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Empowering Cultural Competency in Healthcare Providers

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This is to certify that the doctoral study by

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Abstract

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MS, University of Phoenix, 2006

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Project Submitted in Partial Fulfillment

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Abstract

Racial and ethnic health disparities are highest in communities of color; providing culturally competent care could address these disparities. Culturally competent communication between the healthcare provider and the patient is an essential behavior that may improve health in racially and ethnically diverse women. A quality improvement project was completed with guidance from the 5 constructs of the Campinha-Bacote model as the conceptual framework, and the method used was the Consumer Assessment of Healthcare Providers and Systems survey. The perspective of 20 Mexican American and 20 African American women in El Paso, Texas between ages 45 and 72 with menopausal symptoms was surveyed to determine if culture had an impact on the presence or absence of communication with their healthcare providers. Results showed women's perceptions of positive and negative communication behaviors with their healthcare providers was inconclusive; however, results showed that provider communication about health promotions, use of alternative medicine, and shared-decision making regarding health management needs improvement to promote adherence to medical regimen and feelings of mutual respect. Integrating cultural competence into existing evidence-based care can positively impact the delivery of services and help improve the quality of care. Healthcare providers can impact positive social change through the lessening of burdens associated with the lack of diversity in the workforce by including cultural competence training into the curriculum of nursing and medical schools.

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Dedication

To my Lord and Savior Jesus Christ I dedicate all that I am to you. This body of work is a tribute to my late mother Leola Dement, who always believed I was destined for more and showed me that prayer changes everything. I am grateful to my late father, Charles E. Dement, for giving me the ability to conquer the business side of life. To my siblings your positivity and encouragement is a blessing. To Jenna (daughter) and Cameron (grandson), you kept me focused with my eyes on the finish line.

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To Almighty God from whom all blessings flow, I am thankful for life, health, and strength. I am eternally grateful to my late parents Charles and Leola Dement, family and friends for their support, encouragement and continually elevating me to pursue higher heights. To my brother Gregory for knowing what to say when I needed strength, and my sisters Mara and Edwina for fortifying me with prayers. Thank you, Shiloh Baptist Church family, for your prayers and encouraging words. Dr. J. Lujan you are the best and thank you for recognizing my professional attributes and recommending me for opportunities to utilize my talents. Much love and thanks to Shelly and Azucena for your friendship and support. Walden University professors your guidance has been greatly appreciated especially Dr. Farrar who guided me through project completion. A special thanks to Dr. A. V. M. (mentor) who afforded me the opportunity to enter her professional world.

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Section 1: Nature of the Project

Introduction

A person goes to the doctor or hospital with the expectation of receiving appropriate treatment and respect, including consideration of his or her cultural beliefs, behaviors, and values. Providing culturally competent care to patients should be a priority for healthcare providers; however, personal identity makes it difficult when conducting an initial interview pertaining to culture and ethnicity because everyone has his or her own expectations. The implementation of cultural care practices differs among cultures and it may be difficult for the healthcare provider to be familiar with the expectations of all cultures. Nurses should be familiar with the important cultural aspects of people within their community.

The U.S. Census Bureau (2012) documented Mexican Americans as the fastest growing population, which supports the need for healthcare professionals to listen to the voices of this group and necessitates the implementation of culturally appropriate health policies and programs (Velasco-Mondragon et al., 2016). It is also important to understand the health needs and beliefs of Mexican American women because they often assume primary responsibility for meeting the healthcare needs of the family (Sanchez-Birkhead et al., 2011). The fastest growing U.S. minority population is commonly referred to as “Hispanic” or “Latino” and identified by the U.S. Census Bureau as a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race (Peterson-lyer, 2008). To avoid confusion resulting from the many names used in literature to describe the Spanish speaking female, this

project will use the name Mexican American (MA). There are various descriptions for people of color, but they are referred to as African American (AA) in this project. The AA woman has been described as "strong"; however, this is not an indicator of health and AA women have been identified as having a shorter life span (Belgrave & Abrams, 2016). AA women have been described as having similar cultural needs as MA women, which is why the project included them as another minority that healthcare providers should consider when delivering culturally competent patient care.

Nursing frameworks such as those developed by Leininger (2002), Giger and Davidhizar (2004), Purnell and Paulanka (2003), and Campinha-Bacote (2002) have defined key components regarding the importance of cultural competence in nursing care (Jirwe et al., 2006). Many nurses are not culturally competent and do not know what to do in the presence of diversity and verbalize fear at the thought of making a mistake (Mareno & Hart, 2014). Castro and Ruiz (2009) wrote that MA women verbalized greater satisfaction with nurse practitioners who are also MA, speak Spanish, attended a master's level program, and received cultural competence training and shorter clinic wait times. In this project, MA and AA women who are menopausal and between the ages of 45 to 72 years were administered the cultural assessment survey. The results have the potential to support the fact that positive outcomes occur from incorporating cultural competence into the delivery of care to MA and AA women. The DNP project may encourage nurse educators to include culture competence into nursing curriculums to enhance the delivery of care to diverse groups.

Today's medicine has evolved beyond understanding different diseases, as it is equally important to understand a holistic individual who has expectations regarding the plan of care. Healthcare practitioners often associate similarities between MA and AA cultures because both use social gatherings surrounded by food as an expression of caring and have strong religious beliefs (Bramble et al., 2009). Cultural aspects pertaining to MA and AA females require focus on religion, practices, beliefs, and values that affect healthcare outcomes. The lack of consideration of culture in the delivery of care for MA and AA women may result in a less than optimal outcome. Healthcare practices and practitioners that incorporate cultural competence into the delivery of care have a greater potential for achieving customer satisfaction, compliance, and overall positive outcomes (Campinha-Bacote, 2011).

Problem Statement

As the population is becoming increasingly diverse, it is relevant for nurses to be competent in their ability to assess, diagnose, and treat patients from different backgrounds. A formal area of study and practice are words used to describe cultural competence, as it should be a nursing course focusing on holistic culture care with respect to cultural values (McClimens, Brewster, & Lewis, 2014). Nurses can meet the needs of the patient and improve outcomes if they take the opportunity to assess cultural issues during the pre-admission phase of hospital or clinic admission. The nursing workforce does not reflect the increasing diversity of the population as reported by the U.S. Department of Health Services (2010), which documented that 80% of the licensed registered nurses are non-Hispanic whites (Haynes, 2016). Statistical facts as they pertain

to the nursing workforce support the need for nurses to be prepared to deliver care to diverse cultures.

The community of practice for me as a DNP student has a large population of MAs who believe in family presence when a loved one seeks medical attention. Nurses who are not culturally aware may perceive this large gathering of family to be abusive or counterproductive. Awareness of cultural norms affords the nurse the opportunity to understand, educate, and establish necessary professional boundaries. Lack of knowledge about culture predisposes nurses and patients to less than optimal care and poor outcomes. Language presents a significant barrier, as there is a lack of professional interpreters and services to meet the needs of MA patients (Juckett, 2013).

This doctoral project may increase awareness and increase the use of culturally competent nursing care for the MA population and people of all cultures. Nursing schools and the healthcare industry must mandate that throughout the nurse's professional development there be training on the delivery of culturally competent care. It is important to know if the patient uses alternative healers, herbal supplements, or any nonprescriptive therapies because this could impact the prescribed medical regimen (Barragan, Ormond, Strecher, & Well, 2011). Elderly individuals within the MA population will represent 16.4% by 2050 as documented by the U.S. Census Bureau. These elderly individuals may have an English comprehension deficit or inability to read and remain linguistically isolated as they may only speak Spanish resulting in a barrier to accessing medical and social services (Mutchler & Brallier, 1999). It is not fair to assume that two patients of the same ethnicity share the same beliefs or practices. The time allocated for assessment is

opportune for the gathering of pertinent data to assist in developing a plan of care that includes cultural norms, practices, beliefs, and values.

Purpose Statement

The objective of this project is to (a) assess the relevance of culturally competent healthcare to MA and AA women, (b) enhance knowledge of the nursing community as to the importance of delivering culturally competent care, and (c) to recommend an evidence-based need for developing patient-centered culturally competent plans of care for patients in healthcare settings. There are theories and models that identify the key components of culturally competent healthcare; however, the patient perspective is often missing from the literature. The setting for this project is a privately-owned clinic where the physician who, when appropriate, supports the use of alternative medicine therapies and provides culturally competent care. Complementary therapies that promote health and wellness have been widely used by 75% of MAs in West Texas for cultural reasons (Tafur, Crowe, & Torres, 2009).

If healthcare practitioners speak negatively about patients' health practices, they send a message of disrespect to the patients. Language barriers, use of medical terminology, and fears associated to seeking medical care can generate negative patient feelings. Multiple barriers ignite perceptions of inferiority or unfair treatment by MAs regarding Western medicine (Buckley, 2012). Culturally competent care has been documented as leading to a reduction in disparities and generally producing positive patient outcomes (Grady, 2014). There are deficits in healthcare practice associated to culture that could benefit from this project:

- Assessment of cultural norms for all patients on admission
- Assessment of cultural practices associated to illnesses and use of alternative and complementary therapies on admission
- Implementation of cultural awareness into nursing curriculum
- Annual cultural competent competencies for nurses
- Increased patient comprehension and compliance with medical regimen
- Consideration of patient cultural needs included in the assignment of the bedside nurse

A proactive approach to culturally competent care can facilitate effective communication and may lead to patient compliance and increased satisfaction. The practice-focused question in this project was "In MA and AA females with menopausal symptomatology aged 45–72, what are their perspectives about culturally competent patient care being incorporated into the plans of care by their provider?"

Nature of the Doctoral Project

The source of evidence was obtained from data collected by administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Item Set survey (Appendices C & D) to MA and AA women participants. The survey given to the MA women took place during an office visit and the AA women at church. The reliability and validity of the CAHPS survey was shown in the work of Weech-Maldonado et al. (2012; Appendix B). The factors or domains of this survey are Doctor Communication-Positive Behaviors; Doctor Communication-Negative Behaviors; Doctor Communication-Health Promotion; Doctor Communication-Alternative Medicine;

Shared Decision Making; Equitable Treatment; and Trust. The groups of women being assessed are menopausal; however, menopause was not the primary focus of the study but a sensitive diagnosis noted in this culturally diverse community. Collected data from the surveys revealed the importance of cultural competence to healthcare, especially in the area related to using alternative medicine.

The latest version of the CAHPS survey in both the English and Spanish languages was used in this project (Appendices C & D). Care was given to keep the MA responses separate from those of the AA women with item sets to be tallied and compared in each category. Although gender was not an item of consideration, emphasis was placed on communication, decision-making, trust, and language. Data obtained from the survey could serve to close the gap on the importance of cultural competence in healthcare. MAs in El Paso, Texas demographically represent greater than 80% of the population (U.S. Census Bureau, 2012) with an extreme shortage in nurses from this culture. Attention to this documented fact resulting from this project can result in a positive change in healthcare, with recommendations that stakeholders mandate cultural sensitivity training of nursing personal.

Significance

The primary stakeholders are the patients, their families, and community, as culturally competent healthcare has the potential to improve outcomes and patient satisfaction. The healthcare institutions, physicians, and healthcare providers can benefit through increased profits resulting from customer compliance and satisfaction, increased ratings, and word-of-mouth advertisement. There is a significant lack in the ability for

healthcare practitioners to provide the same healthcare considerations to all ethnic groups. The nation's increase in diversity presents a major challenge for healthcare practitioners, healthcare systems, and policy makers to create and deliver a culturally competent service. The nation is faced with racial and health disparities that are complicated by the linguistic needs of patients and the lack of cultural competence of physicians and nurses (Georgetown University, 2004).

Many stakeholders have drawn attention to the need for cultural competence in managed care, government, and academia to reduce healthcare disparities (Betancourt et al., 2005). Every patient regardless of race, ethnicity, culture, or language is entitled to the highest quality of care possible. Development of a healthcare workforce that is culturally competent can assist in providing equality for all. Cultural competency training should be required for nurse educators, students, and staff nurses as well as included in annual competencies. Culturally competent care could increase patient satisfaction, as MA women verbalize wanting care providers that are sensitive to their cultural needs (Sanchez-Birkhead et al., 2011).

This doctoral project has the potential to encourage the local healthcare facilities and nursing schools to evaluate and implement cultural competence into programs and institute cultural competence training as a staff expectation. The shortage of MA nurses emphasizes the need to mandate that nurses within a community such as El Paso, Texas with 84% MAs (United States Census Bureau, 2012) incorporate cultural competency training into the annual competencies. Evidence obtained from the DNP project has the potential to be a gateway for future projects pertaining to benefits from incorporating

cultural competence into the delivery of care. The greatest impact of the project is for culturally diverse groups to have increased confidence in the delivery of care that is patient-centered to meet the cultural needs of them and their families.

Summary

The data analysis from the MA and AA women surveyed provided evidence-based findings from the patient perspective about culturally competent care. The survey results support the acknowledgement of the importance of culturally competence by healthcare providers in this diverse and changing world. Knowing the significance of cultural competence is greater than demographics, economics, disparities, and customs (Campinha-Bacote, 2003). Leininger and McFarland (2006) identified cultural competence as an expectation of nurses that should be included in nurse training to ensure the provision of holistic cultural care (McClimens et al., 2014). Seeing the patient as a unique person is at the core of cultural competence and must be included in the nurse's annual competences that contribute to the delivery of patient-centered health care (Campinha-Bacote, 2011). There are multiple frameworks and models in nursing that outline the importance of incorporating cultural competence into the delivery of care. The five constructs of the Campinha-Bacote model provided support and structure to this DNP project.

Section 2: Background and Context

Introduction

Increases in population diversity mandates that healthcare professionals be competent in the delivery of culturally competent care. The practice-focused question for this project was "In MA and AA females with menopausal symptomatology aged 45–72, what are their perspectives about culturally competent patient care being incorporated into the plans of care by their provider?" Many older MA women are accustomed to a traditional or complementary approach to healthcare with less use of Western medicine. Customer satisfaction, increased compliance, more appropriate testing, and fewer errors were reported when care was given by a practitioner who spoke the patient's language and respected the values, beliefs, and behaviors (Lehman, Fenza, & Hollinger-Smith, 2012). What makes MA women unique is the strong commitment to family well-being that results in neglect to self. Trust is important, as these women are not quick to report their personal and intimate information. The healthcare provider must know the appropriate questions to ask to elicit a response that leads to the most beneficial treatment plan (Lugo, 2016).

Menopause is accompanied by an array of symptoms due to a decrease in the production of estrogen. Although there is a list of symptoms such as lack of libido, night sweats, hot flashes, mood swings, fatigue, sleep disorders, itching, and memory loss, patients generally do not experience them all. A problem associated to the lack of libido is a difficult yet necessary topic for the MA women that rely on the cultural awareness and assessment skills of the practitioner. Healthcare professionals must be aware that

MAs use alternative therapies from Mexico and may not report usage if not specifically asked, as many remedies are not classified as a medication (Giger, 2017). The diversity of MAs as a group results in apprehension of some healthcare professionals faced with the delivery of care. There is an overwhelming fear of making a mistake due to language barriers and a lack of comprehending cultural differences (Sobel & Sawin, 2014). A partnership must be established between the patient, family, and healthcare provider that emphasize the sharing of a common goal. The practitioner can assist with the elimination of healthcare disparities by supporting the guidelines as established in Health People 2020 through cultural awareness and competency (Elminowski, 2015).

A culturally competent clinician is familiar with patient's cultural beliefs and plays a vital role in recommending the appropriate treatment plan. Some physicians discourage the use of alternative medicine such as natural hormones due to a lack of association to scientific medicine or difficulty in assessing effects. The practitioner's goal for clients should be to promote wellness through self-care and decision-making abilities. Education can enhance understanding of natural hormone replacement therapy (HRT) supporting patient preference resulting in a positive impact on compliance. The Campinha-Bacote model was used in this project to educate nurses about components required for the development of cultural competence. This project can be a resource of information for healthcare practitioners, especially those who provide services in diverse communities. The diversities of the border community of El Paso, Texas are magnified by the fact that it is home to the huge Army base know as Fort Bliss, Texas. The role of the DNP student is to maintain a commitment to life-long learning and to support the

community in the form of educating future and present nurses on the importance of culturally competent care.

Campinha-Bacote Model

The Campinha-Bacote model (1991) is a culturally competent model of care whose structural framework is supported by four constructs: cultural awareness, cultural knowledge, cultural skill, and cultural encounters. In 1998 the construct of cultural desire was added with all five depicted by overlapping interdependent circles. As the body of work of Campinha-Bacote continued to evolve, so did the representing pictorial (see Figure 1).

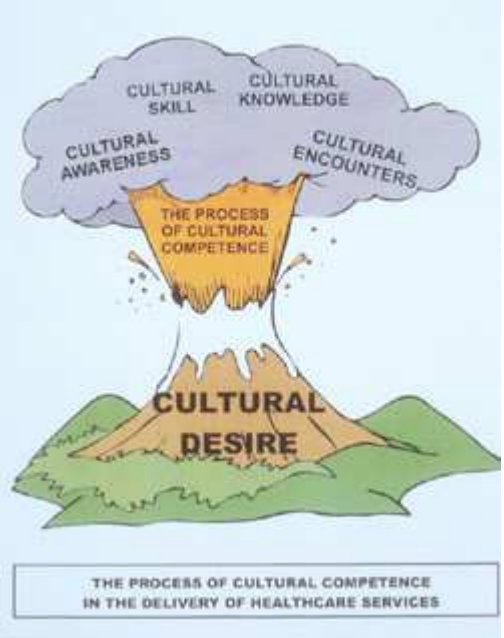

Figure 1. Process of cultural competence. This figure was developed by Campinha-Bacote, 2002. "The Process of Cultural Competence in the Delivery of Healthcare Services," is copyrighted by Campinha-Bacote and reprinted with permission from Transcultural C.A.R.E. Associates. The Campinha-Bacote model was chosen as the

theoretical framework for this project as her commitment to culture is clear and easy to incorporate into training nurses as well as planning the care of diverse groups.

The Campinha-Bacote model does not draw attention to one distinct culture but prepares the practitioner to perform in any cultural setting. The Campinha-Bacote model served as the conceptual framework for this project with focus on patient-centered care in the presence of cultural compliance. Healthcare professionals must embrace cultural competence, as this model encourages nurses to envision themselves as becoming culturally competent through the integration of cultural desire, cultural awareness, cultural knowledge, cultural skills, and cultural encounters (Campinha-Bacote, 2011). A component of the Campinha-Bacote model is self-examination as awareness of cultural bias, is vital to the professional's ability to deliver safe and effective care (Harris et al., 2013).

Campinha-Bacote Model Constructs

The following are the five constructs that make up the most updated version of the Campinha-Bacote model (2002):

- *Cultural Desire*: Nurses must first want to engage and make a difference in the presence of cultural diversity by becoming aware, knowledgeable, and skillful during encounters with patients.
- *Cultural Awareness* (Sensitivity): Nurses must be able to self-evaluate as to his or her own cultural identity and biases toward other cultures.
- *Cultural Knowledge* (Views): Nurses must obtain information as to the impact of the patient's culture on health and wellness.

- *Cultural Skills* (Assessment): A learned skill used by nurses that demonstrates the ability to collect necessary cultural data from patients about their illness.
- *Cultural Encounters* (Practice): Nurses must have the ability to culturally interact with patients of diverse groups.

The importance of culturally competent care lacks significance without providing information on actual performance. The five constructs of the Campinha-Bacote model are identified as a guide for nurses to follow with similar works developed by Giger and Davidhizar (2002) and Leininger and McFarland (2006). It is significant to understand that culturally competent care cannot be delivered without self-evaluation, as the manifestation of biases or prejudice is a possibility. A construct that is important is the desire to become culturally competent as a professional.

Relevance to Nursing Practice

Since Florence Nightingale, nursing has remained a profession in which there is a constant quest for the best possible patient outcomes. Even the task of good handwashing continues to benefit all areas of medicine; however, the expectations and demands of the healthcare consumer have increased from the physical satisfactions of bedside nursing to a total experience of gratification. Proficiency in the performance of clinical skills is the expected norm; however, this alone does not result in a healthcare institution achieving Magnet status (rating excellence in patient outcomes, staff and customer satisfaction). Compassion and respect are a part of the patient's list of expectations when seeking a facility to provide their healthcare needs.

It is inevitable that an aging woman will experience menopause and a decrease in estrogen production which for MA and AA women means the possible onset of aggravating vasomotor symptoms. Hormonal signals rhythmically originate as the endocrines hierarchical system governs diverse functions throughout the body. A disruption in this "governing" system leads to abundance or lack of hormones resulting in isolated systematic dysfunction (Gaudard et al., 2013). Not all women will experience aggravating symptoms related to the hormonal imbalance of menopause; however, there should be available treatment options.

Consumers of healthcare rely on literature, studies, research, news, and medical professionals to stay informed as to appropriate treatment protocols. Before the Women's Health Initiative Study of 2002, HRT was widely used but use declined drastically when linked to health risk, heart attacks, strokes, and cancer. Studies that are more recent have identified protective benefits of HRT, especially when used before age 60 in women who suffer from hormonal imbalance due to menopause. Between the ages of 40 to 72 years is referred to as the passing of the reproductive stage of life and premenopausal transition leading to the postmenopausal years. This time is noted for the vasomotor symptoms of hot flashes that result in a negative impact on a woman's life and can be accompanied by emotional lability, poor concentration as well as sleep disturbances (Gaudard et al., 2013). Review of current literature stresses that the decision to use HRT be that of the individual woman and her menopausal symptoms. The British Menopause Society (Hamoda et al., 2016) published that use of HRT before age 60, or 10 years prior to menopause, resulted in fewer cardiovascular incidents. Subsequent paragraphs and

sections of this project will address cultural differences as they pertain to menopause in the MA and AA female.

Menopause Symptoms and Therapies

MA women go to their physician with symptoms associated with hormonal imbalance from menopause such as night sweats, hot flashes, mood swings, fatigue, sleep disorders, itching, and memory loss (Gaudard et al., 2013). The prescribing of additional medications for side effects has been reported as problematic for MA women. Treatment protocols can be difficult for the MA women who prefer natural treatments or seek alternative medicine to manage their symptoms. Individualized tailoring of therapy has reduced risk of side effects with lower doses and deviation from the conventional norms (MacLennan, 2009). For example, bioidentical hormone replacement therapy (BHRT) is compounds with a molecular chemical structure identical to hormones produced by the ovary (Gaudard, de Silva, de Souza, Torloni, & Macedo, 2013).

Healthcare Practices in the Mexican American Culture

The MA woman is respectful of her elders and often seeks advice from an older female role model. She accepts the role of providing a nurturing family environment and maintaining the health of her children and family (Sanchez-Birkhead et al., 2011). *Curanderismo* is a term used to describe some traditional healing practices in MA communities. The practices have been widely studied to understand certain health practices of Mexicans living in the United States (Faver & Cavazos, 2009). The curandero (or curandera, if a female) views health from a purely religious perspective and assists clients with a variety of illnesses physical or mental in nature (Giger, 2017).

Lindberg et al. (2013) conducted a study on MA women using complementary and alternative medicine, explaining the terms for traditional Mexican medicine -*Yerbero* specializing in the use of medicinal herbs and plants and *curanderos* practitioners of spiritual and physical healing. The use of teas, herbs, poultices, salves and nonprescription therapies remain common and perceived by many in the MA community to be traditional and natural treatments for specific aliments (Buckley, 2012).

Mexican American Women and Menopause

It is not uncommon to have a family member in the MA household that fills the role of caregiver and is knowledgeable in the treatment of acute and chronic illnesses and assists in maintaining a sense of self-care and control (Sobel & Sawin, 2014). Folk medicine has been practiced by many elderly MA women and is a component that involves alternative therapies such as herbs, teas, and visiting folk healers. Faith is another aspect of health as many MAs feel that prayer helps and that God will take care of them (Giger, 2017). Doctors may be helpful; however, another health belief is that wellness occurs when there is balance. Folk medicine is still practiced and many use herbs to treat illnesses as well as teas and cinnamon. Although Western medicine has medications available for the aggravating symptoms associated to menopause, the MA woman seeks and is more comfortable with culturally competent healthcare that is comparable to natural, alternative or complementary treatments (Shattell et al., 2013).

Menopausal symptoms of a Hispanic cohort studied by Green et al. (2010) revealed an increased incidence of vasomotor symptoms such as hot flushes, cold sweats, and night sweats in addition to vaginal dryness. Culturally competent care for MA

women experiencing menopause translates into specific actions such as possibly including complementary medicine as alternatives to traditional treatments. BHRT is a complementary treatment that has been considered culturally relevant for MA women with hormonal imbalance due to menopause (Hyman, 2007).

African American Cultural Beliefs

Cultural aspects as they pertain to healthcare and the use of HRT for the AA female were limited in the literature other than barriers to seeking healthcare services. A 17-year study of 1,449 women across the United States included a report that AA women experience menopause for the longest amount of time; however, they were least likely to use medical treatments (Johnson, 2015). The menopausal symptoms endured by the AA woman are vasomotor in the form of hot flashes and can occur up to 10 years (Kenney, 2016). Insight into expectations for natural menopause in the AA female has been studied and concluded that menopause occurring before age 40 was linked to all-cause mortality (Li et al., 2013).

African American Women and Menopause

Dillaway et al. (2008) wrote that AA women seem to joke more about menopause and feel it is an inevitable life circumstance. Fear of medical care and lack of finances often resulted in the AA women taking a more positive approach to menopause and perceiving it as not an issue for great concern. A study conducted by Appling et al. (2007) revealed that AA women who were postmenopausal were more likely to complain of vasomotor symptoms (hot flashes, night sweats and sweating) than white women.

Many of the AA women verbalized never discussing their symptoms with a medical provider.

Menopausal Comparisons: Mexican and African American Women

Researchers at UCLA found variants in chromosome 4 that increased the incidents of hot flashes in white, Black, and Latino women (Kenney, 2016). Information obtained from the review of literature presented in this project will connect menopause symptoms and treatments to both MA and AA women and the relevance of culturally competent care.

Outcomes of Culturally Competent Care

Culturally competent care is important when interacting with a client because it can be beneficial to both client and healthcare provider. Taking the time to speak or translate the subject to be communicated in the patient's own language is perceived as a sign of respect. Increased awareness of the MA cultural phenomena and guidance for nurses on the provision of culturally competent care meets the needs of women and families (Eggenberger et al., 2006). The culturally competent practitioner should also consider including the family and extended family in the teaching process of MAs (Giger & Davidhizar, 2004; Purnell & Paulanka, 2005).

Literature Search Strategies

The search engines reviewed to find relevant cultural competence information included: CINAHL, Cochrane database of systemic reviews, EBSCO, Medline, Ovid Nursing Journals, ProQuest, Sage Journals, Walden University Library Database, PubMed, Google Scholar and the Online Journal of Issues in Nursing.

Limits applied: To increase the likelihood of finding articles that were no more than 10 years old led to the entry of specific dates from 2007 to 2017. The search was limited to the English language and included:

- Peer reviewed
- Human subjects
- Adult
- Hispanic/MA women research projects
- AA women research projects

Inclusion and Exclusion Criteria

All articles that were within the limits were reviewed if they pertained to cultural competence especially articles written by or that included the Campinha-Bacote model as this work is deeply embedded in the project. Excluded were articles that were more specifically about mental health and obstetrical issues or those not in English.

Search terms that were used included *culture, cultural competence, cultural identity, cultural desire, cultural awareness, cultural skill, cultural knowledge, Hispanic/Mexican American women, healthcare, African American women, menopause*, and *Campinha-Bacote*.

Documentation of Search Process

Care was given to choose studies and articles that were no more than 10 years, evidence-based, and peer reviewed, except for when choosing a framework. The Campinha-Bacote model was used extensively as her work gave support and structure to the proposal. An inclusion criterion was Mexican American women 45 to 72 years of age

who are menopausal and not in perimenopause. Males are included in the exclusion criteria and women must fit the criteria as identified.

History and Purpose of Research Question

The process of an illness is not the only factor that impacts care of a patient as cultural beliefs, practices and identity are also contributory. United States is becoming more diversified with each passing year with MAs accounting for a vast portion of the population. The statistical influx of MAs demands that the healthcare profession increase their knowledge pertaining to this group. All ethnic groups have their own beliefs and practices; however, this research poses that MAs more so than AAs utilize more cultural related healthcare practices. MAs in an age group such as the baby boomers (born between 1946 and 1964) seek a physician that practices or understands their heritage and cultural beliefs.

Strengths and Weaknesses of Literature

Strengths

The literature unanimously supports the need for cultural competence in the delivery of care. Hispanics, Latinos, and Mexican Americans (are names used synonymously) is the group mentioned most frequently due to their projected annual population growth. The growth of this group has a direct impact on the education of doctors and nurses, as comprehension of care at this level will contribute to successful outcomes for all. Much of the literature utilized the Campinha-Bacote model, which is an excellent resource as it provided consistency and stability to the various bodies of work.

Weaknesses

Limitations and gaps in research were identified in certain bodies of work as focus was directed toward one objective which pertained to its subject matter. A broader search must be conducted into cultural competence and the patient's views as opposed to total focus on the healthcare provider and their need to be culturally competent. A more patient directed approach may be required, and ways of supporting nursing and medical students to increase their cultural competence into performance at the bedside.

Gaps in Current Literature

Current literature has general statements applicable to all cultures; however, geographical locations near the U.S. Mexican borders seem to have a greater demand for healthcare professionals to understand the impact of culture on health. Language barriers are but one aspect in the care delivery paradigm of this group. All too often the presence of a translator is not adequate as the perception of a lack of interest or respect remains. When patients perceive a lack of respect or a negative response on the part of the healthcare provider they are less likely to comply with the medical regimen. Whenever possible there needs to be a balance between the patient's complimentary or cultural practices and Western medicine. The literature is not conclusive, as continual study is necessary for the integration of cultural competence and overall cultural awareness into healthcare to generate a positive outcome.

Local Background and Context

The concept for the project began in the mentor's office of the DNP student who is a MA private practice female physician in the border town of El Paso, Texas. Females

with hormone related illnesses are a large percentage of the office clientele with many being MA. Observation and communication with the MA female patients stimulated a professional and personal interest associated to culture. The significance of the observation was not the numerical representation of MA females, but in what appeared to be a shyness or cautious demeanor when speaking to them about personal issues. The MA women has barriers related to communication that may be associated to a lack of trust, perceived disrespect by healthcare professions, or issues related to language and literacy (Lugo, 2016). She maintains the role of matriarch in charge of the health of her family; however, the MA woman seems to have difficulty expressing her own needs when of a sexual nature. My preceptor (mentor) for this project will be referred to, as Dr. A.V.M. who I think of as being "old school" as she is not only culturally competent, but takes the time to teach and maintain a trusting rapport with the clients.

The United States documents MAs as the fastest growing population increasing in cultural diversity and minority populations accounting for 48% by 2050 with MAs representing 24.4 percent (Kratzke & Bertolo, 2013). The nursing shortage is a worldwide problem that increases annually. Not only is there a global migration of populations but also of nurses resulting in an increased need to educate nurses in the delivery and importance of culturally competent care. Only 3.6 % of the nursing workforce in 2008 considered themselves to be Hispanic resulting in a problem for this culturally diverse group (Millan, 2012). Organizations throughout the world structure the delivery of care to meet the needs of their specific population based on the cultural standards from political, economic and social systems (Douglas, et al., 2011). It is

difficult to deliver quality care to diverse populations without a framework to guide the interactions between patient, provider and healthcare system (Weech-Maldonado et al., 2012).

The local MA communities are faced with the care of aging parents while confronted with an additional burden associated to the nursing shortage. When choosing a care provider for family, MAs would select a provider who understands the culture language and preferences. The MA woman can be complex as she is committed to her beliefs, values, traditions, family, and demands healthcare that meets social, cultural and linguistic needs (Buckley, 2012). The diversity of populations has the potential to have a profound impact on healthcare as the expectation of the patient is to receive care from someone who has a respect for their cultural values and beliefs in addition to them as a person.

"In MA and AA females with menopausal symptomatology aged 45–72, what are their perspectives about culturally competent patient care being incorporated into the plans of care by their provider?" is the question that must be examined in this project. Healthcare institutions in the community strive for excellence in patient care and focus on the achievement of Magnet status (a symbol of excellence). Culture has not been included in any healthcare advertisement although healthcare providers are committed to the health of the community. Annually the U. S. increases in diversity with there being an estimated 54 million MAs which count for over 17% of the population (CNN, 2017). Despite the development of the 12 standards of practice for culturally competent nursing care (Figure 2) the subject remains a low healthcare priority.

Table 1: Standards of Practice for Culturally Competent Nursing Care 2011 Update	
1.	**Social justice** – the profession nurse shall advocate for and provide social justice for all patients, family, community and other healthcare professionals.
2.	**Critical reflection** – nurses must engage in critical reflection into their own values and beliefs and cultural heritage for insight into their ability to provide culturally competent care.
3.	**Knowledge of cultures** – nurses will gain knowledge of complex variables, perspectives, traditions, values, family systems, diversities of the cultures, populations and communities in which they serve.
4.	**Culturally competent practice** – nurses are to implement culturally sensitive skills into the delivery of care.
5.	**Cultural competence in healthcare systems and organizations** – healthcare organizations should provide and make available resources as needed for diverse populations.
6.	**Patient advocacy and empowerment** – nurses shall empower and advocate for the inclusion of patient cultural beliefs and practices in all aspect of healthcare.
7.	**Multicultural workforce** – nurses are to engage in the assembly of a multicultural workforce via strengthening the processes of recruitment and retention.
8.	**Education and training in culturally competent care** – nurses should be prepared educationally to meet the needs of a culturally diverse population. Responsibility for one's clinical education and training to maintain skills at an optimal level for diverse populations should be a stipulation of the employment.
9.	**Cross cultural communication** – nurses should be able to use effective verbal and non-verbal communication to identify client's beliefs, values, practices, perceptions, and culturally competent healthcare needs.
10.	**Cross cultural leadership** – nurses should be influential in achieving positive outcomes of culturally competent care for individuals, groups, and systems.
11.	**Policy development** – nurses should be capable of developing policies and standards for professional organizations and communities for the evaluation of culturally competent care.
12.	**Evidence-based practice and research** – nurses are to utilize the most recently available evidence-based practices in the delivery of culturally competent care to diverse populations. (Douglas, et al., 2011)

Figure 2. Standards of practice for culturally competent nursing care.

Definitions

Culture: refers to integrated patterns of human behavior specific to language, thoughts, communications, actions, customs, beliefs, values, and institution of racial, ethnic, religious, or social groups (Office of Minority Health, 2005).

Cultural awareness: The deliberate self-examination and in-depth exploration of one's biases, stereotypes, prejudices, assumptions and “isms” that one holds about individuals and groups who are different from them (Campinha-Bacote, 2011).

Cultural competence: a cultural concept that includes awareness and understanding of social groups to include their culture, health beliefs and values (Cope, 2015).

Cultural desire: The motivation of the healthcare professional to "want to" engage in the process of becoming culturally competent; not the "have to” (Campinha-Bacote, 2011).

Cultural encounters: The continuous process of interacting with patients from culturally diverse backgrounds to validate, refine or modify existing values, beliefs, and practices about a cultural group and to develop cultural desire, cultural awareness, cultural skill, and cultural knowledge (Campinha-Bacote, 2011).

Cultural knowledge: The process of seeking and obtaining a sound educational base about culturally and ethnically diverse groups (Campinha-Bacote, 2011).

Cultural safety: type of healthcare that identifies, understands and respects the bio-physical, economic, psychosocial, spiritual, and cultural characteristics of the patient, their family, environment and community (Purnell, 2008).

Cultural skill: The ability to collect culturally relevant data regarding the patient's presenting problem, as well as accurately performing a culturally-based physical assessment in a culturally sensitive manner (Campinha-Bacote, 2011).

Diverse populations: represents the variety of populations at the level of the individual, significant others and communities with respect to beliefs, cultures, ethnic groups, and representational societies from which they originate by the Task Force on Cultural Competencies (Purnell, 2008).

Transcultural: content crosses cultural boundaries and may be universal or the same for all cultures such the concepts of caring, health and birthing (Purnell, 2008).

Role of the DNP Student

The Center for Health Care Strategies, Inc. (CHCS) identified that by the year 2050 almost half of the U.S. population will be non-white, which will have significant impact on the healthcare industry and highlights the need for increased cultural sensitivity and health literacy. Healthcare providers must recognize cultural beliefs, practices and language differences or risk poor health outcomes (CHCS, 2013). Nurses are charged with the responsibility of assessment, implementation and evaluation of care to patients and their families, which are greatly impacted by understanding culture and values. As a healthcare system focuses on positive patient outcomes, it is imperative to be culturally sensitive which implies acknowledgement and respect in beliefs, attitudes, and cultural lifestyle (Sanchez-Birkhead et al., 2011).

My role as a DNP student is to use knowledge obtained from research to create, implement, and evaluate practice interventions in the health delivery and nursing educational systems. My goal is to make a positive impact on patient outcomes through fulfilment of provider, leader, and innovator type nursing positions. Additionally, I must strengthen my own position as an educator and incorporate the 12 Standards of Practice

for Culturally Competent Nursing Care (Figure 2). I am functioning as the DNP project leader who will analyze the data and train the physician, office receptionist and church representatives on the survey inclusion and exclusion criteria.

Role of the Project Team

The role of the project team is to smoothly guide the project to completion through data collection. As DNP student (project leader), I provided the members with a brief synopsis of the project before the project began. Care was given to emphasize the voluntary, non-monetary aspects of the project.

1. Team members invited potential participants based on inclusion and exclusion criteria.
2. A project flyer was given.
3. Questionnaires were completely anonymous as no names or personal identity was placed on them.
4. Participants were informed of the inconvenience time frame of 20 minutes to complete the questionnaire.
5. Implied consent was obtained.
6. Participants were informed of their right to terminate the project at any time.
7. Questionnaire was offered in English or Spanish.
8. Completed questionnaires were placed in large brown envelop.
9. All team members were given the contact phone numbers and email address of the project leader.
10. Data was collected for two weeks.

11. DNP student (project leader) collected all project data to include completed questionnaires.

Care was given to maintain separation of MA from AA completed questionnaires. The team members were not responsible for reviewing or tallying any data obtained from the questionnaires or encouraged to coerce participation.

Summary

The increase in cultural diversity mandates that healthcare professionals meet the needs of all not only culturally similar groups. Cultural education must take place in the didactic and clinical settings of medical and nursing schools to have the greatest impact on the development of culturally competent professionals (McClimens et al., 2014). A partnership must be established between the caregiver, patient, family, or community that defines the cultural perspective and competence based on human interactions (Garneau & Pepin, 2015). The process of aging is inevitable; however, a rich productive life should remain an expectation. A culturally competent nurse makes a significant contribution to positive patient outcomes and overall customer satisfaction.

Section 3: Collection and Analysis of Evidence

Introduction

The large population of MAs in the community of El Paso, Texas supports the need for better understanding of their culture to promote health and wellness. The groups of MA and AA women surveyed are menopausal, but the focus of the survey is related to culture. The primary concern for this project was to enhance comprehension of the importance of cultural competence to the delivery of care. The lack of cultural understanding of healthcare practices can present a problem to the practitioner and patient. There is apprehension among healthcare workers to care for MA patients who do not speak English, as there is an overwhelming fear of making a mistake due to language barriers. Many MAs if given the opportunity would choose a nurse who spoke the language and understood their culture; however, the nursing shortage for MA nurses is great as they represent only 4.8% of the nursing workforce (Minority Nurse, 2010).

AAs are the second largest ethnic group in the United States after MAs and although they have similar health related issues such as hypertension, diabetes, and cardiovascular disease, culturally considerations are not the same (Purnell, 2009). Symptomatology associated to menopause such as a lack of libido, vaginal dryness, and painful intercourse is private topics and there can be resistance to sharing this information. The hesitance for the MA woman to share personal information requires a safe environment and a skilled practitioner. AAs on the other hand if unable to ignore the symptoms would seek cost effective treatment (Purnell, 2009). As an observing DNP

student, the advantage of a culturally competent physician assessing the menopausal symptoms of the MA female was professionally enlightening.

A goal of the project was to assess the perspective of MA and AA women about the incorporation of culturally competence in their plan of care by providers and making a positive impact on closing the gap in the literature pertaining to the importance of providers being culturally competent. It is believed that AA women have expectations of healthcare; however, reviewed literature did not support concerns as they apply to culture. Healthcare practitioners have a responsibility to promote health and wellness especially in their community. Assessment of the El Paso community reveals an area that is rich in culture and a population of greater than 80% MAs. Culture has a significant impact on the delivery of healthcare services especially the planning of care. A culturally competent healthcare provider is respectful of the values, beliefs, and practices of all cultures.

This quality improvement project can apply to areas beyond the United States, Mexico border of El Paso, Texas. It is not limited to immigrants, visitors, or travelers as culture individualizes people. Examination of local and national views mandates the need for culturally competent healthcare. As an American (faced with language and cultural barriers), the thought of seeking healthcare in a foreign country is frightening. The same would likely be true for a foreigner in America. The implementation of quality improvement policies designed to incorporate cultural competency into healthcare could potentially eliminate fears. Worldwide culturally competent care is a huge undertaking; however, the transition of change is incremental and begins locally. An accomplishment

of this project as DNP student could be the ability to close a gap in literature as it pertains to culturally competent healthcare.

Practice-Focused Question

Question: In MA and AA females with menopausal symptomatology aged 45–72, what are their perspectives about culturally competent patient care being incorporated into the plans of care by their provider?

The purpose of this project is to draw attention to the benefits of culturally competent professional healthcare and its impact on positive patient outcomes. The fact that a culturally competent professional can elicit patient compliance and satisfaction can be supported by results obtained from the survey. MA women between the ages of 45 to 72 years who are menopausal and suffer with annoying symptoms of hormonal imbalance seek treatment from a provider that is culturally competent.

MA women observed in the office of Dr. A.V.M. advertise to their family and friends about specific treatment and quality of life improvements associated to care and HRTs. Listening to the stories of the women during a greater than 2-year completion of field hours supported the premise that cultural competence has a positive impact on the healthcare needs associated to menopause of MA women. AA women represent another ethnic group in the community chosen for comparison; however, there was less information obtained relating to culture.

The local churches frequented by AA were the best option to encounter enough women to survey. General conversation with AA women who met inclusion criteria did not reveal significant data, as many did not refer to themselves as menopausal due to a

lack of significant information, hysterectomy, and ability to ignore symptoms or poor understanding of definition of menopause. It is believed that Anglo American women in general do not have difficulty changing doctors to receive what they feel is appropriate treatment. The acceptance of menopause as a way of life is not an option for the American business woman suffering with disturbances in mood and memory related to hormonal imbalance (Thierry, 2017).

Sources of Evidence

The information gathered from the surveys provided data indicating the significance of cultural competence in the care of menopausal MA women compared to AA women. Cultural competence has been identified in literature as reducing disparities and producing positive patient outcomes (Grady, 2014). Surveys from the perspective of the patient gave additional insight into cultural awareness. Evidence obtained from data collected has the potential to improve patient outcomes which is a major goal in the delivery of healthcare. The implementation of cultural competence into nursing school curriculums can benefit the practice of future nurses. The desire of healthcare professionals to understand and respect the culture of their patients ultimately can contribute to patient compliance and satisfaction. The evidence obtained by the project supported the importance of cultural competence in healthcare as it pertains to the patient as well as the nurse.

Participants

One group of participants was MA women and the other was AA women (that met the inclusion and exclusion criteria) between the ages of 45 to 72 years who were

menopausal. Recruitment of the MA women took place on day of office visit during check-in while at receptionist desk. The AA women were recruited while attending a church service. The receptionist at the physician's office and the representative at the church as members of the team were given project knowledge by the DNP student (team leader) and can give and collect the surveys. All participants were given the same information prior to consent and survey that the project was non-invasive, voluntary, could be terminated at any time and there was no monetary reimbursement associated to participation.

Procedures

The CAHPS survey (Appendices C & D) was available in English and Spanish. The reliability of the questionnaire was tested using Cronbach alphas with examination of the validity of measurers using exploratory and confirmatory factor analysis, multitrait scaling analysis and regression analysis by Robert Weech-Maldonado et al. (2012). Permission was granted by R. Weech-Maldonado to utilize the English and Spanish versions of the questionnaires (Appendix B). The questionnaire is designed to assess factors that impact the quality of care in diverse populations. The 64 (eight grade reading level) questions are divided into categories reflective of interactions between the patient, provider, staff and overall healthcare systems. The response to questions are yes/no or a choice option (never, almost never, sometimes, usually, almost always, always).

The CAHPS survey obtains the patients perspective on culturally competent care from their provider. The five constructs from the Campinha-Bacote model have been paralleled with five of the domains from the CAHPS survey to increase the relevance to

nursing and the quality improvement of healthcare (Table 1). Communication can be verbal or non-verbal, but most importantly must be effective to impact change or outcomes. The construct of *cultural awareness* is matched to the CAHPS survey domain of "Doctor Communication-Positive Behaviors" as self-awareness is a crucial component of communication. For the doctor or healthcare professional to communicate and influence positive behaviors they must be aware of personal biases, prejudices, and discriminations. The construct of *cultural skills* is paired with "Doctor Communication-Health Promotion" as the need to perform physical as well as cultural assessment is crucial in developing a plan of care.

The practitioner's skills transition far beyond psychomotor as the assessment of health risk and issues of the patient impact the promotion of wellness. The construct of *cultural knowledge* is aligned with "Doctor Communication-Alternative Medicine" because knowing the practices and illnesses associated to diverse populations provides insight for the practitioner. MA are a cultural group known for utilizing herbs, teas and other alternative medicines to promote healing. A knowledgeable health care provider can prevent possible interactions between Western and alternative medicines through appropriate communication.

The construct of *cultural desire* is paired with "Trust" as the practitioner is committed to being truthful and honest with the client. Caring, love, sacrifice, social justice and humility are pivotal components of this construct as a foundation is provided for cultural competence. The construct of *cultural encounters* directs the project to "Access to Interpreter Services" as comprehension of communication is imperative for

the client to follow medical regimen (Table 1). Today healthcare providers can anticipate encounters with diverse cultural groups and linguistic competence is mandatory for a positive outcome.

Table 1: *Parallels between model and survey*

Campinha-Bacote model	CAHPS Domains
Cultural awareness	Doctor communication-Positive behaviors
	Doctor communication-Negative behaviors
Cultural skills	Doctor communication-Health promotion
Cultural knowledge	Doctor communication-Alternative medicine
	Shared decision-making
	Equitable treatment
Cultural desire	Trust
Cultural encounters	Access to interpreter services

Use of the questionnaire afforded the DNP student (team leader) the opportunity to assess culturally competent care from the perspective of the patient / participant. Potential participants who met the inclusion and exclusion criteria were approached by a member of the team such as the leader, doctor, receptionist or church representative and given a recruitment flyer (Appendix E). All steps were followed as identified in the role of the team. Members of the team had the contact information for the DNP student (team leader). Participants took 20 minutes or less to complete the questionnaire depending on the number of answered questions. Participants that answered no to questions 1, 4, 42, 46, or 50 were directed to question 57 (Appendices C & D). The questionnaire was administered in its entirety as developed to maintain the integrity and the reliability of the tool.

Protections

Institutional Review Board (IRB) approval from the university preceded survey and consent distribution to the selected groups. As a quality improvement project, a site approval form was signed and the Walden IRB was accepted by the facilities (Appendices E & F). There was no data collected or participant recruitment prior to IRB approval. The identity of the participants remained private as there was no personal information collected. Participants were informed that they could terminate their affiliation to the project prior to completion. It was clearly established that there were no monetary gains; however, participation could potentially have a positive impact on healthcare. The survey was available in English and Spanish to eliminate a language barrier. The name of the client was not used or any other personal identifiable information. The IRB approval number is 02-13-18-0489125.

Analysis and Synthesis

Healthcare efforts designed to produce positive outcomes require quality improvement programs and policies to be successful. The project questionnaire assessed domains that impact culturally competent care from the perspective of the patient. The assessed domains are listed as followed: 1) Doctor Communication-Positive Behavior; 2) Doctor Communication-Negative Behaviors; 3) Doctor Communication-Health Promotion; 4) Doctor Communication-Alternative Medicine; 5) Shared Decision Making; 6) Equitable Treatment; 7) Trust; and 8) Access to Interpreter Services. Although health organizations and literacy are areas that require quality improvement efforts they were not focal points of this project. Using the CAHPS survey (Appendices C & D) developed

by Weech-Maldonado et al. (2012) facilitated assessment of participants perception of culturally competent healthcare.

Summary

Increases in population diversity mandates a deviation from the status quo to a healthcare delivery system that focuses on positive outcomes impacted by culturally competent professionals. The measurements for success are customer satisfaction, compliance and profitability to include stakeholder satisfaction. There are surveys available that assess cultural competence of the professional; however, this CAHPS survey (Appendices C & D) was designed to reflect the patient perspective. The collection of surveyed data from the MA and AA women provided evidence-based data about variations associated to culture. Access to interpreter services is vital as linguistic barriers for MA women have a significant impact on the delivery of healthcare, patient satisfaction and compliance. Care was given to ensure that the latest version of the survey was used as it is available online (AHRQ, 2014).

Section 4: Findings and Recommendations

Introduction

The increase in diversity of the U.S. population demands that healthcare practitioners be aware of cultural norms. Effective communication paves the way for positive outcomes; however, barriers to comprehension hinder success. There is a lack of adequate and professional translators. A quality improvement healthcare initiative to promote medication safety could be to assess the client's use of Complementary and Alternative Medicine (CAM). The use of certain CAM could result in an adverse reaction to Western medicine (National Institute of Health (NIH), 2007).

Although the MA and AA women surveyed in the project were menopausal, there was no assessment of the individual participant's symptomatology. The age of these two groups is relevant as they represent the age bracket of people seeking medical care today. Over the next 20 years, 3 million baby boomers will reach retirement age and present a huge impact on the healthcare system, as the workforce is also aging (Barr, 2014). Studies that assess the perspective of the participants are not frequently noted in the literature.

Findings and Implications

The findings from the project showed the similarities and differences in the responses of the MA and AA participants in each domain of the CAHPS survey. The project consisted of giving the survey to 40 participants at different times. The participants were menopausal women whose inclusion and exclusion criteria were assessed during the completion of the recruitment flyer (Appendix G). There were 20 MA

women who over the course of 2 weeks were administered the survey during their office visit. The 20 AA women (over the same time) were given the survey in a church setting. The project was noninvasive and anonymous and the participants provided implied consent prior to survey completion.

Clarity was provided for each domain of the cultural competence survey to compare the perspective of the participants from both ethnic groups. All questions pertain to communication or the relationship between the participants and their doctor; however, responses are not created equally. For example, the question of how often your doctor interrupted you or cared for you as a person over the last 12 months elicited different point values. The point value of 5 for *never* is good for no interruptions but in terms of a caring doctor a 5 for ***alway***s is the best score. A tool was used to tally the domain points to each participants survey (Appendix H). The data was inputted into an EXCEL spreadsheet and displayed in a manner that satisfied the visual and statistical demands of the project. Once the scores were totaled and the maximum score for each domain assessed the results were converted to a percentage. All project findings that represented the questions in each domain was displayed in Figure 3. Excel was used to display the first 4 domains and the last 4 domains (Figure 4 and Figure 5). Question 27 is not listed in the domains, but the results were significant to the results obtained from the domain associated to the use of alternative medicine therefore this question is displayed in an independent graph Figure 6.

Project Findings: Survey Results according to Domains with Ethnic Group Points followed by Category Percentage					
Campinha-Bacote Model	**CAHPS Domains**	**CAHPS Survey Items # represents survey question**	**CAHPS Response Scale**	**Mexican American**	**African American**
Cultural Awareness	**Doctor Communication-Positive Behaviors**	5) In the past 12 months how often did this doctor explain things in a way that was easy to understand?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always	**86.8%**	**80.6%**
		6) In the last 12 months, how often did this doctor listen carefully to you?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always		
		7) In the past 12 months how often did this doctor spend enough time with you?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always		
		15) In the last 12 months, how often did this doctor show respect for what you had to say?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always		
		18) In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always		
	Doctor Communication-Negative Behaviors	8) In the last 12 months how often did this doctor interrupt you when you were talking?	(**5**) Never (**4**) Almost Never (**3**) Sometimes (**2**) Usually (**1**) Almost Always (**0**) Always	**96%**	**86.6%**
		9) In the last 12 months, how often did this doctor talk too fast when talking with you?	(**5**) Never (**4**) Almost Never (**3**) Sometimes (**2**) Usually (**1**) Almost Always (**0**) Always		
		13) In the last 12 months, did this doctor ever use a condescending, sarcastic, or rude tone or manner with you?	(**0**) Yes Definitely (**0**) Yes Somewhat (**5**) No		
Cultural Skills	**Doctor Communication-Health Promotion**	20) In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No	**68.2%**	**66.2%**
		21) In the last 12 months, did you and this doctor talk about the exercise or physical activity you get?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No		
		22) In the last 12 months, did you and this doctor talk about things in your life that worry you or cause you stress?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No		
		23) In the last 12 months, did this doctor ever ask you whether there was a period of time when you felt sad, empty or depressed?	(**5**) Yes (**0**) No		
Cultural Knowledge	**Doctor Communication-Alternative Medicine**	26) In the last 12 months, has this doctor ever asked you if you have used these other people to help with an illness or to stay healthy (for example, acupuncturist or herbalist)?	(**5**) Yes (**0**) No	**15%**	**17.5%**
		28) In the last 12 months, has this doctor ever asked you if you used natural herbs?	(**5**) Yes (**0**) No		
	Shared Decision Making	30) In the last 12 months, did this doctor talk with you about the pros and cons of each choice for your treatment or health care?	(**5**) Yes (**0**) No	**45%**	**32.5%**
		31) In the last 12 months, when there was more than one choice for your treatment or health care, did this doctor ask which choice you thought was best for you?	(**5**) Yes (**0**) No		
	Equitable treatment	34) In the last 12 months, how often have you been treated unfairly at this doctor's office because of your race or ethnicity?	(**5**) Never (**4**) Almost Never (**3**) Sometimes (**2**) Usually (**1**)Almost Always (**0**) Always	**95%**	**94%**
		35) In the last 12 months, how often have you been treated unfairly at this doctor's office because of the type of health insurance you have or because you don't have health insurance?	(**5**) Never (**4**) Almost Never (**3**)Sometimes (**2**) Usually (**1**) Almost Always (**0**) Always		
Cultural Desire	**Trust**	36) Do you feel you can tell this doctor anything, even things that you might not tell anyone else?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No	**91.4%**	**85.8%**
		37) Do you trust this doctor with your medical care?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No		
		38) Do you feel this doctor always tells you the truth about your health, even if there is bad news?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No		
		39) Do you feel this doctor cares as much as you do about your health?	(**5**) Yes Definitely (**4**) Yes Somewhat (**0**) No		
		40) In the last 12 months, how often did you feel this doctor really cared about you as a person?	(**0**) Never (**1**) Almost Never (**2**) Sometimes (**3**) Usually (**4**) Almost Always (**5**) Always		
Cultural Encounters	**Access to Interpreter Services**	48) In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor's office?	(**0**) Yes (**5**) No	**90%**	**0%**
		51) In the last 12 months, how often did your visit with the doctor start late because you had to wait for an interpreter? Do not include friends or family members.	(**5**) Never (**4**) Almost Never (**3**) Sometimes (**2**) Usually (**1**) Almost Always (**0**) Always		
		55) In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor's office? Do not include friends and family members.	(**0**) Yes (**5**) No		

Figure 3. Project findings: Survey results according to domains.

	A	B	C	D	E
1		M.A. 86.8% A.A. 80.6% Positive Behavior	M.A. 96% A.A.86.6% Negative Behavior	M.A. 68% A.A. 66% Health Promotions	M.A. 15% A.A.17.5% Alt. Medicine
2	Mexican Americans	434	288	273	30
3	African Americans	403	260	265	35

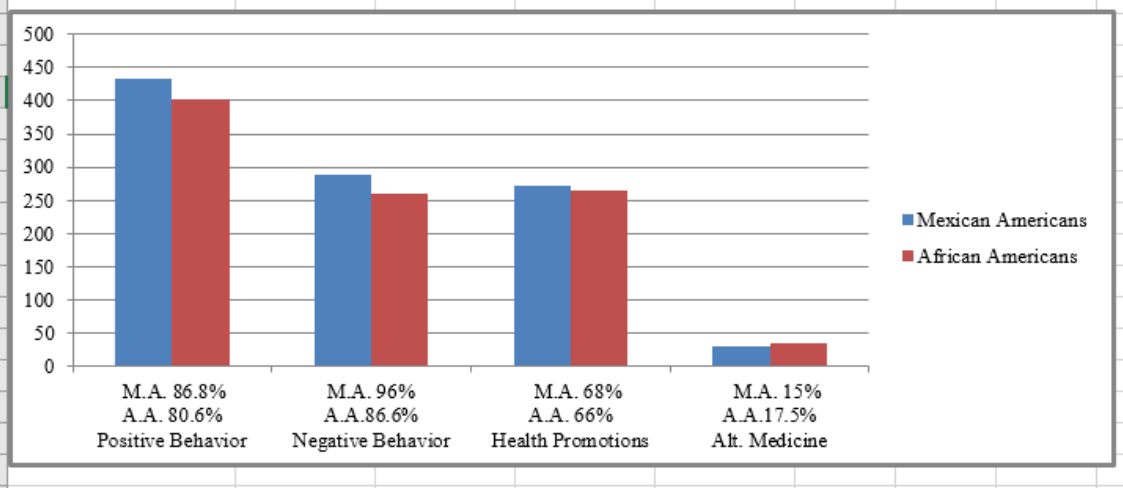

Figure 4. Project survey results for first four domains.

	A	B	C	D	E
1		M.A. 45% A.A.32.5% Shared Decision Making	M.A. 95% A.A. 94% Equitable Treatment	M.A. 91.4% A.A. 85.8% Trust	M.A. 90% A.A. 0% Access to Interpreter
2	Mexican Americans	90	190	457	270
3	African Americans	65	288	429	0

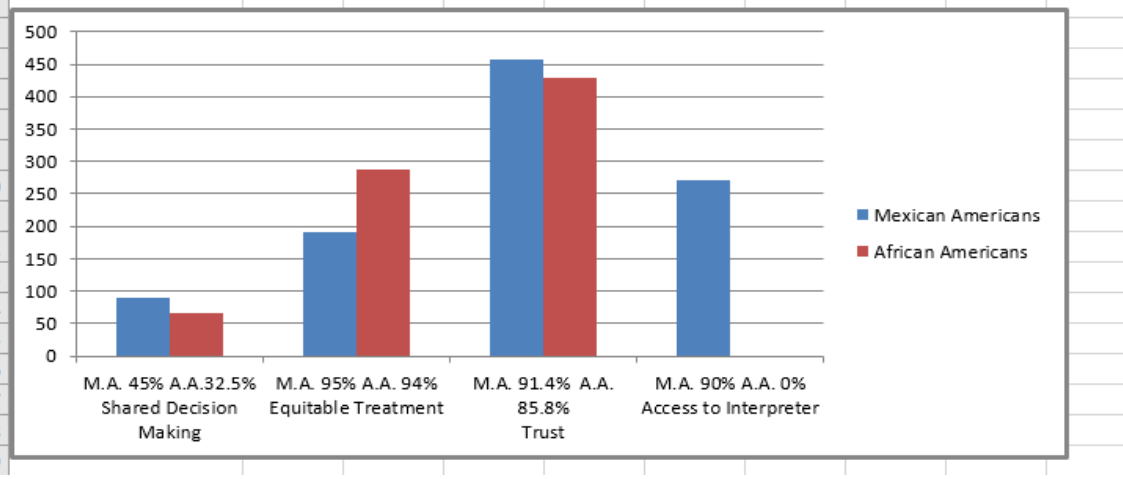

Figure 5. Project survey results for last four domains.

Domain: Doctor Communication-Positive Behaviors

The questions in this domain (5, 6, 7, 15, & 18) are indicative of the participant's perception of positive communication behaviors between them and their doctor. Results showed that 86.8% of MA women and 80.6% of AA women surveyed engage in positive communication with their doctors. Out of the maximum possible 500 points, the MA group received 434 while the AA group received 403. Although the scores are good for both groups, an expectation of all patients is to engage in conversations with their doctor that generate positive behaviors and outcomes.

Domain: Communication-Negative Behaviors

The questions in this domain (8, 9, & 13) are indicative of the participant's perception of negative communication or interactions between them and their doctor. The results showed that MA women (96%) and AA women (86.6%) responded positively for the perception of no negative communication. The maximum score is 300 for this domain with the MA group receiving 288 and the AA group 260 with the majority choosing *never* or *almost never* encountering communication related negative behaviors. The negative behaviors could be the doctor interrupting the client or speaking in a rude or sarcastic manner. Quality improvement on a larger scale such as in a hospital or university setting could benefit from adding effective communication techniques to annual competencies.

Domain: Doctor Communication-Health Promotion

The questions in this domain (20, 21, 22, & 23) are indicative of the doctor asking the participants what activities they engage in to promote health. The results were 68.2%

of MA women and 66.2% of AA women, which validates a need for quality improvement for patient-centered care. The Institute of Medicine (2001), advocates patient-centered care, which is parallel to culturally competent care that is respectful of the patient and their family's needs and values, creates positive outcomes. The maximum score for this domain is 400, reflecting doctor communications with the patient about activities that promote health such as diet, exercise, depression, or stress reduction. The score for the MA group is 273 and 265 for the AA group. There are many factors that impact a patient's health such as socioeconomics, demographic patterns, lifestyle habits, and familial diseases. The World Health Organization in 2012 documented that the promotion of health is not just to be free from disease and illness, but a state of wellness in the physical, social, and mental aspects of a person's life (Kumar & Preetha, 2012).

Domain: Doctor Communication-Alternative Medicine

The questions in this domain (26 & 28) are reflective of communication with the doctor about the use of alternative medicine. The results were that 15% of MA women and 32.5% of AA women agree to engaging in dialogue with their doctor about their use of alternative medicine. The maximum potential score is 200 in this 2-question domain with the MA totaling 30 and 35 for the AA group. The decreased point value validates a need for quality improvement in assessing the use of alternative medicines, which is synonymous to CAM. Question 27 is not included in this domain; however, the responses that 80% of the MA group and 45% of the AA group admit to the use of herbs or other CAM is additional validation for needing quality improvement pertaining to the use of alternative medicines.

Domain: Shared Decision Making

The questions in this domain (30 & 31) are reflective of shared decision-making between the patient and the practitioner. The results were 45% of MA women and 32.5% of AA women. The Institute of Medicine (2001) advocates that client participation in the decision-making process helps to promote adherence to medical regimen and a feeling of mutual respect and value. The two questions in this domain have a maximum point value of 200 with the score of 90 for the MA group and 65 for the AA group. The scores in this domain validate the need for quality improvement as a lack of sharing in the decision-making process is a direct link to lack of compliance and customer satisfaction. A report from the Agency for Health Care Research and Quality (2012) mentioned that MA and AAs are among the groups that mention having minimal input in decision making process with their healthcare provider.

Domain: Equitable Treatment

The questions in this domain (34 & 35) are reflective of equitable treatment. The results showing 95% of MA women and 94% of AA women demonstrates that neither ethnic group has the perception of harsh treatment from their practitioner due to their ethnicity or type or lack of insurance. The maximum score is 200 with the MA group receiving 190 and 188 for the AA group. Prejudice is not an acceptable behavior for either of the ethnic groups surveyed; however, despite the results it does exist. Discrimination and racism continues to exist toward practitioners and patients, as it is deeply ingrained in all aspects of our society, leading to the desire for equitable treatment (Tello, 2017).

Domain: Trust

The questions in this domain (36, 37,38, 39, & 40) pertain to the trust perceived between the participant and the doctor. The results were: MA women 91.4% and AAs women 85.5%. The maximum point value is 500 with the MA group collectively receiving 457 points and 429 for the AA group, indicating that both ethnic groups trusted their practitioners would not purposefully cause them harm. Open communication creates trust that impacts improvements in patient satisfaction and outcomes (Michelson, 2017). A fundamental expectation of healthcare is to have a relationship of trust in the provider and the entire health system. Advances in technology has broadened the understanding and development of evidence-based cures; however, not everyone trusts that the advancements are available to them (Gopichandran, 2013).

Domain: Access to Interpreter Services

The questions in this domain (48, 51, & 55) reflect access to interpreter services. Results showed 90% for MA women and 0% for AA women, indicating that access to interpreter services is not a perceived problem for the groups. Although 300 is the maximum score the MA group received 270 and a 0 for the AA group as interpreter services had no relevance. The high score as it pertained to availability of an interpreter in the doctor's office is expected as she and her entire staff speak fluent Spanish. Language barriers do exist in healthcare and a different result could occur in hospitals and universities that have a shortage of adequate interpreters.

A tally sheet (Appendix H) was used for each survey completed in the project. After the tallying process was completed the totals for each question were added together

to represent a combined total for each ethnic group. The questions were not reviewed in order, but according to the appropriate CAHPS domain with the same formation being followed for both groups. Each domain was assessed to determine the maximum possible score then the total score from each domain was written in the column of the appropriate ethnic group followed by conversion to a percentage. The church representative member of the team validated the mathematical aspect of the project.

Quality Improvement Safety Recommendation: Question 27 Results

Plants have been used for medicinal purposes long before the prehistoric times in Indian, European, Mediterranean, Roman, Egyptian, Chinese medicine, and many more cultures. The World Health Organization (2009) documents over 21,000 plant species that can be used as medicine and 80% of people worldwide that rely on herbal medicine (Khan, 2016). MAs comprise a large and extremely rapid growing part of the U.S.; however, research into mental and health needs are limited (Hoeflich, 2010). Literature also reveals that herbal remedies are widely used by MA to promote wellness and cure illness, but use is seldom reported to healthcare practitioners. This information is supported by results from question 27 in the survey used for this project. Figure 6 represents the responses of the MA and AA for Question 27 pertaining to the use of alternative medicine.

In 2007, the NIH compiled an extensive list of CAM and the healers that use them such as *Curandero*, *Espiritista*, *Hierbero* or *Yerbera* and *Sobador*, which are more familiar to elderly MAs. A quality improvement effort for healthcare is to open the lines of communication and ask every patient during the assessment process if they use herbs

or any type CAM. Increased dialogue about CAM can enhance patient safety and prevent adverse reactions with Western medicine (NIH, 2007). Many of the herbal remedies used by MA are passed down for generations and revered as the initial response to certain illnesses (Giger, 2017). The response by MA to Question 27 could be a topic for additional research, especially when comparing the score of 30 out of a maximum of 200 points in the domain for doctor communication about using alternative medicine.

Question 27	**Some people use natural herbs for health reasons or to stay healthy. Natural herbs include things such as ginseng, green tea, and other herbs. People can take them as a pill, a tea, oil, or a powder. In the last 12 months, have you ever used natural herbs for your own health? (CAM = Complementary and Alternative Medicine)**		
Mexican American	20 surveys. 5 points for yes 0 points for no.	16 yes responses 80% out of a maximum of 100%	Result: 80% of the Mexican American women surveyed admit to using CAM for health and wellness. Quality Improvement: Use of CAM is an important question to ask during assessment.
African American	20 surveys. 5 points for yes 0 points for no.	9 yes responses 45% out of a maximum of 100%	Result: 45% of the African American women surveyed admit to using CAM for health and wellness. Quality Improvement: Use of CAM is an important question to ask during assessment.

Figure 6. Explanation of results from question 27.

Recommendations

There are numerous benefits to having cultural competence in hospital or care systems for the organization as well as the community. Social, health and business are three identifiable areas of benefit:

Social Benefits:

1. Increased trust and respect between the patient and the organization as well as increased responsibility for self-health.

2. Increased participation and involvement in care from patient, families, and community health issues.

Health Benefits:

1. Increased efforts for illness prevention, reduction of medical errors resulting in increased cost savings.
2. The collection of data is reflective of improvements with numbers that represent fewer missed medical visits.

Business Benefits:

1. Decision-making processes are reflective of multiple perspectives, ideas, and strategies that eliminate barriers to progress while meeting legal and regulatory guidelines.
2. Increased profitability for shareholders as well as increased efficiency and care in overall services (American Hospital Association, 2013).

Quality Improvement Recommendation for Question 27. A quality improvement effort for healthcare is to ask every patient during the assessment process if they use herbs or any type CAM to enhance patient safety and prevent possible adverse reactions with Western medicine (NIH, 2007).

Contributions of the Doctoral Project Team

Team members were given a synopsis of the project prior to the beginning by the DNP student (team leader). The doctor, nurse, receptionist and church representative supported the project by administering and collecting the completed surveys. Clients were exposed to English and Spanish recruitment flyers when they arrived for the office

visit (Appendix G) as they were displayed on the countertop. The office team members gave patients meeting inclusion criteria the opportunity to participate or decline. All participants completing the survey were given a copy of the consent which covered specific information about the survey to include a contact email and the IRB number. The surveys were distributed on four occasions over the course of the two weeks. The project was explained to the church pastor and his wife prior to site agreement and surveys.

It was originally anticipated that several churches would be needed; however, the required number for participants that met the inclusion and exclusion criteria were available at one church. Surveys were administered on four different occasions over the course of two weeks in the church setting. The pastor's wife took care to collect three surveys and distribute consents and maintain the anonymous integrity of the survey. All collected surveys were maintained in a large brown envelop and given to the DNP student (team leader). The team members did not participate in reviewing or tallying the surveys; however, the church representative was utilized to double check statistical calculations. Dialogue with the office nurse about surveys resulted in the suggestion of obtaining as much data prior to office visit to ensure clarity and efficiency of communication between patients and doctor otherwise there are no specific plans to extend the project beyond this timeframe.

Strengths and Limitations of the Project

Strength of the project was the cooperative nature of the patients that were visiting the clinic during the time of survey. The patients were familiar with the DNP

student (team leader) who frequented the clinic for years while completing field hours. The doctor and her staff were supportive of the project and assisted with Spanish translations. A culturally competent healthcare medication safety recommendation resulted from the project. The validity and reliability of the survey provided enormous strength.

The size and number of the participants was a project limitation in additional to the lack of individual interactions with the participants about their survey. The venue of a hospital or university may have generated more significant results due to the possibility of an increase in diversity. The fact that the surveys had no identifiable information may have been a limitation in a group of this size.

Future studies pertaining to cultural competence need to be conducted to include male patients and the lack of compliance to healthcare regimen in minorities. The inclusion of cultural competence training into the curriculum of nursing and medical schools would be the greatest contribution toward easing the burden of a lack of diversity in the healthcare workforce.

Section 5: Dissemination Plan

Diversification of the country brings about an increase in healthcare challenges, which are multiplied by the shortage of professionals in all aspects of medicine. The development of a system that meets social, cultural and linguistic needs of patients is a burden for the providers, policy makers, and stakeholders. Review of healthcare in terms of racial and ethnic minorities places MA and AAs at the top of the list for higher morbidity and mortality from chronic diseases (Georgetown University, 2004). Support

for the quality improvement efforts of this project, is important for the results to be effectively disseminated. Dissemination of this information could have a positive impact on healthcare by increasing the knowledge of providers and improving patient outcomes.

The development of goals for the project results to have the greatest impact on the community and healthcare guided dissemination of the evidence. Publishing of the project will increase the availability to the end-users such as nurse educators, practitioners, healthcare systems, policy makers, and nursing schools.

The dissemination of information gathered from Question 27 could easily be demonstrated by poster presentation (Hanrahan, et al, 2010). The poster would include the statistical data collected (Figure 6) as well as the importance of inquiring during the admission process if the patient uses CAM. The NIH (2010) documented that there is a broad use of CAM for the pursuit of health and well-being; however, clinical trials are lacking to support the specific usage. To prevent possible adverse reactions, staff responsible for assessments must communicate clearly and ask specific questions that reveal the use of herbs and nonpharmaceutical interventions and CAM that have the potential to interact with Western medicine. An oral presentation in addition to submission of the project results for publication will be an excellent platform to disseminate the findings of the project.

Analysis of Self

This project afforded me the opportunity for increased self and reader awareness into the impact of culture on healthcare from the patient perspective. The Essentials of Doctoral Education for Advanced Nursing Practice guides my practice focused doctoral

program and project that impacts patient outcomes through receiving care from culturally competent practitioners. If hospitals, doctor's offices, and clinics increase their awareness and knowledge as to the benefits of cultural competence they could potentially have a positive impact on the healthcare delivery system. The project of the DNP student may contribute to an awareness of the relevance of culture to healthcare and the importance of its inclusion in nursing curriculums. Nursing administrators and educators can improve knowledge enhancement into cultural competence by including this topic to annual nursing competencies. I believe that my project contributes to improving the quality of healthcare in diverse populations and could positively impacting patient outcomes.

Summary

Integrating cultural competence into existing evidence-based care will have a positive impact on the delivery of services and provide improvement in quality of care at the individual and family levels. A goal of the healthcare system is to deliver care in the presence of illness; however, the expectation of recipients is to be treated with respect of culture, values and practices. The CAHPS survey utilized for this project collected reliable information from patients about the care they received from their provider. The project results were determined by participants' responses to eight domains. The first two domains pertained to the communicative connection between the participant and their doctor. The other domains dealt with interactions between the participant and the doctor, staff and healthcare system to include additional issues related to trust, discrimination, literacy and quality care.

The domain “Access to Interpreter Services” did not provide new information as there were no deficits in this area since the doctor and entire office staff speaks fluent Spanish and the AA group did not require interpreter services. Enhancement of communication during the admission assessment to include the use of alternative medicine could potentially impact medication safety and prevent possible adverse reactions with Western medicines. Literature clearly establishes that MAs represent the fastest growing minority population which increases the possibility of healthcare practitioner’s exposure to this group. Practitioners in the hospitals, clinics, and educational level to name a few have the potential to impact healthcare outcomes when they increase their knowledge about culturally diverse groups.

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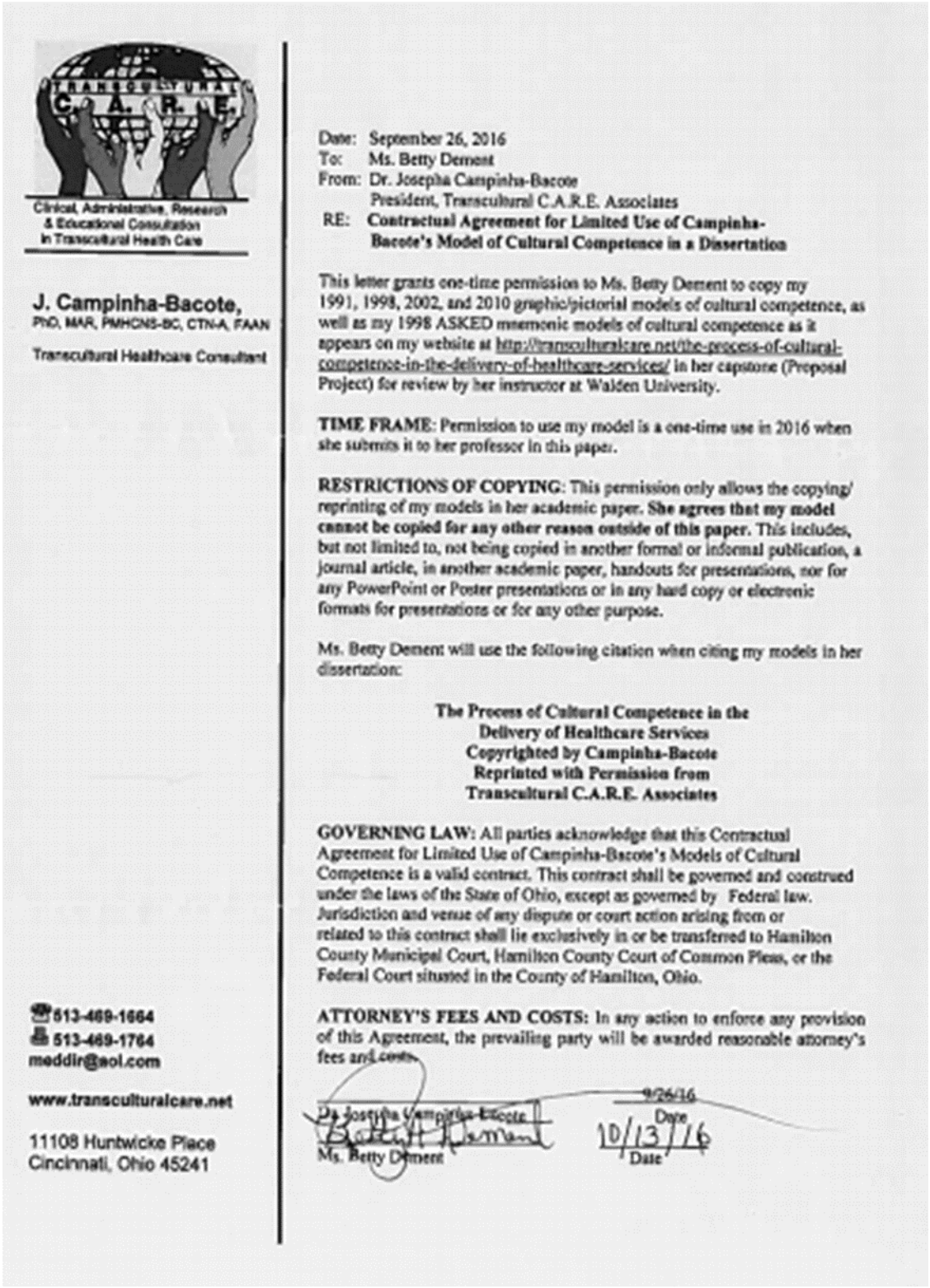
Appendix A: Permission from J. Campinha-Bacote



TRANSCULTURAL C.A.R.E.

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To: Ms. Betty Dement
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates
RE: **Contractual Agreement for Limited Use of Campinha-Bacote's Model of Cultural Competence in a Dissertation**

This letter grants one-time permission to Ms. Betty Dement to copy my 1991, 1998, 2002, and 2010 graphic/pictorial models of cultural competence, as well as my 1998 ASKED mnemonic models of cultural competence as it appears on my website at http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/ in her capstone (Proposal Project) for review by her instructor at Walden University.

TIME FRAME: Permission to use my model is a one-time use in 2016 when she submits it to her professor in this paper.

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Ms. Betty Dement will use the following citation when citing my models in her dissertation:

The Process of Cultural Competence in the Delivery of Healthcare Services
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GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Dr. Josepha Campinha-Bacote — 9/26/16 Date

Ms. Betty Dement — 10/13/16 Date

Appendix B: Permission from Robert Weech-Maldonado

Wed 3/22, 9:09 PM
'Betty Dement' [redacted]

CKV - PACC English Draft 06.30.08.doc182 KB
Download
Save to OneDrive - Laureate Education

Hi Betty:

Glad you are interested in our research work. Yes, you can use our survey measures for your research. I have also attached the full survey as a reference. We just ask that you cite the paper as the source of the survey.

Best of luck with your research!
Rob

****
Robert Weech-Maldonado, MBA, Ph.D.
Professor & L.R. Jordan Endowed Chair
Co-Director, NSF I/UCRC Center for Health Organization Transformation
Department of Health Services Administration
University of Alabama at Birmingham
[redacted]

Attached.
Best wishes,
Rob

Thu 5/4, 9:37 PM

CKV - PACC Spanish Draft 06.30.08.doc172 KB
Download

Hi Betty:

Glad you are administering the survey in Spanish. We did translate the survey into Spanish. Please see attached.
Best wishes,
Rob

Appendix C: CAHPS Survey in English

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence Survey – English Version

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **You are sometimes told to skip over some questions in the survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:**

○ Yes ➔ *Go to Question 1*
○ No

START HERE

YOUR DOCTOR

1. **A personal doctor is the one you would see if you need a checkup, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?**

   ○ Yes
   ○ No ➔ *Go to Question 57 on Page 7*

Please think of that doctor as you answer the survey.

2. **Is this the doctor you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?**

   ○ Yes
   ○ No

3. **How long have you been going to this doctor?**

- ○ Less than 6 months
- ○ At least 6 months but less than 1 year
- ○ At least 1 year but less than 3 years
- ○ At least 3 years but less than 5 years
- ○ 5 years or more

YOUR CARE FROM THIS DOCTOR IN THE LAST 12 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

4. **In the last 12 months, how many times did you visit this doctor to get care for yourself?**

- ○ None ➔ *Go to Question 57 on Page 7*
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

COMMUNICATION WITH YOUR DOCTOR

5. **In the last 12 months, how often did this doctor explain things in a way that was easy to understand?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

6. **In the last 12 months, how often did this doctor listen carefully to you?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

7. **In the last 12 months, how often did this doctor spend enough time with you?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

8. **In the last 12 months, how often did this doctor interrupt you when you were talking?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

9. **In the last 12 months, how often did this doctor talk too fast when talking with you?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

10. **In the last 12 months, how often did this doctor use medical words you did not understand?**

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

11. In the last 12 months, were any of the explanations this doctor gave you hard to understand because of an accent or the way the doctor spoke English?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

12. In the last 12 months, did this doctor ever ignore what you told him or her?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

13. In the last 12 months, did this doctor ever use a condescending, sarcastic, or rude tone or manner with you?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

14. In the last 12 months, did this doctor ever show interest in your questions and concerns?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

15. In the last 12 months, how often did this doctor show respect for what you had to say?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

16. In the last 12 months, how often did this doctor answer all your questions to your satisfaction?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

17. In the last 12 months, did you talk with this doctor about any health problems or concerns?

- ○ Yes
- ○ No ➔ *Go to Question 19*

18. In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

19. Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate this doctor?

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Worst doctor possible										Best doctor possible

20. In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

21. In the last 12 months, did you and this doctor talk about the exercise or physical activity you get?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

22. In the last 12 months, did you and this doctor talk about things in your life that worry you or cause you stress?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

23. In the last 12 months, did this doctor ever ask you whether there was a period of time when you felt sad, empty or depressed?

- ○ Yes
- ○ No

24. People sometimes see someone else besides their doctors or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist?

- ○ Yes
- ○ No

25. In the last 12 months, have you ever used an herbalist?

- ○ Yes
- ○ No

26. In the last 12 months, has this doctor ever asked you if you have used these other people to help with an illness or to stay healthy (for example, acupuncturist or herbalist)?

- ○ Yes
- ○ No

27. Some people use natural herbs for health reasons or to stay healthy. Natural herbs include things such as ginseng, green tea, and other herbs. People can take them as a pill, a tea, oil, or a powder.

In the last 12 months, have you ever used natural herbs for your own health?

- ○ Yes
- ○ No

28. In the last 12 months, has this doctor ever asked you if you used natural herbs?

- ○ Yes
- ○ No

SHARED DECISIONS

29. Choices for your treatment or health care can include choices about medicine, surgery, or other treatment. In the last 12 months, did this doctor tell you there was more than one choice for your treatment or health care?

- ○ Yes
- ○ No ➔ *Go to Question 34 on Page 5*

30. In the last 12 months, did this doctor talk with you about the pros and cons of each choice for your treatment or health care?

- ○ Yes
- ○ No

31. In the last 12 months, when there was more than one choice for your treatment or health care, did this doctor ask which choice you thought was best for you?

- ○ Yes
- ○ No

32. How often do you prefer that your doctor asks your opinion about the choices you have?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

33. How often do you prefer to leave decisions about your treatment or medical care up to your doctor?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

YOUR EXPERIENCE AT THIS DOCTOR'S OFFICE

34. In the last 12 months, how often have you been treated unfairly at this doctor's office because of your race or ethnicity?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

35. In the last 12 months, how often have you been treated unfairly at this doctor's office because of the type of health insurance you have or because you don't have health insurance?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

THE TRUST YOU HAVE IN THIS DOCTOR

36. Do you feel you can tell this doctor anything, even things that you might not tell anyone else?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

37. Do you trust this doctor with your medical care?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

38. Do you feel this doctor always tells you the truth about your health, even if there is bad news?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

39. Do you feel this doctor cares as much as you do about your health?

- ○ Yes, Definitely
- ○ Yes, Somewhat
- ○ No

40. In the last 12 months, how often did you feel this doctor really cared about you as a person?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

41. Using any number from 0 to 10, where 0 means that you do not trust this doctor at all and 10 means that you trust this doctor completely, what number would you use to rate how much you trust this doctor?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10

Do not trust this doctor at all — Trust this doctor completely

LANGUAGE ACCESS

42. Is English your primary language?

- ○ Yes ➔ *Go to Question 57 on Page 7*
- ○ No

43. How well do you speak English?

- ○ Very well ➔ *Go to Question 45 on Page 6*
- ○ Well
- ○ Not well
- ○ Not at all

44. In the last 12 months, how often have you been treated unfairly at this doctor's office because you do not speak English very well?

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

45. How well do you understand English?

- ○ Very well
- ○ Well
- ○ Not well
- ○ Not at all

46. An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include friends or family members, staff from the doctor's office, or telephone interpreters. In the last 12 months, did you ever use an interpreter to help you talk with this doctor?

- ○ Yes
- ○ No ➔ *Go to Question 57 on Page 7*

47. In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this doctor?

- ○ Never ➔ *Go to Question 50*
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

48. In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor's office?

- ○ Yes
- ○ No

49. In the last 12 months, did you use friends or family members as interpreters because that was your personal preference?

- ○ Yes
- ○ No

50. Now we would like you to think about OTHER interpreters, which can include staff from the doctor's office, or in-person or telephone interpreters provided by the doctor's office. In the last 12 months, how often did you use other interpreters when you talked with this doctor?

- ○ Never ➔ *Go to Question 57 on Page 7*
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

51. In the last 12 months, how often did your visit with this doctor start late because you had to wait for an interpreter? Do not include friends or family members.

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

52. In the last 12 months, when you used an interpreter provided by the doctor's office, who was the interpreter you used most often when you talked with this doctor?

- ○ A nurse, clerk or receptionist from this doctor's office
- ○ A professional interpreter hired by this doctor's office to help patients talk with the doctor
- ○ A telephone interpreter
- ○ Someone else Who?

_____

53.In the last 12 months, how often did the interpreter you had most often at this doctor's office treat you with courtesy and respect? Do not include friends or family members.

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

54. Using any number from 0 to 10 where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate the interpreter you had most often in the last 12 months? Do not include friends or family members.

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

0 1 2 3 4 5 6 7 8 9 10

Worst interpreter possible — Best interpreter possible

55. In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor's office? Do not include friends or family members.

- ○ Yes
- ○ No ➔ *Go to Question 57*

56. In the last 12 months, how often did you need an interpreter and did not get one at this doctor's office? Do not include friends or family members.

- ○ Never
- ○ Almost Never
- ○ Sometimes
- ○ Usually
- ○ Almost Always
- ○ Always

ABOUT YOU

57. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

58. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

59. Are you male or female?

- ○ Male
- ○ Female

60. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

61. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, not Hispanic or Latino

62. What is your race? Please mark one or more.

- ○ White
- ○ Black or African American
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ American Indian or Alaskan Native
- ○ Other

63. Did someone help you complete this survey?

- ○ Yes ➔ *Go to Question 64*
- ○ No ➔ *Thank you.*

64. How did that person help you? Mark all that apply.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way (Please print)

_____

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

Appendix D: CAHPS Survey in Spanish

La evaluación del consumidor de los prestadores de servicios y sistemas (CAHPS®) competencia Cultural encuesta – versión en Español

INSTRUCCIONES PARA EL CUESTIONARIO

- **Por favor asegúrese de llenar el círculo a lado de su respuesta completamente. Use un bolígrafo con tinta negra o azul o un lápiz oscuro para llenar el cuestionario.**

Forma de marcar correcta	Formas de marcar incorrectas
●	⊘ ✓ ✓

- **A veces hay que saltarse alguna pregunta. Cuando esto ocurra, una flecha a la derecha de la respuesta le indicará a qué pregunta hay que pasar. Por ejemplo:**

  ○ Sí ➔ *Pase a la pregunta 1*
  ○ No

↓ EMPIEZE AQUI ↓

SU DOCTOR

1. **Un doctor personal es el doctor al que iría si necesita un chequeo, si quiere consejos sobre un problema de salud o si se enferma o lastima. ¿Tiene usted un doctor personal?**

   ○ Sí
   ○ No ➔ *Pase a la pregunta 57 en la página 7*

Por favor piense en este doctor al contestar el cuestionario.

2. **¿Es este el doctor al que usted va generalmente si necesita un chequeo, si quiere consejos sobre un problema de salud o si se enferma o lastima?**

   ○ Sí
   ○ No

3. **¿Cuánto tiempo hace que ha estado yendo a este doctor?**

   - ○ Menos de 6 meses
   - ○ Al menos 6 meses pero menos de 1 año
   - ○ Al menos 1 año pero menos de 3 años
   - ○ Al menos 3 años pero menos de 5 años
   - ○ 5 años o más

LA ATENCIÓN QUE RECIBIÓ DE ESTE DOCTOR EN LOS ÚLTIMOS 12 MESES

Estas preguntas son acerca la atención médica que usted ha recibido. No incluya la atención que recibió cuando pasó la noche hospitalizado. No incluya las consultas al dentista.

4. **En los últimos 12 meses, ¿cuántas veces fue a ver a este doctor para recibir atención médica para usted mismo?**

   - ○ Ninguna ➔ *Pase a la pregunta 57 en la página 7*
   - ○ 1 vez
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5 a 9
   - ○ 10 veces o más

COMUNICACIÓN CON SU DOCTOR

5. **En los últimos 12 meses, ¿con qué frecuencia este doctor le explicó las cosas de una manera fácil de entender?**

   - ○ Nunca
   - ○ Casi nunca
   - ○ A veces
   - ○ La mayoría de las veces
   - ○ Casi siempre
   - ○ Siempre

6. **En los últimos 12 meses, ¿con qué frecuencia este doctor le escuchó con atención?**

   - ○ Nunca
   - ○ Casi nunca
   - ○ A veces
   - ○ La mayoría de las veces
   - ○ Casi siempre
   - ○ Siempre

7. **En los últimos 12 meses, ¿con qué frecuencia este doctor pasó suficiente tiempo con usted?**

   - ○ Nunca
   - ○ Casi nunca
   - ○ A veces
   - ○ La mayoría de las veces
   - ○ Casi siempre
   - ○ Siempre

8. **En los últimos 12 meses, ¿con qué frecuencia este doctor le interrumpió cuando estaba usted hablando?**

   - ○ Nunca
   - ○ Casi nunca
   - ○ A veces
   - ○ La mayoría de las veces
   - ○ Casi siempre
   - ○ Siempre

9. **En los últimos 12 meses, ¿con qué frecuencia este doctor hablaba demasiado rápido cuando conversaba con usted?**

   - ○ Nunca
   - ○ Casi nunca
   - ○ A veces
   - ○ La mayoría de las veces
   - ○ Casi siempre
   - ○ Siempre

10. **En los últimos 12 meses, ¿con qué frecuencia este doctor usó palabras médicas que usted no entendía?**

    - ○ Nunca
    - ○ Casi nunca
    - ○ A veces
    - ○ La mayoría de las veces
    - ○ Casi siempre
    - ○ Siempre

11. En los últimos 12 meses, ¿fue difícil de entender alguna de las explicaciones de este doctor debido al acento o a la forma en que hablaba inglés el doctor?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

12. En los últimos 12 meses, ¿sintió que este doctor realmente se preocupaba por usted como persona?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

13. En los últimos 12 meses, ¿usó este doctor un tono o trato condescendiente, sarcástico o grosero con usted?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

14. En los últimos 12 meses, ¿mostró este doctor interés en sus preguntas e inquietudes?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

15. En los últimos 12 meses, ¿con qué frecuencia este doctor demostró respeto por lo que usted tenía que decir?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

16. En los últimos 12 meses, ¿con qué frecuencia este doctor contestó todas sus preguntas de manera satisfactoria?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

17. En los últimos 12 meses, ¿habló con este doctor sobre algún problema médico o inquietud?

- ○ Sí
- ○ No ➔ ***Pase a la pregunta 19***

18. En los últimos 12 meses, ¿con qué frecuencia este doctor le dio instrucciones fáciles de entender sobre qué hacer para resolver esos problemas médicos o inquietudes?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

19. Usando un número del 0 al 10, el 0 siendo el peor doctor posible y el 10 el mejor doctor posible, ¿qué número usaría para calificar a este doctor?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
El peor doctor posible — El mejor doctor posible

20. En los últimos 12 meses, ¿hablaron este doctor y usted sobre una dieta saludable y sobre hábitos alimenticios sanos?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

21. En los últimos 12 meses, ¿hablaron este doctor y usted sobre el ejercicio o la actividad física que realiza?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

22. En los últimos 12 meses, ¿hablaron usted y este doctor sobre las cosas de su vida que le preocupan o le causan estrés?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

23. **En los últimos 12 meses, ¿alguna vez le preguntó este doctor si hubo un periodo de tiempo durante el cual usted se sintió triste, vacío o deprimido?**

- ○ Sí
- ○ No

24. **Además de ir a ver al doctor o al especialista, la gente a veces va a ver a otras personas para que le ayuden con una enfermedad o a mantenerse saludable. En los últimos 12 meses, ¿ha ido usted a ver a un acupunturista?**

- ○ Sí
- ○ No

25. **En los últimos 12 meses, ¿ha ido usted a ver a un hierbero?**

- ○ Sí
- ○ No

26. **En los últimos 12 meses, ¿le ha preguntado alguna vez este doctor si usted ha ido a ver a estas personas para que le ayuden con una enfermedad o a mantenerse saludable (por ejemplo, un acupunturista o hierbero)?**

- ○ Sí
- ○ No

27. **Algunas personas usan hierbas naturales por razones de salud o para mantenerse saludables. Las hierbas naturales incluyen el ginseng, el té verde, y otras hierbas. Uno las puede tomar en forma de pastilla, se puede hacer un té, aceite, o en polvo.**

En los últimos 12 meses, ¿alguna vez ha usado hierbas naturales para su salud?

- ○ Sí
- ○ No

28. **En los últimos 12 meses, ¿le ha preguntado alguna vez este doctor si usted ha usado hierbas naturales?**

- ○ Sí
- ○ No

TOMA DE DECISIONES SOBRE SU ATENCIÓN MÉDICA

29. **Entre las opciones de tratamiento o atención médica se pueden incluir opciones sobre medicina, cirugía u otros tipos de tratamiento. En los últimos 12 meses, ¿le dijo este doctor que había más de una opción para su tratamiento o atención médica?**

- ○ Sí
- ○ No ➔ *Pase a la pregunta 34 en la página 5*

30. **En los últimos 12 meses, ¿le habló este doctor acerca de los pro y los contra de cada opción de tratamiento o atención médica?**

- ○ Sí
- ○ No

31. **En los últimos 12 meses, cuando había más de una opción de tratamiento o atención médica, ¿le preguntó este doctor cual opción creía usted que le convenía más?**

- ○ Sí
- ○ No

32. **¿Con qué frecuencia prefiere que su doctor le pregunte su opinión sobre qué opciones tiene?**

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

33. **¿Con qué frecuencia prefiere dejar en manos de su doctor las decisiones sobre su tratamiento o atención médica?**

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

EL TRATO QUE RECIBE CUANDO LE ATIENDEN

34. En los últimos 12 meses, ¿con que frecuencia le han tratado de manera injusta en el consultorio de este doctor debido a su raza o grupo étnico?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

35. En los últimos 12 meses, ¿con que frecuencia le han tratado de manera injusta en el consultorio de este doctor debido al tipo de seguro médico que tiene o porque no tiene seguro médico?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

LA CONFIANZA QUE LE TIENE A ESTE DOCTOR

36. ¿Siente que le puede decir cualquier cosa a este doctor, incluso cosas que quizás no le diría a nadie más?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

37. ¿Confía en este doctor con respecto a su atención médica?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

38. ¿Siente que este doctor siempre le dice la verdad sobre su salud, aún si son malas noticias?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

39. ¿Siente que este doctor se preocupa por su salud tanto como usted?

- ○ Sí, definitivamente
- ○ Sí, algo
- ○ No

40. En los últimos 12 meses, ¿con que frecuencia sintió que a este doctor realmente le importa como persona?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

41. Usando un número del 0 al 10, donde el 0 significa que no confía para nada en este doctor y el 10 significa que confía completamente en este doctor, ¿qué número usaría para calificar cuánto confía en este doctor?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No confío para nada en este doctor — Confío completamente en este doctor

ACCESO A SERVICIOS DE INTERPRETACIÓN

42. ¿Es el inglés el idioma que habla principalmente?

- ○ Sí ➔ ***Pase a la pregunta 57 en la página 7***
- ○ No

43. ¿Qué tan bien habla inglés?

- ○ Lo hablo muy bien ➔ ***Pase a la pregunta 45 en la página 6***
- ○ Lo hablo bien
- ○ No lo hablo bien
- ○ No hablo inglés

44. En los últimos 12 meses, ¿con que frecuencia le han tratado de manera injusta en el consultorio de este doctor porque no habla inglés muy bien?

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

45. ¿Qué tan bien entiende inglés?

- ○ Lo entiendo muy bien
- ○ Lo entiendo bien
- ○ No lo entiendo bien
- ○ No entiendo inglés

46. Un intérprete es una persona que le ayuda a hablar con otras que no hablan su idioma. Los intérpretes pueden ser familiares, amigos, empleados del consultorio del doctor, o intérpretes por teléfono. Durante los últimos 12 meses, ¿necesitó alguna vez un intérprete para que le ayudara a hablar con este doctor?

- ○ Sí
- ○ No ➔ ***Pase a la pregunta 57 en la página 7***

47. En los últimos 12 meses, ¿con qué frecuencia usó a amigos o familiares como intérpretes cuando habló con este doctor?

- ○ Nunca ➔ ***Pase a la pregunta 50***
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

48. En los últimos 12 meses, ¿usó a amigos o familiares como intérpretes porque en el consultorio de este doctor no había un intérprete disponible?

- ○ Sí
- ○ No

49. En los últimos 12 meses, ¿usó a amigos o familiares como intérpretes porque usted lo prefería así?

- ○ Sí
- ○ No

50. Ahora nos gustaría que pensara en OTROS intérpretes, los cuales pueden incluir empleados del consultorio de este doctor o intérpretes que provee el consultorio de este doctor que ayudan en persona o por teléfono. En los últimos 12 meses, ¿con qué frecuencia usó otros intérpretes cuando habló con este doctor?

- ○ Nunca ➔ ***Pase a la pregunta 57 en la página 7***
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

51. En los últimos 12 meses, ¿con qué frecuencia su consulta con este doctor comenzó tarde porque usted tuvo que esperar a un intérprete? No cuente las veces en que el intérprete fue un amigo o familiar.

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

52. En los últimos 12 meses, cuando usó un intérprete que le proporcionó el consultorio de este doctor, ¿quién fue su intérprete la mayoría de las veces en que usted habló con este doctor?

- ○ Una enfermera, oficinista o recepcionista del consultorio de este doctor
- ○ Un intérprete profesional contratado por el consultorio de este doctor para ayudar a los pacientes a hablar con el doctor
- ○ Un intérprete por teléfono
- ○ Alguien más ¿Quién?

_____

53. En los últimos 12 meses, ¿con qué frecuencia el intérprete que usted tuvo más a menudo en el consultorio de este doctor le trató con cortesía y respeto? No cuente las veces en que el intérprete fue un amigo o familiar.

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

54. Usando un número del 0 al 10, donde 0 es el peor intérprete posible y 10 es el mejor intérprete posible, ¿qué número usaría para calificar al intérprete que tuvo con más frecuencia en los últimos 12 meses? No incluya a amigos ni familiares.

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
El peor intérprete posible — El mejor intérprete posible

55. En los últimos 12 meses, ¿hubo alguna ocasión en la que necesitó un intérprete y que no le proporcionaron uno en el consultorio de este doctor? No cuente las veces en que el intérprete fue un amigo o familiar.

- ○ Sí
- ○ No ➔ *Pase a la pregunta 57*

56. En los últimos 12 meses, ¿con qué frecuencia necesitó un intérprete y no le proporcionaron uno en le consultorio de este doctor? No cuente las veces en que el intérprete fue un amigo o familiar.

- ○ Nunca
- ○ Casi nunca
- ○ A veces
- ○ La mayoría de las veces
- ○ Casi siempre
- ○ Siempre

SOBRE USTED

57. En general, ¿cómo calificaría toda su salud?

- ○ Excelente
- ○ Muy buena
- ○ Buena
- ○ Regular
- ○ Mala

58. ¿Qué edad tiene?

- ○ 18 a 24
- ○ 25 a 34
- ○ 35 a 44
- ○ 45 a 54
- ○ 55 a 64
- ○ 65 a 74
- ○ 75 o más

59. ¿Es usted hombre o mujer?

- ○ Hombre
- ○ Mujer

60. ¿Cuál es el grado o nivel escolar más alto que ha completado?

- ○ 8 años de escuela o menos
- ○ 9 a 12 años de escuela, pero sin graduarse
- ○ Graduado de la escuela secundaria (high school), Diploma de escuela secundaria, preparatoria, o su equivalente (o GED)
- ○ Algunos cursos universitarios o un título universitario de un programa de 2 años
- ○ Título universitario de 4 años
- ○ Título universitario de más de 4 años

61. ¿Es usted de origen o ascendencia hispana o latina?

- ○ Sí, hispano o latino
- ○ No, ni hispano ni latino

62. ¿A qué raza pertenece? Por favor marque una o más.

- ○ Blanca
- ○ Negra o afroamericana
- ○ Asiática
- ○ Nativa de Hawai o de otras islas del Pacífico
- ○ Indígena americana o nativa de Alaska
- ○ Otra (Por favor escriba en letra de molde)

_____

63. ¿Le ayudó alguien a contestar esta encuesta?

- ○ Sí ➔ ***Si contestó "Sí", pase a la pregunta 64***
- ○ No ➔ ***Gracias.***

64. ¿Cómo le ayudó esa persona? Marque todo lo que corresponda.

- ○ Me leyó las preguntas
- ○ Anotó las respuestas que le di
- ○ Contestó las preguntas por mí
- ○ Tradujo las preguntas a mi idioma
- ○ Me ayudó de otra forma (Por favor escriba en letra de molde)

_____

Gracias de nuevo por contestar la encuesta!
Agradecemos sus respuestas.

Por favor cuando haya completado el cuestionario, devuélvalo en el sobre con porte o franqueo pagado a:

Appendix E: Quality Improvement Appendix A Site Approval

Site Approval Documentation for Quality Improvement Doctoral Project

[redacted]

Date: January 15, 2018

The doctoral student, [Betty A. Dement RN], is involved in a Quality Improvement project at our organization, and is therefore approved to access and analyze internal, deidentified site records that I deem appropriate to release for the student's doctoral project. This approval to use our organization's data pertains only to this doctoral project and not to the student's future scholarly projects or research (which would need a separate request for approval).

I understand that, as per DNP program requirements, the student will publish a scholarly report of this QI project in Proquest as a doctoral capstone (withholding the identity of the site).

The student will be responsible for complying with our organization's internal policies and requirements regarding access and use of site data for QI purposes.

I confirm that I am authorized to approve these activities in this setting.

Signed, [redacted] MD

Authorization Official Name

Title

Appendix F: Quality Improvement Appendix A Site Approval

Appendix A
Site Approval Documentation for Quality Improvement Doctoral Project

Partner Site: [redacted]
Contact Information: [redacted]
[redacted]
Date: February 4, 2018

The doctoral student, **[Betty A. Dement RN]**, is involved in a **[Quality Improvement Project]** at our church organization, and is therefore approved to (speak to and survey the members that are in agreement and meet criteria) access and analyze internal, deidentified site records that I deem appropriate to release for the student's doctoral project. This approval to use our organization's data pertains only to this doctoral project and not to the student's future scholarly projects or research (which would need a separate request for approval).

I understand that, as per DNP program requirements, the student will publish a scholarly report of this QI project in Proquest as a doctoral capstone (withholding the identity of the site).

The student will be responsible for complying with our organization's internal policies and requirements regarding access and use of site data for QI purposes.

I confirm that I am authorized to approve these activities in this setting.

Signed,

Authorization Official Name
Title

Appendix G: English and Spanish Recruitment Flyer

[redacted]

Healthcare Quality Improvement Project

Can you change healthcare? Please help! Answer a survey

El Paso Community registered nurse with a focus on nursing education is conducting a survey as part of a project to complete her study for a Doctorate in Nursing degree.

1. Your participation is needed. Please complete a survey if you are a woman between the ages of 45 to 72 years old.
2. Have reached menopause (no menstrual period for 12 months) either natural or surgical.
3. The survey will take about 20 minutes of your time. Available in English and Spanish.
4. There is no payment for participation.
5. You may stop at any time as it is voluntary.
6. None of your personal information will be used.

Please make sure you qualify

1. Females only! Between ages 45 to 72 [ ] yes [ ] no
2. No menstrual bleeding (monthly period) for the past 12 months [ ] yes [ ] no

betty.dement@waldenu.edu

[redacted]

Proyecto de mejora de calidad asistencial

¿Se puede cambiar healthcare? Por favor ayuda! Contestar una encuesta

Enfermera de la comunidad del Paso con un enfoque en la educación de enfermería está llevando a cabo una encuesta como parte de un proyecto para completar su estudio de doctorado en enfermería grado.

1. su participación es necesaria. Por favor complete una encuesta si eres una mujer entre las edades de 45 a 72 años de edad.
2. han llegado a la menopausia (sin período menstrual por 12 meses) ya sea natural o quirúrgica.
3. la encuesta tomará aproximadamente 20 minutos de su tiempo. Disponible en inglés y español.
4. no hay ningún pago para la participación.
5. usted puede detener en cualquier momento ya que es voluntario.
6. ninguna de su información personal será utilizada.

Por favor, asegúrate de que cumples los requisites

1. Solo mujeres! Entre edades de 45 a 72 [ ] sí [ ] no
2. no hay sangrado menstrual (menstruación) para los últimos 12 meses [ ] sí [ ] no

betty.dement@waldenu.edu

Appendix H: Tool to Tally Surveys of Participants

Tally Sheet for Survey's from Mexican and African Americans								
Question #	CAHPS Survey Questions	Response Point Value					Mexican American	African American
5	In the past 12 months how often did this doctor explain things in a way that was easy to understand?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
6	In the last 12 months, how often did this doctor listen carefully to you?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
7	In the past 12 months how often did this doctor spend enough time with you?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
15	In the last 12 months, how often did this doctor show respect for what you had to say?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
18	In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
8	In the last 12 months how often did this doctor interrupt you when you were talking?	(5)Never (4)Almost Never (3)Sometimes (2)Usually (1)Almost Always (0)Always						
9	In the last 12 months, how often did this doctor talk too fast when talking with you?	(5)Never (4)Almost Never (3)Sometimes (2)Usually (1)Almost Always (0)Always						
13	In the last 12 months, did this doctor ever use a condescending, sarcastic, or rude tone or manner with you?	(0) Yes Definitely (0) Yes Somewhat (5) No						
20	In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits?	(5) Yes Definitely (4) Yes Somewhat (0)No						
21	In the last 12 months, did you and this doctor talk about the exercise or physical activity you get?	(5) Yes Definitely (4) Yes Somewhat (0) No						
22	In the last 12 months, did you and this doctor talk about things in your life that worry you or cause you stress?	(5) Yes Definitely (4) Yes Somewhat (0) No						
23	In the last 12 months, did this doctor ever ask you whether there was a period of time when you felt sad, empty or depressed?	(5) Yes (0) No						
26	In the last 12 months, has this doctor ever asked you if you have used these other people to help with an illness or to stay healthy (for example, acupuncturist or herbalist)?	(5) Yes (0) No						
28	In the last 12 months, has this doctor ever asked you if you used natural herbs?	(5) Yes (0) No						
TOTAL POINTS: FIRST PAGE			1	2	3	4	5		

30	In the last 12 months, did this doctor talk with you about the pros and cons of each choice for your treatment or health care?	(5) Yes (0) No						
31	In the last 12 months, when there was more than one choice for your treatment or health care, did this doctor ask which choice you thought was best for you?	(5) Yes (0) No						
34	In the last 12 months, how often have you been treated unfairly as this doctor's office because of your race or ethnicity?	(5)Never (4)Almost Never (3)Sometimes (2)Usually (1)Almost Always (0)Always						
35	In the last 12 months, how often have you been treated unfairly at this doctor's office because of the type of health insurance you have or because you don't have health insurance?	(5)Never (4)Almost Never (3)Sometimes (2)Usually (1)Almost Always (0)Always						
36	Do you feel you can tell this doctor anything, even things that you might not tell anyone else?	(5) Yes Definitely (4) Yes Somewhat (0) No						
37	Do you trust this doctor with your medical care?	(5) Yes Definitely (4) Yes Somewhat (0) No						
38	Do you feel this doctor always tells you the truth about your health, even if there is bad news?	(5) Yes Definitely (4) Yes Somewhat (0) No						
39	Do you feel this doctor cares as much as you do about your health?	(5) Yes Definitely (4) Yes Somewhat (0) No						
40	In the last 12 months, how often did you feel this doctor really cared about you as a person?	(0)Never (1)Almost Never (2)Sometimes (3)Usually (4)Almost Always (5)Always						
48	In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor's office?	(0) Yes (5) No						
51	In the last 12 months, how often did your visit with the doctor start late because you had to wait for an interpreter? Do not include friends or family members.	(5)Never (4)Almost Never (3)Sometimes (2)Usually (1)Almost Always (0)Always						
55	In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor's office? Do not include friends and family members.	(0) Yes (5) No						
TOTAL POINTS:			**1**	**2**	**3**	**4**	**5**	