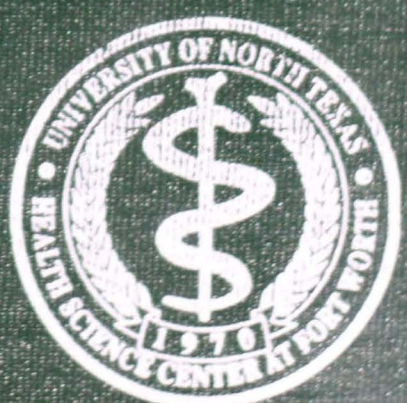
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The American healthcare system largely serves English-speakers, but 21 million Latinos in this country speak limited English. This cross-sectional study examines language laws and patient experiences in overcoming communication barriers. The study's responses suggest lack of awareness of language access rights among Latinos and non-compliance with language laws by some public and private healthcare providers. Communication gaps can result in untreated or misdiagnosed illness, injury or death. However, life-threatening disparities experienced by Latinos could be alleviated if patients learned of their language rights through media campaigns. Medical treatment would drastically improve through the hiring, training and supporting bilingual healthcare professionals; through the strengthening the enforcement of language services laws; and through the allocating funds for cultural and linguistic services in healthcare.

LANGUAGE AND CULTURAL ACCESS SERVICES

FOR HEALTHCARE OF LATINOS:

A STUDY OF THEIR EXPERIENCES

IN DALLAS COUNTY

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LANGUAGE AND CULTURAL ACCESS SERVICES FOR HEALTHCARE OF LATINOS: A STUDY OF THEIR EXPERIENCES IN DALLAS COUNTY

THESIS

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CHAPTER 1

INTRODUCTION

Reducing communication obstacles between a population of patients and its healthcare providers has the potential to increase access to healthcare and improve health outcomes. In a healthcare setting, a communication gap can be dangerous, possibly resulting in injury or death (Flores, 2003). Latinos compose the second largest ethnic group in the United States and nearly half of Latinos living in the U.S. speak English with limited proficiency (Census Bureau 2000). Bridging the language barrier between patient and provider for Latinos with limited English skills is the important public health challenge that this thesis project is addressing. This paper describes a cross-sectional study exploring the experience of a convenience sample of Latinos with limited English proficiency in healthcare settings in the Dallas region.

The U.S. Department of Health and Human Services Office of Minority Health issued the National Standards for Culturally and Linguistically Appropriate Services (OMHRC, 2000), in an effort to close the language gap faced in healthcare situations. The Standards, directed at healthcare providers that receive federal funds, consist of fourteen mandates for the provision of free information and assistance to patients who speak limited English or speak only other language(s) than English. The mandates call for the timely use of bilingual personnel or language interpretation in the patient's primary language and culture. Interpretation must be accessible in all areas of hospitals

and clinics. Patients have the option to bring their own interpreter, as long this individual is not a minor. The mandates also direct that printed forms must be easy to understand and in the primary language of the patient.

Are the rights afforded to people through these laws aimed at reducing communication barriers known to them especially as clients in a clinical setting? This study surveyed a convenience sample of Latinos with limited English proficiency about their experiences related to language assistance in healthcare settings to answer this and other questions (see research questions).

Purpose

The purpose of the study is to describe language and cultural barrier issues experienced in healthcare settings by a Dallas-area Latino population with limited English proficiency.

Research Questions

Primary:

1. What are the study population's experiences with language services in the healthcare settings in Dallas?

2. Do the services differ based on healthcare setting?

3. What level of knowledge does the study population have of their rights to access language and cultural services in a healthcare setting?

Secondary:

4. Does their knowledge differ based on: gender, age, length of time living in the United States, and education attained?

Delimitations

The study is delimitated by:

- Participants who were only from Latino origin
- Latinos who spoke Spanish and spoke no English or spoke English with limited proficiency.
- Participants who were over 18 years of age
- Participants who typically visited healthcare settings in the greater Dallas County Community during the last year.

Limitations

The study is limited by:

- Country of origin from most study sample participants was Mexico.
- The healthcare settings visited by participants were in Dallas County.
- Latinos who spoke no English or spoke limited English.
- Investigator observations of participants' confusion in answering question eighteen of survey instrument.

Definitions of Terms

Latino - The term *Latino* is defined as "all persons living in The United States whose origins can be traced to Spanish-speaking regions of Latin America, including the Caribbean, Mexico, Central America, and South America. Although *Hispanic* has been the official term used by the federal government to refer to these same populations, *Latino* is more inclusive of the indigenous and African cultures' roles in Latin American history (Timmins, 2002).

Limited English Proficient (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled language assistance with respect to a particular type or service, benefit, or encounter (U.S. Department of Justice, 2005).

Language Access Laws - Federal laws particularly applicable to language access include Title VI of the Civil Rights Act of 1964, and the Title VI regulations, prohibiting discrimination based on national origin, and Executive Order 13166 issued in 2000. Many individual federal programs, states, and localities also have provisions requiring language services for LEP individuals (U.S. Department of Justice, 2005).

Language Access Services - For the purpose of this study, *Language Access Services* will refer to the fourth, fifth, sixth, and seventh National Standards issued by the U.S. Department of Health and Human Services' Office of Minority Health (Appendix 1). Language access services are described in these standards as the appropriate actions designed in timely synchronization with locations, procedures, and staff to respond to the needs of LEP individuals in their preferred language.

Culturally Competent Care - For the purpose of this study, *Culturally Competent Care* will refer to the first, second, and third National Standards issued by the U.S. Department of Health and Human Services' Office of Minority Health (Appendix 1). Cultural appropriateness is described in these standards as the provision of care in a manner compatible to the patients' health beliefs and practices, and their preferred language.

Importance of the Study

This study recognized communication barriers as a cause for health disparities and suggested areas of improvement in order to overcome those barriers, and ultimately support the goal of health for all. This study presents the evidence-based status of "rights awareness" and of "language and cultural services performance," which as deducted by the comments of authors Laurie Anderson, et al. (2003), and Timmins (2002), are two preconditions that may help to increase access and quality in healthcare services. The study's findings suggest there is a lack of knowledge by Latinos of their language service rights. In addition, there is a lack of promotion of the laws by as well as attempts to eliminate the communication barriers by the health community sites in the study. The results may provide advocates of minority language rights to find the most effective and efficient ways to improve patient-provider communication and understanding.

CHAPTER 2

LITERATURE REVIEW

Although the United States is a multicultural and multilingual society, the healthcare system in this country is largely geared toward serving English-speakers (Timmins, 2002). According to the U.S. Census Bureau's population count in 2000, more than 46 million foreign-born people reside in the United States. Of those, more than half, or 28.4 million, are Latinos. The 2000 Census found that 21 million of those Latinos over the age of 5 years speak English less than "very well" and 11.9 million households are considered "linguistically isolated," which the government defines as a household in which all members 14 years old and over speak a non-English language and have difficulty speaking English. This segment of the Latino population described here is concentrated in states in the east and southwest regions of the U.S., along with two east coast states, New York and Florida.

The review of the literature revealed few studies in this area other than government regulations and some heath care quality works demonstrating the impact of language barriers on the healthcare of Latinos.

This review serves as background for this study, but literature was not found that directly addresses the success of the enacted language access laws or that defines and enforces these laws as civil rights that guarantee overcoming of the communication barriers for non-English-speakers in the United States.

The areas reviewed include: 1) examples that describe the impact of communication barriers on the healthcare of Latinos in the United States; 2) an overview of the existing language access laws and its afforded rights to provide services aiming to eliminate communication barriers in healthcare settings; 3) attempts and issues in offering appropriate culturally and linguistically services.

Examples of Impact of Communication Barriers on Healthcare

Language and cultural barriers play a significant role in reducing access to healthcare and/or in diminishing quality in healthcare services of Latinos. The Centers for Medicaid and Medicare Services report that language barriers have numerous negative impacts on people who speak limited English or none at all; (CMS 2002). The CMS report stated that patients with linguistic barriers: 1) are less satisfied with care; 2) make fewer visits and receive fewer preventive services; 3) are less likely to use or return to clinics; 4) score lower on health knowledge, and understanding of diagnosis and treatment; and 5) have longer hospital stays.

Glenn Flores, et al., (2003) discuss the harmful effects of language barriers in the delivery of appropriate care. The authors state:

> "studies document that Limited English Proficiency (LEP) patients often defer needed medical care, have a higher risk of leaving the hospital against medical advice, are less likely to have a regular healthcare provider, and are more likely to miss

follow-up appointments, to be non-adherent with medications, and to be in fair/poor health (p. 6-14). "

Findings of a survey released in December 2001 by the Robert Wood Johnson Foundation (RWJF, 2001) established that difficulties Spanish-speaking Latinos and healthcare providers have in communicating with each other contributes to inconsistencies in healthcare treatment and outcomes for this population (Revista Panamericana, 2002).

Lack of medical insurance is a serious concern for the Latino community. A survey of Latino families in San Rafael, California found that 85% of children in the community were eligible for subsidized medical insurance. However, due to parents' lack of information, 28.5% of them were not enrolled (Manos, et al., 2001). Language difficulties may be a cause of Latinos being under-insured or uninsured.

Other studies investigate the impact of cultural and communication barriers to health disparities in healthcare settings. From a different perspective that goes beyond stereotypical discussion of cultural differences, Jacobson (2001) discussed the cross-cultural communication issues between physicians and Spanish-speakers. The author discusses the effects of cultural barriers as an important element in language proficiency, going beyond simply speaking the language. Jacobson states, "if speakers do not share the same norms of usage for speech acts, then there is a greater possibility that the impact of a speaker's words will not be what was intended (2001, p II)."

Overview of the existing language access laws and rights

The Hill-Burton Act issued by Congress in 1946 encouraged economic support of public and non-profit community hospitals and health centers. Receiving economic support forces the recipient hospital to comply with "community service obligation," one of these obligations is not discriminate on grounds of national origin and to provide language assistance to those in need of such services (Goode, et al., 2001).

Nonetheless, national policy regarding the provision of language assistance in healthcare settings is a relatively new development. President Clinton's *Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency* was issued in August 2000. This executive order built upon Title VI of the Civil Rights Act of 1964. Title VI, states "No person in The United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance," (Goode, et al., 2001). President Clinton's executive order acknowledged that without any provision for interpretation services, eligible citizens who do not speak English proficiently face great obstacles to participating in federal programs. President Clinton stated that EO 13166 would address the problem of these populations being excluded, break down barriers, and ensuring access to services (Clinton, Statements by President, 2000).

In response to president Clinton's Executive Order, The U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) issued The National Standards for Culturally and Linguistically Appropriate Services (CLAS, 2000)

(Stinson, 2000), which are organized into three main categories covered by fourteen standards in the following way:

Standards 1, 2, and 3 address the culturally competent care category as recommended mandates for acceptance by national healthcare organizations in U.S.A. (Appendix 1). These mandates recommend organizations ensure that its personnel at all levels know how to provide equitable and effective treatment to all people entering the healthcare system in a culturally appropriate manner.

Standards 4, 5, 6, and 7 address the language access services category as federal requirements to healthcare organizations that are recipients of federal funds (Appendix 1). These requirements serve as general guidelines to know what, when and how to assure the provision and access of language services to patients with limited English proficiency or monolingual Spanish speakers. Some examples of these requirements, among others are: provide language assistance (bilingual staff and interpretation), notifications to patients of rights to free language services, and availability of patient-related materials in their preferred language.

Standards 8, 9, 10, 11 12, 13, and 14 address the organizational support for cultural competence category as recommended mandates for acceptance by national healthcare organizations. The standard 14 was the only suggested for voluntary acceptance (Appendix 1). These mandates describe general procedures for providers to implement appropriate linguistic and cultural services to their patients with language barriers in English. Examples of these procedures among others are: development of strategic plans for culturally and linguistically service implementation, conduct

organizational self-assessments, establish data management information systems, develop process of conflict and grievance resolution.

Important to mention are the Medicaid regulations that require Medicaid providers and participating agencies to offer culturally and linguistically appropriate services. Medicare reimburses hospitals for the cost of the provision of bi-lingual service to patients (CMS 2002). Also, The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals with emergency departments to provide language assistance to persons of limited English proficiency, otherwise, they are potentially liable to federal authorities for civil penalties (Goode, et al., 2001). More over the aforementioned Medicaid and EMTALA regulations is described in a document identified as CMS 10130 from the Department of Health and Human Services about the Section 1011 that provides $250 million per year for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens; (2005)

Issues in Offering Appropriate Culturally and Linguistically Services

The examples above cited, about the impact of communication barriers as a significant factor in injurious and unfavorable outcomes to Latinos' health and healthcare institutions, should be enough evidence to resolve those communication barriers. However, as we will see in proceeding notes, many are the prevalent issues encountered in the attempts to offer appropriate culturally and linguistically services. Many of those issues might be the result of the impact caused by linguistic and power dynamics between majority and minority groups of a society and the fundamental and current philosophical

challenges it creates (May, 2001). Stephen May, describes the process of how language loss and language shifts take place in a multicultural environment. The author points out how the uses of biological, evolutionary descriptions reinforce a widely held view that language loss is an inevitable part of the cycle of social and linguistic evolution, but he adds: "the language loss beyond being a linguistic issue has much more to do with power, prejudice, (unequal) competition and, in many cases, overt discrimination and subordination (p.3-4, 2001)."

More than a decade ago Young (1990) proposed that institutions unknowingly perpetuate discrimination against certain subpopulations of a society with the procurement of oppressive policies and procedures by which they operate. This claim implies that institutions serving the public are given the responsibility to actively promote anti-discriminatory practices. Language policy has long been a controversial issue in the United States, as well as in countries where multilingual populations exists (Schmidt, 2000). In his book, *Language Policy and Identity Politics in the United States*, political scientist Ronald Schmidt declares that policy makers often use language to establish ethnic divisions. The provision of linguistic services for people who speak limited to no English at all in the U.S. healthcare "system" works against institutionalized oppression as mentioned in Young and Schmidt statements.

The importance of the provision of linguistic services to address health disparities is accepted among health services scholars and practitioners (Bauer, 2000; Xuequin, 2000; Jacobs, 2001; Lee, 2002; Bischoff, 2003). However, controversy exists with some provider associations, special interest groups, and policymakers as to whether it is

possible to adequately fund and implement interpreter service programs at the provider level (Asian & Pacific Islander American Health Forum, 2001; The Press Box, 2001).

Political and financial pressures, as well as lack of law enforcement on part of key federal agencies validate Young's (1990) statement that institutions "unknowingly" perpetuate discrimination against certain subpopulations. Such discrimination is reflected in cases of special interest groups, including the American Medical Association (AMA) that denounced the Clinton mandate on the grounds of financial burden to physicians. Despite the challenges, Clinton's Executive Order 13166 still stands as a mandate to support the cause of people with needs of culturally and linguistically appropriate services (Elster, 2003).

Issues raised against the implementation of linguistic services due to cost have been confronted by some organizations. Their calculations reported favorable outcomes with implementation of linguistic services. A recent report from the Office of Management and Budget, estimates that language services would only add an extra 0.5 % to the cost of the average healthcare visit. Moreover, the Centers for Medicare and Medicaid Services (CMS) have informed states that federal reimbursement for language services is available for medical and State Children's Health Insurance Program (SCHIP) enrollees. (Youdelman, 2002; Perkins, 2002).

The cost of reimbursement for language services has been considered reasonable compared to other types of care during 1995-1997. For example, Medicaid expenditures in 1996 for persons with mood disorders, diabetes, or heart disease were from $1,957 to

$2,328, compared with the cost of $279 per person per year for interpreter services (Jacobs et al., 2004).

Another obstacle to providing adequate linguistic services is the lack of access, effectiveness, and quality of the services. Possible substandard language access services to Latinos could be related to Latinos' unawareness of their rights of services for assistance to overcome cultural and linguistic communication barriers in healthcare settings (Timmins, 2002). The quality of interpretation offered is questionable as evidenced studies conducted by the Robert Wood Johnson Foundation (RWJF, 2001). Research also found these services were often improvised or "makeshift" (Revista Panamericana, 2002).

The information gathered in this literature review could partially explain the reasons that: (1) Latinos appear unaware of their rights and the resources to receive assistance to overcome cultural and communication barriers; (2) the lack of effective efforts by healthcare providers to inform the beneficiaries of culturally and linguistically appropriate services; (3) the quality of such services. One strategy to confirm this assumption is to gather information from the recipients of such language services and to describe their experience about language and cultural services received in the healthcare settings they regularly visit, and to assess the knowledge these recipients have of their rights. The results could identify deficiencies in data on the issue, and suggest future opportunities for researchers, practitioners, policy makers, and advocates to design effective strategies to integrate linguistic services into institutions which, in turn, may create better medical outcomes for those whose first language is not English.

CHAPTER 3

METHODOLOGY

This paper describes a cross-sectional study completed to explore the experience of Latinos with limited English proficiency in healthcare settings in the Dallas region.

Sample

The study sample was a total of 191 participants from Latino origin that spoke Spanish and either spoke no English or spoke English with limited proficiency in Dallas County. The participants were recruited in different locations in the Dallas County area (North, South, East, and West). The rationale was to obtain sample participants from different neighborhoods within the study target area.

Protection of Human Participant

All measures were taken to protect the confidentiality of subjects. No participant identifiers (e.g., participant name, social security number, etc.) appeared on the questionnaire. The investigator collected all completed questionnaires from participants. While in transit all data from the questionnaires was kept securely in the possession of the investigator.

All reports and potential publications are reporting aggregate information only-participants are not identified and cannot be identified. Due to the procedures implemented by the investigator, there are no risks of harm to the subjects.

Data Collection

Participants were surveyed on a single occasion with a participant-administered questionnaire. Their participation was voluntary. The instrument was available in both English and Spanish and took approximately 15-20 minutes to complete. The participants completed the survey at different community organizations in the Dallas County area. The sites were geographically spread out within Dallas County to assure sample representation of participants from different neighborhoods of the study's target area. The locations were selected in known areas of high visible presence of Latinos who fit the participation criteria for the study. Most data was collected at the Mexican Consulate from participants who reside in different location within the Dallas County. Participants were also recruited and completed questionnaires at Los Barrios Unidos Clinic in West Dallas; an ESL class in Irving from the organization "Debes Creer En Ti;" and other locations (restaurants, cleaners, and schools) in Richardson, Carrolton, Garland, and Grand Prairie.

The investigator guided the participants through the introductory cover letter. The investigator was available to assist participants who agreed to complete the questionnaire when they needed him. Examples of the types of assistance that the investigator gave were clarifying a survey question, reading the survey aloud, and occasionally helping participants to read the questions and write their responses to the questionnaire. At the end of the survey session, the investigators collected the surveys.

Instrumentation

The investigator developed a questionnaire in Spanish and translated into English to identify current experiences related to language and cultural access services in Dallas County healthcare settings, differences in services by healthcare setting, and knowledge of language rights and by subgroups. The translated version was proof-read by one or more bilingual members in the Health Science Center of the University of North Texas, and authenticated by an official notary in the same University. The questionnaire was administered to a small convenient sample of community residents before used in the at large target area of the study.

The 21-item questionnaire consisted of nine demographic items, ten current experiences related to language and cultural access services items, and two knowledge awareness items. These were the two outcome variables of interest with the potential predictors included for the development of the questionnaire (appendix 2). Most questions were scored on a Likert-type scale ranging from "none" to "all the times". Some of the items' categories were modified from the cultural and language access services profile for purposes of proper analyses.

Data Analyses

After data accuracy and distributional checks were completed, descriptive analyses provided a basic overview of demographic and response characteristics. ANOVA and Chi-squares were computed using an alpha level of .05, which determined the statistically significant difference between healthcare setting type and the various outcomes. Post Hoc comparisons using the Tukey HSD comparison test was calculated to

indicate the differences between the categories of the main factor, and the effect size was measured to the significant results of these comparisons. Secondary analyses were completed by cross-tabulating demographic variables with knowledge, one of the main outcome variables, to determine their association.

CHAPTER 4

RESULTS

Of the 191 Latinos completing the survey, 122 (64.2%) were women and 68 (35.8%) men. The age of participants ranged from 18 to 65+ years (mean=38). Eighty percent identified as Mexicans, and the reminder described themselves as Central Americans (9.5%) and South Americans (7.9%). At least 92% of this population reported to be monolingual Spanish. The length of time living in United States ranged between less than one year and 20+ years, 121 (63.3%) reported between 4-20 year, 42 (22%) less than one to four years, and 28 (14.7%) more than twenty years. The level of education that the study population reported was seventy-three (39%) with high school, forty-eight (25.7%) with elementary school, forty-two (22.5%) with some college, fourteen (5.9%) with bachelor degree and postgraduate studies, and ten (5.3%) with no academic school at all (Table 1).

TABLE 1
Demographic Characteristics of Sample Study Participants

	n	%
Gender		
Male	68	36%
Female	122	64%
Age		
18-25 yrs	40	21%
26-35 yrs	59	31%
36-50 yrs	63	33%
51-65 yrs	20	10%
65+ yrs	8	5%

Table 1 Continued

	n	%
Country of Origin		
USA	4	2%
Mexico	152	80%
Central America	18	9%
South America	15	8%
Other	1	1%
Level of Education		
None	10	5%
Elementary	48	26%
High School	73	39%
Some College	42	22%
Bachelors Degree	11	6%
Post-grad Studies	3	2%
Length in the US		
Less than a Year	7	4%
1-4 yrs	35	18%
4-10 yrs	62	32%
10-20 yrs	59	31%
20+ yrs	28	15%
Typical healthcare		
Public Hospital	87	45%
Private Hospital	18	9%
Public Cmty. Clinic	64	34%
Private Clinic	22	12%
Payment Type		
Private Insurance	23	12%
Medicare	16	9%
Medicaid	12	6%
Employ Ins.	19	10%
Cash	110	59%
Other	7	4%
Preferred Language		
Spanish	177	93%
English	2	1%
Other	2	1%
Spanish/English	10	5%

Research Question # 1:

What were the study sample participants' experiences with language services in the healthcare settings in Dallas County?

Exactly 89.5% of the respondents to this survey question accounted visiting a doctor in Dallas County during the last year minimum one time. In addition, 79% reported using public healthcare settings (Community clinics and/or hospitals) and 21% reported using private healthcare settings (Private clinics and/or hospitals). Ninety-two percent of the participants reported Spanish to be their preferred language at healthcare settings. In contrast, 57% reported that providers speak rarely or never Spanish to them. Twenty-eight percent of the respondents reported to have received interpreter services every time they visited the doctor, and 61% reported to have waited less than thirty minutes to two or more hours for interpreting services at their healthcare setting. In addition, 42% reported to have been allowed to bring a minor as their interpreter, and 65% reported that they had not been culturally offended by providers in healthcare settings. A substantial proportion of study sample participants (69%) described that they did not understand all the forms given by providers, specially the ones requiring their signatures; also (42%) indicated that they did not always understand the doctor's diagnosis and treatment (Table 2).

TABLE 2
Study sample Participants' Description with Language Services

Item	n	%
Language Preferred at Healthcare Setting		
Spanish	172	92%
English	13	7%
Other	1	1%

Table 2 Continued

Item	n	%
Provider Spoke Preferred language		
Always	76	42%
Rarely	94	52%
Never	10	5%
NA	2	1%
Times Attended Doctor Dallas Co./Last Year		
None	19	11%
1-3 times	103	57%
4-8 times	37	20%
9-15 times	11	6%
20+ times	11	6%
Help by Interpreter in Healthcare Last Year		
None	45	25%
Everytime	50	28%
1-3 times	69	39%
4-8 times	13	7%
10+ times	2	1%
Understood Doctor's Diagnosis & Treatment		
Everytime	102	58%
1-3 times	60	34%
4-8 times	8	5%
10+ times	5	3%
Waiting Time when Needed Interpreter		
None	69	38%
Less than 30 mins	55	31%
30 mins to 1 hr	28	16%
1-2 hours	19	11%
Over 2 hrs	8	4%
Allowed to Bring Minors as Interpreters		
Always	26	15%
Sometimes	46	27%
Never	70	41%
Other	30	17%
Understood Written and Given Med Forms		
All	56	31%
Some	76	42%
None	21	11%
N0 - different Lang	28	15%
No Given	1	1%
Have Been Culturally Offended		
Always	11	6%
Sometimes	37	20%
None	119	65%
NA	16	9%

Research Question # 2

Did the services differ based on healthcare setting?

Analyses of variance (ANOVA) revealed significant differences between healthcare facilities on number of times that respondents visited a physician in Dallas County in the last year ($F(3,177) = 3.82$, $p < .02$), and the amount of waiting time when the respondents needed an interpreter ($F(3,175) = 3.30$, $p < .03$). Post Hoc comparisons using the Tukey HSD comparison test indicated that the number of times that respondents visited a physician in Dallas County in the last year was significantly greater at public community clinics than at public hospitals and private clinics ($p < .03$). The effect size between public community clinics and public hospitals was $d = .45$, and public community clinic and private clinics was $d = .39$. Also, post hoc comparisons using the Tukey HSD test indicated that the amount of waiting time when the respondents needed an interpreter was significantly greater at public hospital and public community clinics than at private hospitals and private clinics ($p < .03$). The effect size between public and private hospitals was $d = .25$, and between public community clinics and private clinics was $d = .64$. In addition, there were no significant differences between healthcare facilities for the outcomes of help by an interpreter in the last year ($F(3,175) = 1.80$, ns), and respondents' understanding of doctor's treatment ($F(3,172) = 1.17$, ns)

Chi-square analyses revealed no significant differences between healthcare facilities on respondents' being allowed to bring an interpreter less than 18 years old ($\chi^2(9) = 13.30$, ns). Providers speak preferred language of respondents ($\chi^2(9) = 13.35$, ns). Respondents' understanding writing information given by providers ($\chi^2(12) = 10.98$, ns).

Respondents' answered to have been culturally offended by providers (χ^2 (12) =9.6, ns). Respondents' notified in writing/verbally of language rights by provider (χ^2 (12) =14.02, ns) (Table 3).

TABLE 3
Comparison data on Language Services by Type of Healthcare Setting

	Public Hospital		Private Hospital		Public Com Clinic		Private Clinic	
Item	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Q12 -Times Visited doctor in Dallas County last year	1.27	0.98	1.33	0.76	1.72	1.01	1.04	0.66
Q13-Help by interpreter in health- care site last year	1.37	0.96	0.94	0.87	1.43	0.98	1.05	0.94
Q14-Understood doctor's diagnosis and treatment	1.52	0.73	1.33	0.48	1.34	0.57	1.33	0.65
Q15-Waiting time when needed interpreter	1.24	1.2	0.94	1.1	1.24	1.16	0.4	0.82

Research Question # 3

What level of knowledge did the study sample participants had of their rights to access language and cultural services in a healthcare setting?

A significant proportion of respondents (82%) reported no having any knowledge about their language access rights and cultural services in healthcare settings. In addition, 49% responded that never have been notified in healthcare setting of their language access rights. Further more, 18.2% identified healthcare settings as the source where they

learned about their language access rights, in comparison with 33.3% from the media and 24.2% by themselves (Table 4).

TABLE 4
Sample Participants' responses to Knowledge of Rights & Services

Item		n	%
Notified in Writing/Verbally of Language Srvs.			
	Always	48	27%
	5-10 times	14	8%
	1-5 times	17	9%
	None	88	49%
	NA	13	7%
Knowledge of Language Rights & Srvs.			
	yes	33	18%
	no	151	82%
Source of Knowledge of Language Rights			
	Own	8	24%
	Media	11	33%
	Healthcare facility	6	18%
	Responding this survey	4	12%
	Other	4	12%

Secondary research question # 4

Did their knowledge differ based on: (a) gender? (b) age? (c) time living in the United States? (d) education attained?

The cross-tabulation between the dependent variable (knowledge of language rights and services) and some independent demographic variables (gender, age, national origin, length living in USA, education) indicated a predominant unawareness of language rights in study sample participants. Ten males out of 67 and 22 females out of 116 responded to have knowledge of the language rights. Thirty-three out of 183 participants with

different, age (18–60 plus years), Latino nationalities, length of time living in USA, and education level responded that knew about the language rights. (Table 5)

Chi-square analyses revealed no significant differences between Knowledge of language rights on the following demographic variables: Gender (χ^2 (1) = 0.48, ns), age (χ^2 (4) = 4.43, ns), time living in the United States (χ^2 (4) = 5.63, p = ns), and education attained (χ^2 (5) = 4.5, ns).

TABLE 5
Cross-tabs between Knowledge Language Rights/ Demographic aspects

		YES	NO
Gender			
	Male	10	57
	Female	22	94
Age			
	18-25 yrs	7	32
	26-35 yrs	6	49
	36-50 yrs	13	48
	51-65 yrs	4	16
	65+ yrs	3	5
Country of Origin			
	USA	1	3
	Mexico	28	119
	Central America	1	16
	South America	3	12
Length living in USA	> 1 yr.	1	5
	1-4 yrs	2	32
	4-10 yrs	11	49
	10-20 yrs	11	45
	20+ yrs	8	20
Education Level	None	1	8
	Elementary	10	37
	High School	14	57
	Some College	7	33
	Bachelors Degree	0	11
	Post-grad Studies	1	1

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The findings in this study suggested the need to strengthen the case that the federally mandated bilingual services in medical care must be enforced, improved, and placed as a higher national priority. However, health services research that describes cultural and linguistic access services as a civil right was not found or has not been done until now.

The literature review in this study estimated the extent of some medical errors and other negative effects arising from language barriers in healthcare settings. This indicates that the language-access issues are not only a race and ethnic disparity problem, or a neglected civil right, but also is a quality of care concern.

This study described the experience about language and cultural access services received, and knowledge of rights, of a convenience sample of Latinos. The study sample's participants share similar characteristics, such as, being monolingual Spanish speakers, living in Dallas County, having low level of education, and being older than 18 years old. Therefore, the experience can not be generalized to all groups of people who do not speak English, or speak limited English, neither to participants who visited healthcare settings outside of Dallas County.

In addition it is important to observe that during the data collection, some participants asked for clarification of "cultural offense," when in question eighteen of the survey they were asked, "how many times felt culturally offended during their medical appointments?" once "cultural offense" was clarified, a few of them that had responded "none" changed their answers to reflect occurrence of the item asked. This survey limitation may lead to false responses from other participants who experienced similar confusion and responded the question without asking or receiving further clarification.

In spite of the aforementioned limitations, the study addresses a national priority of reducing health disparities related to one of the 10 leading health indicators identified as priority public health issues for Healthy People 2010, improving quality and access to care. President Bill Clinton, in his Presidential Statement in year 2000, stated that Executive Order 13166 would address the problem of 46 million non-English-speaking s (Census 2000) by preventing their being excluded, breaking down barriers, and ensuring access to services.

However, five years have passed since some language access laws were enacted, and the experience of the participants in the study sample in Dallas County indicated there is room to improve. The findings suggested, as it has been already mentioned, that there is a lack of proper enforcement methods to assure the compliance with those laws. Nevertheless, the enactment of the Culturally and Linguistically Appropriate Services (CLAS) federal mandates, by the Department of Health and Human Services (DHHS) in December 2000, to overcome communication barriers in healthcare setting was victory for language access' advocates.

However, these mandates do not seem being properly implemented according to the reported experiences of the participants in the study sample in Dallas County

Language Access Services Status

The experience of the study sample in Dallas County indicated that 82% of the study sample was unaware of their language access rights and services. Furthermore, 49% claimed not to have heard about their rights in healthcare settings. The non significant association between knowledge of the laws and other demographic aspects from the study sample such as age, length of time in the United States, gender, and education made it easy to assume that healthcare organizations are not compliant with the fifth mandate (Appendix 1) of CLAS. This mandate orders healthcare organizations to inform patients verbally and in writing about their right to receive language assistance services. A similar situation is indicated for the fourth, sixth, and seventh mandates (Appendix 1). The stipulations in these mandates are that healthcare settings must offer and provide language assistance services in timely manner during all hours of operation, prohibits the use of minor children as interpreters, and written materials (forms, prescriptions) related to the patient's treatment should be in the patient's preferred language. These materials must be written in a form that can easily be understood by a patient. This study found that a substantial proportion of its participants (69%) did not understand all the forms given to them by healthcare providers, especially the ones requiring their signatures. And (42%) indicated that they did not always understand the doctor's diagnosis and course of treatment. Forty-two percent (42%) reported to have been allowed to use a minor as their interpreter. Of the study participants, 61% reported

having to wait from less than thirty minutes to two or more hours for interpreting services.

Culturally Competent Care

The aforementioned weaknesses in this study create difficulties to determine the culturally competent care given to the participants in this study. For example, the percentage of 65% who reported that they had not been "culturally offended" by providers in healthcare settings is questionable due to the observation made by the investigator who had to clarify the meaning of "culturally offended" to some participants during the data collection. There is a strong possibility that many answered without further clarification on this item in the questionnaire.

Also, the lack of diversity and proper demographic representation in the staff at healthcare settings were determined only by assumption on the indication given by 92% of the participants in this study who reported Spanish to be their preferred language at healthcare settings, and 57% reported that the providers rarely or never spoke Spanish to them. This providers' limited use of the Spanish language presumes the providers are mostly from different cultures and/or ethnicities than the patients in reference.

The social class aspect is also an important factor to include in relationships among people of Latino/Hispanic background. Many participants in this study informally commented that they had low cultural identification with their interpreters regardless of their ethnic and/or language congruence. The impact of class differences between providers and patients of the same ethnicity and/or language fluency is an area for future research.

Public Healthcare Language Access Services versus Private Healthcare Ones

Seventy nine percent of the study sample participants reported using public healthcare settings and 21% who used private services. The only significant difference between the public and private sectors in language services, according to the Latino study sample participants' experience, was the period of waiting time for an interpreter. The participants indicated the waiting period to be longer at public facilities than at private ones (Table 3) with a small difference between public and private hospitals, and a medium difference between public community clinics and private clinics. These significant differences might be the result of many uninsured Latinos being forced to use public health services over private healthcare. When private medical care was used, Latinos reported seeking treatment from practitioners who speak their same language. This may clarify the small difference between the use of public healthcare clinics versus private clinics. Assumptions that the private healthcare sector neglects the provision of professional linguistic and cultural services is supported by the suggestion in this study of no other significant difference in comparison with the language services of the public healthcare sector in Dallas County. Dallas County is the provider for a great portion of federal funded programs and is significantly more than those programs in the private sector. This implies a greater obligation to implement the federal language access policies.

Recommendations

The indications suggested in the results of this study are that Latinos participants may lack awareness of their rights to overcome cultural and communication barriers in

healthcare settings, services in healthcare settings may have room for improvement, and a lack of proper enforcement may allows noncompliance of the existing language access polices. The risks of these findings were already generally described in the introduction, literature review, and the discussion of this study.

This study suggests participants learn more about their language access rights in the media than in the healthcare settings themselves. It is possible to educate large communities with effective radio and television programs. More attention and support should be given to the bilingual professional in health related areas. Improving bilingual services in healthcare settings has the potential to significantly reduce expenditures for emergency room care and malpractice fees.

Strengthening enforcement of existing polices for language and cultural access services, making the language in the mandates more specific and forceful, creating monitoring systems, and allocating financial resources for cultural and linguistic services in healthcare settings can be preventive measure to curb disparities and improve healthcare for all.

APPENDIX

Appendix 1

National Standards for Culturally and Linguistically Appropriate Services in Healthcare

Standard 1- Healthcare organizations should ensure that patients or consumers receive effective, understandable, and respectful care from all staff members that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2- Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3- Healthcare organizations should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4- Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5- Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6- Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters

and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).

Standard 7- Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

Standard 8- Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

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

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

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

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

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

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

Appendix 2

List of Variables

Variable type	Variable	Definition	Components
Outcomes	Awareness of language rights	Acknowledge knowing about Language services rights.	Yes No
	a) Language services experience	a) Compliance of national mandates 1-3	Likert Scale questions
	b) Cultural services experience	b) Compliance of Mandates 4-7	Likert Scale questions
Predictors	Age	Age in years older than 17 years of age.	Age in years
	Gender	Gender	Male Female
	Length of time living in the U.S.	Number of years living in the U.S.	Total time in years
	Time living in US	0-5 yrs 5-10 10+	Establish length of time in years
	Education Level	Literate Level School accomplished	Options from None – University
	Type of Healthcare Setting	Public Hospital Private Hospital Community Clinic Private Clinic	Establish frequency by times

Appendix 3

SELF-ADMINISTERED QUESTIONNAIRE

Latino Experiences Related to Language Access Rights and Services from Healthcare Settings in Dallas County

Please read each question and check the answer that best tells us about you:

1. Your gender is: 1☐*Male* 2☐*Female*

2. Age in years: 1☐*18 – 25 years old* 4☐*51 – 65 years old*
(If you are less than 18 years 2☐*26 – 35 years old* 5☐*More than 65 +...*
do not complete this questionnaire) 3☐*36 -50 years old*

3. Country of birth: 1☐*USA* 4☐*South-America*
2☐*Mexico* 5☐*Other*_____.
3☐*Central-America*

4. Number of years that you have lived in the United States: 1☐*Less than 1 year* 4☐*10 – 20 years*
2☐*1 – 4 year* 5☐*More than 20 yrs.*
3☐*4 – 10 years*

5. What level of school have you completed? 1☐*None* 4☐*Some College*
2☐*Elementary* 5☐*University degree*
3☐*High School* 6☐*Post graduate.*

6. What type of hospital or clinic do you visit more often? 1☐*Public Hospital* 4☐*Community Clinic*
2☐ *Private Hospital* 5☐ *Other* _____.
3☐ *Private Clinic*

7. What is the name of the hospital or clinic that you go more often? 1☐ 2☐ 3☐ 4☐ 5☐ 6☐
(Fill in the blank)

8. How do you usually pay for your medical services? 1☐*Private Health Insurance* 4☐*Employer-pays*
2☐*Medicare* 5☐*Pay cash*
3☐ *Medicaid* 6☐*Other*_____.

9. Which language or languages do you speak well? 1☐*Spanish*: ☐YES ☐NO
2☐*English*: ☐YES ☐NO
3☐*OtherLanguage*: ☐YES ☐NO__.

Please read each question and check the answer that best tells us about your experience:

10. Which language do you prefer to communicate in when you go to the doctor?

1☐*Spanish*
2☐*English*
3☐*Other language*_____.

11. Do they speak in your preferred language in the medical appointments you have been during the last year ?

1☐*Always*
2☐*Very Little*
3☐*Never*
4☐*Does not apply*

12. How many times approximately have you visited a doctor during the last year in Dallas County?

1☐*1 – 3 times*
2☐ *4 – 8 times*
3☐*9–15 times*
4☐*More than 20*
5☐ *None*

13. How many times in the last year has an interpreter helped you at the hospital or clinic that you went?

1☐*All the times*
2☐*1 – 3 times*
3☐*4 – 8 times*
4☐*More than 10*
5☐ *None*

14. Did you understand your health problems and treatment after talking to your doctor during your medical appointments last year?

1☐*All the times*
2☐*1 – 3 times*
3☐*4 – 8 times*
4☐*More than 10 times*
5☐ *None*

15. How much extra time typically do you have to wait for an interpreter in your medical appointments during the last year?

1☐*Nothing*
2☐*Less than 30 minutes*
3☐*30 minutes - 1 hr*
4☐*1– 2 hrs.*
5☐*2 hrs +*

16. Have you been allowed during medical appointments in the last year to bring as an interpreter someone under 18 years of age?

1☐*Always*
2☐*Sometimes*
3☐*Never*
4☐*Other* _____

Please read each question and check the answer that best tells us about your experience:

17. Has it been easy for you to understand written information specially the information given for your signature when visiting a hospital or clinic? (for example: consent forms for medical treatment).

1☐ *I understand everything*
2☐ *Something*
3☐ *Nothing*
4☐ *It is not in my language*
5☐ *Did not receive any*

18. How many times were you culturally disrespected in your medical appointments during last year? (Example: like criticizing you for not speaking English)

1☐ *All the times*
2☐ *5 – 10 times*
3☐ *1 – 5 times*
4☐ *None*
5☐ *Does not apply.*

19. Have you been informed in writing or verbally of your rights to have an interpreter during your medical appointments in the last year?

1☐ *All the times*
2☐ *5 – 10 times*
3☐ *1 – 5 times*
4☐ *None*
5☐ *Does not apply.*

20. Are you aware of any laws or rights to improve understanding between patients and medical personnel in the United States?

1☐ *YES* 2☐ *NO*

21. If you answered YES to question 20 how do you learned about these laws or rights?

1☐ *On your own*
2☐ *Newspaper/TV/Radio*
3☐ *From a healthcare provider*
4☐ *From answering this survey*
5☐ *Other*_____.

THANK YOU FOR YOUR PARTICIPATION!

Appendix 4

CUESTIONARIO AUTO-ADMINISTRADO

Experiencias de los latinos sobre los derechos y servicios para comunicarse en su idioma en los hospitales y clínicas del condado de dallas

**Por favor lea cada pregunta y marque el cuadro☐ con la respuesta que mejor acuerde con su propia persona:*

1. ¿Usted es...?: 1☐Hombre 2☐ Mujer

2. ¿Su edad esta entre...? *(Si es menor de 18 años no llene este cuestionario)*

1☐18 a 25 años 2☐26 a 35 años 3☐36 a 50 años

4☐51 a 65 años 5☐ Más de 65 años

3. ¿Cuál es su país de origen?

1☐Estados Unidos 2☐ México 3☐América Central

4☐ Sur América 5☐Otro (donde)_____

4. ¿Cuanto tiempo ha vivido en los Estados Unidos?

1☐menos de 1 año 2☐1 a 4 años 3☐4 a 10 años

4☐10 a 20 años 5☐ Más de 20 años

5. ¿Cuánto estudio ha completado?

1☐Nunca estudié 2☐Escuela Primaria 3☐ Secundaria

4☐Algo de Colegio 5☐Grado Universitario 6☐ Postgrado Universitario

6. ¿A que hospital o clínica va usted más seguido?

1☐Hospital Publico 2☐ Hospital Privado 3☐ Clínica Privada

4☐ Clínica Comunitaria 5☐

Otro_____.

7. ¿Como se llama el hospital o clínica a donde va usted más seguido?

_____

(Escriba su respuesta en este espacio)

8. ¿Como paga normalmente sus servicios médicos?

1☐Seguro Médico Privado 2☐Medicare 3☐Medicaid

4☐Seguro de Empleo 5☐Pago en Efectivo 6☐

Otro_____

9. ¿Cuál Idioma o Idiomas habla bien? *(Marque más de un cuadro si necesita)*

1☐Español: ☐SI ☐NO

2☐Inglés: ☐SI ☐NO

3☐Otro idioma: ☐SI ☐NO_____.

**por favor lea cada pregunta y marque el cuadro☐ con la respuesta que mejor muestre su propia experiencia:*

10. ¿En que idioma prefiere que le hablen cuando va al médico?

1☐Español 2☐ Ingles 3☐ Otro idioma_____.

11. ¿Le hablan en su idioma preferido en sus visitas al médico durante el último año?

1☐Siempre 2☐ Muy Poco 3☐Nunca 4☐No corresponde

12. ¿Cuántas veces más o menos ha ido al médico durante el último año en el Condado de Dallas?

1☐1 – 3 veces 2☐4 – 8 veces 3☐9 – 15 veces 4☐ 20+
5☐ Ninguna

13. ¿Cuántas veces le ayudó un intérprete en el hospital o clínica donde fue durante el último año?

1☐Todas las veces 2☐ 1 a 3 veces 3 ☐4 a 8 veces
4☐ Más de 10 veces 5☐ Ninguna vez

14. ¿Después de hablar con el doctor en sus citas medicas del último año le entendió sus problemas de salud y los tratamientos que le recomendó?

1☐Todas las veces 2☐1 a 3 veces 3☐4 a 8 veces
4 ☐ Más de 10 veces 5☐Ninguna vez

15. ¿Cuánto tiempo de más ha tenido que esperar por alguien que interprete en sus citas médicas durante el último año?

1☐Nada 2☐ Menos de 30 minutos 3☐30 mins a 1 hora
4☐1 hr. a 2 hrs. 5☐ Más de 2hrs…

16. ¿Le han permitido traer un interprete menor de 18 años de edad a sus citas medicas durante el ultimo año?

1☐Siempre 2☐ Algunas veces 3☐ Nunca 4☐Otra _____

17. ¿Entiende fácilmente la información escrita que le dan en su hospital o clínica? ¿especialmente la que necesita su firma? *(Ejemplo: consentimiento médico para tratamiento)*

1☐Entiendo todo 2☐ Entiendo algo3☐ No Entiendo
4☐ No están en mi idioma 5☐No recibí información

Appendix 5

Cover Letter for Questionnaire

According to the U.S. Census Bureau 2000, Latinos have become the second largest ethnic group in U.S. and nearly half of this population speaks English with limited proficiency or not at all. This factor endangers their health status because of communication barriers between Latinos and healthcare personnel at medical centers. In spite of government efforts to resolve this issue, it continues affecting a great segment of the Latino population.

It appears that Latinos may be unaware of their right to receive assistance to overcome communication barriers in healthcare settings. Therefore, a faculty member and a student in the School of Public Health of the University Of North Texas Health Science Center are conducting research to describe if Latinos know about their rights to receive assistance to overcome communication barriers and if they experience are receiving this assistance in the Dallas County area.

This questionnaire is for information purposes only. Participation in this research survey is completely voluntary and there will be no way to identify you as a participant since we are not asking for any identifying information. You can return your questionnaire to the investigator as soon as you have finished. **Your choice to participate, or not participate, in this survey will not in any way affect healthcare services that you receive.**

If you have any questions about this survey, please feel free to contact the study director, Dr. Claudia Coggin al UNT Health Science Center at 817/ 735-2360 or to Juan Prieto at 469/ 441-3855, or If you have any question about your rights as a participant in this study, please contact the Director of the Institutional Review Board Dr. Jerry McGill, 817/ 735-5457.

Thank you for your participation.

Appendix 6

Carta de Presentación para el Cuestionario

De acuerdo a los datos de la oficina del Censo del año 2000, los latinos son el segundo grupo étnico más grande en los Estados Unidos. Cerca de la mitad de esta población habla muy poco o nada de inglés. Esto es un problema que pone en riesgo la salud de los latinos, especialmente cuando van al médico, debido a los malentendidos en la comunicación entre muchos de ellos y el personal en los centros médicos. Se sospecha que a pesar de los esfuerzos que ha iniciado el gobierno para solucionar este problema, aún sigue afectando una gran mayoría de latinos.

Los latinos, parece que no están informados o no entienden sus derechos de recibir asistencia para solucionar las dificultades de comunicación en inglés, especialmente en los centros médicos. Por esta razón, una profesora y un estudiante de la Facultad de Salud Pública en el Centro de Ciencias de la Salud de la Universidad del Norte de Texas, están llevando a cabo esta investigación para describir si los latinos, en el distrito de Dallas, están informados de sus derechos a recibir la asistencia mencionada anteriormente y si notan que están recibiendo esa asistencia.

Este cuestionario es sólo con fines informativos. Su participación en esta encuesta es completamente voluntaria y no habrá forma de identificar a ningún participante porque no le estamos pidiendo ninguna información que lo identifique. Al terminar de responder su cuestionario usted puede regresarlo al investigador. **El que usted decida participar, o no participar, en esta encuesta no afectará en ninguna manera los servicios que usted recibe en los centros de salud.**

Si usted tiene alguna pregunta sobre esta encuesta, por favor llame a la directora del estudio, Dr. Claudia Coggin al UNT Health Science Center al 817/ 735-2360 o a Juan Prieto al 469/ 441-3855, o si tiene preguntas sobre sus derechos como participante en este estudio, favor de comunicarse con el director del comité para la protección de los participantes en proyectos de investigación, el Dr. Jerry McGill al 817/ 735-5457.

Gracias por su participación.

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