

SHAMAN INTEGRATION INTO WESTERN HEALTHCARE SERVICES

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Abstract

The objective of this study is to increase Western healthcare service rates among Hmong persons who are currently not receiving culturally sensitive health care from Western providers. Using a simple time-series design, the research team will measure the effects of incorporating Shamans as consultants into Western medical care through multiple surveys administered to providing physicians. The results will offer insight into future studies and may offer a possible solution to developing culturally competent medical resources for Hmong persons living in St. Paul, Minnesota.

Keywords: Hmong, Shamans, traditional healing

Problem

Due to historical and contemporary grievances with Western health and mental health services and a predisposition to traditional Shamanistic healing methodology, many people from Hmong communities will not utilize available Western health care (Hamilton-Merritt, 1992; Warner & Mochel, 1998). Those who do, frequently find providers to be culturally incompetent (in regards to Hmong culture) and their methods to be confusing, backwards, or dangerous; providers that discourage or deny the use of Hmong Shamans further destroy the relationship with and healing of the client (Yang, 1998). As such the problem has risen that Hmong persons are not receiving culturally sensitive health care, thereby increasing risks to their health and wellbeing and discouraging them from using Western resources.

Background

A history of perpetual combat with Asian nations that still continues to this day has created a forced sense of solitude and solidarity among the Hmong peoples (Fadiman, 1997). Those they thought they could trust – namely, the Americans during the Vietnam War – turned their backs on the Hmong at the close of the war and provided medics and missionaries that were less than helpful with their confusing foreign methods (Duddeck, 2007; Fadiman, 1997). When many Hmong sought refuge in the United States they brought with them their suspicion of Western medical and social service practices as well as their distrust of outsiders (Fadiman, 1997). History had taught them to rely only on their own community for support and help, and as such they live in very close, almost impenetrable communities.

Literature Review

Causes

Hmong have had bad experiences with Western practitioners and medicine.

Many Hmong persons have had negative experiences with Western missionary practitioners in camps in Laos during the Vietnam War. The medics took no time to learn of Hmong customs or beliefs and offered very confusing and sometimes harmful treatment (Duddeck, 2007; Fadiman, 1997). When many Hmong sought refuge in the United States they brought with them their suspicion of Western medical and social service practices as well as their distrust of outsiders (Duddeck, 2007; Fadiman, 1997).

Unfortunately, due to various reasons (e.g., cultural incompetence of doctors, mistrust of doctors, forced use of Western medical services), there are still accounts of many Hmong persons who have used Western services with disastrous results (Culhane-Pera, Vawter, Xiong, Babbitt, & Solberg, 2003; Fadiman, 1997). Negative accounts repel Hmong persons from utilizing available health care and social services, thereby limiting their resources to help.

Some Hmong are scared of procedures and do not trust doctors. Cultural differences in medicine between the Western world and Hmong are vast and complex. Many of the procedures Western practitioners do seem outrageous and deadly to the Hmong. What's more, many Hmong are of the belief that American doctors see the Hmong as intriguing experiments and do not treat them the same as American patients (Barrett, Shadick, Schilling, Spencer, Rosario, & Vang, 1998; Hickman, 2006). They therefore think that many of the surgical procedures or operations are experimental and potentially deadly and refuse treatment.

Western medical care and medicines are too expensive. Many Hmong persons feel that Western medical services are too expensive or are more expensive than they are worth (Barrett et al., 1998; Depke & Onitilo, 2011; Liverpool, Alexander, Johnson, Ebba, Francis, & Liverpool, 2004; Offiong, 1999). Sometimes, this is due to insurance issues.

Western practitioners are culturally incompetent. When practitioners are ignorant of Hmong's traditional beliefs and customs, the Hmong may see the practitioner's advice or plan as confusing, backwards, or dangerous. Likewise, if the practitioners do not understand Hmong healthcare, they may misunderstand the purpose or motivation behind Hmong methods of treatment. Also, the lack of translation services for Hmong patients also poses a barrier to effective healthcare, as non-English speaking Hmong persons cannot express their needs well and may misunderstand directions.

Risk Factors

Legal consequences. There are many reported cases of Hmong persons falling into legal problems due to their use of traditional methods or their refusal to use Western services. The family in Fadiman's novel, *The Spirit Catches You and You Fall Down* (1997), for example, was approached by the police many times for ritualistically killing animals in their backyard; and their daughter was taken away by social services when they refused to give her the medicine the doctors prescribed that they thought was killing her. What's more, due to many Shamanistic healing treatments that involve whipping, doctors sometimes think that patients are being abused at home. This is particularly problematic when the patient is a minor.

Hmong patients may misuse medicine. If doctors do not take the time to properly explain the uses and risks of taking a certain medicine, and if the Hmong patients do not think the medicine will help or is helping, the patients may misuse the medicine or not take it at all. Doctors may see this as neglect the parents are responsible for a child patient; and, of course, the patient, regardless of who he or she is, may react adversely if medicine is administered incorrectly or not at all.

Hmong limit their health resources. By not utilizing Western health services, the Hmong limit their available health resources to those within the Hmong community. The study done by Hickman (2006) showed that Hmong persons feel blurred vision, kidney problems, appendicitis, gall stones, broken bones, gout, and illness of the internal organs are more successfully cured by Western medicine. If this is true and Hmong persons do not use doctors to cure these problems, then they are not getting the best and most effective treatment.

Theories

None of the literature indicates the use of a theory for direction or analysis; however, some use a very clear cultural competency framework (Deinard & Dunnigan, 1987; Depke & Onitilo, 2011; Fadiman, 1997; Her & Culhane-Pera, 2004; Hickman, 2006; Liverpool et al., 2004; Uba, 1992). These articles look at the problem and solution from a “needs” viewpoint in terms of what the Hmong patients need and what the Western practitioners need to do. The blame in these instances tends to fall upon the practitioners, implying that they are ignorant of Hmong culture and/or are ignorant of

how to best provide service to Hmong patients. Suggestions for change in these articles always involve some form of accommodation on the practitioner's behalf.

Programs that Have Been Developed in Response to Problem

Only three articles discuss programs that have been made in response to immigrant or indigenous populations not using Western health care due to cultural differences, fear, or cultural incompetency of the practitioners; and of those three only one is in regard to the Hmong. The other two articles discuss integration programs in Nigeria, Ethiopia, and Ghana.

Depke and Onitilo (2011) state two current programs in California designed to better serve the Hmong and propose their own for breast cancer screening, "Cancer Awareness 101" and "Life is Precious." "Cancer Awareness 101" is "the centerpiece of the Asian American Network for Cancer Awareness, Research and Training Hmong outreach" (Depke & Onitilo, 2011), and works to give the Hmong community, particularly the Shaman and elders, baseline cancer knowledge in hopes that they will share the knowledge. "Life is Precious" was a study that resulted in the development and promotion of linguistically and culturally appropriate brochures, flipcharts, and videos about breast cancer. A program as a result of the study also educates men to support their wives through breast cancer screening.

Unfortunately, Depke and Onitilo do not go on to say if either program has been successful or where they stand today. However, the reader can assume that the programs have at least been mildly successful, as Depke and Onitilo assert that, based on those two programs, the new breast program screening program they are trying to develop for

Hmong women absolutely need to incorporate the Hmong community. They emphasize the necessity of including Hmong health care practitioners and male leaders in the program.

Offiong and Rappaport and Rappaport's (1999; 1981) articles on the integration of traditional and Western medicine in Africa demonstrate very successful programs. Their focuses are primarily on Nigeria, although Offiong states that similar programs in Ghana and Ethiopia have also been successful. The majority of persons in Nigeria utilize traditional healers and Shaman instead of Western practitioners mostly for financial reasons, although many Nigerian people have stated that they have a predisposition to use traditional methods of healing (Offiong, 1999; Rappaport & Rappaport, 1981). In response to this, some villages have created treatment programs that incorporate the local medicine man and Shaman as consultants. These programs have been immensely successful.

Gaps in the Literature

The articles that stated or implied that Hmong participants were involved in the research studies all failed to state the ages, genders, religions, time spent in America, incomes, and education levels of the participants. Demographic details were entirely omitted by the author(s), leaving a plethora of questions necessary for clarification and application. Do Hmong men feel differently than women? How do younger Hmong generations feel in comparison to older generations? Are Hmong persons who have lived in America for a certain period of time more accepting of Western health practices? What

about the feelings of Hmong persons with life-threatening illnesses? How many times have the participants seen a Western health practitioner?

The studies also did not note if Shamans or clan leaders participated in the studies. As the participation of Shamans and clan leaders in Western health services is a solution many researches proposed, the opinion of clan leaders and Shamans is instrumental. Are they opposed or in favor of integrating traditional and Western health practices? What would they suggest change or not change? Not all the articles indicated the religion of their participants, either. As a few articles noted (Deinard & Dunnigan, 1987; Hickman, 2006), Christian Hmong feel very differently about traditional Hmong medicine. By not specifying and recognizing the participants' religions, the researcher studies two very different subcultures and applies the results to all. Any incongruences may consequentially be attributed to an incorrect reason or not analyzed at all.

Furthermore, no article used more than thirty Hmong participants, and the participants were all only from one city in each study. Using such a small and confined pool of participants severely limits the ability to apply any results to a larger population.

Consistencies and Inconsistencies

There are various and multiple themes within the literature due to the diversity of the articles, so little can be said to be true of every piece. Regarding the question of what causes the problem: there are different viewpoints, but none fully contradict another.

Over half of the literature reviewed (Deinard & Dunnigan, 1987; Depke & Onitilo, 2011; Fadiman, 1997; Her & Culhane-Pera, 2004; Hickman, 2006; Uba, 1992) asserts that Hmong persons are scared or hesitant to use Western treatments due to cultural

differences regarding health, and over half of the literature states reasons of cultural incompetency in Western health care practitioners (Fadiman, 1997; Deinard & Dunnigan, 1987; Her & Culhane-Pera, 2004; Hickman, 2006; Uba, 1992). A couple of articles (Barrett, Shadick, Schilling, Spencer, Rosario, & Vang, 1998; Hickman, 2006) note that many Hmong patients feel American doctors do not treat them the same as their American counterparts and see Hmong patients as experiments. Furthermore, a few articles (including those about integration of medical practices in Africa) insist that the high expense of Western medicine and healthcare deters persons from utilizing their services (Berrett et al, 1998; Depke & Onitilo, 2011; Liverpool et al., 2004; Offiong, 1999). Of course, some of the literature also mentions the Hmong's shady history with American medics during the Vietnam War (Duddeck, 2007; Fadiman, 1997).

A few articles (Berrett et al, 1998; Hickman, 2006; Offiong, 1999), however, note that many Hmong persons use both Western and traditional healthcare systems, although exclusively or usually by younger generations. One of those authors, Hickman (2006) strongly insists that the majority of Hmong persons use Western medicine more than traditional medicine, although he later contradicts himself by stating that many Hmong persons are still scared to go to the American doctor for various reasons.

Proposed solutions to the problem seem to be split between incorporating Hmong community members in healthcare decision-making (Barrett et al., 1998; Depke & Onitilo, 2011; Her & Culhane-Pera, 2004; Rappaport & Rappaport, 1981; Uba, 1992), integrating Shamans into Western healthcare as co-providers or representatives (Barrett et al., 1998; Depke & Onitilo, 2011; Hickman, 2006; Liverpool et al., 2004; Offiong, 1999; Rappaport & Rappaport, 1981), training Hmong providers (Hickman, 2006; Liverpool et

al., 2004;), and training Western practitioners to be more culturally competent (Deinard & Dunnigan, 1987; Her & Culhane-Pera, 2004; Uba, 1992). Many articles indicate that the Hmong should be able to retain their traditional culture, and Western providers should therefore work to accommodate them (Her & Culhane-Pera, 2004; Uba, 1998). It should also be noted that one article (Deinard & Dunnigan, 1987) mentioned that some clinics have tried placing Hmong interpreters in intensive training programs on Western medical concepts with the intention of using them as consultants to the Hmong patients. It proved highly unsuccessful and problematic as the interpreter constantly felt pulled in two directions.

Research Questions and Hypotheses

This study is primarily exploratory, as very little research has been done on the topic. Research questions explored in this study are: is the introduction of Shamans into Western healthcare associated with increased service use by Hmong persons? For what situations do Hmong persons use Western healthcare services? Does age play a part in the frequency of use of Western healthcare services among Hmong persons?

Hypotheses explored in this study are: 1) the incorporation of Shamans into Western healthcare services will be associated with increased services rates by Hmong persons, and 2) a lack of Shamans will be associated with Hmong persons only using Western healthcare services for life-threatening emergencies and terminal illnesses.

Additionally, it is expected that age and English-speaking ability will be moderating factors with regards to increased service use, and increased faith among Hmong persons in the service they will receive from Western healthcare providers will be a mediating factor

Research Design

For the purposes of this experiment, a quasi-experimental design will be employed – specifically, a simple time-series design, as a control group is not needed. It is necessary to assess the dependent variables (DV) – that of increased service rates (as per hypothesis 1) and service use only for life-threatening emergencies and terminal illnesses (as per hypothesis 2) – pretest and posttest in order to determine if Western healthcare service use by Hmong persons has increased, and it would be even more useful to know how service use will change over time (a point-in-time observation before and after the test may not be truly representative of the long-term results); so a simple time-series design is therefore practical and useful.

In the simple time-series design there will be multiple observations of the DVs pre- and posttest – or, in other words, before and after the interventions – to measure the DVs over time. The interventions (i.e. the independent variables [IV]) in this case are the introduction of Shamans (as per hypothesis 1) and the lack of Shamans (as per hypothesis 2). The notation is

O1 O2 O3 X O4 O5 O6 O7 O8 O9 O10 O11 O12 O13 O14 O15

Due to the nature of the simple time-series design, the study is longitudinal.

Strengths and Weaknesses

Simple time-series designs are feasible and less expensive than other experimental or quasi-experimental designs, because they do not require a control or comparison group. Also, because they track results and observations over time, the likelihood of alternative explanations or interventions being attributed to the posttest results is reduced. For this same reason, simple time-series designs also allow for the

researcher to obtain a more accurate idea of the influence of the intervention (IV) and the pattern of variability over time (Grimshaw, Campbell, Eccles, & Steen, 2000).

On the other hand, time-series designs are very time consuming, and for this reason there is a greater chance of participants dropping out of the study. It is also necessary that an appropriate and significant amount of observations be conducted in order to reach more accurate results. The design also does not provide protection of other events contributing to the posttest results and has less internal validity (Grimshaw, Campbell, Eccles, & Steen, 2000).

Sampling Strategy

Sampling method

Since this is a relatively small explorative study, nonprobability sampling methods – specifically, purposive sampling – will be utilized. By using this method, the research can target Western healthcare facilities that are located in densely Hmong-populated areas. Since funding limits the number of facilities that we can study, random sampling is not feasible. If more facilities could be studied, probability sampling methods could be utilized for higher reliability.

Population

The sampling frame is Western healthcare service physicians in St. Paul, MN. Participants will be both male and female, ages 25 to 75, and of any racial or ethnic background and sexuality. Due to the nature of the profession, participants will likely have a higher education and a salary of at least \$80,000 and speak fluent English. There will be an anticipated 50 participants.

Variables

In this study there are two IVs, two DVs, two mediating variables, and one moderating variable. In testing the first hypothesis, the IV is the introduction of Shamans and the DV is increased service rates. The IV is conceptualized as a healthcare facility employing (as a volunteer or paid employee) a Hmong Shaman to assist healthcare staff in serving Hmong patients. It is operationally defined for the purpose of this study as a healthcare facility employing (as a volunteer or paid employee) a Hmong Shaman as a consultant to physicians with job duties of, but not limited to: translating, counseling, educating physicians of Hmong cultural practices, acting as liaisons and peacekeepers, addressing patient concerns, and performing alternative traditional healing methods in addition to modern methods when appropriate. The DV is conceptualized as more Hmong persons seeking services at healthcare facilities than prior to the introduction of the IV. Operationally defined, the DV is a 10% or more increase in Hmong patients in participating healthcare facilities within one year of the introduction of the IV. Service rates only include Hmong patients who actually saw a physician or nurse by appointment or walk-in.

In testing the second hypothesis, the IV is a lack of Shamans and the DV is service use only for life-threatening emergencies and terminal illnesses. The IV is conceptualized as Western healthcare facilities not having enough Shamans to serve the Hmong patients. It is operationally defined as having no Shamans employed (as a volunteer or paid employee) on staff at Western healthcare facilities. The DV is conceptualized as Hmong persons only going to see a Western healthcare practitioner for emergencies. The operational definition is Hmong persons only seeking service (determined by healthcare facility intake records) from Western healthcare practitioners if

they (Hmong persons) are in a life-threatening emergencies or have a terminal illness and not for routine care.

Moderating variables are age and English-speaking ability. Age is both conceptually and operationally defined as how many years one has been alive; however, for the purpose of this study, age will be determined by the age listed on the patients' intake forms or by verbal statement of the patients. English-speaking ability is conceptualized as one's proficiency in the English language. For this study, English-speaking ability is operationally defined as beginning, intermediate, advanced, fluent, or native proficiency, determined by the healthcare staff's estimation through verbal communications with the Hmong patients.

A mediating variable is increased faith among Hmong persons in the service they will receive from Western healthcare providers. It is conceptualized as Hmong persons believing they are getting better service from Western healthcare providers. In this study it is operationally defined as Hmong patients feeling they are receiving more quality service from their Western healthcare providers than prior to the introduction of Shamans.

Measurement Instruments

Surveys will be used to measure service rates before and after the introduction of Shamans. Qualitative and quantitative questions in surveys will provide the research team with information regarding current service use of Western healthcare by Hmong persons, for what situations Hmong persons use Western healthcare services, and what level of faith Hmong persons put in Western physicians. Pretests can also acquire information as to what services that take into consideration cultural differences are currently being

provided to Hmong patients in Western healthcare facilities. The pretest information – specifically the current rates of Western healthcare service use by Hmong persons – will set the stage for the intervention and be a comparison for the posttest results.

An individualized survey will be created for the purposes of this study. Questions will be qualitative and quantitative. Types of question asked on the survey include but are not limited to: current service rates, demographics of Hmong patients, for what reason Hmong patients are seeing practitioners, criticisms of services from Hmong patients, and perceived attitudes towards and faith in Western healthcare providers by Hmong patients. The “Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (see Appendix),” will be used in pretest surveys to assess cultural competency.

Reliability and Validity

Surveys are beneficial in research because they: are relatively inexpensive; can be administered from a distance by telephone, email, or mail; can ask qualitative and quantitative questions and multiple questions at one time; offer standardized questions; have high levels of generalizability and reliability; and are able to reach large populations. Surveys also enable the research to “analyze multiple variables simultaneously” (Rubbin & Babbie, 2010).

The downside to surveys is that: they cannot always point to a cause; they limit question response and explication and may overlook context; they are subject to random error, cultural bias, and social desirability error; they have low validity; it is sometimes hard for participants to recall memories or past events; and the researcher is forced to develop questions that are broad and general if the sampling population is large as to be applicable to multiple participants (Rubin & Babbie, 2010).

Data Collection

Three Western healthcare facilities in high Hmong population areas (determined by census statistics) in St. Paul, MN will be chosen by using purposive sampling. I will contact the facilities' Human Resources staff and Program Director and explain my desired study. I will then ask for names of physician staff in the facilities that I could reach out to and then personally call and email the physicians provided to me, describing in detail the purpose and scope of the study and asking for participation. Those who agree will participate in three pretest surveys two months apart, starting in March and ending September. In September Shamans from the Hmong community will be introduced into the facilities as consultants to physicians. Every two months thereafter for the following year the research team will conduct posttest surveys (given to the same physicians) asking the same questions given in the pretests.

Ethics

Risks in this study are minimal: anxiety and discomfort sharing responsible with new staff (i.e. Shamans) and stress from extra work during busy schedules. Our research team will offer assistance in managing data collection (should the facilities allow) to ease the burden of extra work. Confidentiality is the largest issue. The research team will make sure all terms and conditions are understood by the physicians before obtaining written consent to maintain confidentiality.

Discussion

Hmong persons are currently in deep need of culturally sensitive healthcare services, as miscommunications and cultural clashes have and continue to lead to serious negative consequences in Hmong patients. Furthermore, the lack of culturally competent

services has caused Hmong persons to avoid using Western healthcare services, which limits resources for care. This study aims to find a possible solution through the incorporation of traditional healers – Shamans – into Western healthcare services. The research team will survey physicians at three different healthcare facilities in St. Paul, Minnesota to determine pre-test service rates of Hmong patients, for what situations Hmong persons seek services, and current perceived levels of faith Hmong persons feel they receive among other relatable questions. Shamans will then be employed by the facilities as consultants, and posttest surveys will be administered every two months thereafter for the following year to observe changes in the survey results.

Limitations

Internal validity. This study has a high degree of internal validity; however, extraneous events may occur during the course of the study that may confound the results. This may be an outbreak of some illness in the Hmong community that may cause Hmong persons to seek help from Western clinics; or possibly many Shamans in the community may die, leaving Hmong persons fewer healthcare options. These are only two examples, but there could many more. There is no sure way to prevent extraneous events from affecting the study; however, we (the research) team will ask participating physicians to keep a sharp eye out for emerging patterns that might indicate other reasons (i.e. other than the introduction of Shamans) why there could be a sudden influx in Hmong patients seeking services. The research team (at least two members of the research team will be Hmong) will also do their best to stay in tune with news in the Hmong communities (they will do this by reading flyers and newspapers in the Hmong

communities) to identify any events that may trigger a need for Hmong persons to utilize Western healthcare services.

External validity. Unfortunately, this study has low external validity, as such as small sample is being used, both in number and geographical area. At best, the results could be applied to the Minnesota and Wisconsin states, as the two states share similar culture, weather (which can affect physical and mental health), hospitals, Hmong population, and even resources. Furthermore, due to proximity and immigration history, many Hmong persons living in Minnesota have family living in Wisconsin. This is an exploratory study with limited funding, so unfortunately, the extent to which we can generalize the findings is limited. With the development of future studies, external validity will become higher.

Other limitations. Because this study strictly focuses on incorporating Shamans into healthcare services (operationally defined in this study as strictly medical clinics and hospitals), the results cannot be generalized to social or mental health services. Also, time-series designs are very time consuming, so there is a greater chance of participants dropping out of the study.

Strengths

Design. To briefly reiterate the strengths of our design choice, it is inexpensive and feasible (in comparison to other experimental or quasi-experimental designs) because we will not be using a control or comparison group. Also, the likelihood of alternative explanations or interventions being attributed to the posttest results is reduced, because we track results and observations over time. Our chosen design also allows for our research team to obtain a more accurate idea of the influence of the intervention (IV) and

the pattern of variability over time. This will help counter the limitations previously discussed. Additionally, by using a survey as a measurement tool, we can ask qualitative and quantitative questions and analyze multiple variables at once.

Other strengths. There is a large body of literature backing the severity of the problem and the current limitations. Also, the St. Paul-Minneapolis metro area has the largest population of Hmong persons in the nation; so even by being able to generalize the results to that specific area, we are able to target a large percentage of the Hmong population in the United States. Likewise, the availability to Shamans that could be interested in participating is higher than in other areas of the United States, and more physicians may be willing to participate due to more frequent contact with Hmong persons outside of work than other physicians living in other areas of the United States. They therefore may better understand the need for such services that would be implemented in this study.

Implications for Social Work, Human Rights, and Social Justice

By refusing Hmong the use of Shamans or Shamanic healing practices, one denies them their right to free practice of religion and prevents them from achieving basic human needs, such as physical and mental health. Furthermore, by forcing clients to use only Western methods, one denies the client his or her right to self-determination and autonomy and forces a culture to assimilate.

Incorporating Shamans into Western healthcare will allow Hmong persons to access additional, valuable medical services while significantly decreasing the risk of miscommunication and culturally incompetent service. Allowing Hmong persons to use

both Shamans and Western physicians also helps Hmong persons to preserve and continue maintaining their traditional culture.

Directions for Further Research

The results of this study would lead the way for future research on incorporating traditional healing methods into Western healthcare services, Shamanistic or otherwise. If this researcher's hypothesis is correct and the results of this study indicate increased service use by Hmong persons, additional studies should be conducted spanning a larger geographical area and sampling more healthcare facilities and physicians. Recommended cities would include: Bloomington, MN; Minneapolis, MN; Eau Claire, WI; Milwaukee, WI; Wausau, WI; and Fresno, CA.

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Appendix

CONDUCTING A CULTURAL COMPETENCE SELF-ASSESSMENT

Developed by^[1]_[SEP]Dennis Andrulis, SUNY/Downstate Medical Center, Brooklyn, NY In collaboration with^[1]_[SEP]Thomas Delbanco, Beth Israel Deaconess Medical Center, Boston, MA Laura Avakian, Massachusetts Institute of Technology, Boston, MA

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CONDUCTING A CULTURAL COMPETENCE SELF-ASSESSMENT

Developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian and Yoku Shaw-Taylor

PURPOSE

There are several reasons why a healthcare organization may wish to conduct an audit of

its cultural competence. First, it may want to validate its understanding of the ethnic and cultural composition of its patient and employee populations. Further, it may seek to identify the unique attributes of a given cultural group to ensure access, appropriate treatment and effective communication between providers and patients. Additionally, the audit may reveal opportunities for the organization to make itself more attractive to diverse populations, thereby enhancing its marketing capabilities as well as strengthening its ties to community. Most important, the very act of conducting the self-assessment is a statement to the workforce, patients and community that the organization values diversity and desires to increase its cultural competence.

HOW TO CONDUCT THE SELF-ASSESSMENT

A. Create a task force of stakeholders

Ultimately, quite a number of people will be involved in the process because you will want to scan the breadth and depth of the organization. However, the audit should be led by a small committee

that represents certain key functions or departments. A typical self-assessment team consists of 8

to 12 people.^[11] On the audit team should be individuals who can access and interpret data addressing the

composition of the patient and staff population. Team members may come from finance, admitting, patient registration, human resources, information systems, or administration.

Additionally, there should be individuals whose jobs are directly concerned with ethnic/cultural

issues, i.e. diversity coordinators, translators/interpreters, social workers, community relations and employee relations specialists, and clergy. Different clinical disciplines should also be represented:

doctors, nurses, therapists. The team may benefit by inviting patients or representatives of your community as members. The team itself should also reflect ethnic/cultural diversity.

B. Select a task force leader

Who serves as leader of the assessment team is an important decision. He or she should be an

individual who is well-positioned within the organization—one who has access to people at all

levels and information from all sources. He or she must be credible, respected, and generally regarded as sensitive to diversity issues. Equally important is the explicit support for this initiative

from the CEO and other prominent leaders. They can demonstrate such support through written

and verbal communication, as well as by devoting time and other resources needed to conduct the audit.

STEPS IN THE SELF-ASSESSMENT PROCESS

There are generally five steps in the self-assessment. However, organizations will vary the time spent or depth of inquiry at various stages of the process.

Step 1

(a) (b)

(c) (d)

Step 2 (a) (b)

Step 3 (a)

(b) Step 4

(a) (b)

Step 5 (a)

(b)

Organization

The CEO appoints the team leader and task force. ^[L]_{SEP}CEO and other organizational leaders affirm the project team's charter.

The task force develops a timeline for the entire project. Individual task force members take assignments.

Completing the Questionnaire

Task force members determine who is best able to complete each section of questionnaire and takes responsibility for its completion. Task force members discuss what supplementary materials may support the information provided in the questionnaire (e.g. patient information pamphlets) and take responsibility for obtaining them.

Interviews

The task force reviews and discusses findings from the questionnaire. Based on those results, the task force determines what individual or group interviews should be conducted to explore further some issues identified in the questionnaire or to clarify areas that are ambiguous. Members of the task force decide who will complete each of the interviews. (Possible interview subjects and exploratory questions are suggested below.)

Evaluation of Results

The task force reviews the data from the questionnaire and the interviews.

Drawing on the data and analyses, the team decides where the organization fits along the “spectrum of cultural competence.”

Report and Action

Depending on the charge given the team in Step 1, the task force discusses its findings with

multiple audiences. These findings are often offered in a written report to the CEO or a

Board committee.^[1]^[SEP]In addition to a self-assessment of overall cultural competence, the report will likely

include specific recommendations for actions to be taken, identifying who would be accountable for taking the actions.

3

HOW LONG DOES THE SELF-ASSESSMENT TAKE?

Depending on the availability of data and the complexity of the organization, the entire self-

assessment can be completed in three to six weeks. Completing the questionnaire and conducting the interviews can be simultaneous if desired.

THE INTERVIEWS

There is no magic number of interviews, but individuals from each of the following groups should contribute:

Board of Trustees Administration

Community leaders Patients

Translators/interpreters

Social Workers

Nurses^[L]Physicians Emergency Unit staff Diversity trainers

Dietitians^[L]Admitting and registration staff

Human Resources staff Marketing staff

Community Relations staff Clergy

Maintenance/housekeeping staff

Public Relations staff

Patient advocates Union leadership

Before the interviews are scheduled, the CEO should issue a general announcement about the

assessment, its purpose, and what the organization will do with the results. Members of the

committee should contact the interviewees, emphasizing that each interview is confidential and that results will be shared only in aggregate form. The interview will generally last 15 to 45 minutes, and

participants should be encouraged to bring along relevant data, materials etc. Invite them to show you materials such as patient information pamphlets, special menus, translated

newsletters, etc.

In general, the interviews should elicit information about those policies and practices that impact on ethnic/cultural competence. They should identify both support and barriers to ethnic/cultural

competence. Additionally, they provide the opportunity to learn about individuals' opinions and

attitudes about this subject and to explore related areas that may not be covered in the questionnaire. Interview questions are suggested below. You will want to add or delete some based on your particular findings and interests.

SUGGESTED QUESTIONS FOR INTERVIEWS*

The following are questions that might be posed to individuals both within and external to the organization who are interviewed as part of the self-assessment process. The purpose of the interview is to add the dimension of personal experience to the information gleaned from the questionnaire and to identify unexplored areas. While many of these questions are covered in the questionnaire, additional insights will be obtained as the interviewees address these questions in terms of their experience and the context of their jobs.

Along with data reported in the questionnaire, these answers will help your organization assess its overall cultural competence and identify steps for action. These questions may be supplemented by others suggested by the committee. Also, interviewees may wish to

discuss other aspects of diversity and/or share written materials with you.

4

QUESTIONS

- When you hear the term “cultural competence,” what comes to mind?
- What are the most challenging priorities of the multi-ethnic and cultural nature of the healthcare organization?
- What are the major organizational obstacles (policies, organizational characteristics) inhibiting ^{[[]]}_{SEP} ethnic and cultural understanding among staff, patients, providers, etc.? What are the major ^{[[]]}_{SEP} organizational characteristics that enhance the multi-ethnic and cultural nature of the healthcare organization?
- As the healthcare organization has attempted to meet the needs of ethnic and cultural diversity, what issues have arisen (need for resources, conflict, etc.)?
- What mechanisms, if any, are in place that promote communication among different levels and departments of the healthcare organization in regard to issues of cultural competence?
- What has the healthcare organization done to provide the best care for the multi-ethnic and ^{[[]]}_{SEP} cultural patient population (e.g. educating providers in regard to different ethnic/cultural beliefs and practices; use of specific services—interpreters, community liaisons, etc.)?

- In what ways have you addressed the ethnic and cultural needs of patients as they receive care throughout the continuum (home health, social services, etc.)?
- What services, programs, etc. are available to staff regarding ethnic/cultural-related issues?
- In what ways are providers trained and helped to deal with ethnic and cultural issues (e.g. ^{[[[]]]}_{[[SEP]]} trained to recognize diseases common in certain populations, mechanisms and protocols by ^{[[[]]]}_{[[SEP]]} which providers can request assistance in dealing with ethnic/cultural patient issues and needs)?
- What relationships does the healthcare organization have with particular community groups ^{[[[]]]}_{[[SEP]]} and how have these relationships affected the ethnic/cultural competency effort (community businesses under contract, initiatives with neighborhood health centers, etc.)?
- What community outreach actions have been taken by the healthcare organization (e.g. health ^{[[[]]]}_{[[SEP]]} education programs, materials and forums for various ethnic/cultural groups, community support for patients of various ethnic/cultural backgrounds)?
- In what ways are ethnic and cultural differences recognized throughout the healthcare ^{[[[]]]}_{[[SEP]]} organization (e.g. celebration of certain days, programs focused on specific health needs of a particular group)?
- What, if any, ethnic/cultural professional programs are there to develop, as well as attract staff? Are internships targeted toward ethnic professionals? Mentoring programs? What are the challenges in developing and delivering these programs?

- What government guidelines or regulations guide or influence your programs and initiatives regarding ethnic/cultural diversity and cultural competence?

5

- What are the greatest strengths and the biggest concerns of the healthcare organization in [SEP] regard to the delivery of care to and interactions with the multi-ethnic/cultural populations of its community?
- What have you seen or would you like to see in terms of actual effects of ethnic/cultural initiatives on the work environment and on patient care?
- What are your concerns about any of the ethnic/cultural activities undertaken by your organization?

*(Acknowledgment is given to Deborah Dwork, Employee Relations Director, Beth Israel

Deaconess Healthcare organization, Boston, MA, who developed many of the above questions for use in its self-assessment.)

6

HOW THE QUESTIONNAIRE IS ORGANIZED

The questionnaire is divided into three sections, each with distinct features.

Questions in Section 1 relate to the ethnic/cultural characteristics of the staff and

organization.

There are two sub-sections covering the following: (a) board, staff, and patient/community profiles; and (b) healthcare organizational recognition of diversity needs.

Questions in Section 2 relate to healthcare organizational approaches to accommodating diversity

needs and attributes. There are three sub-sections covering the following areas: (a) diversity training; (b) human resource programs; and (c) union presence.

Questions in Section 3 are dedicated to healthcare organizational links to the communities you

serve as well as patient and staff diversity initiatives. This section is divided into five parts: (a) healthcare organizational links to community; (b) organizational adaptation to diversity; (c)

database systems and data development; (d) language and communication needs of patients and staff; and (e) business strategies attracting patients from diverse cultures.

USING THE RESULTS

This self-audit will help an organization evaluate where it sits within a “spectrum of cultural competence.” However, it is important that the team completing this assessment not view it as a quiz with a set of perfect answers. It is, rather, an opportunity to consider candidly the extent to which the healthcare organization is meeting the needs of diverse

populations, both patients and those in the work force. The findings will, in themselves, suggest actions an organization may take to improve its cross-cultural competence. The results of this internal review will help the healthcare organization gain a broad perspective of its policies, programs and procedures relevant to ethnic and cultural concerns. Please refer to the accompanying scoring guide for data analysis and interpretation.

7

PART 1: ETHNIC/CULTURAL CHARACTERISTICS

This section contains questions on the characteristics of your staff and the healthcare organization.

Questions relate to two broad areas: staff profiles and healthcare organizational recognition of diversity needs.

PART 1A: BOARD, STAFF AND PATIENT/COMMUNITY PROFILES

1. Ethnic and Cultural Characteristics - For each of the five ethnic/cultural groups, please provide percentages, estimates or ranges for the past fiscal or calendar year. Base responses on the past

fiscal or calendar year. Please indicate whether (1) fiscal year: from _____ to _____, or (2) calendar year: from _____ to _____

"	"	"		
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	Administration / Management	Support Staff	Board Members	Non-Physician Providers
African-American*				
Asian/Pacific Islander				
Hispanic/Latino				

European- American**				
American Indian/ Eskimo/Aleut				
" Total 100% "	" "	" " "	" " "	" "

* Includes persons of Caribbean descent and non-Hispanic ** Non-Hispanic

"	"	"		
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	House Staff	Attending Physicians	Patients by Discharge	Community Characteristics
African-American*				
Asian/Pacific Islander				

Hispanic/Latino				
European-American**				
American Indian/ Eskimo/Aleut				
Total 100%				

* Includes persons of Caribbean descent and non-Hispanic ** Non-Hispanic

2. To what degree do your board members reflect the ethnic/cultural characteristics of your community?

12345

almost a somewhat not at all perfect match

3.

4.

Has the administration identified ethnic/cultural competence as an organizational concern? Yes No

In what ways has the administration identified ethnic/cultural competence as an organizational concern?

6.

Has the board/administration adopted a mission or goals statement that explicitly Yes No (if no, skip to Q 8)

To what degree does this statement reflect the current issues and concerns of the organization?

12345 completely somewhat not at all

5. ^[L]_[SEP] incorporates a commitment to cultural diversity?

7. ^[L]_[SEP]Year _____

What year was this done? Please attach the mission statement, or type in sections that address this.

9

PART 1B: HEALTHCARE ORGANIZATIONAL RECOGNITION OF DIVERSITY NEEDS

8. What are the major organizational characteristics that inhibit ethnic and cultural understanding among staff, patients, providers? Attach extra sheets if necessary.

	<p>Administration/ Support Staff</p>	<p>Patients</p>	<p>Providers- Physicians/ Nurses</p>
--	--	-----------------	--

<p>Characteristic #1</p>			
<p>Characteristic #2</p>			
<p>Characteristic #3</p>			

For example: Facilities are spread Communication difficulties Signage and

across broad geography for non-English speaking patients communication problems

9. To what degree are there strategies in place to recruit/retain actively a culturally diverse management/administration?

12345 high somewhat not at all

10. To what degree are there strategies in place to recruit/retain actively a culturally diverse

support staff?

12345

high somewhat

not at all

10

11. What are these strategies?

	Management/ Administration	Support Staff
--	----------------------------	---------------

Strategy #1		
Strategy #2		
Strategy #3		

For example: Minority search firm Mentoring^[1]12. Are ethnic and cultural practices of minority staff accommodated through:

- (a) Time off for religious observance? Yes No

. (b) Dietary/Cafeteria preferences? Yes No

. (c) Holidays? Yes No

. (d) Other _____ Yes No

(please specify)

13. Overall, to what degree does the healthcare organization accommodate needs and preferences of ethnic and cultural staff?

12345

completely somewhat

not at all

11

14. An organization can identify several ways to increase cultural competence. Below are potential initiatives and areas in which organizations address diversity. To what extent has

your healthcare organization identified these and other areas? Please use the following scale in responding.

12345 great extent somewhat not at all

. (a) Awareness of cultural issues in establishing measures for attracting and retaining minority & female staff

- . (b) Awareness of cultural issues in improving achieving outcomes related to low birth weight, prenatal care utilization, immunization rates, etc.
- . (c) Cultural awareness/participation is recognized as important factor in decision making
- . (d) Soliciting minority input in developing programs, models, guidelines and training materials
- . (e) Long-term commitment to achieving cultural competence has been established
- . (f) Other (please specify)

12

**PART 2: HEALTHCARE ORGANIZATIONAL APPROACHES TO
ACCOMMODATING DIVERSITY NEEDS AND ATTRIBUTES**

This section contains questions on how your healthcare organization addresses diversity needs. Questions relate to diversity training, human resource programs and union presence.

PART 2A: DIVERSITY TRAINING

15. Are staff members educated regarding the special needs and characteristics of each other; including the education of one ethnic/cultural group about another ethnic/cultural group?

. (a) Cultural beliefs Yes No

. (b) Adherence to treatment regimens (e.g. dietary requirements) Yes No

. (c) Integration with patient-preference for alternative therapies Yes No

. (d) Gender roles Yes No

. (e) Other (please specify) _____ Yes No

If no to all of the above, skip to Q 20

16. How are staff members educated, and how effective are these methods?

12345

extremely somewhat effective

not effective

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	Yes/No	Effectiveness
Training		
Orientation		
Reading materials		

13

17. If yes to training above (Q16), is it mandatory or voluntary? Please check appropriate box. If no to training above (Q16), skip to Q 20

	Mandatory	Voluntary	If Voluntary, what is compliance rate (percent)
All staff			
All but physicians			

Management			
Support			
Volunteers			
Other _____ (please specify)			

18. Please rate the general impressions of effectiveness of the training initiatives:

123456

extremely somewhat not beneficial don't know beneficial beneficial

19.

(a) Workforce relationships _____ (b) Staff-patient interactions _____ (c) Patient adherence to treatment protocols _____

Does your organization conduct formal evaluations of training programs that include pre and post measurements?

(a) Workforce relationships Yes No

(b) Patient adherence to treatment protocols Yes No

If yes to any of the above, please attach findings from these studies.

14

PART 2B: HUMAN RESOURCE PROGRAMS 20. Does your healthcare organization have the following programs?

(a) Career development activities

(b) Succession planning (c) Technical training (d) Management development (e)

Other _____ (please specify)

If no to all of the above, skip to Q 24

Yes No

Yes No

Yes No

Yes No Yes No

21. If yes to any of the above (20), for which staff? _____

22. Do you have the following activities available?

(a) Mentoring Yes No

(b) Tuition reimbursement Yes No

(c) Personal counseling/^[]SEP employee assistance programs Yes No

(d) Other _____ Yes No (please specify)

If no to all of the above, skip to Q 24

23. If yes to any of the above (Q 22), how effective are those programs identified in Q 22

in

contributing to organizational goals for ethnic/cultural staff, and to what extent do they participate?

1 2 3 4 5 6

extremely somewhat not beneficial don't know beneficial beneficial

--	--	--

	Effectiveness	Percent staff participation
Mentoring		
Tuition reimbursement		
Personal counseling		

	.	
Employee assistance	.	.
Other _____ (please specify)	.	.

24. With regard to ethnic/cultural staff at your organization, what trend do you observe over the last 5 years?

15

(a) Discrimination charges are not increasing Yes No

(b) Retention of ethnic/cultural minorities is not a problem Yes No

(c) Promotions of ethnic/cultural minorities is not a problem Yes No (d) Turnover is not a problem Yes No

25. Are there human resource policies and procedures in place to address concerns or complaints concerning unfair treatment in the area of ethnic/cultural issues?

Yes No (if no, skip to Q 27)^[SEP]26. What are these human resource policies and procedures, and how effective are they?

12345

extremely somewhat not at all effective

Please attach policies and procedures if more space is required.

	Description	Effectiveness
Policy and procedure # 1		

<p>Policy and procedure # 2</p>		
<p>Policy and procedure # 3</p>		

27. Has the organization developed a special office or function to address ethnic/cultural diversity; for instance an Office of Diversity?

Yes No (if no, skip to Q 30)

28. Provide a list of principal duties. ^{[[1]]}SEP (a) _____ (b)
 _____ (c) _____

29. Please identify (a) where the responsibilities reside; and (b) the position title.

SEP(a) _____ (b)

30. Are there marketing initiatives to identify, select and retain minority staff? Yes
No (if no, skip to Q 32)

31.

What are these marketing initiatives? Provide example. (For instance, are there specific goals to recruit Asian speaking staff to strengthen the ability to reach Asian mothers?)

16

32. Is there specific financial support for cultural diversity activities or programs? Yes No
(if no, skip to Q 35)

33.

This question is in three parts. Please provide responses in the table below (see next

page).

(a) How much money has been allocated to the following key areas of cultural diversity activities or programs? Please provide dollar estimates in column titled ‘Allocation.’

(b) How beneficial have these programs been in achieving related objectives? In column titled

‘Benefits,’ please indicate whether they have been 123456

extremely somewhat not beneficial don’t know beneficial beneficial

Please base your responses on past fiscal or calendar year.

	Allocation	Benefits
Staff Training		

<p>Community Based Outreach (Clinical Programs)</p>		
<p>Community Education Programs</p>		
<p>Other _____ _____ (please specify)</p>		

17

34. If the allocation has changed over the past fiscal or calendar year, by what percentage has it changed? Indicate whether change has been positive (+) or negative (-). If budget has not

changed, skip to Q 35.

	<p>.</p> <p>.</p> <p>Change in allocation</p>
<p>Staff Training</p> <p>.</p>	<p>.</p> <p>.</p> <p>.</p>
<p>Community Based Outreach (Clinical Programs)</p>	
<p>Community Education Programs</p>	<p>.</p> <p>.</p>

.
Other _____ _____ (please specify)

PART 2C: UNION PRESENCE ^[1]_[SEP] 35. Is your organization unionized?

Yes No (if no, skip to Q 40) ^[1]_[SEP] 36. Please provide the names of the unions represented.

1. _____ 2. _____ 4. _____ 5.

3. _____ 6. _____

37. What functions or employee groups in the system are unionized? E.g. maintenance, housekeeping.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ 38. Please rate the impact of unions on promoting diversity within the organization.

123456

extremely somewhat not beneficial can't judge beneficial beneficial

39. If you circled (1) or (2) above, list programs or activities that reflect this involvement.

1. _____ 2. _____ 3. _____

18

PART 3: HEALTHCARE ORGANIZATIONAL LINKS TO PATIENTS AND THE COMMUNITIES YOU SERVE

Questions in this section are dedicated to healthcare organizational links to the communities you

serve as well as patient and staff diversity initiatives. This section is divided into five parts: (a) healthcare organizational links to community; (b) organizational adaptation to diversity; (c)

database systems and data development; (d) language and communication needs of patients and staff; and (e) business strategies attracting patients from diverse cultures.

PART 3A: HEALTHCARE ORGANIZATIONAL LINKS TO COMMUNITY

Questions in this section address your healthcare organization's links to the communities you serve and the effectiveness of these linkages.

40.

This question is in three parts; use table below:

- . (a) Identification of service links - please name up to four (4) groups/organizations with which your healthcare organization has substantial links. If more than four, please attach pages.
- . (b) What are the service linkage activities - please describe activities in the space provided, or attach additional pages if necessary.
- . (c) How effective are these linkages - please use the scale below.

12345

extremely somewhat effective

not at all

Please identify Community Advocacy Groups with which you have links	Activities	Effectiveness
1		

.	.	.
2		
.	.	.
3		
.	.	.
4		
.	.	.

19

Q 40 continued

.	.	.
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Please identify Local/State Provider Associations with which you have links	Activities	Effectiveness
1		
2		
3		

4		
<p>Please identify Ethnic/Cultural Newspapers with which you have links</p>	<p>Activities</p>	<p>Effectiveness</p>
1		
2		

3		
4		
<p>Please identify Churches with which you have links</p>	<p>Activities</p>	<p>Effectiveness</p>
1		

2		
3		
4		

Q 40 continued

<p>Please identify Schools with which you have links</p>	<p>Activities</p>	<p>Effectiveness</p>
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		.
--	--	---

20

.	.	.
1	.	.
.	.	.
2	.	.
.	.	.
3	.	.
.	.	.

4		
<p>Please identify Business Groups with which you have links</p>	<p>Activities</p>	<p>Effectiveness</p>
1		
2		

3		
4		

41. How closely does your healthcare organization work with these external resources in accomplishing diversity objectives?

1 2 3 4 5 [] a lot somewhat not much

42. Does your healthcare organization engage in the following community outreach activities:

(a) Provide an ombudsman office to assist ethnic/cultural populations? [] If yes, how long have you had this activity? _____(in years)

If no, do you have plans to undertake this activity?

(b) Involve the community in planning/evaluating functions?

If yes, how long have you had this activity? _____(in years) If no, do you have plans to undertake this activity?

(c) Encourage staff to participate in community meetings? If yes, how long have you had this activity? _____(in years)

If no, do you have plans to undertake this activity?

(d) Select patient advocates for their ethnic/cultural diversity? If yes, how long have you had this activity? _____(in years)

Yes No

Yes No Yes No

Yes No Yes No

Yes No Yes No

21

43.

44. 45.

46.

47.

48. 49.

Has your healthcare organization established links with minority businesses for health promotion in the community?

Yes No (if no, skip to Q 45)^[L1]_[SEP]How long have you had this link or program? _____(in years)

Skip to Q 46

Do you have plans to undertake this activity? Yes No

Does your healthcare organization explicitly seek contract arrangements with ethnic/cultural businesses in your community?

Yes No (if no, skip to Q 49) If yes, please give examples.

How long have you had this initiative or program? _____(in years)

Skip to Q 50

Do you have plans to undertake this activity? Yes No

If no, do you have plans to undertake this activity?

(e) Offer to communities educational programs that address health beliefs/needs of ethnic/cultural population?

If yes, how long have you had this activity? _____(in years) If no, do you have plans to undertake this activity?

Establish or contribute to community support groups for certain ethnic/cultural populations?

If yes, how long have you had this activity ?_____ (in years)

If no, do you have plans to undertake this activity? (g) Other

_____ (please specify)

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

Yes No Yes No

Yes No Yes No

Yes No Yes No

Yes No

PART 3B: ORGANIZATIONAL ADAPTATION TO DIVERSITY

22

50.

51.

52.

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54. 55.

56. 57. 58.

59.

Do you have an organized way to collect data on the ethnic/cultural characteristics of patients (including patients who use community-based services)?

Yes No (if no, skip to Q 52)

Is the database or information system used to identify the special needs of the ethnic/cultural patients in the following areas?

(a) Special meals Yes No

(b) Scheduling appointments Yes No

© Translation Yes No

(d) Other _____ Yes No (please specify)

How does your healthcare organization determine the ethnic/cultural characteristics of the patients served?

Do you survey patients to determine their perception of your services?

Yes No (if no, skip to Q 59)^[11] How often do you survey patients? _____

Does your survey ask questions assessing service satisfaction related to cultural diversity? Yes No (if no, skip to Q 57)

How many questions addressing these issues are on the survey?

Please attach copy of survey. ^{[[]]}_{SEP} Is the survey available in languages other than English?

Yes No ^{[[]]}_{SEP} If yes to Q 57 above, in what languages is the survey available?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

In addressing the ethnic/cultural needs of patients throughout the continuum of their care, do you provide the following, and if you do, how well do they work?

12345

extremely somewhat well

not at all

Use table for response.

23

<p>.</p>	<p>.</p>	<p>.</p> <p>If yes, how well</p>
----------	----------	----------------------------------

	Yes/No	do they work?
A. Appointment systems tailored for ethnic/cultural ^[SEP] populations in outpatient or specialty clinics		
B. Protocols for addressing ethnic/cultural interpreting needs		
C. Signs that direct patients to language/ cultural assistance		

<p>D. Accommodations for religious preferences of patients</p>	<p>.</p>	<p>.</p>
<p>E. Accommodations for the ethnic/cultural dietary preferences of patients</p>	<p>.</p>	<p>.</p>
<p>F. Assistance for ethnic/cultural populations in discharge planning</p>	<p>.</p>	<p>.</p>
<p>G. Other _____ _____ (please specify)</p>	<p>.</p>	<p>.</p>

60. If yes to Q 59 C above, in what languages are the signs available?

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

If no to Q 59 C, skip to Q 62

24

61. If yes to Q 59 C above, where are these directions posted?

(a) Emergency room^[SEP] (b) Admissions^[SEP] (c) Outpatient clinics^[SEP] (d) Other

_____ Yes No

(please specify)

PART 3C: DATABASE SYSTEMS AND DATA DEVELOPMENT

62. Does your healthcare organization maintain a computerized database documenting the

characteristics of your ethnic/cultural staff? Database refers either to management information system (MIS) or human resources information system (HRIS).

Yes No (If no, skip to Q 67)

63. Does your database or information system include the characteristics of ethnic/cultural

staff; such as salary, rate of turnover, promotions, staff tenure, performance appraisals,

training, absenteeism?^[SEP] Circle yes if one or more of the above apply.

Yes No (if no, skip to Q 66)

64. Is the database analyzed?^[1]_[SEP] Yes No (if no, skip to Q 66)

65. Describe the nature of analyses that apply to such data.

66. Identify initiatives, programs or policies developed based on such analyses.

Yes No

Yes No Yes No

25

PART 3D: LANGUAGE AND COMMUNICATION NEEDS OF PATIENTS AND STAFF

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69. 70. 71.

72.

73.

74.

Does your healthcare organization have written policies that relate to the provision of interpreter/translator services?

Yes No (if no, skip to Q 69)^[SEP]Please describe or attach these policy statements.

Are hospital-based interpreter services required in your state or by any regulatory agency?

Yes No Don't know^[SEP]Does your healthcare organization have interpreter/translator services?

Yes No (if no, skip to Q 85) Are your interpreter/translator services

(a) Hospital/Health System based? Yes No (b) Non-hospital based? Yes No

If no to (a) and yes to (b), skip to Q 79 If no to (a) and no to (b), skip to Q 85

If services are hospital based, is one specific office or department responsible for providing interpretation/translation services?

Yes No (if no, skip to Q 79)^[SEP]What is the name of the office or department?

What are the principal duties of this office?

(a) _____

(b) _____

(c) _____

26

75. If your healthcare organization does not have a specific office dedicated to

76.

interpreter/translator services, please identify (a) the office or department; (b) the position title; and (c) how your healthcare organization addresses the language needs of patients and staff.

. (a) _____

. (b) _____

. (c) _____ In general, how effective are the hospital-based interpreter/translator services in addressing the needs of your ethnic/cultural population?

12345

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80. 81.

82.

83.

Does this office or your healthcare organization maintain a central registry documenting requests for interpreter/translator services?

Yes (if yes, skip to Q 79) No^[11]_{SEP} How do you track or document the utilization of interpreter/translation services?

What kind of non-hospital based interpreter/translator services does your healthcare organization have?

(a) AT&T phone translation Yes No

(b) Friend or family Yes No

(c) Other _____ Yes No (please specify)

Does your system allocate support specifically for interpretation services?

Yes No (if no, skip to Q 85) What is the dollar amount of this support?

Has the allocation changed over the past fiscal or calendar year? Yes No (if no, skip to Q

85)

What is the percent change in allocation. Indicate whether the change is positive (+) or negative (-).

What percent of your interpreter/translator services is 'paid,' in contrast to voluntary?

extremely somewhat not effective effective

84.

27

STAFF ISSUES

85. 86. 87.

Does your healthcare organization have a policy for recruiting bilingual staff?

Yes No Does your healthcare organization give preference in hiring to bilingual staff?

88. 89.

90.

Are interpreters trained in cross-cultural medical language?

Yes No (if no, skip to Q 91) How are the interpreters trained?

(a) In house training Yes No (b) Outside contractors Yes No

How effective is this training?

12345

Yes No^[] How or where are translators used?

For Patients:

(a) In the emergency room

(b) In ambulatory units

(c) On inpatient units (d) At discharge^[] (e) On-call for off-shifts

For Staff:

(f) Employment interviews (g) Employee counseling

Yes No

Yes No

Yes No

Yes No Yes No

Yes No Yes No

extremely somewhat not effective effective

91. Are interpreters and other staff trained to understand and respond to ethnic or cultural traditions (e.g. death/dying rituals, involvement of family, dietary preferences, etc.)?

Yes No (if no, skip to Q 94)^[SEP]92. Describe how interpreters and other staff are trained.

93. How effective is this training?

28

94. 95.

96.

97.

98. 99.

Does your healthcare organization assess the quality of interpretation services?

Yes No (if no, skip to Q 97)^[SEP]How does your healthcare organization assess the quality of these services?

Does your healthcare organization test interpreters in their knowledge of medical technology?

Yes No (if no, skip to Q 98)^[SEP]Are results used to make personnel decisions:

(a) Retrain an interpreter Yes No

(b) Evaluate interpreter performance Yes No

© Other _____ Yes No (please specify)

Are interpreters accredited, or otherwise evaluated for proficiency? Yes No

Are medical staff and medical students given any training in communicating with ethnic/cultural minority patients?

12345

extremely somewhat not effective effective

Yes No (if no, skip to Q 102)^[SEP]100. Describe how medical staff and medical students are trained.

29

101. How effective is this training?

12345

extremely somewhat not effective effective

PATIENT ISSUES^[SEP]102. Does your healthcare organization identify languages spoken in your service community?

Yes No

103. How does your healthcare organization identify patients needing interpretation and

translation?

(a) Identification by admissions assessment Yes No

(b) Identification by nursing assessment Yes No

(c) Identification by physician Yes No

(d) Medical support staff assessment Yes No

(e) Self-identification Yes No

(f) Other _____ Yes No (please specify)

104. What languages, other than English, are the principal languages of your patients and staff?

Language	% of Patients

.	.
.	.
.	.
.	.

	.
Language	% of Staff
	.
	.

Please indicate up to four (4) languages for which you have the highest demand for interpretation or translation.

How does your healthcare organization acquire translated materials? Circle all that apply

Languages	Percent of all requests

.	
.	

108.

(a) Translated by hospital staff or person hired by contract Yes

(b) Translations by volunteers Yes

(c) Translations purchased from professional translator Yes

(d) Translated material secured from another hospital facility

No

(e) Translated material secured from other (non-hospital) ^{[[[[} agency or organization Yes

(f) Other _____ Yes (please specify)

No No No

Yes

No No

109. What materials are translated into other languages? For Patients:

(a) Patient education materials

(b) Patient menu^[11]_{SEP}(c) Patient satisfaction survey

(d) Marketing/Advertisements

(e) Billing information^[11]_{SEP}(f) Directions to sites/services

(g) Patient directives (e.g. DNRs) (h) Medication instructions

For Staff:

(a) Employee handbook^[11]_{SEP}(b) Employee newsletters (c) Employment application

Yes Yes

Yes

Yes Yes

Yes

Yes Yes

Yes No

No No

Yes No

No

Yes No

No No

No

No No

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110. Does your healthcare organization have programs designed to address the needs of hearing or sight-impaired patients?

Yes No^[]_{SEP} If yes, please describe:

111. Does your healthcare organization provide interpreter services for the hearing or sight impaired patients?

Yes No

112. Does your healthcare organization have special clinical or educational programs for gay/lesbian patients?

Yes No^[]_{SEP} If yes, please describe:

113. Does your healthcare organization have special clinical or education programs for the physically disabled?

Yes No^{[[]]}_{SEP} If yes, please describe:

114. Does your healthcare organization have special clinical or education programs for the mentally disabled?

Yes No^{[[]]}_{SEP} If yes, please describe:

PART3E: BUSINESS STRATEGIES ATTRACTING PATIENTS FROM DIVERSE CULTURES

115. Are you undertaking special initiatives to target patients and expand services to ethnic/cultural populations in the following areas:

(a) Marketing: ^{[[]]}_{SEP} (a1) Advertising (e.g. newspapers, community fliers, churches, etc.)?

If yes, how long have you had this initiative? _____(in years)

If no, do you have plans to undertake such an initiative? (a2) Recruitment drives in ethnic/cultural neighborhoods?

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

Yes No

Yes No Yes No

Yes No

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(a3) Meetings with ethnic/cultural community organizations?

No^[]_{SEP} If yes, how long have you had this initiative? _____(in years)

If no, do you have plans to undertake such an initiative?

(a4) Meetings with ethnic/cultural business groups?

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

(a5) Other _____

(please specify)^[]_{SEP} If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

(b) Services:

(b1) Developing services in ethnic/cultural communities?

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

(b2) Expanding services in ethnic/cultural communities?

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

(b3) Developing special ethnic/cultural related health programs, such as

Yes

hypertension education in Hispanic communities?^[SEP]If yes, how long have you had this initiative? _____(in years)

If no, do you have plans to undertake such an initiative?

(b4) Monitor outcomes regarding ethnic/cultural minorities

If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

(b5) Other _____

(please specify)^[SEP]If yes, how long have you had this initiative? _____(in years) If no, do you have plans to undertake such an initiative?

Yes No 116. Do you have written policies for reviewing and assessing ethnic/cultural patient needs?

Yes No (if no, skip to Q 121)

33

Yes No Yes No Yes No Yes No

Yes No

Yes No Yes No Yes No Yes No

Yes No Yes No Yes No Yes No Yes No

117. Please describe or attach these policies and procedures for reviewing and assessing ethnic/cultural patient needs; e.g. ombudsman, cross organizational team.

118. Do these policies and procedures address all of your ethnic/cultural patient groups that have substantial numbers of patients?

Yes (if yes, skip to Q 121)

119. What groups are omitted? 1. _____ 4. _____

120. What groups are included? 1. _____ 4. _____

No

2. _____ 5. _____

2. _____ 5. _____

3. _____ 6. _____

3. _____

6. _____

121. Has consideration of ethnic/cultural minority patient issues been incorporated into your healthcare organization's Quality Improvement efforts?

Yes No^[]_{SEP} 122. Please describe how this has been done.

E-mail: irb@monmouth.edu

Application for Review of Human Subjects Research

A. IDENTIFYING INFORMATION

1. Principal Researcher's Contact Information:

Name(s): CAITLIN SPRAGUE

Address: 38 BENSON AVE.

Phone Number: 612-716-2495

E-mail: CSPRAGUE@MONMOUTH.EDU

2. Co-Researcher(s) Contact Information:

Name(s): N/A

Address:

Phone Number:

E-mail:

3. Department/School: MONMOUTH UNIVERSITY, SOCIAL WORK

4. Title of the Study: SHAMAN INTEGRATION INTO WESTERN HEALTHCARE SERVICES

B. HUMAN PARTICIPANT PROTECTIONS REQUIRED TRAINING

1. I have attached the [NIH Protecting Human Research Participants Training Certificates](#): Yes No

C. SUPERVISING PROFESSOR'S CONSENT (required only for student research)

1. I have attached my [supervising professor's consent form](#): Yes No N/A

D. RESEARCH PROJECT DESCRIPTION

1. Purpose of the Study (*What is the central research question and/or hypothesis that this study examines? What is the goal/objective of this study? Approximately 150 words.*):
This study is exploratory. The central research question that this study examines is: is the introduction of Shamans into Western healthcare associated with increased service use by Hmong persons? The hypothesis is that services rates of Western healthcare utilization by Hmong persons will rise with the incorporation of Shamans into Western healthcare services. The goal of this study is to find a possible solution to the current problem of Hmong persons being discouraged from using Western medical resources because they are not receiving culturally sensitive healthcare, thereby increasing the risks to their health and wellbeing.
2. Brief Rationale for the Study (*Why is this study needed? How does it fit in with existing research? What new knowledge will this study potentially add? Approximately 150 words.*):
Many Hmong persons in the United States are not receiving culturally sensitive healthcare and social services, and thereby increasing risks to their health and wellbeing and discouraging them from using Western resources.

3. Research Design/Method (e.g., *Experimental; Quasi-Experimental; Comparative (specify the number of groups); Correlational; Predictive Model; Psychometric Testing of an Instrument; Phenomenological; Ethnography; Grounded Theory; Case Study; etc.*):
QUASI-EXPERIMENTAL SIMPLE TIME-SERIES DESIGN
4. Plan for Data Analysis (What statistical test(s) will you use?):
I WILL USE SELF-DESIGNED INTERVIEW SURVEYS FOR DATA ANALYSIS

E. SAMPLING METHOD AND PARTICIPANT REQUIREMENTS

1. Sampling Method (e.g., *random, convenience, purposive, snowball, etc.*):
PURPOSIVE
2. Affiliation of Participants (e.g., *Monmouth students, institution, hospital, general public, etc.*):
WESTERN HEALTHCARE SERVICE PROVIDERS
3. Participant Characteristics (*List sex, age range, and projected number of participants. Please provide any inclusion/exclusion criteria. If vulnerable subjects are recruited, explain why their inclusion is necessary*):
Participants will be both male and female, ages 25 to 75, of any racial or ethnic background. There will be an anticipated 50 participants.
4. What is the population from which you will select participants for the study?
Please mark an X in all appropriate box(es)

<input type="checkbox"/> MU Students	<input type="checkbox"/> Non-English Speaking Persons
<input type="checkbox"/> MU Employees	<input type="checkbox"/> Physically Disabled
<input checked="" type="checkbox"/> General Public	<input type="checkbox"/> Mentally Disabled
<input type="checkbox"/> Pregnant Women	<input type="checkbox"/> Prisoners
<input type="checkbox"/> Children/Minors	<input type="checkbox"/> Economically Disadvantaged
<input type="checkbox"/> Institutionalized Persons	<input type="checkbox"/> Educationally Disadvantaged
<input type="checkbox"/> Critically or Terminally Ill	<input checked="" type="checkbox"/> Elderly
<input type="checkbox"/> Other, please specify: .	
5. Access to Participants (*How will you gain access to participants? Will you use a participant pool?*)
I WILL SELECT THREE WESTERN HEALTHCARE FACILITIES IN HIGH HMONG-POPULATED AREAS OF ST. PAUL, MN. I WILL CONTACT THE FACILITIES' HUMAN RESOURCES STAFF AND PROGRAM DIRECTOR AND EXPLAIN MY DESIRED STUDY. I WILL THEN ASK FOR NAMES OF PHYSICIAN STAFF IN THE FACILITIES THAT I COULD REACH OUT TO.
6. Participant Recruitment (*How will you recruit participants? Who will do the recruiting? How will participants initially learn what the study is about?*):
I WILL PERSONALLY CALL AND EMAIL PHYSICIANS PROVIDED TO ME BY THE HR STAFF AND/OR PROGRAM DIRECTOR, DESCRIBING IN DETAIL THE PURPOSE AND SCOPE OF THE STUDY AND ASK FOR PARTICIPATION.

Please mark an X in the appropriate box(es). (*Please append any of these materials to this application*)

- | | |
|---|---|
| <input type="checkbox"/> Flyers/Posters | <input checked="" type="checkbox"/> Telephone |
| <input type="checkbox"/> Letter | <input type="checkbox"/> Internet |
| <input checked="" type="checkbox"/> E-mail | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Participant Pool | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Other, please specify: . | |

Please include the information you will use to recruit participants here (i.e., any information about your study that you give to participants prior to participation): Due to historical and contemporary grievances with Western health and mental health services and a predisposition to traditional Shamanistic healing methodology, many people from Hmong communities will not utilize available Western health care and social service resources (Warner & Mochel, 1998; Hamilton-Merritt, 1992). Those who do, frequently find providers to be culturally incompetent (in regards to Hmong culture) and their methods to be confusing, backwards, or dangerous; providers that discourage or deny the use of Hmong Shamans further destroy the relationship with and healing of the client (Yang, 1998). As such the problem has risen that Hmong persons are not receiving culturally sensitive health care and social services, thereby increasing risks to their health and wellbeing and discouraging them from using Western resources. By incorporating Shamans into the healthcare service Hmong patients receive, Hmong persons may be more inclined to utilize Western healthcare services and expand their resources.

7. Participant Expectations (*Note: You will provide specific information about manipulations, measures, etc. in Section G. Here, please generally describe a typical participant's experience from the beginning until the end of the study. Please include how many participants will be tested at a time.*):
THE PARTICIPANTS WILL PARTICIPATE IN THREE INTERVIEW SURVEYS TWO MONTHS APART, STARTING IN MARCH AND ENDING IN SEPTEMBER. SURVEY QUESTIONS WILL FOCUS ON CURRENT HMONG SERVICE RATES, CULTURALLY COMPETENT SERVICES OFFERED TO HMONG PATIENTS, REASONS WHY HMONG PATIENTS SEE THE PHYSICIAN, AND THE DEMOGRAPHICS OF HMONG PATIENTS. IN SEPTEMBER A SHAMAN FROM THE HMONG COMMUNITY WILL BE INTRODUCED INTO THE FACILITIES AS CONSULTANTS TO PHYSICIANS WITH HMONG PATIENTS. EVERY TWO MONTHS THEREAFTER THE RESEARCH TEAM WILL CONDUCT ANOTHER SURVEY (GIVEN TO THE SAME PHYSICIANS) ASKING QUESTIONS ABOUT CURRENT HMONG SERVICE RATES, REASONS WHY HMONG PATIENTS SEE THE PHYSICIAN, AND THE DEMOGRAPHICS OF HMONG PATIENTS.
8. Participant's Estimated Time Commitment:
31 MONTHS
9. Setting for Data Collection (*e.g., school, hospital, clinic, home, lab, etc. Be specific.*):
WESTERN HEALTHCARE FACILITIES
10. Timeline for the Study (*month and year; e.g., 9/10 – 5/11*):
Expected Start Date: MARCH 12, 2013 Expected Completion Date: SEPTEMBER 30, 2015

11. Does this research involve the IRB approval of one or more participating institutions or organizations other than that of Monmouth University?

No

Yes (Please append appropriate documentation to this application)

Contact Person: Mary Spoon

Name(s): ST. MARY'S HOSPITAL

Address: N/A

Phone Number: N/A

E-mail: N/A

12. Does this research involve the participation or sponsorship of an outside entity, agency or business?

No

Yes (Please include a signed agreement or memorandum of understanding about the arrangement and explain the nature of this relationship including the way the organization or business would use information from this research.)

F. INFORMED CONSENT/ASSENT PROCEDURES

1. Will this study seek consent from participants?

Yes

No

If consent will not be sought, please explain why and what procedure you will use to ensure the participant's understanding in order to guarantee his or her rights.

2. What type of document(s) will be used to obtain consent? (Please append a copy to this application)

Signed consent form

Parental Consent Form

Letter of Consent

Child Assent

Other, please specify: .

G. MANIPULATIONS, MEASURES, AND QUALITATIVE DATA COLLECTION

1. Manipulation Information (Will this study include a manipulation?):

No

Yes

Please describe in detail the manipulation being used. (Please append a copy of the relevant materials—what participants will see—to this application.)

A SHAMAN FROM THE HMONG COMMUNITY WILL BE INTRODUCED INTO THE FACILITIES AS CONSULTANTS TO PHYSICIANS WITH HMONG PATIENTS. PHYSICIANS MAY CONSULT WITH THE SHAMANS WHEN SEEING A HMONG PATIENT AND/OR HMONG PATIENTS MAY CONSULT WITH THE SHAMANS FOR GUIDANCE AND/OR ASSISTANCE.

2. Measure Information (What will participants be asked? Provide the name of any instrument(s) being used and a citation/reference): (Please append a copy of relevant materials—what participants will see—to this application.)

An individualized survey will be created for the purposes of this study. Questions will be qualitative and quantitative. Types of question asked on the survey include but are not limited to: current service rates, demographics of Hmong patients, for what reason Hmong patients are seeing practitioners, criticisms of services from

Hmong patients, and perceived attitudes towards and faith in Western healthcare providers by Hmong patients. The “Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems,” will be used in pretest surveys to assess cultural competency.

3. Qualitative Data Information (*What will you ask participants? e.g., Focus group discussions, interview questions, field notes, list of discussion topics, any “starter” questions for each topic, etc.*): (*Please append a copy of relevant materials —what participants will see—to this application.*)

Demographics of Hmong patients, for what reason Hmong patients are seeing practitioners, criticisms of services from Hmong patients, and perceived attitudes towards and faith in Western healthcare providers by Hmong patients.

4. Feedback (*What information will be provided to participants concerning their test results?*):

PARTICIPANTS WILL BE TOLD HOW SERVICE RATES HAVE CHANGED, IF AT ALL, AFTER THE INCORPORATION OF SHAMANS. RESULTS FROM THE STUDY WILL ALSO BE PUBLISHED AND SHARED.

H. DATA COLLECTION AND CONFIDENTIALITY

1. Please indicate if you will use any/all of the following:

N/A Audio recording Video recording Other, please specify: .

2. Is confidentiality promised to participants?

Yes

No

If no, please explain why retaining identifying information is necessary. Also explain who will have access to this information (*e.g., a list that identifies participants and the assigned identification numbers*):

3. Will identification numbers be assigned to each participant and used on data collection forms to protect the participant(s) responses?

Yes If Yes, who will assign the identification numbers? THE PHYSICIANS

No If No, please explain .

4. Where, how, and for how long will the data from the study be stored? (*All research records must be stored for a minimum of three years. Describe how you will ultimately dispose of your records after this time. If you do not plan to destroy research records, please provide a justification and how you will ensure confidentiality*)

DATA WILL BE STORED FOR AT LEAST FIVE YEARS WITH MONMOUTH UNIVERSITY’S SOCIAL WORK DEPARTMENT IN PROTECTED COMPUTER FILES AND LOCKED FILE CABINETS. THE FILES WILL NOT BE DESTROYED, BUT CONFIDENTIALITY WILL BE ENSURED BY LIMITING ACCESS TO THE FILES AND REQUIRING THAT A CONFIDENTIALITY FORM BE SIGNED BEFORE BEING GIVEN ACCESS.

5. Will signed informed consent forms be kept separately from the data? Yes No

I. RISKS TO RESEARCH PARTICIPANTS

Risks can be either physical, psychological, legal, or social. No research has zero risk. Please describe even minor risks (e.g., potential embarrassment, anxiety, feeling left out, etc.) Include those aspects of the procedure that might cause unusual discomfort or inconvenience to the research participants, including the impact on their self-esteem or self-image.)

1. Potential Immediate Risks
ANXIETY AND DISCOMFORT SHARING RESPONSIBILITY WITH NEW STAFF (I.E. SHAMANS), STRESS FROM EXTRA WORK DURING BUSY SCHEDULES
2. Potential Long-Range Risks
STRESS FROM EXTRA DATA COLLECTION WORK (E.G. MANAGING AND EXAMINING FILES), STRESS FROM EXTRA WORK DURING BUSY SCHEDULES
3. If there are immediate or long-term risks to the participant, how will you mitigate these risks?
OUR RESEARCH TEAM WILL OFFER ASSISTANCE (WITH APPROPRIATE CONSENT/CONFIDENTIALITY FORMS FROM THE FACILITIES) IN MANAGING PATIENT RECORDS AND DATA COLLECTION

J. BENEFITS TO RESEARCH PARTICIPANTS

1. Describe any benefits participants may receive as part of volunteering in your study.
PARTICIPANTS WILL BETTER UNDERSTAND HOW TO SERVE THEIR CLIENTS, WILL BECOME MORE CULTURALLY COMPETENT, WILL BE ABLE TO SERVE MORE MEMBERS OF THE COMMUNITY, AND WILL CREATE BETTER RAPPORT WITH THEIR CLIENTS AND THE HMONG COMMUNITY
2. Will participants be compensated for their time?
 No
 Yes, please explain: .

K. DECEPTION

1. Will you be utilizing deception?
 No (Please skip to section L.)
 Yes
2. What is the nature of the deception involved? Will this be significant to participants? (If possible, please provide citations for published research that has used similar methods.)
.
3. Why is this deception necessary?
.
4. Deception Debriefing (Describe the procedure you will use to debrief your subjects regarding the deception. How will you explain the deception to participants?):
.

L. DEBRIEFING

1. Will you debrief participants?
 Yes

- No (*Please consider that it may be advisable that subjects receive a full debriefing for educational purposes, to answer any questions, and/or to provide an additional opportunity for participants reveal if the study caused any feelings of discomfort.*)
2. Debriefing Procedure (*How will debriefing take place? When? Where? Individually or in groups?*):

PARTICIPANTS WILL BE FULLY-INFORMED OF ALL PROCEDURES THROUGHOUT THE STUDY.

M. RESEARCHER RESPONSIBILITIES

As a researcher you have ultimate responsibility for the conduct of the study, the ethical performance of the project, the protection of the rights and welfare of human participants, and strict adherence to any stipulations imposed by the MU IRB. You must abide by the following principles when conducting your research:

1. Perform the project by qualified personnel according to the approved application.
2. Adhere to ethical codes and applicable policies and procedures of the University, the sponsoring agency, relevant professional organizations and cooperating institutions (if any).
3. Do not implement changes in the approved study or consent form without prior MU IRB approval by completing an Addendum Form (except in a life-threatening emergency, if necessary to safeguard the well-being of human subjects).
4. If written consent is required, obtain the legally effective written informed consent from human subjects or their legally responsible representative using only the currently approved MU IRB consent form. Store informed consents, and data in a secure place for a minimum of three (3) years.
5. Promptly report all undesirable and unintended, although not necessarily unexpected adverse reactions or events, that are the result of therapy or other intervention, within five (5) working days of occurrence. All fatal or life-threatening events or events requiring hospitalization must be reported to the MU IRB in writing within 48 hours after discovery.
6. Submit the [Annual Review Form](#) at least one year from date of Approval Notice to the Office of the IRB.
7. Retain required records for a minimum of three (3) years.

____ Caitlin Sprague _____

____ 4/10/2012 _____

Signature of Principal Researcher

Date

____ N/A _____

Signature of Co-Researcher

Signature of Co-Researcher

Signature of Co-Researcher

Signature of Co-Researcher

N. Appendices Checklist

Please remember to attach copies of the following materials (where applicable), to the end of this document. The completed application and supporting materials should be sent electronically via email as a **single attachment** to the IRB (irb@monmouth.edu). Please include your last name in the file attachment. Due to the volume of applications the IRB handles, these procedures help ensure the expeditious review of all applications. Failure to adhere to the submission protocol will delay the review of your application.

1. [Certificate from NIH Protecting Human Research Participants Training](#) (You can insert into the application as a picture)
2. Informed Consent Document(s) (Several types are available under the “Informed Consent” menu on the IRB website)
3. Study Materials (Please include everything that a participant will see or experience such as: recruitment material, manipulations, questionnaires, surveys, interview questions, demographics, etc.)
4. [Debriefing Materials](#)
5. [Supervising Professor’s Consent Form](#) (Student Research Only)
6. IRB Approval from participating institutions or [organizations](#) other than Monmouth University
7. [Contact Verification Form](#)
8. [Research in Schools Form](#)