

Disparities in Health Access: Voices from Minnesota's Latino Community

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El objetivo de HACER es aumentar la capacidad de la comunidad Hispana para crear y controlar la información acerca de sí misma para influenciar la toma de decisiones y planeación a nivel institucional. HACER es una colaboración de CURA (Centro para Asuntos Regionales y Urbanos) de la Universidad de Minnesota, la Universidad Estatal Metropolitana, el Condado de Ramsey, y CLUES (Chicanos Latinos Unidos En Servicio.)

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HACER's purpose is to increase the capacity of the Hispanic community to create and control information about itself in order to affect critical institutional decision making and planning. HACER is a collaborative of CURA (Center for Urban and Regional Affairs) of the University of Minnesota, Metropolitan State University, Ramsey County, and CLUES (Chicanos Latinos Unidos en Servicio.) Interim Director: Claudia Fuentes.

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Table of Contents

I.	Executive Summary.....	1
	Resumen Ejecutivo.....	4
II.	Introduction: Health Access and Minnesota’s Latino Community.....	7
III.	Study Methods and Approach.....	10
	A. Project Description.....	10
	B. Overview of Focus Groups.....	10
	C. Geographic Description of Communities Visited.....	11
IV.	Overview of Findings.....	14
	A. Process, Knowledge and Education.....	14
	US Health Care System Difficult to Maneuver.....	14
	Confusion About the Concept of Health Insurance and Role of Public Programs....	15
	Cultural Barriers are Significant.....	16
	Differences between Rural and Metro Groups.....	16
	B. Access to Care and Health Insurance Coverage.....	17
	Lack of Insurance Coverage.....	17
	Employer-Specific Issues Related to Access.....	17
	Cost of Care.....	18
	Strained Patient/Provider Relations.....	19
	Location of Health Services Varied.....	20
	Access Barriers Create Difficult Choices.....	21
	Differences between Rural and Metro Groups.....	21
	C. Service Quality and Health Status.....	22
	Lack of Preventative Care.....	22
	Occupational Health at Meat- and Poultry-Processing Plants a Major Issue.....	22
	Accessing Affordable Housing Not Easy.....	23
	Differences between Rural and Metro Groups.....	23
V.	Additional Cultural Issues.....	24
	A. Heterogeneity.....	24
	B. Cultural Norms and Communication.....	24
	C. Attitudes and Values.....	26
VI.	Recommendations.....	27
	A. Focus Group Member Recommendations.....	27
	B. Policy Recommendations.....	28
	C. Increase Access to Health Insurance.....	28
	D. Implement Enrollment Specialists to Facilitate the Insurance Enrollment Process....	29
	E. Improve Provider and Service Delivery.....	29
	F. Data Collection and Information Collection.....	29
VII.	Bibliography.....	30
VIII.	Appendix A: Demographic Questionnaire.....	31
	Questionario Demografico.....	31
IX.	Appendix B: Questions from July 1999, May 2001.....	32
	Preguntas.....	34
X.	Appendix C: Latino Health Advisory Committee Members.....	36

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Executive Summary

Minnesota has experienced several demographic changes in the last decade, including a significant increase in the number of Latino residents living in both rural and urban areas. These changes have brought diversity to Minnesota, as well as challenges to meet the health and social needs of new populations. This report presents the results of a series of focus groups conducted with Latinos in Minnesota to discuss issues related to health care access issues.

The report represents the synthesis of eight Latino focus group findings, conducted over the course of a two-year period. These focus groups were funded by several programs including the Minnesota Department of Health (MDH), the Minnesota Medical Foundation, and most recently by the U.S. Health Resources and Service Administration State Planning Grant through a sub-contract to the University of Minnesota¹ (1). The study represents a collaborative community-based research approach. Included in the collaborative were investigators from University of Minnesota School of Public Health, Division of Health Services Research and Policy, and Hispanic Advocacy and Community Empowerment through Research (HACER) with input from The Minnesota Department of Health (MDH). The focus of this ongoing research has been to understand the health and health care access needs of Latinos in Minnesota. Our aim was to understand community members' concerns, needs and knowledge of existing programs and services in an effort to better target programs and policies. The focus group results presented in this

report represent four metro and four rural communities. Also included in this summary report are the results of an additional three rural focus groups conducted by Kathy Seolle-McAllister in 1998. The goal of this research was consistent with the current project and has provided an additional voice for Latinos in rural Minnesota. Our key findings include the following points which fell into three broad categories 1) process, knowledge and education, 2) access to health care, and 3) health status.

Focus group participants discussed a number of barriers to accessing adequate health care.



¹Three of the eleven focus groups were conducted and analyzed as part of a School of Public Health student's master's thesis.

Many (Latinos) said they have to make difficult decisions and must weigh the need for health care against other basic needs.

Process, Knowledge and Education

▷ Many Latinos find it difficult to understand the dynamics of the U.S. health care system and the concepts of health insurance. We found a lack of understanding of the difference between Medicare and Medicaid, as well as confusion over such concepts as deductibles, co-pays and insurance. Maneuvering the health care system is difficult and at times overwhelming. A majority of participants feel that they needed more information on how the system works.

▷ Many Latinos who are familiar with Medical Assistance and MinnesotaCare meet obstacles when it comes to finding out more about these programs and work predominantly with English-speaking program officers. Title VI of the Civil Rights Act of 1964 requires that all programs receiving federal assistance (such as Medicare and Medicaid) are structured to provide appropriate interpretive services and translation of written materials for clients with limited English proficiency. Yet lack of Spanish materials and Spanish-speaking case-workers is a common complaint. Additionally, many participants don't know where to go to find out more about available health care services and assistance.

▷ Several participants said that they or others they know inadvertently decide that they were not eligible for services, before they check out the requirements. These decisions are based on rumors, eligibility requirements of other states where they previously lived, as well as on expectations about income qualifications. Information is often shared by word-of-mouth through community and family relations.

▷ Many participants fear encounters with government institutions. Even if a person had legal status, there is concern about the role of the U.S. government and fear of deportation. It is because of this that government sponsorship and/or government involvement in public health care programs is often a concern for Latinos.

Access to Care and Health Insurance Coverage

▷ The cost of health care, including the cost of premiums, deductibles and co-pays is a significant concern for focus group participants. Many said they have to make difficult decisions and must weigh the need for health care against other basic needs. This leads to access problems and infrequent use of clinics and providers unless absolutely necessary.

▷ There is a general clash of cultures, lack of comprehensible information and limited professional understanding of cultural issues by the public health and medical professions. Together, these create a situation that is extremely frustrating to Latinos new to Minnesota.

▷ While some individuals have found providers and clinics that meet their needs and understand their health concerns, others encounter problems with interpreter services and cultural understanding on the part of providers and clinic staff. For these reasons, participants frequently expressed disappointment with available providers.

▷ Many individuals find the cost of both private and some public insurance programs to be prohibitive. It is because of this that, even when their employers offer insurance as an option, many individuals feel they cannot afford to purchase it.

▷ Metro group participants spoke of using hospital emergency room services more frequently than the rural participants did. They also noted long waits before they could arrange an appointment with a provider, as well as long waits once they were in the health care facility.

▷ Rural group participants spoke of geographic location more often than metro group participants did. They told of difficulties in travel and noted that the only available hospital is sometimes a long distance from their homes.

Service Quality and Health Status

▷ There are numerous concerns that affect health which were expressed by the Latino community including housing issues, occupational safety concerns, and issues with the more vulnerable members of their communities (such as the elderly, diabetic, etc.)

▷ Several participants said that they feel knowledgeable about the need for preventive services, but believe that prevention is not always possible if it means extra doctor visits for screenings. Participants associated any trip to the doctor or hospital with significant out-of-pocket costs. The above dilemma often leads to difficult choices in care for participants, including lack of care when needed.

▷ Metro group participants listed more neighborhood and housing issues (such as a lack of affordable housing and poor upkeep) as a cause of health issues than those participants from rural groups. Rural focus groups tended to discuss employer discrimination and occupational hazards as health issues more than their metro counterparts.

The overwhelming response to the focus groups was positive. The group participants were interested in sharing their concerns and seemed hopeful that they could assist in making improvements to existing programs. Several participants stressed the importance of proper dissemination of focus group results to community members. Often times they are involved in research but do not see the results or findings. They also spoke of the importance of a collaborative, community approach when trying to engage Latinos in health care system improvements.

Resumen Ejecutivo

Muchos (latinos) dijeron que tuvieron que tomar decisiones difíciles y que compararon la importancia de contar con servicios de salud con la de otras necesidades básicas.

Minnesota ha experimentado varios cambios demográficos en la década pasada, incluyendo un aumento significativo en el número de residentes latinos que viven en áreas rurales y urbanas. Estos cambios han traído diversidad a Minnesota, pero también nos enfrentan al reto de satisfacer las necesidades sociales y de salud de las nuevas poblaciones. Este reporte presenta los resultados de una serie de estudios realizados con latinos en Minnesota utilizando grupos de enfoque donde se discutió el acceso a los servicios de salud.

Este reporte sintetiza los encuentros de ocho grupos de enfoque, llevados a cabo durante un periodo de dos años. Estos grupos de enfoque fueron financiados por varias instituciones incluyendo el departamento de salud de Minnesota (Minnesota Department of Health), la fundación médica de Minnesota (Minnesota Medical Foundation), y más recientemente por fondos otorgados por el departamento de recursos para la salud y servicios administrativos de los Estados Unidos para la planificación a nivel estatal (United States Health Resources and Service Administration State Planning Grant) a la Universidad de Minnesota quién ha sido subcontratada por dicho departamento² (1). El estudio representa un método de investigación basado en la colaboración y la comunidad. Los colaboradores incluyeron investigadores de la escuela de salud pública de la Universidad de

Minnesota, la división de investigación de servicios de salud, y HACER. El enfoque de ésta investigación que está en curso ha sido entender mejor las cuestiones de salud y de acceso a los servicios de salud de los latinos en Minnesota. Nuestro objetivo era entender las preocupaciones de los miembros de la comunidad, sus necesidades y su conocimiento acerca de los programas y servicios existentes.

Los resultados de los grupos de enfoque incluidos en este reporte representan cuatro comunidades metropolitanas y cuatro comunidades rurales. Los resultados de tres grupos de enfoque en comunidades rurales, obtenidos por Kathy Seolle-McAllister en 1998, también se incluyeron en este resumen. El objetivo de esta investigación fue consistente con el proyecto que se está llevando a cabo y ha dotado una voz adicional a los latinos en las comunidades rurales de Minnesota. Nuestros resultados más importantes incluyen los cuatro puntos siguientes que a su vez clasificamos en tres amplias categorías 1) proceso, conocimiento y educación, 2) acceso a los servicios de salud, y 3) el estado de salud.

Proceso, Conocimiento y Educación

▷ Muchos latinos han encontrado difícil entender las dinámicas y conceptos del sistema de servicios de salud y seguro médico de los Estados Unidos. Encontramos una falta de entendimiento

² De los once grupos de enfoque, tres fueron realizados y analizados como parte de una tesis de Maestría de una estudiante en la escuela de salud pública en la Universidad de Minnesota.

de la diferencia entre Medicare y Medicaid y también confusión sobre conceptos como deducibles, co-pagos y seguro médico. Navegar dentro del sistema de salud es difícil y a veces abrumador. La mayoría de los participantes sentían que necesitaban más información acerca de como trabaja el sistema.

▷ Muchos de los latinos que estaban familiarizados con los servicios de salud y Minnesota Care frecuentemente enfrentaron obstáculos al tratar de encontrar más información sobre estos programas y la mayoría de las veces se encontraron con oficiales que hablaban inglés. El Título VI del Acto de Derechos Ciudadanos del 1964 requiere que todos los programas que reciben asistencia federal (como el Medicare y Medicaid) sean estructurados para proveer servicios de interpretación y traducción de materiales escritos apropiados para clientes con capacidad limitada de inglés, sin embargo una queja común de los participantes fue la falta de literatura en español y de trabajadores que hablaran español. Además, muchos participantes no sabían adónde ir para buscar más asistencia e información sobre los servicios de salud disponibles.

▷ Varios participantes dijeron que se pronunciaron como no elegibles para servicios inadvertidamente, sin primero revisar los requisitos. Estas decisiones frecuentemente se basaron en rumores y en las expectativas sobre los requisitos de ingreso. La información con frecuencia es compartida verbalmente a través de la comunidad y la familia.

▷ Muchos participantes temían enfrentar a las instituciones del gobierno. Incluso si una persona contaba con estatus legal, se preocupaba sobre el rol del gobierno de los Estados Unidos y temía ser deportado. Por esta razón, el patrocinio y/o involucramiento del gobierno en los programas de salud pública eran frecuentemente expresados como preocupaciones.

Acceso al Cuidado y a la Cobertura de Seguro Médico

▷ Una de las preocupaciones significativas para los participantes de los grupos de enfoque era el costo de los servicios de salud, incluyendo el costo de las primas de seguro, deducibles, y co-pagos.

Muchos dijeron que tuvieron que tomar decisiones difíciles y que compararon la importancia de contar con servicios de salud con la de otras necesidades básicas. Esto resulta en problemas con el acceso y uso infrecuente de clínicas y proveedores a menos que sea absolutamente necesario.

▷ En general existe un choque de culturas, falta de información comprensible, y comprensión limitada de cuestiones culturales por parte de la profesión médica y de los trabajadores de salud. Combinados, estos problemas crean una situación que es extremadamente frustrante para los latinos que recién llegan a Minnesota.

Los problemas que enfrentan muchos latinos con relación a servicios de salud crean una situación extremadamente frustrante.



- ▷ Mientras algunos individuos encontraron proveedores y clínicas que satisficieron sus necesidades y entendieron sus preocupaciones de salud, otros enfrentaron problemas con servicios de intérpretes y con el entendimiento cultural de parte de los proveedores y empleados de las clínicas. Por estas razones, los participantes expresaron con frecuencia desilusión con los proveedores disponibles.
- ▷ Muchos individuos encontraron el costo del seguro privado y el de algunos programas públicos igual de prohibitivo. Por esta razón, hasta cuando sus empleadores le ofrecieron el seguro como una opción, muchos individuos sentían que no tenían con que compararlo.
- ▷ Los participantes del grupo metropolitano hablaron del uso de la sala de emergencias del hospital con más frecuencia que los participantes de las áreas rurales. También mencionaron largas esperas antes de recibir una cita con un proveedor, además de las largas esperas una vez que estaban en el establecimiento de cuidado medico.
- ▷ Los participantes de los grupos rurales hablaron de la localización geográfica con más frecuencia que los participantes del grupo metropolitano. Ellos contaron de las dificultades para viajar y mencionaron que a veces el único hospital disponible queda a largas distancias de sus hogares.

Calidad de Servicios y el Estatus de Salud

- ▷ Hay varias preocupaciones expresadas por la comunidad latina relacionadas a la salud incluyendo a cuestiones de vivienda, preocupaciones sobre la seguridad en el trabajo, y asuntos con los miembros más vulnerables de sus comunidades (como la gente mayor, diabéticos, etc.) Había una preocupación en general sobre como conseguir los servicios que necesitaban, y más específicamente por el costo.
- ▷ Varios participantes se sentían bien informados sobre la necesidad de servicios preventivos, pero veían que la prevención no es siempre posible si requiere visitas adicionales al doctor. Los participantes asociaban cualquier visita al doctor o al hospital con costos significativos. Este dilema frecuentemente resulta en decisiones difíciles sobre el cuidado para los participantes, incluyendo una falta de atención cuando ésta es necesaria
- ▷ Los participantes de los grupos metropolitanos enumeraron más cuestiones de la vecindad y de la vivienda como causas de problemas de salud que los participantes de los grupos rurales. Los grupos de enfoque rurales tendían a mencionar la discriminación de empleadores y riesgos ocupacionales como problemas para la salud más que los grupos metropolitanos.

La gran respuesta al proceso de los grupos de enfoque fue positiva. Los participantes de los grupos estaban interesados en compartir sus preocupaciones y parecían esperanzados en que podrían ayudar a traer mejoramientos a los programas que existen ahora. Varios participantes enfatizaron la importancia de la difusión apropiada de los resultados de estos grupos a los miembros de la comunidad. Frecuentemente, los miembros de la comunidad participan en investigaciones pero no ven los resultados. También hablaron de la importancia de usar un método comunitario y cooperativo cuando se trata de involucrar a los latinos en mejorar el sistema de servicios de salud.

This report examines the health challenges and concerns of Latinos in Minnesota, building upon recent collaborative research conducted by the University of Minnesota School of Public Health and Minnesota’s Latino community, represented by HACER. The purpose of this study is to further examine health insurance knowledge and attitudes, sources of care, and accessibility of care within the Minnesota Latino community. An initial summary report entitled, “Public Health and Health Care Access: Minnesota’s Latino Community” (2), served as the foundation for the focus group research analyzed in the following pages.

Our research uses the most recent 2000 U.S. Census data to provide an overview of the growth of Latinos in Minnesota. Following a profile of Latinos in Minnesota, the overall study approach is presented along with the results from eight focus groups conducted with Latino immigrants in urban and rural Minnesota counties, plus the results of three additional focus group described in “A Needs Assessment of Latinos in Madelia,

Minnesota” by K. Seolle-McAllister. We conclude with a discussion of the implications of changing demographic trends for the health care system and provide recommendations for continued research.

Health Access and Minnesota’s Latino Community

Information from the 2000 U.S. Census estimated that almost 13 percent of the U.S. population, or 35.3 million people in the U.S. are of Latino origin. Latinos are now the largest minority group in the U.S. (3). It is estimated that by the year 2005, Latinos will surpass African Americans as the largest racial/ethnic group in Minnesota, and may have already when undocumented Latinos are considered. While much of the focus on population changes within the Latino community is concentrated on border states, this growth is projected across the entire U.S. More than 36 states expect to see a 150 percent increase in the number of Latinos in the next twenty-five years, with projections including rural as well as urban counties (4).

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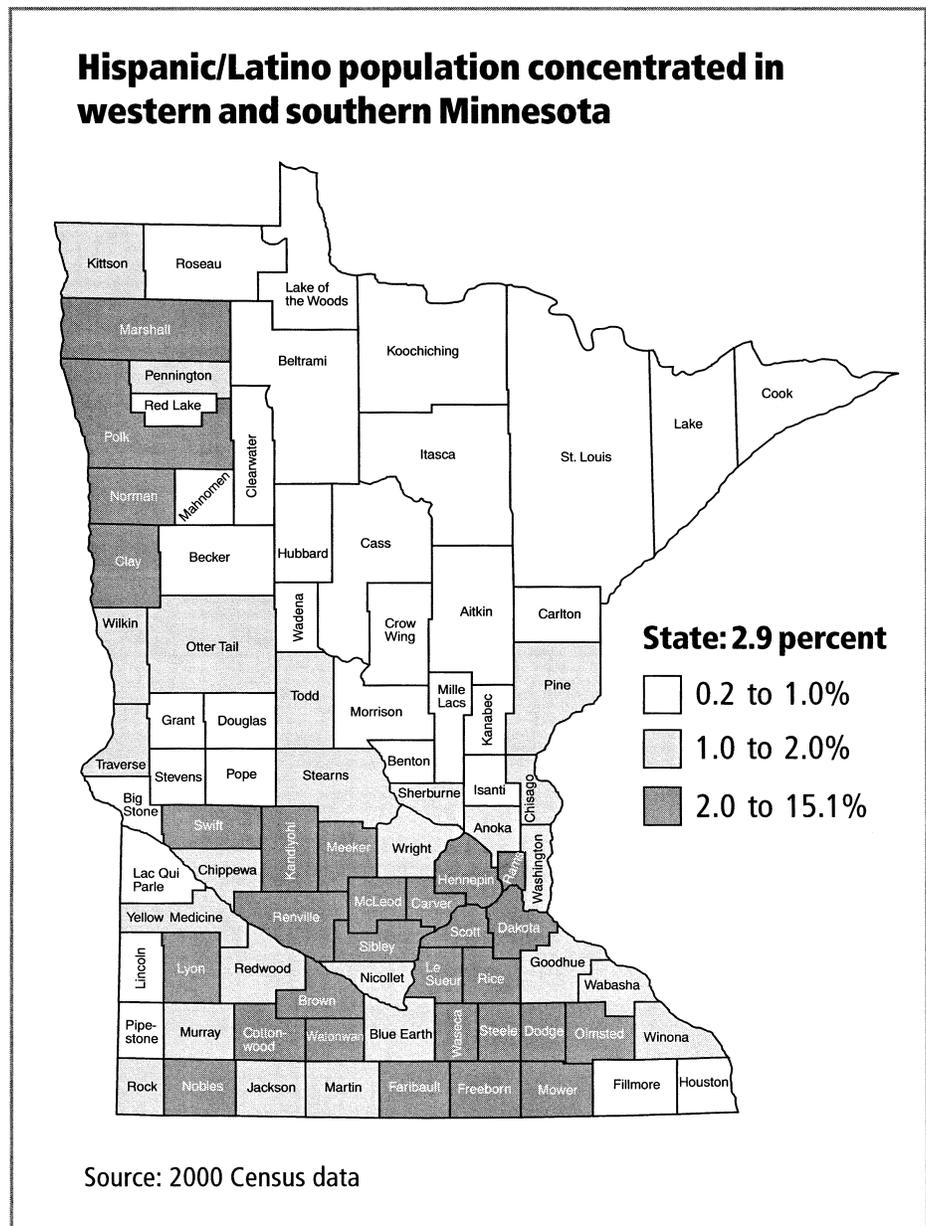
Table 1. Latino Focus Group Locations and Totals

City	Number of Groups and Participants
Worthington (Nobles County)	2 groups; 15 participants
Pelican Rapids (Otter Tail County)	1 group; 7 participants
St. James (Watonwan County)	1 group; 9 participants
Madelia (Watonwan County)	3 groups; 22 participants
Minneapolis/St. Paul (Hennepin and Ramsey Counties)	4 groups; 33 participants
Total	11 groups; 86 participants

Looking at Minnesota's demographics, we find that Latinos are the fastest growing with a growth rate of 166 percent during the 1990s from 53,884 to 143,382 (5). The Minnesota Planning Department predicts that the Hispanic-origin population will grow almost 250 percent between 1995 and 2025, compared to an 8 percent increase in the white population and just over 100 percent growth in the African American and Asian/Pacific Islander populations. If the estimates are correct, Minnesota's Latino population will grow to approximately 296,400 in 2025 (6).

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And while two-thirds of Minnesota's Latino population resides in the seven-county metropolitan area, as of the 2000 U.S. Census there were nine non-Metro Minnesota counties that had Latino populations numbering greater than 1,500 (7). The following illustration from the Minnesota Planning Department shows which counties experienced the highest growth rates between 1990 and 2000 as well as how the Latino population is largely concentrated in western and southern Minnesota (8).



Lack of access to health care is one of the most pressing health problems that Latinos face. As the fastest growing population in Minnesota, Latinos are more likely than other ethnic groups to be uninsured and in fair or poor health, even when they have higher incomes (9). In 1999, national rates of Latino uninsurance were 33 percent. Preliminary findings from the Minnesota Health Access Survey from 2000, which included oversampling for minority populations, showed that Hispanics had the highest rates of uninsurance among minority groups, at 18 percent (10). Even though the rates of Latinos who lack insurance are lower in Minnesota than the national average, the gap between white non-Latinos and Latinos is greater. There are three times as many Latinos without health insurance as white non-Latinos in Minnesota compared to twice that number nationally (10).

There are many reasons for lack of health insurance among Latinos, as supported by our focus group findings. A common reason is that most literature and information about health insurance, both public and private, is only offered to Latinos in English. However, Title VI of the Civil Rights Act of 1964 (28 C.R.F. Part 42, Subpart F) requires that all programs receiving federal assistance (such as Medicare and Medicaid) are structured to provide appropriate interpretive services and translation of written materials for clients with limited English proficiency. Unfortunately, there were many reported instances in Minnesota where there were no Spanish materials available to explain or promote existing public programs. Employer-based health insurance programs are not under such legal requirements, so the availability of interpreters is even more rare.

Both documented and undocumented Latinos find themselves unable to obtain health care services that are widely available to other individuals. It is a common occurrence for taxpaying citizens who are eligible for government services to be faced with barriers to enrollment and access of public health care services. Undocumented immigrants find themselves in an even more complicated situation — they risk their health by not seeking health care when needed, or they risk their chance of survival here in the U.S. by possibly being reported as undocumented. There has been talk, but no direct action, on national legislative action granting amnesty to many undocumented immigrants in the U.S. These proposals focus on offering fair treatment and services for people who have lived and worked in this country for years, leading productive lives and contributing to the economic vitality of the country.

Undocumented workers make significant contributions to the U.S. economy, many of which go unrecognized. A September, 2000 HACER report titled “The Economic Impact of Undocumented Workers in Minnesota” outlines these contributions. For example, these workers generate economic activity, in turn producing taxable income, property taxes and fees. They produce services and goods that are of value to consumers and stimulate demands in the economy that create jobs for other workers. Estimates from the report place contributions from undocumented labor in Minnesota to be worth at least \$1.6, and more likely \$3.8 billion to the Minnesota economy (11). This translates into approximately 2.4% of the Minnesota Gross State Product coming from undocumented labor in Minnesota (11).

As the fastest growing population in Minnesota, Latinos are more likely than other ethnic groups to be uninsured and in fair or poor health, even when they have higher incomes

Study Methods and Approach

Overall, over half of the participants said they had children, and most had some sort of health coverage for their children. However, many individuals said that they, themselves, had no insurance coverage.

This project grew from a community-based collaborative research effort organized to assess the health and health access needs of the growing Latino population in Minnesota. Research that comes from within the community of interest, also known as participatory research, may be more valuable than interventions that come from the dominant culture without sufficient collaboration. Several researchers cite community support and collaboration as key to the success of their assessments and surveys, some noting that this type of organizational structure helps to keep the research connected with the views, attitudes and feelings of the groups of interest (12,13).

Project Description

Beginning in 1999, researchers from the University of Minnesota School of Public Health worked collaboratively with a Latino Health Advisory Committee made up of representatives from several local Latino research and advocacy organizations (see Appendix C for list of members). This collaboration was intended to facilitate access to populations in addition to providing a vehicle to disseminate findings back to the community through Latino-based media and community organizations.

The research design involved a multi-component project with two phases. The first phase consisted of a comprehensive literature review of Latino health and access, based on both national and local studies and reports, and 19 key-informant interviews with leaders from the Latino

community who were selected by the Latino Health Advisory Committee for their knowledge about health and health care access issues among Latinos in Minnesota. This initial phase culminated in a comprehensive report, “Public Health and Health Care Access: Minnesota’s Latino Community” (2).

Phase Two of the project involved conducting focus groups around the state in both rural and urban areas. We completed four focus groups in rural and four in urban areas.³ This report highlights the key findings of the focus groups (Phase Two), building on the rich information and knowledge-based development in the first phase of the project.

Overview of Focus Groups

The project involved eight focus groups, conducted in Spanish, in four metro and four rural Minnesota communities. The metro groups took place in Minneapolis and St. Paul and were coordinated through the assistance of several community groups including La Clinica in St. Paul, along with Chicanos Latinos Unidos En Servicio (CLUES), and Guatemalans/Latinos United Efforts. Rural communities were chosen based on the following criteria: (1) they were in counties with a significant number of Latinos who live and work in the community; and (2) local contacts were available to recruit community members for focus groups. While these communities were not meant to be representative of all rural Minnesota, they served as an important

³Two of the four urban focus groups were funded by the Minnesota Department of Health HRSA Planning Grant and used a slightly altered set of questions (Appendix B).

first step in collecting health and health care access information on Latino communities that are adjusting to life in rural Minnesota.

A local community member was solicited to assist in the study process and recruited participants in each of the focus groups. The contact was provided with information about the study and disseminated it to Latino community members as part of the recruiting process. This contact person described the study to potential participants as a collaborative research project conducted by investigators who were interested in learning about Latino health care experiences. The participants were asked a series of questions regarding their demographics and health care utilization experiences. All of the focus groups were conducted in Spanish, taped, transcribed, and translated into English. Each session was moderated by a staff person from HACER and lasted for approximately 90 to 120 minutes. Both the community member and the participants were paid a nominal fee for their participation.

The focus groups in each community consisted of six to fifteen persons plus the three Madelia groups for a total of 86 individuals overall. Each group varied by sex, age, country of origin, immigration status, health insurance status, employment status, and years residing in the U.S. and Minnesota. In one group, most of the participants were originally from Mexico. In another, there was a wide assortment of Latino countries represented. And in yet another, many of the participants had lived in California and Texas before coming to Minnesota. Overall, over half of the participants said they had children, and most had some sort of health coverage for their children. However, many individuals said that they, themselves, had no insurance coverage. While a small minority of participants had group coverage through an employer, most of these individuals were not able to pay the premium for their entire family. Others told of being on a variety of public programs

including, MinnesotaCare (Minnesota's state subsidy program for the working poor) and Medical Assistance (MA).

Geographic Description of Communities Visited

The following descriptions will give some general characteristics of the communities we visited. In our summary we have also included results from an additional focus group study conducted in Madelia, MN, in 1998 (1). Although not part of the current study, the approach was similar and the results were consistent with our findings.

Focus group participants varied in sex, age, country of origin, immigration status, health insurance status, employment status and years residing in the U.S.



St. Paul, MN – St. Paul lies in Ramsey County and has a population of approximately 287,151 with 7.9 percent (27,715 people) of the population estimated to be Latino (7). The Hispanic growth rate between 1990 and 2000 was 98 percent (14).

We conducted two focus groups in St. Paul: One group of seven women who had varying lengths of time in the U.S. (from three months to ten years), and one mixed group of nine men and women, six of whom came from Mexico. In both groups, the majority did not have health insurance. One person had insurance through his employer and one had MinnesotaCare. Many participants used health care services at La Clinica, a sliding fee scale clinic with Spanish speaking providers that is part of the Westside Health Center. The local hospital, owned by Ramsey County, but leased by HealthPartners, is Regions Hospital in downtown St. Paul.

Minneapolis, MN – Minneapolis is located in Hennepin County and has a total population of approximately 382,618 (7). Minneapolis has a Latino population of approximately 7.6 percent (29,175) individuals (7). The Latino growth rate between years 1990 and 2000 was 269 percent (14).

We conducted two focus groups in Minneapolis: One group consisted of four men and four women who had all been in the U.S. a relatively short period of time and were from a mixture of Latin American countries. The second group was made up of six men and three women, again most of whom had been in Minnesota under two years, but most of whom had arrived from other U.S. cities. Only three of the seventeen had health insurance. Of those who had coverage, two had employer coverage and one had MinnesotaCare. Many of the participants use health care services at Hennepin County Medical Center (HCMC) located in downtown Minneapolis.

Worthington, MN – Worthington is located in Southwest Minnesota in Nobles County. The 2000 total population for Worthington was 11,283 with 19 percent (2,175 people) of the population estimated to be Latino (7). The Hispanic growth rate between 1990 and 2000 was 798 percent (14).

We conducted two focus groups in Worthington: one group of eight women and one group of seven men, representing multiple Latino backgrounds. In the group with eight women, three people did not have insurance coverage. Medical Assistance covered four people and one person had coverage through her employer. Within the group of seven men, three had employer based coverage, one had Medical Assistance and three were uninsured. Swift & Company, a pork processing plant, and subsidiary of ConAgra, employs many of the participants.

The two primary sources of health care available to the groups were Worthington Regional Hospital and the local Worthington Specialty Clinic. Medicaid and family coverage from Swift insured some of the participants, but many completely lacked coverage.

Pelican Rapids, MN – Pelican Rapids is located in West Central Minnesota in Otter Tail County. The 2000 total population estimate for Pelican Rapids was 2,374 with 19.5 percent (465 people) of the population estimated to be Latino (7). The Hispanic growth rate between 1990 and 2000 was 849 percent (14).

The focus group consisted of six women and one man. Similar to Worthington, most of the people interviewed were employed by the meat and poultry processing industry. One had coverage through work, three had MinnesotaCare, two were on MA and one was uninsured. West Central Turkeys is the largest employer in Pelican Rapids, and employed 36 percent of the entire town's population in 1998.

The primary source of health care available to the group is the Pelican Valley Health Center, which employs two physicians. The closest hospital to the town is located 22 miles away in Fergus Falls. The participants were insured by public and private programs and some had no coverage. All moved to Minnesota after living in another state for a significant period of time, which may also play a role in health care access. For example, the differences in state Medicaid programs (including outreach, eligibility and enrollment processes) may create confusion among those who came from states with different policies and procedures.

St. James, MN – St. James is located in South Central Minnesota in Watonwan County. The 2000 total population estimate for St. James was 4,695 with 24 percent (1,116 people) of the population estimated to be Latino (7). The Hispanic growth rate between 1990 and 2000 was 236 percent (14).

Our focus group consisted of twelve women and three men. Of the fifteen participants, five had insurance coverage through their employers, four were enrolled in MinnesotaCare, four were uninsured, one was on MA and one was on Medicare. Two of the largest employers of the Latino population are Swift-Eckrich and Tony Downs Foods. Swift-Eckrich, another meat processing ConAgra subsidiary, employs 550 people, and is the city's largest employer. Tony Downs Foods is a locally owned food preparation company that employs 55 people. About 94 percent of St. James Latinos are of Mexican origin, which can be partially attributed to the hiring practices of Tony Downs Foods. In the past, Tony Downs has sent recruiters into Texas and Mexico to bus workers up to processing plants in St. James and other regional locations. St. James health care facilities include a local hospital and two clinics.

Madelia, MN – Madelia is also located in South Central Minnesota in Watonwan County. The 2000 total population estimate for Madelia was 2,340 with 21 percent (491 people) of the population estimated to be Latino (7). The Hispanic growth rate between 1990 and 2000 was 148 percent (14).

There were three focus groups ranging from six to nine members, for a total of 22 participants. Approximately 90 percent of the Latinos in Madelia work for Tony Downs Foods. The two primary sources of health care services available to the groups were Madelia Community Hospital and the local Madelia Clinic. Many of the participants lacked insurance coverage, or received insurance through Tony Downs Foods.

Focus groups were conducted throughout the state in both metro and rural areas.



Overview of Findings

Participants in our focus groups listed numerous frustrations with the process of obtaining health care insurance, and generally lack information on how to sign up for programs and what is available to them.

The findings are arranged into the following general themes of Process, Knowledge and Educational Issues; Access to Health Care and Insurance Coverage; and Service Quality and Health Status. Each will be discussed in turn and is followed by the significant differences found between the rural and metro focus group comments.

Process, Knowledge, and Education

Participants in our focus groups listed numerous frustrations with the process of obtaining health care insurance, and generally lack information on how to sign up for programs and what is available to them. The reasons are described more fully in the following text and were mentioned in the focus group discussions as fundamental causes for low rates of health insurance among Minnesota's Latino communities.

► U.S. Health Care System Difficult To Maneuver

Many Latinos find it difficult to understand the dynamics of the U.S. health care system. Securing adequate medical care and insurance, and abiding by the rules that govern the health care service industry is difficult for most people, even those born in the U.S. Adding a language and cultural barrier, and the high cost of health care and insurance, creates a situation that is even more confusing for the participants of our study. The inherent difficulty in maneuvering the health care system is an obvious source of frustration for Latinos, and this discomfort leads to a feeling of distrust and dissatisfaction toward the medical community.

Participants told us:

We just need to know (about available health services and insurance programs). Only certain people know.

We are very isolated. We don't know, but once someone talks to someone else things like this happen (information about health services and insurance programs is acquired). They tell you 'look here they can help you,' but we live in isolation where we barely talk about health issues.

Many of the metro-area focus group participants know that county public assistance programs were available, but said that the county system and staff were so big that they didn't know whom to contact. Often times, even when they know where to go for help, they find that many county staff members do not speak Spanish, making communication very difficult and uncomfortable. A high level of frustration was expressed with answering machines and voicemail, both of which are intimidating and burdensome for someone with Spanish-only language skills. Participants in one of the metro groups said that they called many times a day, but always reached the answering machine, which had a message in English. Others discussed problems understanding and reading program enrollment materials when they are in English:

You know that we have this Medical Assistance card. They send us a book of all the benefits and services that are available to us, but it's all in English. We can't understand any of it. What good is it to us if they send us all this information and they fill it with literature that

we can't understand? Well, I am Hispanic, and 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.

A factor that seems to make a difference in experiences between communities is the link between the U.S. Department of Agriculture's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and access to MinnesotaCare. While some participants said that Latinos find out about public programs by word of mouth, it seems that the presence and availability of a community social service improved access to health care and health insurance for several of our focus group participants.

► Confusion About the Concept of Health Insurance and Role of Public Programs

In many cases, focus group participants said they are confused by the fundamental characteristics of health insurance such as co-pays, deductibles and premiums. The term "insurance" often meant something different in their native country. There is a general belief that individuals who pay taxes should have a right to health care. Many describe their understanding of insurance as a more comprehensive form of security, including paid sick leave and full coverage of health care services. Several individuals said that they expect to pay nothing even on MinnesotaCare, a program designed for the working poor with a monthly premium based on income and family size.

This confusion is amplified by the wide-range of coverage, benefit and payment options found within health plans. Our focus group findings show that current insurance coverage for the participants is a diverse and fragmented mix of public and private programs. This was especially the case in families, where it was not uncommon to find more than one health insurance plan and a mix of public and private programs.

When asked about a preference for private or public coverage, the participants in the last two urban focus groups did not express a preference. If the coverage is affordable and easy to sign up for, many participants said that they would gladly enroll in either a public or a private program. A problem is that the participants do not know where to go, who to contact, or how to enroll. Then, once they go through the enrollment process, many find that the billing systems, co-pays, premiums and deductibles are still very confusing. They often think that they are asked to pay twice for the same services — services that they consider inadequate because they have to deal with long waiting times, multiple doctors, patronizing staff, and a lack of interpreters. A Twin Cities metropolitan area woman told of her experience:

My daughter was bitten by a dog and I took her to the hospital. She has insurance that comes from the government. So they ask me for my papers and now, why are they charging me for the bill? I don't know why. It is supposed to be that the insurance covers everything. And the bill is very big because it was at the hospital's emergency room.

Many Latinos are confused by the health care system and the way insurance and care is provided.



Participants from the rural communities, in particular, expressed confusion about multiple aspects of the process of accessing health care services. One man described his frustration with Medical Assistance as follows:

It's not that you just arrive (at family services) and they simply accept you if you qualify. There's a lot of inspection. They give you a huge mountain of papers to fill in and answer, and if you make an error, or an unintentional accident, or you don't answer only one question, they don't accept your application. They tell you that it's not complete. There are books that they have you fill out and then every month you have to report all of your taxes. If you go over one cent, you don't qualify anymore...they ask you for the same papers again and again.

Another man described his discomfort with the referral process:

The only thing about the system that I don't like is that since I have the clinic here as my primary clinic, I have to always go there. So, to send me to the location of the nearest hospital for my daughters, they have to write me a referral. It's happened to me that sometimes they wouldn't see me until they spoke to the MinnesotaCare clinic. I don't think that's okay because I bring her to the emergency room because she needs medical attention.

And others:

They (local Latinos) aren't familiar with the MinnesotaCare programs. Many times we disqualify ourselves before going to visit. One thing that I am trying to tell the Hispanics is that you shouldn't disqualify yourself — first go for a visit, and if you don't qualify they'll tell you. Because of their wages, they think that they don't qualify for these programs, and this isn't true. Many times even though they have good wages, they do qualify for some of these programs.

Many Latinos simply do not know how to sign up for public programs. All partici-

pants expressed the need for information in Spanish and clinicians that spoke the language. In both rural and metro groups, participants repeatedly said that they didn't understand why they had to pay such high prices for health care services, and pay several times (with a deductible, a co-pay and the premium) when they believe they receive little help in return.

► Cultural Barriers are Significant

The focus group participants discussed a wide range of cultural differences that exist between clinical visits in the U.S. and in their native countries. For example, it was reported that clinicians in Mexico take time to build a relationship with the patient, a practice that is difficult with the time constraints placed on U.S. medical practitioners. Additionally, we were told that in Mexico, when you walk into a clinic, you always leave with something: Whether it is a toothbrush, or a toy for the children, the patients never leave empty handed. This clash of cultures, lack of comprehensible information, and limited professional understanding of cultural issues by the public health and medical professions create a situation that is extremely frustrating for the participants. There is a gap between expectations and services received.

► Differences between Rural and Metro Groups

Participants in both rural and metro communities share most of the same outreach, education, and knowledge-based concerns regarding health insurance coverage. In both communities, people who had been in the U.S. longer seemed to have more knowledge of the system. However, almost everyone expressed some confusion and lack of understanding about the health care system. Participants said they'd like to see more Spanish-speaking providers and staff, and had interest in having more outreach services available in their communities (such as public health visiting nurses) rather than having to deal with the frustrations they encountered trying seek care.

Access to Care and Health Insurance Coverage

Access to health care is a major concern for residents in all the focus groups. Many described specific employer-based barriers, such as long waiting periods for health insurance eligibility, difficulty taking time off from work for appointments, and prohibitive premium costs. Others said they have problems with providers and clinic staff due to a lack of cultural understanding and communication. An overarching theme is that the combination of barriers created considerable obstacles for accessing health care services.

►Lack of Insurance Coverage

Many participants lack insurance coverage for a variety of reasons such as cost, lack of knowledge about programs and where to sign up, not speaking English, and distrust of the government. It was notable that some families had coverage for the children of the family, but not for any of the adults. Many other families had a mix of public and private health plans.

►Employer-Specific Issues Related to Access

Long Enrollment Waiting Periods – Some participants immediately secured insurance coverage from their employer upon hire, while others describe waiting periods of up to nine months. Waiting periods are generally put in place to ensure that an employee does not seek temporary employment to obtain health care for a short time and take care of medical needs, only to later quit their job. Many of the rural employers have waiting periods of up to nine months after the employees hire date before they become eligible for insurance. Again, our focus group discussions revealed a general lack of knowledge about the concept of insurance and the rules of coverage, including specific waiting periods and understanding of when coverage begins.

Time Off Work For Health Care Visits Difficult – Many of the participants in rural Minnesota work in food-processing plants. Harsh conditions and discrimination in the workplace is a common complaint among rural focus group participants. Few appointment times are available in the evenings and weekend hours. Some participants expressed difficulty getting time off work to go to the doctor during the work day:

...you ask permission. You make an appointment. But you have to ask permission. If you don't ask for permission, they say, 'Well, what do you need? You're not sick. What do you need to get out of your shift for?' And they won't pay you that time either that you're gone.

Say I have an appointment at 9:00 at the dentist and they say 'Well, you come in at 7:00 and I'll let you go 15 minutes before 9:00 for the dentist. But you have to come.' If you ask (for time off) they'll say 'Well, where do you need to go?' even though it's really none of their business.

Cost of Employee Contribution to Insurance Premium – Many participants said their employer offers basic coverage (catastrophic), but in many cases this means a large employee contribution, significant deductibles, and high co-pays.

Several individuals said that they earn a livable wage, but are obliged to send money back to their families in their native countries. This often leads to frustration because health care costs are high, even with employer-sponsored insurance. They decide to take the risk of illness or injury and forego insurance coverage. And, as a result, they live on very little income, and live in fear that a medical emergency will render them helpless and in debt.

Many (participants) described specific employer-based barriers, such as long waiting periods for health insurance eligibility, difficulty taking time off from work for appointments, and prohibitive premium costs.

► Cost of Care

Participants in the focus groups spoke of the prohibitive cost of health care in the U.S., and included the cost of care with insurance within this category. Premiums and the cost of any visit, whether paid for out-of-pocket or through co-pays and deductibles, are considered very expensive by many participants. This perception is largely influenced by confusion about the system, as mentioned in the previous section. For example, one metro participant said:

When my son was born, I had two insurance providers that were supposed to pay for the expenses. Then I had to take him to the emergency room because he was bleeding, but I was told it was not an emergency. Then I got a \$200 bill for that service, so I called the insurance company but they said they would not pay because it was not an emergency. So I finally had to pay the bill in two payments. Now I have a health insurance provider and the insurance includes visits to the dentist, eye clinic, and ER. It costs me about \$80 per month, but it doesn't include my son.

Another focus group participant told of her understanding of premiums and how they work:

I think visiting a doctor is very expensive, especially for those like me who don't have a health care provider through our jobs. And if we have insurance through work, they take a lot of money from our checks.

Many also believe that they are ineligible for public programs and assistance. Participants report that they themselves and other Latinos they know don't even bother to check into their eligibility for public health care programs because they have reason to believe that their income is high compared to others in their communities. Through informal discussions, participants hear that paperwork requirements are substantial and that they would not be eligible anyway.

Most participants agree that cost was one of the most significant deterrents to visiting a hospital or clinic. There is a pervasive belief that they received little care for the money they pay, and say that the cost for a simple consultation is exceptionally large even when no specific diagnosis or remedy was supplied. One participant from the metro area told of a \$3,000 hospital bill for no services, but simply for being in the hospital. He said:

I have tried to get some insurance but I have not been accepted because they say my annual income is high, but I have expenses here and down in Mexico that I need to take care of.

There was a general lack of understanding about the concepts of co-pays and deductibles. Based on comments made from individuals in the group, it became clear that many did not know when their deductibles were paid, or how co-pays figure in to the overall cost of care. A woman from Mexico who moved to rural Minnesota three years ago to be with her husband explained:

People say to themselves, if I'm going just for them (clinicians) to look at me and they don't even give me a pill or anything and it's like \$200 or more, they don't go.

Another participant explained how lack of insurance and the high cost of medical care limits their family's ability to attain health care services:

As far as routine things, well, you know, we don't go, because we don't have insurance. And they're going to charge us seventy dollars and that's too much. Most of us don't have insurance and there is nothing left over, you know, to go get anything checked, like pressure checked or whatever. We don't go.

►Strained Patient/Provider Relations

Many focus group participants spoke of difficulties establishing relationships with their providers due to cultural barriers.

Some of these problems are due to discrimination and lack of respect; other problems were directly related to communication and language barriers.

Several participants commented on the lack of interpreters and long waiting times for service. Others talked about the lack of respect and patronizing attitude of providers towards new Latino immigrants. A woman from rural Minnesota captures some of the frustration between patients and providers, and shows why many of the people from her community have decided to seek health care outside of their town:

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. Then, the last time, my child was throwing up blood and I said let's take my child to the nearest town. The doctor didn't want to let me do that. The doctor talked to me like I didn't understand, he talked down to me. I do understand some English. So, since then, I don't come here for anything.

Many focus group participants had similar difficulties with their local clinic, illustrating how easily provider relations can negatively impact primary and secondary prevention.

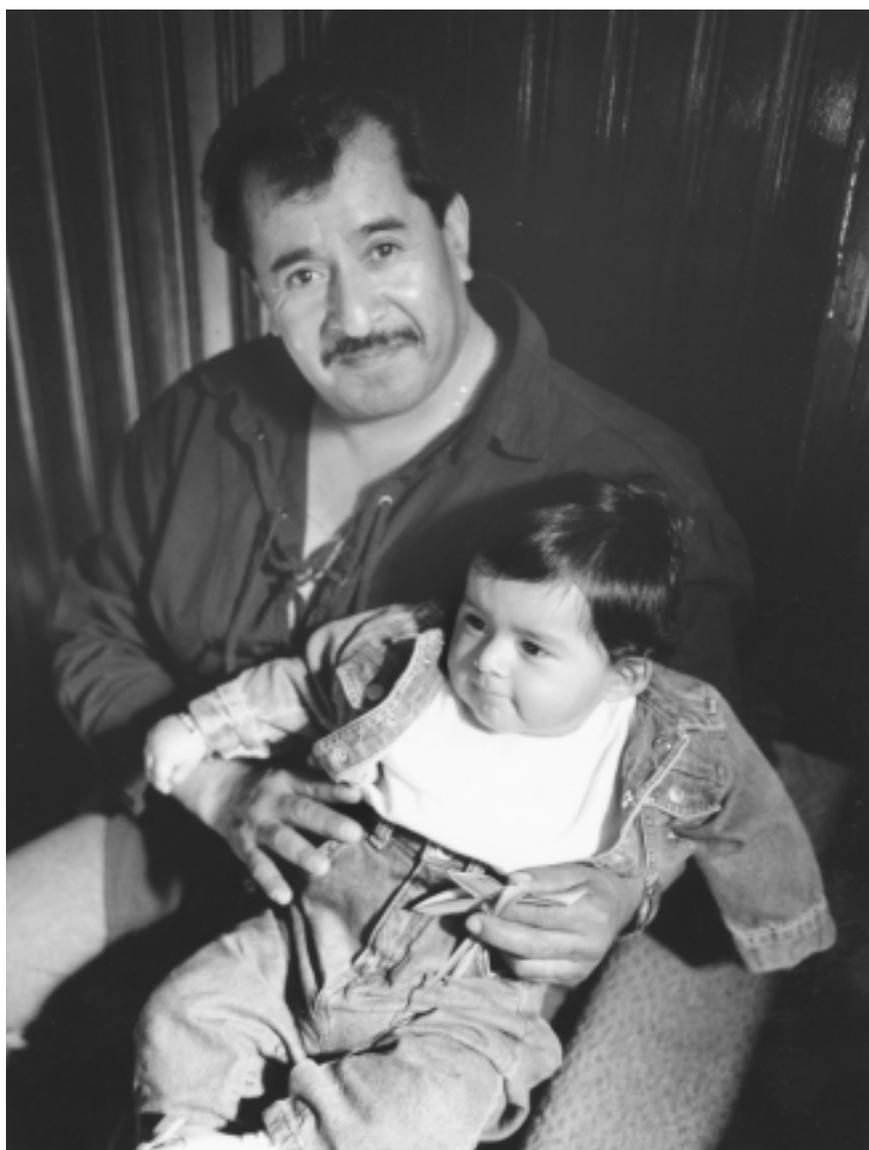
I had to go to the clinic one time with my small children, they're less than two years old, and we went to the local clinic because there was no place else to go. And they had a cough and the flu. And one time the nurse asked me, 'What exactly does she have? She's not that bad. Why did you bring her here before she was really sick?' I said, 'Well, you know, she looked like she was starting to get sick. She had a cough and she was getting a fever. I didn't really want to wait until

she got worse.' And she said, 'No, she doesn't have anything.' And she made me think that I wasn't supposed to bring them to the clinic until they were really sick. Which didn't seem really right.

A woman from the metro area mentioned the fear that accompanies doctor visits for undocumented residents:

We fear going to the doctor/clinic... what if we are asked for documents? It would be good to have a place where each newcomer can stop by and get checked, a place that we can trust and where our legal status doesn't matter or is not taken into consideration.

Past problems, fears and confusion create difficult decisions for many Latinos about whether or not to seek health care.



While some individuals have found that providers and clinics meet their needs and understood their health care concerns, others encountered problems with interpreter services and cultural understanding on the part of providers and clinic staff.

A participant in one of the groups reiterated the need for clinicians to build relationships with Latinos when she described a pleasant experience with her personal physician. She told of how the physician remembered not only her name, but also her health history. This technique of patient interaction was new to the patient and very much appreciated.

I am very happy with my own doctor because that's the family doctor. I have not moved from the clinic because the doctor has been very efficient and responsible. I've had times that an emergency is happening, then I call and say 'I need my doctor to see me' and they answer, 'She doesn't have time... can you be assisted by another doctor?' But immediately, my female doctor calls me back and says that she knew I was in for a visit and that she wants me to explain the situation and how I am doing to her.

Overall, the resulting trends found in the focus group discussions show mixed results regarding access issues. While some individuals have found that providers and clinics meet their needs and understood their health care concerns, others encountered problems with interpreter services and cultural understanding on the part of providers and clinic staff. Additionally, participants spoke of folk medicine including its frequency of use and its perception among American doctors. In some cases, the lack of cultural understanding about such remedies leads to strained patient provider relations. One participant explained the situation as follows:

So what happens if a patient goes to the doctor and say that his/her child got 'mal de ojo' and the doctor says it does not exist, it is superstition and that the patient is wrong? If this happens, this woman/patient won't go back to the doctor. Ultimately, she is explaining to the doctor what her kid has based on what she knows through her Mexican culture.

Another participant supported this comment and explained that in some clinics, the doctors are working with natural, ancient methods of treatment and healing. These doctors are learning from Latino doctors who come up from Central and South America and who have studied the medicines of the Latino community, their ancestors and relatives. Without this knowledge and understanding, there are wide chasms in the beliefs of the provider and patients. One participant explained how the scenario might play out:

This is important because what if you go to the doctor but he doesn't believe in anything you are saying to him? If he gives us a medication and we don't believe in it, perhaps it won't work either, you know, because you don't feel comfortable or agree with what he is saying. If they could understand our pain and our culture, I think it would be easier.

Positive comments about local providers were heard from participants who used metro clinics with Spanish-speaking doctors and staff, especially in St. Paul. Participants expressed satisfaction with these providers and interpreters and said that the Latino community needs more health care settings with similar features. The Spanish-speaking providers, paired with a sliding fee scale payment system and the overall approach used by these clinics lead to the satisfaction of many participants.

► Location Of Health Services Varied

Rural focus group participants, in particular, discussed the importance of having easily accessible health care facilities and said that close proximity is an important link to their satisfaction. A few rural residents said that when problems arise with local clinics and hospitals, there are limited options to pursue. When this happens, they said they had no choice but to travel a long distance to another clinic or use services of the local hospital, which they know will leave them with a high level of debt.

► Access Barriers Create Difficult Choices

Although many families that immigrate are young, they still find themselves confronted with difficult health care choices. They said that those choices are often significantly magnified for other vulnerable groups of Latinos who face the same barriers to health care, but are at higher risk for becoming sick. One woman expressed concern about her ninety-year-old aunt who was undocumented:

She doesn't have any insurance and there are times when she gets really sick because she has diabetes. She is very frail and doesn't have any papers.

The following examples reflect the significance of health care access as a public health issue, and how aggregated barriers can create unfavorable situations for anyone trying to maintain their health.

Well, the concern that people have is...if they get sick...what are they going to do? Try to cure them as best they can at home? Because my son Juan said, 'Mom my chest hurts.' Oh, just wait son, because if I go to the hospital now it's gonna cost me an arm and leg. So now he doesn't even tell me if it hurts, so I don't know if it hurts him. When he says 'Mama it hurts me here' then I tell him don't exercise, or don't go running around.... People start thinking about the bill that's gonna come, and how they will pay. Not that I want my son to die, but thank God it hasn't been that bad. But you get scared that they'll get sick, and you get scared of the bills that will come.

And another rural participant describes the lengths community members go to in order to maintain their health:

Most of the Mexicans are like this — they end up sending to Mexico for medicine because they can't communicate with the doctor. We bring medicine when we come back and we take care of it the best that we can. We bring back whatever medicine that we need — penicillin, whatever.

► Differences between Rural and Metro Groups

The majority of participants in both the metro groups said they go to the emergency room or hospital when they encounter an illness or injury. Most expressed fear at these situations, realizing that a medical emergency could financially ruin their futures. It is not clear why, but more of the rural comments pertained to clinics, not hospitals.

Several metro participants mentioned long waits before they could even be scheduled to see a doctor, long waits once they were in the health care facility, and disappointment that they rarely saw the same doctor or had a relationship with their provider. Both rural and metro groups discussed difficulties in being linked with interpreters and noted that the quality of

Some differences were observed in the issues confronting rural and metro participants.



interpreters is also an important factor. Rural group participants spoke more of the location of health services and travel time to see a provider than metro group participants did.

Service Quality and Health Status

Most participants expressed satisfaction with care received, once they actually were seen by a provider. While there were complaints about lengthy amounts of time spent in waiting rooms and large delays in getting appointments with doctors, the majority feel that the care they received when ill was good quality. Several women spoke of the comprehensive pregnancy services that are available to them. Others said that services in a hospital setting are good quality.

Yet there were a significant number of people who said that they did not always receive appropriate medical attention when they were ill. As described above, some simply do not seek care when they are sick because they fear the high cost of health services and are dissatisfied with the medical profession. A man from one of the metro groups summed up some health status challenges that undocumented Latino immigrants face:

When I came, I was healthy, but because of the stress, tension, fears, nervousness, etc., you start feeling bad somehow. Also, we don't know if when swimming to cross the border you got an infection or were bitten by an insect. So then you get here and the food is different, you cannot find the kind of food you are used to, so it is obvious that it affects your health. Then you have to deal with finding a job, not having papers, etc. It means both physical and emotional distress.

Other reasons for lack of care and poor health status are as follows:

►Lack of Preventive Care

Participants told us that they were used to receiving free public health services in their countries of origin, including vaccination campaigns with workers positioned on every street corner. Participants from Ecuador and Mexico said that public health workers there cover entire communities with their outreach efforts. Other group participants said that they would go to the doctor at least two times a year in their own country, just for preventive services and screenings.

A metro focus group participant told us:

After I got here, I wanted to get my sugar blood level checked, you know, for diabetes, but here things work differently. In my country, you go to any clinic and you get your blood pressure, diabetes and heart checked for free. Here we don't even know where the clinic is, we don't know if we're going to be told 'you are illegal, you can't get any medical attention,' we don't know how to explain to them what's going on or why we went there because of the language barrier.

While there seems to be little or no continuity of care or disease management for the women in one of the rural communities, we discovered that participants in another community go to visit health care providers regularly. Many of the metro group participants stressed the importance of regular health checkups in their native countries, and said that they simply could not afford to maintain that same level of care in the U.S.

►Occupational Health At Meat- and Poultry-Processing Plants a Major Issue

It was common for participants to speak of occupational safety and health issues, especially in the rural areas where food-processing plants are the main source of employment for Latinos. Several times, participants noted the frequency of

accidents in the plants. Participants reported that certain people at the plants were trained to perform first aid and in some plants nurses were available. The Latino communities' overwhelming belief, however, is that many of the working conditions are dangerous. One man said:

I lost two fingers. In the end, the company paid me \$90 for each finger that I lost. And I complained for two months before that that the machine didn't have a cover, but they never fixed it. But I'm never going to be the same.

► Accessing Affordable Housing Not Easy

It is evident that many factors outside the realm of health care services impact the health of these communities. Some participants said that living conditions are not adequate and that there is a lack of affordable housing. In some communities, apartment managers seem to ignore their property.

Many participants seemed confused with the process of acquiring housing and expressed the need for appropriate information. Additionally, there is a general belief that low-wage jobs and discrimination prevent Latinos from accessing adequate housing and health insurance. One participant told us about her experience with discrimination in housing:

The problem is that if there are really nice apartments, really nice and well-kept apartments, I notice that they don't want to rent to Latinos. I applied to some of those apartments because, I saw that they were always in the paper, and I wanted to get away from where I am now. I called almost every week to see what was going on. And they always gave me a different story, 'We haven't reviewed your application' or 'Your application is at number, whatever' and the woman gave me a different explanation. I understood that they didn't want to rent to me. Because a person's voice, even if their English is perfect, you can always tell that the voice is Latino. And they never called me.

Another said he was having difficulty locating affordable housing:

I'm now living in an apartment that is cheap, but soon they will remodel and are going to kick us out of there. It was \$450 and I have looked everywhere and they are more than \$650 and up. I have three kids so they will not accept me in one room. That is the problem I have, that there is nowhere I can go and the man is saying that if I don't leave by April 1, he will kick me out.

Another backed up this concern, saying:

Housing is very difficult to find now... it is difficult to find a place if you have children. This is the first question you are asked and you can't deny them. If you have children they say they don't have places to rent.

► Differences between Rural and Metro Groups

The main difference between the rural and metro groups was in response to questions related to issues and concerns about health. The metro groups tended to spend more time talking about neighborhood and housing issues, while the rural groups focused largely on conflicts with their employers. Neighborhood and housing complaints ranged from lead paint, to absentee landlords who didn't listen to their complaints about problems with rats and cockroaches. Issues that participants had with employers ranged from discrimination and unsafe working conditions, to difficulty taking time off for doctor appointments and other health concerns.

The metro groups tended to spend more time talking about neighborhood and housing issues, while the rural groups focused largely on conflicts with their employers.

Additional Cultural Issues

The differences in (Latino) subgroups illustrates the extent of training and information that is needed by U.S. providers and policy makers in order to be culturally competent in their delivery of health care.

Several factors may affect the interpretation of focus group discussion. Among these are the different experiences each individual brought to the focus group discussion depending on his or her country of origin and the amount of time each individual has lived in the U.S. Other issues such as cultural communication, attitudes and values play a key role in understanding the Latino point of view. This section describes a few of those elements of Latino culture.

Heterogeneity

Our focus groups were designed to capture the broad experience of Latinos in Minnesota. In the process, several Latino subgroups were grouped together. Literature shows that there are significant differences by country of origin in Latino health statistics, health services utilization and health insurance coverage (15, 16). Researchers found that Cuban Americans and Puerto Ricans who were under 65 years old were more than twice as likely as white non-Latinos to lack health insurance. This ratio increased substantially when Mexican Americans were studied. The rate of uninsurance for Mexican Americans was 3.5 times that of white, non-Latinos (16). A great portion of this difference may be attributable to economic circumstances and immigration status. However, the differences may be the result of differences in attitudes about sickness, native country customs and the use of western health care services.

Findings such as these point to the importance of culture in health care beliefs and attitudes. Depending on their country of origin, each Latino experience varies and affects the likelihood that the individual will understand the U.S. health

care system. The differences in subgroups illustrates the extent of training and information that is needed by U.S. providers and policy makers in order to be culturally competent in their delivery of health care.

Cultural Norms and Communication

Each culture has unique forms of communication between individuals. While these attributes may seem to stereotype a culture or region's behavior patterns, they may also serve as a tool in understanding how individuals perceive and react to specific behavior (17). While Minnesota is a broad generalization of Minnesota communication styles, it also may help a new resident adjust their interpersonal communication and avoid the common complaint that Minnesotans mask their true feelings in an effort to avoid conflict. Likewise, understanding Latino cultural scripts may help policy makers and providers adjust their communication style so as to foster better communication and improve health access.

“Simpatico” is a cultural script that may affect response patterns among Latinos. Latinos are more likely than non-Latinos to avoid conflict and encourage positive social behaviors (18). The word simpatico does not have an English equivalent, but means to behave in a way that others may find likeable, fun and easy-going. Individuals who are simpatico tend to show conformity and the ability to understand other's feelings. Because direct conflict is considered rude, a respondent may tend to avoid disagreeing or appearing negative unless this can be done in a cordial manner (19).

This cultural script may affect the relationships that Latinos have with their providers. They expect that respect and an attempt to understand one another's feelings will be part of the health care interaction. "Respeto" is a Latino cultural norm dictating the appropriate behavior to others (20). When they sense that there is disregard for their experiences, values and world, they may choose to turn away from the health care system.

Part of the awareness of respeto comes from social clues and body language. Body language and subtle influences of power are quickly noticed, as noted by the awareness of disrespectful behavior from providers. Many Latinos read these clues as signs that the provider views them as less intelligent or less important than other individuals. Space and touching also affect the interaction between a patient and their provider. "Touching, how you make eye contact, the subtle things all count," explains a Mexican American pharmacist (20).

In our focus groups, participants told of situations in which they brought their child to a clinic or hospital for an injury and, during the examination, were asked if they abused their child. While this line of questioning is part of the legal protection granted to children in the U.S., it is viewed as disrespectful and too direct by Latinos. The focus group respondents said they feared bringing their children in for care if they, themselves, would face such extreme questioning. Specific questions about personal issues should be asked indirectly so as not to embarrass or challenge the cultural beliefs of Latinos (20). Directly asking personal questions challenges the level of respect between a patient and provider.

An outward "locus of control" (sometimes referred to as "fatalism") is another factor affecting Latino beliefs and communications. This outlook on life is based on the belief that life events are largely out of one's hands; that fate is in control rather than the individual (18). Some

analysts have connected an outward locus of control with non-compliance in health promotion activities (i.e., use of preventive services, changes in lifestyle or behavior) (21, 22). But the nature of this philosophy, which places the locus of control outside the individual and tends to focus on the present rather than the future, needs to be placed in the correct context. Examples of the outward locus of control in our focus group discussion include the use of traditional healing methods. Belief in negative health influences outside the realm of physiology and Western medicine are an important part of the Latino culture. Latinos believe that there are many circumstances that the individual cannot control which contribute to the experiences of life.

Cultural differences can lead to feelings of frustration, confusion and disrespect.



Attitudes and Values

Latino communities have numerous strengths that enhance the health and well being of their members. While different from many parallel U.S. attitudes and values, these strengths should be recognized and built upon in Latino immigrant communities.

The Latino culture as a whole is centered around the family. The value of good parenting cannot be stressed enough. With the family and children as a core value in Latino communities, pregnant women have circles of support from extended family as well as strangers offering advice and recommendations. It is through this social network that many Latinas have uncomplicated pregnancies and labor experiences. These cultural tendencies also lead women to become the manager of healthy behaviors and health care access for most families.

There are several points embedded in these cultural practices that are important in improving health care access and delivery. Health care messages that get through to women in the Latino culture may be carried further than those that specifically target men or are gender neutral. Once a Latino community's women are engaged in delivering a health care message, word will travel fast due to social networks and interaction.

Another key attribute of Latino culture is the importance of community and sharing. The culture is based on interdependence as opposed to the U.S. focus on independence. Cooperation and sharing is an important part of the Latino community and may be vastly different than the competitive nature that is a fundamental part of U.S. culture. This does not diminish the need for personal communication and interaction rather than group or institutional relationships. Latinos expect that providers will be interested in their lives and establish a relationship with them (20). They are unlikely to think of their relationship with a clinic or HMO as more important than the personal interaction they receive from a specific provider.

Community and sharing are apparent in many health care interactions between Latinos. For example, Latinos will share prescription medications with their neighbor as well as advice and care. Families and neighbors help each other out and take care of one another. This has little to do with challenges to accessing prescription medications and health care services and more to do with the value of sharing what one has. Understanding this aspect of Latino culture helps explain the confusion, challenges and misunderstandings that many face when learning about our health care system.

Recommendations

Meeting Latino health care needs has become a challenge to which many states, not just those on the U.S. border, must commit. The disparities in health care access and health status illustrate the need for such focus and emphasize the need for change and new ideas that come from within the community of interest.

The focus groups helped to identify several themes about Latino health and health care access in Minnesota. It was known, prior to receiving feedback from participants, that access was difficult and that many could not afford health insurance. Yet Latino perceptions of their health care providers and the quality of care that they received were not clearly defined. Nor was the extent to which Latinos found the U.S. health system confusing and frustrating. The focus group results illustrate that a significant effort must be conducted to improve outreach campaigns, increase use of Spanish written and spoken word in the communication flow, and increase provider and staff training on cultural competence.

Focus Group Member Recommendations

The specific recommendations that came from the focus group members included developing “welcome centers” around the state that would be staffed to test new immigrants for disease, perform basic preventive screening tests and disseminate information about public health and health care access issues. These centers would be available to all new residents, regardless of immigration status.

Other suggestions include public health outreach programs where public health nurses use the Latino media to inform residents about specific health-focused days — such as a vaccination day and a blood pressure screening day. Many individuals were used to these types of campaigns in their native country and felt that preventive health was unaffordable here in the U.S.

Additionally, groups discussed several recommendations repeatedly, such as requirements on employers to cover more of the health insurance payments. While a good portion of participants believed that they made too much income to qualify

Some of the recommendations include working with employers to increase access to health care options.



Both incremental approaches building on existing employer-based coverage and public programs as well as new programs targeted to the needs of new immigrant populations are needed.

for public programs, but too little to be able to afford employer coverage, many felt that employers paid too little and offered health care options that were too expensive for the average Latino employee to afford.

Finally, while no recommendations were specifically addressed on the issue of provider competence, those individuals who seemed most satisfied with their providers and quality of care shared several characteristics. They all had a consistent doctor who followed up visits with phone calls and extra attention if circumstances required another doctor to see their patient. Also, many participants agreed that a Spanish-speaking doctor makes a big difference in the security and trust that is established in the provider-patient relationship. All satisfied participants agreed that, in an emergency, their doctor should be reachable by phone. The doctors who received positive comments manage to see their patients without long waiting periods and often make calls to their patient's homes.

Policy Recommendations

With both phases of research complete, the information collected from the key informant interviews correlated well with the results from the focus groups. Although our research has found multiple factors affecting access to health and public health services that need to be addressed, this final section focuses on initial recommendations that we believe are the most important in reducing health disparities in Minnesota's Latino population.

Increase Access to Health Insurance

Our health care access research with Latinos has shown that in designing programs, policies and new ways of delivering service, two components are essential: a community-based process and ongoing communication. In Minnesota, we have responded to the needs of the working poor through the MinnesotaCare program and have one of the lowest rates of uninsured people in the nation. Now we must do better and reach out to the new members of our community in order to enroll them. We will all benefit from the changing demographics of Minnesota in terms of diversity and economic growth. Having essential health care services is a critical component of the successful integration of new communities.

Our research shows that lack of health insurance is a function of many variables for Latino communities, including the high percentage of Latinos in low-wage jobs and the limited availability of adequate health coverage. An increase in private and public health program participation would facilitate Latino's access to the health insurance market. Both incremental approaches building on existing employer-based coverage and public programs as well as new programs targeted to the needs of new immigrant populations are needed.

Implement Enrollment Specialists to Facilitate the Insurance Enrollment Process

Results from the focus groups showed that many people eligible for public insurance did not sign up for that insurance because they did not understand the process. They didn't know where to sign up for public programs, how to contact people who could help them, or even the extent to which these programs would benefit their financial situation. The availability of a culturally competent enrollment specialist to streamline the enrollment process would be a beneficial outreach program to those eligible for public insurance. In addition to increasing the access to health care for these populations, the program would also decrease the amount of uncompensated care in Minnesota.

Improve Provider and Service Delivery

During focus groups and interviews, we discovered that cultural understanding plays a unique role in Latinos' decision to seek out health services. To increase the cultural competency of key professions that affect population health we recommend establishing a provider cultural-competency continuing education program in collaboration with the continuing education infrastructure already in place in local medical schools. Such a program would promote the development of a profession-specific cultural competency program in the fields of medicine, public health, nursing, dentistry, education, and law.

Data Collection and Information Collection

A key component of forming policy to affect access to health care is the availability of accurate data. There is currently limited data available to understand or monitor access and health issues for immigrant populations and other communities of color. The key to developing good policy solutions is good baseline data. Our third recommendation focuses on increasing state data collection for populations of color. Minnesota should develop an information and data collection strategy to establish baseline information on access to health insurance coverage and methods for periodic follow up to monitor change in health coverage over time for immigrant populations and other populations of color.

These policy recommendations are only a first step to eliminating health disparities in Minnesota's growing Latino population. We have targeted health insurance, provider services, and data collection because we believe these are the best combination of long and short-range solutions to address these problems.

Addressing these problems will help eliminate disparities in health access in Minnesota's Latino community.



Bibliography

- 1 Seolle-McAllister, K. *A Needs Assessment of Latinos in Madelia, Minnesota*. Minneapolis: University of Minnesota; 1998.
- 2 Ulrich, E. *Public Health and Health Care Access: Minnesota's Latino Community*. A collaboration between the University of Minnesota School of Public Health, Chicanos Latinos Unidos En Servicio, Hispanic Advocacy and Community Empowerment through Research, Minnesota Department of Health; 1999.
- 3 US Census Bureau. *Census 2000*. Washington DC: US Census Bureau; 2000.
- 4 U.S. Bureau of the Census. *States Ranked by Hispanic Population in 1997*. In: U.S. Bureau of the Census; 1998.
- 5 Minnesota Planning. *2000 Census Shows a More Racially and Ethnically Diverse Minnesota*. St. Paul: Minnesota State Demographic Center; May, 2001.
- 6 Minnesota Planning State Demographic Center. *Faces of the Future: Minnesota Population Projections 1995-2025*. St. Paul: Minnesota Planning State Demographic Center; May, 1998.
- 7 U.S. Census. *2000 Summary File 1 (SF1)*. U.S. Census Bureau; 2001.
- 8 Minnesota Planning. *2000 Census Shows a More Ethnically Diverse Minnesota*. Population Notes. St. Paul; May, 2001.
- 9 Staveteig, S., et al. *Racial and Ethnic Disparities: Key Findings from the National Survey of America's Families*. Washington: The Urban Institute; February 2000.
- 10 Marcotty, J. *Study Finds Minnesota Minorities Far Less Likely to Have Health Insurance*. In: Star Tribune. Minneapolis: 2001.
- 11 Kielkopf, J. *The Economic Impact of Undocumented Workers in Minnesota*. Hispanic Advocacy and Community Empowerment through Research (HACER). Minneapolis; 2000.
- 12 Hughes, A.O., Fenton, S., Hine, C.E., Pilgrim, S. & Tibbs, N. Strategies for Sampling Black and Ethnic Minority Populations [published erratum appears in J Public Health Med 1995 Sep;17(3):375]. *Journal of Public Health Medicine*, 1995;17(2):187-92.
- 13 Stepick, A. & Stepick, C.D. People in the Shadows: Survey Research among Haitians in Miami. *Human Organization*, 1990;49(1, Spring):64-77.
- 14 U.S. Census. *1990 Summary Tape File (STF)*. U.S. Census Bureau; 1991.
- 15 Schur, C.A. Bernstein & B. M.L. The Importance of Distinguishing Hispanic Subpopulations in the use of Medical Care. *Medical Care*, 1987; 25(7):627-641.
- 16 Trevino, F.M., et al. Health Insurance Coverage and Utilization of Health Services by Mexican Americans, Mainland Puerto Ricans, and Cuban Americans [Published erratum appears in JAMA 1991 Feb 27; 265(8):978] [see comments]. *JAMA*, 1991; 265(2):233-7.
- 17 Caudle, P. Providing Culturally Sensitive Health Care to Hispanic Clients [see comments]. *Nurse Practitioner*, 1993; 18(12):40, 43-6, 50-1.
- 18 Flores, G. Patient-Physician Relationship: Achieving Culture Competency in Health Care. *Journal of Pediatrics*, 2000; 136:14-23.
- 19 Triandis, H.C., et al. Simpatia as a Cultural Script of Hispanics. *Journal of Personality and Social Psychology*, 1984; 47(5):1363-1375.
- 20 N.A.F.H. *Quality Health Services for Hispanics: The Cultural Competency Component*. DHHS, HRSA, Bureau of Primary Health Care; Office of Minority Health; SAMHSA; 2000.
- 21 Schlenk, E.A., Hart, L.K. Relationship Between Health Locus of Control Health Value, and Social Support and Compliance of Persons with Diabetes Mellitus. *Diabetes Care*, 1984; 7(6):566-74.
- 22 Shope, J.T. Compliance in Children and Adults: Review of Studies. [Review] [42 refs]. *Epilepsy Research - Supplement*, 1988; 1:23-47.

Appendix A

Demographic Questionnaire

1. Age_____
2. Gender_____
3. Do you currently have health insurance? (check one) Yes___ No___

Please give brief answers to the following questions. A few words to a few sentences is all that is needed.

IF YES:

- 4a. How did you hear about health insurance?
- b. How did you get your current insurance coverage (state program, employer)?
- c. How long have you had this insurance (number of months or years)?
- d. Does your health insurance also cover your spouse or children if necessary?
- e. How well does your insurance meet your needs?

IF NO:

- 5a. Have you ever had insurance?
- b. How long ago did you last have insurance?
- c. What caused you to lose it or choose not to have it?
- d. How do you usually pay for health services now?

Questionario Demografico

1. Edad_____
2. Hombre_____ Mujer_____
3. ¿En este momento tiene seguro medico? Sí___ No___

Por favor de contestar las siguientes preguntas. Unas palabras o una frase es todo lo que se necesita.

Si contesto SI a # 3

- 4a. ¿ Como oyó del seguro medico?
- b. ¿Cómo consiguió el seguro medico que tiene ahora? (Programa del estado, mo empleador)
- c. ¿Por cuánto tiempo ha tenido este seguro? (meses o años)
- d. ¿Su seguro medico también cubre a sus niños o a su esposo/ esposa si lo necesita?
- e. ¿Qué tal bien le satisface sus necesidades el seguro?

Si contesto NO a # 3

- 5a. ¿Alguna vez a tenido seguro medico?
- b. ¿Hace cuanto tiempo que tuvo su ultimo seguro?
- c. ¿Qué le causo perderlo o escoger no tenerlo?
- d. ¿Cómo usualmente paga usted por servicios médicos ahora?

Appendix B

The following questions were used to conduct the Latino focus groups. The first set of questions were used on the first six groups that took place. The second set of questions was used on the last two groups which were completed in conjunction with the Minnesota Department of Health HRSA State Planning Grant. These questions include the particular themes and concepts that MDH wished to examine through the grant. Although slightly different, the two sets of question are fairly close in similarity.

Latino Health Care Access Project
Community Focus Group Questions
July 1999

Objective: (1) To learn more about Latino's experience with the health care system in rural Minnesota; (2) To understand why Latino's do not sign up for public programs (Medicaid/Medical Assistance, MinnesotaCare); (3) To understand the personal implications of barriers to access.

INTRODUCTION

- Collaborative Project: U of M School of Public Health, HACER and CLUES
- We want to learn more about your experience with the health care system
- Our objective is to provide input to decision makers about how to improve the health care system for Latinos in Minnesota
- We are doing a number of focus groups around the state and developing a report
- We will share our results with you if you are interested in leaving your name and address (...Present Voluntary Sign in Sheet)
- We will not reveal any names or information about the specific participants in this discussion. You may be free and candid with your remarks. We will use only summary comments in our report and again, we will not identify individuals.

LOGISTICS

1. Demographic Form
2. Sign Up Form for Final Report
3. Receipt of Money Form
4. Other...

OPENING QUESTION

1. Please describe
 - How long you have been in Minnesota
 - Where did you live before you moved to Minnesota?
 - What brought you here?
 - How many of your relatives are here with you in Minnesota?

INTRODUCTION TO TOPIC

2. I want to go around and have each of you describe briefly your key concerns with the health care system or health conditions in your community. We will then get into some more specific questions. Leave this open ended and then go into the specifics..

SPECIFIC PROJECT QUESTIONS

3. Where do you go if you or a member of your family have is sick or has an injury?
 - Do you only go to the clinic only when you are sick?
 - Do you ever go for regular check ups or screening for other conditions?
 - Do you have a doctor or provider that you see on a regular basis?
4. Have you been to a health care provider (doctor or hospital) in the last year?
 - Did you get the care you needed?
 - Can you describe your experience?
 - How did you pay for this visit?
 - How much did you pay on that day out of your own pocket?

5. I would like to go around again and ask each of you to tell me if you have health insurance and what type of coverage you have.

- Can you tell me the name of your health plan?
- Where did you get your coverage? (county, work, husband's work etc..)
- Are you satisfied with your coverage? Does it cover what you need?

FOR THOSE ON MINNESOTACARE PLEASE GO TO QUESTION #5B ON NEXT PAGE...

FOR THOSE NOT ON MINNESOTACARE PLEASE CONTINUE WITH QUESTION #6...

FOR THOSE ON MINNESOTACARE (5B)

5B. How did you hear about MinnesotaCare? (friends, social worker, family, health care provider etc...)

- Where did you go to sign up?
- Did you have any problems with the process of getting on MinnesotaCare? (Application form, translation, getting to office to sign up...)
- Do you have any specific recommendations on how to improve this process for Latinos?

FOR THOSE NOT ON MINNESOTACARE (6)

6. I would like to know if any of you have heard of the MinnesotaCare program (information is in the packet and new Spanish versions will be available in Sept)

- Do you know how and where to sign up?
- Are you interested in learning more about this program?
- If you haven't signed up, why not?

6B How about Medical Assistance (Medicaid)?

- Have you heard about this program?
- Do you know where and how to sign up?
- Are you interested in learning more about this program?
- If you haven't signed up, why not?

7. Do you have any specific concerns about health care?

- Any specific concerns about the elderly in your community and health care?
- Any specific concerns about the children?
- Any specific concerns about living conditions?

8. Do you experience discrimination in this community? Could you describe your experience?

8B. Have you experienced discrimination in health care in this community? Please describe. (...health providers, county social workers, making appointments, employers, etc..)

9. What specific programs or ideas do you have that would help increase access to health care services for Latinos in your community?

ENDING QUESTIONS

10. Given our discussion today, could you summarize your major concern about health care?

11. What I've heard today is that (moderator should summarize very briefly the key themes that emerged during the discussion)

12. Moderator to give short overview of objectives of the study and then ask participants if they missed anything or if there is any other items that participants want to mention.

DO YOU HAVE ANY QUESTIONS OF US?

Latino Health Care Access Project Community Focus Group Questions (Revised May 2001)

Objective: (1) To learn more about Latino's experience with the health care system in rural Minnesota; (2) To understand why Latino's do not sign up for public programs (Medicaid/Medical Assistance, MinnesotaCare); (3) To understand the personal implications of barriers to access.

INTRODUCTION

- Collaborative Project: U of M School of Public Health and HACER
- We want to learn more about your experience with the health care system
- Our objective is to provide input to decision makers about how to improve the health care system for Latinos in Minnesota
- We are doing a number of focus groups around the state and developing a report
- We will share our results with you if you are interested in leaving your name and address (...Present Voluntary Sign in Sheet)
- We will not reveal any names or information about the specific participants in this discussion. You may be free and candid with your remarks. We will use only summary comments in our report and again, we will not identify individuals.

LOGISTICS

1. Demographic Form
2. Sign Up Form for Final Report
3. Receipt of Money Form
4. OTHER...

OPENING QUESTION

1. Please describe
 - How long you have been in Minnesota
 - Where did you live before you moved to Minnesota?
 - What brought you here?

INTRODUCTION TO TOPIC

2. I want to go around and have each of you describe briefly your key concerns with the health care system or health conditions in your community. We will then get into some more specific questions. Leave this open ended and then go into the specifics.

SPECIFIC PROJECT QUESTIONS

3. Where do you go if you or a member of your family is sick or has an injury?

- Do you only go to the clinic only when you are sick?
- Do you ever go for regular check ups or screening for other conditions?
- Do you have a doctor or provider that you see on a regular basis?

4. Have you been to a health care provider (doctor or hospital) in the last year?

4B. Did you get the care you needed?

4C. How did you pay for this visit?

- How much did you pay on that day out of your own pocket?

5. I would like to go around again and ask each of you to tell me if you have health insurance and what type of coverage you have.

- Where did you get your coverage? (county, work, husband's work etc..)

If public program: Do you pay for this coverage or is it free?

- How long have you had this health care coverage?
- Do you understand how your health care coverage works (billing, fees, co-pays, referrals, networks)?
- Does it cover who and what you need covered (e.g. spouse, children, specific medical conditions)?

FOR THOSE NOT ON MINNESOTACARE PLEASE CONTINUE WITH QUESTION #6A&B...

FOR THOSE ON MINNESOTACARE PLEASE GO TO QUESTION #7 ON NEXT PAGE.....

FOR THOSE NOT INSURED PLEASE CONTINUE WITH QUESTION #8A&B.....

FOR THOSE NOT ON MINNESOTACARE (6A&B)

6A. I would like to know if any of you have heard of the MinnesotaCare program
– Do you know how and where to sign up?
– Are you interested in learning more about this program?
– If you haven't signed up, why not?

6B. How about Medical Assistance (Medicaid)?
– Have you heard about this program?
– Do you know where and how to sign up?
– Are you interested in learning more about this program?
– If you haven't signed up, why not?

FOR THOSE ON MINNESOTACARE (7)

7. How did you hear about MinnesotaCare? (Friends, social worker, family, health care provider etc...)
– Where did you go to sign up?
– Did you have any problems with the process of getting on MinnesotaCare? (Application form, translation, getting to office to sign up...)
– Do you have any specific recommendations on how to improve this process for Latinos?

FOR THOSE NOT INSURED (8A&B)

8A. What would you describe as the main reason that you don't have health insurance?

8B. If you were offered health insurance through your employer, would you sign up? Why or why not?

9. Would you prefer getting health insurance from an employer or through a government program? Please explain why.

10. Do you have any specific concerns about health care?
– Any specific concerns about the elderly in your community and health care?
– Any specific concerns about the children?
– Any specific concerns about living conditions?

11. Have you experienced discrimination in health care in this community? Please describe. (Problems with health providers, county social workers, making appointments, employers, etc..)

12. What specific programs or ideas do you have that would help increase access to health care services for Latinos in your community?

ENDING QUESTIONS

13. Given our discussion today, could you summarize your major concern about health care?

14. What I've heard today is that (moderator should summarize very briefly the key themes that emerged during the discussion).

15. Moderator to give short overview of objectives of the study and then ask participants if they missed anything or if there is any other items that participants want to mention.

DO YOU HAVE ANY QUESTIONS OF US?

PREGUNTAS

Objetivos:

1. Aprender mas sobre las experiencias de Latinos con el sistema de cuidado de Salud en MN.
2. Entender porque los Latinos no se están matriculando en programas públicos del estado (Medicaid/ Medical Assistance, Minnesota Care).
3. Entender las implicaciones personales de las barreras al acceso.

INTRODUCCIÓN

- Colaboración: Escuela de Salud Publica en la Universidad de Minnesota, HACER y el Centro de Salud Cultural.
- Queremos aprender mas de sus experiencias con el sistema de cuidado de salud.
- Nuestro objetivo es proveerle información a las personas que hacen decisiones sobre como mejorar el sistema de cuidado de salud para Latinos en MN.
- Estamos conduciendo dos grupos de enfoque en Minneapolis y St. Paul, y produciendo un reporte.
- Vamos a compartir los resultados con ustedes si les interesa dejar su nombre y dirección.
- No se reportara nombres o información especifica de los participantes. Pueden ser honestos y decir lo que verdaderamente piensan. Solo usaremos los temas generales en el reporte y una vez mas, no vamos a identificar a individuales.

PREGUNTAS

1. ¿Cuanto Tiempo llevan en Minnesota?
– ¿Dónde vivían antes de moverse a Minnesota?
– ¿Qué los trajo a MN?

2. Quiero dar la vuelta y que cada uno de ustedes me describa brevemente sus preocupaciones mas grandes con el sistema de cuidado de salud o con las condiciones de salud en su comunidad. Despues seguimos con preguntas mas especificas.

3. ¿Adónde van sí ustedes o alguien en su familia esta enfermo/a o herido/a?

– ¿Solamente van a una clínica cuando están enfermos?

– ¿Alguna vez van para chequeos regulares o para chequearse para otras condiciones?

– ¿Tienen un/a doctor/a que ven regularmente?

4. ¿Han ido a un doctor, una clínica o a un hospital en el año pasado?

4b. ¿Recibieron el cuidado que necesitaban?

4c. ¿Cómo pagaron por esa visita?

– ¿Cuánto pagaron ese día de su propio dinero?

5. Quiero dar la vuelta de nuevo y pedirles que me digan si tienen seguro medico y que tipo de cobertura tienen.

– ¿De dónde recibieron su seguro? (El condado, trabajo, el trabajo de su esposo/a...

Si es programa publico: ¿Usted paga por su seguro o es gratis?

– ¿Por cuánto tiempo a tenido este seguro medico?

– ¿Entienden como trabaja su seguro medico? (Facturas, cargos, pagos, referimientos, asociaciones)

– ¿Cubre lo que necesitas o a las personas que necesitan cobertura (esposo/a, hijos, ciertas condiciones medicas)?

6. ¿De lo que conocen ustedes sobre los programas públicos de seguro medico, como Minnesota Care y Medical

Assistance, díganme que tan fácil piensan que es recibir información o matricularse en estos programas?

– ¿Saben como o donde matricularse?

– ¿Están interesados en aprender mas sobre estos programas?

– ¿Si no se han matriculados, porque no?

7. (Si están matriculados en Minnesota Care)

– ¿Adónde fueron a matricularse?

– ¿Tuvieron algún problema en el proceso de coger Minnesota Care? (La forma de aplicación, traducción, llegando a donde tenían que ir para matricularse...).

– ¿Tienen alguna recomendación especifica para mejorar este proceso para Latinos?

8. (Si no tienen seguro)

– ¿Cuál dirían que es la mayor razón por cual no tienen seguro medico?

– ¿Si ustedes fueran ofrecidos/as seguro medico atravez de su empleador, se matricularían? ¿Por qué o porque no?

9. ¿Ustedes preferirían recibir seguro medico de un empleador o atravez de un programa del gobierno? Por favor expliquen porque.

10. ¿Ustedes tienen algunas preocupaciones especificas sobre el cuidado de salud?

– ¿Alguna preocupación especifica sobre los ancianos en su comunidad y el cuidado de salud?

– ¿Alguna preocupación especifica sobre sus niños?

– ¿Alguna preocupación especifica sobre las condiciones de vivienda?

11. ¿Han tenido experiencias de discriminación con el cuidado de salud en esta comunidad? Por favor describanla.

(Problemas con proveedores de salud, trabajadores sociales del condado, haciendo citas, empleadores, etc...)

12. ¿Qué programa especifico o idea tienen que podría ayudar a aumentar el acceso a servicios de cuidado de salud para Latinos en su comunidad?

13. ¿Nos podrían dar un resumen de las mayores preocupaciones sobre el cuidado de salud que se han discutido hoy?

14. RESUMEN DEL/A FACILITADOR/A

15. DESCRIBE EL OBJETIVO Y PREGUNTA SI FALTO ALGO O SI QUIEREN AÑADIR ALGO

Appendix C

LATINO HEALTH ADVISORY COMMITTEE MEMBERS

Nancy Barcelo, Ph.D.
Former Associate Vice President for
Multicultural Affairs, University of
Minnesota

Lynn A. Blewett, Ph.D.
Assistant Professor, University of
Minnesota School of Public Health

Mavis Brehm, MBA
Executive Director, Westside Community
Services (La Clinica)

Paul J. Carrizales, MA
Former Executive Director, Hispanic
Advocacy and Community
Empowerment through Research
(HACER)

Teresa Chapa, Ph.D.
Former Chief Operating Officer,
Chicanos Latinos Unidos En Servicio
(CLUES)

Lou Fuller (deceased, April, 2001)
Former Director, Office of Minority
Health, Minnesota Department of Health

Jesse Bethke Gomez, MMA
President, Chicanos Latinos Unidos En
Servicio (CLUES)

Scott Leitz, MA
Director, Health Economics Program,
Minnesota Department of Health