forever indebted to all of you.

At this time I am working to get the dissertation completed for December graduation. TAMU allows for a newer style of dissertation that has publishable articles as the "guts" of the dissertation. The information from your work is so extensive that my co-chairs encouraged me to write two articles, graduate, and then pursue further dissemination of the results. At this time the first draft of the dissertation contains two articles intended for the journal of the Society for Public Health Education, *Health Promotion Practice*. One is an overview of the study, and one is a framework for assessing "respect and trust" both culturally and linguistically since it was the group of elements which you ranked as most important by a considerable margin. At the end of the second article, I recommend that other frameworks need to be developed based on your work. I am scheduled to defend the dissertation on October 10, and as soon as my graduate committee signs off on the work, I will email a copy of the dissertation to each of you although it will not contain the complete data set.

As time allows, I am trying to assemble a complete set of the results, group by group, and item by item. I will make that available to all of you as well when I have it assembled. While I am being encouraged to get the work out through journal articles, I am particularly sensitive to the totality of the picture that your work paints. I do not wish to "piece it out" in such a way as to contribute in any way to stereotyping. I am looking for a way to get the work out in its totality although several of you note that it is so long as to be overwhelming.

I am attaching the files of the tables from the dissertation that reveal the Delphi Panel, the preliminary broad results of the study by groups, and the summary of the work. I continue to note that the results are preliminary because the data set currently contains only 24 responses. I have received the responses from one more Panel member and am hopeful that the last Panel member will have time to respond, but at this time I reiterate that the results reflect 24 of 26 responses. Running the data sets requires a fair amount of time from staff at the Center for Distance Learning, and I would like to have them run the information only one more time if at all possible.

Again, many thanks! Have a wonderful Labor Day Holiday, and I will continue to send updates as they are available. If you have questions, please don't hesitate to contact me.

Sincerely,
Linda Ponder

VITA

Name: Linda Milam Ponder

Address: 2513 Memorial Drive
Bryan, Texas 77802
979-776-1880

Email Address: LMPONDER@tamu.edu

Education: B.A., Interdisciplinary English, Texas Tech University, May 1976
M.A., English, Texas Tech University, August 1980
Ph.D., Health Education, Texas A&M University, December 2005

Areas of Expertise: Rural health systems, vulnerable populations, Texas Medicaid,
public health policy process, cultural competency, Texas
environmental health

Professional Experience: 12 years of secondary language arts teaching in West Texas
7 years of health education and public health teaching at
Texas A&M University
6 years as Program Director for Parent Case Management at
West Texas Rehabilitation Center, San Angelo and Abilene
2 years as a Training Specialist at San Angelo State School
1 year of consulting with Accenture, LLP
9 years on the Texas Medical Care Advisory Committee; 7
years as Vice-chairman, 1 year as Chairman
8 years on the Community Resource Coordination Group
State Team for Children
7 years on Texas Planning Council for Developmental
Disabilities
3 years on Board of Directors for Advocacy, Inc.
2 years on National Board of Advisors for the Communities
Can! Initiative