

Barriers to Immigrant Health Care:
A Needs Assessment for Scott County, Minnesota

by

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ABSTRACT

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Minnesota has documented a nearly 150% rise in its Hispanic population between the last two federal censuses. Many communities in Minnesota have seen staggering growth rates in their Hispanic populations, creating significant challenges and pressures for health care and social service providers. Barriers to quality health care for this population are continuously being identified. St. Francis Regional Medical Center, a community hospital located in Scott County, Minnesota has taken a proactive role in reducing these barriers for their immigrant populations. By partnering with government and private agencies, they are establishing a nursing clinic for immigrant women and children. This study was conducted to determine barriers to seeking preventative health

care and to formulate recommendations for the design of a nursing center based on their needs.

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Chapter I: Introduction

According to the 2000 United States (U.S.) Census, people of Hispanic origin now surpass African-Americans as the largest racial/ethnic group. The data also shows an unprecedented growth rate of this population in the Midwest Census Region. Besides new immigrants, increased growth rates can also be related to a younger population with high fertility rates (Blewett, Smaida, Fuentes, & Zuehlke, 2003). Coupled with fast paced growth are concerns for meeting the needs associated with health care and social services.

It should be like in Mexico, with the clinics. Here, this is the richest country in the world, but there isn't just a clinic or something that could help people. In Mexico, there are places that you can go like "Centro de Salud" [health centers] and they help you with whatever you can give them. Here there is nothing like that (p. 37).

This statement reflects the challenge that many Hispanics have when seeking appropriate health care in the United States. When compared with other ethnic groups, Hispanics are consistently found to be in fair or poor health with more than half of Hispanic children in the U. S. lacking health insurance coverage (Staveteig & Wigton, 2000). Two primary factors have been linked to high rates of underinsurance or non-coverage: parents working in economic systems that do not provide employment-linked health benefits and multiple and continuous barriers to accessing health care (Avruch, Machlin, Bonin, & Ullman, 1998; Bartman, Moy, & D'Angelo, 1997). Lack of health insurance has been strongly associated with Hispanic children using emergency rooms as a primary source of care (Flores et al., 2002). In comparison to African-American and

non-Hispanic Whites, as Hispanic children get older they are less likely to seek care from a physician (Zambrana & Logie, 2000).

Community partners in Scott County are working together to begin narrowing the health care gap for their Hispanic residents. A Steering Committee comprised of hospital, county government, and community partners was formed to develop a nursing center for immigrant women and children. A critical aspect in the movement towards that development is the involvement of the affected groups. One effective approach is to use focus groups (Clark et al., 2003). Focus groups were used for this study in order to obtain the perspectives and perceptions of the affected groups. From this inquiry, a customized comprehensive health care program can be developed based on the needs of the community.

Statement of the Problem

The growth of the Hispanic population in Scott County requires changes in existing medical systems in order to provide accessible, affordable, quality health care services.

Purpose of the Study

The purpose of this study is to assess health care related needs of immigrant populations in Scott County and to assist in recommending health care services provided by the planned women and children's nursing center.

Assumptions of the Study

There were three basic assumptions associated with this study:

1. Focus group participants honestly disclosed information that was representative of their health care needs.

2. Focus group participants provided answers that were representative of the total Hispanic population in the County.
3. Information that was used to develop methodology and appropriate focus group questions from areas with high-density Hispanic populations (Texas, New Mexico, California, Florida, and New York) can be related to Hispanics in Scott County, which has a comparatively less dense Hispanic population.

Definition of Terms

Acculturation. “A change in the cultural behavior and thinking of an individual or group through contact with another culture” (Soukhanov, 2001, p. 9).

Culture. “The beliefs, customs, practices, and social behavior of a particular nation or people” (Soukhanov, 2001, p. 348).

Ethnocentrism. “Believing that one’s social or cultural group is superior to other’s behavior or someone who will judge other groups as inferior to their own” (Diver, Molassiotis, & Weeks, 2003, p. 390).

Focus Group. “A small group of people brought together to share opinions and beliefs about a certain topic. Groups are generally representative of a population and often times have personal experience with the topic of interest” (Soukhanov, 2001, p. 553).

Hispanic. “Of Spanish speaking people, relating to Spanish speaking people or their culture” (Soukhanov, 2001, p. 681). People who identify their origin as

Spanish, Hispanic, or Latino may be of any race from any one of the 21 Spanish-speaking countries (U.S. Census Bureau, 1990 & 2000).

Midwest Census Region. States included in the Midwest Census Region are Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin (U.S. Census Bureau, 2000).

Personalismo. “A friendly, kind, interpersonally warm, and social approach to care” (Clark, 2002, p. 170). Examples of such care can include an unhurried approach, social greetings, and a caring face.

Limitations of the Study

The areas of potential weakness in the study that could not be controlled follow:

1. Hispanics were not identified in the U.S. Census, on birth and death certificates, or in other national data systems until the past two decades (U.S. Census Bureau, 2000).
2. The demographics of Hispanic populations are not limited to legal status. Immigrants officially residing in the U.S. are considered documented and therefore are represented by the U.S. Census Bureau. Undocumented immigrants or those without legal status are not always represented in cited population statistics despite use of emergency medical services (the 2000 Census made considerable effort to capture both). Statistics are reported by the 2000 Census as well as updated reports made in 2003 from the U.S. Census Bureau. Numbers are representative of documented

immigrants and number of persons who are noted to have entered the United States, regardless of legal status.

3. The scope of this study is limited to the opinions and beliefs expressed by the focus group participants from Scott County.
4. This study generalized results for Hispanics from all countries of origin. Identified health care needs and recommendations could work better for one group than another. Considerable differences have been documented regarding cultural differences among Hispanics.

Methodology

A community-collaborative-based approach was used for this study. In order to effectively identify barriers to health care, focus groups were established to facilitate access to the Hispanic population in Scott County. Focus groups were held in a location that was comfortable and convenient for the participants. Nineteen female individuals of Hispanic backgrounds provided input. This distribution was consistent with the anticipated population being served by the clinic. Female facilitators were used to add to the comfort level of the majority of participants. Responses were documented in writing and qualitative analysis was performed to identify themes. Recommendations for services provided by the Nursing Center were drafted and presented to the Steering Committee.

Chapter II: Literature Review

Introduction

According to the U.S. Census Bureau (2000), “Nearly 13% of the U.S. population, or 35.3 million people, is of Latino [Hispanic] origin, which now surpasses non-Latino, African-Americans (34.6 million) as the largest racial/ethnic group” (p. 1). Estimates project that almost five million Hispanics have immigrated to the U. S. since the 2000 Census (Bernstein, 2004). Between the 1990 and 2000 Census, the average Hispanic population increase for the Midwest states was 7.9%, while the average Hispanic population increase for the total population was 69%. The highest increase in Hispanic populations among Midwest States was Minnesota at 141.7% (see Appendix A for more information).

Growing numbers in the Hispanic population have forced health care workers to take a closer look at culturally appropriate services in regards to health status and care. Despite high growth rates and an increase in the need for health care, Hispanics typically under-utilize health services in comparison to their Caucasian counterparts (Diaz, Prigerson, Desai, & Rosenheck, 2001; Weinick, Jacobs, Stone, Ortega, & Burstin, 2004). Hispanics are also most likely to face barriers to comprehensive care that prevent access to services and health needs being met (Clark et al., 2003). Perceived barriers constitute one of the most important factors (and often the most overlooked) that influence the health status of the Hispanic population (Larson, Stroebel, & Perkey, 2001). Documented barriers impeding utilization include lack of health insurance, poverty, communication barriers, low levels of acculturation and inadequate means of transportation to name a few (Diaz et al., 2001; Larson et al., 2001).

Research has documented the underutilization of health services of Hispanics in regards to seeking regular, preventative care by a physician. As a result, emergency room services (primarily pediatrics) bear an undeniable burden of non-insured patients who use this as their primary care method (Clark, 2002). For hospitals, this has caused an increase in debt load that most likely will never be paid back. Hispanics are also putting their own health at risk when they fail to seek medical attention on a consistent basis (Sundquist & Winkleby, 1999). These collective factors call for an action plan of culturally and linguistically appropriate health promotion programs that are based on community involvement (Larson et al., 2001).

Demographic Information

Hispanic population growth in Scott County jumped 17% between the 1990 and 2000 Censuses (see Table 1). Updated estimated reports would imply that the numbers have increased even more in the past four years (U. S. Census Bureau, 1990 & 2000).

Table 1

Demographics of the Hispanic population in Scott County from 1990 to 2000

	Total Population	Hispanic Population
1990	57,846	407
2000	89,498	2,381
% Change	64.6%	17%

According to a Community Health Status Assessment conducted in 2003 by Scott County, the number one concern for Hispanics was the inability to pay for health care. Hispanics cited time and again the difficulties they had in trying to pay for health care with lower income levels. In many instances, Hispanics explained the process they went

through in applying for health insurance only to find out later that they did not qualify or that their health insurance was canceled or denied altogether (Scott County Community Health Service, 2003). This concern aligns to national statistics that indicate Hispanics were more than four times as likely as non-Hispanic whites and almost 2.5 times as likely as non-Hispanic blacks to have been uninsured for more than one year (Cohen, Hao, & Coriaty, 2004; see Figure 1).

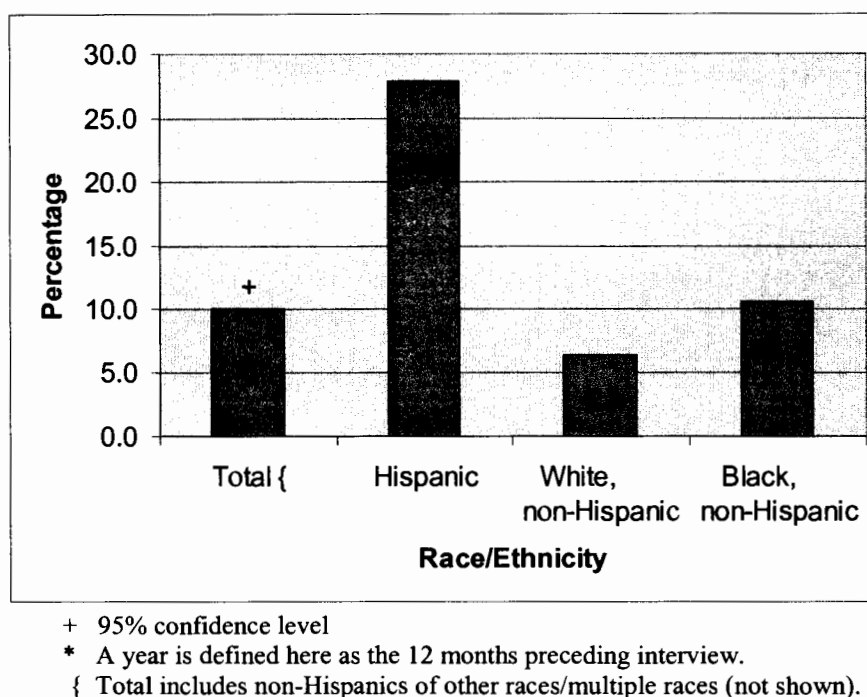


Figure 1. Percentage of Persons Who Lacked Health Insurance Coverage for More Than One Year*, by Race/Ethnicity --- United States, January—June 2004 (Center for Disease Control, 2004).

Health Care Needs

Continuous efforts need to be directed at Hispanics to prevent disenfranchisement from medical systems and to begin to reduce disparities in health status. Regardless of national efforts launched at improving health in the U. S., Hispanics continue to bear a much larger burden when it comes to disease and mortality rates (Larson, et al. 2001).

Despite disparities in categorization methods (previous census information counted many Hispanics as White), statistical data can provide a much-needed look into the health concerns of Hispanic populations (U. S. Census Bureau, 2000; Hulme et al., 2003; Zambrana & Logie, 2000).

General Health Concerns

Compared to non-Hispanic whites, Hispanics have much higher rates of cardiovascular disease and diabetes. An increased rate of cardiovascular disease among Hispanics (primarily Mexican-Americans) has been attributed to behavioral and lifestyle choices that put this population at risk (Sundquist & Winkleby, 1999). Behavioral risk factors include a sedentary lifestyle, smoking, obesity, inadequate medical management and lack of access to primary health care (Levy et al., 2004).

A six-year trans-cultural analysis study conducted by the American Journal of Public Health found that Hispanics (primarily Mexican-Americans) are in desperate need of effective heart disease prevention programs (Sundquist & Winkleby, 1999). Focus group participants revealed that they knew that obesity, lack of exercise and smoking contributed to heart disease and they expressed a desire to make lifestyle changes. However, they did not know where to go to get help or how to begin. Participants also desired information on healthy cooking, nutrition and physical fitness but said that it was extremely difficult to find in their communities (Levy et al. 2004).

At least 15% of Hispanics in the U.S. are affected by Type II diabetes, making this disease the third leading cause of death for females and fourth for males. Despite advancements in technology and improvements made in medical treatment, diabetes-related complications are on the rise (Lipton, Lee, Giachello, Mendez, & Girotti, 1998). A 1999 study on creating culturally competent diabetes education programs found that

effective education programs regarding risk reduction in populations with diabetes could reduce complications with the disease by one third (Brown & Harris, 1999).

Tuberculosis (TB) is on the rise again in the United States, particularly among immigrant and refugee populations. In 2000, 46% of documented cases of TB were from foreign-born individuals. Of those individuals, 41% were from Spanish speaking countries in Central and South America and the Caribbean (Ailinger, Armstrong, Nguyen, & Lasus, 2004). With estimates at nearly 700 million dollars for health care related to TB, knowledge of and adherence to treatment is a necessity. Scott County Public Health had eight documented cases of TB in the year 2003 (Scott County Community Health Service, 2003).

Health Concerns for Women

Primary health concerns for women include proper prenatal care and annual breast and cervical cancer screenings. Proper pre-natal care is imperative to the health of both mother and child. Women who consistently receive pre-natal care experience lower rates of disabilities among newborns. Typically, babies are also born with higher birth weights. Early pre-natal visits can also help women to lower their risk of hypertension, diabetes and other conditions that can develop throughout the pregnancy. Studies have shown that for every dollar spent on prenatal care, three dollars will be saved on postpartum care (Jordan, 2004).

The leading cause of death for women between the ages of 40 and 79 is cancer. High mortality rates in some cancers can occur despite efforts directed towards detection. Cervical cancer is one such example that affects women. When detected at an early stage, cervical cancer is one of the most treatable forms of cancer (Boyer, Williams, Callister & Marshall, 2001). Never having a Pap smear or testing for cervical cancer can

contribute to one of the largest risk factors for death. When compared to non-Hispanic white women, significant detection barriers regarding incidence and mortality rates were found to exist for Hispanics and non-Hispanic Blacks. Second only to non-Hispanic Blacks, Hispanic women experience one of the highest death rates from cervical cancer.

For women, the most useful and cost-effective screening method for cervical cancer continues to be a Pap smear. Compared to non-Hispanic white women (9%), 25% of Hispanics have never had a Pap smear and nearly fifty percent of Hispanic women reported not having been screened within the past year (Boyer et al., 2001). Cervical cancer screening with accompanying breast exam is imperative to the health and well-being of the female Hispanic population.

Health Concerns for Children

When analyzing evidence for health care needs, the outlook for Hispanic children (4 to 17 years) appears dismal. In comparison to African American and non-Hispanic white children, Hispanics

. . . generally (1) are less likely to be immunized, (2) have higher obesity and sedentary activity, (3) have more dental cavities, (4) are more likely to experience intentional and unintentional injuries, and (5) are more likely to reside in hazardous environments. Latino [Hispanic] adolescents are more likely to use drugs, alcohol, and tobacco, less likely to use contraceptives, more likely to be injured, and more likely to attempt suicide than African American and non-Hispanic White adolescents. (Zambrana & Logie, 2000, p. 1828).

Childhood obesity among Hispanics is an ever-growing concern. Out of all racial and ethnic groups in the United States, Hispanic male children are the most overweight and Hispanic females the second most overweight (Flores et al., 2002). In 1999,

researchers conducting a study on Mexican-American children found that nearly 27% of elementary school children were overweight, making them very high risk for developing Type II diabetes. Thirty eight percent of the students had below average physical fitness scores (Suminski, Poston & Foreyt, 1999). Projected diabetes risk factors that contribute to obesity deal with excessive quantities of saturated fats and half the recommended daily fruit and vegetable servings (Trevino et al., 1999).

Asthma affects over 500,000 Hispanic children in the United States.

Documented cases of asthma in Hispanic children outnumber all other groups by two-fold (Flores et al., 2002). While Puerto Rican children are the most affected, Hispanic children overall have disproportionately much higher risks of exposure to air pollutants, hazardous waste sites, pesticides, lead, and mercury due to the location of their homes (Mott, 1995). These problems can result in premature death from asthma, lead poisoning, developmental or behavioral problems as well as an increased risk for cancer (Metzger, Delgado & Herrell, 1995). External, environmental exposure factors are thought to be substantial based on conclusions from the National Research Council. Their findings reveal that 3% of neurobehavioral disorders in children are from the environment (Flores et al.).

Hispanic children belonging to migrant families face particularly high risks when it comes to their health. Ninety four percent of the one million children who travel with their families to seek employment on a seasonal basis are Hispanic (Flores et al., 2002). A 1999 report about health care for children of migrant farm workers found that

[Hispanic] children receive inadequate preventative care; experience high rates of infectious diseases, including tuberculosis, parasites and sexually transmitted diseases; have inadequate preparation for school entry and low rates of school

completion; have impaired access to appropriate day care, forcing parents to bring them to the fields, where they have increased risks of pesticide exposures and injuries; work as farm laborers often in unsafe working conditions; and are at risk for nutritional disorders, such as anemia, diabetes, failure to thrive, and obesity.

(Flores et al., p. 86)

Access barriers need to be reduced for migrant families to begin to provide early education programs and preventative health screening. Presently, health care centers for migrant workers serve only 20% of eligible migrant children.

Barriers to Seeking Health Care

Unprecedented growth rates in Hispanic communities have created access barriers to quality health care that are staggering (Flores, et al., 2002). Health care officials need to be wary when attempting to evaluate and measure barriers to seeking health care.

Cultural differences surrounding expectations for care contribute to misinformed health care clinicians and inaccuracies in reported problems. Hispanics typically receive less than average medical care and at the same time, under report barriers to health care.

Conflicting statements like this have lead researchers to examine the appropriateness of measures used to determine access barriers (Cunningham & Kemper, 1998). “If an individual never uses the health care system, they do not develop any expectation of care. It is simply outside of their frame of reference” (Austin, 2001, p. 1). Only the process of using the health care system allows individuals to develop a sense of need for it. Regular, preventative care decreases risks of illness, disease, and other conditions (Diaz et al., 2001).

Lack of Health Insurance

Hispanics are the largest minority group in the United States without insurance and generally have the poorest health even when socioeconomic status is accounted for (Blewett et al., 2003; Zambrana & Logie, 2000). A 1999 study by the Urban Institute in Washington D.C. found that nearly 33% of non-elderly Hispanics in the United States were uninsured, almost double that that of the national average (Staveteig & Wigton, 2000). Industries are quick to offer Hispanics low-wage jobs with even lower rates of health insurance coverage. These working poor rarely have funds to pay for high premiums on private or employer-based health insurance. Unfortunately for many, wages for these positions are just high enough to make them ineligible for government sponsored aid programs (Blewett et al.). Outreach efforts to provide information on health insurance (primarily targeted for children) have also been ineffective due to language barriers (Flores et al., 2002).

Cost

Whether insured or not, Hispanics still bear an enormous economic burden when it comes to health care costs. Prohibitive costs of health care prevent many from obtaining critical medical supplies and prescription drugs (Levy et al., 2004). A focus group participant in one rural community had this to say about how costs prevented him from obtaining needed medical care:

For the past 7 years, I have had jobs that have no benefits. Every time I have to go to the doctor, or with the kids I have to pay in cash or in payments because paying through an agency [insurance] is about \$300 to \$400 a month. Sometimes I don't go to the doctor so that I can save money for my children to go instead. (Blewett et al., 2003, p. 38)

Under Representation in the Workforce

A continuous decline of Hispanic physicians and nurses is also cause for concern. A National Sample Survey of Registered Nurses found a dismal 2% of nurses in the workforce today are Hispanic (Flores et al., 2002). Those numbers do not get better for other health care professions. Three percent of medical school faculty, 5% of pediatricians, and less than 3% of dentists are Hispanic (Flores et al.). Even more alarming is that Hispanic communities around the United States are more likely to have shortages when it comes to medical staff (Komaromy, Grumback, & Drake, 1996). Hispanic doctors are more likely to care for other Hispanics with or without insurance than non-Hispanic doctors. Hispanic patients also generally seek health care more frequently, and report a higher level of satisfaction of care when treated by another Hispanic (Barbot et al., 2002; Barcelona de Mendoza, 2001).

Lack of "Culture Savvy" Health Care Workers

With the changing face of demographics in this country, health care institutions face a tremendous challenge trying to meld a cultural mismatch between patients and health care staff. Cultural sensitivity and cultural competency are two concepts that all practitioners need to be aware of in order to better meet the needs of minority patients (Jones, Cason, & Bond, 2004). Not taking important steps to understand medical needs of other cultures can result in negative experiences by the patient that may hamper future visits (Clark, 2002). Misconceptions surrounding Hispanics as a single, monolithic group can also impede efforts targeted at reducing health care inequalities. Improvements can not be "one size fits all" when factors such as language capabilities, length of time in the U. S. and country of origin play a critical role in success rates of accessing health care (Institute of Medicine, 2002).

Providers also need to be aware of actions and behaviors that may lead to a lack of trust by patients. Focus group participants often share stories of condescending and patronizing attitudes.

I came with my first child and the doctor said that my child didn't have any problems---that it was all in my head. It turned out that we went to the emergency room like four times---he was dehydrated. The doctor talked to me like I didn't understand, he talked down to me. So, since then, I don't come here for anything. (Blewett et al. 2003, p. 39)

Communication Barriers

Culture and language barriers can profoundly affect quality of health care. Failure of clinicians to consider these factors can result in negative consequences for the patient such as dissatisfaction with care, medical errors, fewer usage of prescriptions and an increased use of home (often harmful) remedies (Flores, Gee, & Kastner, 2000). Principle barriers to seeking care often deal with a lack of Spanish speaking staff and inadequate interpreting services. When trained interpreters are unavailable or availability is limited, patients must then rely on other family members or their children to interpret potentially complex information (Blewett et al., 2003). Adverse effects regarding access to health care, health status, misdiagnosis, and inappropriate usage of medication, can all be skewed when ineffective translations are made. Limited language proficiencies require many health providers to spend more time and resources when it comes to ensuring that all information is properly understood (Munet-Vilaró, 2004).

Factors impeding preventative health care are considerable when few resources are available to patients in their native language. Information available in Spanish would

help when attempting to explain or promote existing health programs (Blewett et al., 2003).

You know that we have this Medical Assistance care. They send us a book of all the benefits and service that are available to us, but it's all in English. We can't understand any of it...it would be great if they could send it to me in Spanish so that I could truly understand what it is that I am receiving, or what it is I could receive. (p. 38.)

Examples can be found throughout focus group narratives. Even when patients are eligible for insurance, they often cannot understand the packets of information they are given to select a provider (Clark, 2002).

Fear of Immigration Authorities

Even when funding is provided for children and adults to seek health care, delays in seeking treatment, no matter what the symptoms, are noted due to fear of immigration and government authorities (Asch, Leake, & Gelberg, 1994). Decreased applications for free health programs have also been attributed to having to provide proof of citizenship (Clark, 2002). Many practitioners fail to consider these variables for patients in seeking health care that may potentially lead to the detection, deportation, or disqualification from medical assistance (Asch, Leake, & Gelberg; Clark).

Native Folk Remedies

Understanding customs and folk medicine practices of immigrants is imperative for a practitioner in order to ensure that compliance of treatment is met. In the Hispanic community, customs such as *mal de ojo*, *empacho*, *curanderos* and the use of native home remedies will allow the staff to better understand what the patient believes to be the problem (Wilson & Robledo, 1999). Native folk medicine and cultural beliefs coupled

with ethnocentric practices can produce a recipe for disaster. Among many Hispanics the belief in mal de ojo or the “evil eye” is very prevalent. Mal de ojo occurs when someone admires another person’s child and looks at the child without ever touching him or her. Symptoms include diarrhea, vomiting and fever (Wilson & Robledo). Documentation citing many Hispanic mothers attempting to seek treatment for this problem have been dismissed. Findings from a focus group reported that one woman was told that she was wrong about mal de ojo, that it did not exist and that it was only a superstition (Blewett et al., 2003). Mal de ojo is very real to many Hispanics and treatment like this prevents many from returning for future care.

Poverty Level

Economic factors also come into play when evaluating predictors to accessing health care (Barcelona de Mendoza, 2001). When compared to African Americans and non-Hispanic whites, Hispanics are more likely to work jobs that do not offer health insurance, more likely to have insufficient funds to afford health insurance, and less likely to access public programs that assist with medical expenses (Zambrana & Logie, 2000). Hispanics are also more likely to have income levels below the government-established poverty level (Barcelona de Mendoza). Poverty related issues also contribute to lack of transportation to medical facilities.

Education Level

With the highest dropout rate in the nation (29%), Hispanic youth often face consequences later on. Hispanics typically make less money annually, join a less skilled workforce, and face increased numbers of unemployment (Flores et al., 2002). Only 20% of children under the age of five are enrolled in early childhood education programs. A

disproportionate number of children (as early as kindergarten) are also held back each year, which can be associated with high drop out rates in later years.

Framework for Identifying Needs

One approach to identifying and evaluating community health needs of minorities or immigrants is through the use of focus groups. Poor and ethnic minorities often rely on oral traditions to disseminate and acquire information. Focus groups allow participants to better align to their cultural values (Clark et al., 2003). Understanding Hispanic cultural values and beliefs could be helpful in understanding practices, behaviors and responses. For example, three values central to many Hispanics emphasize interpersonal relations and behaviors. Allocentrism stresses the collective group over the individual. *Simpatía* calls for the reliance on others' behaviors to create harmonious social relationships. Familialism is a concept that emphasizes the bond and strong ties that each person should have with his or her family (Hulme et al., 2003).

Focus groups can be a way to balance both power and culture between the leader and a group. Talking and discussing feelings and ideas in a group setting are more conducive to the cultural values of Hispanics. "The informal style of focus groups is conducive to identifying barriers to care, exploring belief systems, gaining perspective on the specific issues, and evaluating and developing successful culturally relevant interventions" (Benavides-Vaello, Garcia, Brown, & Winchell, 2004, p. 238).

Chapter III: Methodology

The purpose of the women and children's clinic sponsored by St. Francis and government and private agencies is to provide for the health care needs of the uninsured and underinsured. In order to fully understand the needs of the community, focus groups were established in conjunction with EvenStart, a community based education group for Hispanic mothers and children. Families associated with EvenStart participate in public assistance programs and generally do not see all of their health care needs met. Having input from community members interested in using the services provided by the clinic is imperative to their success. Discussed in this chapter is a detailed outline of subject selection, instrumentation, data collection, analysis and limitations.

Subject Selection and Description

Subjects asked to participate in the focus groups were residents of Scott or Carver County who belong to EvenStart. Hispanics with an interest in explaining their health care needs and barriers to seeking medical care were asked to join a focus group. Participants were informed prior to the focus group (in both English and Spanish) that their participation was entirely voluntary and they did not need to answer any questions that they did not want to. The director of EvenStart ensured (via translators) that only those wishing to participate in the study needed to show up at the designated time and place. A total of 19 women participated in the focus groups.

Instrumentation

A 12-question survey was developed with follow-up questions to address critical needs areas for the future clinic. The focus group session was conducted in Spanish. Copies of the survey read by the facilitator were available in both English and Spanish. A certified translator verified for accuracy the survey administered in Spanish. The

survey was limited to 12 open-ended questions to allow participants the opportunity to expand and take questions in any direction they chose (Appendix D and E).

To begin, participants were asked general questions about how they liked living in Minnesota, how long they had been in the United States, and what their biggest adjustment was in a new country. No personal questions regarding age, employment status, income level, or legal status were addressed. Participants had an opportunity to explain where they seek medical attention and how they feel about their experiences. Individual health concerns as well as those of their family members were also addressed. Other questions pertaining to inadequacies in their current health care situation and ways in which they could be improved were addressed to help facilitate discussions toward services that the free clinic could offer.

Data Collection Procedures

Detailed notes documenting answers from focus group participants were recorded based on the administered survey. Advice from a professional in Scott County warned against the use of tape and/or video recording devices as it had been shown to severely limit the scope of answers in previous focus groups. Two people (a recorder and facilitator) both took notes to ensure accuracy in documentation. Discussions held immediately after the focus groups concluded helped to ensure that an equal understanding of responses was noted.

Data Analysis

A qualitative analysis was used to look for trends in responses. Using the prescribed qualitative analysis methods of Miles and Huberman (1994) for handwritten field notes, words were the basic form in which the data was collected. Field notes were converted into a content summary sheet, which was then coded and analyzed (Appendix

B). Coding patterns or labels were then used to assign units of meaning to the words, phrases and sentences that were shared by the focus group members during the survey process. Provisional descriptive codes were set up based on the results of the literature review. Additional codes were added based on the content in the contact summary sheet. Responses mentioned three or more times were included in the final recommendations presented to the steering committee. Coding techniques were based on a chart of examples located in Appendix C.

Limitations

One or more of the following factors may have limited this study. The scope of the study is limited to the opinions and beliefs expressed by the focus group participants. Therefore the steering committee must assume that recommendations made from the focus groups are reflective of the needs of the community. Answers from the focus group are also limited to the information that participants honestly disclosed. The relatively small number of participants used could also affect the outcome of results. Caution should be exercised not to over generalize the needs of this unique population.

Chapter IV: Results

In order to follow through with any health improvement initiative, information from the affected demographic group must be collected. Opinions from this representative sample allow for accurate planning and successful implementation. The director of EvenStart allowed the focus groups to be conducted in the early afternoon instead of regular program activities. Information from the affected demographic group could easily be collected as the EvenStart program helps Hispanic women of all ages and from all different backgrounds. For the purposes of this study, it was determined that collecting specific demographic information from the participants would not be ethical. Sharing personal information regarding legal status could have negative outcomes for those individuals.

Two focus groups were conducted on April 13th, 2005 in the Chaska community center where EvenStart is housed. The community center was a convenient location and also allowed the participants to feel more at ease in a comfortable and relaxed atmosphere. The first focus group consisted of nine women while the second focus group had 10 participants, also all women. Mothers and children belonging to EvenStart attend classes and activities from 11:30 to 3:30 on a daily basis. All of the participants were animated in conversation and very willing to share information. Many started to cheer when they heard that their comments regarding barriers to healthcare would be used to help open a free clinic in the area. Knowing that their participation and input would be used almost immediately had a direct and positive impact on the results.

Summary of Focus Group Findings

The interview protocol used can be found in Spanish in Appendix D and in English in Appendix E. Following are the main findings of the focus groups:

- Most of the immigrants migrated north to find better job opportunities and a decent place to raise children. The range in time spent in the United States varied from as little as eight months to as much as 21 years.
- All of the participants enjoyed living in Minnesota with the exception of one woman who cited cold weather and snow as the primary reason for disliking Minnesota. All agreed that Minnesota was one of the best states to live in due to high rates of pay (in comparison with Texas, California, or Mexico) and sufficient employment opportunities.
- Besides the cold weather, the largest adjustment that many of the mothers faced was finding adequate childcare for their children. Few of the women could work because they could not afford the high cost of daycare for their children. Other major hardships that made adjustment difficult included an inability to find “good” or “real” Mexican food and the lack of public transportation. Three women stated that lack of public transportation was particularly difficult especially since the county did not have a taxi service.
- The biggest health concern that all of the women shared was having enough healthy food, like vegetables and fruits, to feed their children. Many complained that the only food their children wanted to eat was pizza.

- When asked how people in the Hispanic community find out about available health care services, many were speechless. Numerous reasons were mentioned as to why they do not get their health care needs met. For many without insurance, seeking medical care is not an option. The costs are too high. Free clinics usually have long waiting lists upwards of four weeks to see a physician and by then the problem usually goes away or they learn to live with it. Also, all were in agreement that the community is in desperate need of information in Spanish. Many knew that free clinics existed but had no idea where they are located or how to contact them. Without interpreters staffed at healthcare facilities, most have no way to communicate their needs. Many had even returned home to México to seek free medical treatment.
- Without question the greatest health needs of the community for women, men, and children was dental care. Not one of the women in the focus groups had any source for reliable dental care. All of them had children with dental problems and none of them could find someone who would agree to see them. Waiting lists for dental schools were hundreds long and even those with Medicaid were consistently denied.
- Long waits, a lack of interpreters, and high costs had prevented all of the women from seeking medical care for the past year or more. Many hospitals now require a 400 dollar down payment from uninsured persons to help guarantee payment. One mother of two children paid the money (a month's salary) because she was so concerned about her child and the doctor prescribed Tylenol. She has not returned to the clinic since.

- Many women did say that there was a clinic in Minneapolis that helped with “life change” problems. Upon arrival to Minnesota many were prescribed medication and found help from counselors for seasonal depression. All of the women said their mental health had greatly improved since coming to EvenStart. They had a community where they felt safe and their children had structured activities to keep them busy all day long.
- All of the women stated that they, along with everyone they knew, were aware that hospitals could not give out their names or medical information to anyone (especially immigration officials). One woman explained that she was told that on her first day arriving to Minnesota.
- None of the women knew of any particular employer who hired immigrants or refugees but many stated that there were certain professions in which their husbands or boyfriends could more easily find jobs. Examples include construction, painting, and landscaping. Only three women had ever had employers offer health insurance but none of them accepted due to the high cost.
- The most convenient place to receive health care services was at the hospital provided they could get in. All of them agreed that the hours the hospital operated were conducive to their schedules. Most preferred to have vaccination clinics at their children’s schools so they would not have to drive to have their children get a shot.

- The primary service that the women wanted to see at the free clinic was dental care. After that many needed low or no cost prescription drugs, and much more information and literature on a variety of health care topics in Spanish.

All of the findings from the focus group were consistent with the review of literature. One important distinction was the overwhelming concern these women expressed for an inability to receive dental care. Also, while none of the women mentioned needing any sort of prenatal or gynecological care, it was noted that over half of the women who participated were pregnant. According to the director of EvenStart, prenatal care is readily available through a number of services in the county.

Chapter V: Discussion

Staggering growth rates have created significant pressures and challenges for hospitals to meet the growing health care need of immigrants. Through support of St. Francis Regional Medical Center and other affiliates, Scott County is helping to reduce disparities in health care status for their Hispanic residents. The opening of a new women and children's nursing clinic allows continuous efforts to be directed at preventing disenfranchisement from medical systems. Targeted health care needs of community members can now be satisfied in a safe and supportive environment. Their proactive stance allows Hispanics in Scott County to develop a framework for healthcare that can help build a foundation for preventative care.

Limitations

This study provided a glimpse into the health care needs for Hispanic residents in Scott County. Acknowledged limitations of this study include the relatively small sample size of focus groups. Participants were also sampled through convenience (all were in the same location for EvenStart) rather than through simple random sampling. Findings are only representative of the backgrounds and health care needs of the women present in the focus groups. Caution should be exercised when attempting to generalize results to all Hispanic patients.

Conclusions

The use of focus groups to target the Hispanic population was an effective mechanism for obtaining input. Participants were very giving of their time and information regarding both personal and community health care needs. As a result of the discussion the women asked if a community representative could come to EvenStart and give a talk about more options (for public assistance) for Hispanics in the community.

The results of this study reflect findings from the literature. Focus group findings had a high correlation rate with those cited in the literature review. Participants could easily identify culturally specific health care needs. The focus groups also promoted a sense of ownership in helping to assess needs of the community for the clinic use. Many of the women also expressed a desire to have more meetings (focus groups) so they could talk about other issues and concerns they faced. The success of their participation helped build confidence and lay a foundation for continued participation in community efforts to solve problems.

Recommendations

This study was intended to assess the health care needs of Hispanic residents for Scott County, Minnesota. Recommendations for system improvements and further research are intended to guide medical staff and public workers in implementing methods for improvement. Recommendations for the hospital foundation to pursue align with both corporate and strategic goals as well as initiatives funded and supported by public and community assistance programs. Formulated recommendations are also ethnically specific and targeted for the appropriate needs of the Hispanic community based on the conducted focus groups. The following recommendations and ideas for further research are not intended to all be implemented, but rather to be used as a tool to begin the process of closing the gap in barriers to seeking health care.

1.) Develop a culturally competent staff

- a. Culturally competent workers display behaviors and attitudes that reflect having knowledge of a specific culture. Individuals and other hospital systems with culturally competent workforces value, promote and support differences. This can be achieved through experience or formal education

and training. Communication processes may have to change in order to clearly transmit information.

- b. Provide cultural sensitivity training to medical staff. Techniques can be related so the staff understands implications for economic and family circumstances. Medical staff also need to understand how to relay information to the patient in a culturally appropriate way without offending him/her.
- c. Hire bilingual staff that can take a case-management approach for monolingual patients. Future medical appointments can be arranged and assessments can be followed-up based on referrals. A case management approach allows for increased patient-worker contact. Additional time should be made available to answer questions the patient has regarding medication management and other prescribed treatments. This method ensures the patient is fully aware of their diagnosis and understands the necessary care for treatment. Positive experiences (along with regular check-ups) will allow the patient to feel more comfortable returning.
- d. Acknowledge culturally related practices and home remedies. Dismissing native folk remedies often results in the patient not returning for care. Culturally competent care plans begin with validation of the correct usage of home remedies. Physicians need to be aware that these exist and that some medications may interfere with what is already being administered.
- e. Culturally competent workers acknowledge differences that are rooted in cultural norms. In many Hispanic cultures, when going to a clinic the patients always leave with something. Whether the “something” is a

prescription, vitamins, or a toothbrush, the patients never leave empty-handed. Frustrations can arise when expectations for care differ.

- f. Recognize that some cultural considerations may contribute to unhealthy lifestyles. Cultural considerations such as lack of adequate care, income level and location and safety of the home environment may all be outside factors that contribute to problems with nutrition and the rise of obesity in/among Hispanic children. The television often times becomes the caretaker for parents who must work without proper care for their children. Healthy food is often more expensive than high carbohydrate and low nutrition food. Unsafe neighborhoods and lack of police in certain neighborhoods can contribute to a lack of exercise and inability to play outside.
- g. Hispanics are not a single, monolithic population. Failure to understand the consequences of generalizing among Hispanic populations can have negative consequences. There are 21 different Spanish-speaking countries all with distinct cultural backgrounds. Assuming one group is the same as the next is inexcusable and limiting to treatments for care.

2.) Initiate Community Outreach Programs

- a. Establish community-based activities, including exercise programs for both parents and children. Health promotion programs can help to create support systems and foster friendships that lead to an atmosphere of support. Talking about health issues can begin to make Hispanics aware of the problems and start to take a vested interest in making improvements. These programs need to be well advertised.

- b. Set up community based initiatives that provide health education and community awareness outreach efforts. Outreach efforts can help to define disparities, and focus priority issues. Hispanics (and other minorities) may benefit from information and experts available to them in one location.
- c. Initiate a media outreach campaign. Communication mediums such as radio and television can have a profound impact on topics to which people pay attention. A continuous campaign can focus on the importance of preventative health care measures (like screenings) as well as modifying individual behaviors. Media messages can be developed with input from community action focus groups to make them relevant to the community.
- d. Conduct a health fair where people can come and ask questions and get valuable information regarding their health care concerns. Health promotion programs can also focus on reducing smoking and alcohol consumption, increasing physical activity, and improving eating habits. Ensure that all of this information is presented in Spanish and at an easily accessible location. Again, focus groups can provide insight into their needs.

3.) Communicate

- a. Continue conducting focus groups and other community assessments to identify community health needs. Delivery programs can also be evaluated through resident involvement. Bi-annual programs would allow for small, but necessary changes in healthcare. Hispanics in the community would have an opportunity to voice concerns and issues. A

wide venue of locations would allow for a culturally responsive assessment and be a more representative sampling of the community.

Focus groups allow professionals to determine what health care services are useful and what can be improved.

- b. Increase the number of nurses who are fluent in Spanish. Patients will be better able to voice their issues or concerns. Communication barriers can also be broken down in this way and less confusion can result for both parties. Bi-lingual healthcare workers can also lead to an improved condition in the overall health status of the patient. Allow nurses and other healthcare workers to attend language classes.
- c. Have information and other literature available to patients in Spanish. Literature is needed on a variety of topics stemming from stress reduction, asthma, diabetes prevention, cardiovascular disease, depression, and nutrition information. Find out (in community based focus groups) what information is needed and make it readily available at hospitals, clinics, community centers, and churches. Also, contact sheets with a list of resources are needed in Spanish with names and phone numbers of places to go for help that do not require health insurance.
- d. Initiate discussion in the exam room - involve the use of translators if necessary. Often time Hispanic patients are looking for a relationship with their clinician. Demonstrate “Personalismo” or a friendly, kind, and social approach to care. Showing respect for cultural differences and taking time to listen to the patient can make huge strides in closing the patient-care provider gap.

- e. Include Hispanic mothers in a care plan for their children. Facilitate dialogue to ensure understanding of the illness being treated. Ask what they are already doing to care for the child and assess their understanding of the treatment.
- f. Careful and thorough assessments should be exercised when considering the possibility of domestic abuse. Nurses and other medical workers need to understand the scope of this problem among Hispanic communities. Supportive environments allow a woman to feel more comfortable discussing potential situations for abuse. Among Hispanics, Spanish speaking healthcare workers also significantly contribute to the number of reported cases of abuse.

4.) Educate

- a. Implement peer education programs. Making contacts with Hispanic educators can have a positive impact on how well information is received. Also, peer educators can cut down on time some health care workers need to spend coaching patients. A 1998 study conducted by Doctor Denise Palmeri and her team of researchers (Auld, Taylor, Kendall, & Anderson) found that using Hispanic abuelas (grandmothers) as educators can have a tremendous effect on educational efforts as they are highly respected among Hispanic communities. To ensure accuracy and reliability, guidance and training may need to be administered to both peer educators and abuelas if this method is used.
- b. Have information about nutrition and other healthy eating habits readily available. Concern for inadequate nutrition and children being brought up

on unhealthy “American” foods like pizza, pop, and candy is leading to problems with obesity and diabetes. Offer cooking classes that include food preparation and healthy recipes as part of the curriculum.

- c. Continue to allow students to conduct research. The hospital can have access to valuable and useful information. This can usually be at low or no cost to the hospital. Students gain valuable research tools and at the same time can understand the dynamics of healthcare in relation to diverse populations.

5.) Other recommendations/initiatives to consider

- a. Begin a paradigm shift that allows the focus for healthcare solutions to move toward prevention, protection, and promotion instead of treatments for illnesses. Multiple parties (hospital, government, community etc...) can participate to make such an initiative successful. Strong partnerships and innovative methods can help to form a foundation for encouragement, engagement and empowerment of individuals. Such a paradigm shift will, over time, help individuals to learn to help themselves when it comes to taking charge of their health.
- b. Encourage regular cervical and breast exams. Set up days for free or low cost screenings. Set up a mobile clinic that can travel to various areas (schools, church, etc...) where Hispanics have easy access to receiving annual exams. Provide educational material in Spanish describing the benefits of receiving annual exams, and risks of not.
- c. Improve access to health care by allocating resources to public health clinics and systems. Public health can help pave the way in initiating new

outreach methods and identifying ways to provide education for Hispanics to live a healthy lifestyle.

Summary and Future Research

Improvements in health care service and accessibility for Hispanic residents in Scott County (and across the United States) are desperately needed. Following the recommendations outlined will allow health care providers to begin to meet the growing needs of this population. This is supported by research and validated through focus groups representing this population.

Recommendations for further research can also be assessed. A tremendous need for comprehensive dental care programs among Hispanics was astoundingly evident based on findings from the focus groups as well as personal interviews with public health clinicians. Identification of basic nutrition needs were also identified to be a major contributing factor for health problems among Hispanics. New investigations and programs need to be established to further review culturally specific nutrition needs of Hispanics.

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Appendix A: Midwest Latino and Total State Population Percentages for 1990 to 2000

Table 1

Growth in Midwest Population: Percent Latino and Total State Population 1990 to 2000.

Geography	1990 Latino %	2000 Latino %	Percent Change	1990 Total Population (in 1000s)	2000 Total Population (in 1000s)	Percent Change
<i>Midwest</i>	2.9	4.9	69.0	59,669	64,393	7.9
Illinois	7.9	12.3	55.7	11,431	12,419	8.6
Indiana	1.8	3.5	94.4	5,544	6,081	9.7
Iowa	1.2	2.8	133.3	2,777	2,926	5.4
Kansas	3.8	7.0	84.2	2,478	2,688	8.5
Michigan	2.2	3.3	50.0	9,295	9,938	6.9
Minnesota	1.2	2.9	141.7	4,375	4,919	12.4
Missouri	1.2	2.1	75.0	5,117	5,595	9.3
Nebraska	2.3	5.5	139.1	1,578	1,711	8.4
North Dakota	0.7	1.2	71.4	639	642	0.5
Ohio	1.3	1.9	46.2	10,847	11,353	4.7
South Dakota	0.8	1.4	75.0	696	755	8.5
Wisconsin	1.9	3.6	89.5	4,892	5,364	9.6

(U.S. Census Bureau, 1999-2000)

Appendix C: List of Codes

Code	Definition
NT/O	Nutrition and or concerns with obesity
P-N	Pre-Natal Care
DT	Diabetes
AE	Annual exams
PVT	Poverty Level
ED	Education
HI	Lack of health insurance
C	Cost
WF	Under representation in the workforce or lack of culture savvy workers
CB	Communication Barriers
IA	Fear of immigration authorities
NFR	Native Folk Remedies
DNT	Dental

Appendix D: Focus Group Questions in Spanish

El cuestionario

Introducción:

Primero, presentarse. Explique que vamos a hacer algunas preguntas sobre servicios de salud. Todas las respuestas son completamente confidenciales y no nos recordamos de sus nombres. Las respuestas pueden ayudar a aconsejar al personal del hospital en cómo encontrar sus necesidades de asistencia sanitaria.

¿Quiere usted hacer cualquier pregunta antes de empezar?

Digame su nombre y cuánto tiempo ha estado en los Estados Unidos.

1. ¿A usted le gusta vivir en Minnesota? ¿Por qué o por qué no?
2. ¿Qué piensa usted es el ajuste más grande que usted ha tenido que hacer desde su llegada a Minnesota?
3. ¿Qué es su preocupación más grande de su salud?
4. ¿En que manera encuentra usted (o su familia) servicios de salud.
5. En su opinión, ¿cuáles son las necesidades más grandes de la salud de mujeres (o de hombres o de niños) en la comunidad hispana? ¿Por qué?
6. En su opinión, ¿que la ayudaría a usted como mujer (O que ayudaría a los hombres o niños) a obtener el cuidado que necesita? (El personal bilingüe, horas convenientes, el transporte etc...)
7. ¿Ha usted necesitado asistencia médica durante el último año sin poder conseguirlas? (O un miembro de su familia).
 - A. Si no, ¿dónde consiguió usted el cuidado médico?
8. ¿Ha usted necesitado asistencia dental en el último año sin poder conseguirla (O un miembro de su familia).
 - A. ¿En este caso, ¿por qué no pudo usted conseguir ayuda?
 - B. ¿Si usted consiguió ayuda, ¿dónde la consiguió?
9. ¿Hay problemas en la comunidad hispana con el estrés, el alcoholismo, o el abuso doméstico? ¿Donde se busca ayuda con estos problemas?
10. En general, ¿cree usted que los latinos saben que los hospitales y clínicas no dan información medical ni nombres a personas oficiales de la inmigración?

A. Cuál es la mejor manera para informarse?

11. ¿Quiénes son los mayores empleadores de inmigrantes o refugiados?

A. Ellos ofrecen seguros médicos a sus empleados?

12. ¿Cuál es el lugar más conveniente a usted para recibir los servicios de asistencia médica (centro comercial, en el trabajo, en el edificio de apartamento, el hospital, etc...)?

¿Utilizaría usted los servicios de asistencia médica de su empleador?

Gracias por hablar con nosotros. ¿Quiere usted hacer más preguntas?

Appendix E: Focus Group Questions in English

Questionnaire:

Introduction:

Explain that St. Francis has pulled together a group of persons who are refugees/and or immigrants to Scott County, Minnesota who can help advise the hospital in how to meet their healthcare needs. I'll be asking what services are currently available to meet you and your family's needs; the type of services or help that immigrants need that isn't available; and the problems people have in getting available services. Note that the things that you say today are completely confidential and will only be reported in a way so that no one reading the group summary could identify the source/person of a particular piece of information or opinion.

Any questions before we start?

We're going to go around the room and have everyone tell us your name (first name only) and how long you have been in the United States.

1. Has living in the Minnesota been what you expected? Why or why not?
2. What do you think is the biggest adjustment you have had to make since moving to Scott County?
3. What is your biggest health worry?
4. How do people in the Hispanic community find out about available health care services?
5. What do you think are the greatest health needs of women (or men or children) in the Hispanic community? Why?
6. What do you think would help women (or men or children) get the care they need? (Bi-lingual staff, convenient hours, transportation etc...)
7. Have you or a family member needed health care in the last year but were unable to get it?
 - a. If yes, why didn't you get care?
 - b. If no, where did you get care?
8. Have you or a family member needed dental care in the last year but were unable to get it?
 - a. If yes, why didn't you get care?
 - b. If no, where did you get care?

9. Are behavioral health issues, such as stress, alcoholism, or domestic abuse, a problem in the Hispanic community? Do people have a place to go for help with these issues? If so, where?
10. How could health care providers better inform recent immigrants/refuges that their health care information can't be provided to anyone without the patient's permission?
11. Who are the major employers of immigrants/refugees? Do they provide care or insurance to their employees?
12. What is the most convenient place for you to receive health care services (shopping center, employer, apartment building, hospital, etc...)? Would you use health care services provided at your employer?

Thank you for taking time to speak with me. Should you have any questions, concerns, or additional thoughts you would like to share after today, please do not hesitate to contact me. Information will be provided in the beginning of the session.