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Hospice Agencies Serving the Cultural Needs of the Hispanic Community

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Maria Ormonde

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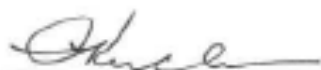Hospice Agencies Serving the Cultural Needs of the Hispanic Community

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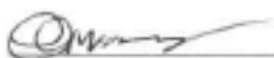for the degree Doctor of Public Administration

_____
Pat Kircher, DPA Committee Chair

_____
Scott Dunbar, DBA Committee Member

_____
Ogbochi McKinney, DrPH Committee Member

_____
Dirk Davis, Ed.D Associate Vice President of Academics

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I am thankful to my entire family, each of which, in a one way or another has helped me while I have gone through my educational journey. You know who you are. I extend my deepest appreciation to my husband and children for your support and understanding.

DEDICATION

This dissertation is dedicated to my husband and children.

This is my hard work for you.

ABSTRACT

Hospice Agencies Serving the Cultural Needs of the Hispanic Community

by Maria Ormonde

The Medicare Hospice Benefit (MHB) is a national policy that was enacted in 1982 to reduce end-of-life care expenditures and improve quality end of life. Hospice care is of value to all qualifying individuals who have a terminal diagnosis. The focus of hospice is to provide comfort care through pain and symptom management while providing psychosocial and spiritual support. Research reports that the Hispanic population is one of the most underserved populations in healthcare, with hospice care being one of those services. In a study by O'Mara and Zborovskaya (2016), utilization of hospice services was found to amount to 5% among Hispanics. It is projected that by the year 2050, the Hispanic senior population over the age of 65 years of age will increase by 14%. The Hispanic population continues to be one of the fastest-growing populations in the United States. In this study, the researcher explored whether hospice agencies utilize culturally linguistically appropriate services (CLAS) standards while providing hospice services. In addition, she examined whether hospice agencies are promoting social equity, best practices, and cultural competencies and meeting the needs of the underserved communities with specific attention focusing on the Hispanic communities. The theoretical framework used to analyze this study was social equity and its relationship to cultural competence. Much of the hospice expenditure coverage comes from federally-funded Medicare, making the MHB an entitled benefit for many; therefore, it is imperative that the MHB be equitable and accessible to all those who qualify. This study interviewed 2 hospice administrators and 7 hospice social workers. The analyzed data

determined that hospice staff personnel felt they were competent in their abilities to serve

all populations that are receiving services through their agencies, especially when it

comes for servicing the Hispanic populations. However, some agencies recognized the

need to implement services for the deaf and blind communities. The researcher has

proposed that additional studies guided by the principles of CLAS should be conducted

more extensively in order to better meet the needs of the underserved populations,

ultimately improving quality end of life.

Keyword: hospice care, diverse population, social equity, cultural competence, end of

life, quality end of life

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CHAPTER 1: INTRODUCTION

Spanish-speaking Hispanic families are prone to suffer great disadvantages when receiving healthcare services because of the poor communication and language barriers. Hospice care is one of those services. The hiring practices of some agencies do not satisfy all cultural needs. Some agencies often do not meet the immediate needs of neighboring communities and families that they could potentially provide services to because of the lack of personnel diversity. That may be due to organizational barriers in cultural competence from healthcare providers. A cultural competence system is one that maximizes diversity, conducts community assessment, analyzes community feedback preferences, develops quality measures for diverse populations, and ensures culturally and linguistically appropriate health education materials, health promotion, and disease prevention intervention (Reese & Beckwith, 2015). It is important for providers to understand the needs of those whom they serve at all levels of care and continuity of care.

As a medical social worker in a hospital setting, when all medical efforts have been exhausted and hospice is a recommendation from a physician, social workers will often have the duty and responsibility to provide continuity of care by conducting a hospice referral. The social worker provides education to the patient and/or family on hospice philosophy, mission, and entitled benefits of services. Social workers further provide resources of hospice community partners. The patient and family have the right to select the hospice agency that will be providing end-of-life care. Social workers will then arrange face-to-face contact between agency personnel and patients and/or family.

Oftentimes, because of language barriers from agency personnel or lack of understanding from the recipient and/or families, miscommunication can occur between

agencies and patients and families. Misinformation and a lack of understanding of the primary language of patients and family members may create disparity in receiving services of which the patient is entitled.

Healthcare disparities also exist among ethnic minority populations in comparison to their Caucasian counterparts. Research has shown that ethnic and racial minorities bear a disproportionate burden of illness, disability, and premature deaths (U.S. Department of Health and Human Services, 2015). Minorities also receive a poorer quality of life and encounter more barriers when seeking healthcare than non-Hispanic Whites (U.S. Department of Health and Human Services, 2015). A recent systematic review analyzed 15 studies to determine whether there was ethnic/racial bias among healthcare professionals. The study found that most healthcare providers appear to have implicit biased positive attitudes toward Caucasians but have negative attitudes toward people of color (Hall et al., 2015).

A study by Karanth, Rajan, Sharma, Yamal, and Morgan (2018), who analyzed racial-ethnic disparities in end of life, found significant disparities among the care options and quality of care for lung cancer patients of non-Hispanic Blacks as compared to non-Hispanic Whites. The study analyzed cases of patients ≥66 years who were diagnosed with Stages I-IV lung cancer and died between the years 1991-2013. The study measured quality of care by these three themes: (a) potentially preventable medical encounters, (b) delayed hospice referral, and (c) aggressive chemotherapy provisions during end of life. The results demonstrated that in comparison with non-Hispanic whites, non-Hispanic Blacks and Hispanics had higher odds of experiencing potentially preventable medical encounters in the last month of life. Furthermore, the results reported that propensities of

delayed hospice referrals and aggressive chemotherapy provisions during end of life were lower in non-Hispanic Blacks as compared with non-Hispanic Whites. Overall, the study indicated that there continues to be a lack of access and care among minorities, which can limit the access to hospice care at the end-of-life stage (Karanth et al., 2018).

According to the United States Census as of July 1, 2017, there were 58.9 million Hispanics living in the United States (U.S. Census Bureau, 2018b). Thus, Hispanics became the largest ethnic/racial minority group in the nation. Hispanics make up 17.8% of the nation's population, composed of Mexicans at 63.2%, Dominicans at 3.3%, Cubans at 3.9%, Salvadorans at 3.8%, Puerto Ricans at 9.5%, Guatemalans at 2.5%, and other Hispanics (Central and South American or other Hispanic or Latino origin) at 13.8% (U.S. Census Bureau, 2017).

Current literature has suggested that this country's Hispanic population endures the consequences of healthcare inequalities, including hospice care. In a study by O'Mara and Zborovskaya (2016), utilization of hospice services was found to amount to 5% among Hispanics.

Medicare has reported the following findings on admissions to hospice services: Hispanics 2.1%, African Americans 8.3%, and Caucasians 86.5% (U.S. Census Bureau, 2017). By 2050, the United States is projected to have a 14% increase in the population of seniors over 65 years old; many of them will be Hispanics (Cruz-Oliver, Talamantes, & Sanchez-Reilly, 2014). Cruz-Oliver et al. (2014) stated that this figure is obtained from studies reporting that a predominantly older Hispanic community will live longer. They will exhibit poorer health, have the burden of disease and illnesses, and have less access to medical care.

In order for hospice agencies to be effective in serving this projected surge of elderly Hispanics, it is imperative that this nation address cultural barriers that create healthcare disparities. Villa, Wallace, Bagdasaryan, and Aranda (2012) reported that Hispanics aged 65 years and older are the fastest growing population, representing 7% of the U.S. population, or 2.9 million individuals. The Hispanic population is expected to grow to 20%, or 17.5 million people, by the year 2050 and will be the nation's largest minority group (Villa et al., 2012). As this group continues both to increase in numbers and in age, there will be a need to investigate additional means to ease the acculturation process of hospice. These means must include viable options to end-of-life care.

In this study, the researcher investigated measures that have been taken by hospice agencies to meet the cultural needs of diverse communities. This study is intended to provide insight and awareness to hospice organizations as it relates to how their agency may address the issue of cultural awareness and competence for services they provide. It will also provide knowledge and educational opportunities for other hospice agencies in the Hispanic communities. Finally, this study should contribute to the efforts that have been made toward a more culturally competent hospice system.

Background

Hospice care was introduced into the United States by Dame Cicely Saunders. It evolved as the result of a series of lectures that were held at Yale University during the 1960s. In 1967, Dame Cicely Saunders established St. Christopher's Hospice in Sydenham, England (Robinson, Hoyer, & Blackford, 2007). In 1970, the concept of hospice was developed in the United States to address end-of-life care needs with an

emphasis in pain and symptom management (Carlson, Morrison, & Bradley, 2008; Harrison & Connor, 2016; Stevenson, 2012).

In the mid-1970s, hospice philosophy promoted a holistic approach to end-of-life care and received much favor in the United States (Mor & Teno, 2016). The benefits of hospice care include skilled nursing, medical social work, physicians, spiritual counseling, occupational and speech therapy, and bereavement counseling for families.

In 1982, the Reagan administration implemented the Medicare Hospice Benefit (MHB), a national policy set in place to reduce end-of-life expenditures and improve the quality of end-of-life care. The MHB is an entitled benefit program for individuals who meet qualifying criteria. Hospice services are provided to individuals who are terminally ill and have a life expectancy of 6 months of life or less, and no aggressive medical interventions are desired from the patient and family members (U.S. Department of Health and Human Services, 2018a).

Hospice care is covered under Medicare, Medicaid, and some private-pay medical insurances. However, much of the funding, which is about 85.5%, is generated through MHB (Rising, Hassouneh, Lutz, Lee, & Berry, 2018). During the last 35 years, hospice services have gone through minimal changes as they relate to financial government responsibility and program qualifying factors. Historically, hospice care has remained predominantly utilized by the dominant Caucasian, middle-class, cultural and religious Christian segment (Taxis, Keller, & Cruz, 2008). The hospice program has not evolved to accommodate the changes that have occurred within the United States. These changes include population growth and the growing population of ethnic minorities' cultural imperatives, access to healthcare, and healthcare legislations. Reese et al. (2017)

reported that "numerous studies have indicated that patients from diverse cultural groups are not receiving the same quality or quantity of care as those from the dominate culture" (p. 64). The MHB needs to be more equitable and accessible to those who qualify for the benefit even if their culture, values, beliefs, and spirituality or religion are not in line with the majority White population.

Problem Statement

The Hispanic population became the largest ethnic/racial minority group in the nation, making up 18.1% of the nation's population living in the United States (U.S. Census Bureau, 2018b); however, utilization is low among the Hispanic population. Literature has concluded that poor quality of care and the lack of hospice services being utilized by Hispanics can be attributed to the following factors: the lack of knowledge of healthcare and hospice services in the Hispanic community, language barriers, cultural incompetence from healthcare professionals, culture, norms, beliefs, religious values, and location of patients (Carrión, 2007; Randall & Csikai, 2003; Ruiz, 2005; Taxis, Keller, & Cruz 2008). Hospice is an option for end-of-life care, and it is important for the Hispanic community to be knowledgeable of end-of-life care options. It is also important to provide the Hispanic community information of the benefits of hospice care in the primary language spoken by the recipient. This study investigated the ways hospice agencies are meeting the diverse cultural needs of the Hispanic community.

Purpose of the Study

The aim of the study was to investigate how hospice agencies are promoting social equity, social justice, best practice, and cultural competencies within the hospice agency through the provision of culturally linguistically appropriate services (CLAS).

The purpose of this qualitative phenomenological study was to investigate how hospice agencies are meeting the needs of the underserved communities with specific attention focusing on the Hispanic community in several metropolitan cities in Southern California. It is vital for hospice agencies to serve and meet the end-of-life needs of the underserved and vulnerable communities and promote more equitable and fair practices.

Research has reported that the Hispanic population underutilizes hospice services; Kirkendall, Holland, Keene, and Luna (2015) reported that, in 2011, 93.8% of hospice patients were non-Hispanic compared to 6.2% who were Hispanic patients. This study examined how agencies address cultural barriers and staff competencies while servicing patients and families in hospice care. The results of this study revealed that many cultural barriers continue to exist in hospice agencies. The underserved populations with language barriers, the deaf community, and the blind community continue to experience issues related to access to hospice care.

Research Question

The research question examined whether hospice agencies are aware of cultural barriers, language differences, religious beliefs, and other norms that may limit the Hispanic populations in accessing hospice services as an end-of-life care option. In addition, this study examined what agencies are doing to meet the needs of diverse populations. This study has been guided by the standards of the national standards for CLAS in health care. CLAS standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities.

The following was the research question for this study: How are hospice agencies addressing, responding to, and promoting social equity best practice and cultural

competencies to meet the needs of diverse populations with an emphasis on Hispanics within several surrounding metropolitan communities in Southern California?

Theoretical Framework

This study was analyzed through two important theoretical concepts: (a) social equity, a major pillar of public administration, and (b) its relationship to cultural competence. Social equity is the representation of fair, just, and equitable management and distribution of public services (Johnson, 2012). Cultural competence is defined and guided by 15 standards for CLAS. The 15 CLAS standards are categorized into four themes: (a) "Principle Standard," (b) "Governance, Leadership, and Workforce," (c) "Communications and Language Assistance," and (d) "Engagement, Continuous Improvement, and Accountability" (U.S. Department of Health and Human Services, 2016, p. 5). CLAS has been developed to guide equitable and fair healthcare practices (U.S. Department of Health and Human Services, 2013, 2018c). Cultural competence is congruent with the values of social equity. When cultural competency is met, social equity follows.

Definitions of Terms

Beliefs. A state or habit of mind in which trust and confidence are placed in some person or thing ("Beliefs," 2019).

Culture. A concept often incorporating race, ethnicity, religion, language, and national origin ("Culture," 2019).

Culturally and Linguistically Appropriate Services (CLAS) standards. Mandated guidelines created by the U.S. Department of Health and Human Services Office of Minority Health in 2000. The purpose of CLAS is to guide and facilitate

recommended practices related to cultural and linguistic competence in health services

(U.S. Department of Health and Human Services, 2013).

Cultural competence. A culturally competent system, one that understands the

importance of social and cultural influences that play on patients, such as health beliefs

and behaviors, to achieve cultural competence in the healthcare system. It is important to

"acknowledge and incorporate culture, assessment of cross-relations, vigilance toward

the dynamics from cultural differences, expansion of cultural knowledge, and adaptation

of service to meet culturally unique needs" (Betancourt, Green, Carrillo, & Anahen-

Firempong, 2003, p. 294).

End-of-life care. Support and medical care provided surrounding death (National

Institute on Aging, 2019).

Filial piety. The important virtue and primary duty, involving respect, obedience,

and care for one's parents and elderly family members (Cruz-Oliver et al., 2014).

Familismo. A social pattern in which the family assumes a position of

ascendancy over individual interest (O'Mara & Zborovskaya, 2016).

High-quality end-of-life care. The results of healthcare professional

involvement, including: (a) assurance of desired physical comfort and emotional support,

(b) promotion of shared decision making, (c) treatment of the dying person with respect,

(d) provision of information and emotional support to family members, and (e)

coordination of care across settings (Teno et al., 2004).

Healthcare literacy. Individuals' concept of comprehending skill, motivation,

and proficiency in navigating the healthcare system (Christensen, 2016).

Hospice care. A care program for individuals with a life expectancy of 6 months

or less. Hospice services include pain relief and supportive medical, social, and pastoral

care (U.S. Department of Health and Human Services, 2018a).

Length of stay. Period of time a beneficiary is on hospice services.

Palliative care. Care that is the part of hospice care, which focuses on

(a) helping people who are terminally ill and (b) helping their families maintain their

quality of life. Palliative care can address physical, intellectual, emotional, social, and

spiritual needs. It supports independence, access to information, and ability to make

choices about individual healthcare (U.S. Department of Health and Human Services,

2018a).

Quality of life. State of well-being that is a composite of two components: the

ability to perform activities of daily living (including everything from physical health,

psychological health, and social well-being), and the self-satisfaction of the person with

his/her level of functioning and control of illness (Bottomley, 2002).

Recertification. Certification of terminal illness for each benefit period the

patient is on hospice. There are two 90-day initial periods, followed by an unlimited

number of 60-day periods, so long as the patient continues to qualify for services as

determined by the hospice medical director (English & Mazanec, 2016).

Biblical Integration

Death is the one thing that is certain in life. The death of a loved one is a personal

and individual experience. People do not want to lose a loved one, and death is

inevitable, and although it may be prolonged through curative measures, the loss of

someone one loves will come. This is evident in an Old Testament passage from 2 Kings:

> Elisha went to Damascus, and Ben-Hadad king of Aram was ill. When the king was told, "The man of God has come all the way up here," he said to Hazael, "Take a gift with you and go to meet the man of God. Consult the Lord through him; ask him, 'Will I recover from this illness?'" Hazael went to meet Elisha, taking with him as a gift forty camel-loads of all the finest wares of Damascus. He went in and stood before him, and said, "Your son Ben-Hadad king of Aram has sent me to ask, 'Will I recover from this illness?'" Elisha answered, "Go and say to him, 'You will certainly recover.' Nevertheless, the Lord has revealed to me that he will in fact die." He stared at him with a fixed gaze until Hazael was embarrassed. Then the man of God began to weep. "Why is my lord weeping?" asked Hazael. (2 Kings 8:7-11, New International Version)

Throughout the Bible there are a multitude of scriptures that speak of death and dying:

> On his arrival, Jesus found that Lazarus had already been in the tomb for four days. Now Bethany was less than two miles from Jerusalem, and many Jews had come to Martha and Mary to comfort them in the loss of their brother. When Martha heard that Jesus was coming, she went out to meet him, but Mary stayed at home. "Lord," Martha said to Jesus, "if you had been here, my brother would not have died. But I know that even now God will give you whatever you ask." Jesus said to her, "Your brother will rise again." Martha answered, "I know he will rise again in the resurrection at the last day." Jesus said to her, I am the

resurrection and the life. The one who believes in me will live, even though they

die: and whoever lives by believing in me will never die. Do you believe this?"

(John 11:17-26, NIV)

When death is inevitably nearing for individuals, they and their loved ones may

turn to faith to get them through those difficult times. Many believe that there is another

place far more glorious than earth, and suffering will end; this notion, for many, plays a

significant role in the grieving and acceptance phase of end of life. Jesus Christ showed

mercy in his role as leader, counselor, healer, and spiritual advisor. Jesus Christ set the

standard and hope for everlasting life through his grace and biblical teachings: "Let the

peace of Christ rule in your hearts, since as members of one body you were called to

peace; and be thankful" (Colossians 3:15, NIV). The death process for individuals and

loved ones is difficult for all people; however, for some individuals, acceptance is more

tolerable when a spiritual component exists, as seen in Revelation 1:17-18: "When I saw

him, I fell at his feet as though dead. Then he placed his right hand on me and said, "Do

not be afraid. I am the First and the Last, I am the Living One; I was dead, and now look,

I am alive for ever and ever! And I hold the keys of death and Hades" (NIV).

CHAPTER 2: LITERATURE REVIEW

This chapter reviews relevant literature that emphasizes how the lack of cultural competence contributes to low hospice utilization among the underserved populations with an emphasis on the Hispanic/Spanish-speaking communities. The study is based on two theoretical concepts guided by social equity and cultural competence. This study focused on how cultural competence, or the lack of competence, affects the promoting of social equity benefits in hospice services.

This research introduces the historical underpinnings of the hospice program by discussing the evolution of the Medical Hospice Benefit (MHB) and its political and economic influences. The research illustrated how hospice has evolved over the last 35 years and the impact it has on the vulnerable with an emphasis on the Hispanic population.

The primary focus of this hospice research study is to reference literature that illustrates why there is low utilization of hospice services among vulnerable populations with an emphasis on Hispanic communities and to investigate how cultural competence may play a role. Factors such as limited English proficiency (LEP), lack of health literacy, language barriers, culture, beliefs, attitudes, and the lack of cultural competence may contribute to low hospice utilization among Hispanics (Adams, Horn, & Bader, 2006; O'Mara & Zborovskaya, 2016; Price, Parast, Haas, Teno, & Elliott, 2017; Taxis, Keller, & Cruz, 2008).

Healthcare and Hospice in the United States

Hospice Expenditures

Current literature and studies support the position that hospice care saves federal money during the end-of-life stage of individuals. As stated below, hospice seems to be economically beneficial for the individuals and the healthcare industry since hospice saves money by diverting dying patients "from hopeless yet expensive curative treatment" (Robinson et al., 2007, p.129). A retrospective case study by Taylor, Ostermann, Van Houtven, Tulsky, and Steinhauser (2007) analyzed program expenditures of Medicare decedents between the years 1993 and 2003. The results of that study determined that hospitalization cost Medicare approximately $2,300 more per individual than utilizing hospice services for end-of-life services.

Taylor et al. (2007) found evidence that greater savings for the Medicare program may be attributed to hospice care during the last year of life. Taylor (2009), in additional research, determined that longer lengths of stays in hospice (about seven weeks) reduced Medicare costs by approximately $7,000 for cancer patients and $3,500 for other patients.

In addition, Taylor (2009) concluded that seven out of 10 hospice decedents would have saved Medicare money had they utilized hospice services for a few weeks or even a few days longer. Fine and Davis (2017) agreed with the work of Taylor et al. (2007) and concluded that hospice reduces Medicare expenditures significantly.

Fine and Davis (2017) reported that hospice is underutilized and suggested that each 1% increase in hospice days in the last year of life would reduce hospice benefits and save Medicare approximately $2,300 per individual utilizing hospice services for end-of-life services. Fine and Davis agreed with the work of Taylor et al. (2007).

Taylor et al. also found evidence that greater savings for the Medicare program are attributed to hospice care during the last year of life and concluded that hospice reduces Medicare expenditures, possibly by as much as $567 million a year. The authors also added that the recipients and family care experiences would be expected to improve.

In their study, Kelley, Deb, Du, Aldridge Carlson, and Morrison (2013) determined that the Medicare hospice benefit improves quality of life and demonstrates savings for Medicare expenditures when patients were enrolled from as little as 53 days to 105 days. A study that analyzed hospitalization cost during the last 6 months of life of patients who died in 2010 compared hospice-utilizing patients versus non-hospice-utilizing patients who had similar diagnoses. The concluding results were that hospice beneficiaries who used the services for more than 2 weeks were associated with fewer hospital days and expenditures (Zuckerman, Stearns, & Sheingold, 2015). Furthermore, the authors added that the Medicare hospice benefit is effective in achieving its goals of reducing unnecessary, invasive, and uncomfortable treatments.

Medicare paid providers a total of $16.9 billion for care in 2016. That averaged $11,820 per decedent for hospice care (NHPCO, 2018a). This may be compared to the total cost for Medicare expenditures in 2016, which was $3.3 trillion. Of this amount, hospital care was 32% of the cost, physician and clinical services were 20%, prescription drugs 10%, government administration net cost of health insurance was 8%, nursing care facilities and continuing care was 5%, other health resident and personal care was 5%, and other spending was 20% (National Health Statistics Group, 2016).

Aldridge and Kelley (2015) reported that in 2011, approximately $205 billion was devoted to cover the cost of the last year of life of individuals. If $16.9 billion is

accounted for covering hospice care from the approximate $205 billion devoted to end-of-life care, the last year of life of patients would still end up costing Medicare $188 billion.

Medicare Hospice Benefit (MHB)

During the 1970s, the United States developed hospice to address end-of-life care needs, such as support for pain and symptom management (Carlson et al., 2008; Harrison & Connor, 2016; Mor & Teno, 2016; Stevenson, 2012). MHB is a national policy that has been set in place to reduce the high cost that comes with end-of-life care and to improve the quality of end of life.

In 1982, after negotiations, the budget director for the Reagan administration maintained that Medicare would not pay for concurrent curative services and hospice care. Advocates for the hospice program agreed to the restrictions, and Congress created the MHB, which is funded through Medicare federal funding.

MHB is an entitled benefit for those who have an advanced terminal illness and qualify for the benefit. An individual can be admitted into hospice care once a physician has certified that the patient has a life expectancy of 6 months of life or less. Individuals who elect to use hospice services forego progressive treatment and choose to receive comfort measures for the remainder of their life (U.S. Department of Health and Human Services, 2018b).

The hospice program is facilitated by a multidisciplinary team, which includes physicians, nurses, medical social workers, health aides, clergy/spiritual counselors, trained volunteers, occupational therapists, and other medical therapists who may aid or make the patient comfortable during the end-of-life transition. Hospice care for the

individual may take place in various settings, including private homes, nursing homes, hospitals, or long-term care facilities.

The objective of the MHB is to discontinue aggressive treatment for those individuals who want palliative care measures without frequent hospital visits. The hospice benefit initiated under the Tax Equity and Fiscal Responsibility Act (TEFRA), was "a landmark public policy decision to include hospice care in the Medicare program" (Finestone & Inderweis, 2008, p. 595). The primary purpose of hospice was to serve individuals who had a cancer diagnosis. In 2008, noncancer diagnoses were also covered under the benefit. These included Alzheimer's disease or related dementias (ADRD), heart failure, stroke, noninfectious respiratory disease, and adult failure to thrive (Zuckerman, Stearns, & Sheingold, 2015).

The Medicare hospice benefit continues to provide quality and compassionate care for a multitude of patients with different terminal diagnoses (U.S. Department of Health and Human Services, 2018b). Zuckerman, Stearns, and Sheingold (2015) concluded that the Medicare hospice benefit is succeeding in its goals to reduce hospital care stays during end of life and also indicated that these trends may continue with more policies encouraging a timely initiation of hospice. Stevenson (2012) reported that for the last 30 years, the Medicare hospice benefit has provided individuals with a dying alternative to traditional methods. To maintain the integrity of the MHB program and to prevent Medicare fraud, in 2011, a new process of recertification was introduced. The Affordable Care Act required that the Centers for Medicare and Medicaid Services conduct face-to-face encounters with every patient after the third period of hospice benefits (English & Mazanec, 2016). The regulations state that once hospice admission

has begun, there will be two 90-day periods of services with certification, then recertification will be every 60-days until death or discharge (English & Mazanec, 2016).

Hospice and Hispanics

Historically, it is standard practice for those in the Hispanic culture to take care of their own family members when they become ill. End-of-life preferences among the Hispanic culture are attributed to *filial piety*, which is the important virtue and primary duty involving respect, obedience, and care for one's parents and elderly family members (Cruz-Oliver et al., 2014). *Familismo* also plays an important role, and it is defined as the social pattern in which the family assumes a position of ascendancy over individual interest (O'Mara & Zborovskaya, 2016). Cruz-Oliver et al. (2014) evaluated literature involving end-of-life preferences among Hispanic individuals as it relates to hospice and caregiving. The authors concluded that many elders in the Hispanic community have acculturation practices that prevent the receptiveness toward hospice and caregiving support (Cruz-Oliver et al., 2014). Hispanics tend not to seek out hospice resources but rather embrace family roles (Price et al., 2017). Hospice care services seem to coincide with the values of the Hispanic community. Most hospice services are typically provided in a patient's home, and primary care is normally delivered by family members (NHPCO, 2018b).

Kirkendall et al. (2015) evaluated hospice care by family members of Hispanic and non-Hispanic patients in their study. They concluded that hospice is adequately meeting the needs of both groups. Additional findings, however, determined that caregivers/family members of Hispanic patients reported receiving more attention than desired for emotional issues and were inconsistent with patients' wishes. The study noted

that those reactions "may be attributed to the lack of culturally sensitive approach when addressing Hispanics' emotional and spiritual needs" (Kirkendall et al., 2015, p. 319). O'Mara & Zborovskaya (2016) reported that "ethnically diverse hospice patients are less likely to receive the right amount of emotional support and are less likely to receive end-of-life care consistent with his or her wishes" (p. 53).

Pan, Abraham, Giron, LeMarie, and Pollack (2015) examined hospice familiarity among minority populations. Their study demonstrated that hospice familiarity among those of Hispanic descent was low and indicated that many Hispanic individuals did not know anyone who had ever utilized hospice services before. Results from the study also revealed that many Asians and Hispanics would be interested in discussing and receiving information about hospice services if it were provided in their respective native languages.

Research, including the work of Adams et al. (2006), determined that Hispanics underutilized hospice for reasons including culture, beliefs, language, limited English proficiency, lack of knowledge, and cost. Ten years later, the literature continued to report that Hispanic underutilization of hospice is attributed to lack of knowledge about hospice. This lack includes limited English proficiency, limited access to the healthcare systems, reluctance to talk about death, and cultural values on informal caregiving (Park, Jang, Ko, & Chiriboga, 2016).

Cruz-Oliver and Sanchez-Reilly (2016) identified three barriers to quality end-of-life care for Latinos: language, religion, and family culture. Park et al. (2016) reported that ethnic minority individuals with greater English proficiency are more likely to access and utilize hospice services than individuals with limited English proficiency. Their

study illustrated that language is one of the major barriers in the accessibility of hospice services.

The Hispanic population, especially those of advanced age, may not be familiar with the concept of hospice. There is often some confusion since the word "hospice" translates to "hospicio," which in Spanish, refers to an "asylum" or "orphanage" (O'Mara & Zborovskaya, 2016, p. 56). Hospice care in Latin America is known as palliative care, which translates to "Cuidados Paliativos." Mexico, for instance, has developed its palliative care program with the same goal: to provide end-of-life care for those with an irreversible terminal illness, and who have 3 to 6 months to live (Gonzalez et al., 2012).

Ironically, palliative care measures were introduced in Mexico in 1972, which is around the same time that hospice was introduced to the United States. At that time, palliative care began to address the needs of those patients suffering from pain because of a terminal illness. Throughout the 1990s and most recently in 2009, there has been a continuum of laws revolving about end-of-life care for dying patients in Mexico (Gonzalez et al., 2012).

Although hospice has been introduced to Mexican citizens, many individuals still have no knowledge of exactly what hospice care is, especially since hospice was initially a European concept. Hospice/palliative care has, of late, been a part of the mainstream health system. However, studies continue to document the underrepresentation of Hispanics utilizing hospice services.

O'Mara and Zborovskaya (2016) reported that cultural values, such as family roles, relationships, influence, religion, and communication, affect a person's decision-making during end of life. Hicks (2012) reported that personal beliefs provide essential

cultural influences for Hispanic patients. Based on the research, one may conclude that culture is a driving factor when developing healthcare choices for Hispanics. Furthermore, to have equitable and accessible benefits for the Hispanic community, it is imperative to implement cultural competence as part of healthcare choices; however, there are still limitations in this area that prevent the promotion of equitable hospice care services.

In an integrative review of the literature on Hispanics and hospice services, Rising et al. (2018) found that Hispanic individuals experience challenges when enrolling in hospice services. This may be due to Hispanics who face socioeconomic hardships, including poverty, lack of citizenship, and lack of insurance.

Theoretical Foundation

This study was based on and analyzed through the lens of social equity, a major pillar of public administration, and its relationship to cultural competence perspective. Both concepts are relevant to equitable access to healthcare benefits for the underserved Hispanic community.

Frederickson (1990) developed the compound theory of social equity, which "serves as the language of the framework for attempts in both theory-building and practice" (p. 231). According to the compound theory of social equity, when justifying whether policies claiming to enhance social equity follow through, policy choices need to be analyzed through the following questions:

1. Is this equality, individual, segmented or blocked?
2. Is this equality direct, or is it a means-equal opportunity or prospect-equal opportunity?

3. What forms of social equity can be advanced so as to improve the lot of the least advantaged, yet sustain democratic government and a viable market economy? (Frederickson, 1990, p. 231)

Frederickson's (1990) introduction of the value of equality began with the concept of lot equality wherein shares and benefits are identical and equal. In lot equality, individuals judge what pleases or displeases them. Frederickson explained that lots can be easily measured and distributed without implying anything about equal well-being. Therefore, this concept may be "insensitive to significant variations in need" (Frederickson, 1990, p. 231). The belief that most individuals automatically access the lot benefits does not recognize that some may be excluded because of the limits of accessibility of such lot. Therefore, the concept of "person equality" was suggested, which means that there is a "non-arbitrary rule-based distribution of shares based on non-neutral judgements about individual's needs" (Frederickson, 1990, p. 231).

Vulnerable and disadvantaged populations require additional assistance in order to have "person equality" and be equal to others who have greater advantage when accessing lot equality benefits. Some Hispanic individuals who suffer from a terminal illness may be vulnerable and disadvantaged due to sociocultural barriers. Sociocultural barriers are discussed in the cultural competence section. Sociocultural barriers may prevent this population from reaching lot equality because of a poor culturally competent system, which can prevent the promotion and accessibility of certain benefits. Once cultural competence in hospice services is evident for the Hispanic population, social equity of services will increase.

Social Equity: A Pillar of Public Administration

The term *equity* first made its appearance in the seminal work of Woodrow Wilson in 1887. The concept has transformed into "social equity," and it has been the normative basis for public administration application (Frederickson, 2010). The objectives and rationale of conventional public administration seek more efficient or economical management of services. Social equity is part of the new public administration and adds to the body of knowledge by wanting to enhance equity within those services (Frederickson, 2010; Hart, 1974; Johnson, 2012; Wooldridge & Gooden, 2009). After social equity was introduced by Frederickson in the 1960s, the National Academy of Public Administration (NAPA) created the Standing Panel on Social Equity in Governance, which defined social equity as

> the fair, just, and equitable management of all institutions serving the public directly or by contract; the fair, just, and equitable distribution of public services; the implementation of public policy; and the commitment to promote fairness, justice, and equity in the formation of public policy. (as cited by Johnson, 2012, p. 471)

The literature has identified healthcare disparities as those that have affected the accessibility to utilize hospice services by those who qualify for the benefits. Velasco-Mondragon, Jimenez, Palladino-Davis, Davis, and Escamilla-Cejudo (2016) analyzed literature on Hispanic health and found that social and ecological determinants such as health disparities, risk factors, and lack of health services have created epidemiologic profiles for Hispanics in the United States. Furthermore, Velasco-Mondragon et al. (2016) reported that Hispanics lead the population in cases of mortality, which include

cancer, cardiovascular disease, and unintentional injuries. Because of the ethnic disparity in healthcare, the Hispanic population has become a socially disadvantaged group, and this has become a social equity issue.

Social equity theory is most appropriate for the study because it focuses on fairness, justice, and equitable distribution of services. Svara and Brunet (2004) stated that "equitable administrative process practices promote social equity" (p. 253). It is imperative that hospice benefits be designed and promoted to meet the needs of all of those who qualify. This is especially important as it responds to the overwhelming documented epidemiological profiles of Hispanics in the United States.

Guy and McCandless (2012) introduced the concept of the social equity lens, saying "it is a lens through which needs are identified and processes are grounded" (p. s9). They asserted that the lens "provides a means of identifying stumbling blocks and establishing meaningful goals, and a real opportunity to provide a desired end-state that can be benchmarked" (Guy & McCandless, 2012, pp. s9-s10). Social equity is a leadership commitment that begins with changes from higher level administrators, those who have an active role in policy-making (Svara & Brunet 2004). Administrators within the healthcare system must analyze the unmet needs of underserved populations and advocate for new policies or programs that advance equity.

Originally, hospice became policy as a result of those who promoted and wanted to support pain and symptom management during the end-of-life stage (Harrison & Connor, 2016; Stevenson, 2012). Hospice care has been the choice for many to improve their quality of end-of-life care. It is vital that these end-of-life care options be equitable

and accessible to all who qualify. This form of social equity in hospice services may be achieved by promoting cultural competence by hospice organizations.

The concept of hospice care coincides with the principles of the New Public Administration introduced by Frederickson (2010). It continues efforts to enhance and execute policies that generally improve the quality of life for all, as well as seeks to carry legislative mandates as efficiently and economically as possible (Frederickson, 2010). The New Public Administration has incorporated social equity to their values of economy, efficiency, and effectiveness, so now these critical values have moved toward cultural competence.

Cultural Competence

Many scholars have defined cultural competence. Hicks (2012) defined cultural competence as the ability to view individuals by their cultural backgrounds and experiences. Cultural competence has been defined as a perspective based on a number of "supportive social theories, such as socialization, which includes theories of power, and theories of diversity as well as values such as equity and social justice" (Gallegos, Tindall, & Gallegos, 2008, p. 57). Betancourt et al. (2003) defined cultural competence in terms of disparities and barriers in healthcare, particularly those that affect ethnic minorities. These authors have defined a culturally competent system as one that understands the importance that social and cultural influences have on patients' health beliefs and behaviors (Betancourt et al., 2003, p. 294). Gallegos et al. (2008) contributed that cultural competence is "the process in which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, ethnic

backgrounds, religions, and other diversity factors" and recognizes and affirms and values the worth and dignity of individuals (p. 54).

Furthermore, to achieve a culturally competent healthcare system, it is important to "acknowledge and incorporate culture, assessment of cross-relations, vigilance toward the dynamics from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt et al., 2003, p. 294). Individuals in positions of authority can identify potential factors that can prevent social inequalities; those factors are known as sociocultural barriers.

Betancourt et al. (2003) developed the term *sociocultural barriers*, which is the basis that social factors, such as socioeconomic status, supports/stressors, or environment relating to cultural factors, have an influence on individuals. Those in the healthcare system must recognize that social dynamics exist in order to achieve cultural competence in the healthcare field. Betancourt et al. identified three types of these sociocultural barriers, which are important for professionals to be aware of in order to prevent disparities. These are organizational barriers, structural barriers, and clinical barriers. Organizational barriers refer to the availability and acceptability of minority representation in the broader healthcare platform, such as healthcare workforce and institutional leadership. Structural barriers include an outdated and underfunded bureaucratic system, one that lacks implementation of a cultural-linguistic-appropriate health education, the bureaucratic intake process, and difficulty accessing or navigating healthcare system and services. Clinical barriers transpire when there is a sociocultural difference between the provider and the patient (Betancourt et al., 2003).

Organizational barriers. Organizational barriers refer to the availability and acceptability of minority representation in the broader healthcare platform (Betancourt et al., 2003). In an unpublished research study in 1999, Reese and Raymer (2004) found that only 3% of bereavement coordinators who participated in a national survey represent a diverse ethnic population. Reese, Melton, and Ciaravino (2004) conducted a study that surveyed 22 directors of hospice and palliative care organizations regarding their attitudes toward and assessment of their diverse population. The results concluded that directors should take on more of a leadership role approach in welcoming diversity. This may be done through the incorporation and inclusion of more culturally diverse training, recruitment of bilingual staff and volunteers, conducting of more community outreach meetings, public education, and health fairs.

In a study of 207 hospices, researchers identified organizational barriers that prevent cultural competence as those that (a) lacked funding for additional staff to provide community outreach, development of culturally competent programs, (b) lacked applications from diverse professionals such as bilingual staff, (c) lacked knowledge about diverse culture's needs, and (d) lacked knowledge of which cultural groups in the community are not being served (Reese & Beckwith, 2015).

The study recommended that, in order to prevent organizational barriers, agencies must know the needs of their communities. Identifying the needs of the community begins through community outreach by assessing the community cultural needs. Agencies should have diverse staff provide cultural competence training and education on how to better serve diverse cultures (Reese & Beckwith, 2015). A literature analysis by Carrizales, Zahradnik, and Silverio (2016) highlighted the challenges that prevent a

culturally competent healthcare sector. The authors concluded that the challenges are attributable to the lack of a diverse workforce.

Structural barriers. Structural barriers are outdated, underfunded, bureaucratic systems, lacking cultural-linguistic-appropriate health education and have difficulty accessing or navigating healthcare (Betancourt et al., 2003). A study conducted by Adams et al. (2006) focused on Hispanics' access to hospice services within a predominantly Hispanic community. The study indicated that structural barriers continue to affect the accessibility of receiving hospice care benefits for those in the Hispanic community. Adams et al. (2006) identified that the Hispanic community did not access hospice services because of lack of insurance, lack of knowledge of insurance benefits, limited English proficiency, communication literacy and translation differences, and lack of trust in the medical profession. Many authors reported that the Hispanic community is often unaware of their health insurance benefits, including the hospice benefits for end-of-life care (Adams et al., 2006; Hicks, 2012; O'Mara & Zborovskaya, 2016). One finding reported that twice as many Hispanics as Whites described that they had less access to health services associated with hospice access and affirmed that they would have enrolled to receive hospice care sooner had they known it was a Medicare-covered benefit (Adams, Horn, & Bader, 2007).

LEP, or language barriers, are structural barriers that affect Hispanic patients in the healthcare industry. Patients who are LEP received lower quality end-of-life care, the result of an inadequate understanding about prognosis, goals, plan of care, and inadequate symptom management during the end-of-life timeframe, such as pain and anxiety (Cruz-Oliver et al., 2014; Silva et al., 2016).

A study by Adams et al. (2006) identified the fact that fewer than 44% of Hispanics reported that they could read a newspaper or book, and 30% reported that they had problems communicating with healthcare providers because of language barriers. The authors recommended that the field of palliative medicine move toward a more systematic approach to improve the quality of life of LEP patients (Adams et al., 2006). This approach would include the use of professional English interpreters, symptom management, and emotional support for patients and their families (Silva et al., 2016).

Clinical barriers. Clinical barriers are the result of sociocultural differences between providers and patients (Betancourt et al., 2003). Perhaps the most prolific clinical barrier is attributed to the communication between the provider and patient, primarily due to the limited health literacy of patients. Christensen (2016) stated that certain "medical terminology can impede a patient's ability to comprehend intended messages; likewise, oversimplifying can result in negatively impacting understanding" of critical information; furthermore, "healthcare professionals may overestimate a patient's health literacy" (p. 545).

Carrión (2007) explored the role physicians play when referring Hispanic patients to hospice services. She reported that physicians are the "gatekeepers" for hospice services in her work. Physicians often will not refer Hispanics to hospice because of their observation of caretaker roles in the family, assuming that they may not accept hospice due to cultural reasons (Carrión, 2007, p. 338).

Colon (2012) conducted a study to explore the experiences of physicians who refer Hispanic patients to hospice. The study exposed the fact that physicians often refer a patient to hospice based on the family members' involvement with his or her care.

These physicians reported that first-generation Americans embrace traditional beliefs and are more dependent on family members who are second or third generation. They tend to have more American mainstream views when considering their decision making (Colon, 2012).

Obermeyer, Powers, Makar, Keating, and Cutler (2015) analyzed the relationship between the physician's characteristics and hospice enrollment in a sample of patients who died between 2006 and 2011. The results of the study determined that most hospice-enrolled patients had greater medical comorbidity, were of older age, were female of White race, and lived in zip code areas with higher median income. In addition, referring physicians who cared for the majority of hospice-enrolled patients were oncologists and physicians from not-for-profit hospitals, who cared for an average of 15 to 17 patients (Obermeyer et al., 2015). The study also reported that internists and other medical specialists and surgeons cared for approximately three-to-five patients on average (Obermeyer et al., 2015). The study determined that patients cared for by internists or family practitioners, medical subspecialists, or surgeons are less likely to enroll in hospice when compared to patients enrolled with medical oncologists.

Prochaska, Putman, Tak, Yoon, and Curlin, (2017) conducted a study that surveyed 2016 practicing U.S. physicians—internal practitioners, family doctors, and other subspecialties. These practicing physicians overall identified that hospice care was a better option for end-of-life care for patients. The study determined that the great majority of physicians (98%) agreed that most patients who receive hospice care have better care during the end-of-life phase than patients who do not receive hospice.

O'Mara and Zborovskaya (2016), after conducting their study on end-of-life care for Hispanics, developed recommendations for healthcare providers to implement culturally competent care. The factors involved included:

1. The Hispanic population is vast, originating from over 20 countries, all of which have their own influences, their own beliefs, and their own attitudes;

2. When talking to patients, easy and simple language is most effective;

3. Understanding that Hispanics demonstrate "respeto" (respect) and may not be assertive with concerns during visits;

4. Healthcare providers need to create an effective therapeutic relationship with their patients, display respect, and aim to gain the trust of their patients;

5. Grieving is a natural reaction, and mental health services may not always be welcomed;

6. Some Hispanics may utilize alternative medicine;

7. Hispanics value "respeto," and want to be asked before a physical examination is conducted; and

8. Family-centeredness is important to Hispanics as it presents a good opportunity for education. (O'Mara & Zborovskaya, 2016, p. 58)

In an effort to promote a culturally competent clinical practice, Narayan (2001) created a six-step clinician's guide that falls in line with CLAS standards. The guide ensures that individuals in the healthcare system receive the equitable and effective treatment that they deserve. Her six steps toward cultural competence include the following:

1. Cultivation of attitudes associated with excellent transcultural care. The core attitude a clinician should take are caring, empathy, openness, and flexibility. . . .

2. Development of an awareness of the impact culture has on beliefs, values, and practices of the patient and the clinician. Clinicians must be knowledgeable and understand communication patterns and social etiquette as it relates to some social values, health beliefs, and values. . . .

3. Obtaining of background information about the patients' cultures. Clinicians need to be knowledgeable of the cultural norms by the population that most receives services. . . .

4. Performance of a cultural assessment. An assessment and cultural questioning should incorporate the areas of nutrition assessment, medication assessment, pain assessment, and psychological assessment. . . .

5. Planning for culturally sensitive care, using a preserve-accommodate-restructure framework. This may be done by encouraging patients to preserve cultural practices that help patients achieve health goals. . . .\

6. Avoidance of defensiveness and recovering from cultural mistakes. (Narayan, 2017, pp. 41-46)

Cultural Competence in Public Administration

Cultural competence is an important role for those in public administration. In a book review, Koliba (2013) cites Norman-Major and Gooden's (2012) work, which states that "cultural competency is a characteristic of good government" (p. 377). Furthermore, Koliba added that cultural competence should be more than just tolerance,

accommodation, or incorporation, but rather it should convey a message of embracing diversity to achieve good governance goals. Cultural competencies are vital to programing, promoting, and delivering services.

Rice (2007) explained that a culturally competent public administration and public services delivery system acknowledges and incorporates the importance of culture assessment, vigilance of differences, and expansion of knowledge and needs. Rice's research also identified important elements that add to the literature of cultural competence in public administration and public service delivery from the following authors.

Applewhite (1998) reported that knowledge, values, and skills serve as the foundation for embracing cultural context when direct public service takes place. Per Geron (2002), advancing cultural competency presents an opportunity to address the incomplete and oftentimes inaccurate public services and programs that geared to minority populations. Boyle and Springer (2001) identified that a focus on cultural competency increases relevancy of public agencies' services and programs to those individuals who can best utilize them. Researchers Suzuki, McRae, and Short (2001) recognized that when professionals have the knowledge, awareness, and skills in cultural competency, service-delivery professionals are better equipped to do their jobs.

American Society for Public Administration

As a supporting foundation in the field of public administration, the American Society for Public Administration (ASPA) has implemented a code of ethics. These standards and principles must be exhibited by practicing public servants. The society's

first goal is to "advocate strong, effective and ethical public governance" (ASPA, 2014, p. 1). ASPA code of ethics are the following:

1. Advance the Public Interest. Promote the interests of the public and put service to the public above service to oneself.

2. Uphold the Constitution and the Law. Respect and support government constitutions and laws, while seeking to improve laws and policies to promote the public good.

3. Promote democratic participation. Inform the public and encourage active engagement in governance. Be open, transparent, and responsive, and respect and assist all persons in their dealings with public organizations.

4. Strengthen social equity. Treat all persons with fairness, justice, and equality, and respect individual differences, rights, and freedoms. Promote affirmative action and other initiatives to reduce unfairness, injustice, and inequality in society.

5. Fully inform and Advise. Provide accurate, honest, comprehensive, and timely information and advice to elected and appointed officials and governing board members, and to staff members in your organization.

6. Demonstrate personal integrity. Adhere to the highest standards of conduct to inspire public confidence and trust in public service.

7. Promote Ethical Organizations. Strive to attain the highest standards of ethics, stewardship, and public service in organizations that serve the public.

8. Advance Professional Excellence. Strengthen personal capabilities to act competently and ethically and encourage the professional development of others. (ASPA, 2014, p. 1)

The fourth principle of the ASPA code of ethics is to strengthen social equity. It includes the admonition to "treat all individuals with fairness, justice and equality, and respect individual differences, rights, and freedoms, as well as to promote affirmative action and other initiatives to reduce unfairness, injustice, and inequality in society" (ASPA, 2014. p. 1).

Federal Government's Role in Promoting Cultural Competence

The federal government has created laws promoting cultural competency for the nation. Rice (2007) reported that these laws define cultural competence and detail those individuals who comprise the special population covered. Some of those laws include: The Disadvantage Minority Improvement Act of 1990, Development Disabilities Assistance and Bill of Rights Act of 1994, and the Emergency Medical Treatment Act of 1996 (Rice, 2007).

In 2000, the U.S. Department of Health and Human Services, through the Office of Minority Health, first introduced National Standards for CLAS in Health Care. The national standards were intended and developed to help eliminate healthcare disparities by advancing health equity, improving quality through the implementation of culturally and linguistically appropriate health services (U.S. Department of Health and Human Services, Office of Minority Health, 2016).

A decade later, in the fall of 2010, the Office of Minority Health improved the National CLAS standards and enhanced the 15 standards, which are categorized into four themes:

1. Principle Standard,

2. Governance, Leadership and Workforce,

3. Communications and Language Assistance, and

4. Engagement, Continuous Improvement, and Accountability. (U.S. Department of Health and Human Services, Office of Minority Health, 2016, p. 5)

The principle standard is to "provide effective, equitable, understandable, and respectful quality services that respond to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (U.S. Department of Health and Human Services, Office of Minority Health, 2016, p. 5).

The National CLAS standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for healthcare organizations. Those standards include the following:

The Principle Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/ or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.

6. Inform all individuals of the availability of language assistance services clearly, and in their preferred language, both verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs, using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (U.S. Department of Health and Human Services, Office of Minority Health, 2016, p. 5)

The National CLAS standards have incorporated social equity principles and cultural competence to promote equitable care, quality care, and eliminate healthcare disparities in the healthcare system. The work of CLAS has been introduced through cultural competence education, which is widely available to all level of healthcare practices. CLAS has increasingly been a part of local and national legislation, regulations, and a requirement for accreditation by entities that receive grants from health insurance exchanges. This includes the Affordable Care Act (U.S. Department of Health and Human Services, 2013).

On a greater platform under Title VI of the Civil Rights Act of 1964, it is essential that when receiving federal funding, it is required that appropriate measures should be taken to ensure that all programs are accessible for individuals with LEP. The standards that enforce that mandate are Standards 5 through 8, which are Communication and Language Assistance. In addition, the report has identified that accreditation bodies, such as the Joint Commission and the National Committee for Quality Assurance, have also established standards to increase cultural competence. Currently, for hospice agencies to bill Medicare and receive funding for hospice services, those agencies must be accredited through the Joint Commission healthcare administration.

Explaining Social Equity for Hospice Care

Social inequalities continue to persist at all levels of service, including those in healthcare. In an effort to identify and prevent inequalities in the public arena, there exists a four-step, measurement-criteria system. The assessment of inequality is provided through the conceptual framework of procedural fairness, access, quality, and outcomes, which was developed by NAPA. Svara and Brunet (2005) stated that social equity can be meaningful and measurable, and has contributed to the definition of the four dimensions in the following ways:

1. *Procedural fairness* "entails that all individuals, regardless of their personal characteristics, be treated fairly, have equal protection, equal rights, and due process" (Svara & Brunet 2005, p. 256). Procedural fairness entitles individuals the right to equitable eligibility determination within program criteria. Hospice agencies must adhere to the Centers for Medi-Care/Medicaid Services guidelines to determining eligibility of individuals to utilize hospice benefits.

2. *Access* "encompasses the distribution and availability of services and benefits equally to beneficiaries, with greater advantage for those who are less advantaged to receive greater benefits" (Svara & Brunet, 2005, p. 257). Access, as it relates to hospice care for the Hispanic population, is limited due to organizational barriers. The lack of minority representation includes cultural competence application within hospice, lack of diverse professionals, such as bilingual staff, lack of knowledge about diverse culture needs, and a lack of knowledge of which cultural groups in the community are not being served (Reese & Beckwith, 2015). In addition to structural barriers, limiting accessibility to hospice care for the Hispanic population is especially evident as it relates to those individuals who have limited English proficiency and other linguistic needs.

3. *Quality* "relates to the need to have consistency in quality of services when delivering benefits (Svara & Brunet, 2005, p. 257). Individuals who received hospice care should have the same level of quality services. Hospice benefits are covered under Medicare, Medicaid, private insurances, and even private pay; the level of quality needs to be consistent across the board.

4. *Outcomes* "seek to achieve an equal level of accomplishment of outcomes in social and economic conditions for individuals and seek to eliminate differences in outcomes for groups" (Svara & Brunet, 2005, p. 257). Literature has identified that the Hispanic population is not receiving an equivalent level of hospice care services as other Caucasian groups.

Jennings, Ryndes, D'Onofrio, and Baily (2010) discussed the disadvantages that many individuals endure when it comes to adequate dying practices because of a

"societal failure to perceive the ethical and human cost of limited access . . . of, hospice care" (p. s3). The authors also addressed arguments that they believe are barriers to the accessibility of hospice services; one of those barriers is financing and the other barrier is delivery of services. Jennings et al. also defined *equitable access* by stating "equitable access to healthcare requires that all citizens can secure an adequate level of care without excessive burdens" (p. s4). The burdens they referred to exist in many ways, whether they are financially draining or emotionally exhausting to family, loved ones, and patients. Moreover, the authors claimed that the following problems are related to hospice care accessibility:

- Equitable access to hospice services does not exist in the United States, and this constitutes a violation of justice and fairness in our society that should be rectified;

- Many factors limit access to, and utilization of, hospice services, but governmental policies and professional practices are especially significant. Understanding what steps are appropriate to increase access to and utilization of hospice care services will reveal why we should not define the mission of hospice care narrowly; and

- Steps taken to increase access to hospice care and to design the new system should be driven, first and foremost, by an explicit discussion of the ethical values that the end-of-life caregiving should embody. (Jennings et al., 2010, pp. s4-s5)

Summary

The review of the literature has identified that the Hispanic population underutilize hospice services at much lower rates in comparison to other ethnic groups. In the year 2011, 93.8% of hospice patients were non-Hispanic compared to 6.2% who were Hispanic patients (Kirkendall et al., 2015, p. 313). Per the research, Hispanics underutilize hospice services because of culture, beliefs, language, LEP, lack of knowledge of the healthcare system, cost, limited access to the healthcare systems, reluctance to talk about death, and cultural values on informal caregiving (Adams et al., 2006; Park et al., 2016). The literature reported that by 2050, the United States is projected to have a 14% increase in the population of seniors over 65 years old with many of those seniors being Hispanics (Cruz-Oliver et al., 2014). As the population continues to increase and age in the United States, it is essential to address cultural needs in healthcare.

Individuals' attitudes, values, beliefs, religions, and culture are significant when it comes to end-of-life care. Hospice care is for those with a terminal illness, defined by Medicare as a life expectancy of 6 months or less if the disease runs a natural course. The focus of hospice is on pain and symptom management, including and addressing the stress that arrives from of a severe illness. The goal of hospice is to provide comfort care through pain and symptom management and psychosocial and spiritual support. Hospice services and benefits are mostly provided to patients in an environment of their or the family's choice. Increasing the knowledge and philosophy of hospice service providers in the community, as well as increasing cultural competence in agencies, is a great leap toward social equity of services.

CHAPTER 3: RESEARCH METHODS

The purpose of this qualitative study was to explore measures that have been taken by hospice agency providers when addressing the needs of the Hispanic community. The available literature has identified the underutilization of hospice services by Hispanics, which is attributed to language, cultural values, beliefs, and religious barriers. Hispanics have a strong cultural value system, which tends to guide much of their decision-making with regard to healthcare choice. Therefore, it is imperative to be cognizant in recognizing those barriers and meeting those needs.

The government has identified and acknowledged that individuals will take into consideration their own personal cultural beliefs and values to address healthcare needs. One of those measures has been the inclusion and development of cultural and linguistic appropriate services (CLAS) standards to serve as a guide for meeting principles in the practice of healthcare facilities. These principles have been implemented to diminish healthcare disparities and increase fair and equitable healthcare for all.

This study utilized the guiding standards of CLAS to determine whether cultural awareness is identifiable and cultural competence is achieved within the hospice organizations. In an article by Narayan (2017), she identified that the country is becoming increasingly racially, ethnically, culturally, and linguistically diverse; these distinct cultural norms influence the way members of each group think and act about healthcare choices. Furthermore, Narayan (2017) recognized that many individuals have limited health literacy, with only 12% of the population being health literacy proficient and reported that American Sign Language is the primary language for 500,000 to 2 million Americans. Narayan (2017) acknowledged the importance of a culturally and

linguistically competent care for success in home health agencies. Narayan (2017) also

identified that the CLAS standards are an outline and guide for agency leaders of home

health agencies to provide services that promote equitable outcomes for diverse

populations. Furthermore, Narayan (2017) stated that, by achieving equitable practices,

agencies are likely to meet their clinical and financial objectives. Equally, hospice

agencies can strive to achieve the same in their practice.

Research Question

How are hospice agencies addressing, responding to, and promoting social equity

best practice and cultural competencies to meet the needs of diverse populations with an

emphasis on Hispanics within several surrounding metropolitan communities in Southern

California?

Research Design

This was a phenomenological qualitative study. A qualitative research design

"explores and understands the meaning individuals or groups ascribe to a social or human

problem" (Creswell, 2014, p. 246). Furthermore, "the process of research involves

emerging questions and procedures; collecting data in the participants' setting; analyzing

the data inductively, building from particulars to general themes; and interpretations of

the meaning of the data" (Creswell, 2014, p. 246). Qualitative studies are appropriate to

use when a researcher aims to explore a phenomenon and focuses on the experiences of

individuals. This researcher utilized in-person interviews, which are important when

attempting to understand a participant's experiences. In-depth interviews reflect the

individual's knowledge, opinions, perceptions, feelings, and description of people's

actions, behaviors, interactions, and activities (Roberts, 2010). A phenomenological

study is one type of research under the qualitative approach. Through a phenomenological study, a researcher can explore and understand everyday experiences without preconceived knowledge of certain experiences (Converse, 2012). A phenomenological study is recommended when attempting to get a deeper understanding of a phenomenon. Underutilization of hospice care among Hispanics seems to have become a noticeable phenomenon.

In this study, the researcher did not attempt to analyze large amounts of data to reach statistical specifics, nor did the researcher analyze numbers, closed-ended questions, or the relationships among variables (Creswell, 2014). Therefore, a quantitative research is not an appropriate design in this case. In this study, the researcher explored the measures that have been taken by hospice agencies to address cultural competency in hospice services, and, in turn, address underutilization of hospice services among the Hispanic community.

Target Population and Sample Recruitment

In this qualitative study, hospice agencies that participated provide hospice care services to one of the largest Hispanic populated counties. As of July 2017, the identified county had an approximate population of 49.1% of individuals who identify as being Hispanic or Latino origin (U.S. Census Bureau, 2018a). This study utilized a nonprobability convenience sample based on proximity and accessibility to a hospice agency. Nonprobability sampling is a three-step procedure: (a) identify the target, (b) identify the sample frame, and (c) recruit the sample (El-Masri, 2017).

The first procedure was to identify who would take part in the study. Utilizing the Medicare.gov website, the researcher searched hospice agencies servicing the identified

county that was selected to be studied. Results populated a plethora of hospice agencies. The researcher randomly contacted agencies for recruitment and invited administrators and social workers to participate in the study via a recruitment phone call. The second procedure was to identify hospice agencies that provide services to residents living in the selected county chosen for this study by the researcher. The third procedure involved the recruitment of participants, which was completed via phone calls. The researcher contacted several hospice agencies to introduce herself and the study. During the phone calls, the researcher voiced that she was inviting administrators and social workers to participate in the study.

Social workers are an integral part of hospice care, as they are fully involved with families and patients in addressing psychosocial needs. The profession of social work has played a significant role in the life of individuals by "improving people's health through prevention, integrated healthcare, and improving the social determinants of health" (Steketee, Ross, & Wachman, 2017, p. s256).

Steketee et al. (2017) conducted a systematic review of the literature and analyzed the impact that social work has on the healthcare system. Their studies determined that social work services show positive benefits in healthcare and economic outcomes for older adults, vulnerable populations, pregnant women, and children.

Recruitment Procedures

Once hospice agencies were identified, the researcher obtained their contact information from the Medicare.gov website and proceeded to contact them. Agencies were contacted through a recruitment phone call. The researcher introduced herself to the office staff; office staff who were interested in participating provided the researcher a

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company e-mail address. The researcher then e-mailed an invitation to participate letter (Appendix A). Office staff reported that the research information would be forwarded to their administrators and social workers. Interested and potential participants responded to the researcher's e-mail or called via phone. Interested participants were sent additional information on the study and a PDF copy of the informed consent (Appendix B). Participants also arranged to meet with the researcher for a face-to-face interview.

Instrument

In this qualitative study, the researcher attempted to provide descriptive detail from the perspective of the participants (Roberts, 2010). This was accomplished through in-depth elite interviews. Elite interviews refer to those interviews conducted with individuals who are in a unique position, usually based on professional expertise within a subject matter (Harvey, 2011).

The interviews with hospice administrators or social workers were arranged at their hospice agency or another location of their choice. The interviews took no more than 30 minutes, which included details of the study, informed consent agreement, and the voice-recorded interview, which was submitted to Rev Transcription services for transcribing. The participant's name, demographic information, or position title was not audio-recorded as part of the interview that was transcribed. All identifying information was kept in a code book available only to the researcher. For security and confidentiality purposes, the transcribing company utilized the following security mechanisms:

Data Encryption: All data that passes between the researcher and the automated program were encrypted using field-standard TLS (transport layer security) 1.2.

Secured Access: Information can only be accessed from the transcripts in the

account by username and password. Network Protection: Multiple layers of security, including firewalls, intrusion protection systems, and network segregation, were employed. Transcriptionists are required to sign strict confidentiality agreements. Files were deleted upon request. (Rev, n.d., n.p.)

Interview Questions

Interview questions were based on National CLAS Standards. The questions were designed to analyze perspectives of administrators and social workers as they related to cultural diversity. There were 14 questions that served as the basis for collecting data to support and provide insight to the research question (Appendix D).

Data Analysis

The research data were captured from interviews. Responses from the interviews were transcribed. This approach was significant as it allowed the researcher to analyze the data by coding themes and categories of the comprehensive and detailed information. The interview questions were to examine whether hospice agencies were implementing CLAS standards that incorporate these three major objectives:

1. Governance, Leadership, and Workforce,

2. Communication and Language Assistance,

3. Engagement, Continuous Improvement, and Accountability. (U.S. Department of Health and Human Services, Office of Minority Health, 2016, p. 5)

Coding involved creating a table with the three categories and organizing it by participants' responses. Through this technique, an array of discoveries was revealed.

Researcher's Role

The researcher earned a master's degree in social work and has been actively practicing clinical social work with different employers, which enabled the researcher to remain current with policies, procedures, and changes. The researcher worked in public service for 13 years. This researcher's experience has been in the healthcare field, most notably in the hospital setting with individuals at all stages of life; however, she worked most prominently with the elderly and infirm populations. In her working capacity, she provides emotional support for patients and families at all levels of care, from a newly terminal diagnosis to the active dying phase of life of individuals. The researcher's experience with hospice involves introducing and providing education to families and individuals on the benefits and practices of hospice services. In the hospital setting, social workers provide the resources for hospice care when medical personnel determine that all medical procedures have been exhausted, and the patient and/or family has opted to discontinue aggressive and curative treatment.

Medical social workers are expected to enlighten individuals regarding the philosophy of hospice care and the roles of the hospice care team. It is their ethical responsibility and obligation, as a social worker, to practice cultural competencies when providing services to all those who are served.

Hospice agencies function best with an interdisciplinary team, including a physician, nurses, chaplain, volunteers, bereavement coordinator, and a master's-level social worker. The code of ethics for the medical social worker requires that he/she must uphold and follow proper standards in the work setting. That is expressed in Standard 1.05 Cultural Awareness and Social Diversity.

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(d) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

Ethical Procedures

Before conducting a study involving human participants, the researcher must request permission from her or his designated Institutional Review Board (IRB) since some participants may be prone to a degree of risk. The level of risk to participants in this study was minimal although participants could have experienced slight discomfort or embarrassment during the interview process. This was a qualitative research study in which participants provided voluntary information. In addition, questions were worded in an approachable manner to maximize the interviewee's comfort level. The researcher

also provided contact information for community resources of local counseling agencies as part of the consent to participate form.

Permission to collect data was obtained through the California Baptist University IRB. Participants who expressed interest in the study were emailed a PDF file of the consent to participate form and additional information on the purpose of the study.

Because the interviews were not anonymous, participants were informed that these interviews would be kept confidential, and the names of the hospice agency that they are associated with would not appear in any documents. Participants' identities were protected by providing an alpha-numerical code to identify each interviewee. Participants were advised that interviews had to be recorded for transcribing purposes. Participants were informed that they had the right to withdraw from the study at any time.

The researcher maintained electronic documents of the transcribed interviews, which were saved in protected files in the researcher's password-protected computer. Transcribed interviews were printed by the researcher's personal printer. All raw data were kept for 5 years, after which the computer files were deleted and hard copies shredded.

CHAPTER 4: RESULTS

The aim of the study was to investigate how hospice agencies are promoting social equity, social justice, best practice, and cultural competencies within the hospice agency through the provision of culturally, linguistically appropriate services (CLAS). This study explored how hospice agencies are providing adequate services to diverse populations in metropolitan cities located in Southern California by implementing the National CLAS Standards within their hospice practice. CLAS standards have been set in place to address the service needs of this nation's increasingly diverse communities. This study was analyzed through the standards of CLAS. The three major categories of CLAS are listed as follows:

1. "Governance, Leadership, and Workforce." This theme emphasizes the importance of CLAS implementation as a systemic responsibility, requiring the endorsement and investment of leadership, and the support and training of all individuals within an organization

2. "Communication and Language Assistance." This theme broadens the understanding and application of appropriate services to include all communication needs and services (e.g., sign language, braille, oral interpretation, and written translation).

3. "Engagement, Continuous Improvement, and Accountability." This theme underscores the importance of establishing individual responsibility for ensuring that CLAS is supported, while maintaining effective delivery of CLAS across organizations (U.S. Department of Health and Human Services, Office of Minority Heath, 2016, p. 5).

Using sociologist Michael Quinn Patton's (1987) approach to qualitative interviewing, a researcher can ask questions from six types of categories, which allows respondents to be expressive. The categories are (a) "experimental and behavioral," which explores individuals' past and current experiences; (b) "opinion, beliefs, and values," which is designed to understand what it is people think about a certain issue or experience; (c) "feeling," which attempts to seek an emotional response of their own experience and thoughts; (d) "sensory," which asks respondents to explain to the interviewer what can be seen, heard, touched, tasted, or smelled in regard to what is being asked of the participant; and (e) "background and demographics questions," which asks about age, education, occupation, and time in a particular program or setting (Patton, 1987, pp. 115-119).

The study was conducted using a semistructured interview with participants involving seven hospice social workers and two hospice agency administrators. Interviews were recorded and transcribed. Content analysis of each participant's response was conducted by identifying themes pertaining to the standards of CLAS. The findings were organized by three major themes: governance and leadership; communication and language assistance workforce engagement; and continuous improvement accountability.

This study provided insight into the reality of healthcare providers who are currently employed in the field of hospice care. The study results provided awareness of the indicators that may impact end-of-life care while one receives hospice services. The responses of participants were expected to define real-time encounters with cultural diversity in the workplace setting. The responses obtained during the interview process

provided a consensus on culture competency while providing medical services to diverse populations. This chapter presents participant demographics, data collection, data analysis procedures, and results of the study.

Research Question

The current study was designed to investigate and address the following question: How are hospice agencies addressing, responding to, and promoting social equity, best practice, and cultural competencies to meet the needs of diverse populations with an emphasis on Hispanics within several surrounding metropolitan communities in Southern California?

Setting

To gather statistics for this study, interviews were conducted from several hospice agencies located in different counties in Southern California. The settings are profit-based organizations approved by the Centers for Medi-Care/Medicaid Services (CMS).

Participant Demographics

The sample populations utilized for this study consisted of seven social workers and two administrators. The educational backgrounds of the administrators consisted of one having a high school diploma and one having an RN and an associate's degree. The social workers had all earned a master's degree in social work. One had a current license governed by the Board of Behavioral Sciences. The length of employment varied among participants. The average length of employment years was 4 years, which is presented in Table 1.

Table 1

Participant Demographic Data

Participant code	Gender	Ethnicity	Current position	Highest level of education	Years working in hospice
P1	F	African American	Social worker	Master's degree	1-4
P2	M	Caucasian	Social worker	Master's degree	1-4
P3	F	Caucasian	Social worker	Master's degree	1-4
P4	M	Caucasian	Social worker	Master's degree*	1-4
P5	M	Hispanic/Latino	Administrator	RN. Associate's degree	1-4
P6	F	Caucasian	Social worker	Master's degree	>1
P7	F	Caucasian	Social worker	Master's degree	>l
P8	F	Caucasian	Social worker	Master's degree	4-8
P9	M	Filipino	Administrator	High school diploma	4-8

*Licensed clinical social worker.

Presentation of Findings

Theme 1

The first major theme that emerged related to Governance, Leadership, and Workforce. This theme emphasizes the importance of CLAS implementation as a systemic responsibility, requiring the endorsement and investment of leadership and the support and training of all individuals within an organization.

Cultural diversity training in the workplace. Participants were asked whether their agency provided cultural diversity training. Seven participants (77%) stated that their agency provided training and tools on effective practices while providing services

with a diverse population. One participant stated that cultural diversity training was not inclusive in his or her agency; however, it was part of the hiring practice.

One social worker stated, "No, they don't [include diversity training]. Part of the interview involved assessing if the social worker has received training before and experience before, but they did not offer." Another interviewee reported that cultural training is a must. This administrator reported, "Yes, absolutely [cultural diversity training] is required of all staff going into the field." The participants who reported that cultural diversity training was implemented in their agency stated that it was done through in-services, training modules, online programs, or informally through interdisciplinary team (IDT) meetings. A majority of the participants shared that the main topic incorporated in their training of cultural sensitivity was how to respond to death and dying situations as they pertain to different cultural ethnic diversities. Participant 4 stated that a major component to cultural awareness training included the arena of sensitivity: "Overall level of awareness that you're going to be working with while serving a diverse population is sensitivity. Sensitivity to different populations and understands that everybody responds to end-of-life situations differently based on their cultural perspective." Participant 5 added that in their agency, cultural awareness training included how to identify end-of-life cultural differences.

Responsibility and implementation of cultural diversity training. Participants were asked to identify who had the responsibility of implementing cultural diversity training. Pertaining to this area, there was a common theme, which was the concept of shared responsibility through all levels of discipline. Some participants reported that it is the responsibility of administration while other participants reported that it was the

responsibility of the licensed clinical social worker (LCSW). In addition, some participants voiced that it was their own responsibility. One participant, a social worker, responded that the responsibility was shared among the team: "[It is the responsibility of] the administrator, human resources, individual initiative, and [our] ongoing education." Another participant, an administrator, similarly reported that it was everyone's responsibility: "It starts from every single one of us, it starts from the leadership point of view, so myself, . . . we start from the top." Two participants reported that cultural diversity training was the responsibility of the LCSW. Based on all the responses, it was implied that the participants believed that cultural diversity training is a shared responsibility within their agencies.

Formal training and education. Participants in the study identified that training and education on cultural diversity is a key component in effectiveness while working with different cultures and races. When participants were questioned about the importance of formal training/education on cultural diversity, six social workers (85%) responded that they felt they were competent and prepared with their level of formal education, training, and experiences. The participants credited their previous formal education and curriculum included in their master's level education, which incorporated instruction on cultural competence. Social workers voiced statements, such as "[Cultural awareness training was] incorporated when receiving my master's degree." Another social worker voiced, "[My] educational background [is attributed to the level of preparedness]" and it has prepared her to serve diverse communities. One social worker stated, "My master's program was in social work and geriatrics, and it was a very culturally sensitive program [pertaining to level of preparedness]." Another social

worker said that her level of preparedness was due to, "my college education, [and] I've done my own independently cultural diversity training."

Relatedly, an administrator voiced that his level of preparedness is attributed to the "discipline and educational background from [his] formal education." In addition, he stated the importance of continuous education units (CEU), which are required by different disciplines. This administrator added that his/her agency provides courses via the "online program, Relias."

Level of preparedness. Participants were asked about the level of preparedness staff members have when working with diverse populations. Eight participants (88%) reported that they felt staff was prepared to work with the culturally diverse populations they serve. Participants reported that the level of preparedness when providing services to diverse populations was a conglomeration of the interdisciplinary team and the effective use of communication among staff. Participant 2, a social worker, stated:

There's some initial training as part of new staff training and the rest is less formal, based upon communication between the team members. For instance, a team usually consists of a social worker, a home health aide, a nurse, an LVN and based upon what is working or not working or things that any of the team [members] have observed we will discuss or problem solve issues that arise or specific differences.

Additionally, Participant 3, a social worker, stated, "I would say we do have basic knowledge [pertaining to cultural awareness]. I think we could improve, and the basic knowledge is relative to hospice issues, so beliefs about end of life, even beliefs about

say, cremation versus burial, making preparations, the caregiving provided during this time. And there are a lot of differences."

Participant 4, a social worker, felt that as a hospice agency, they were as prepared as they could be; however, he or she felt that staff should have cultural diversity training and stated, "I think we're very prepared as a hospice. I think as prepared as we can be. But I think that if all of our staff had complete cultural diversity [training], that would be fantastic. I don't think we're there yet though. I think we're somewhere in the middle on that." Participant 5, an administrator, reported that his/her agency was prepared to serve the Hispanic population and admitted that when the agency does not believe it can serve a certain population group, it will refer the patients to another agency:

> Everyone feels well prepared [while providing culturally competent services] as far as the [serving the] Hispanic population, and of course, American population. We have a diverse staff here as well. There have been a couple of incidents where we felt uncomfortable with certain populations, in those cases we refer to other agencies that tailor to that specific culture and can do a better job, then we go ahead and pass it off.

> Similarly, Participant 7, a social worker, believes that her agency is equipped to address the Filipino population and is "not convinced" that the agency is equipped to acknowledge cultural diversity and the needs of other populations that are being serviced by the agency.

Training/education while servicing the Hispanic communities. The participants were asked during the interview to precisely identify whether they as staff were provided with training or education while working and servicing the Hispanic

population. Five of the participants identified that they believed they were competent and

prepared with their level of formal education, training, and experiences while servicing

the Hispanic population. Three participants, however, admitted that they had no training

specific to the Hispanic community. Participant 2, a social worker, reported that he

learned from other coworkers. Participant 3, a social worker, reported that her training

and formal education on how to work with the Hispanic community is attributed to her

own college education and continuous education. Furthermore, this social worker added

that "[the discipline of] social work is to develop and provided cultural diversity in-

services to staff." Participant 5, an administrator, reiterated that the staff at his agency is

offered courses through the online program, Relias. Participant 6, a social worker,

recognized that his or her agency's ongoing training is informal and conducted during

IDT meetings. This social worker identified that any concerns pertaining to Hispanics'

practices and beliefs are addressed during the agency IDT meeting. Participant 7, another

social worker, reported that his or her agency offers online courses. Lastly, Participant 9,

an administrator, admitted that staff should be understanding of Hispanic cultural roles.

Theme 2

      Meeting communication needs and language services. The second major

theme of this study addressed Communication and Language Assistance. This area was

intended to broaden the understanding and application of appropriate services to include

all communication needs and services (e.g., sign language, braille, oral interpretation, and

written translation). Literature has identified that language barriers are one of the greatest

limitations when accessing and attaining services. It was imperative to examine

participating hospice agencies as to how they were addressing the linguistic needs of

potential patients. Participants were asked how they were meeting the needs of patients

and whether they were providing language services.

Meeting communication needs. Four participants (44%) responded that their

reliance weighed heavily on family members for their translations needs, telephonic

translation services, and informal free applications on their cellular phones. Participant 2,

a social worker expressed,

> Often, I meet with family members and the primary language is Spanish speaking
>
> only, I will do my best to reach out to other family members or someone that they
>
> feel comfortable with who is bilingual, so we can work to facilitate the
>
> development of a patient social worker relationship to get things done.

Participants 2, 3, and 7 identified that they utilized the assistance of their

colleagues for translation needs. Participants 1, 4, 6, 7, and 9 stated that they routinely

use language services for linguistic barrier deficits. Participant 4, a social worker,

disclosed that the cultural climate and protocol within the agency was to use family

members and telephonic translation services. Participant 1, a social worker, identified

multiple ways in which their agency provides communication and language assistance

when rendering service for hospice patients. Participant 1, a social worker, stated:

> A lot of times we have patients that we are not able to communicate with, so we
>
> will use the family member or caregiver that we can communicate with. If not,
>
> for example if there's a patient that their primary language is Spanish, the family
>
> speaks Spanish, we have a social worker who's a runner and tends to all families
>
> and patients that have a primary language of Spanish. As far as sign language and
>
> Braille, there is a translating service we can use. I personally have never needed

to use it because there's always someone, a primary caregiver, family or even another staff member that we can use to interpret or communicate the needs of the family.

The consensus based on hospice employee feedback regarding communication barriers displayed that their agencies did in fact provide translating services. The findings showed that six out of nine participants reported that their agencies provided tools for language translation. Four out of the nine participants further elaborated that their agency provided onsite services whereas five out of the nine participants reported their agency employed contract-for-hire translating services.

Participant 5, an administrator, contemplated ways in addressing patients when it comes to visually impairment and the impact the agency would bear when addressing such needs of patients:

That would be interesting [referring to addressing the needs of patients with visually and hearing impairment], we haven't had someone on hospice who requires sign language, or someone who's blind . . . to be honest with you, I haven't thought about that. So we'd have to get pretty creative if that happened. Hopefully we would use family members in cases like that.

Language services. All participants who engaged in the interview process were asked the following question, "In what languages do you provide resources for your services?" All participants within the study parameter reported that Spanish was the most prominent language, and appropriate forms were presented during the election of benefit process. Vietnamese, Chinese Mandarin, Tagalog, and Korean were also presented to

families, if warranted. Providing services to eyesight and hearing-impaired patients and families continues to be a struggle for all agencies

The unanimity from all contributors concluded the importance of acknowledging and addressing language barriers is a critical component in providing optimal service to patients and families. All agencies recognized the need to address language barriers and the significance in providing the necessary tools to all staff members to achieve a successful outcome while rendering services. There continues to be a favorable need when providing services to the eyesight and hearing-impaired communities.

Theme 3

Experience, encounters, and exposure. The third major theme of this study is related to Engagement, Continuous Improvement, and Accountability. This theme underscores the importance of establishing individual responsibility for ensuring that CLAS is supported while maintaining effective delivery of CLAS across organizations. The interviews conducted during the survey specifically asked participants about their personal experiences, exposure, and perspective related to cultures, beliefs, religions, and practices other than their own. Participants were asked to elaborate on how their personal experiences/exposures have impacted their professional growth and professional experience. Per Patton (1987), during qualitative interviews, it is worthy to ask participants about life experiences and exposure as it allows participants the ability to reflect on common practices that affect everyday life. As an open-ended question, participants disclosed personal and professional experiences that molded their professional growth in the field of hospice care. Contributors who participated in the

study expressed that previous experiences, exposures, and beliefs play a major factor in providing appropriate services to cultures that differ from their own.

Participant 1, a social worker, revealed that she had an abundance of experience and exposure working with a wide range of cultural backgrounds and differences while in a professional capacity. In addition, she acknowledged that she provides the same care and treatment plan with the same professional respect of all patients and families regardless of cultural differences. Participant 2, a social worker, reported that no formal training in cultural sensitivity and no in-service training was offered from his agency. However, he recognized that he has plenty of field hours and hands-on experience performing hospice care that allows him to feel confident to perform job-related responsibilities above job expectations pertaining to cultural dilemmas. Participant 2, a social worker stated,

> If I notice something or didn't understand something I know for certain, [for instances] in some cultures people are not as comfortable in discussing long range plans, be it burial or cremation. In some cultures, it's more of a collective decision rather than one person making the decision.

Participant 2, a social worker, added that face-to-face interactions, direct conversations, and the assessment of patients and families have been his biggest assets in achieving a level of competence in the field while providing service.

Participant 3, a social worker, shared that she can relate to how ethnic minority patients must feel. Participant 3 also stated that she has the insight to sympathize with patients and further added the following:

I can tell you this is the first place I've ever been employed where I've been the

minority, and that's quite a different experience. It has clearly helped me

understand the Filipino culture better. I would also say it has helped me

understand myself better, it helps me to have more insight into my own behavior

and how I'm perceived by others.

Participant 4, a social worker, disclosed that he has seventeen years in the

healthcare field, and his experience has formed a wide range of elements in providing

service to a variety of multicultural backgrounds. Participant 4, also stated, "I've been in

the field [referring to public service], I've worked with multiple different cultures,

multiple different ethnicities, multiple different backgrounds, and ages." Participant 4,

moreover, articulated that prior work experience played a significant impact on the

delivery of service. He stated,

If you come in with the understanding and clarity that certain cultures may view

differently than the way "I'm going to view it." I accept the differences and work

where they are at. Going into a situation, I already have a general idea of how

this family might be coping or dealing with a situation based on their cultural

background.

This participant [4] identified that cultural norms tend to change across the generations

based on life experiences. Participant 5, an administrator, shared similar experiences and

recognized that exposure has helped identify and understand cultural family hierarchy.

He admits that previous experience does not always work favorably as there is not a one

size fits all when dealing with people of different cultures, backgrounds, and experiences.

He stated, "Sometimes we're wrong and say, 'no we're completely Americanized

[referring to the patients and families] and we understand'; in those situations, we own it and address the concern before it becomes a bigger issue." This administrator voiced that prompt attention to field concerns genuinely improves and may diffuse issues that could arise.

When Participant 6, a social worker, was asked to share her experiences and exposures and how they have helped in providing services to a diverse population, she stated that language barriers was one of the biggest hurdles to overcome when providing service to non-English-speaking clients. Participant 6 provided the following example: "I went to a hospital and we had a Spanish speaking family and patient. My director allowed the Chaplain who is fluent in Spanish [to] go with me." One valuable criterion when providing prime service is that an agency must consider the primary language of the recipient who will be receiving services. Having personnel who are fluent in the recipient's primary language is vital and should not hamper any person to receive entitled benefits from the agency. Optimum service should be generated to all people across the spectrum on an equal basis.

Participant 6 also contributed that when death and dying is imminent for patients, it is important for medical social workers to understand cultural norms, anticipating grieving process, coping mechanisms and strategies of various cultural groups. Having prior knowledge when working with patients and families allows the development of providing coping skills and education for staff on the needs of the family and helps to set realistic expectations. Participant 6 also disclosed that having field experience working with an array of different cultures such as the Ethiopian, Arabic, Asian, and Filipino communities has helped her understand different perspectives and values of diverse

populations. Participant 6 also concluded that continuing education is critical in implementing a cohesive plan of care.

When Participant 8, a social worker, was asked to share her experiences and exposures and how they have helped in providing services to diverse population, she voiced that patients should have autonomy. Participant 8 stated that when providing hospice care, "one should not interject one's personal belief system, and meet, the patient and family where they are at [referring to level of comprehension]." This is an important component when providing and evaluating for social needs. Furthermore, she added that it is important to understand the community of the participant and know what resources are immediately available when providing care service to patient and families. Participant 8 added, "I've learned about different cultures. As far as being sensitive, [and] understanding better on how to communicate and understanding how people feel, especially in a hospice."

Continuous education. Participants were asked to elaborate on whether they were provided with continual education while working with diverse populations. Participants 1, 2, and 7 reported that continuing education was not offered; however, the topic is discussed when concerns arise. Participant 1, a social worker, reported that no continuing education or training is offered within the agency setting. Participant 2, another social worker, added that continuing education is not offered on a regular formal manner. The process is informal and generally is brought up during IDT meetings. Participant 7, a social worker, added that she was doubtful about whether ongoing education or in-services were offered at her agency.

Overall, six participants from the study concurred that continuing education was offered or provided by administration to support staff and kept them abreast of cultural changes and diversity. Participant 3, a social worker, reported that continuing education is offered and encouraged. She also revealed that the agency does not provide continuing education classes; however, access to a multitude of resources is available through the National Association of Social Work website, and the agency administration would reimburse the cost. Participant 4 also confirmed his agency provides in-services to staff that include education and awareness. Participant 5, an administrator, revealed that at his agency, staff is provided with access to Relias. Relias is an online learning management system that provides courses and programs that have a vast array of opportunities to meet competency standards in healthcare practice. When asked whether their agency provided continuing education while working with diverse populations, Participant 6, a social worker, confirmed that taking continuing education classes online is mandatory for all staff members. That participant added that the completion of those mandatory online training courses is addressed during the annual review process. Participant 8, a social worker, also shared that at her agency the LCSW was responsible for providing in-service training sessions and education to all staff members once a year for cultural competencies compliance.

Tracking staff's engagement and efforts when working with a diverse population. Participants were asked whether their agency used a tracking and engagement tool when working with diverse populations. Participant 1, a social worker, was uncertain whether the agency used a tracking system to measure engagement efforts. This participant divulged that there was a team within the agency called improvement

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specialists. The focus of the improvement specialist is mainly on customer service, which measures the quality of service received by hospice patients. Participants 2, 3, 5, and 6 disclosed that human resources tracks all information pertaining to mandatory staff competency completion on diverse populations. Participant 3, a social worker, reported that after completing online education courses, a certificate is given, and human resources is responsible for securing items in personnel files. Participant 6, a social worker, similarly mentioned that competencies were tracked and evaluated during the staff members' annual review. Participant 5, an administrator, revealed during the study that he receives a monthly compliance report. The monthly compliance report tracks which staff members have or have not completed mandatory training sessions. Participant 4, a social worker, and Participant 9, an administrator, reported that an outside agency is responsible for satisfaction surveys that specifically ask about sensitivity to culture and professionalism. Participant 7, a social worker, stated that all patient demographics are included in the patient's chart in the electronic software program that staff uses for charting and communication purposes. The study results conclude that all agencies in one form or the other have a system to track employee engagement and efforts when working with diverse populations.

Connection to Theoretical Framework and Discussion

This study showed that some diverse populations are being underserved. The study also provided sound data that hospice agencies continue to struggle to facilitate servicing certain populations who require specialized needs such as languages and the deaf and blind communities. Although agency staff members reported they are equipped with field practice and education to consider themselves culturally prepared, there

continue to be areas for growth. Hospice is a federal and private-pay benefit that is provided through a person's medical insurance company to those who qualify and elect to utilize the benefit for comfort care, focused treatment at the end of life as opposed to seeking progressive medical treatment.

The data collected and analyzed in this study were examined through the compound theory of social equity, by Frederickson (1990) and cultural competence as defined by CLAS standards. Frederickson's introduction of the value of equality began with the concept of lot equality, wherein shares and benefits are identical and equal for all. In lot equality, individuals assess what needs they may have and how will they gain access to benefits. Frederickson explained that lots can be easily measured and distributed; however, he did not address equal well-being. The belief that most individuals automatically acquire the benefits does not recognize that some may be excluded because of limits of accessibility of benefits. Social equity refers to

> The fair, just, and equitable management of all institutions serving the public directly or by contract; the fair, just, and equitable distribution of public services; the implementation of public policy; and the commitment to promote fairness, justice, and equity in the formation of public policy. (as cited by Johnson, 2012, p. 471)

Hospice agencies must adhere to the governing body guidelines of CMS. The Medicare Hospice Benefit (MHB) is a representation of a federally funded benefit, which is an entitled benefit for those who qualify. Based on the study, some populations may not be receiving equitable hospice benefit services due to the lack of CLAS standards not

being met. This is particularly problematic when hospice agencies seek federally funded reimbursement for their services.

Betancourt et al. (2003) defined cultural competence in terms of disparities and barriers in healthcare, particularly those that affect minorities. The authors have defined cultural competence as a systematic way of understanding cultural influences that hinder or promote health beliefs and behaviors. They developed the term *sociocultural barriers*, which emphasize social factors such as socioeconomic status, supports/stressors, or environment relating to cultural factors that have an influence on individuals (Betancourt et al., 2003). Betancourt et al. acknowledged three types of sociocultural barriers that also can be applied for hospice personnel to prevent disparities. They are organizational barriers, structural barriers, and clinical barriers.

Organizational barriers refer to the availability and acceptability of minority representation in the broader healthcare platform. Hospice agencies can eliminate organizational barriers by incorporating a diverse staff, providing cultural competence training, educating staff on how to better serve different types of cultures, and conducting community outreach meetings, public education, and health fairs. Structural barriers are identified as those barriers that lack culturally, linguistically appropriate health education, and that make it difficult to access or navigate the healthcare system. Several different factors play a role in disparity of hospice services. Some contributing factors include lack of insurance, lack of knowledge, limited English proficiency, communication literacy and translation differences, and lack of trust in the medical profession. Clinical barriers are the result of sociocultural differences between providers and patients. The most prolific clinical barrier is attributed to the communication style and health literacy

between healthcare providers and patients. Results of the study showed there is a direct correlation in disparity of services and communication efforts between all hospices. Hospices are not prepared to provide services to the deaf and blind population and oftentimes lack the staff to service Spanish-speaking patients and their families.

Summary

In conclusion, the data collection obtained during the survey process concluded that hospice agencies continue to enhance, react to, and implement strategies and techniques to improve and serve all communities and cultures. Ongoing strides continue at all agencies in addressing language barriers and services for the blind and deaf communities. The agencies that participated in the survey did not have staff who knew sign language as a second language. Additionally, materials in braille were unavailable. As of this writing, there are no guidelines to address certain factors that hamper servicing all people with pristine services across the spectrum. Implementation for federal agencies that provide funding to privatized hospice organization needs to address ongoing concerns.

CHAPTER 5: SUMMARY, RECOMMENDATIONS, AND CONCLUSION

This final chapter concludes the researcher's study. The chapter presents the summary of the research and summary of findings. Lastly, this chapter discusses the limitations of the study, provides recommendations for further research, and concludes the research.

Summary of Research

The Medicare Hospice Benefit (MHB) was enacted in1983, and the focus of hospice is to provide end-of-life care for terminally ill patients who forgo curative measures while promoting quality end of life. Hospice benefits stems from a generalized philosophy that promotes a smooth transition from life as it once was to a comfortable, dignified final phase of life. The focus of hospice is on quality of life and pain management. The MHB is the predominant pay source for hospice services, a federally funded source (Jarosek, Shippee, & Virnig, 2016). The literature has found that many Hispanics are underutilizing hospice benefits. The National Hospice and Palliative Care Organization (NHPCO) reported that in 2013 from 1.5 million hospice recipients, only 6.85 were Hispanic/Latino (Park et al., 2016). The literature reported that there are many cultural barriers that limit Hispanics' accessibility of receiving hospice benefits and that hospice services lack cultural competency measures. According to the literature, the Hispanic population continues to increase and age in the United States. It is important for aging and qualifying Hispanic individuals to have equitable hospice services that meet their cultural imperatives.

The aim of the study was to investigate how hospice agencies are promoting social equity, social justice, best practice, and cultural competencies within the hospice

agency through the provision of CLAS standards. This study was based on two

theoretical concepts: social equity, a major pillar of public administration, and its

relationship to cultural competence, which was defined and guided by the 15 standards

for CLAS. Social equity is the representation of fair, just, and equitable management and

distribution of public services (Johnson, 2012). Consistent with social equity, the goal of

CLAS is to provide equitable and fair healthcare practices. Furthermore, CLAS

standards are intended to advance health equity, improve quality, and help eliminate

healthcare disparities by establishing an outline for healthcare organizations (U.S.

Department of Health and Human Services, 2013). By providing culturally competent,

equitable, understandable, and respectful hospice services to all who qualify, social

equity is promoted.

Summary of Findings

A qualitative examination of the study revealed that hospice agencies continue to

struggle with social equity, social justice, best practice, and cultural competencies of their

services. The results of the survey found that hospice administrators and social workers

are conscientious of the needs of the Hispanic community while recognizing the need to

serve other diverse communities, such as the Asian community and, most notably, the

deaf and blind communities.

Although agencies have made attempts and strides in addressing cultural barriers,

disparity, and servicing diverse populations, social equity remains challenging for

agencies. Participants from the study reported that at some point during their

employment, culture diversity training was provided, offered, or encouraged in the

workplace. All the social workers in the study credited their prior master's level

education and curriculum for preparing them to work with diverse communities. Overall, all participants reported that they felt they shared a sense of responsibility to implement cultural diversity training in the workplace. As far as meeting the communication needs and language services, participants reported that their agencies provided bilingual staff and language translating services, either onsite or contracted.

Participants in the study also revealed they were aware of the inequality and shortcomings their agency faced when servicing diverse populations. Some agencies, such as the deaf and blind communities, were unprepared to service certain populations because of communication barriers. That was a major finding in the study. All agencies felt they were prepared to service all populations based on employee cultural competence; however, some agencies lacked diversified staffing that would meet the needs of the patient and family. In instances where communication barriers presented to be an obstacle, the agency would refer to a different hospice agency that could meet the needs of the patient and family. As far as hospice agencies providing continuous education on cultural diversity training, some participants reported that continuous education was offered or provided by administration through online courses or annual competency training, while some participants reported that continuous education on cultural diversity training was not offered. Lastly, participants reported that their hospice agency in one way or another tracked staff's engagements and efforts while working with diverse populations. That was done through patient surveys and human resources monthly compliance report.

Limitations

This qualitative study had a few limitations, one being that this study was a small sample size of nine participants from hospice agencies within a few Southern California counties. The hospice administrators for purposes of this study were found to be unavailable or displayed reluctance to participate with this survey; therefore, a smaller sample was utilized. Social workers were found to have limited office hours and time constraints as they are predominantly field employees performing patient/family visits. The participants who engaged in the study process were transparent and provided valuable knowledge in regard to applications and tools they utilized within their agency and also their level of cultural competence and understanding. The study results showed that an unequal analysis may not be parallel to other hospice agencies that were not directly involved in the study.

Hospice administrators have multiple variations of educational background and leadership experiences. Social workers have earned a master's degree, can hold a license governed by the Board of Behavioral Sciences, in some instances, can have a bachelor's degree, and have direct supervision from a master's level social worker. Oftentimes, the social worker holds an advanced education degree greater than that of a hospice agency administrator; this can create nonparallel views of patients' and families' needs. Life experience can also provide insight and value to those working in the field of hospice care services.

Recommendations

Cultural competency and awareness should continue to be incorporated in all hospice agencies' hiring practices and ongoing job training, such as in-services, on a

regular basis. As the world continues to grow and change, agencies need to be in tune with immediate community needs. With ongoing fluctuations in government, healthcare changes are inevitable, and hospice agencies need to stay up-to-date with benefit changes. The researcher believes that additional studies guided by the principles of CLAS should be conducted through quantitative, anonymous, mailed surveys for larger geographical areas. Through that measure, the research will better examine and assess the needs of the underserved populations, ultimately maximizing equitable healthcare benefits to improve quality end of life.

During this research study, the researcher encountered a multitude of government run agencies focused on cultural competence training, which have free online programs, educational modules, and viable resources for cultural competence education. These government agencies focus on the inclusion of all diverse communities. Agencies such as the Administration for Community Living, National Center for Cultural Competence (NCCC), cultural competence resources for health care providers through the Health Resources and Services Administration (HRSA), and cultural competence training provided through HHS OMH are a few that offer cultural competence training and education. The researcher believes that the research tools from government agencies can aid hospice agencies in stabilizing hospice struggles, meeting the needs of diverse and underserved communities, and increasing cultural competency levels. Furthermore, additional research is warranted to address other underserved population such as the blind and deaf communities as this community was presented to be underserved in this study.

Conclusion

This qualitative study was conducted to investigate how hospice agencies are promoting social equity, social justice, best practice, and cultural competencies within the hospice agency through the provision through CLAS. The researcher interviewed nine participants from seven different hospice agencies, two administrators, and seven social workers. Participants felt that they were prepared to service diverse populations; however, it was evident that these agencies continue to struggle in meeting the needs of some diverse populations.

The participants have recognized and identified those needs. Across the results it was noticeable that some hospice agencies lack in providing cultural diversity training education and continuous education. This seems problematic since there are so many government agencies focused on and intended to promote and improve equitable healthcare options, with hospice care being one of those services.

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APPENDICES

APPENDIX A

Invitation to Participate in Research Study

Maria Ormonde
10370 Hemet Street, Suite 200
Riverside CA, 92503

Dear Potential Participant,
Thank you for your interest in my study. I have attached a brief statement of purpose and inform consent form. As I mentioned in the phone call, I am a social worker and a doctoral candidate from California Baptist University, Department of Public Administration in Riverside, CA. I am working under Dr. Pat Kircher, Professor of Public Administration at California Baptist University. I am conducting a research study investigating the promotion of cultural competence in hospice agencies located in Southern California. I am recruiting hospice administrators and social workers. I am inviting personnel from your office because your agency has been identified as a hospice services provider for residents of Riverside County.

The knowledge, experience, and testimony of data collected from these interviews will enhance the body of research in the area of hospice services.
The interview will take approximately 20 minutes.
These are strictly **confidential** interviews.
The names of individuals and hospice agencies that participate in this study will not be published.

If you would like to participate, please contact me to schedule an interview, by responding to this email.

If you have any further questions, please contact (Me) Maria Ormonde at 909-601-4940 or at mariad.ormonde@calbaptist.edu or contact Dr. Pat Kircher at 951-343-3930 or pkircher@calbaptist.edu. For any questions about Your Rights as a Subject, contact the Institute Review Board, California Baptist University at 951-552-8626 or irb@calbaptist.edu.

Respectfully,
Maria Ormonde

Appendix B

Consent to Participate in Research Study

Cultural Competence in Hospice agencies an Aim to Promote Social Equity

You are being invited to participate in a research study conducted by Maria Ormonde, under the direction of Dr. Pat Kircher, Professor of Public Administration at California Baptist University. You have been asked to participate in this study, because your agency has been identified as a hospice service provider for residents of Riverside county. The purpose of this study is to examine how hospice agencies are meeting the needs of the diverse population in Riverside County, most notably the Hispanic community. This study will contribute to the researcher's completion of her doctoral dissertation.

1. Your participation in this project is voluntary, and you may withdraw and discontinue participation at any time from this study without penalty.
2. You will not be paid for participation in the study, nor will you directly benefit from this study.
3. Although you may not directly benefit from this study, potential benefits of this research could lead to improved policies and strategies in the provision of hospice services for the Hispanic population.
4. The meeting can last between 30 minutes to 45 minutes. The meeting includes a demographic questionnaire, followed by 14 interview questions. The interview will be recorded for transcribing accuracy purpose. Some note-taking will also occur during the interview.
5. **Demographic information will not be recorded, will not be transcribed, and will not be shared publicly**.
6. Your identifying information will be kept in strict confidence. All data will be stored in a secure location accessible only to the researcher.
7. The results of this study may be included in the researcher's published dissertation.
8. Interviews may cause a level of discomfort; if you are uncomfortable in any way during the interview session, you have the right to decline a question. In the event, you feel uneasy after this interview or wish to seek treatment from a mental health provider, some resources are provided below.
   a. Riverside County Department of Mental Health- 951-358-4850; Address: 9890 County Farm Road Riverside, CA 92503
   b. Olive Branch Counseling Center Inc,. 951-989-9030; Address: 4041 Brockton Ave. Riverside, CA 92501
   c. Inland Integrated Wellness Center, LLC., 1-888-634-6999; Address: 817 West Grand Blvd. Corona, CA 92882
   d. San Bernardino County Behavioral Health, 1-888-743-1478 or 909- 386-8256; Address: 850 E. Blvd Rialto, CA 92376
   e. Community Counseling & Supportive Services, 714-645-8000; Address: 1040 W. Town and Country Road Bldg. G, Orange, CA 92868
   f. Los Angeles County Department of Mental Health, 1-800-854-7771, Downtown Mental Health Center, 213-680-6350; Address: 631-B Maple Avenue Los Angeles, CA 90014.

9. The results of this study may be included in the researcher's published dissertation.
10. This research study has been reviewed and approved by the Institutional Review Board (IRB) from California Baptist University. IRB is a group of faculty who review research applications to ensure the protection of people participating in research studies. They can be contacted at irb@calbaptist.edu and by calling 951-552-8626

Giving of Consent

I have read this consent to participate in research study form and I understand what is being requested of me as a participant. I freely consent to participate. I certify that I am at least 18 years of age. I understand that I will be offered a copy of this consent form to keep.

Statement of Consent

□ Yes, I consent to participate. I understand I can change my mind.
□ No, I do not wish to participate in the study

Date:_____/_____/_____

_____
Printed Name of Participant

_____ _____
Signature of Participant   Date

This research has been reviewed and approved by the Institutional Review Board at California Baptist University (IRB # 056-1819).

APPENDIX C

Demographics

County: Position: Aggregate:

Participant Demographics and Interview Questions

1. Please provide your name: --

   _____

2. Please indicate your current position:

   ☐ Administrator
   ☐ Social worker
      Are you licensed?
         ☐ Yes
         ☐ No
         ☐ Working on licensure

3. Please provide your highest level of education
   ☐ High school/ Equivalency
   ☐ Associate Degree
   ☐ Bachelor's Degree
   ☐ Master's Degree
   ☐ Doctoral Degree
   ☐ If out of the country, please state degree:

      _____

   ☐ Decline to state

4. Please provide your ethnicity:
   ☐ African American
   ☐ Asian/ Pacific Islander
   ☐ Caucasian
   ☐ Hispanic/Latino
   ☐ Filipino
   ☐ _____

5. How long have you worked in your current position?
   ☐ Less than a year
   ☐ 1-4 years
   ☐ 4-8 years
   ☐ 8-12 years
   ☐ 12-16
   ☐ 16-20 years
         ☐   over 20 years

APPENDIX D

Interview Questions

1. Can you tell me whether this agency provides cultural diversity training on how to work with diverse populations (e.g. culture differences, beliefs, religions, practices and languages)?

2. Follow up question: What is included in the training?

3. Who has the responsibility for implementing cultural diversity training in your agency?

4. What kind of formal training/education on cultural diversity do staff members (e.g. medical director, social worker, Chaplin, nurses, volunteers) have when meeting the needs of a diverse population?

5. Can you tell me how prepare is the staff to work with diverse populations, including, those from different cultural backgrounds, beliefs, religions, practices and languages?

 What kinds of formal training/education do the staff members have when working with the Hispanic community?

6. Can you tell me how is the staff currently meeting the communication and language needs of individuals (e.g. sign language, braille, oral interpretation, and written translations)?

7. In which languages, does this agency provide information of your services?

8. Does this agency provide translating services?

9. Follow up: How are those services provided, on site or contracted?

10. Can you share with me what kinds of exposures and experiences you have with other cultures, beliefs, religions, practices, or languages other than your own?

11. From those experiences, can you share with me how have they helped you while working at this agency and providing services to a diverse population?

12. Can you tell me whether this agency is providing the staff with formal continuous education on how to work with a diverse population?

13. How is the agency tracking staff's engagement and efforts of working with a diverse population?