


Disparities and Barriers to Utilization among Minnesota Health Care Program Enrollees



Final Report

June 2009



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Minnesota Health Care Program Enrollees
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For more information or copies of the report, please call:

Sara Koppe at 651- 431-2616

Or send requests to:

Sara Koppe

Performance Measurement & Quality Improvement

Minnesota Department of Human Services

P.O. Box 64986

St. Paul, MN 55164 - 0986

FAX: 651- 431-7422

E-mail: sara.koppe@state.mn.us

(This information is available in other forms to people with disabilities by contacting us at 651-431-2160 (voice), or through the Minnesota Relay Service at 1-800-627-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay services).

Acknowledgements

This research was supported by the Minnesota Department of Human Services (DHS). We are indebted to representatives from a number of organizations for their contributions, their guidance, and their insight as we navigated through this research project. We extend our sincere gratitude to Nicole Martin-Rogers and her staff at the survey center at Wilder Research, the Cultural Wellness Center (CWC) for hosting the Project Management Team and creating a bridge to the community needed to make this project a success, SHADAC for their help in sampling, weighting, and making this report presentable, and Vicki Kunerth and James McRae at DHS for their support, patience and guidance over the course of this project.

We thank the community members who came together to learn about the survey results and provided recommendations to improve the delivery of health care. We also thank members of health plan, health care and government entities who joined the “Working Together” forum on March 13, 2009 at the CWC.

Finally, without the involvement of thousands of enrollees in Minnesota Health Care Programs, this research would not have been possible. We are very thankful to all those throughout the state who took the time to complete the survey and tell us about their experiences with health care.

Acknowledgements from the Cultural Wellness Center

The Cultural Wellness Center joined the collaborative effort between DHS, the University of Minnesota, and the Mayo Clinic to bring their experience of bringing together cultural elders, guides and consultants as partners in research that will impact how cultural communities gain greater access to resources that improve their health. From the beginning the Center’s vision was to add valuable cultural knowledge as well as community knowledge to this study because we see the findings from the study as having tremendous potential for changing how many members of cultural communities experience their health care provider. With this in mind CWC elders want to thank the cultural consultants listed below who worked with our elders. The knowledge they shared and the leadership they showed was of a very high quality. The CWC is also grateful for the lessons we carry forward to other research partnerships in the future. We will continue to build the capacity of cultural elders, cultural knowledge consultants and teachers so the research professionals are able to work with us as peers and colleagues. This assures that research is of a higher quality and serves to support the community instead of disempowering it.

DHS Disparities Project Management Team (PMT) Members

Atum Azzahir, Cultural Wellness Center, Cultural Elder
Janice Barbee, Cultural Wellness Center, European American Cultural Consultant
Tim Beebe, Mayo, Department of Health Sciences Research
Kathleen Thiede Call, University of Minnesota
Titilope Cole-Adeniyi, University of Minnesota
Julia J. Cook, D/Lakota Cultural Consultant
Farhiya M. Farah, PICA Head Start, Somali Cultural Consultant
Carolyn Garcia, University of Minnesota
Abebech Girma, Cultural Wellness Center, African/African American Cultural Consultant
Pamela Jo Johnson, University of Minnesota
Donna McAlpine, University of Minnesota
Jim McRae, Minnesota Department of Human Services
Juan Vázquez, President, www.lacochera.net, Hispanic Cultural Consultant
Houa Vue, Children's Hospitals & Clinics of Minnesota, Hmong Cultural Consultant
Viva John Yang, Hmong Cultural Consultant

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Executive Summary

This report presents findings from a statewide survey of 4,626 Minnesota Health Care Program (MHCP) enrollees conducted either by mail or by telephone between July and December 2008. This survey was funded by the Minnesota Department of Human Services and had four major goals. The first was to identify and describe barriers to, and experiences with, health care among adults and children who receive health insurance through Minnesota Health Care Programs (MHCP). Adults were surveyed directly; however, when a child was selected, an adult member, typically the parent, answered the questions about the child. Children (less than 18 years old) were not interviewed directly. A second goal was to identify and describe similarities and differences in the use of health services, as well as factors that discourage the use of services among specific race/ethnic groups including African Americans (US born), Native American, Hispanic/Latino, Somali, Hmong, and European Americans (hereafter referred to as “cultural groups”). A third goal was to identify changes in utilization of care and the types of barriers people experienced between 2003 and 2008. (A similar study was undertaken in 2003.) The final goal was to develop recommendations based on the results of the survey with community input for improving the delivery of health care services to MHCP enrollees and reducing disparities in access and quality.

The following are some major findings from the study:

General

- Overall, European Americans enrolled in MHCP, whether adults or children, are less likely to experience barriers to access and utilization of health services than are their counterparts in other cultural groups.
- Among the cultural groups included in the study, members of communities who are recent immigrants to the US (Hispanic/Latino, Hmong, and Somali) generally report the greatest number of barriers, followed by African Americans, Native Americans, and then European Americans. Among immigrant groups, Hmong respondents are most likely to report experiencing barriers.
- Although adults and children experience the same barriers, adults consistently report more problems than do parents of child enrollees.
- The patterns of barriers uncovered in the 2003 study still persist, although the prevalence of several barriers has declined somewhat. While this is good news, barriers have not been reduced to the level where DHS, health plans, providers or enrollees can comfortably claim success.

Use of Services

- Forty-six percent of adults and 34% of child enrollees report going a year or more without a dental visit, which is equally high across cultural groups. Parents of children were more likely to report a dental visit than were adult enrollees. The most common reason for not visiting the dentist in the past year was that the respondent did not perceive they (or their child) needed dental care. The second most common reason provided for not seeing a dentist in the past year was not being able to find a dentist who would accept them as a patient.
- Hmong parents are significantly *more* likely and Somali parents are significantly *less* likely than European American parents to report their child went without an acute care visit in the past year.
- About 24% of adults and 17% of parents did not report a preventive care visit in the past year, which is similar across cultural groups. Without more detailed analysis by specific age, or knowledge of the presence of a condition or health history, it is difficult to judge whether these rates indicate under-utilization.
- Almost three-quarters of adults indicated they had not visited a mental health provider in the past year, which was significantly lower than reports for child enrollees (83%). Hmong parents are much less likely than European American parents to say their child had a mental health visit in the past year. Assessing whether this represents underutilization of services is somewhat difficult to confidently assess with these data. Adults and children who screen positive for depression and report poor emotional health status are significantly more likely to report a mental health visit in the past year than those who do not. However, upwards of 36% of children and upwards of 45% of adults who report a need for services do not report a visit to a mental health provider in the prior year. Of the 17% of adult MHCP enrollees who test positive for depression, just over half (54%) report a mental health visit in the prior year. The level of need in MHCP is higher than in the general Minnesota population, where 7.7% of adults screened positive for depression or for a serious mental illness in a 2004/05. Of adults with need in the general Minnesota population, only 21% received treatment in the prior year.¹ The screening tool used in the general population survey casts a wider net, yet a higher percentage of MHCP enrollees screen positive. Although the questions about receipt of services vary between these two surveys, it appears a higher percentage of MHCP adult enrollees received needed treatment than is true in the general population.
- Adults are more likely than parents of child enrollees to report they did not get care when needed or that they delayed needed care in the past year. Hispanic/Latino and Hmong adults are less likely to report these access difficulties than European American adults.

¹ McAlpine DD, T Beebe, K McCoy, M Davern. 2004/2005 Minnesota Treatment Needs Assessment Survey, January 2006. Available at: <http://mn.drugfree.org/MN%20REPORTS/Household%20Survey%20Final%20Report.pdf>. Accessed May 20, 2009.

Cost and Coverage Barriers

- As was the case in 2003, concerns over cost and coverage remain the largest barriers to care, regardless of age or cultural group. Almost three quarters (73%) of adults and 59% of parents reported at least one of the following problems getting health care: worry that insurance will not cover the care received, worry will have to pay more than expected or more than can be afforded, medication costs, month to month uncertainty about MHCP enrollment, not knowing what services are covered, and not knowing where to go for help when questions arise.
- Although no cultural group was sheltered from these barriers, Hmong, Hispanic/Latino and Somali enrollees appear to be particularly vulnerable. A higher proportion of adults than parents report these barriers.

Access Barriers

- Many MHCP enrollees report problems accessing health care, such as getting an appointment when needed, difficulties getting transportation to visits, inability to see their preferred doctor, inconvenient office hours, not knowing where to go to receive care, work and family responsibilities and lack of child care. Sixty three percent of adults and 61% of parents indicate one or more of these access barriers.
- The inability to get an appointment as soon as needed is identified as one of the most important barriers to accessing health services by European American, Native American, and African American parents. Work and family responsibilities were also reported as major barriers for these populations.

Provider Related Barriers

- All groups but African American parents are more likely than their European American counterparts to report one or more provider related barriers. These include perceptions that doctors do not understand their language, their culture, or don't respect their religious beliefs, as well as beliefs that doctors are not trustworthy and that their usual place of care is not welcoming.
- Smaller proportions of enrollees report provider related barriers (31% of adults and 27% of parents) than report cost and coverage or access barriers.

Concerns about Provider Practice Style, Low Confidence and Trust in Usual Provider

- Adults are significantly more likely than parents (36% versus 26%) to indicate their usual provider does only a fair or poor job of explaining things in a way they can understand, does

not do enough to find out their health care concerns, does not spend enough time to address their health concerns, or does not treat them as partners in making health care decisions.

- For the most part, such concerns about provider practice style are less common among European Americans than other cultural groups.
- Lack of confidence in one's provider is defined as the following: being afraid that their doctor might not do enough to find out what is making them sick, that the health care they receive might make them feel worse, that their provider will tell them they have an illness that they do not have, or that their provider might not find an illness they do have. Half of all adult enrollees report low confidence in their usual provider as compared to 37% of parents seeking care for an enrolled child.
- With the exception of African Americans, all other cultural groups are more likely to report low confidence in their (or their child's) provider than are their European American counterparts.
- In spite of expressing relatively low confidence in providers and having concerns about practice style, relatively few enrollees (less than 10%) indicate they do not trust that their usual provider has their best interests in mind when making health care decisions.

Perceived Discriminatory Attitudes

- Perceived unfair treatment due to ability to pay or enrollment in MHCP is more common than unfair treatment based on gender and race, ethnicity, or nationality. Parents are less likely to perceive that their physician treated their children unfairly based on these characteristics than are adults; 36% of parents and 48% of adults report discrimination based on ability to pay or MHCP enrollment whereas 11% of parents and 13% of adults report race, ethnicity or nationality based discrimination.
- In contrast to European Americans, Hispanic/Latino and Somali adults and parents are *less* likely to report discrimination based on ability to pay or enrollment in MHCP, whereas Native American adults and Hmong adults and parents are *more* likely to report this type of discrimination.
- Reports of discrimination based on race, ethnicity or nationality are significantly higher among all other cultural groups as compared to European Americans.

Interpreter Availability and Quality

- Hmong and Somali adults are more likely than Hispanic/Latino adults to report a need for an interpreter to help them communicate with their health care providers.

- Among those who report a need for interpreter services, almost twice as many Somali than Hispanic/Latino parents report that this need is not met.
- Enrollees report problems with the quality of interpreter services (how well the interpreter helps the patient understand what doctors are asking, helps doctors understand what the patient is telling them, and helps the patient understand what is being done in the medical encounter). Problems with interpreter quality are higher among Hmong and Somali than Hispanic/Latino enrollees (true for adults and parents alike).
- Concerns that interpreters may not keep private the information discussed in the doctor's office are prevalent in all three cultural groups, although much lower among Somali than Hispanic/Latino enrollees.
- There was a significant increase over time (2003 vs. 2008) in the need for interpreter services for Somali adults and Hmong children. However, while availability and quality improved for Hmong children, quality got worse for Somali children.

Relationship Between Barriers and Use of Services

- Barriers are more commonly associated with care that can be viewed as “discretionary,” specifically preventive services, than they are with care associated with an injury or illness.
- A greater proportion of the barriers for adults than children are positively associated with having unmet care needs in the past year.
- With the exception of problems with interpreter services, all barriers increase the likelihood that adults and parents had delayed needed care in the prior year.

Change over Time

- A greater proportion of Hispanic/Latino, Somali and European American parents reported that their enrolled child had a visit to the dentist in the prior year in 2008 than in 2003.
- Many of the barriers found in the 2003 study persist in 2008, although the prevalence of barriers reported has declined some. In particular, access barriers for adults and cost-related barriers for children appear to be lower in 2008, whereas reports of barriers due to availability of childcare increased over the five year period.

Conclusions and Recommendations

One of the important aspects of community-based participatory research is the inclusion of community members in interpreting study results and developing realistic recommendations for change. Members of the Project Management Team (PMT) conducted focus groups in their respective communities to share key results and to solicit advice on solutions and next steps.

Each cultural group raised different concerns, but shared strategies for addressing these persistent problems also emerged. Although many recommendations that were developed target DHS, health plans and providers, many also address the role of community members in assuming responsibility for their health and making sure they are aware of services offered through MHCP. Here we highlight suggestions provided by community members in focus group settings and recommendations by the full research team that are both provided in greater detail in Chapters 4 and 5 respectively.

Worries over having to pay more than expected for care, whether insurance would cover costs, loss of coverage, knowing what services are covered, and so forth were identified as top barriers to service use across all age and cultural groups. A major component of these barriers may be perceptual, because coverage, especially in Medical Assistance, is comprehensive and copays are small. Nonetheless, the sheer prevalence and magnitude of reports of cost and coverage barriers, as well as the strong relationship between these barriers and reports of unmet need and delayed care, indicates the need for a variety of interventions. For example, urging DHS to keep these programs simple, comprehensive, with minimal copayments as well as maintaining stability in eligibility and benefits may help reduce uncertainty surrounding MHCP. The predominance of perceived cost and coverage barriers both years also suggests the need to develop more accessible and effective educational and outreach initiatives to help MHCP enrollees better understand the level of benefits and services available to them. While the large benefits book provided to all enrollees likely contains this information, the format alone may be overwhelming. Some ideas include expanding into less conventional venues to educate enrollees, such as locating information tables and/or outreach workers in the community where members already come together (church, schools, community centers and cultural events), raising awareness of the existence and purpose of the Helpline and Ombudsman, and/or expanding the role of Community Health Workers (CHW) to help educate enrollees about their benefits. Suggestions to DHS include minimizing the amount of change each year, simplifying the information sent in the mail, perhaps requiring that all health plans flag important benefit or change in benefit information in a similar way (e.g., red paper) so that enrollees know what materials are essential to read themselves or need to be translated by a family member or interpreter.

Other ideas to improve understanding among persons enrolled in MHCP might involve a one-page letter to enrollees outlining their rights and responsibilities. A more complicated approach (but still feasible) is for larger community meetings to be established where DHS and health plans can answer questions about MHCP. Improved understanding may also require the use of patient advocates or health care navigators to encourage patients to ask questions and foster communication and respect between patients and providers. Enrollees may lack the confidence to do this on their own and therefore may not be able to make the most of their visits to health care providers. Some enrollees seek a more active role in making decisions about their health and health care. Enrollees should be encouraged to make suggestions, offer praise when care quality is good and express concerns when it is not. MHCP enrollees and their advocates do not always know how to go about voicing their satisfaction, needs or concerns. This might be as easy as having DHS advertising the availability and role of the Helpline (for fee-for-service clients) and the Ombudsman (for managed care enrollees) in fielding their questions and complaints.

Relationships are built on communication, and community members feel that their relationships with health providers are often impaired by discrimination, not feeling welcomed at the place they go for health care or because their provider does not adequately explain things, listen or spend enough time with them. These obstacles to positive relationship are reported among the English speaking enrollees but are more prevalent among non-English speaking enrollees. Although difficult problems to solve, it is clear that community members felt that holding providers, staff and interpreters accountable for disrespectful behavior and poor quality service might help. Some ideas included consumer surveys, providing a number to call and provide anonymous feedback (as discussed above, advertise the Helpline as venue for providing suggestions), public reporting, and calling on patient advocates. However, plans and providers must also indicate whether and how concerns have been addressed to demonstrate that patient feedback is taken seriously, rather than collecting survey data to meet a requirement that is merely a one-way exchange of information. Brief reports on survey results (e.g., positive and negative findings, and what actions will be taken to address complaints) and compilations of frequently asked questions (FAQs) and responses based on issues raised on the Helpline could be distributed with regular mailings to enrollees and featured prominently on the web, community clinics, community centers, etc.

Dissatisfaction with provider practice style and reports of discrimination (both racial and socioeconomic) suggest the relevance of cultural sensitivity education across the health care system (i.e., providers, clinic and agency staff). Guidance for providers is available through the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS).² However, only the 4 standards (of 14 total) dealing with the availability of language services are mandated of those receiving federal funds. The standards dealing with culturally competent care generally, and organizational supports for these standards specifically, are simply "recommended." Cultural sensitivity or competency training without mechanisms for credentialing, enforcement, evaluating success and quality improvement diminish the value of these activities for providers and enrollees. DHS and health plans should encourage continued investment in these issues for continuing education units (CEU) across the spectrum of providers.

Perceptions of discrimination are likely exacerbated by provider turnover and the limited amount of time providers have to spend with their patients. Increasing the length of visits may go a long way to build trust and the level of calm needed to ensure that nonverbal behaviors on the part of providers (nurses and physicians) are not interpreted as impatience or bias.³ Visits that call for use of interpreter services clearly require additional time and energy, which should be allocated without penalty to providers. The concept of a "health care home" being discussed as part of Minnesota's Reform Initiative may be fitting in the context of MHCP enrollees, particularly those with chronic conditions or who are new to the US health care system. A health care home

² U.S. Department of Health and Human Services, Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. Washington DC, March 2001 Available at: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>. Access April 20, 2009.

³ Burgess D, M van Ryn, J Dovidio, S Saha. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *Journal of General Internal Medicine*, 22(6):882-7. 2007; van Ryn M, J Burke. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science and Medicine*, 50(6):813-28. 2000.

offers care that is, "...accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective" (Minnesota Health Reform Law of 2008⁴). Consistently low Medicaid reimbursement rates in Minnesota may also be partially to blame for perceptions of provider bias, as providers are less well rewarded for providing services to the public as compared to the commercial population. Furthermore, low reimbursement may lead to provider turnover which in turn impedes the likelihood of having a usual provider, which in turn hinders patients' ability to build trusting relationships with their providers.⁵

The results suggest that there have been some improvements in interpreter services since the 2003 study; however, significant problems with availability and quality of interpreter services continue. These are long standing issues and we are aware that a stakeholders group has been working on them for some time. The 2008 legislative mandate to launch a roster of interpreters (Spoken Language Health Care Interpreter Roster) may be viewed as a step in the right direction for access to language services; however, no credentials are required for a provider to be included in the roster.⁶ Thus, in its current form the roster has no impact on ensuring quality of interpreter services. However, DHS is a powerful stakeholder through contract arrangements with the plans that deliver these services to people enrolled in MHCP. **We recommend that fields holding credentialing and health literacy information could be added to the interpreter roster.**

Plans should move towards requiring credentialing of interpreters specifically trained in health literacy, and/or rewarding interpreters trained for medical interpretation with higher payment rates. At the least, DHS or health plans could penalize providers who employ low quality interpreters or interpreters who violate their patients' confidentiality.

Community members emphasized the importance of not letting research results 'sit' until the next study. Instead, sharing results, solving problems and community confidence in these solutions requires on-going dialogue. DHS might consider establishing a steering group, or call on existing advisory groups, made of community members, community based organizations, advocacy groups, health plans, providers, CHWs and researchers, who meet on a regular basis and are accountable for driving change, monitoring results and sharing successes broadly so information provided by enrollees is seen as instrumental to positive change.

Addressing the barriers identified in this study, most of which have persisted since the 2003 study, will require the commitment and creativity of all stakeholders: the legislature, DHS, health plans, providers, professional associations and societies, educational systems, community organizations, community members and MHCP enrollees. All of these stakeholders are needed to resolve the barriers outlined in this report. Community members are willing partners in creating solutions to these problems and are in an excellent position to both shape and evaluate the merits of proposed policy and practice interventions, and inform the implementation of proposed

⁴ Minnesota Health Reform Law of 2008, S.F. 3780. 2008. Retrieved from <http://www.health.state.mn.us/healthreform/hchomes.html>, April 7, 2009.

⁵ Zuckerman S, AF Williams, KE Stockley. Trends in Medicaid Physician Fees, 2003–2008. *Health Affairs*, 28(3):w510–w519, 2009.

⁶ Spoken Language Health Care Interpreter Roster, Minnesota Department of Health. Retrieved from <http://www.health.state.mn.us/divs/pqc/hci/index.html>, May 11, 2009.

changes. Creating the structure to facilitate ongoing dialogue between stakeholders, including community members and MHCP enrollees, should be a priority if change is to occur and trust in the health care system is to be fostered. Any implementation plan should include a plan for measuring success in improving access and reducing barriers, as well as a plan for involving community advocates and sharing outcomes with community members and enrollees.

Chapter 1

Introduction

Project Goals

The 2008 study replicates a study funded by DHS in 2003. In addition to greater recognition of the salience of race/ethnicity in enrollee's experiences with health care following the 2003 survey, the study results were used by DHS to implement several important changes such as expanded interpreter services, the purchase of software needed to track problems reported to the help desk, and support for the movement towards paying community health workers. However, budgetary constraints led to some changes in MHCP (e.g., copays, restricted benefits) that might increase barriers, thereby motivating the 2008 replication study.

The 2008 project has four major goals. The first is to identify and describe barriers to, and experiences with, health care among adults and children who receive health insurance through Minnesota Health Care Programs (MHCP). Adults were surveyed directly; however, when a child was selected, an adult member of the household answered the questions about the child. Children (less than 18 years old) were not interviewed directly. A second goal is to identify and describe similarities and differences in the use of health services, as well as factors that discourage the use of services among specific cultural groups including African American (US born), Native American, Hispanic/Latino, Somali, Hmong, and European American. A third goal is to identify changes in utilization of care and the types of barriers people experienced between 2003 and 2008. We examine whether or not experiences with health care among people in public programs have improved, stayed about the same, or become worse over time. The final goal is to develop recommendations for improving the delivery of health care services to MHCP enrollees and reducing disparities in access and quality.

What are Minnesota Health Care Programs?

Minnesota has three main public health care programs that play an important role in the delivery of health care in the state: (1) Medical Assistance (MA), (2) General Assistance Medical Care (GAMC), and (3) MinnesotaCare. MA, Minnesota's Medicaid program, is a state and federally subsidized health care program that serves primarily low-income women and children. General Assistance Medical Care (GAMC) is a state-funded program that covers low-income individuals (primarily adult men) who are not categorically eligible for MA benefits. Finally, MinnesotaCare is a state and federally subsidized health care program designed to provide health care to Minnesota children and adults who do not have health insurance and are not eligible for MA or GAMC. Enrollees pay a premium based on family size, the number of people covered, and household income.

Methodology

This study represents a collaborative effort between the Minnesota Department of Human Services, the University of Minnesota, Mayo Clinic, the Cultural Wellness Center and community members recruited by Cultural Wellness Center staff. We used a community-based participatory research method that promotes active involvement of the community in all stages of research, a process we believe is critical to improving population health. A multidisciplinary Project Management Team (PMT) was established to design and implement all aspects of the study (see member listing on page ii).

There were many benefits to partnering with community members in conducting this research. We were particularly excited about the skills these partners bring in (1) designing the questions for the survey, (2) overseeing the quality of translations, (3) making decisions about the analysis and interpretation of data, (4) making sure the results were appropriately shared with community members, and (5) developing realistic and community-driven recommendations.

The survey updates a similar statewide survey of MHCP enrollees that was conducted in 2003 and provided information about health care experiences for about 4900 children and adults enrolled in MHCP.⁷ We used similar methodology in both surveys to allow us to assess changes over time. Additional details on the study design, sampling, study measures, response rates, and analytical strategy are provided in Technical Appendix A: Methodology.

Who was surveyed?

The population for this study was all non-institutionalized MHCP enrollees living in Minnesota. We drew the sample from an administrative file of non-institutionalized MHCP enrollees as of March 2008, who are served in both the fee-for-service and managed care sectors. Due to our interest in understanding disparities in service use and barriers to care across several cultural groups and for children and adults, we selected a stratified random sample of enrollees. This strategy allowed us to adequately over-sample from each of five race/ethnic groups (hereafter referred to as “cultural groups”): African American, Native American, Hispanic/Latino, Somali, and Hmong enrollees. Members of the European American cultural group were sampled from the sixth stratum; this population served as the reference group for most of the analyses presented in this report. Over sampling ensured that there were enough respondents in each group to be able to draw meaningful conclusions from their answers.

It is important to understand the barriers to service use for children and adults; therefore, the sample included equal numbers of randomly selected child and adult enrollees of the health care programs. When a child was chosen, an adult member of the household, typically a parent, answered the questions about the child. Children (less than 18 years old) were not interviewed directly.

⁷ Department of Human Services, State of Minnesota. 2003. Disparities and Barriers to Utilization among Minnesota Health Care Program Enrollees. Available at: http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008306.pdf

What was asked in the 2008 survey?

The survey included measures of demographics, health status, health care utilization, health care experiences and barriers to the use of health care services. Decisions about revising the survey that was used in 2003 were guided by the following concerns: (1) ability to analyze trends over time; (2) fully addressing issues that were found to be particularly important in 2003; (3) including the topics that PMT members thought were important; and (4) keeping the survey to a manageable length. This last consideration led to our decision to delete some questions that were used in the 2003 survey but did not yield useful information.

Major changes to the survey included:

- Addition of questions about mental health
- Expanded sections covering cost, coverage and access barriers
- Expanded questions on discrimination
- Expanded questions on interpreter services to capture consistency and privacy, and the enrollee's usual interpreter (e.g., professional interpreter vs. other)
- Additional question about confidence in one's provider
- Deleted several questions: reasons for last visit, time till receipt of appointment, and time spent in waiting room
- Changed the reference period throughout so that the recall period was limited to one year

Where possible, we chose questions that have been used in national surveys such as the National Health Interview Survey (NHIS), the Community Tracking Survey (CTS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) so that benchmarking against those surveys could be done, if desired. Because appropriate measures were not available for some concepts that the PMT considered important (e.g., not feeling welcome at their usual source of care, consistency of interpreters and concern about privacy), several items were developed by the PMT. Appendix B contains the mail versions of the child and adult surveys.

How was the survey conducted?

Wilder Research conducted the survey between July and December 2008. The survey used a mixed-mode, mail and telephone survey, whereby all randomly selected enrollees were sent an initial survey by mail. If they did not respond after a second mailing, interviewers called all non-respondents and attempted to complete an interview by telephone. Although the mailed version of the survey was designed in English only, the follow-up telephone interviews were conducted in Hmong, Somali, Spanish, and English. The cover page of the mail survey also contained text in all four languages providing a telephone number to call if the enrollee preferred to complete the survey over the phone.

Although we used a wide range of methods to maximize the response rate (detailed in Technical Appendix A: Methodology), our overall response rate was 44.2%; a rate lower than what we obtained in 2003 (54%). This lower response rate in 2008 is consistent with the downward trend in response rates that are found in general population surveys. Overall, a total of 2,400 enrollees completed the mail survey, and 2,226 completed the telephone survey for a total of 4,626

respondents in the final sample. As shown in Table 1, there is variation in response rates across the sampling strata, ranging from 34.7% for Native American adults to 63.4% among Hmong child enrollees. The sample design targeted a total of approximately 333 completes in each of the 12 race/ethnic by age strata. This goal was achieved or exceeded for all but four strata: African American adults and children, and Native American and Somali adults.

Table 1. Response rates by sampling stratum

Sample strata^a	Targeted completes	Total eligible	Completed surveys[^]	Response rate
African American Adult	334	873	314	36.0%
African American Child	333	873	317	36.3%
Native American Adult	334	872	303	34.7%
Native American Child	333	875	339	38.7%
Hmong Adult	334	872	462	53.0%
Hmong Child	333	875	555	63.4%
Hispanic/Latino Adult	333	868	372	42.9%
Hispanic/Latino Child	333	874	417	47.7%
Somali Adult	334	868	318	36.6%
Somali Child	333	872	383	43.9%
Residual Adult	333	874	425	48.6%
Residual Child	333	873	421	48.2%
Total	4,000	10,469	4,626	44.2%

^aNote: Sample strata are based on classification of cultural groups in the administrative data. All analyses are based on enrollee's self-reported race/ethnicity.

How were the survey data analyzed?

Prior to analysis, the survey data were weighted to correct for unequal selection probabilities of individuals and to ensure that the distribution of enrollees in the sample matched that of the population from which they were drawn. Unless otherwise noted, the results presented in this report are weighted estimates and all analyses were conducted using statistical software that produces unbiased estimates from data collected through complex sampling designs. Details about key variables are provided in the Technical Appendix.

There were two stages to the analysis. In the first stage we describe the health status, health care experiences, health care utilization and barriers to care for the population enrolled in MHCP in 2008. We examine whether there are differences between adult and child enrollees in MHCP and whether cultural groups differ in their health care experiences. To examine whether any differences may be due to sociodemographic factors or health status, we conducted multivariate logistic regressions that control for these factors. We describe in the text any differences that lose significance after these adjustments. Finally, we examine whether perceived barriers and problems are correlated with utilization patterns.

In the second stage of analyses, we examine whether there have been changes in the health status, health care experiences, health care utilization or barriers to care from 2003 to 2008. Because of the way we sampled in 2003, this analysis is restricted to persons enrolled in managed care. We assess whether any changes may be due to differences in the sociodemographic characteristics or health status of enrollees in each year through multivariate analyses. Finally, we examine whether disparities (defined as differences between the experiences of European Americans and other cultural groups) changed between 2003 and 2008.

Results that are significant at a p-value of ≤ 0.05 were regarded as statistically significant. Any significant differences are denoted by an asterisk (*) in relevant tables and figures.

Developing Recommendations

Community members on the PMT reviewed preliminary survey results, which is an important part of the community-based participatory research approach adopted throughout the project. They provided reactions to survey results, and identified questions that could be explored through additional analysis.

Focus groups were conducted with members of the community to review and reflect on the results. PMT members from the African American, Native American, Hispanic/Latino, Hmong and Somali communities reviewed the data and identified key barriers and concerns to highlight in their presentations to their respective communities. In part, the choice of results to feature in engagement activities was based on those problems that have the potential of being acted on by DHS. The goal of these community engagement activities was to help formulate reality or experientially based recommendations for change and improvement in the delivery of health care to MHCP enrollees. In addition to the recommendations evolving from the community focus groups (presented in Chapter 4), the research team developed more overarching recommendations after reflecting on discussions at PMT meetings over the course of the project, the survey results from both years, and results from various community engagement activities (presented in Chapter 5).

Chapter 2

2008 Survey Results

Characteristics of MHCP Enrollees

Table 2 shows the self-reported race/ethnicity of adults and children enrolled in MHCP. (See the Technical Appendix for a description of the weighting methodology.) Persons enrolled in MHCP are primarily European Americans (58%), with African Americans born in the US (referred to as African Americans) comprising the second largest cultural group (12.3%), and Hispanic/Latino enrollees comprising the next largest cultural group in MHCP. A greater proportion of adults are European American, whereas for children there is somewhat less concentration within the European American cultural group.

Table 2. Weighted distribution of enrollees by cultural group

	Adults	Children	Total
European American	65.9%	48.6%	58.0%
Native American	6.9%	7.7%	7.3%
African American	10.0%	15.0%	12.3%
Hispanic/Latino	4.5%	14.9%	9.3%
Hmong	2.7%	3.4%	3.0%
Somali	3.1%	4.9%	3.9%
Other Asian non-Hmong [^]	4.5%	2.4%	3.5%
Other foreign born African [^]	2.5%	3.2%	2.8%
Total	100.0%	100.0%	100.0%

[^]There are too few cases in these groups (78 and 136 respectively) to include in the analysis.

Enrollees who self identify as Asian or Pacific Islanders (who are not Hmong) make up about 4% of the population in MHCP; however, there are too few individuals in the sample (n = 78) to make precise estimates of service use or barriers for this population. Similarly, there are too few non-Somali foreign-born Africans to make reliable estimates for this group (n = 136). These groups are, therefore, excluded from the presentation of estimates by cultural group throughout the report. They are, however, included in all estimates for the total MHCP population and in analyses that looks at differences between adults and children.

As shown in Table 3 over 80% of adults enrolled in MHCP are born in the United States. However, there are important differences between cultural groups. The vast majority of Somali and Hmong respondents, and about half of Hispanic/Latino enrollees were born outside the US. Although the data indicate that significantly more Native American and African American adult enrollees are US born than European American adults, over 95% of these three groups are born in the United States. Among non-US born enrollees, the average time in the US differs across cultural groups. On average, Somali enrollees have been in the US about seven years which is

about half that of Hispanic/Latino and Hmong immigrants. About two-thirds (65%) of adults in MHCP are women and only for the Hmong community are men and women almost equally represented. The percentage of adult enrollees who are married or living with a partner varies; compared to European American adults, Native American and African American adults are less likely to be married or living with a partner, and Hispanic/Latino and Somali adults are more likely to be married or living with a partner. African American, Hmong and Somali adult enrollees are more likely to live in metro areas⁸ than European American adults. Almost one-half of Hispanic/Latino adults report speaking a language other than English at home, compared to approximately 90% of Hmong and Somali adults.

Finally, the data suggest that some communities in MHCP may be more socio-economically disadvantaged than others. All cultural groups have lower rates of employment than European American adults. Additionally, the proportion of adults with at least a high school education is significantly higher among European Americans compared to all other cultural groups with the exception of Native Americans.

Table 3. Sociodemographic characteristics of adults

	European American	Native American	African American	Hispanic/Latino	Hmong	Somali	Total
US born	97%	99% *	100% *	46% *	19% *	0% *	83%
Average years in US (among non-US born)	25.3	21.5	NA	14.9 *	15.2	7.0 *	14.5
Average age	43.7	40.2	43.2	38.0 *	41.8	40.3 *	43.0
Female	64%	78% *	67%	71%	51% *	67%	65%
Married, living with partner	40%	29% *	22% *	51% *	47%	50% *	39%
Employed	41%	27% *	23% *	32% *	20% *	30% *	37%
High school graduate or better	82%	75%	67% *	61% *	27% *	37% *	76%
Living in metro area	60%	61%	95% *	64%	98% *	93% *	68%
Speak language other than English at home	1%	0%	0%	48% *	89% *	91% *	9%

NA: Not applicable

* Indicates a significant difference compared to European Americans

⁸ The Office of Management and Budget (OMB) definition of Metropolitan Statistical Area was used. Available at <http://www.whitehouse.gov/omb/bulletins/fy2009/09-01.pdf>. Accessed June 15, 2009. Minnesota counties meeting the OMB definition of metro include: Anoka, Benton, Carlton, Carver, Chisago, Clay, Dakota, Dodge, Hennepin, Houston, Isanti, Olmsted, Polk, Ramsey, St. Louis, Scott, Sherburne, Stearns, Wabasha, Washington, and Wright

As shown in Table 4, the characteristics of child enrollees are similar to adult enrollees in many respects: 1) parents of Hmong, Somali, and Hispanic/Latino children are less likely to be born in the US; 2) among immigrants, Somali parents arrived in the US more recently than Hispanic/Latino and Hmong parents; 3) non-English languages are more commonly spoken at home for Hispanic/Latino, Hmong and Somali children; 4) greater proportions of African American, Hmong, Somali and Hispanic/Latino enrollees live in metro areas; 5) smaller proportions of the parents of Native American and African American children are married compared to the parents of European American children enrollees; and 6) parents of European American children are more socioeconomically advantaged (as measured by education and employment) than most other cultural groups.

Table 4. Sociodemographic characteristics of children

	European American	Native American	African American	Hispanic/Latino	Hmong	Somali	Total
Parents US born	97%	97%	100% *	38% *	5% *	15% *	77%
Parents average years in US (among non-US born)	21.8	28.8	NA	13.1 *	14.0	9.1 *	13.4
Average age	8.3	7.9	8.6	6.8 *	8.4	6.9 *	7.9
Female	48%	42%	45%	41%	50%	47%	46%
Parents married, living with partner	71%	48% *	28% *	67%	80%	71%	61%
Parents employed	63%	52% *	57%	55% *	49%	50% *	59%
Parents high school graduate or better	91%	78% *	83% *	53% *	38% *	41% *	79%
Living in metro area	56%	53%	93% *	73% *	98% *	94% *	69%
Speak language other than English at home	0%	0%	0%	57% *	89% *	87% *	17%

NA: Not applicable

* Indicates a significant difference compared to European Americans

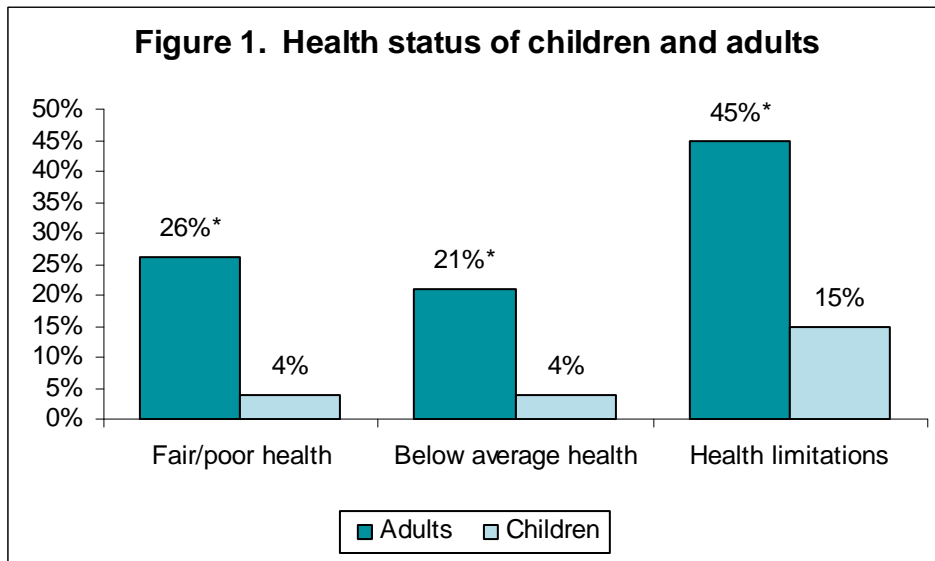
Adult enrollees (Table 3) and parents of child enrollees (Table 4) differ on nativity, marital status, employment, and language spoken at home. In general, a higher proportion of parents are married, employed, speak a language other than English at home and are somewhat less likely to have been born in the US than adult enrollees.

In sum, there are important socioeconomic differences across cultural groups among children and adults enrolled in MHCP and these may be associated with health status, use of services, and experiences in the health care system. It may be important to take these factors into account when examining the influence of cultural background on the use of services and barriers to care.

How Healthy are MHCP Enrollees?

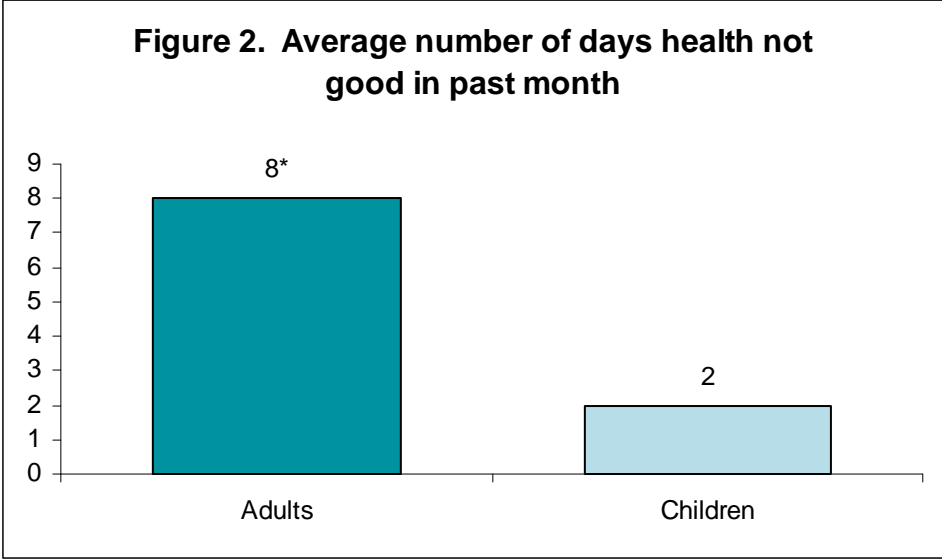
Health status may influence use of medical services, evaluations of care received, and the types of barriers experienced. Respondents were asked to rate their current health (from poor to excellent), whether they thought their current health was below average, average, or above average, and whether physical, mental or emotional problems limited their activities in any way.

Approximately one-in-four adults enrolled in MHCP report they are in fair to poor health, compared to one-in-five who rate their own health as below average (Figure 1). In contrast, a much larger proportion (45%) report that they are limited in any activities because of physical, mental or emotional problems. Adults are about six times more likely than child enrollees to report fair or poor health, five times more likely to report below average health, and three times more likely to experience health limitations.



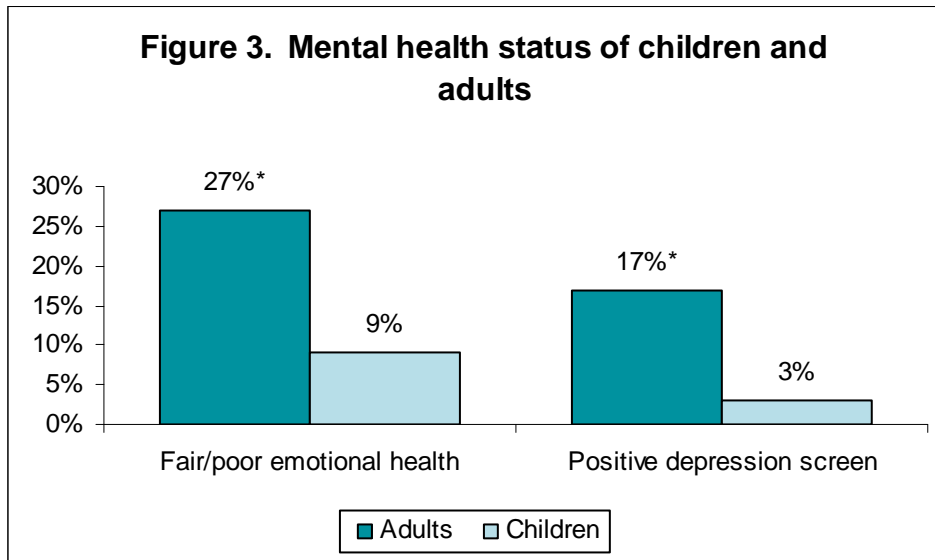
* Indicates a significant difference between adults and children

This age difference in health status is also shown in Figure 2. Adults report an average of 6 days more than children in the past month when their physical health (including injuries and illness) was not good.



* Indicates a significant difference between adults and children

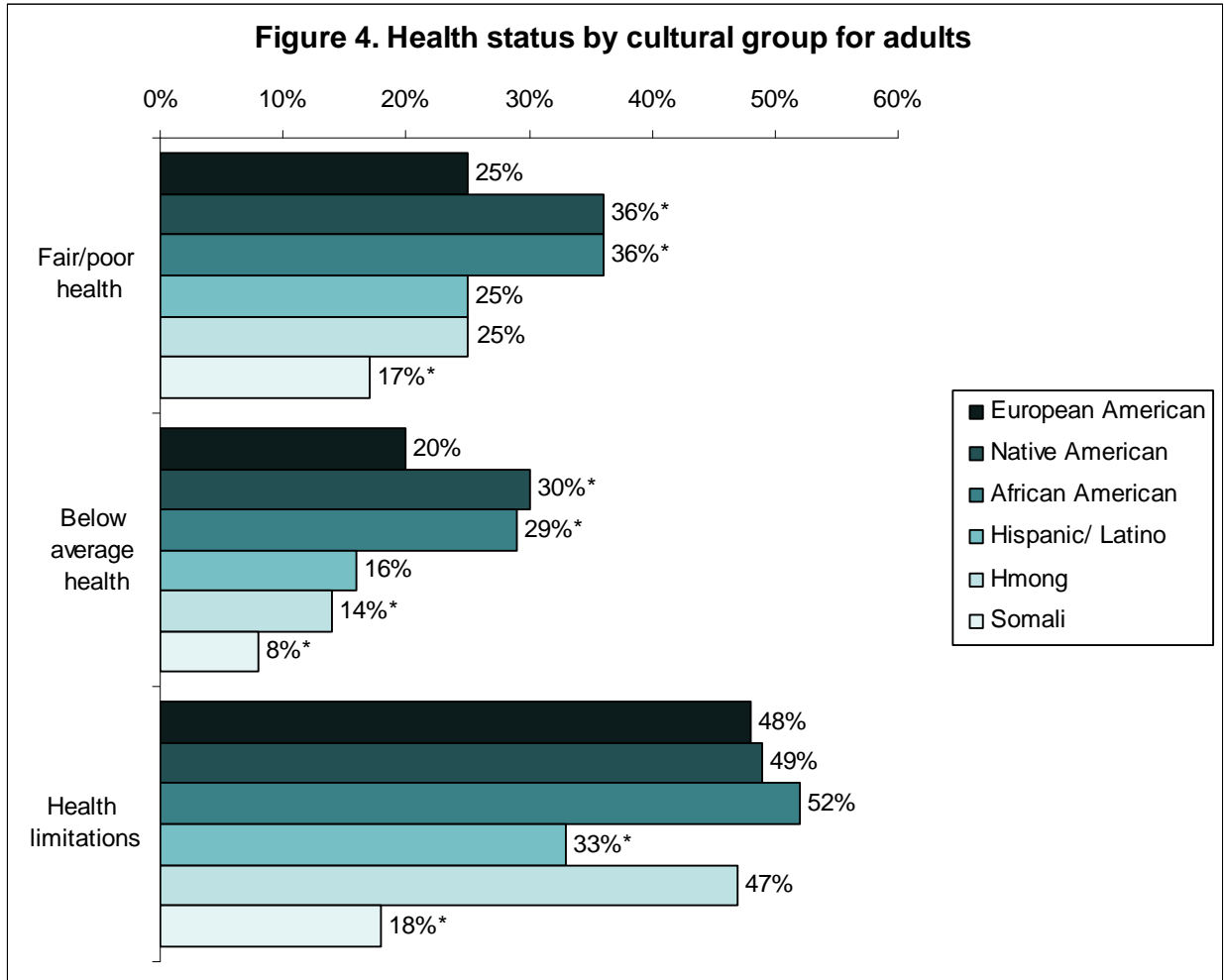
We also asked questions about emotional or mental health. Respondents were asked to rate their emotional health (from poor to excellent), and responded to two questions used to screen for depression. These depression screening questions asked how often during the past two weeks they were bothered by (1) having little interest or pleasure doing things or (2) feeling down, depressed, or hopeless. Adults experience poorer emotional health and are more likely to screen positive for depression than children (Figure 3). To some degree, the estimate of the number of children at risk for depressive symptoms is constrained by including very young children who do not experience these types of mental health problems. If we restrict the analysis to children at least 10 years of age, the estimate of the number of children enrolled in MHCP who screen positive for depression increases to 6%.



* Indicates a significant difference between adults and children

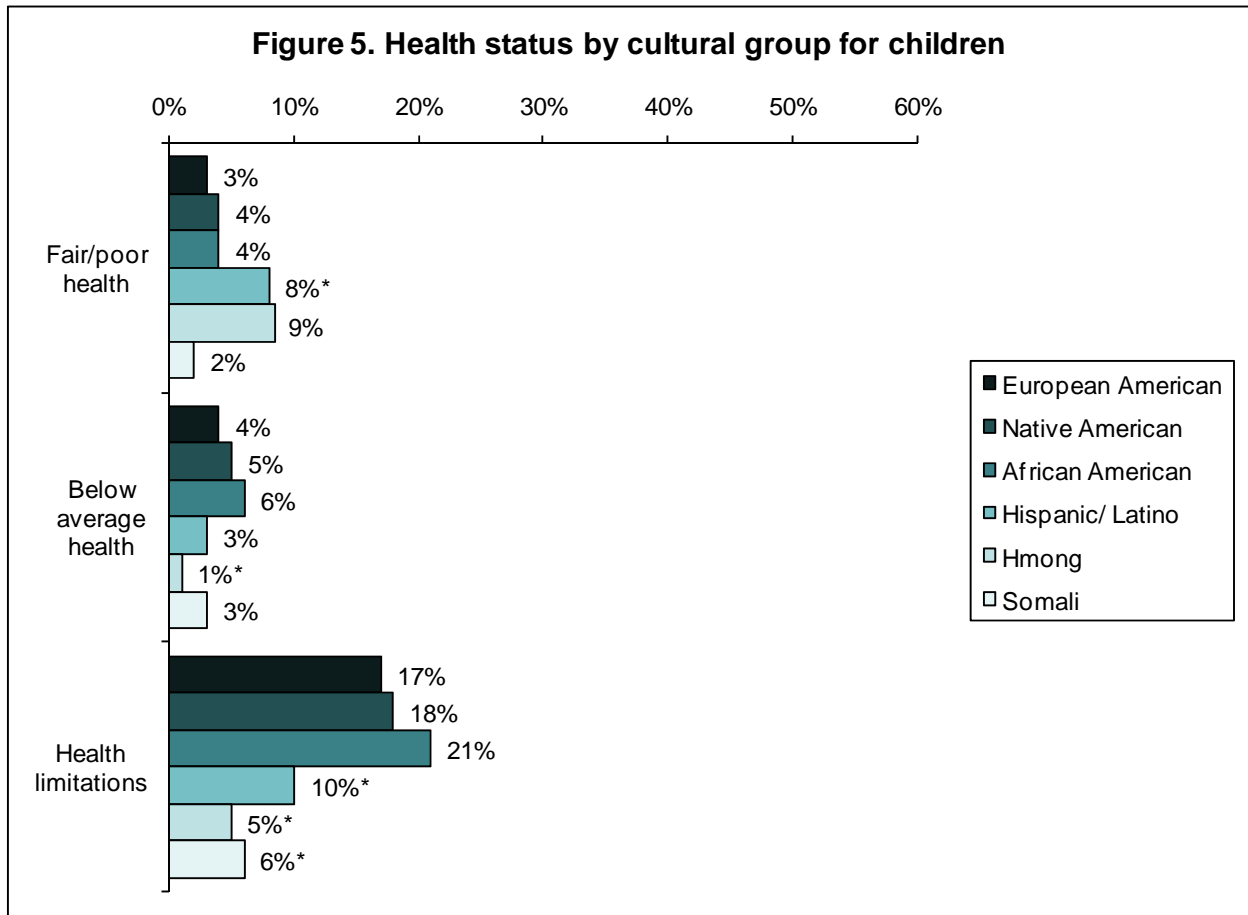
Does Health Status Vary by Cultural Group?

Figure 4 indicates that health status varies between cultural groups. A larger proportion of African American and Native American adults, compared to European American adults report fair or poor health and below average health. By contrast, Somali adults are less likely to report poor health on all three measures, Hispanic/Latino adults are less likely to report that their health limits activities, and Hmong adults are less likely to report below average health.



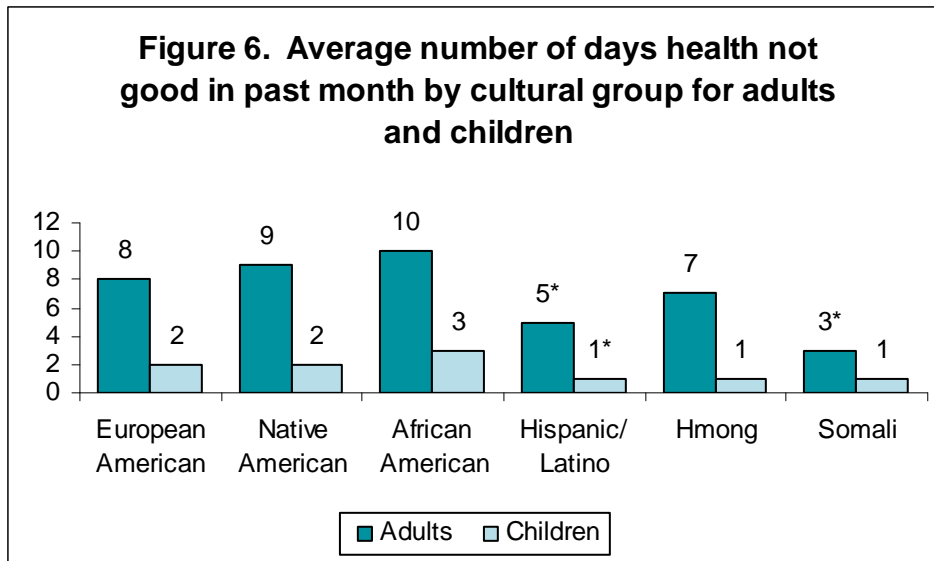
* Indicates a significant difference compared to European Americans

Not surprisingly, children’s health is better than that of adults for all cultural groups across all measures (Figure 5). There are also few differences between European American children and children from other cultural groups. Specifically, Hispanic/Latino children are more likely to be in poor health but less likely to have health limitations, Hmong children are less likely to have below average health or health limitations, and Somali children are less likely to have health limitations.



* Indicates a significant difference compared to European Americans

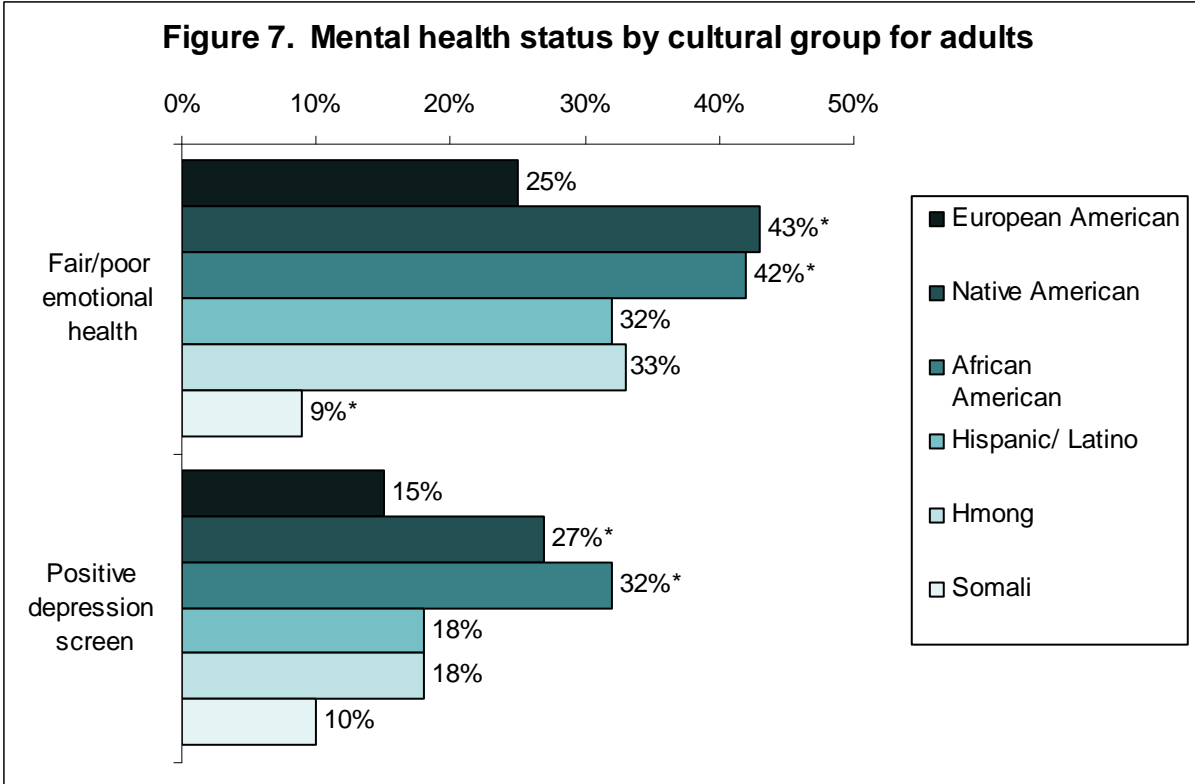
Figure 6 shows the average number of days in the past month that respondents felt that their or their child’s physical health (including injuries and illness) was “not good.” Hispanic/Latino and Somali adults report fewer days when they felt sick than European American adults. Among children only one comparison between cultural groups was statistically significant: Hispanic/Latinos parents report an average of one poor health day compared to an average of two days reported for European American parents (note that Somali and Hmong parents also report only one day in the past year when their child was in poor health, but the comparison did not reach statistical significance).



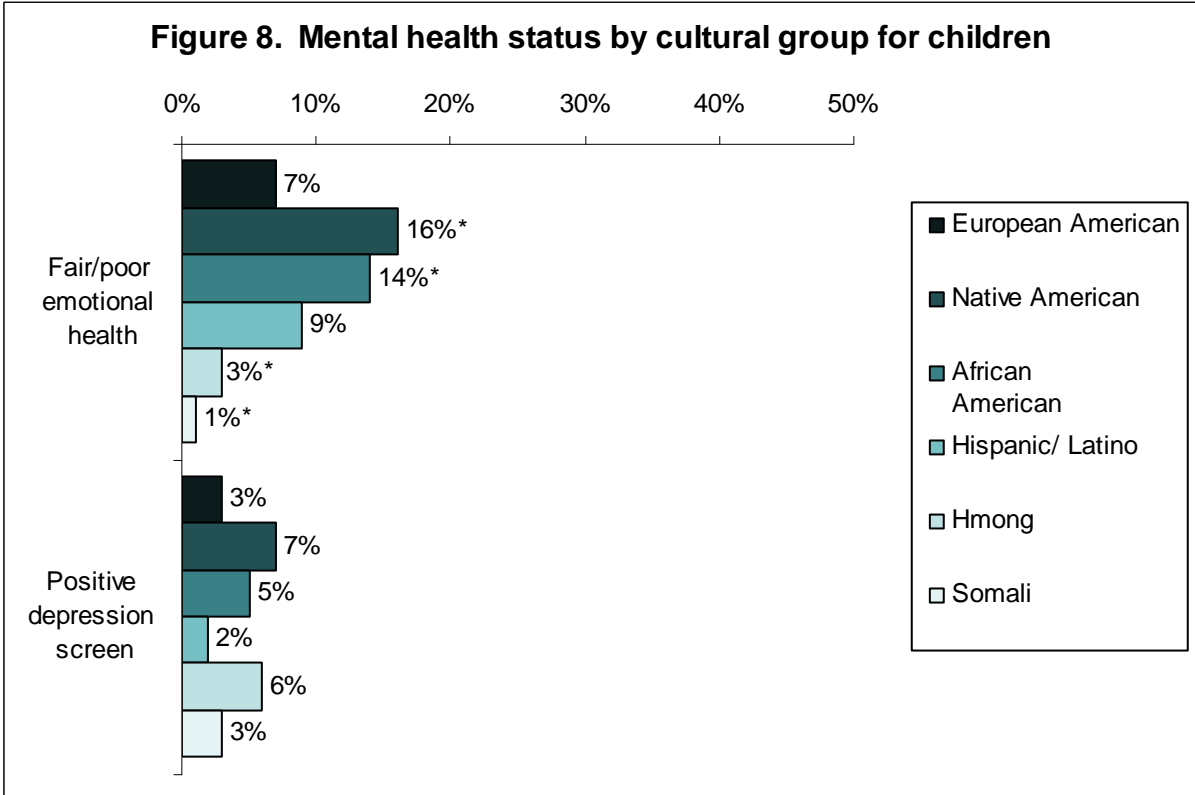
* Indicates a significant difference compared to European Americans

We also examined differences among cultural groups on mental health measures (Figures 7 and 8). African Americans and Native Americans adults are more likely to perceive their own emotional health as poor and to screen positive for depression compared to European Americans. By contrast, adult Somali respondents report better mental health on both measures, although the difference on the depression screen is not significant. Across all cultural groups adults report lower levels of emotional health and are more likely to screen positive for depression than children.

Among children there appear to be greater disparities in mental health status between cultural groups than were found for the self-reported physical health measure. Native American and African American parents are more likely to report their child has fair or poor emotional health than European American parents. In contrast, Hmong and Somali parents are less likely to report their children experience poor emotional health than European Americans.



* Indicates a significant difference compared to European Americans



* Indicates a significant difference compared to European Americans

Table 5 compiles the various measures of health status presented in the figures above by age and cultural group. This summary allows for easier comparison across measures and cultural groups. Several patterns become evident, particularly among adults. First, on several health indicators Native Americans and African Americans are significantly more likely to report worse health outcomes than European Americans. Second, on several measures, a smaller proportion of Hispanic/Latino, Hmong and Somali enrollees report poor health status. Third, Somali adults and parents consistently report better health outcomes and, fourth, adults report worse health outcomes than parents across all measures.

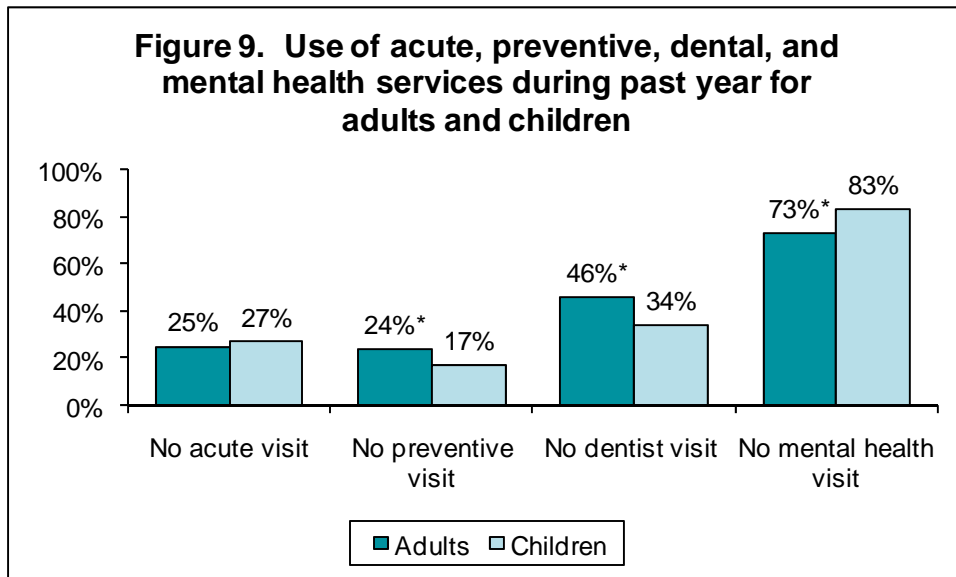
Table 5. Summary of health status measures by cultural group

	European American	Native American	African American	Hispanic/Latino	Hmong	Somali
Adults						
Fair/poor health	25%	36% *	36% *	25%	25%	17% *
Below average health	20%	30% *	29% *	16%	14% *	8% *
Health limitations	48%	49%	52%	33% *	47%	18% *
Average days health not good in past month	8.0	9.5	9.7	5.4 *	6.6	3.4 *
Fair/poor emotional health	25%	43% *	42% *	32%	33%	9% *
Positive depression screen	15%	27% *	32% *	18%	18%	10%
Children						
Fair/poor health	3%	4%	4%	8% *	9%	2%
Below average health	4%	5%	6%	3%	1% *	3%
Health limitations	17%	18%	21%	10% *	5% *	6% *
Average days health not good in past month	2.1	1.8	2.8	1.4 *	1.2	1.2
Fair/poor emotional health	7%	16% *	14% *	9%	3% *	1% *
Positive depression screen	3%	7%	5%	2%	6%	3%

* Indicates a significant difference compared to European Americans

Do Service Use and Access Differ Among MHCP Enrollees?

Figure 9 examines differences in service use across a variety of measures. Specifically, we report the proportion of MHCP enrollees who indicate they did not have an acute care, preventive care, dental or mental health visit in the past year. The choice of time frame for these measures was not straightforward. Guidelines are fairly clear in recommending an annual dental visit. However, this choice of classifying preventive visits may not be ideal as having an annual preventive care visit is not recommended for all age groups. Assessing under or overutilization of services with acute care, preventive care and mental health visits is impossible in this analysis. For example, not going to a doctor for an injury or illness in the past year may or may not signify underutilization. Given clear recommendations for seeing a dentist at least once per year, and a similar time frame for preventive care across many age groups, selecting the time referent of more than one year seemed like a reasonable choice to impose consistency across all four measures.



* Indicates a significant difference between adults and children

Approximately one-quarter of adults and parents report they or their child did not go to a health provider for an illness or injury (acute visit) in the past year. As might be expected with scheduling of well-child visits, a higher percentage of adults than parents indicated no preventive visit in the prior year.

Adults were more likely than parents to report a mental health visit in the past year. Assessing whether this represents underutilization of services is somewhat difficult to confidently assess with these data. We find that adults and children who screen positive for depression and report poor emotional health status are significantly more likely to report a mental health visit in the past year than those who do not. However, upwards of 36% of children and upwards of 45% of adults who report a need for services do not report a visit to a mental health provider in the prior year (data not shown).

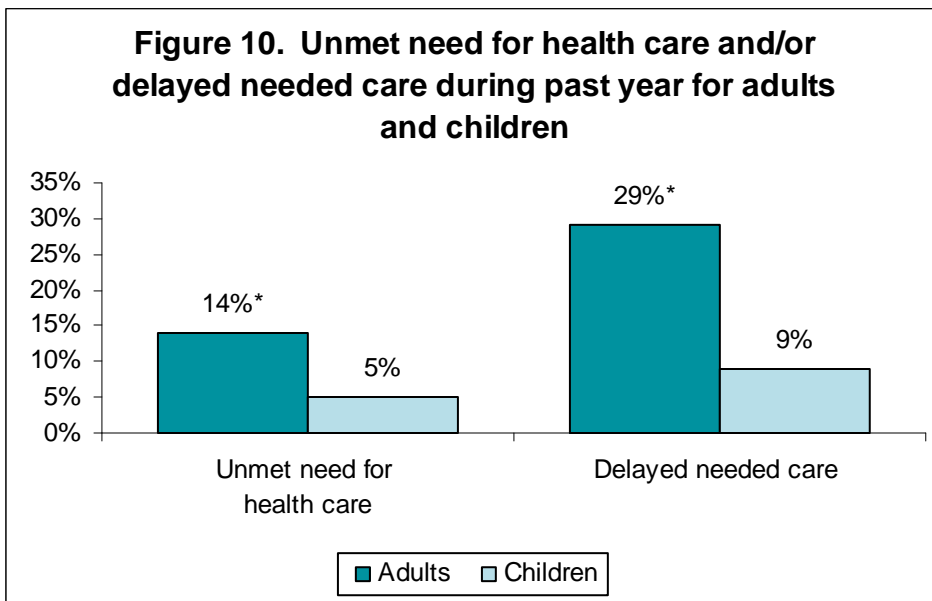
Approximately 46% of adult enrollees and one-third of parents report that they or their child did not visit the dentist in the past year. When we exclude very young children (under 3), the percentage of children who did not visit the dentist in the past year falls to 22%.

Table 6 shows the reasons respondents did not visit the dentist. As shown, the most common response is ‘no need for care.’ The second most common reason for not getting dental care is difficulty finding a dentist who would accept the enrollee as a patient.

Table 6. Reasons for not having a dental visit in the past year

	Adults	Children
No need for care in past year	39%	61%
No dentist would accept you as patient	19%	20%
Didn't know MHCP paid for dental	10%	4%
No appointment at time you could go	8%	5%
Other	25%	9%
	100%	100%

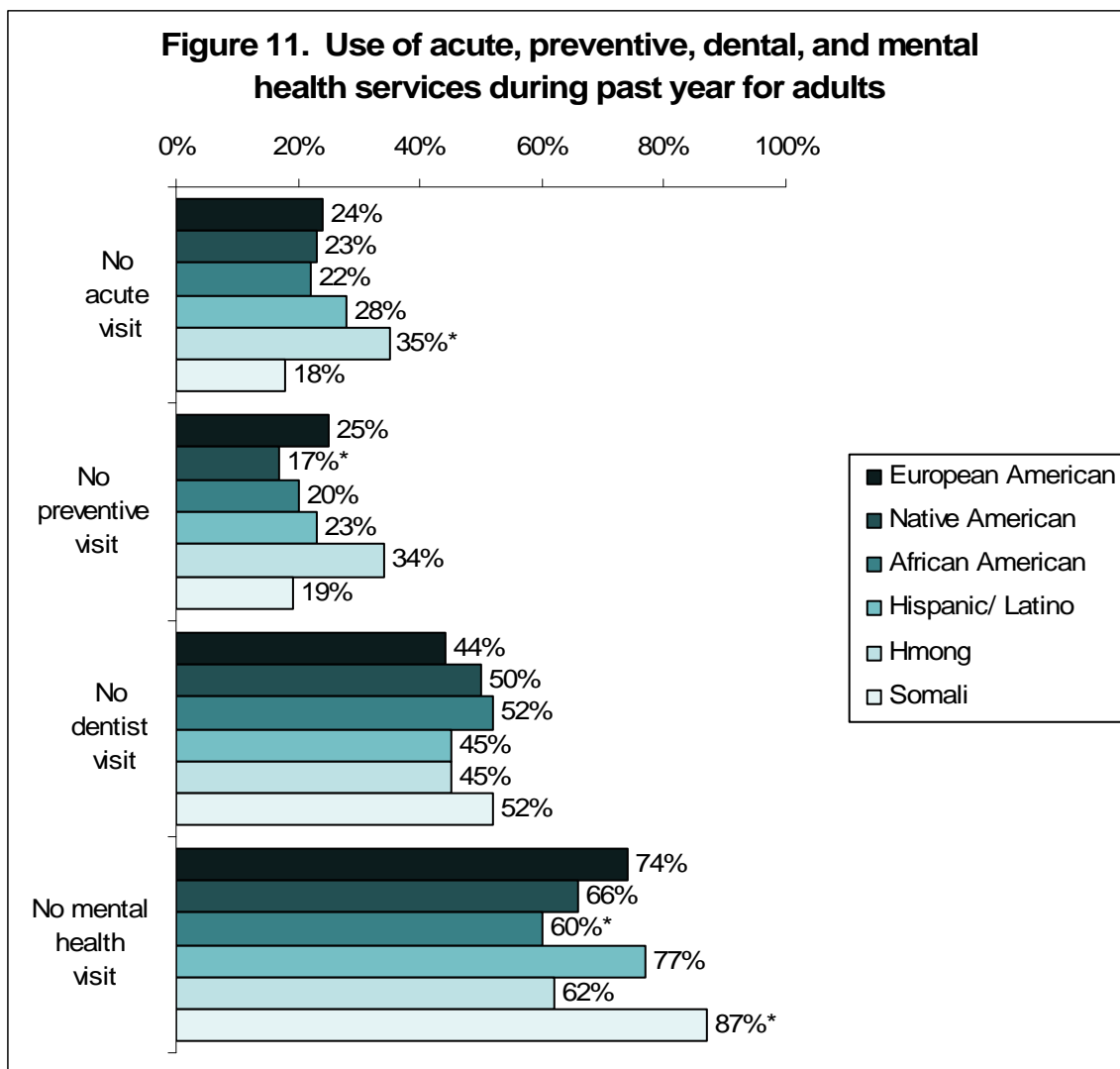
In addition to questions about use of services, we asked respondents whether they perceived that their medical care needs were not met or if they delayed seeking medical care in the past year. Approximately three times as many adults as child enrollees needed medical care but did not get it or experienced a delay in getting needed medical care (Figure 10).



* Indicates a significant difference between adults and children

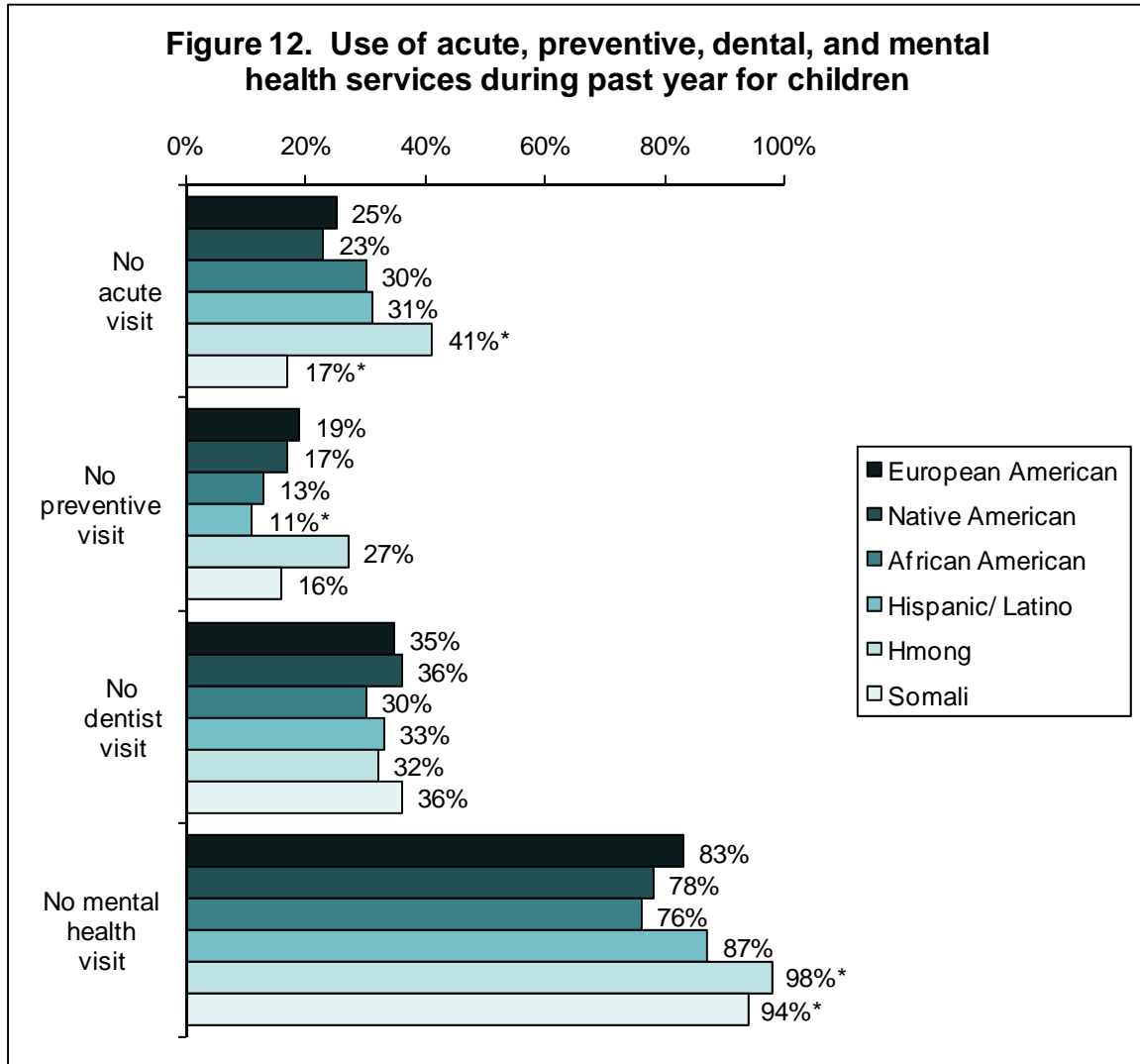
Do Service Use and Access Vary by Cultural Group?

Reports of acute care visits are similar across cultural groups with one exception; significantly higher percentages of Hmong than European American adults say they did not visit the doctor for an illness or injury in the past year (Figure 11). Native American (17%) adults were less likely to report going without a preventive care visit than European American adults (25%). Otherwise, the various cultural groups are similar in reports of going a year or more without preventive care. The percentage of adults who indicate no visit to the dentist in the prior year is similarly high for all groups (44% or greater). Finally, we compare variation in reports of going without a mental health visit in the past year. African American adults are less likely and Somali adults are more likely to report that they did not have a mental health visit.



* Indicates a significant difference compared to European Americans

Figure 12 shows the parallel results for children. As shown, a greater proportion of Hmong and a smaller proportion of Somali than European American parents report no visit to a health care provider in the past year for an illness or injury. A smaller proportion of Hispanic/Latino than European American parents report no preventive visit in the prior year. Larger proportions of both Hmong and Somali parents report no mental health visit in the past year than is true for European American parents.



* Indicates a significant difference compared to European American

It is possible that some of the significant differences in use of services between cultural groups are due to differences between groups in sociodemographic characteristics and health status. We used multivariate analyses (not tabled) to examine whether the initial bivariate differences that we observed persist when we take these factors into account.

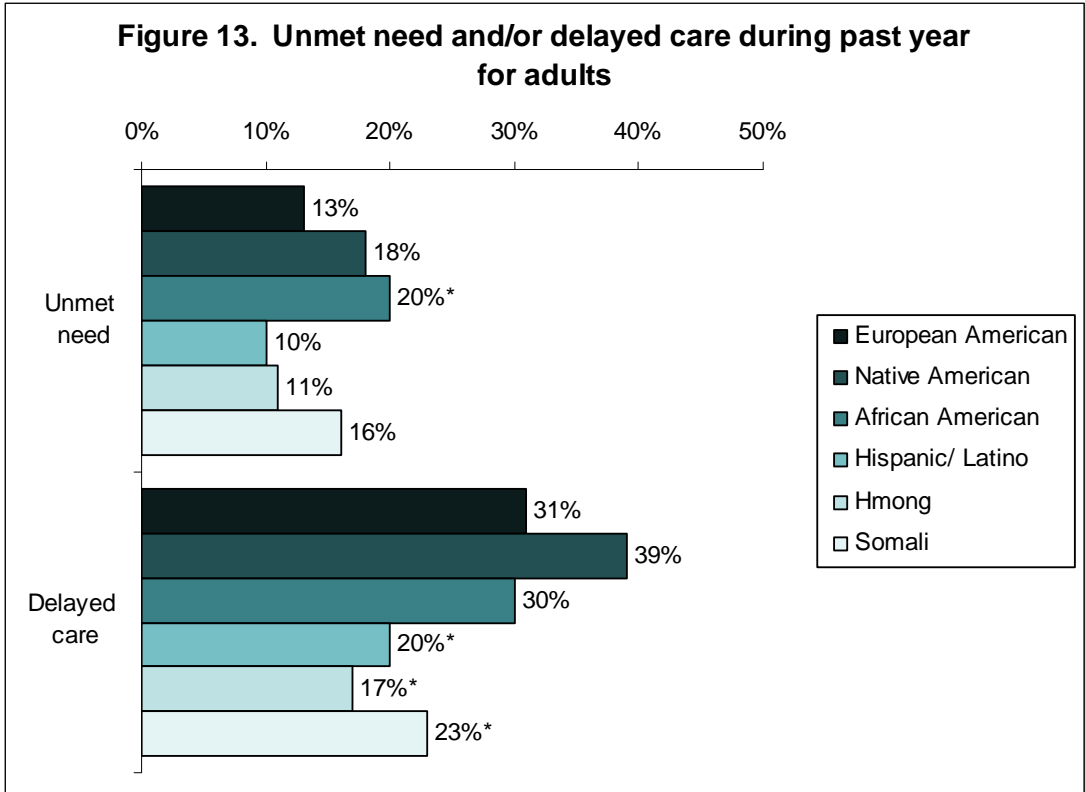
Once we take these factors into account, the differences in service use for an illness or injury among adults shown in Figure 11 are no longer significant. Similarly, the greater likelihood of reporting a preventive care visit among Native Americans is no longer significant after we account for age differences, the higher percentage of female enrollees and greater likelihood of reporting poor health status among Native Americans. The differences in reports of mental health visits do not remain after controlling for marital status and mental health status.

After adjustment Hmong parents continue to be more likely to indicate their child went without acute care and mental health visits in the past year (Figure 12). Somali and European American parents are comparable in reports of their children's use of acute care visits after sociodemographic factors (particularly age and parental marital status) and health status differences are accounted for. Hispanic/Latino children enrollees on average are younger and are more likely to live in metro areas, which account for their greater likelihood of indicating a preventive care visit in the past year. We find that Somali children are less likely than European American children to have mental health care visits as their parents are less likely to report they have mental health problems, along with Somali children being younger and their parents having less education.

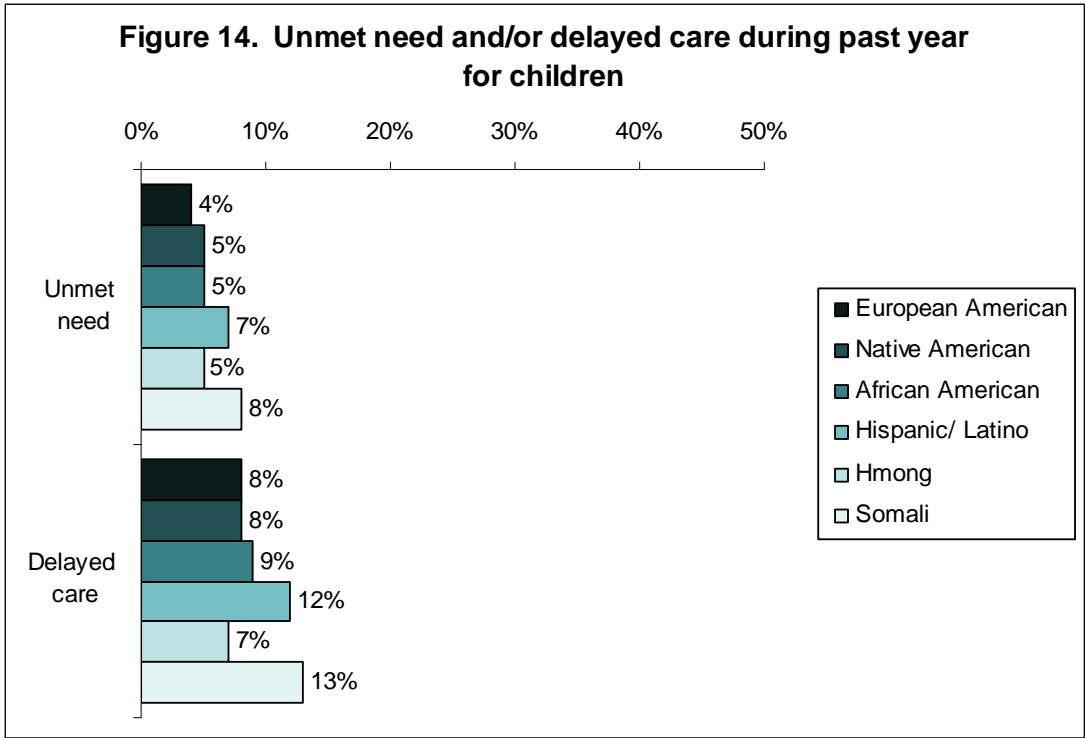
Unmet need and delayed care

There is cultural group variation in unmet need for health care and delayed care in the past year for adults (Figure 13). African American adults are more likely to report that they did not get medical care that they needed in the past year than their European counterparts. Hispanic/Latino, Hmong and Somali adults were less likely to delay needed care. As shown in Figure 14, differences between cultural communities for child enrollees are not significant.

The larger proportion of African American adults reporting poor health status appears to account for their higher reports of unmet need for medical care. Differences among cultural groups in likelihood of delayed care remain significant.



* Indicates a significant difference compared to European Americans



* Indicates a significant difference compared to European Americans

What Barriers to Health Care do MHCP Enrollees Experience?

The survey included a number of questions about barriers to health care and experiences that may affect use of services. As with the questions about health and utilization of services, an adult (usually the parent) answered the questions about the problems and experiences they had getting care for their child.

A series of 19 questions⁹ asked respondents about experiences that may present problems¹⁰ for people when they are trying to get health care. Factor analysis reveals three groupings of variables: (A) cost and coverage barriers, (B) access barriers including such issues as clinic hours, transportation, family and work responsibilities that interfere with seeking care, and (C) provider related problems such as general trust in providers, a clinic or doctor's office that is not welcoming, perceived respect for religious beliefs, speaking one's language or understanding one's culture.

In addition, the survey included measures of (D) perceptions of the practice style of their usual provider and the degree they have low confidence and trust in their usual doctor or health care provider, and (E) perceptions of discrimination. The (F) availability, consistency, privacy and quality of interpretive services were assessed for respondents who indicated they needed an interpreter during medical encounters.

A: Cost and Coverage Barriers to Care

Respondents were asked whether worries that insurance would not cover the care received, that they would have to pay more than expected or can afford, or that medications would cost too much were problems for them when getting health care. Other cost and coverage concerns that may present problems included not being sure from month to month whether they or their child might be dropped from MHCP, and not knowing what services are covered or where to go for help when they have questions about health care.

As shown in Figure 15, these worries were fairly common, with 73% percent of adults and 59% of parents reporting at least one cost or coverage barrier. For all indicators adults are significantly more likely to report these problems than are parents of child enrollees. The most common concern among adults is worrying they may have to pay more for care than they can afford, with over half of all adult enrollees reporting this is a small or big problem. For parents, the most common concern was uncertainty about continuation of enrollment in MHCP.

⁹ This was expanded from 13 questions in 2003 to 19 in 2008.

¹⁰ Respondents perceiving a small or big problem in each of the 19 barrier questions were categorized as perceiving a problem, as opposed to perceiving "no problem at all."

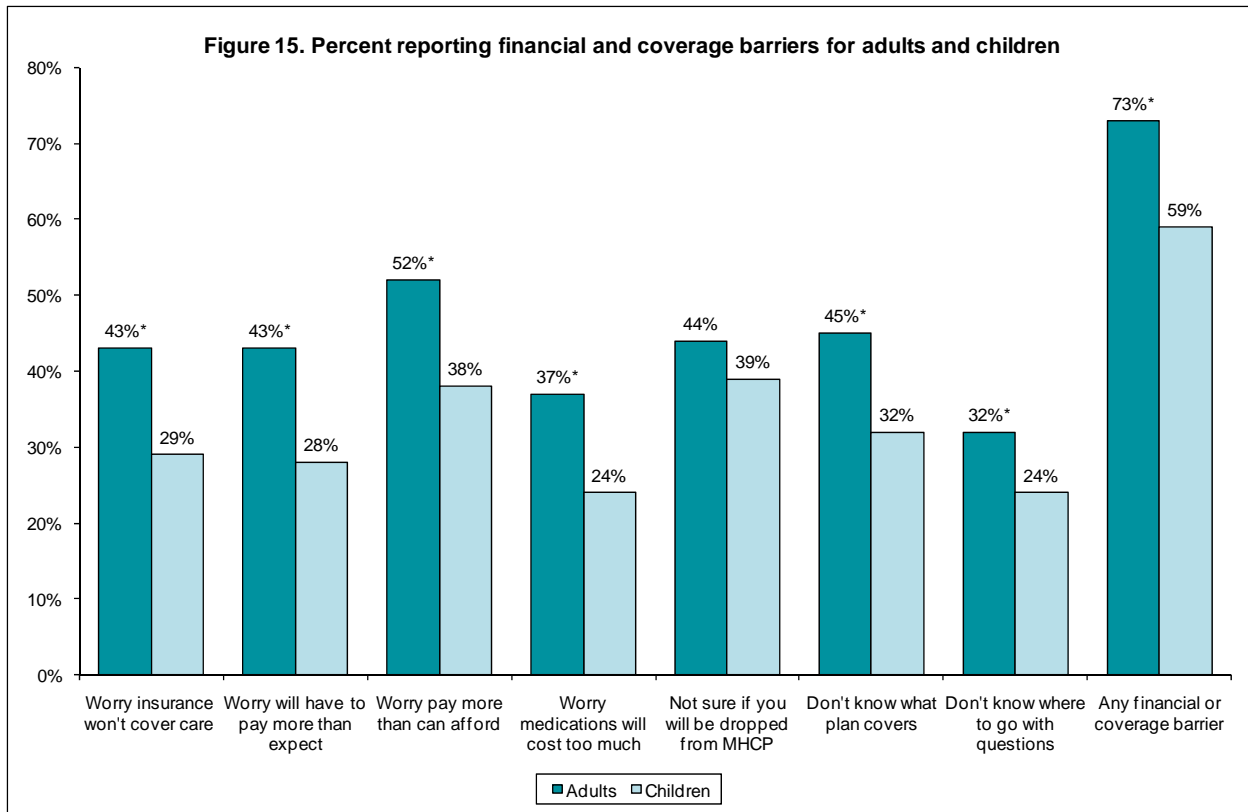
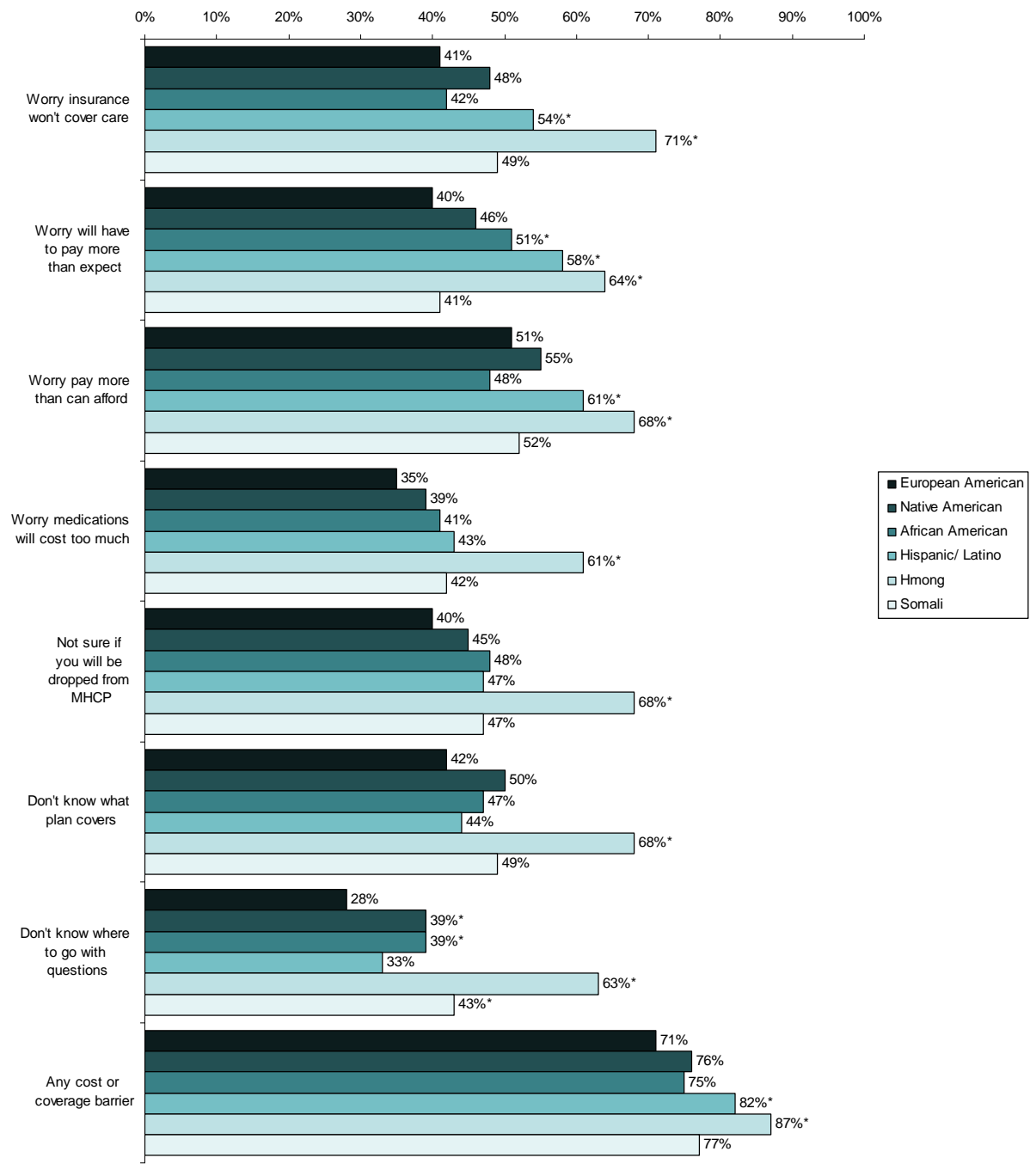


Figure 16 presents the proportion of adults in the various cultural groups reporting perceived cost and coverage barriers to health care. It is striking that a greater proportion of Hmong adults report these problems than any other cultural group. While the differences are not always statistically significant, European American adults are generally the least likely of all cultural groups to report the problems. Hispanic/Latino and Hmong adults are significantly more likely to report cost concerns, particularly that insurance won't cover care, and that they may have to pay more than expected or can afford. Compared to European Americans, all but Hispanic/Latino adults have higher proportions of adults reporting they do not know where to go with questions about health care. It is also notable that in each of the six cultural groups more than 70% of adults enrolled in MHCP report at least one problem getting health care related to cost and coverage issues.

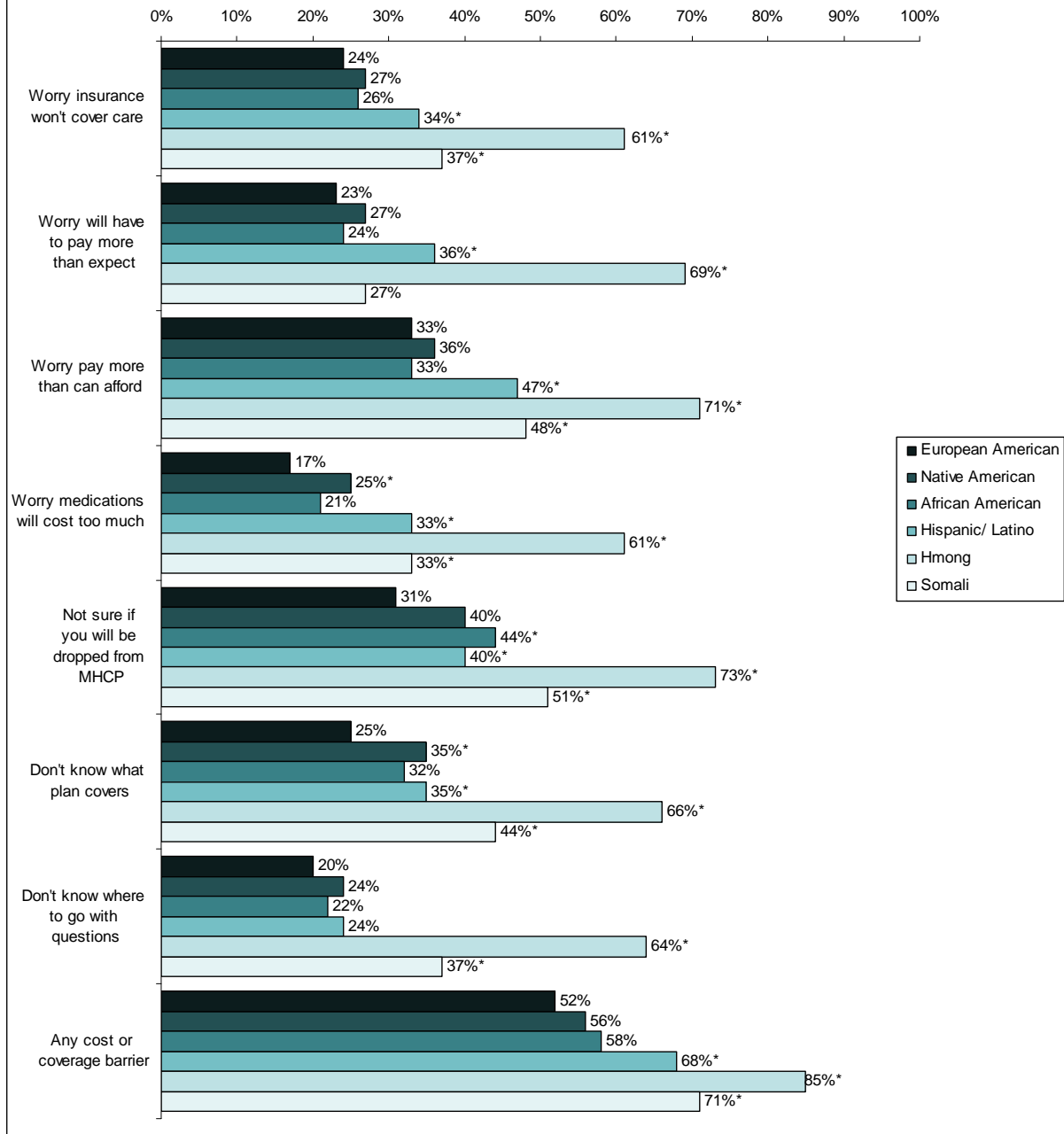
The pattern of results for perceived cost and coverage barriers for child enrollees (Figure 17) are similar to adults; however, overall parents are less likely to report that they experience one of these types of problems when getting health care for their children. One important difference is with Somali adults and children. Although larger proportions of Somali adults than parents report these problems, Somali parents are significantly more likely than European American parents to report all but one barrier. In contrast, only one measure reaches significance among Somali adults, who are more likely to report they do not know where to go with questions about health care.

Figure 16. Percent reporting cost and coverage barriers by cultural group for adults



* Indicates a significant difference compared to European Americans

Figure 17. Percent reporting cost and coverage barriers by cultural group for children

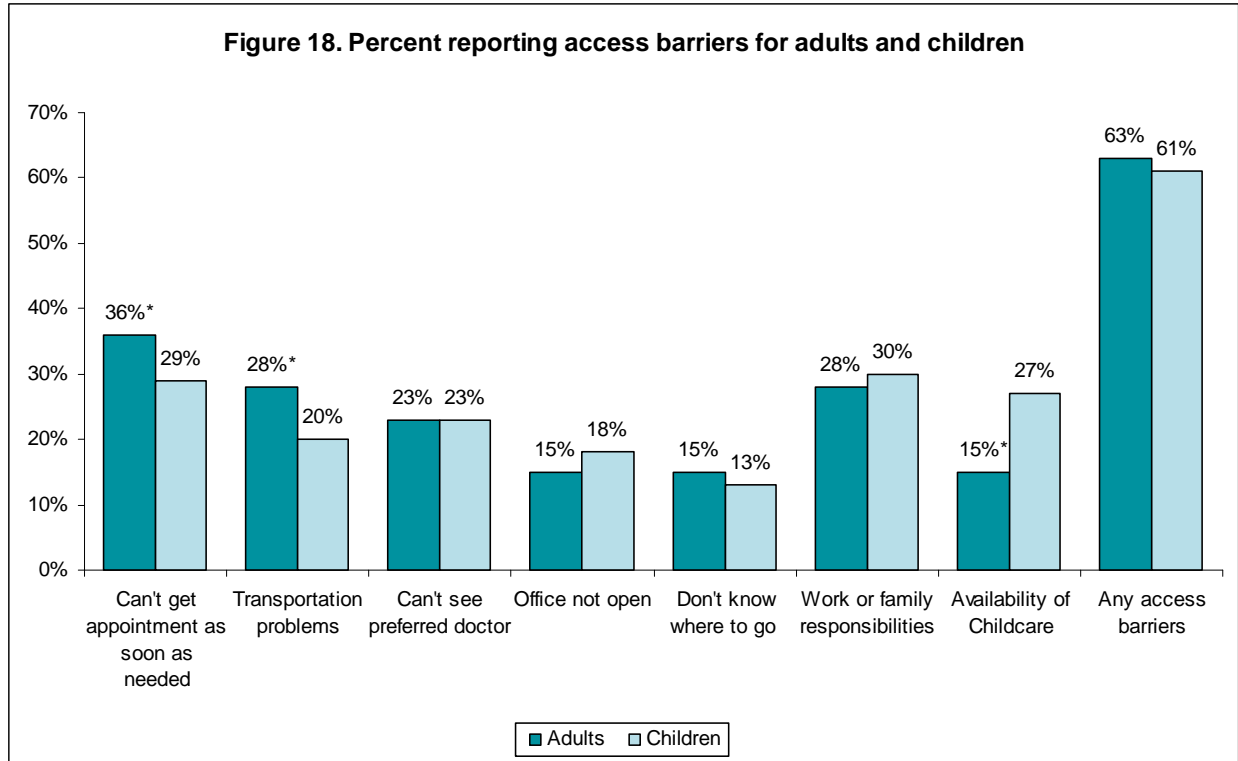


* Indicates a significant difference compared to European Americans

B: Access Barriers

Access barriers include problems getting an appointment when needed, difficulties getting transportation to visits, inability to see the doctor they want to see, inconvenient office hours, and not knowing where to go to receive care. Work and family responsibilities and the lack of child care are also included as potential problems accessing health care.

As shown in Figure 18, getting an appointment when needed and family and work responsibilities are the most commonly reported access problems experienced by adults and parents. Significantly higher proportions of adult than parents of child enrollees experience difficulties with appointments and transportation, whereas higher proportions of parents than adults report that finding childcare poses a problem in getting the health care they need. Overall, adult enrollees and parents are equally likely to experience one or more problems accessing care, with more than 60% reporting at least one access barrier.

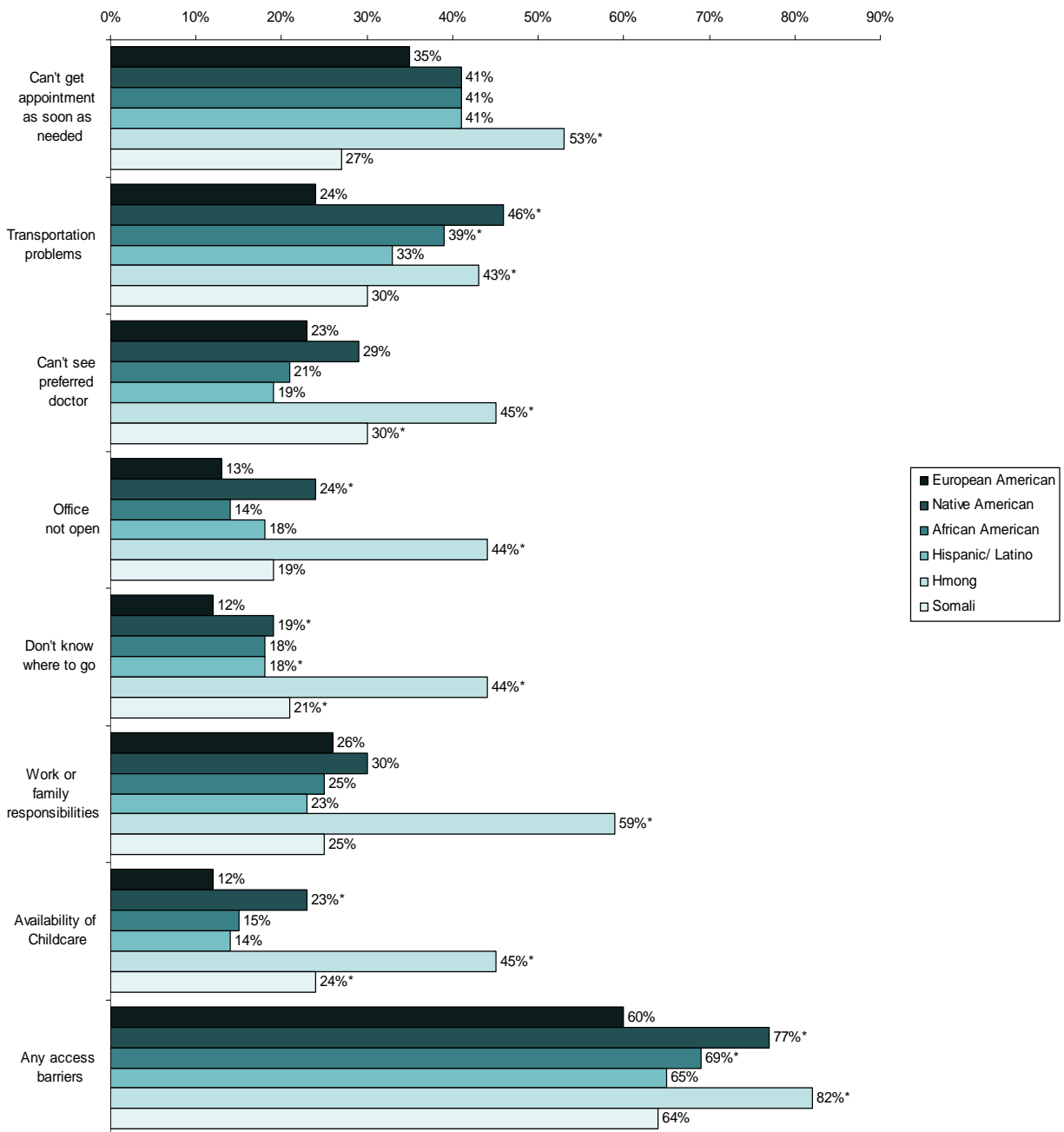


* Indicates a significant difference between adults and children

Consistent with Figure 18, for adults the most common access barrier is getting an appointment as soon as needed regardless of cultural group; the only exception is for Hmong adults for whom work and family responsibilities present a bigger problem (Figure 19). In general, Hmong adults are the most likely and European American adults are the least likely to report most barriers; in fact, Hmong are significantly more likely than European Americans to report every access barrier. Compared to European Americans, American Indians are significantly more likely to report problems with transportation, office hours, not knowing where to go, and childcare. Higher proportions of African Americans report problems with transportation. Hispanics are more likely than European Americans to report not knowing where to go, and Somali are more likely to report problems with not being able to see their preferred doctor, not knowing where to go, and childcare. Overall, Hmong, Native American, and African American adults are significantly more likely to report at least one access related problem.

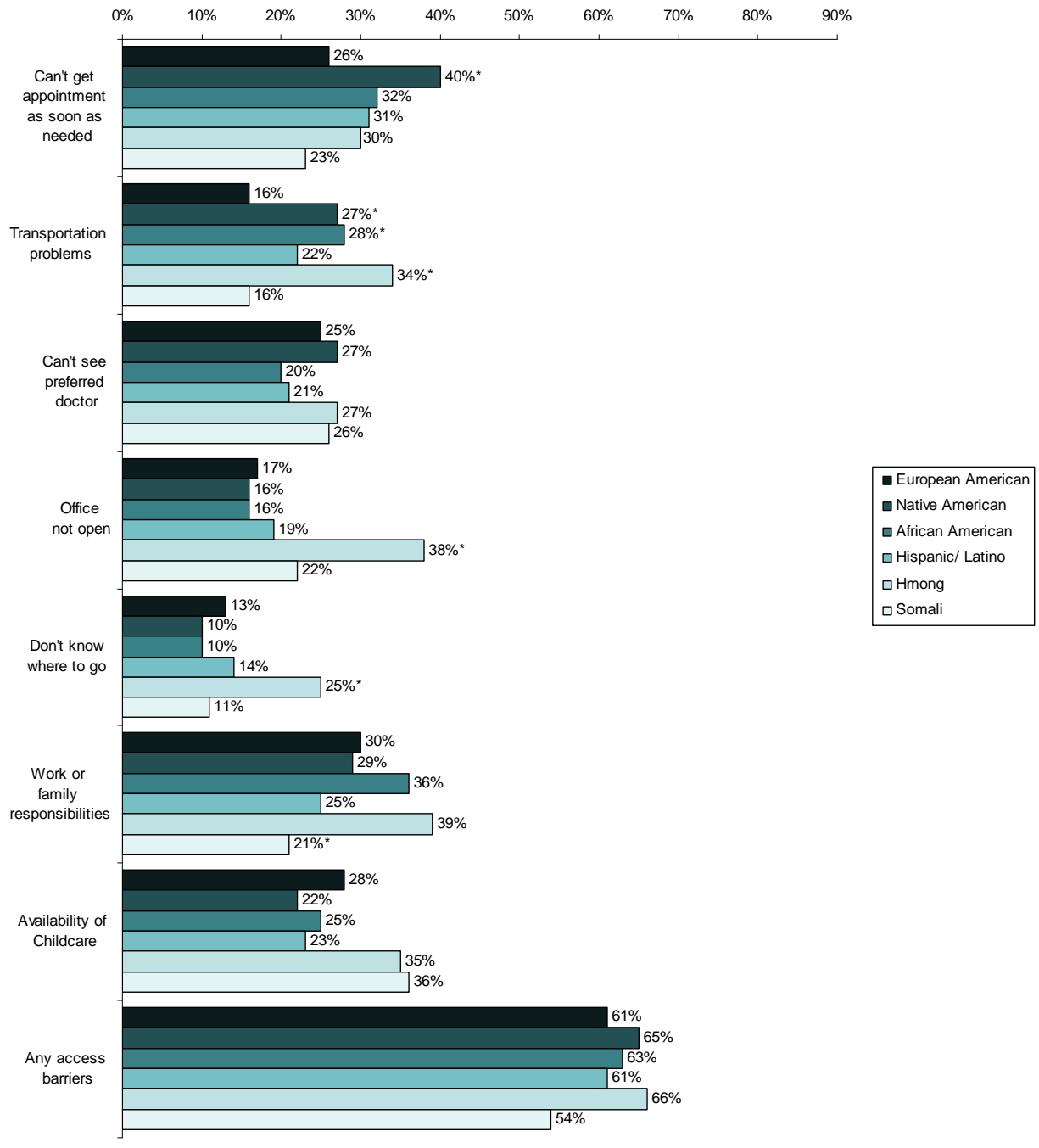
Parents clearly perceive problems related to access when trying to get care for their children. As shown, more than half of parents in every cultural group report at least one problem with access to services. There are fewer differences between cultural groups among children than were observed for adults. Compared to European American parents, Hmong parents are more likely to report transportation problems, problems not knowing where to go for care, and that the office is not open when they can go. Native American parents are more likely to report transportation problems and problems scheduling an appointment. African American parents are also more likely to have problems with transportation. Somali parents are less likely to experience work or family problems that make it difficult to access care compared to European American parents.

Figure 19. Percent reporting access barriers by cultural group for adults



* Indicates a significant difference compared to European Americans

Figure 20. Percent reporting access barriers by cultural group for children

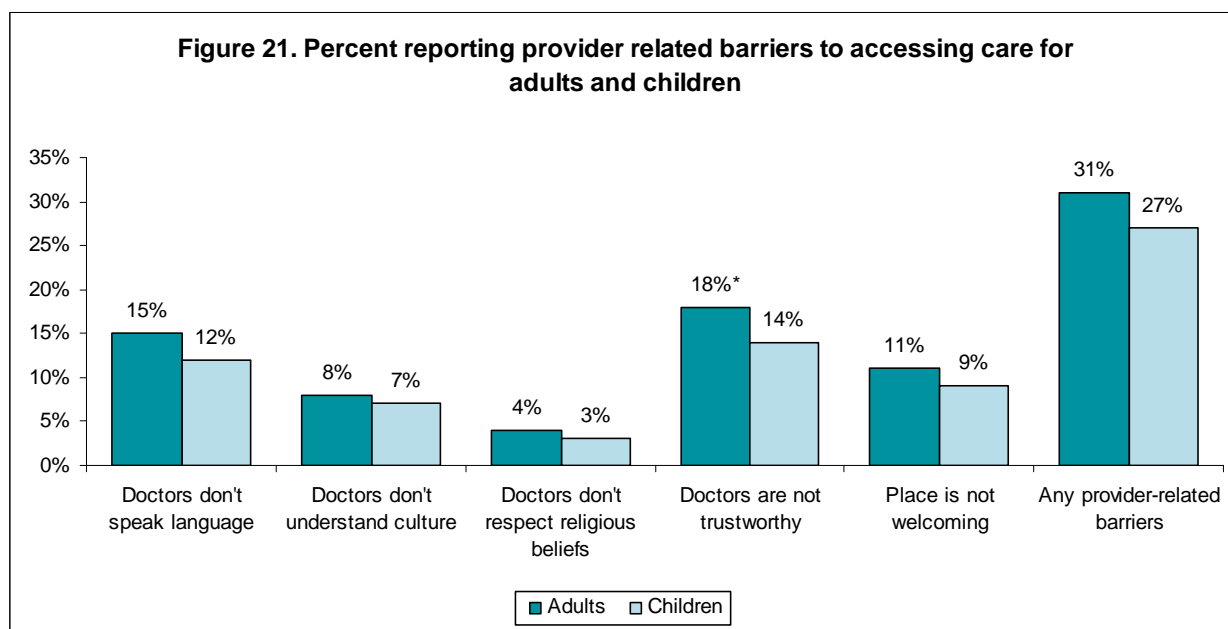


* Indicates a significant difference compared to European Americans

C: Provider Related Barriers

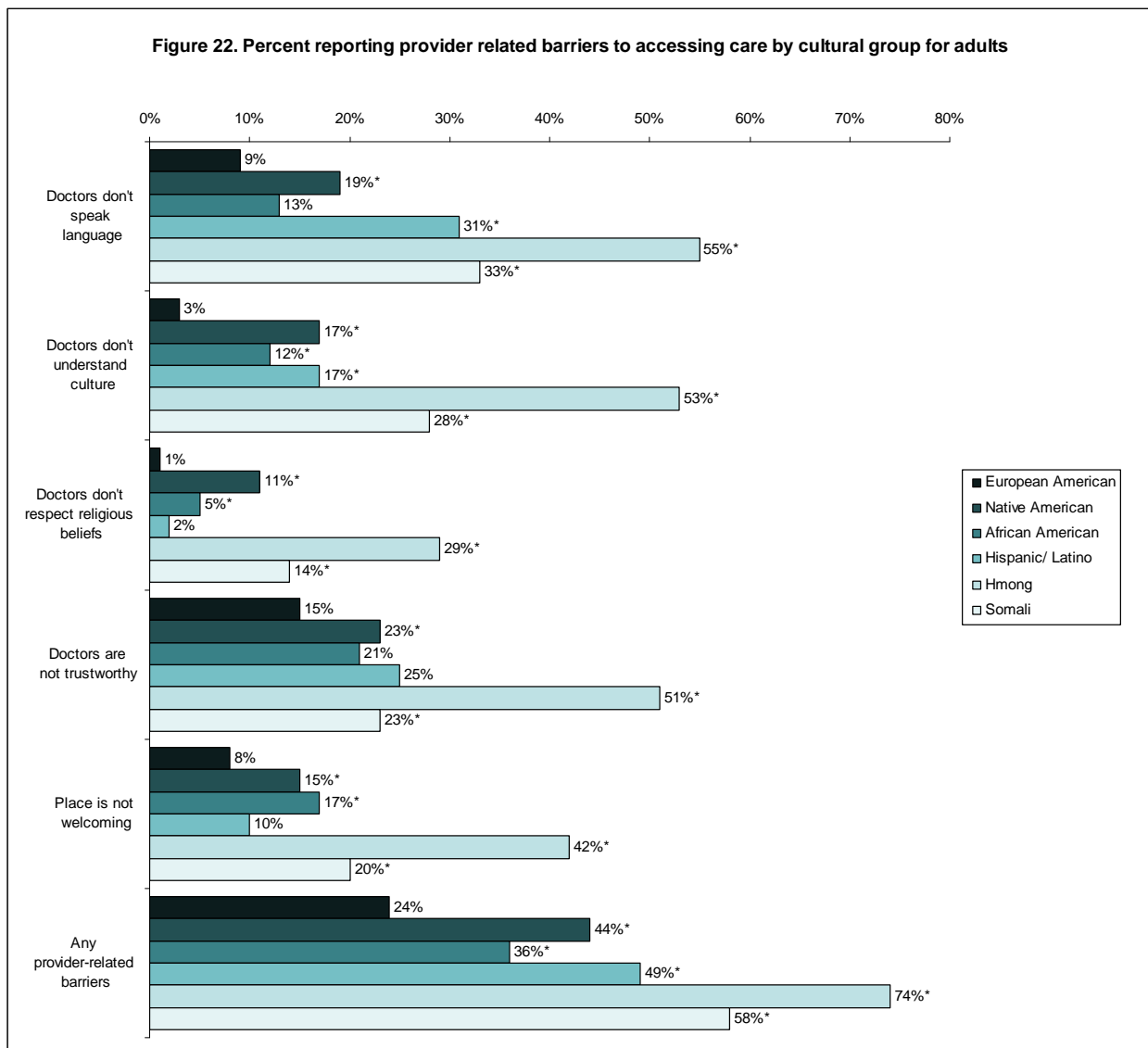
The survey included questions about problems getting health care that are related to providers. These include perceptions that doctors do not speak one's language, understand one's culture or respect one's religious beliefs. Respondents were also asked whether they perceived problems with doctors not being trustworthy or that the place they go to receive care is not welcoming. This series of questions asked for perceptions about doctors generally. Later questions ask enrollees about providers at their usual source of care.

Provider related barriers were cited much less frequently than barriers related to cost and coverage or access. The most common provider related barrier was the perception that doctors, generally, are not trustworthy, and significantly more adults than parents report this problem (Figure 21). The second most frequently reported provider barrier involved language difficulties. Together, almost one third of adults and parents indicate at least one of these issues is a small or big problem in getting health care.



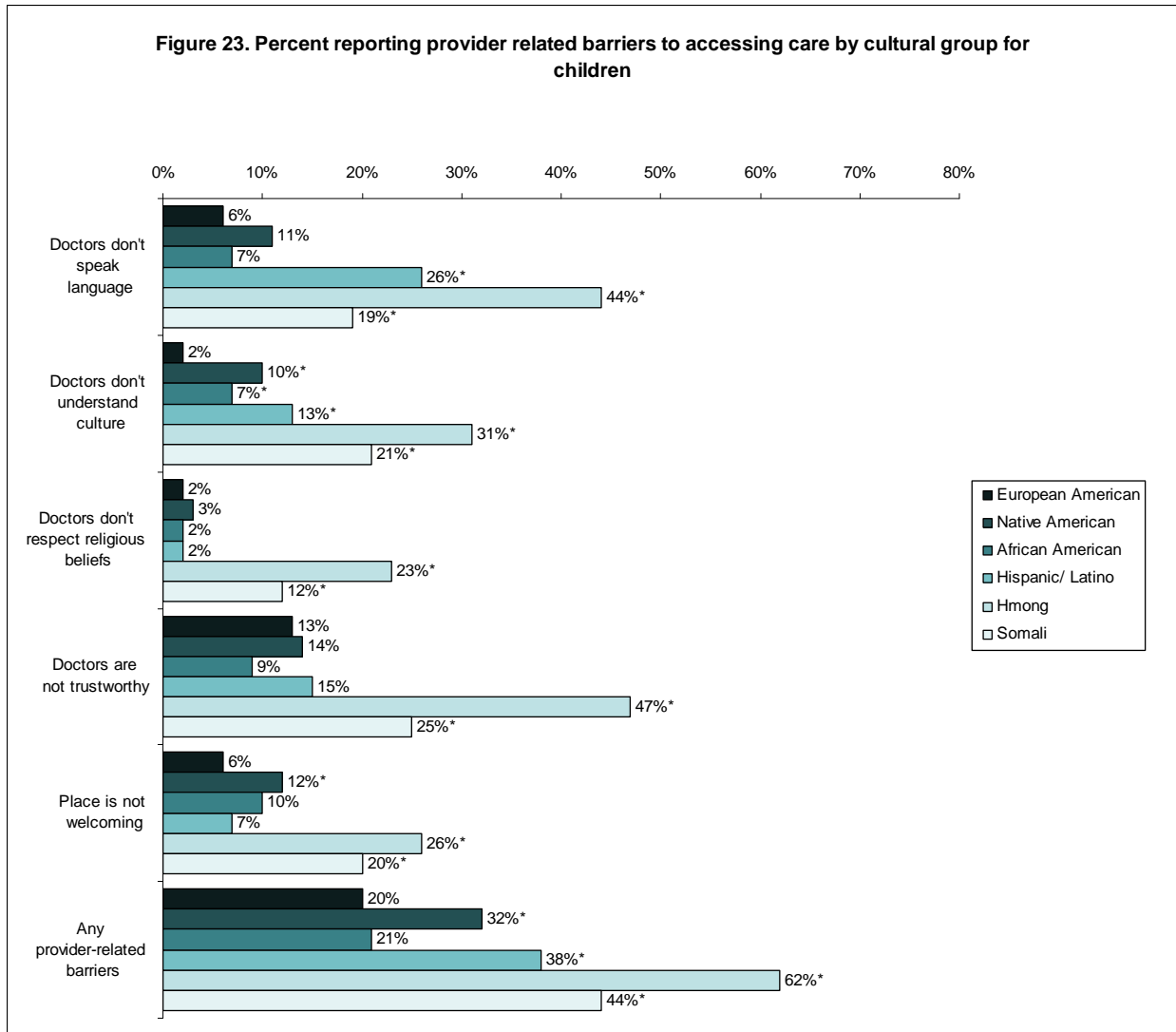
* Indicates a significant difference between adults and children

Figure 22 shows that there are fairly dramatic differences in the frequency of problems related to providers among cultural groups. As might be expected, Hispanic/Latino, Hmong and Somali adults are more likely to report problems with doctors speaking their language. Interestingly, Native American adults also are significantly more likely to report problem with health care providers not speaking their language than are European American adults. A smaller proportion of European Americans than all other cultural groups report that doctors do not understand their culture which is not surprising given that providers are disproportionately European American. Problems related to health care providers not respecting one’s religious beliefs are the least common of these problems but are significantly more likely to be experienced by African American, Native American, Hmong and Somali adults. Native American, Hmong and Somali adults are more likely to report problems with doctors not being trustworthy. A greater proportion of Native American, African American, Hmong and Somali adults report their clinic is unwelcoming. Overall, the proportion of adults who perceived a problem in one of these areas ranges from a low of 24% for European Americans to a high of 74% for Hmong enrollees.



* Indicates a significant difference compared to European Americans

Overall, provider related barriers are less frequently reported by parents of child enrollees than by adult enrollees (Figure 23). Moreover, there are fewer significant differences between European Americans and Native Americans or African Americans than are found with adults. As with adults, higher proportions of Hmong parents cite each barrier as a problem.



* Indicates a significant difference compared to European Americans

Table 7 provides a summary of the various barriers to health care described in the figures above by cultural group for adults and children. Included are the individual items as well as the composites across the three domains: cost and coverage, access and provider related barriers. This detailed table highlights the five most common problems experienced by each cultural group separately for adults and children.

Six important patterns emerge from these findings. First, it is clear that all cultural groups experience problems seeking care. Second, the most prevalent concerns for both adults and parents are cost and coverage problems. Access barriers are also prevalent especially for parents whose children are enrolled in MHCP. Indeed, access barriers rank among the top five barriers for European American, Native American and African American children. Third, the least common problems are related to providers, and European Americans report fewer problems in this area than most other cultural groups. Fourth, of all the groups, Hmong adults and parents are the most likely to experience these problems. Fifth, within every cultural group more adults than parents experience these barriers. Finally, the vast majority (95/110 or 86%) of the significant differences between cultural groups noted in Table 7 remain significant after controlling for sociodemographic factors and health status differences.

Table 7. Barriers summary and top five barriers to health care by cultural group for adults and children

Percent reporting the following problems:	European American		Native American		African American		Hispanic/Latino		Hmong		Somali	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children	Adults	Children
Cost and coverage barriers												
Worry insurance won't cover care	41%	24%	48%	27%	42%	26%	54% *	34% *	71% *	61% *	49%	37% ~ *
Worry will have to pay more than expect	40%	23%	46%	27%	51% *	24%	58% *	36% *	64% *	69% *	41%	27%
Worry pay more than can afford	51%	33%	55%	36%	48%	33%	61% *	47% *	68% *	71% *	52%	48% *
Worry medications will cost too much	35%	17%	39%	25% *	41%	21%	43%	33% *	61% *	61% *	42%	33% *
Not sure if you will be dropped from MHCP	40%	31%	45%	40%	48%	44% *	47%	40% ~ *	68% *	73% *	47%	51% *
Don't know what plan covers	42%	25%	50%	35% *	47%	32%	44%	35% *	68% *	66% *	49%	44% *
Don't know where to go with questions	28%	20%	39% *	24%	39% ~ *	22%	33%	24%	63% *	64% *	43% *	37% *
Any cost and coverage barrier^	71%	52%	76%	56%	75%	58%	82% *	68% *	87% *	85% *	77%	71% *
Access barriers												
Can't get appointment as soon as needed	35%	26%	41%	40% *	41%	32%	41%	31%	53% *	30%	27%	23%
Transportation problems	24%	16%	46% *	27% ~ *	39% ~ *	28% *	33%	22%	43% ~ *	34% *	30%	16%
Can't see preferred doctor	23%	25%	29%	27%	21%	20%	19%	21%	45% *	27%	30% *	26%
Office not open when you can go	13%	17%	24% *	16%	14%	16%	18%	19%	44% *	38% *	19%	22%
Don't know where to go	12%	13%	19% ~ *	10%	18%	10%	18% ~ *	14%	44% *	25% ~ *	21% *	11%
Work or family responsibilities	26%	30%	30%	29%	25%	36%	23%	25%	59% *	39%	25%	21% ~ *
Availability of childcare	12%	28%	23% *	22%	15%	25%	14%	23%	45% *	35%	24%	36%
Any Access Barrier^	60%	61%	77% *	65%	69% *	63%	65%	61%	82% *	66%	64%	54%
Provider related barriers												
Doctors don't understand language	9%	6%	19% *	11%	13%	7%	31% *	26% *	55% *	44% *	33% *	19% *
Doctors don't understand culture	3%	2%	17% *	10% *	12% *	7% *	17% *	13% *	53% *	31% *	28% *	21% *
Doctors don't respect religious beliefs	1%	2%	11% *	3%	5% *	2%	2%	2%	29% *	23% *	14% *	12% *
Doctors are not trustworthy	15%	13%	23% ~ *	14%	21%	9%	25%	15%	51% *	47% *	23% *	25% ~ *
Place is not welcoming	8%	6%	15% *	12% *	17% ~ *	10%	10%	7%	42% *	26% *	20% *	20% *
Any provider-related barriers^	24%	20%	44% *	32% ~ *	36% ~ *	21%	49% *	38% *	74% *	62% *	58% *	44% *

Shaded cells represent five most common problems per age and cultural group

^ Barrier composites are not included in selection of five most common problems

* Indicates a significant difference compared to European Americans

~ Indicates difference is no longer significant after adjusting for age, sex, marital status, education, employment status, metro residence, and self-reported health status

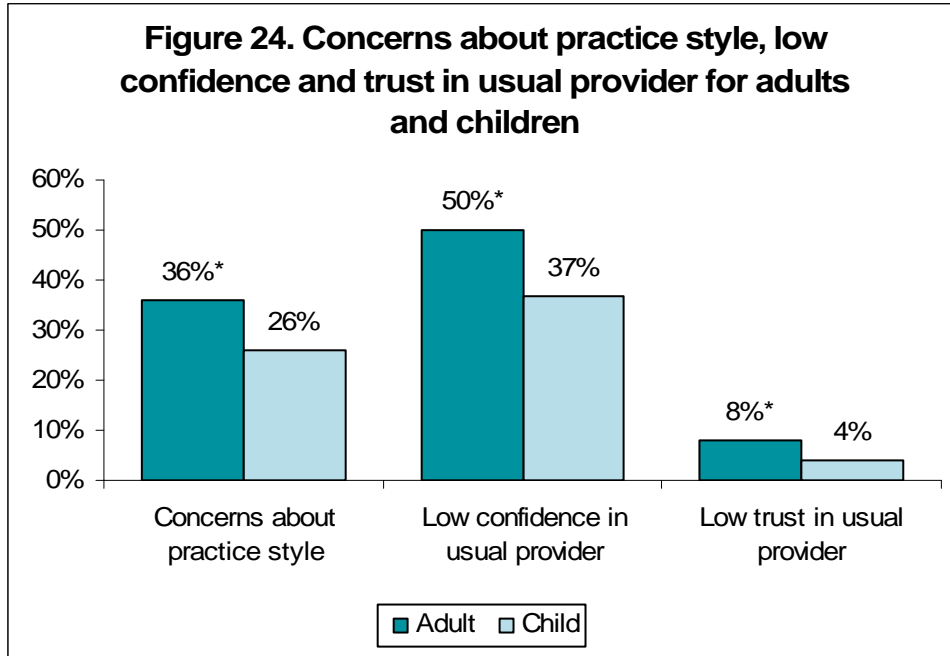
D: Concerns about Provider Practice Style, Low Confidence and Trust in Usual Provider

The next several series of questions were focused on the place the enrollee usually goes for health care. The first question set rates enrollee's assessment of their doctor or other health care provider's practice style, including questions about how well the provider explained things in a way they could understand (poor to excellent with fair/poor indicating a problem), and how often the health care provider "really finds out what your concerns are," spends enough time to address health concerns, or treats them as partners in making health care decisions (with responses of never or sometimes indicative of a problem in these areas). Responses to these items were combined to create a measure of concerns about provider practice style. Reporting a problem on any of these questions was considered a problem on the composite measure.

The second set of questions measures enrollees' confidence in their own doctor or other health care provider. Specifically, enrollees were asked if they are afraid that their doctor might not do enough to find out what is making them sick, that the health care they receive might make them feel worse, that their provider will tell them they have an illness that they do not have, or that their provider might not find an illness they do have. Respondents who indicated that they somewhat or strongly agreed with any of these statements were categorized as experiencing low confidence in their usual provider.

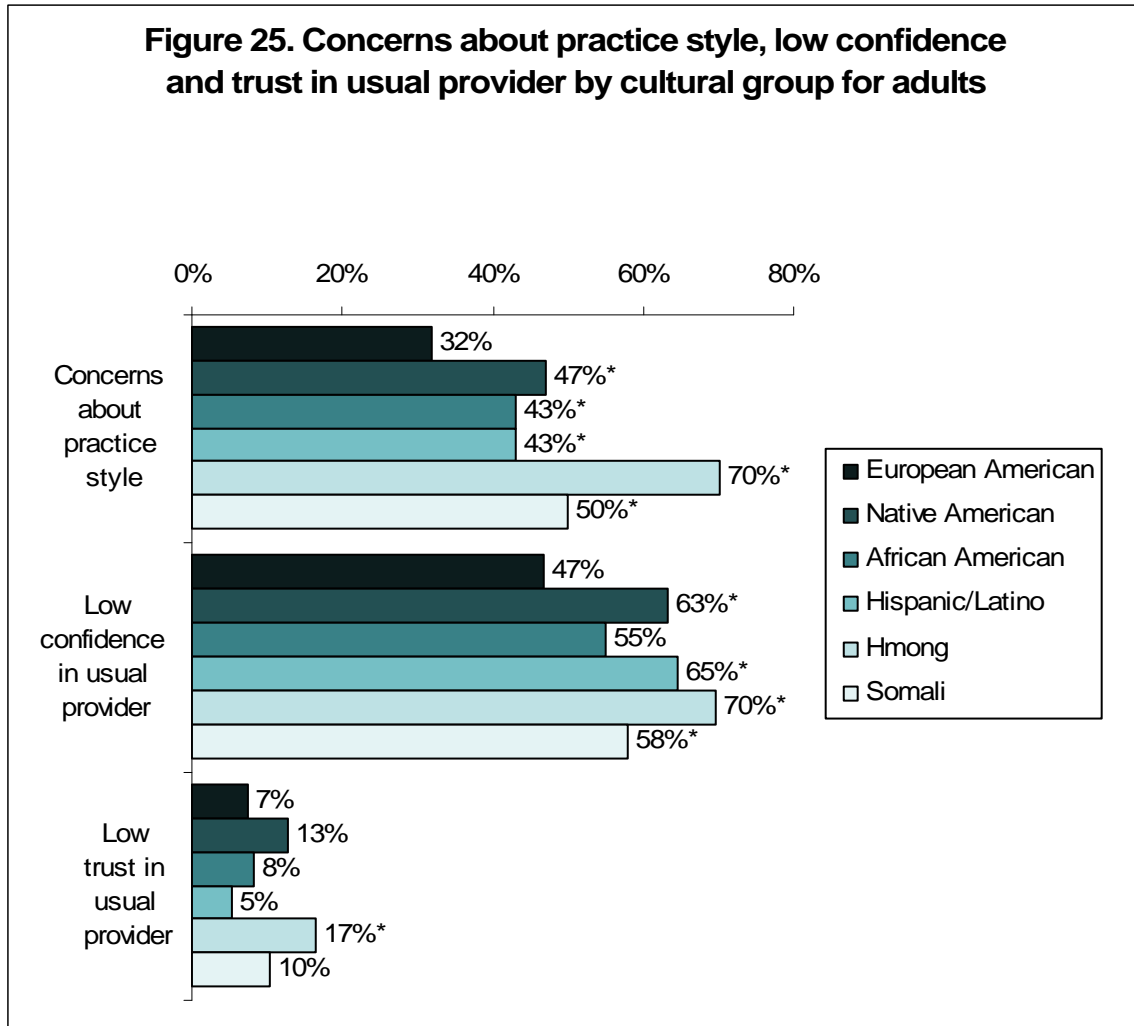
Finally, in addition to asking about general trust in doctors (Section C), enrollees were asked if they trusted that their own doctor or health care provider has their best interests in mind when making health care decisions. Enrollees who somewhat or strongly disagreed with this question were categorized as having low trust in their usual provider.

Figure 24 contrasts the results for adult and child enrollees. Adults enrolled in MHCP are more likely to be concerned about their provider’s practice style, and report low confidence and trust in their provider than are parents of child enrollees. Overall, trust in one’s own or one’s child’s provider is quite high, although about half of adults and a third of parents exhibit low confidence in that provider.



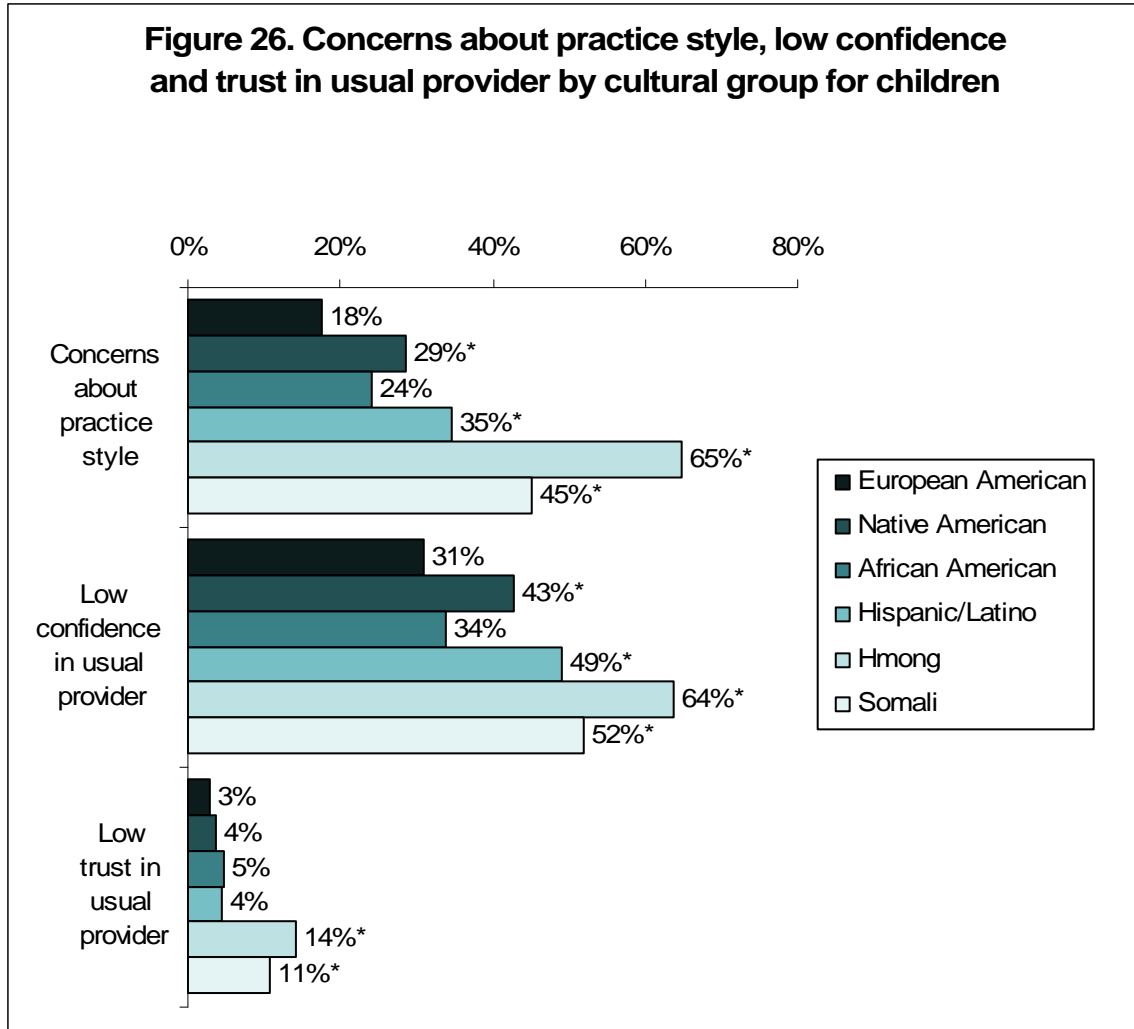
* Indicates a significant difference between adults and children

Figure 25 shows substantial variation across cultural groups. Compared to European American adults, all other cultural groups are more likely to report concerns about their usual health care provider's practice style. The same pattern is shown for low confidence in their usual provider, although the difference between African American adults and European American adults is not statistically significant. The vast majority of all cultural groups trust that their usual provider has their best interests in mind when making health care decisions. However, Hmong adults are significantly more likely to report mistrust.



* Indicates a significant difference compared to European Americans

As shown in Figure 26, the results for children are much the same as presented for adults. However, the proportion of parents reporting these problems with their child’s usual provider is somewhat smaller than among adults.

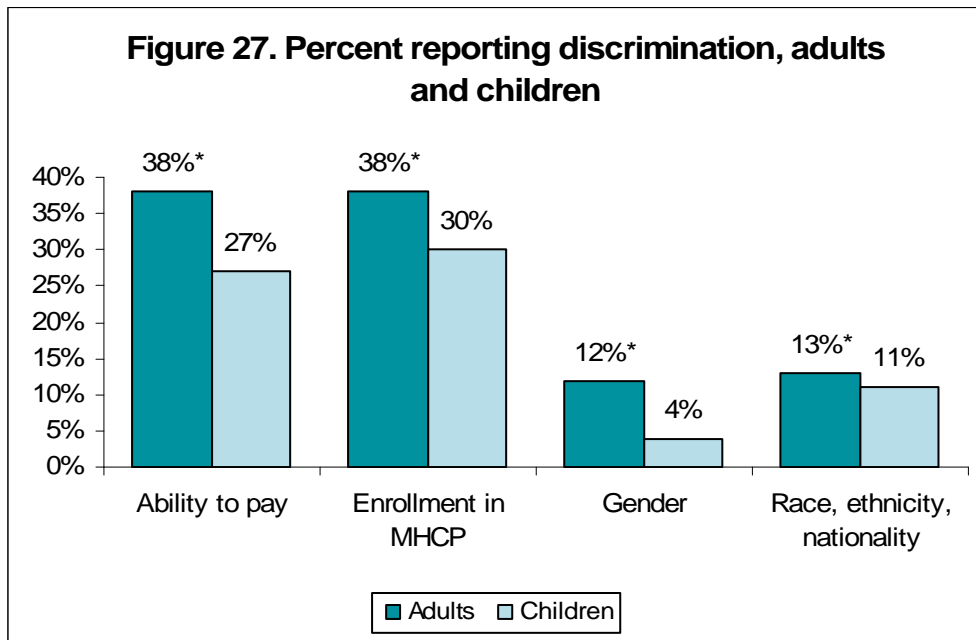


* Indicates a significant difference compared to European Americans

E. Reports of Discrimination

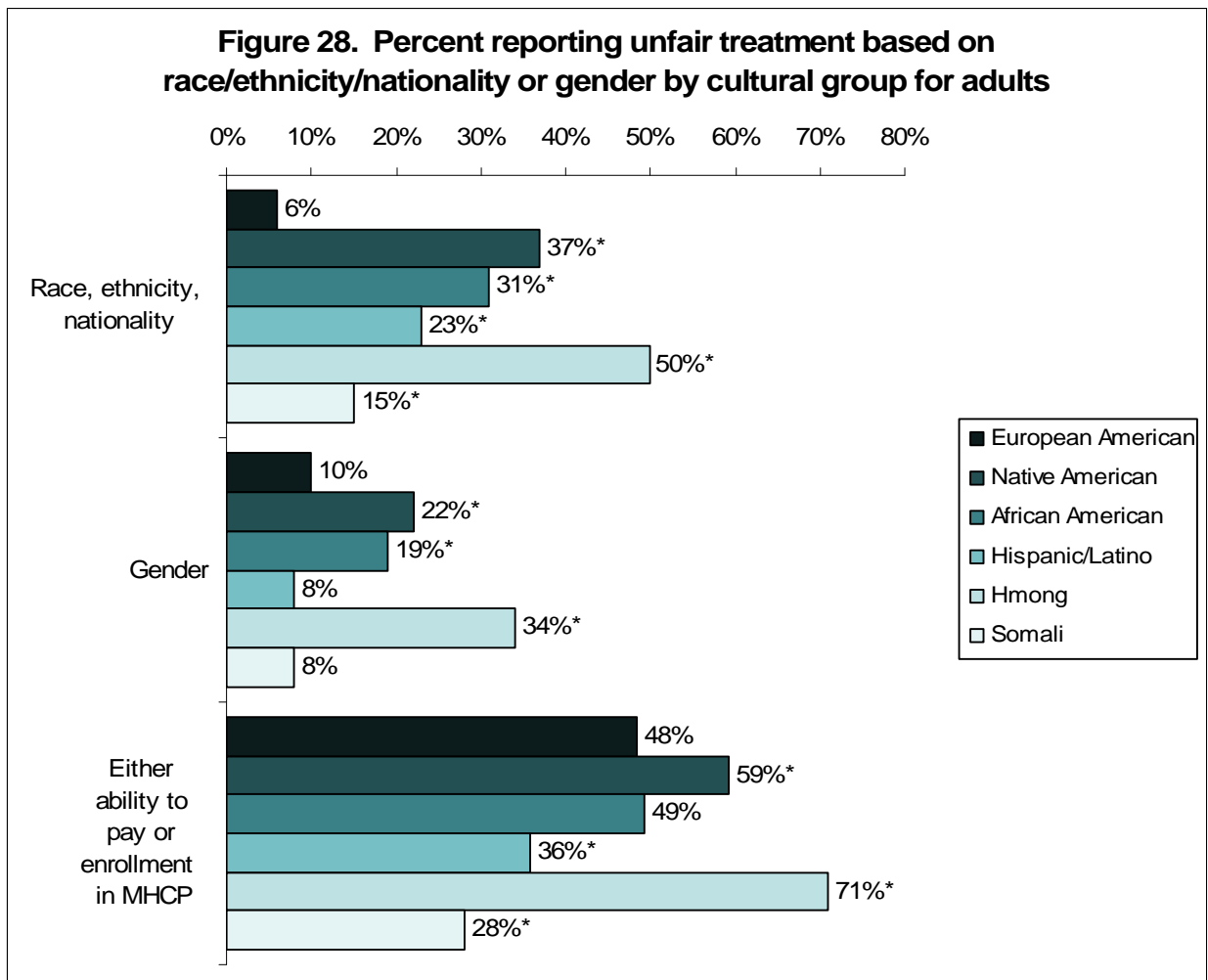
The survey included measures of perceived discrimination from health care providers. Respondents were asked if they felt they were treated unfairly by providers due to their ability to pay or being enrolled in a Minnesota Health Care Program. Respondents were also asked if they ever felt that providers treated them unfairly because of their gender or their race, ethnicity, or nationality. Respondents who indicated that they were treated unfairly sometimes, usually, or often were categorized as perceiving discrimination in these areas.

As shown in Figure 27, the most common forms of discrimination are perceived unfair treatment due to enrollment in MHCP and ability to pay. More than one third of adults and more than one quarter of parents report that they experience this class based bias. Perceived gender bias is generally less common than other forms of discrimination, yet also more common among adults than parents. Overall, 13% of adults and 11% of parents report that they (or their child) are treated unfairly due to race, ethnicity, or nationality.



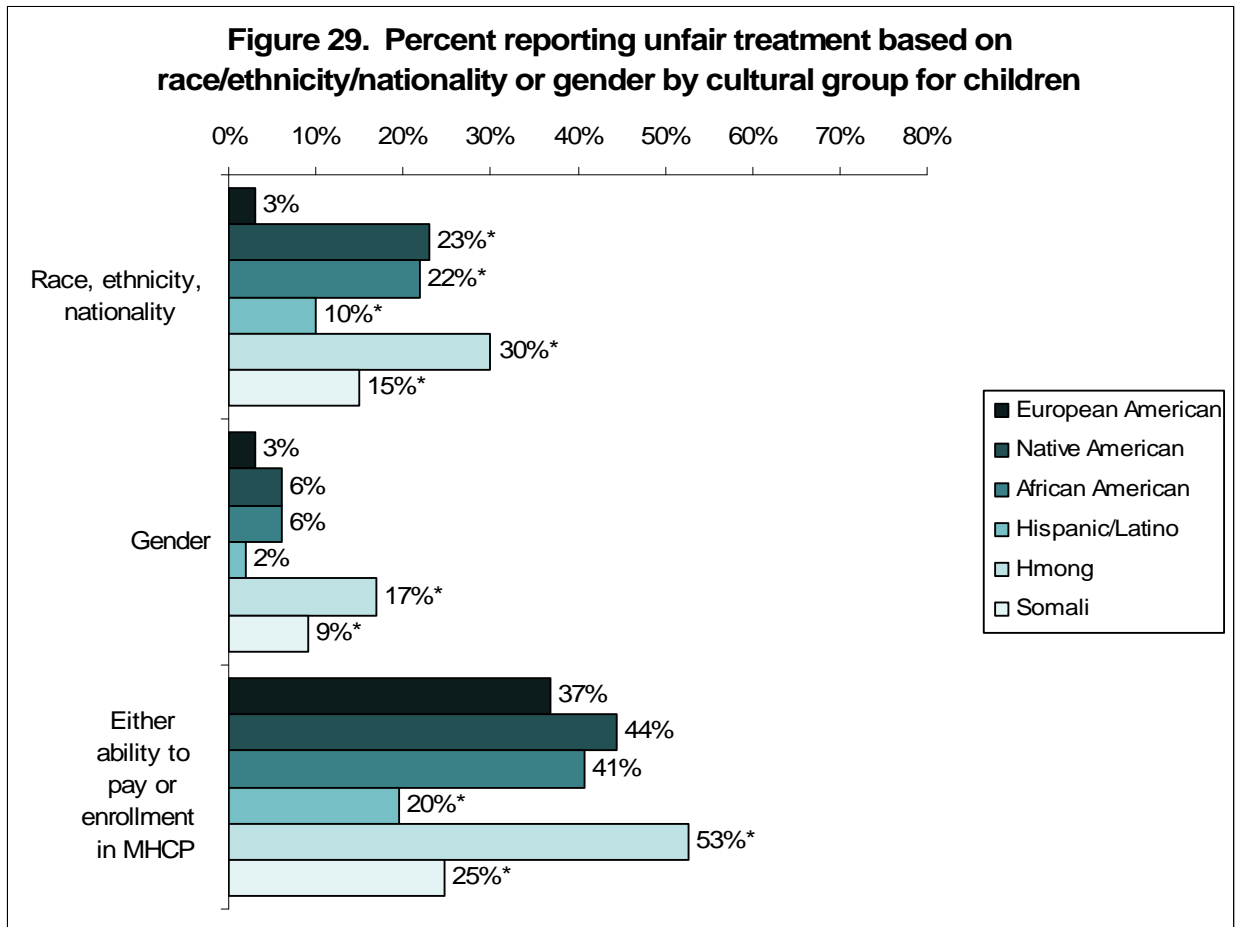
* Indicates a significant difference between adults and children.

Given the similarity in content and in the distribution of responses to questions about perceptions of unfair treatment due to enrollment in MHCP and ability to pay, we combine these two items into a composite labeled “class-based bias” in the remaining analyses. As shown in Figure 28, class-based bias is the most prevalent form of discrimination reported for adults in all cultural groups. While nearly 50% of European American adults reported unfair treatment either due to ability to pay or enrollment in MHCP, the proportions of Native American and Hmong enrollees who reported this problem is even higher. By contrast, the proportion of Hispanic/Latino and Somali adults who reported class based bias is significantly less than for European Americans. Discrimination based on race, ethnicity or nationality is significantly lower among European American adults than all other cultural groups. Gender bias is more likely to be reported by Native American, African American and Hmong adults. Consistent with other results described above, perceptions of discrimination in all three areas are highest among Hmong adults.



* Indicates a significant difference compared to European Americans

Figure 29 provides parallel results for child enrollees. Overall, parents are less likely than adults to report unfair treatment in these areas by health care providers.



* Indicates a significant difference compared to European Americans

Patient-provider cultural congruence

Having a doctor of the same race, ethnicity or nationality may foster greater understanding of cultural issues on the part of health care providers. The survey asked respondents whether or not the doctor or health care provider they usually go to is of their same race or ethnicity. As might be expected, European Americans are most likely (85% of adults and 91% of children) to see a provider of the same racial/ethnic background (Table 8). Somali respondents were the least likely to have a health care provider who was also Somali.

Table 8. Percent reporting having a doctor of the same cultural group by cultural group

	European American	Native American	African American	Hispanic/Latino	Hmong	Somali
Adults	84%	30% *	15% *	14% *	27% *	8% *
Children	91%	23% *	11% *	16% *	20% *	4% *

* Indicates a significant difference compared to European Americans

F: Interpreter Availability, Consistency, Privacy and Quality

We further explored the extent to which language differences between patients and providers present barriers to care. We first asked whether enrollees needed an interpreter to help them communicate with their doctors or other health care providers. Among those who reported a need for interpreter services, we asked about availability, consistency, and quality of interpreter services. A final question asked whether the respondent worried that the interpreter would not keep what they said private. The analyses of these questions are restricted to Hispanic/Latino, Hmong, and Somali respondents because either none or very few respondents in the other groups need interpreter services.

The need for interpreter services is reported in Table 9. A significantly greater proportion of Hmong and Somali adult enrollees report a need for interpreter services than Hispanic/Latino adults. Although reports of need vary similarly among parents, these differences are not significant.

Table 9. Need for interpreter services by cultural group

	Hispanic/ Latino	Hmong	Somali
Adults	38%	69% *	61% *
Children	44%	59%	50%

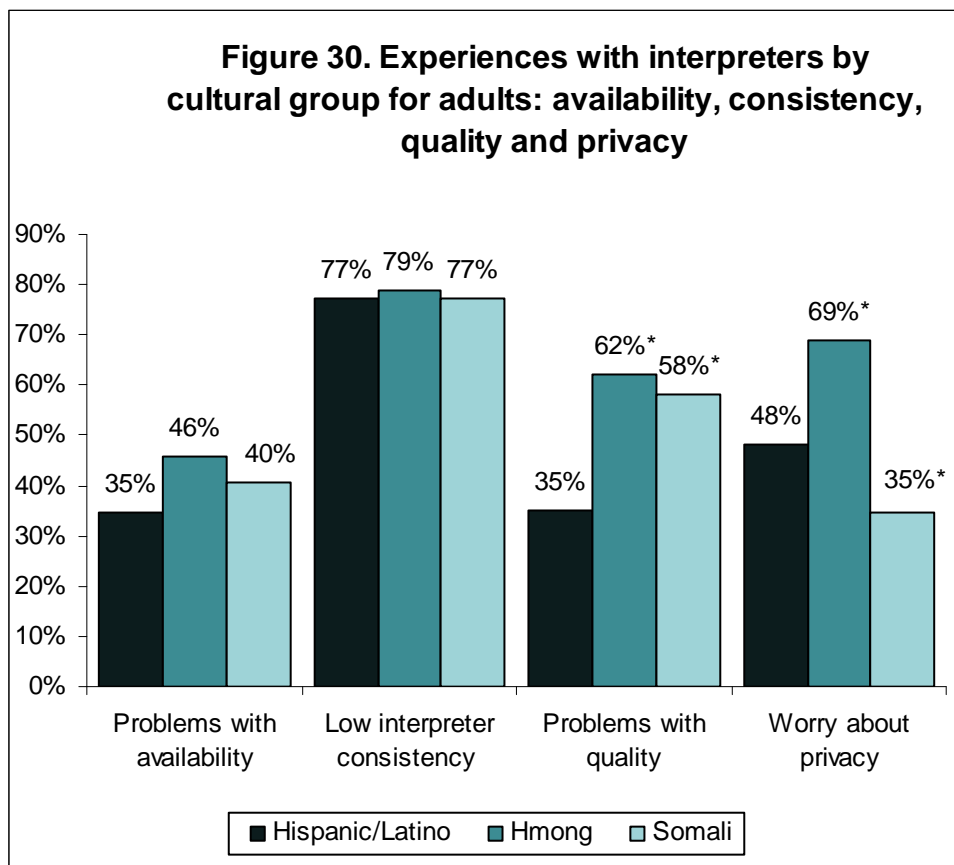
* Indicates a significant difference compared to Hispanic/Latinos

Respondents needing an interpreter were asked how often this need was met; those who indicated that an interpreter was not always provided are characterized as having problems with availability of interpreters. We also asked about the consistency of interpreter services; specifically, the survey asked how often enrollees have the same interpreter when they go to the doctor. We report the percent of enrollees who do not always get the same interpreter. However it is difficult to know whether or not lack of consistency is a problem. Community members describe frustration with having to explain the specifics of their case with every new interpreter and this may interrupt continuity of care. Yet, repeatedly getting the same interpreter if they do not provide quality services is also a problem. Thus, we report the results without a qualitative judgment about the relationship of consistency to quality of interpreter services or care received more generally.

Respondents were asked to assess the quality of interpreters, including how much the interpreter helped them understand what the doctor was asking, helped the doctor understand what they were telling them, and helped enrollees understand what was being done during the medical encounter. Respondents who indicated a problem in any of these areas are characterized as experiencing a problem with the quality of interpreters provided. The pattern of responses to these four items is very similar; therefore, we only provide results from the composite that indicates any problems with quality of interpreter services. Finally, the survey asked whether

respondents were concerned about whether or not the interpreter would keep what they said private.¹¹

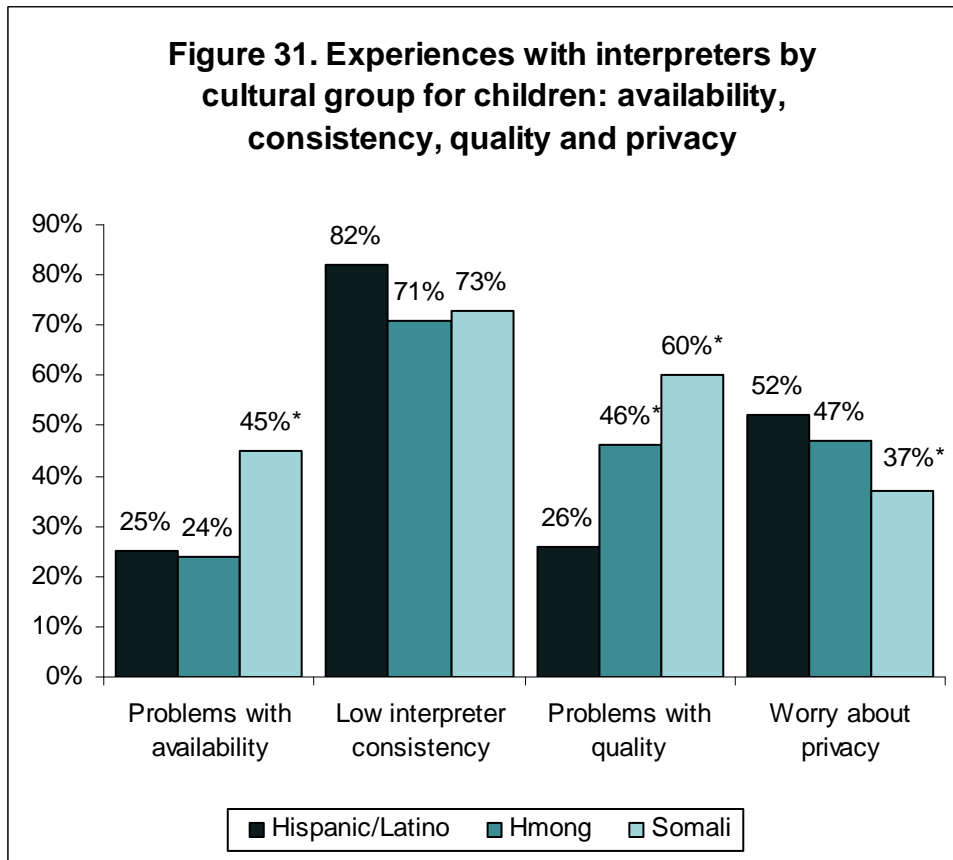
Figure 30 reports Hispanic/Latino, Hmong and Somali adult’s experiences with interpreters. At least one-third of adults in each cultural group report problems getting an interpreter when one is needed. Nearly 80% of adults report that they do not get the same interpreter consistently. Over one-half of Hmong and Somali adults report complaints about the quality of interpreter services, which is significantly greater than for Hispanic/Latino adults. Yet as many as a third of Hispanic/Latino adults indicated problems with the quality of these services. Significantly more Hmong adults worry that the interpreter will not keep what they say private; however nearly half of all Hispanic/Latino adults report privacy concerns. Somali adults are less likely than Hispanic/Latino adults to worry that the interpreter will not keep what they say private.



* Indicates a significant difference compared to Hispanic/Latinos

¹¹ As detailed in the Technical Appendix, respondents for the telephone survey were erroneously given different response option for questions about quality of services than were respondents to the mail survey.

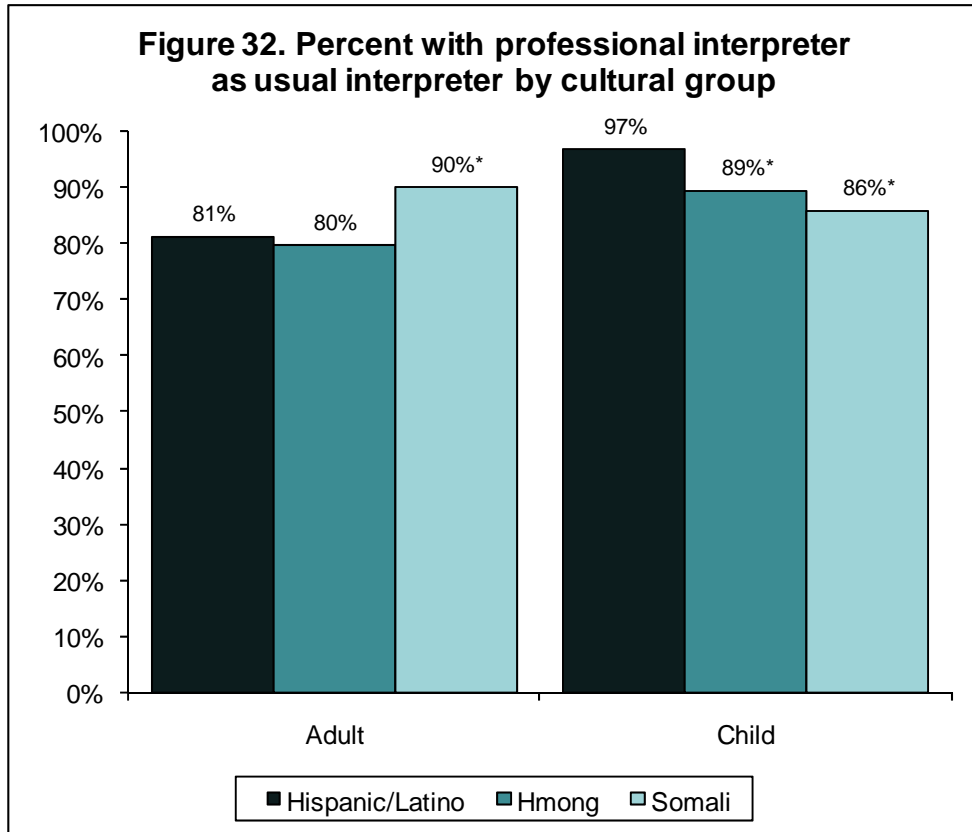
Experiences with interpreters are somewhat similar for parents of child enrollees. However, as shown in Figure 31, problems with availability are more common among Somali parents. The results for consistency of services are similar to those seen for adults. While concerns about interpreter quality are significantly higher among Hmong and Somali than Hispanic/Latino parents, a smaller proportion of Hmong parents have quality complaints than Hmong adults. The proportion of parents who worry about privacy is similar for the Hispanic/Latino and Hmong communities. As found for Somali adults, a smaller proportion of Somali parents report worrying about interpreter privacy.



* Indicates a significant difference compared to Hispanic/Latinos

For adults and children, the differences in experiences with interpreters for Hmong and Somali as contrasted with Hispanic/Latino enrollees found in Figures 30 and 31 remain virtually the same after controlling for other factors.

For respondents who reported a need for interpreters, we asked who they usually have as their interpreter when they get health care. Respondents were given a choice of a family member, friend, professional interpreter, or “other” where they could describe their usual interpreter. Figure 32 below reports the percentage of enrollees who use a professional interpreter for their health care needs. As shown, the vast majority of adult enrollees and parents in all three cultural groups have a professional interpreter as their usual interpreter. Compared to Hispanic/Latinos, higher proportions of Somali adults and lower proportions of Hmong and Somali parents use professional interpreters.



Are Barriers Related to Use of Health Services and Access?

Given the above results concerning differences in use of services and access and barriers, we now explore whether barriers impact enrollees' use of services or reports of unmet need or delayed care. Specifically we examine the association between each of the 11 barrier domains and each measure of utilization and access controlling for sociodemographic characteristics and health status. Each barrier measure is analyzed independently to assess the "effect" of a given barrier on the odds of going without services (acute, preventive, dental or mental health) in the past year, reporting an unmet need for health care, or delaying care in the past year.

We summarize these results in Table 10. The odds ratios represent the associations of reports of barriers with use of services, after adjusting for demographic and health status differences.¹² Significance is noted with an asterisk and shading. All significant odds ratios are greater than 1.0, which indicates that those who report the barrier are more likely than others to not get acute or preventive care, to report an unmet need for care, or to report delaying care. The analyses can only indicate the presence, direction, and magnitude of the relationship between barriers and services use; conclusions about causality are not possible. This is because the utilization measures refer to the year prior to the date the survey was completed whereas the barriers questions ask about current or recent experiences with health care.

We omit summaries of dental and mental health services because none of the associations between barriers and use of dental services are significant. Further, only one barrier is related to use of mental health services, representing 5% of the total possible associations that were tested for mental health; this is what we might have expected to emerge as significant by chance alone.

Table 10 shows that very few barriers (2 of 22 or 9%) are related to going without use of services for injury or illness. Among parents, those who report provider related barriers or class based discrimination are more likely to go without acute care in the past year. Use of preventive care services is more sensitive to the various barriers domains (36% of the odds ratios reach significance). Adults and parents who report unfair treatment based on class are less likely to have gone in for preventive care in the past year. Provider related barriers (e.g., respect for religious beliefs, feeling welcome, etc.) and low trust in one's usual provider are associated with not seeking preventive services in the past year for adults and children. In addition, parents with concerns about cost and coverage as well as problems with the practice style of the usual provider are more likely to go without preventive care for their children.

Nearly two-thirds of the barriers (64%) are associated with reports of unmet need for medical care in the past year. Among adults all but two of the barriers are significant; problems with interpreter availability and quality. By contrast, among parents fewer barriers are significantly associated with unmet need. However, cost and coverage barriers, access barriers, perceptions of class based bias, and problems with both the availability and quality of interpreters are significantly related to parental reports of unmet need for children.

¹² Logistic regressions control for cultural group, age, gender, marital status, education, employment status, metro residence, and self-reported health status.

The findings are particularly striking for reports of delayed care in the past year; 82% of the relationships tested are significant. For the most part, all but problems with interpreter availability impact reports of delayed care for adults and children.

In summary, although it is not possible to draw causal conclusions, it is clear that barriers are associated with care that can be viewed as more “discretionary,” specifically preventive services, and less so with care needed due to an injury or illness. Interestingly, parent’s use of acute and preventive care services for their children appears to be somewhat more sensitive to barriers than use among adults. By contrast, a greater proportion of the barriers for adults than children are positively associated with having unmet care needs in the past year. With the exception of several measures of interpreter services, all other barriers increase the likelihood that adults and parents report delaying care in the prior year.

Table 10. Relationship between barriers, use of services, and access for adults and children

Barrier Domain:	No acute visit		No preventive visit		Unmet need for care		Delayed care	
	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)
Adults								
Cost and coverage barriers	1.00	(0.64,1.55)	1.12	(0.72,1.76)	3.61 *	(1.68,7.77)	3.36 *	(2.04,5.54)
Access barriers	0.69	(0.47,1.03)	1.01	(0.67,1.51)	3.86 *	(2.07,7.20)	3.89 *	(2.54,5.97)
Provider related barriers	1.34	(0.89,2.03)	1.68 *	(1.11,2.55)	2.80 *	(1.76,4.45)	2.56 *	(1.75,3.75)
Problems with usual provider practice style	1.17	(0.78,1.77)	1.32	(0.88,1.99)	3.03 *	(1.90,4.82)	2.83 *	(1.95,4.11)
Low confidence in usual provider	1.11	(0.74,1.66)	1.29	(0.87,1.92)	1.80 *	(1.12,2.90)	1.73 *	(1.20,2.51)
Low trust in usual provider	1.58	(0.87,2.87)	1.82 *	(1.01,3.27)	4.00 *	(2.18,7.32)	2.01 *	(1.10,3.66)
Class based discrimination	1.14	(0.77,1.68)	1.68 *	(1.13,2.49)	2.39 *	(1.48,3.85)	2.31 *	(1.59,3.34)
Race, ethnicity, nationality discrimination	0.77	(0.46,1.29)	0.82	(0.49,1.36)	2.69 *	(1.54,4.68)	1.78 *	(1.14,2.78)
Problem with interpreter availability^	1.11	(0.71,1.73)	0.69	(0.42,1.13)	0.90	(0.50,1.61)	1.59	(1.00,2.53)
Problem with interpreter quality^	1.49	(0.96,2.32)	1.06	(0.65,1.74)	0.97	(0.52,1.80)	1.78 *	(1.13,2.82)
Worry about interpreter privacy^	1.38	(0.85,2.24)	1.54	(0.93,2.56)	2.28 *	(1.18,4.41)	2.10 *	(1.26,3.50)
Children								
Cost and coverage barriers	0.91	(0.65,1.27)	1.65 *	(1.09,2.51)	7.95 *	(2.93,21.58)	4.77 *	(2.58,8.85)
Access barriers	0.96	(0.69,1.34)	1.19	(0.80,1.77)	2.94 *	(1.39,6.23)	3.39 *	(1.92,5.99)
Provider related barriers	1.50 *	(1.04,2.17)	1.61 *	(1.08,2.41)	1.51	(0.83,2.74)	2.24 *	(1.40,3.58)
Problems with usual provider practice style	1.13	(0.79,1.60)	1.58 *	(1.04,2.39)	1.51	(0.86,2.63)	1.87 *	(1.17,2.98)
Low confidence in usual provider	1.15	(0.82,1.62)	1.37	(0.92,2.02)	1.11	(0.62,1.99)	1.63 *	(1.04,2.56)
Low trust in usual provider	0.99	(0.51,1.93)	2.83 *	(1.50,5.32)	1.77	(0.77,4.07)	2.61 *	(1.24,5.52)
Class based discrimination	1.57 *	(1.13,2.20)	1.77 *	(1.21,2.59)	2.13 *	(1.17,3.88)	1.88 *	(1.18,2.97)
Race, ethnicity, nationality discrimination	1.27	(0.85,1.90)	1.24	(0.78,1.98)	1.56	(0.91,2.68)	1.74 *	(1.02,2.96)
Problem with interpreter availability^	0.94	(0.54,1.63)	1.78	(0.95,3.34)	3.52 *	(1.49,8.32)	1.37	(0.66,2.83)
Problem with interpreter quality^	0.66	(0.39,1.12)	1.64	(0.91,2.98)	2.58 *	(1.08,6.17)	1.37	(0.71,2.65)
Worry about interpreter privacy^	1.21	(0.72,2.03)	0.71	(0.37,1.37)	1.98	(0.70,5.61)	1.63	(0.73,3.61)

^ Analysis of interpreter services are restricted to Hispanic/Latino, Hmong and Somali subpopulations

Note: All models adjusted for cultural group, age, sex, marital status, education, employment status, metro residence, and self-reported health status

* indicates the likelihood that a given barrier domain is significantly associated with going without a visit or experiencing access problems in the past year

Summary of 2008 Findings

Most adults and children in MHCP are in good health and most had a visit to the doctor in the year prior to the survey for preventive care. Guidelines vary by age as to how often one should go to the doctor for preventive care and our age cuts were not that refined. However, we find that approximately one-quarter of adults and 17% of children had no such visit in the past year.

Guidelines are more specific for dental care, suggesting that an annual preventive visit is associated with better dental health. Yet, almost one-half of adults, and one-third of children enrolled in MHCP did not have a visit to the dentist in the past year.

Across all cultural groups, African Americans and Native Americans report the worst health, which may partially explain why the latter group is more likely to have gone to the doctor for preventive care. Adults from these cultural groups are at particularly high risk for mental health problems, with over 40% reporting that their emotional health was poor and more than 25% screening positive for elevated depressive symptoms.

There are few differences between cultural groups in use of care when we take into account health status. There are much greater differences between groups in the likelihood of having problems getting care, experiences of discrimination, level of confidence in doctors, perception of one's doctor's practice style and use and quality of interpreter services.

Across these results a number of important patterns emerge. First, adults are more likely to report problems getting care or negative experiences in their medical encounters than are parents whose child is enrolled in MHCP.

Second, across numerous measures, enrollees who are Hmong are the most likely to experience barriers or report negative experiences with care. However they are not less likely to use services and they do not report greater unmet need for care or delays in getting care.

Third, when asked directly about issues that may present problems in getting health care, respondents were more likely to perceive problems with cost and coverage than barriers related to access or providers. Indeed, 73% of adults and 59% of parents report at least one of the following problems getting health care: worry that insurance will not cover the care received, having to pay more than expected or more than can be afforded, medication costs, month to month uncertainty about being dropped from MHCP, not knowing what services are covered, and not knowing where to go for help when questions arise. Concerns about cost and coverage issues were common across all cultural groups.

The emphasis on cost and coverage issues does not imply that relationships with providers or perceptions of the care one receives were unimportant. A substantial proportion of each cultural group report concerns about their providers practice style or low confidence in their provider.

While overall a smaller proportion of respondents perceived being treated unfairly due to race, ethnicity or nationality than to enrollment in MHCP or ability to pay, the former type of

discrimination remains important. Indeed, among adults, one-half of Hmong enrollees, about one-third of Native Americans and African Americans, about one-quarter of Hispanic/Latinos and over one-tenth of Somali respondents felt they were treated unfairly due to their race, ethnicity or nationality.

Among enrollees who need interpreter services during the medical encounter, there are significant problems with availability, quality and concerns about confidentiality. Hmong and Somali enrollees were more likely to report problems with quality than Hispanic/Latinos. Whereas privacy concerns were high among Hmong adults, they were lower among Somali adults and parents compared to Hispanic/Latinos.

Finally, overall the pattern suggests that European Americans are less likely to experience barriers than many other cultural groups enrolled in MHCP. However, it is notable that Somali enrollees also report relatively low levels of problems compared to the other groups.

Many of the barrier domains are significantly related to going without various health care services in the past year. A larger number of barriers are associated with going without preventive than acute care services. This makes sense in that people make active choices about making appointments for preventive care. Therefore any concerns about cost, whether a given service is covered, taking time off from work, and negative experiences with service providers or clinics are likely to influence how timely these appointments are made or kept. These concerns are more likely to be overlooked or ignored in the case of an illness or injury.

A substantial proportion of the barriers are associated with not getting needed medical care and delaying care in the past year. This is particularly true for adult enrollees, while somewhat fewer barriers are associated with foregoing care for children. Whereas barrier domains like cost and coverage, provider related barriers, trust, confidence and concern about the practice style of their usual provider, and reports of discrimination are fairly consistently related to preventive care use, unmet need and delayed care, we find that problems with availability, quality and privacy of interpreter services are less consistent influences on use of services or problems accessing care.

Chapter 3

Change Over Time: Results

From the 2003 and 2008 Surveys

The central focus of this chapter is examining whether the experiences of children and adults enrolled in MHCP have become worse, stayed the same or improved between the two surveys (2003 and 2008). Due to how we sampled in 2003 (see Technical Appendix), it is only possible to compare children and adults enrolled in managed care programs; however, in each year over 70% of the samples were in managed care programs so the majority of the sample are included in these analyses.

Analysis of change in the health care experiences of enrollees requires understanding whether the population being study has changed. For example, if the health status of children or adults in MHCP has become better since the time of the first survey (2003) we might find changes in utilization of services that are simply due to less need for services, and can not be attributed to worse access to health care. Thus, we first examine changes in the population of enrollees included in the study. We then examine whether utilization of services, perceived problems getting health care and experiences with health care have changed between 2003 and 2008. For any changes that occurred, we assess whether they are due to changes in the health status or demographic characteristics of the population. All analyses are run separately for adults and children, and for each cultural group. Finally, we also examine whether disparities between European Americans and the other cultural groups have increased, decreased, or stayed the same between 2003 and 2008.

Changes over Time in the Characteristics of Enrollees

As shown in Table 11, there are few changes over time in characteristics of children and adults enrolled in MHCP over the 5 year period. The average age of adult enrollees declined by about two and a half years between 2003 and 2008. Further, the adult population is also somewhat healthier in 2008 as indicated by the decline in the proportion of adult enrollees reporting fair/poor health status.

Table 11. Sociodemographic characteristics of enrollees

	Adults		Children	
	2003	2008	2003	2008
Average age	45.2	42.7 *	7.3	7.7
Female	71%	67%	49%	46%
Married, living with partner	39%	44%	59%	64%
Employed	47%	44%	57%	61%
High school graduate or higher	76%	78%	78%	78%
Living in metro area	63%	63%	67%	66%
Fair/poor health status	26%	22% *	4%	3%

* Indicates a significant difference over time

The change in age composition of adult enrollees is not consistent across cultural groups (Table 12). The average age of adult enrollees increases over the 5-year period for Hispanic/Latino and Somali enrollees and decreases for European American and Hmong enrollees. The proportion of adults that are female increases for Native American enrollees but drops for Hmong enrollees over time. The only statistically significant change in health status is among the European American adult population, where a lower percentage report fair/poor health in 2008 than in 2003. It is noteworthy that the opposite pattern is observed for Native American, Hmong and Somali adults, however in these cases the increases in the proportions of these population reporting fair/poor health fail to reach statistical significance (perhaps due to the smaller sample sizes for these groups; see Table A-4 in Appendix A for sample size).

The bottom panel of Table 12 shows that there are a few changes in the characteristics of child enrollees. The average age of Hispanic/Latino children increased over the five-year period; European American parents are significantly more likely to be married in 2008 than 2003; a smaller proportion of Native American children are living in metro areas; and a larger proportion of Hispanic/Latino parents have at least a high school degree in 2008.

Thus, overall, these results suggest that the population in MHCP in 2008 is similar to the population in the program in 2003. However, it is important to take into account changes that did occur to determine whether they are responsible for any changes observed in utilization patterns, problems accessing health care, or differences in experiences getting health care.

Table 12. Sociodemographic characteristics by cultural group for adults and children

	European American		Native American		African American		Hispanic/Latino		Hmong		Somali	
	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008
Adults												
Average age	46.8	43.6 *	38.9	37.4	39.4	41.9	34.2	38.5 *	48.5	41.1 *	34.4	41.3 *
Female	71%	66%	67%	83% *	76%	74%	72%	77%	68%	48% *	65%	65%
Married, living with partner	40%	47%	29%	28%	21%	24%	63%	60%	44%	46%	42%	50%
Employed	49%	48%	44%	34%	39%	31%	44%	40%	24%	24%	26%	29%
High school graduate or higher	80%	83%	72%	82%	71%	73%	56%	58%	30%	36%	33%	35%
Living in metro area	57%	56%	75%	70%	97%	93%	70%	65%	96%	98%	92%	93%
Fair/poor health status	26%	19% *	30%	36%	31%	30%	24%	24%	19%	27%	14%	18%
Children												
Average age	7.8	8.0	6.8	7.5	7.9	8.2	4.3	6.6 *	9.8	8.8	6.2	6.7
Female	51%	47%	53%	45%	46%	47%	42%	44%	49%	45%	48%	46%
Parent married, living with partner	65%	75% *	39%	51%	30%	24%	70%	67%	83%	79%	60%	71%
Parent employed	62%	67%	53%	58%	57%	58%	46%	54%	52%	50%	41%	52%
Parent high school graduate or higher	89%	91%	87%	83%	81%	83%	38%	52% *	52%	40%	40%	43%
Living in metro area	52%	51%	84%	65% *	96%	93%	77%	74%	92%	98%	98%	94%
Fair/poor health status	3%	1%	3%	0%	7%	3%	8%	5%	2%	9%	5%	1%

* Indicates a significant difference over time

Does Service Use Change Over Time?

We examined past year utilization of acute care, preventive care, and dental care for adult and child enrollees in the two time periods (see Table 13). The proportion of adults with no past year visits for each of the three types of medical care did not significantly change over time. Parents were less likely to report a visit for an acute illness for their child in the year prior to interview in 2008 compared to 2003. The opposite pattern holds true for annual dental visits; about one-half of parents of child enrollees did not report a visit to the dentist in 2003 compared to just over one-third in 2008.

Table 13. Use of services in the past year

	Adults		Children	
	2003	2008	2003	2008
No acute visit	27%	28%	23%	28% *
No preventive visit	27%	27%	22%	19%
No dentist visit	49%	47%	50%	35% *

* Indicates a significant difference over time

The significant changes over time may be due to differences in the demographic make-up or the health status of the populations between 2003 and 2008. Indeed, when we control for these factors the change in acute visits for children is no longer significant. Older children and those whose parents are married or living with a partner are more likely to not have a visit to the doctor for an illness or injury. The population of children in 2008 are older and are more likely to have married parents and these factors appear to account for the significant increase in the proportion of children who report no visit to the doctor for an acute illness in 2008 than in 2003. Demographic and health status changes in the population, however, do not explain the increase in likelihood of seeing a dentist.

Did Service Use Change Over time by Cultural Group?

We also examined changes between 2003 and 2008 in utilization of services for each cultural group (Table 14); there are few significant changes. There were no significant changes for adults. Among child enrollees, the only significant change over time was for dental visits. The proportion of parents in all groups who did not report a visit to the dentist for their child in the past year declined between 2003 and 2008, although the change was significant only for Hispanic/Latino, Somali and European American children.

Table 14. Use of services in past year by cultural group

	No acute visit		No preventive visit		No dentist visit	
	2003	2008	2003	2008	2003	2008
Adults						
European American	27%	29%	28%	31%	49%	45%
Native American	20%	18%	26%	18%	49%	55%
African American	29%	19%	21%	13%	47%	51%
Hispanic/Latino	28%	32%	26%	19%	39%	46%
Hmong	45%	43%	39%	42%	55%	51%
Somali	17%	18%	23%	15%	55%	49%
Children						
European American	23%	27%	24%	21%	47%	36% *
Native American	17%	25%	23%	16%	50%	38%
African American	28%	33%	20%	15%	41%	33%
Hispanic/Latino	21%	28%	12%	12%	67%	33% *
Hmong	38%	45%	40%	29%	33%	26%
Somali	19%	17%	16%	17%	72%	38% *

* Indicates a significant difference over time

Even when we take into account changes in the age, sex, marital status, educational attainment, employment status, metro residence and self-reported health status, the significant decline in the proportion of children who did not visit the dentist remained. Specifically, the odds of no dental visit was significantly lower among 2008 enrollees compared with 2003 enrollees for Hispanic/Latino children (OR = 0.31, 95% CI = 0.21, 0.46), Somali children (OR = 0.18, 95% CI = 0.08, 0.38), and European American children (OR = 0.61, 95% CI = 0.41, 0.90) (Table not shown).

Have Barriers to Health Care Changed Over Time?

We examined changes in barriers to health care for adults and children between the 2003 and 2008 time period (Table 15). These analyses are based on questions that asked if each of these issues was a problem when they (or their child) tried to get health care. If respondents indicated that it was a big or small problem (as compared to no problem) it was defined as a potential barrier to health care.

Only those barriers that are measured consistently in both years are included in the over time analysis. Factor analysis drawing on the smaller set of barriers measured with the same questions in 2003 and 2008 did not yield the same clustering as presented in the analysis of the 2008 data above (for example, see Table 7). Therefore we opted to present the over time analysis using the same categorization of barrier measures as used in the 2003 report.

Among adults, the majority of these barriers are less likely to be experienced in 2008 than in 2003 (although the differences do not always reach statistical significance), or are about equally likely (within 1 percentage point) in both time periods (4 of 17 or 23%). Only two barriers show the opposite pattern (transportation problems and availability of childcare), but in both cases the increase is not statistically significant.

The significant changes for adults involve access barriers; 62% of adults reported at least one access barrier in 2003 compared to 54% in 2008. Specifically, the percentage of adults who reported problems due to not seeing the preferred doctor, inconvenient clinic hours or not knowing where to go declined.

Overall, the proportion of parents experiencing these barriers stayed almost the same (47% of barriers), or decreased (35% of barriers). There were statistically significant reductions in problems related to worries that insurance will not cover care and any cost-related barrier. The only barrier that is significantly more likely to be reported by parents of enrollees in 2008 than in 2003 is problems finding childcare.

When we took into account changes in the socio-demographic characteristics of the population, the difference over time in the proportion of adults who reported a problem getting health care because the doctor's office was not open at a convenient time was no longer statistically significant.

Table 15. Barriers to health care services

	Adults		Children	
	2003	2008	2003	2008
Cost and coverage barriers				
Worry insurance won't cover care	46%	43%	32%	26% *
Worry will have to pay more than expect	43%	39%	30%	26%
Any cost or coverage barrier	53%	51%	38%	31% *
Access barriers				
Can't get appointment as soon as needed	40%	36%	31%	27%
Transportation problems	20%	22%	17%	20%
Can't see preferred doctor	28%	22% *	24%	23%
Office not open when you can go	19%	15% *	20%	17%
Don't know where to go	17%	11% *	11%	11%
Any access barrier	62%	54% *	52%	50%
Family and work responsibilities				
Work or family responsibilities	31%	30%	28%	29%
Availability of childcare	13%	17%	16%	26% *
Any family/work barrier	41%	37%	38%	40%
Trust in providers				
Doctors are not trustworthy	19%	15%	16%	15%
Language, culture and religious barriers				
Doctors don't understand language	12%	12%	12%	11%
Doctors don't understand culture	7%	6%	7%	7%
Doctors don't respect religious beliefs	3%	3%	2%	3%
Any language or cultural barrier	18%	15%	16%	15%

* Indicates a significant difference over time

We also examined whether barriers changed for each cultural group. There were few significant changes in reported barriers to accessing care among adult enrollees over time (Table 16). Significant changes were all in the direction of improvement. For Hmong adults there was a significant decrease in problems getting an appointment soon enough. Somali adults were less likely to report problems with access barriers or due to family or work responsibilities in 2008 compared to 2003. European Americans were significantly less likely to report an access barrier in 2008 compared to 2003. Specifically, the proportion of European American adults who experienced a problem getting care due to inconvenient office hours or because they did not know where to go declined. Moreover, after taking into account changes in the health status or demographic characteristics of each cultural group, all of these differences remained significant.

While there were more significant changes for child enrollees (Table 17), the overall pattern is still of relative stability or reductions in these barriers over time for each cultural group. European American parents are less likely to perceive each of the barriers related to cost when trying to get their child health care in 2008 than in 2003. Over time, Native American parents are less likely to report barriers related to having to pay more than they expected, that the office is

not open, and that doctors are not trustworthy. Transportation problems declined for Hispanic/Latino parents as did problems related to work or family responsibilities. Among Hmong parents, a smaller proportion report problems getting an appointment as soon as needed in 2008 compared to 2003. Problems getting an appointment and transportation problems also declined over the five year period for Somali parents.

Only a small number of barriers to care for children are more prevalent in 2008 than in 2003. European American and Hispanic/Latino parents are more likely to report that finding childcare is a problem when trying to get their child health care in 2008 compared to 2003. The likelihood of Hmong parents reporting that they worry that they will have to pay more than expected increased over the five year period.

After controlling for health status and demographic characteristics, most of these differences remain. Thus, changes in the population are not responsible for changes in reports of barriers. The only exceptions are the differences over time in reports of worries that insurance will not cover care and worries that one will have to pay more than expected for European Americans, which are reduced to non-significance with adjustment.

Table 16. Barriers to health care services by cultural group for adults

	European American		Native American		African American		Hispanic/Latino		Hmong		Somali	
	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008
Cost and coverage barriers												
Worry insurance won't cover care	44%	40%	50%	55%	53%	47%	56%	55%	62%	66%	52%	47%
Worry will have to pay more than expect	41%	36%	46%	48%	45%	51%	50%	52%	66%	63%	51%	40%
Any cost or coverage barrier	51%	48%	56%	62%	57%	59%	66%	60%	74%	72%	58%	54%
Access barriers												
Can't get appointment as soon as needed	38%	33%	44%	41%	51%	52%	49%	37%	66%	50% *	46%	27% *
Transportation problems	16%	17%	37%	39%	33%	39%	36%	25%	43%	42%	30%	29%
Can't see preferred doctor	27%	21%	18%	20%	27%	20%	31%	22%	43%	41%	37%	34%
Office not open when you can go	18%	12% *	21%	28%	23%	20%	23%	19%	51%	42%	22%	22%
Don't know where to go	15%	8% *	24%	18%	24%	19%	22%	16%	43%	43%	20%	23%
Any access barrier	59%	50% *	66%	68%	73%	69%	69%	60%	81%	73%	70%	57% *
Family and work responsibilities												
Work or family responsibilities	29%	29%	41%	35%	39%	32%	31%	29%	52%	50%	39%	28%
Availability of childcare	11%	15%	24%	30%	20%	18%	26%	18%	29%	36%	31%	23%
Any family/work barrier	38%	34%	53%	49%	47%	39%	44%	35%	62%	59%	61%	40% *
Trust in providers												
Doctors are not trustworthy	17%	12%	21%	18%	25%	22%	27%	17%	51%	48%	23%	26%
Language, culture and religious barriers												
Doctors don't understand language	10%	8%	9%	15%	13%	14%	29%	28%	60%	54%	35%	37%
Doctors don't understand culture	4%	2%	6%	13%	15%	9%	25%	17%	53%	47%	39%	30%
Doctors don't respect religious beliefs	1%	1%	4%	6%	3%	4%	7%	2%	35%	30%	17%	15%
Any language or cultural barrier	13%	9%	15%	24%	27%	19%	38%	36%	67%	64%	58%	50%

* Indicates a significant difference over time

Table 17. Barriers to health care services by cultural group for children

	European American		Native American		African American		Hispanic/Latino		Hmong		Somali	
	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008	2003	2008
Cost and coverage barriers												
Worry insurance won't cover care	29%	22% *	31%	17%	32%	25%	38%	34%	53%	60%	33%	36%
Worry will have to pay more than expect	29%	22% *	34%	17% *	26%	25%	35%	35%	40%	69% *	23%	26%
Any cost or coverage barrier	36%	25% *	35%	23%	37%	29%	45%	41%	55%	74%	36%	40%
Access barriers												
Can't get appointment as soon as needed	29%	24%	26%	35%	32%	34%	34%	27%	63%	31% *	53%	25% *
Transportation problems	11%	16%	21%	20%	24%	28%	28%	20% *	25%	36%	47%	17% *
Can't see preferred doctor	27%	24%	15%	21%	17%	21%	19%	21%	36%	27%	35%	26%
Office not open	18%	16%	33%	9% *	22%	19%	19%	17%	36%	41%	31%	21%
Don't know where to go	9%	12%	14%	5%	13%	10%	14%	9%	27%	20%	11%	11%
Any access barrier	47%	47%	58%	50%	55%	58%	59%	50% *	70%	62%	70%	47% *
Family and work responsibilities												
Work or family responsibilities	26%	29%	30%	22%	33%	40%	28%	19% *	39%	36%	29%	20%
Availability of childcare	15%	27% *	16%	16%	17%	27%	13%	20% *	35%	31%	33%	36%
Any family/work barrier	33%	42% *	47%	32%	44%	45%	44%	30% *	48%	44%	53%	41%
Trust in providers												
Doctors are not trustworthy	14%	13%	26%	9% *	16%	12%	18%	14%	36%	51%	14%	24%
Language, culture and religious barriers												
Doctors don't understand language	5%	5%	6%	7%	10%	7%	32%	25%	39%	46%	33%	18%
Doctors don't understand culture	2%	2%	6%	6%	10%	8%	13%	11%	44%	31%	24%	20%
Doctors don't respect religious beliefs	1%	1%	5%	0%	1%	2%	1%	2%	23%	24%	13%	13%
Any language or cultural barrier	8%	6%	11%	12%	19%	12%	35%	29%	60%	53%	40%	30%

* Indicates a significant difference over time

Confidence in Providers

We examined confidence in usual providers for adult and child MHCP enrollees in the two time periods (see Table 18). The proportion of adults and parents of child enrollees reporting low confidence in their own (or in the child's) usual provider did not change significantly over time.

Table 18. Low confidence in usual provider over time

	Adults		Children	
	2003	2008	2003	2008
Low confidence in usual provider	50%	46%	39%	36%

* Indicates a significant difference over time

Table 19 shows the proportion of enrollees in each cultural group who reported low confidence in their usual provider for 2003 and 2008. The only significant change for adults is among Native Americans who were significantly more likely to report low confidence in their provider in 2008 than in 2003. For children, the only significant change was among Hispanic/Latino parents who were less likely to report low confidence in their child's usual provider in 2008 than in 2003. These changes remain significant when we control for changes in health status and demographic characteristics.

Table 19. Low confidence in provider by cultural group for adults and children

	Adults		Children	
	2003	2008	2003	2008
European American	49%	42%	33%	30%
Native American	43%	61% *	40%	36%
African American	49%	48%	36%	34%
Hispanic/Latino	64%	62%	64%	46% *
Hmong	78%	68%	67%	57%
Somali	57%	58%	57%	51%

* Indicates a significant difference over time

Perceptions of Discrimination

We examined perceptions of discrimination for adults and children enrolled in MHCP in the two time periods (Table 20). The proportion of adults and parents of enrollees who felt that they (or their child) were treated unfairly because of class (ability to pay or enrollment in MHCP) or race, ethnicity or nationality remained stable over the five year time period.

Table 20. Perceptions of discrimination

	Adults		Children	
	2003	2008	2003	2008
Discrimination				
Class based discrimination	44%	45%	36%	34%
Race, ethnicity or nationality	10%	10%	8%	9%

Table 21 shows the proportion of each cultural group that perceived discrimination in 2003 and 2008. For adults, the only significant change is that Native American adults were more likely to report unfair treatment due to class in 2008 than they did five years earlier. There were only two significant changes for children; Hispanic/Latino parents were significantly less likely to report they or their child experienced unfair treatment due to class or due to race, ethnicity or nationality in 2008 compared to 2003. These differences remain when we control for changes in the health status or demographic characteristics of these populations over time.

Table 21. Perceptions of discrimination by cultural group for adults and children

	Adults		Children	
	2003	2008	2003	2008
Unfair treatment based on class				
European American	43%	44%	37%	35%
Native American	44%	66% *	39%	39%
African American	53%	48%	37%	44%
Hispanic/Latino	44%	36%	33%	17% *
Hmong	54%	66%	43%	52%
Somali	37%	28%	23%	25%
Unfair treatment based on race, ethnicity or nationality				
European American	5%	3%	2%	2%
Native American	21%	29%	20%	14%
African American	33%	33%	16%	24%
Hispanic/Latino	26%	28%	14%	8% *
Hmong	50%	54%	35%	31%
Somali	18%	16%	15%	16%

* Indicates a significant difference over time

Interpreter Services

We examined need for, access to, and quality of interpreter services for Hispanic/Latino, Hmong and Somali adult and child enrollees in the two time periods (Table 22). Among both adult enrollees and parents of child enrollees, the proportion reporting that they needed an interpreter did not change significantly over time. Among those who needed an interpreter, there were no changes in perceived availability or quality.

Table 22. Need, availability and quality of interpreter services over time among Hispanic/Latino, Hmong and Somali enrollees

	Adults		Children	
	2003	2008	2003	2008
Need an interpreter	47%	53%	49%	48%
Of those who need an interpreter				
Problems with availability	47%	41%	38%	30%
Problems with quality	46%	51%	32%	37%

* Indicates a significant difference over time

Over the five year period from 2003 to 2008, need for an interpreter significantly increased for adult Somali enrollees and for Hmong child enrollees (Table 23). Availability and quality appear to have significantly improved for parents of Hmong child enrollees. However, parents of Somali children who needed an interpreter are significantly more likely to report problems with quality in 2008 compared to 2003. Controlling for background characteristics only reduced the differences in need for interpreters for Hmong children to non-significance. The other changes remain significant. More information is needed to understand why problems of availability and quality remain unchanged over time for Hmong adults yet are significantly reduced for Hmong parents.

Table 23. Need, availability and quality of interpreter services over time by cultural group

	Hispanic/ Latino		Hmong		Somali	
	2003	2008	2003	2008	2003	2008
Adults						
Need an interpreter	39%	39%	61%	64%	46%	64% *
Of those who need an interpreter						
Problems with availability	33%	36%	55%	44%	52%	43%
Problems with quality	33%	35%	51%	54%	54%	55%
Children						
Need an interpreter	52%	45%	31%	58% *	45%	48%
Of those who need an interpreter						
Problems with availability	31%	26%	76%	25% *	53%	43%
Problems with quality	27%	26%	73%	35% *	36%	58% *

* Indicates a significant difference over time

Did Disparities Increase over time?

For each of the measures of service use, barriers to care, confidence in doctors and discrimination we examined whether disparities had changed over time. That is, we assessed whether the difference between European Americans and the other cultural groups increased, decreased, or stayed the same between 2003 and 2008. There were no significant changes in disparities for any of these measures over the five-year period.

Summary of Changes over Time

The analyses of changes over time allow us to assess whether access to services and experiences with health care are getting better, worse or staying about the same for people who are insured through MHCP. With a few important exceptions, these findings paint a picture of either stability or improvement.

The observation that overall 15% more children enrolled in MHCP visited the dentist in the past year is encouraging. We found that this improvement was significant in the European American, Hispanic/Latino and Somali communities.

Similarly, it is encouraging that when there is change over the five year period, the pattern suggests reductions in problems. In particular, access barriers for adults and cost-related barriers for parents appear to be substantially lower in 2008 than they were in 2003. The notable exception to this trend is availability of childcare, which is more likely to be cited as a problem in 2008 than in 2003.

Chapter 4

Community Engagement and Recommendations

As stated in the methodology section, PMT members from the African American, Native American, Hispanic/Latino, Hmong and Somali communities conducted focus groups to share key results from the survey and solicit advice from members of their respective communities. Below we provide an overview of these activities, an overview of what was learned in each cultural community, and a compilation of recommendations from all cultural communities organized by barrier domain.

Community Engagement Activities

Each community partner proposed a unique engagement strategy for reaching their respective communities in order to share the results, discuss the meaning of the results from the community's perspective, and develop suggestions to improve the care provided in MHCP. The goal was to generate community-specific recommendations that might be addressed by providers, the health care system generally, DHS, and people within the community.

After decisions were reached amongst PMT members concerning engagement formats and processes, the engagement process was tailored by the PMT member from that community based on what they thought would work the best. For all cultural groups, this included a gathering of community members in a familiar and comfortable setting, describing the study and gathering signatures on consent forms, providing a presentation and overview of the project and key results, and a facilitated dialogue to generate reactions and advice from community members. In addition to a facilitator for this discussion, a note-taker was also present to ensure that key recommendations and comments were captured. Hmong and Somali PMT members opted to hold two separate focus groups to seek advice from different sectors of their communities based on context (e.g., community center versus church). The focus groups ranged in size from 8 to 19 participants, with participants ranging in age from 20 to 97 (however, most were non-elderly adults), and all were mixed gender but included more females than males (which is consistent with MHCP enrollment). Each engagement format included provision of refreshments, a gift card as a token of appreciation for participation, and childcare when needed.

It should be noted that all focus groups were conducted in the Twin Cities metro area. This limitation is less problematic in terms of the potential representativeness of recommendations solicited amongst African American, Hmong and Somali community members as MHCP enrollees from these communities are predominantly urban dwellers (Tables 3 and 4). Clearly some barriers are likely to be exacerbated for those living in non-metro areas of the state, such as transportation difficulties, office hours and availability of childcare. Further, problems with the availability, quality and privacy of interpreter services may be more common for Hispanic/Latino enrollees living in non-metro areas of the state. Although we cannot know with certainty, it is possible that the experiences of MHCP enrollees in non-metro areas are similar in character although potentially different in magnitude. If differences in enrollee experiences are

small in terms of their nature and large in terms of their frequency, in general the recommendations solicited by focus group participants in these cultural groups would not vary dramatically based on metro or non-metro residence.

Before turning to the results of the community specific engagement activities summarized in this chapter, we note that a larger forum was held on March 13, 2009 which brought together community members and representatives from health plans, health care delivery systems and government. PMT members from the various cultural communities presented their recommendations to the full forum membership. This was followed by facilitated small group review and discussions, and a large group dialogue outlining potential courses of action. Notes and suggestions derived from this process are available as an addendum to this report. Hopefully, this activity represents an initial step in what should be ongoing conversations among community members, community organizations, researchers, government and health plans to facilitate improvements in access and quality of the services provided through MHCP.

Results and Recommendations

Below is a brief summary of discussion points, concerns raised and recommendations suggested from each of five cultural groups. A separate, more detailed report is available upon request.

Native American community

The Native American focus group provided recommendations for preventive care and cost and coverage barriers, barriers to access, and discrimination. To encourage people to get more preventive care, the group stressed the importance of a personal connection and being able to build a trusting relationship with care providers. The more people can build a relationship with their provider, the more they can build trust and willingness to seek preventive care.

Recommendations regarding cost and coverage barriers centered on the need for better communication. Many people do not read information sent to them, and would prefer more personal contact in the form of an easy to access help-line or, preferably, a Native advocate or navigator. There should be better ways to inform people about costs prior to receiving care and about which clinics and procedures are covered by which health insurance. The rights and responsibilities of patients need to be more accessible and readable. Participants also recommended simplifying the paperwork. Reporting could be done online. They suggested there should be no waiting time for MHCP enrollment.

Regarding accessing care for children, many of the participants said that transportation was available, but often people do not know if it is covered by their insurance. This information needs to be better communicated. Caring for children is still a huge barrier to getting to the doctor and drop off childcare that is available is not viewed as trustworthy. They suggested community based clinics with onsite childcare. There should also be a liaison/cultural broker (Ojibwa, Dakota) who can act as an advocate. People said they would like a community based clinic based in Native culture. The suggestion was also made for creating a Native hospital where the teachings of Native peoples could be incorporated into the care.

Regarding discrimination, participants felt there should be more effective diversity training for providers. Providers should learn more about how to give ‘TLC’ (tender loving care) and be encouraged and given the time to establish relationships. There should be opportunities for dialogue between providers and the community.

As a strategy to protect people from negative experiences, people should be encouraged to go with another person to their appointments until advocates are in place. Health care providers should not direct the medical process; instead, doctors and patients should be partners. People have to know what is happening to their bodies and know their bodies. People should be encouraged to request the same health care provider to establish a more personal connection and relationship. People often do not realize that they have a choice of which doctors, clinics and health care providers they can use, so they should be better informed about their choices. The participants suggested a class to learn how to better advocate for themselves in the health care system. They also want to learn what their rights are and how to report a grievance.

The group also talked about the need for more Native American doctors. Native people need to keep them close to the community, because a lot of time when Native people get educated, they become removed from the community and lose their traditional values, connectedness and humility.

Another recommendation was for the formation of an independent, autonomous health monitoring body funded through DHS that is voluntary and regulatory, to monitor and advocate for patient rights, to create a dialogue between the community and the health care providers and make recommendations for positive change. This model was used in the formation of the Bemidji Area Race Relations Council to monitor racism in the 14 county Bemidji Court system in the 9th Judicial District in 1996. It worked very well and was made up of people who cared about fairness and who understood if someone was being treated in a racist manner.

African American community

In the African American focus group, participants focused on three issues for their recommendations: preventive care, adult coverage and cost barriers, and discrimination. To increase use of preventive services, they suggested that more providers should send reminders of appointments, provide more information about what tests are needed by age and gender, and provide more information about prevention at appointments and listen better to their patients. They also said that people need to take more responsibility for their own health.

To address problems with adult coverage and cost barriers, participants suggested several ways for better communication: providing more accessible and respectful points for getting information out (for example, an improved help line, friendlier receptionists, and group orientation session); putting more information online, including reporting requirements for people on Minnesota Family Investment Program (MFIP); and providing group orientation sessions on MHCP for MFIP participants who are not clear that they have to reapply for both. The participants stressed the need for more personalized communication. They also suggested that the process for renewing a health care plan could be simplified. Participants spoke often

about the difficulty with bureaucracy, with being overwhelmed with information which was difficult to understand about their health plan and about the difficulty of getting helpful, friendly information.

It was surprising to the facilitator and several other people present how many of the participants reported having a good experience with their providers. All but three had a primary care provider, and all of those who had a primary care provider had good experiences. They said their provider sent reminders, talked to them in a personal way, and gave them information they requested. Only three participants consistently did not have positive experiences and none of these three had a primary care provider. There was some discussion speculating about whether people had low expectations or were good at advocating for themselves and whether this might skew people's assessment of their care.

People acknowledged that discrimination is still an issue within their cultural community. They recommended that DHS and providers take the results of the survey seriously. They suggested that health care providers take classes on cultural sensitivity to understand other people's culture and therefore treat them with respect. There was some discussion on how cultural sensitivity training could be improved; that what is currently provided is a band-aid solution. Participants emphasized the need for concrete suggestions for improvement. There should be consequences for health care providers that discriminate and more African Americans should be hired.

Participants criticized the health care system on several points, but they also talked about their own personal responsibility to take care of themselves, to complete paperwork, ask questions, make appointments, and go in for check-ups and screenings. Transportation was not a problem for most participants.

Hispanic/Latino community

In general, the Hispanic/Latino participants were not surprised by the results of the survey. They were more engaged in the discussion of issues related to barriers to health care, improving relationships with usual health care providers, and the quality of interpreter services. It was surprising to the PMT community representative who facilitated the group that participants did not consider being enrolled in a MHCP a negative stigma. Most of them felt that the doctors do not pay attention to MHCP enrollment when they are being seen at an appointment.

Participants indicated many concerns about the lack of cultural sensitivity they experience from clinic/agency staff members. Many expressed disappointment about the services offered by bilingual staff as well, and felt that services received even from those who speak Spanish are often of poor quality. All participants agreed that they have the choice to attend any clinic their health insurance accepts, but they also said that they most often opt to go to clinics with bilingual or Spanish speaking providers and staff. Thus, participants emphasized the important role language plays when determining which clinic or health care provider to seek out.

Interestingly, most of the parents mentioned that they take their children to children's hospitals or clinics where their children will be seen by a pediatrician or a specialist. The most important

factor in seeking care for these parents is the quality of the care they expect to receive, not necessarily whether or not the care is provided by someone who speaks Spanish.

Lastly, members of the group showed concern regarding the lack of quality in interpreting services and they cited specific examples of experiences with an interpreter provided by a clinic who knew less about medical terms than a relative or the patients themselves. A community member recalled an example where a patient almost died because of problems in communication between the patient, interpreter and provider.

Hmong community

There was a consensus among Hmong community participants that too much information is mailed to enrollees and that translating materials into Hmong does not always help because some older enrollees do not read or write in English or Hmong. Some suggestions provided were to: make Hmong language videos explaining any changes in benefits; have community discussion sessions; or have a shorter version of the insurance information with only the main points and a phone number to call for more information (in English or Hmong).

One of the major reasons participants felt there was little trust or confidence in providers was the lack of consistency with providers. Many of the enrollees did not know that they could select a primary health care provider. Instead, they were scheduling with the clinic but not asking for the same provider. Participants indicated that they would like to be educated about how to select a primary provider and would like the clinics to work to reduce provider turnover.

Participants also expressed mixed feelings about how much a provider should tell them about procedures and potential diseases they may have. More of the young participants wanted to know a lot about what was being done, such as what particular tests are for and the odds of recovery from treatment or a disease process. The older participants wanted less information in the diagnostic phases of care. For example, they didn't want to be told that a test was to determine the presence of a cancerous growth. They only wanted to know that tests were being run and to be informed of results or the purpose of a test once a diagnosis was determined. They explained that if the doctors told them they were being tested for a specific disease they would worry or experience stress that may be unnecessary if the test results indicate the absence of that disease.

One group of participants felt discrimination was not a serious issue for their community. The other group felt there is a need to create a way to capture how much individuals are experiencing discrimination in their health care encounters. A few participants pointed out that going to a Hmong clinic/provider did not eliminate discrimination; they may experience unfair treatment from Hmong providers as well.

Interpreter services were discussed extensively in both groups. All participants had experience with a bad interpreter and shared specific experiences. Participants felt that most interpreters working in health care either know a lot of Hmong but not enough English or vice versa. Some suggestions to address this problem included offering standardized classes that are developed and delivered by an academic or governmental agency. The participants felt that any certification

examination or test should be administered verbally because participants felt that written and spoken language abilities (Hmong or English) are distinct. It was suggested that a random audit of interpreters would help. For example, an expert could show up at an appointment and verify that what is being translated is correct. If it is not correct there should be some way of holding the agency responsible for poor quality interpreters. Lastly, privacy issues with interpreters were discussed. Enrollees felt that they did not know their rights regarding patient privacy. They suggested that fines or being able to sue an agency might help to hold interpreters accountable for keeping information private. Participants also thought that it was possible that interpreters do not always know their responsibility for patient privacy and they should be reminded by signing a privacy form before every appointment they are called to.

Somali community

The Somali community focused on how to overcome barriers related to interpreter services and to health care coverage. Recommendations related to interpreters targeted three audiences; care delivery agencies (e.g., clinics), interpreter agencies and DHS.

There was general praise for hospital interpreter services whereas clinics were perceived to have poor performance in providing quality interpreter services. Clinics were urged to hire their own professional interpreters with demonstrated medical terminology competency. Participants felt that agencies should establish standards in evaluating language competencies of interpreters.

Participants outlined recommendations related to the quality of services provided rather than access to services. DHS was recognized as the contracting agency providing funding to clinics which then identify and contract with interpreter agencies. To this end, participants recommended that DHS intervene in this area to tighten enforcement and set new accountability guidelines that improve interpreter services which are provided by an agency outside of the health care delivery system.

To overcome barriers related to coverage, participants requested better service coordination ranging from insurance applications at the county offices to the point of service at the clinic or hospital. For example, having clinics provide information about coverage would be efficient and useful to clients. A hotline with multiple languages available would be useful as well to help verify coverage for services. Clinics could promote this number and ask patients to verify coverage at the clinic prior to receiving care. Clinics/health care delivery systems might also advise people about what public insurance covers when they are given referrals or are advised to have a particular procedure done.

Compilation of Recommendations across Cultural Groups by Barrier Domain

Below we provide a compilation of concrete suggestions that emerged from the community engagement activities. As shown below, there are multiple targets for these recommendations as well as an acknowledgement that community members themselves have a role and responsibility

in working toward improved service use and quality of the health care experience. These suggestions are organized across the 11 barrier domains used throughout this report.

A: Perceived cost and coverage barriers

Information needed:

1. About the level and cost of benefits so enrollees know immediately or prior to a procedure, whether it is covered and how much it is going to cost. (People don't go because they don't know if they are going to be able to afford care.)
2. Which clinics are covered by which health insurance plans.

What would help:

1. Better accessibility to, and readability of, information that the insurance companies send.
2. Need liaisons, advocates or help desks that can answer insurance questions.
3. Quicker turn around in determining MHCP eligibility.
4. Need information from DHS and providers in multiple languages.
5. Social workers, with manageable case loads, who can respond in a timely manner when enrollees have questions.
6. More accessible and respectful points for getting information – for example, help line, receptionists, and online information.
7. Consider sending important details in a separate envelope (from general information), in bullet point format, or on a different color paper or envelope. Keep this consistent across all health plans so every time this color paper or envelop appears, it will be read or help will be sought to read the information. This should be sent in multiple languages and include a phone number to call for more information (phone number should have the option of speaking to someone in multiple languages).

What do community members need to do:

1. Read the booklet the insurance plan sends.
2. Verify insurance information at each clinic each time care is sought.
3. Inquire about benefits when getting enrolled.
4. Take more responsibility for health and knowledge.

B: Access barriers

Transportation:

1. Provide information about transportation services; when it is available and how to make arrangements.

Childcare:

1. Improve drop off childcare; it is not viewed as trustworthy and safe.

Improving access:

1. Provide reminder calls or mailings.
2. Simplify the process of renewing MHCP enrollment.
3. Provide more information online in user-friendly format.
4. Conduct group-style orientation about MHCP, including MFIP participants who may not be familiar with MHCP.
5. Personalize contact with enrollees.
6. Provide information about what tests are recommended by age and gender.

C: Provider related problems

Trust in providers:

1. Personal connections are important and often absent from medical systems. Community members want to be able to build a trusting relationship with their care providers, and providers need to build trust with them.
2. Offer personalized care.
3. Encourage patients to request the same health care provider to establish more personal connection and relationship.

Respect from providers:

1. Ask providers to relay more information about prevention, talk to patients respectfully as adults, not children.
2. Providers need to listen more.
3. Allow providers to pay more attention to the patient being seen, improve the quality of service (doctors are expected to rush through a lot of patients in a small period of time).

Training providers:

1. There should be more effective diversity/cultural sensitivity training for providers.

What does community need to do:

1. Learn to advocate for themselves (offer classes on this).
2. There is a desire to be partners in health care rather than letting providers alone direct medical care.
3. Community members want to learn more about their bodies and what is happening with their bodies to help become partners in care.
4. Community members want to learn more about their choices in selecting doctors, clinics and health care providers (see A above too).

D: Provider practice style concerns, low confidence and trust in usual doctor

Want providers who:

1. Come from and remain close to or in the community. (Members of community who are educated often become removed from the community and lose their traditional values, connectedness and humility.)
2. Spend more time with patients.

3. Listen and hear descriptions of symptoms and concerns.
4. Create a mechanism that allows patients to offer feedback when service quality is good or poor.
5. Readily refer patients to specialists when primary care providers cannot determine the problem.
6. Understand various cultures, their eating habits, and way of life.
7. Sustain employment over time (discourage rapid provider turnover and lack of continuity in care).
8. Offer much more information. Patients may not feel comfortable asking a lot of questions or may feel it is not their place; need to rely on providers to relay important information and put patients at ease to ask questions.

E: Perceptions of discrimination

Experiences of racism/discrimination:

1. Discrimination is viewed as the status quo in many health care settings (e.g., example of providers refusing to conduct certain procedures or prescribe medications before conducting a drug and alcohol screening).
2. Underlying racism/discrimination is exacerbated by the small amount of time spent with each patient and long wait periods. (Patient can wait for hours, but health care providers cannot spend time with patient because they are working to see as many patients and write as many prescriptions as they can in a day).

Community members need encouragement to:

1. Demand the best care (advocate for themselves- see C above).
2. Learn mechanisms for reporting when quality of care is not optimal and discrimination is experienced.
3. Bring an advocate to health care visits until they can advocate for themselves.

Health care providers should:

1. Limit who has access to insurance information at the clinic.
2. Ensure patients have a choice of whether or not to be seen, treated, or observed by a student.
3. Provide an immediate response when a grievance or complaint of discrimination or poor treatment quality is filed.
4. Take customer care surveys seriously.
5. Take classes on cultural sensitivity in order to better understand other people's culture and treat patients with respect.
6. Be sanctioned if they discriminate.
7. Be hired from similar cultural backgrounds as those being served.
8. Ensure that clinic or agency staff is trained so that the services provided are culturally appropriate and respectful.
9. Have a form available at each appointment that allows patients to express feelings about the provider, clinic, and hospital with regard to discrimination (without disclosing patient names).

10. Compile these concerns into a report that informs concrete changes.

DHS should:

1. Form an independent, autonomous health monitoring body that is voluntary and regulatory, to monitor and advocate for patient rights, and to create a dialogue between the community and the health care providers that can lead to recommendations and actions for positive change.
2. Require that clinic staff be properly trained, respectful and fair to patients enrolled in MHCP.

F: Availability, consistency, quality and privacy of interpreter services

Community needs:

1. Multicultural interpreters familiar with the language they are translating.
2. Interpreters who are certified by a responsible institution.
3. Health care providers who are sensitive to the gender of the patient.
4. Information on how to provide feedback to the interpreter agency when an interpreter is not an employee of the clinic.

Health care provider should:

1. Hire their own interpreters instead of hiring from outside agencies.
2. More critically scrutinize interpreting agencies that are utilized.
3. Test interpreters and require that they take a customer service course.
4. Remind interpreters of their responsibility to keep information private.

DHS/Regulating Agency should:

1. Fine an agency, hospital, provider, or interpreter if an investigation shows that the interpreter disclosed patient information inappropriately.
2. Inform patients about their rights and who to contact when their rights are violated. Interpreters should also be told about or reminded of this fine.
3. Regulate standard classes for interpreting that require a verbal test be passed before the person can officially act as interpreter.
4. Encourage periodic auditing of interpreters from an outside agency.

Chapter 5

Key Findings, Recommendations, and Conclusions

This project is a follow-up to a study undertaken in 2003 focused on deepening our understanding of disparities and barriers to health care utilization among Minnesota Health Care Program (MHCP) enrollees from six cultural communities: Somali, Hmong, Hispanic/Latino, African American, Native American, and European American. Specifically, the Minnesota Department of Human Services (DHS) sought answers to several important questions:

- Do MHCP enrollees differ in their use of services and access to care and are there disparities in use based on cultural group membership?
- What barriers do enrollees experience when seeking health care, and do these barriers vary by cultural group?
- Have service utilization and barriers to care changed over the five-year period between the two surveys for each cultural group?

Does service use differ among MHCP enrollees and does use vary over time?

- Patterns of reported utilization are fairly similar for the different cultural groups. There are no consistent differences between groups in self-reported service use, although there is a slight tendency for fewer Hmong to report use of **preventive and acute care** services.
- Adults are more likely to go without **preventive care** in the past year than are child enrollees (24% versus 17%).
- Hmong parents were significantly more likely and Somali parents were significantly less likely than European American parents to report their child had gone without an **acute care visit** in the past year.
- Hmong parents were significantly less likely than European Americans to report their child had a **mental health visit** in the past year.
- Hispanic/Latino and Hmong adults were much less likely to report **not getting health care** when they thought they needed it or **delaying care** than European American adults (only measured in 2008).
- Overall, **use of health care** (acute, preventive and dental) services across cultural groups was **very consistent over the five-year period**. One exception to this general trend is the significant reduction in the numbers of European American, Hispanic/Latino, and Somali parents reporting no dental visits for their child in the past year. However, reports of **dental care** do not meet recommendations: 46% of adults and 34% of children went without dental care in the past year.

What barriers to care do MHCP enrollees experience and do barriers change over time?

- **Perceived cost and coverage barriers** are primary obstacles for all cultural groups. This includes worrying that insurance will not cover the health care received, having to pay more than expected or more than can be afforded, medication costs, month to month uncertainty about MHCP enrollment, not knowing what services are covered, and not knowing where to go for help when health care questions arise. Hmong and Hispanic/Latino adult enrollees are particularly vulnerable as are parents of Hispanic/Latino, Hmong, and Somali children.
- Native American, African American and Hmong adults and parents are more likely than their European American counterparts to report an **access barrier** such as getting an appointment when needed, difficulties getting transportation to visits, inability to see their preferred doctor, inconvenient office hours, not knowing where to go to receive care, work and family responsibilities, and lack of child care.
- Overall, **provider related barriers** are less prominent than cost, coverage and access barriers. With a few exceptions, European Americans are less likely than other cultural groups (adults and parents) to report provider related barriers such as doctors not understanding one's language or culture, doctors not respecting one's religious beliefs, belief that doctors are not trustworthy, and perception that their usual place of care was not welcoming.
- The likelihood of enrollees reporting problems with their usual **provider's practice style** (i.e., provider does a fair or poor job explaining things in a way that they could understand, provider does not do enough to find out their health care concerns, provider does not spend enough time to address their health concerns, or provider does not treat them as a partner in making health care decisions) is higher among all other cultural groups than among European Americans, although the difference for African American parents is not significant
- **Low confidence in their usual provider** - in the form of being afraid that their doctor might not do enough to find out what is making them sick, that the health care they receive might make them feel worse, that their provider will tell them that they have an illness that they do not have, or that their provider might not find an illness they do have – was more prevalent among all cultural groups except African American adults and parents as compared to European Americans.
- In spite of concerns about practice style and low confidence in their usual provider, a relatively small proportion of enrollees indicate they have low **trust** in their (or their child's) provider: on average 8% of adults and 4% of parents. Low levels of trust are significantly higher for Hmong adults and Hmong and Somali parents as compared to their European American counterparts.
- **Discrimination** based on ability to pay and/or enrollment in MHCP is reported with higher frequency than unfair treatment based on gender or on race, ethnicity or nationality. In contrast to European Americans, Hispanic/Latino adults and parents and Somali adults are *less* likely to report discrimination based on ability to pay or enrollment in MHCP, whereas Native American adults and Hmong adults and parents are *more* likely to report such discrimination. Reports of discrimination based on race, ethnicity or nationality are significantly higher among all racial/ethnic groups as compared to European Americans.

- Hmong and Somali adults are much more likely than their Hispanic/Latino counterparts to report a need for **interpreter services** to help them communicate with their health care providers (the other cultural groups were excluded from this analysis due to their low need for interpreter services). Almost twice as many Somali as Hispanic/Latino parents report that their need for an interpreter is unmet. A substantial lack of consistent access to the same interpreter when they go to the doctor was observed across all three groups, although it is unclear what impact this has on communication or quality of services. Interpreter quality problems – in the form of interpreters not helping them understand what doctors are asking, not helping the doctor understand what they are telling the doctor, and not helping understand what is being done in the clinical encounter – are higher among Hmong and Somali enrollees regardless of age. Interpreter privacy concerns are prevalent across all three groups, although concerns were much *higher* among Hmong adults and much *lower* among Somali adults and parents than their Hispanic/Latino counterparts.
- Although a causal **relationship between barriers to care and service use or access** cannot be established with these data, we do find that barriers, particularly concerns about cost and coverage barriers and negative experiences with providers, are related to going without preventive health care services in the past year. An alarming proportion of barriers are associated with reports of not getting needed medical care and delaying care in the past year. This is particularly true for adult enrollees, whereas somewhat fewer barriers are associated with foregoing care for children.
- Overall, there were few changes **over time** (2003 vs. 2008). The trend was largely toward fewer reported barriers with a few exceptions. In particular, access barriers for adults and cost-related barriers for children appear to be substantially lower in 2008 than they were in 2003. The notable exception to this trend is availability of childcare, which is more likely to be cited as a problem in 2008 than in 2003.

Recommendations

The recommendations outlined below were developed by the research team after reflecting on multiple sources of information: discussions at PMT meetings over the duration of the project, the survey results in both years, and results from the various community engagement activities. Our suggestions are organized within the six overarching barrier domains outlined in the report: cost and coverage barriers; access barriers; provider related barriers; practice style concerns, low confidence and trust in usual doctor; discrimination based on race, ethnicity, nationality and class; and availability, consistency, quality and privacy of interpreter services. It is our hope that the recommendations below are of use not only to DHS but to the health plans and providers with whom they contract. Even more importantly, the recommendations will hopefully result in some form of action that benefits members of the communities served by MHCP.

Cost and Coverage Barriers

Worries over having to pay more than expected for care, whether insurance would cover costs, and whether services received will be covered persist over the 5 year period in spite of investments in the helpline service. Given that coverage through the Minnesota Health Care Programs, particularly Medical Assistance, is comprehensive and copayments are small,

concerns about cost and coverage probably have a large perceptual component. These perceptions, nonetheless, may impact use of services and require a response. This barrier area is considered fundamental and essential to getting people in the door and using services appropriately (although there is clearly work to be done in building trust and perceptions of quality that keep patients coming back). **We recommend the development of more accessible educational and outreach initiatives to help MHCP enrollees better understand the level of benefits and services covered.** The information currently provided by health plans is viewed as overwhelming and confusing (see also the “Patient rights and responsibilities” section below).

This will likely require a multi-pronged approach. For example, DHS should require that health plans and providers **supply brief and accessible summaries of benefits and changes in benefits on a separate and highly visible document** that accompanies (or potentially replaces) the existing benefit booklets. DHS should require that plans and providers with whom they contract reach consensus about the color of paper that will be used to draw attention to this information so that enrollees become familiar with this cue and realize that the materials are essential to read even if they change plans. The material should include, in multiple languages, a notice of the telephone number enrollees can call with questions (e.g., the helpline or ombudsman) and the website they can browse for more detailed information.

DHS or their contractors should form a community steering committee or develop a network of community based organization and leaders to draw on in developing these materials. Community organizations and members should be financially compensated for their work. All materials should be pretested with enrollees. However, written material will likely reach only segments of the enrolled population. **DHS and contractors should seek opportunities and accept invitations to attend ongoing regularly scheduled community meetings and events to provide information and answer questions.** This role may be appropriate for community advocates and leaders, community health workers (CHW), health system navigators or public health nurses. **Learning where, when and what are the most appropriate venues for this community-based outreach should be guided by members of the community.** This may require the formation of a community steering committee. However, it is possible that relevant advisory committees, community organizations, advocates and leaders that represent or have continuous contact with community and enrollees already exist and can be tapped and compensated for this additional role (e.g., American Indian Advisory Council, consumer advocacy groups, CHWs, Public Health Nurses, etc.).

Written information and in-person outreach through existing community organizing efforts may still miss very isolated groups of enrollees. Case managers, CHW, health system navigators, primary care or specialty providers may be in the best position to ask if enrollees have questions at the point of an encounter. **We recommend taking advantage of health care encounters with varied providers to answer enrollee questions and concerns.**

To evaluate the effect of the above recommendations, **DHS should continue to compile and code the nature of calls to the Helpline and Ombudsman.** Although a rich source of data and a guide to improving the information provided in the benefits book, this mode of dissemination does not appear to work effectively given the predominance of coverage and benefits concerns over the five year period. **DHS should develop a mechanism to share what has been done to**

respond to enrollee questions and concerns, indicating whether enacted solutions have resulted in a change in the pattern of inquiries over time. Furthermore, calls to the Helpline and Ombudsman may represent only a select group of enrollees who are both aware of the existence of these tools and have the time and energy to initiate contact. **DHS should make sure enrollees understand the dual function of the Helpline and Ombudsman for answering questions and recording enrollees concerns.**

Access Barriers

Recommendations for tackling problems such as getting an appointment when needed, office hours, securing transportation and child care, seeing the provider of choice, knowing where to go to receive care, and juggling work and family responsibilities mirror the recommendations cited above for **improving outreach and education as well as the recommendations cited below around patient rights and responsibilities.** The existing strategy in the form of the benefits book must not be working if, for example, enrollees continue to report difficulty securing transportation over the five-year period given this is a benefit reimbursed by Medicaid.

The increased prominence of childcare problems suggests that this is an area in need of particular attention. **Perhaps the legislature could allow a modest portion (for example 10%) of Minnesota's Child Care Assistance Program (CCAP) to be used to cover health care appointments.** CCAP helps families pay child care costs for children up to age 12 and for children with special needs up to age 14, but it does not currently cover health care visits. **Plans and providers might evaluate the benefits of offering child care services,** by appointment, to reduce barriers to preventive and acute care services as well as reducing last minute cancellations and no-shows.

Finally, though the severity of this problem is less acute in 2008 than in 2003, many MHCP enrollees still appear to have trouble finding a dentist who would accept them as patients (it was the second most highly cited barrier to dental care). Given that extant guidelines suggest that children over 3 years of age ought to be seen by a dentist twice per year, better access to such care is warranted. **Increasing reimbursement rates would likely increase the number of available dentists willing to serve MHCP enrollees. Further, it may be important to educate the legislature and MHCP enrollees of all ages about the virtues of preventive dental care and the relationship between dental health and physical health, specifically heart and respiratory health.**

Provider Related Problems

DHS should make enrollees aware of resources available to them (e.g., patient advocates, health care navigators, CHW, consumer surveys, suggestions boxes, etc.) to foster good communication with their providers and staff at the clinics they visit. These resources may help enrollees feel comfortable asking questions of providers and staff, taking part in health care decisions, discussing care options generally and particularly when the patient views their provider's recommendation as unattainable, and empowering them to provide both positive and negative feedback about services received.

DHS, and the plans and providers with whom they contract, should remind enrollees that the Helpline and Ombudsman are venues for airing consumer praise and complaints. However, this should be accompanied by reciprocal communication about the steps DHS or providers have taken to address enrollee concerns. Absence of two-way communication (i.e., complaint voiced, response provided) may lead enrollees to believe their concerns have been ignored and therefore will discourage this form of communication. Learning DHS and providers' perspectives on issues raised may offer enrollees an opportunity to better understand the difficulty of these roles.

Providers, staff and interpreters should be held accountable for disrespectful behavior and poor quality service. **DHS should require a mechanism for tallying complaints against clinic staff, interpreters and providers, along with stated consequences for those receiving an inordinate numbers of complaints.**

As cautioned above with regard to the Helpline and Ombudsman, unless patient feedback is a systematized or ritualized part of the health care encounter, it is impossible to assess how representative the feedback is. Consistent with suggestions above, **we recommend that plans developed for empowering patients, improving feedback and communication, and handling repeat problems in the delivery of health care be formulated in partnership with representatives of the community and enrollees.**

Provider practice style concerns, low confidence and trust in usual doctor

DHS should encourage training in Culturally and Linguistically Appropriate Services (CLAS) standards, cultural sensitivity and communications training beyond those that are currently mandated of providers receiving federal funds. In addition, some form of monitoring and evaluation should be implemented with real consequences for violations of 4 required CLAS standards. Currently only standards focusing on the availability of language services are mandated, whereas the remaining 10 standards concerned with culturally competent care and organizational supports for CLAS standards are simply "recommended."¹³ Training and monitoring should occur at all personnel levels; receptionists, interpreters, lab technicians, nurses, and physicians. However, cultural sensitivity or competency training without mechanisms for credentialing, enforcement, evaluating success and quality improvement diminishes the value of these activities for providers and enrollees. **One suggestion is that the Legislature raise reimbursement rates for plans and providers that put CLAS standards training, credentialing and evaluation systems in place.**

Furthermore, the legislature should consider increasing reimbursement rates to primary care providers such that payments are attractive enough to provide an incentive for physicians to serve the MHCP population and to ensure providers already dedicated to

¹³ U.S. Department of Health and Human Services, Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. Washington DC, March 2001 Available at: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>. Access April 20, 2009.

servicing enrollees are duly rewarded. Minnesota is one of only two states that did not increase Medicaid physician fees between 2003 and 2008, with 2008 rates falling below the national average.¹⁴ The goal may be to make payment rates high enough to avoid turnover of providers which interferes with enrollee’s ability to locate and establish rapport with a usual provider.

DHS should consider strategies conducive to enrollees establishing personal relationships with providers and clinic staff. The concept of “health care homes” currently being considered as part of Minnesota’s Health Care Reform Initiative may have relevance to MHCP enrollees in ameliorating these problems with rapport and care continuity. Health care homes offer a range of benefits to patients, including developing trusting relationships between patients/families and their health care provider, coordinating care, and providing connections with community organizations.

The cultivation of health care homes for MHCP enrollees can be undertaken in conjunction with reforming appointment scheduling. Specifically, longer appointments should be allocated for first appointments with a new provider and for patients with chronic health problems where communication about treatment plans that foster adherence is of utmost importance. Longer appointments would offer providers the opportunity to listen and learn more about patient’s preferences for information (i.e., full disclosure of what is being done and why versus only general information about the purpose of the visit so the patient does not fret, providing specifics only once the results are back), privacy (i.e., desire to have family members involved in certain aspects of the visit or consultation), shared decision making (allow doctor to decide what course of action is best or lay out options to reach joint decision), to name a few.

Perceptions of discrimination

Reports of discrimination (both racial and socioeconomic) also **suggest the relevance of cultural sensitivity education across the health care system (i.e., providers, clinic and agency staff) and the need for longer appointments to establish positive relationships with providers.** Although the survey data cannot validate this, focus group participants indicated that perceptions of discrimination are exacerbated by the aforementioned provider turnover and the limited amount of time providers have to spend with their patients.

If possible, DHS should be encouraged to use data collected through their periodic Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and the Minnesota Community Measurement reports¹⁵ to monitor provider group performance and report this to consumers to inform the choice of provider group or medical home. Enrollees should be made aware of these data in making choices about health plans and providers (see “Patient rights and responsibilities” section below). Unfortunately, these data are not reported by consumer race and ethnicity which impedes the ability to monitor this form of bias.

¹⁴ Zuckerman S, AF Williams, KE Stockley. Trends in Medicaid Physician Fees, 2003–2008. *Health Affairs*, 28(3):w510–w519, 2009.

¹⁵ Minnesota Community Measurement’s Health Care Disparities Report for Minnesota Health Care Programs, 2008 see: http://www.mncm.org/site/assets/reports/2008_Health%20Care%20Disparities%20Report_Final.pdf accessed May 20, 2009.

Availability, consistency, quality and privacy of interpreter services

Although the results suggest some improvements in interpreter services since the 2003 study, significant problems with availability and quality of these services continue. DHS should accelerate the process of certifying and training interpreters. **We recommend establishing a pay differential that rewards interpreters who are trained and certified in health literacy and consumer protection (privacy). The registry for interpreters being created is a logical mechanism for documenting training in health literacy and ethics.** Use of telephone interpreter services may be necessary to accommodate these requirements in rural areas. **DHS should improve enrollee awareness of mechanisms for reporting concerns about the quality of interpreter services received, develop a system for monitoring quality, and put in place consequences for quality violations** (see suggestions above for promoting the use of the Helpline or Ombudsman for reporting positive and negative experiences with interpreter services). Privacy emerged as an important concern in the 2008 results. It was recommended that interpreters be required to begin their session by describing to the patient the standards of privacy and confidentiality they are held to as well as the consequences of any violations of these standards. Patients should be instructed to call the Helpline if they feel these standards have been violated.

We also recommend automatically allocating longer appointment times whenever interpreter services are required. More time is always necessary for translation, and this extra time may garner the added benefits of establishing trusting relationships between the patient and provider. Furthermore, facilitating strategies to increase the likelihood that a patient has the same interpreter for all visits (if services are viewed as high quality) may lead to improved communication, care and outcomes overall.

Patient rights and responsibilities

Related to all of the barriers described above, **DHS should develop a brief and accessible guide for enrollees that spells out their rights and responsibilities as patients.** For example, they should be notified of their right to switch clinics and/or providers should they perceive they are treated with disrespect by providers or staff. Other rights and responsibilities may include:

- Their right to make an appointment with the same doctor should they establish a good relationship.
- Their right to transportation reimbursement, to having a family member in the room during visits, and to refuse an interpreter they do not trust.
- Their right to select a health plan or provider.
- Their responsibility to provide feedback about care and interpreter services they received.
- Their responsibility for cancelling appointments with as much notice as possible if it is not feasible to keep the appointment.
- Their right and responsibility to call the Helpline to verify enrollment status, find out whether a given service or procedure is covered, and whether and how much of a copayment will be charged.

- Their responsibility for asking questions if the information provided in clinic or over the Helpline is not clear.
- Their responsibility for seeking appropriate preventive care as well as their right to have guideline information made available by DHS or the health plan.
- Their responsibility to complete redetermination forms on time to continue enrollment.

This brief guidebook to enrollee or patient rights and responsibilities should be sent out at the same time as other benefit information, on the same color paper the plans decide to use to flag essential information. It should include a notice of the telephone numbers, in multiple languages, that enrollees can call for more information or where to look for details in the larger benefit booklet. This guidebook should also be made available and/or advertised in multiple formats: on the web, videos, public service announcements that direct listeners to the guidebook and other community-specific outreach and education venues.

Consistent with all other recommendations outlined above, this guide to enrollee rights and responsibilities should be developed and pretested with community members and enrollees, or at the very least professionals (CHWs, public health nurses, health system navigators) and advocacy groups that work closely with enrollees and have first hand experience with, and understanding of, enrollees' struggles and concerns. Similarly, the same informant groups should be called on to develop dissemination strategies.

Accountability

The need for open communication and accountability was a consistent and persistent message heard by the research team (e.g., in PMT meetings, focus groups, calls from survey respondents to the Principal Investigator). Any actions taken as a result of this and any other data collection efforts by DHS and health plans must be shared. Otherwise data collection is simply viewed as a waste of participants' time and energy. Enrollees report being "surveyed to death" to no good end. However, as discovered when DHS approached the team late in 2007 to replicate the 2003 enrollee survey, much had come of the prior survey in the area of expanded interpreter services, payment of community health workers, and monitoring of calls to the Helpline to improve the delivery of services. This was news to the research team.

DHS should set benchmarks for performance and report how well they are doing in meeting these goals, and work with community members to discover culturally appropriate mechanisms for sharing progress towards these goals. In addition, DHS is encouraged to figure out a way to use the contracting mechanism to foster innovation in care delivery. In addition to encouraging care innovation, DHS should encourage evaluations of innovations and tactics for communicating successes and challenges in meeting performance goals, guided by a process of consumer engagement described above.

Conclusions

Overall, the results support the following conclusions. First, the pattern of barriers uncovered in the 2003 study still persists, although there are some rather slight reductions in the proportions of

respondents reporting barriers. Second, concerns about cost and coverage are the most pronounced barriers, both in 2003 and in 2008. Third, the study also points to problems that impair effective communication between patients and providers. These include but are not limited to availability and quality of interpreter services. Other patient-provider issues include experiencing discrimination and feeling left out of medical decisions. Fourth, European Americans are less likely to report barriers than enrollees from other cultural groups. Among enrollees are especially likely to report barriers relative to their counterparts in other cultural groups. Fifth, across all cultural groups, adults are more likely to report barriers and problems in health care encounters than are parents of child enrollees. Sixth, barriers are related to use of services, reports of unmet need for medical care and delayed use of services.

We uncovered very little change over time in the use of services and disparities in service use. Similarly, there are few changes over time in barriers and disparities in experiences of barriers by cultural group. The fact that disparities between European Americans and other cultural groups have not grown can be viewed as positive, but should not be viewed as a signal of success. In the few instances where change did occur, it is in the right direction indicating improved access to care. However, while reductions in barriers and disparities are important goals, eliminating barriers and disparities are important goals to work toward and there is still much work ahead.

There are multiple targets for solutions to these problems as well as an acknowledgement that community members themselves can play a role in working toward improved service use, quality of the health care experience and health outcomes. Addressing the barriers identified in this study requires the commitment and creativity of all actors: the state legislature, DHS, health plans, providers, professional associations and societies, educational systems, community organizations and advocates, community members and enrollees. Solutions to these problems should be created with and informed by members of the communities and tailored to the needs of the communities affected. The challenge is to engage communities in a meaningful way that acknowledges their wisdom and in a manner that does not suggest or encourage competition for scarce resources across communities. This should not be difficult given that the results suggest similar barriers across all cultural groups. Although there are differences in the magnitude of barriers and concerns, no cultural group is sheltered from negative health care experiences.

Technical Appendix A: Methodology

The Sample

The sample was drawn from administrative records of all non-institutionalized persons enrolled in Minnesota Health Care Programs (MHCP) on March 31, 2008. We sorted the sample frame into five independent race/ethnic strata: Native Americans, African Americans, Somalis, Hmong, and Hispanic/Latinos. The remaining cases comprised a sixth heterogeneous stratum that was largely European Americans (88%) according to the race variable in the administrative data. Information about nationality, language, race and ethnicity from the enrollment files was used to sort enrollees into each stratum.

We further stratified by age to obtain samples of adult and child enrollees. Child enrollees were defined as people less than 18 years of age (based on date of birth) on the date of the sample draw. We selected equal numbers of adults and children within each of the sample strata (with a goal of approximately 333 completes per stratum) to ensure enough cases in each race/ethnicity by age group to produce precise estimates.

To reduce respondent burden and minimize the effects of sample clustering, the sample frame included only one person per household. We followed the sampling guidelines and protocols for surveying adults and children used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Survey (www.cahps.ahrq.gov). Briefly, once the sample frame was drawn, we removed duplicate household members from the list using the following procedure:

- Separate the sample into two groups, (A) adults and (B) children;
- Randomly select adults (from Group A) until there is a sample large enough to obtain the desired number of completed surveys (approximately 666 per stratum);
- Check the adult sample to ensure that there is only one adult per household;¹⁶
- Remove children (from Group B) who are in the same household as a selected adult;
- Randomly select children from Group B until there is enough sample to obtain the desired number of child interviews; and
- Check the children's sample to ensure that there is only one child per household.¹⁷

We anticipated the need to replace some sample due to poor contact information and ineligibility. We imposed a 2.625:1 sample pool to expected completion ratio to guide the sample pull. Stated differently, for every one expected complete, we chose 2.625 pieces of sample. Using this ratio, we require approximately 1,750 sampling elements in each stratum (875 adults

¹⁶ If more than one adult was selected with the same case ID, the second adult was replaced with the next adult case in the randomized sample frame.

¹⁷ If more than one child was selected with the same case ID, the second child was replaced with the next child case in the randomized sample frame.

and 875 children per stratum), with a total of approximately 10,500 elements. The sample was drawn May 5, 2008 after IRB approval was received from DHS and the University of Minnesota.

Data Collection

The 2008 study utilized a mixed mode methodology comprised of an initial contact by mail using the English version of the instrument and a telephone follow-up (available in English, Hmong, Spanish and Somali) to non-respondents.¹⁸ Mixed mode surveys are relatively common; for example, this is the method used with the CAHPS survey (Minnesota Department of Human Services 2001).

An initial mail survey was attractive because it is the least costly method, and address information in the sample frame provided by DHS is often more reliable than data in the telephone field. The possible downsides of a mail-only approach include that this takes longer to conduct, can generate response rates that are lower than telephone and face-to-face interviews (Steeh 1981), and may under-represent persons with low levels of education (Dillman 1978). A telephone follow-up can help overcome these limitations. Wilder Research Center (WRC) collected the data.

What follows is a detailed timeline of the data collection process:

- A sample of all active enrollees on March 31, 2008 was obtained from DHS.
- Pre-notification letters, adult: 5/28/08
- Pre-notification letters, child: 6/4/08
- 1st Mailing, adult and child (with \$2 incentive): Between 7/1/08 – 7/3/08
- Public announcement via print (newspapers and flyers) and radio: Starting 7/1/08 for approximately a 3 week period
- 2nd Mailing, adult and child: 7/22/08 – 7/24/08
- Pretesting English telephone instrument complete: 6/22/08
- Pretesting Hmong telephone instrument complete: 8/18/08
- Pretesting Spanish telephone instrument complete: 8/6/08
- Pretesting Somali telephone instrument complete: 8/31/08
- English telephone interviews begin: 8/4/08
- Hmong telephone interviews begin: 8/28/08
- Spanish telephone interviews begin: 8/22/08
- Somali telephone interviews begin: 9/20/08
- Data collection ended: 12/30/08
- WRC delivered the final combined data set to U.M.: 1/5/09
- WRC delivered the final sample disposition file to U.M.: 1/5/09

¹⁸ Instructions for completing the survey by telephone were printed on the cover page of the mail survey in all four languages with dedicated numbers for each language.

Data Collection Outcomes

Of the 10,500 cases released, only 45 were ruled ineligible.¹⁹ Of the 10,455 eligible cases, a total of 2,400 enrollees completed the mail survey, and 2,226 completed the telephone survey for a total of 4,626 respondents in the final sample. The overall response rate was calculated based on eligible households. Consistent with a vast literature documenting falling response rates over time, the overall response rate for the full sample in 2008 was 44.3%, down from 54.0% in 2003. This represents an 18% drop in the response rate between 2003 and 2008. This loss was greatest for African American and Somali strata, whereas we witnessed a response rate increase of 3% in the Hmong strata. (See Table 1 in the full report for response rate per stratum.)

Each year about 25% of the stratum that are majority European American complete the survey by telephone. As expected, the ethnic strata that may require a translated interview have a larger portion of the total surveys completed by telephone (which was administered in English, Hmong, Somali and Spanish), and a smaller portion completed by mail (which was only available in English). In addition to a greater portion of Hispanic/Latino, Hmong, and Somali interviews being completed by telephone in 2008, a smaller percentage of the telephone surveys were completed in English in 2008 compared with 2003. Specifically, whereas almost 32% of the Hispanic/Latino telephone interviews were completed in English in 2003, only 22% were completed in English in 2008.

Weighting and Post-stratification

The data were weighted to correct for unequal selection probabilities and post-stratified to match population controls (i.e., the sample universe of non-institutionalized enrollees March 31, 2008). Table A-1 below provides the information used to construct the sample expansion or base weights. Briefly, the number of completes and total number eligible in the sample per stratum and type of enrollee household are presented along with the percent distribution of completed interviews in contrast to their true distribution in the universe. In general, the probability of selection is calculated by dividing the number of completes by the total number of individuals eligible within each ethnic and age stratum. Given the goal of minimizing sample clustering described above, the probability of selection in our sample varies for households with adults only, households with child and adult enrollees, and households with only child enrollees. In several strata there were outliers in terms of the number of adult or child enrollees eligible for inclusion in the sample. The base weights were capped at 3 or more adult enrollees and 5 or more child enrollees per household, which has implications for post-stratification of the sample. This results in a range of probabilities of selection per strata and household type. In general, the probability of selection is lowest among those in the largest strata (African American and residual) and higher in strata that make up a smaller portion of the state and MHCP populations (Hmong and Somali).

¹⁹ A total of 224 were ruled ineligible in 2003, 121 of which were in institutional setting (e.g., jail, nursing homes). DHS screened out enrollees in institutional settings when providing the 2008 sample frame.

Table A-1: Contrast of completed interviews to sample universe

Stratum	Enrollees per household	Completes	%	Universe	%
African American					
	Adults only	183	4%	35,728	7%
	Adults and children	346	7%	34,487	6%
	Children only	102	2%	12,660	2%
American Indian					
	Adults only	164	4%	11,553	2%
	Adults and children	346	7%	8,762	2%
	Children only	132	3%	4,092	1%
Hispanic/Latino					
	Adults only	189	4%	11,070	2%
	Adults and children	306	7%	11,465	2%
	Children only	294	6%	18,045	3%
Hmong					
	Adults only	175	4%	9,039	2%
	Adults and children	776	17%	6,907	1%
	Children only	66	1%	841	0%
Somali					
	Adults only	164	4%	11,697	2%
	Adults and children	467	10%	6,521	1%
	Children only	70	2%	1,182	0%
Residual (Everyone else)					
	Adults only	312	7%	204,071	38%
	Adults and children	345	7%	92,940	17%
	Children only	189	4%	54,656	10%
Total		4,626	100%	535,716	100%

We next examined whether post-stratification was needed to represent the population from which the sample was drawn, or to account for differential response rates across key demographic variables in the enrollee populations. Table A-2 presents the comparison of the population distribution by race/ethnicity and age of enrollees compared to the sample distribution with only the base weights applied. As shown, particularly within the proportionally larger sample strata, adjusting for the base weights results in an underrepresentation of adults and over-representation of children. This indicates a need for some level of post-stratification in order to make the sample representative of the MHCP population.

Table A-2: Difference between the Population Distribution and Distribution with Sample Expansion Weights

Race/ethnicity by age	Population Distribution (a)	Weighted Sample (b)	Relative Difference (b-a)	Percent Difference
African American				
Adults	6.7%	4.3%	-2.3%	42.5%
Children	8.8%	12.3%	3.5%	-33.2%
American Indian				
Adults	2.2%	1.4%	-0.7%	40.0%
Children	2.4%	3.2%	0.8%	-27.0%
Hispanic/Latino				
Adults	2.1%	1.4%	-0.6%	36.6%
Children	5.5%	7.4%	1.9%	-28.9%
Hmong				
Adults	1.7%	1.6%	-0.1%	3.6%
Children	1.5%	3.0%	1.5%	-69.4%
Somali				
Adults	2.2%	1.7%	-0.5%	24.2%
Children	1.4%	2.7%	1.3%	-61.2%
Residual (Everyone else)				
Adults	38.1%	26.0%	-12.1%	37.9%
Children	27.6%	35.0%	7.4%	-23.7%
	100.0%	100.0%		

The minimum level of post-stratification adjustments that we considered was to ensure proper representation by age, sample strata and household size (given our decision to cap the number of child and adult enrollees in the expansion, or base weights). Additional adjustments to the data included post-stratifying by gender and metro versus non-metro residence. For the final sample weight, we made one last adjustment to the data to ensure appropriate representation of enrollees within the fee-for-service and managed care sectors.

Construction of Summary Measures and Recoded Variables

The Table below provides an overview of how variables were recoded for the analyses described in this report.

Table A-3. Summary of study measures

Measure	Survey Items*	Recode
Use of preventive care	3	1=More than 1 year ago; 0=other
Use of acute care	2	1=More than 1 year ago; 0=other
Use of mental health care	6	1=More than 1 year ago; 0=other
Use of dental care	7	1=More than 1 year ago; 0=other
Unmet need for care past year	4	1=Yes; 0=No
Delayed needed medical care past year	5	1=Yes; 0=No
Cost and coverage barriers	8K, 8L, 8N, 8P, 8Q, 8R, 8S	1=Big or Small Problem; 0=No problem
Access barriers	8A, 8C, 8D, 8F, 8G, 8I, 8J	1=Big or Small Problem; 0=No problem
Provider related barriers	8B, 8E 8H, 8M, 8O	1=Big or Small Problem; 0=No problem
Perceived discrimination	14A-14D	1=Sometimes, Usually, Always; 0=Never
Low confidence in own provider	12B-12F	1=Somewhat, Strongly Agree; 0=Somewhat, Strongly Disagree
Low trust in own provider	12a	1=Somewhat, Strongly Disagree; 0=Somewhat, Strongly Agree
Provider practice style	10A 10B-10D	1=Fair, Poor; 0=Good, Very Good Excellent 1=Sometimes, Never; 0=Usually, Always
Interpreter availability	15A	1=Never, Sometimes, Usually; 0=Always
Interpreter consistency	15B	1=Never, Sometimes, Usually; 0=Always
Interpreter quality	15C-15E	1=None, A little, Some 0=A lot
Interpreter privacy	15F	1=None, A little, Some 0=A lot
Depression screener	23A, 23B	0=Not at all, 1=Some or Several Days, 2=More than half the days, 3=Nearly Every Day; Positive Screen if (23a+23b) greater than or equal to 3
Self-assessed health	1	1=Fair/Poor; 0=Good, Very Good, Excellent
Self-assessed emotional health	24	1=Fair/Poor; 0=Good, Very Good, Excellent
Limited in activities due to health	21	1=Yes, 0=No
*Question number refers to adult survey		

In the telephone survey, response categories for questions related to interpreter quality and privacy were erroneously read as “never, sometimes, usually, or always.” It is difficult to assess the potential bias this may introduce because telephone respondents were also different than mail respondents on demographic characteristics such as language and race/ethnicity.

The primary classificatory variable in the analyses is race/ethnicity based on respondents’ self-reports (as opposed to their racial and ethnic designations in the administrative files). We see race and ethnicity categories as social groupings and not biological constructs. Rather than use the terms race and ethnicity, we refer to cultural groups within this report. The Office of Management and Budget (OMB) guidelines were used to re-categorize those who reported multiple races into one race/ethnic category using the ‘whole assignment, smallest group’ method. Briefly, this OMB standard recommends that if two responses are chosen, and one is White/European American, the minority race can be assigned. Using this method, when a respondent selected multiple racial categories, the response is assigned to the smallest group. For example, if a respondent marked both African American and Native American, the Native American category was assigned due to this group’s smaller representation in the Minnesota population. The respondent’s ethnicity (Hispanic/Latino, Hmong, or Somali) was assigned before race and takes priority over race. Where race/ethnicity was missing in the survey data, we assigned the value from the administrative data. Using these decisions rules, the race/ethnicity categories (referred to as cultural groups) in this study are: European American, Native American, US born African American, Hispanic/Latino, Hmong, Somali, other foreign born African, and non-Hmong Asian/Pacific Islander. The sample sizes for the latter two groups were too small to provide reliable results in the report and therefore are not presented.

Analyzing the Data

There were two stages to the analysis. In the first stage we describe the health status, health care experiences, health care utilization and barriers to care for the population enrolled in MHCP in 2008. We examined whether there were differences between adult and child enrollees in MHCP and whether cultural groups differ in their health care experiences. To examine whether differences in utilization of services may be due to sociodemographic factors or health status, we present multivariate analyses that control for these factors. Finally, we examined whether perceived barriers and problems are correlated with utilization patterns. Bivariate differences were assessed through two-sided t-tests. Multivariate results were assessed through logistic regression. Results that reached a p-value of ≤ 0.05 were regarded as statistically significant.

In the second stage of analyses, we examined whether there have been changes in the health status, health care experiences, health care utilization or barriers to care from 2003 to 2008. We focused these analyses on measures that were comparable over the two time periods. Because of the way we sampled in 2003, these analyses were restricted to persons enrolled in managed care. As presented in Table A-4, sample loss due to this restriction varies by age and cultural group with the highest level of loss among Native American adult and child enrollees, followed by African American and Hmong adults. Because a smaller proportion of respondents were enrolled

in managed care in 2008, restricting the analyses result in a greater reduction of sample size in the 2008 data compared to 2003.

Table A-4. Count of respondents who were in managed care programs by age, cultural group, and year

	Managed Care			All Respondents			% included in Managed Care		
	2003	2008	Total	2003	2008	Total	2003	2008	Total
Adults									
European American	847	273	1120	987	408	1,395	86%	67%	80%
Native American	243	147	390	358	316	674	68%	47%	58%
African American	228	125	353	321	241	562	71%	52%	63%
Hispanic/Latino	194	238	432	220	361	581	88%	66%	74%
Hmong	399	285	684	513	456	969	78%	63%	71%
Somali	338	211	549	388	295	683	87%	72%	80%
Children									
European American	364	288	652	398	378	776	91%	76%	84%
Native American	143	167	310	202	330	532	71%	51%	58%
African American	286	163	449	316	224	540	91%	73%	83%
Hispanic/Latino	490	362	852	528	445	973	93%	81%	88%
Hmong	191	504	695	201	555	756	95%	91%	92%
Somali	169	353	522	192	403	595	88%	88%	88%

We assessed whether any changes were due to differences in the sociodemographic characteristics or health status of enrollees in each year through multivariate analyses. Finally, we examined whether disparities (defined as differences between the experiences of European Americans and other cultural groups) changed between 2003 and 2008. Unadjusted odds ratios for year of the survey that were significant at the 0.05 level were used to identify significant change over time. Time by cultural group (with European Americans as the reference group) interaction terms were computed to assess whether disparities between groups changed over time. All analysis used software to adjust standard errors to account for the complex sampling design.

Technical Appendix B:
English Versions of Adult and Child Telephone Surveys

**Health Care In Minnesota
Adult Survey**

Activity Code: 70911

May I please speak to (RESPONDENT NAME)?

My name is _____ and I'm calling from Wilder Research. We are working with the Minnesota Department of Human Services and the University of Minnesota School of Public Health on a study to help us better understand the problems people have getting health care. You were selected at random from a list of all people who have been enrolled in one of Minnesota's State Health Care Programs. You may remember receiving a survey in the mail about this – it had a \$2 bill in the envelope. We are following up because we did not receive a completed survey from you yet.

This survey takes about 15 to 20 minutes, depending on your answers. Would this be a good time or would another time be better?

Before we start, let me tell you that everything you say is completely confidential and will be seen only by the research team. Your answers will not affect the health care or health plan you receive or may receive in the future. The researcher in charge of this study is Dr. Kathleen Call; you may have her phone number if you wish to write it down (612-624-3922). If you have any questions as we go along, please feel free to stop me. Or if there is a question you don't want to answer, let me know and we can skip it.

If you have questions regarding this survey and would like to talk to someone other than the researcher, you can call the Research Subjects' Advocate line at 612-625-1650. You may call collect.

IF NEEDED: All individual responses will be kept at the University of Minnesota as secured research files identified with numbers, not names.

**Health Care In Minnesota
Adult Survey**

First, we have just a few questions about your health and use of health care services.

1. In general, how would you rate your overall health? Would you say it is... (DO NOT READ UNLESS NEEDED)

Excellent,	1
Very good,	2
Good,	3
Fair, or.....	4
Poor?	5
Refused	7
Don't know	8

2. About how long has it been since you went to a doctor or clinic to get care for an illness or injury? (DO NOT READ UNLESS NEEDED)

Within the past year	1
More than 1 year, but less than 3 years.....	2
3 to 5 years.....	3
More than 5 years	4
Refused	7
Don't know	8

3. About how long has it been since you went to a doctor or clinic for regular or routine care? By regular or routine care, we mean things like physical checkups, blood pressure or cholesterol checks, mammograms, pap smears, or other types of preventive care.

Within the past year	1
More than 1 year, but less than 3 years.....	2
3 to 5 years.....	3
More than 5 years	4
Refused	7
Don't know	8

4.	Was there anytime <u>during the past year</u> when you needed medical care but did not get it?	
	Yes.....	1
	No	2
	Refused	7
	Don't know	8
5.	Was there anytime <u>during the past year</u> that you <u>delayed</u> getting medical care you felt you needed?	
	Yes.....	1
	No	2
	Refused	7
	Don't know	8
6.	<u>During the past year</u> , have you seen a psychiatrist, psychologist, social worker, psychiatric nurse, counselor, or other doctor for an emotional or mental health problem?	
	Yes.....	1
	No	2
	Refused	7
	Don't know	8
7.	<u>During the past year</u> , did you go to the dentist?	
	Yes.....(GO TO Q. 7a).....	1
	No(GO TO Q. 7b).....	2
	Refused(GO TO Q. 8).....	7
	Don't know(GO TO Q. 8).....	8
7a.	How much of a problem was it for you to get dental care? Was it...	
	A big problem,.....(GO TO Q. 8).....	1
	A small problem, or(GO TO Q. 8).....	2
	Not a problem?(GO TO Q. 8).....	3
	Refused(GO TO Q. 8).....	7
	Don't know(GO TO Q. 8).....	8

7b. What is the main reason you did not go to the dentist during the past year? Would you say...

- You couldn't find a dentist who would accept you as a patient, 1
- You couldn't get an appointment at a time you could go, 2
- You didn't need any dental care in the past year, 3
- You didn't know your Minnesota Health Care Program paid for dental care,
(IF NEEDED: By Minnesota Health Care Program we mean Medicaid,
Medical Assistance, MinnesotaCare, or GAMC), or 4
- Was there some other reason you didn't go to the dentist in the past year?
What was that reason: _____).....5
- Refused 7
- Don't know 8

8. People sometimes have problems getting health care. For each of the following items, please tell me if it is a big problem, a small problem, or not a problem for you in getting the health care you need.

What about...	Is that a...				
	A big problem,	A small problem, or	Not a problem for you?	REF	DK
a. Difficulties with transportation such as getting to the doctor's office or clinic?	1	2	3	7	8
b. The doctors don't speak the same language that you do?	1	2	3	7	8
c. Getting an appointment as soon as you need?	1	2	3	7	8
d. Knowing where to go?	1	2	3	7	8
e. Doctors don't understand your culture?	1	2	3	7	8
f. Work or family responsibilities make it difficult for you to get the health care you need?	1	2	3	7	8
g. The doctor's office or clinic isn't open when you can go?	1	2	3	7	8
h. Doctors don't respect your religious beliefs?	1	2	3	7	8
i. Finding someone to take care of your children makes it difficult to get the health care you need?	1	2	3	7	8
j. You can't see the doctor you want to see?	1	2	3	7	8
k. You worry that your insurance won't cover the care you might receive?	1	2	3	7	8
l. You worry that you will have to pay more for the care than you expect, such as additional charges besides co-pays?	1	2	3	7	8
m. You worry that doctors are not trustworthy?	1	2	3	7	8
n. You worry that your prescription medications will cost too much?	1	2	3	7	8

What about...	Is that a...				
	A big problem,	A small problem, or	Not a problem for you?	REF	DK
o. You think the place you go to get health care is not very welcoming?	1	2	3	7	8
p. You are not sure from month to month whether you might have been dropped from your Minnesota Health Care Program?	1	2	3	7	8
q. You do not know what services your health plan covers?	1	2	3	7	8
r. You do not know where to go for help when you have questions about health care?	1	2	3	7	8
s. You worry that you will have to pay more for care than you can afford?	1	2	3	7	8

Usual Source of Care

The next questions ask about the place you usually go for health care. While there are many types of health care, in this survey we are referring to care provided by doctors or physicians, as well as nurse practitioners, physician assistants, and nurses.

9. Which of the following places best describes where you usually go for your health care? Is it... (CIRCLE ONE)

- A doctor's office or clinic, 1
- An emergency room, 2
- An urgent care center, 3
- A hospital, 4
- An outpatient clinic in a hospital, 5
- A community health center, 6
- An Indian health center, or 7
- Something else? (Specify: _____) 8
- Refused -7
- Don't know -8

10a. Thinking about the place you usually go for health care, how would you rate how well the doctor or other health care provider explained things in a way you could understand? Would you say their explanation was...

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or..... 4
- Poor? 5
- Refused 7
- Don't know 8

10b. Thinking about the place you usually go for health care, how often did your doctor or other health care provider really find out what your concerns are? Would you say...

- Never,..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

10c. Thinking about the place you usually go for health care, how often did your doctor or other health care provider spend enough time with you to address your health concerns? Would you say...

- Never,..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

10d. Thinking about the place you usually go for health care, how often did your doctor or other health care provider treat you as a partner in making health care decisions? Would you say...

- Never,..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

11. Is the doctor or health care provider that you usually go to the same race or ethnicity as you?

- Yes 1
- No 2
- Volunteered: No Usual doctor or health care provider..... 3
 - Refused 7
 - Don't know 8

Still thinking about the doctor or health provider you usually see, for each of the next statements, please tell me if you agree or disagree.

12a. I trust that my doctor or other health care provider has my best interests in mind when making health care decisions. Do you...

- | | |
|------------------|-------------------------------|
| Agree, or..... | Would you say you... |
| | Strongly agree, or 1 |
| | Somewhat agree? 2 |
| Disagree? | Would you say you... |
| | Somewhat disagree, or 3 |
| | Strongly disagree?..... 4 |
| Refused | 7 |
| Don't know | 8 |

12b. I am afraid that my provider might not do enough to find out what is really making me sick. Do you...

- | | |
|------------------|-------------------------------|
| Agree, or..... | Would you say you... |
| | Strongly agree, or 1 |
| | Somewhat agree? 2 |
| Disagree? | Would you say you... |
| | Somewhat disagree, or 3 |
| | Strongly disagree?..... 4 |
| Refused | 7 |
| Don't know | 8 |

12c. I am afraid that the health care I receive might actually make me feel worse. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

12d. I am afraid that my provider might tell me that I have an illness I don't really have. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

12e. I am afraid that my provider might not find an illness I do have. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

12f. I am afraid my provider might not do enough to help me feel better. Do you...

- Agree, or.....Would you say you...
 Strongly agree, or..... 1
 Somewhat agree? 2
- Disagree?Would you say you...
 Somewhat disagree, or 3
 Strongly disagree?..... 4
- Refused 7
 Don't know 8

Overall Experience With Health Care

Now thinking about your health and health care providers in general...

13. Overall, how would you rate your health care? Would you say...

- Excellent, 1
 Very good, 2
 Good, 3
 Fair, or..... 4
 Poor? 5
 Refused 7
 Don't know 8

14. For each of the following, please tell me how often you think it causes health care providers to treat you unfairly.

What about...	Do you think this causes health care providers to treat you unfairly...					
	Never,	Sometimes,	Usually, or	Always?	REF	DK
a. Your race, ethnicity, or nationality?	1	2	3	4	7	8
b. Your ability to pay?	1	2	3	4	7	8
c. Your sex or gender?	1	2	3	4	7	8
d. Being enrolled in a Minnesota Health Care Program? (IF NEEDED: By Minnesota Health Care Program we mean Medicaid, Medical Assistance, MinnesotaCare, or GAMC)	1	2	3	4	7	8

15. Do you ever need an interpreter to help you speak with doctors or other health care providers due to language difficulties?

- Yes..... 1
 No(GO TO Q. 16)..... 2
 Refused(GO TO Q. 16)..... 7
 Don't know(GO TO Q. 16)..... 8

	Would you say...					
	Never,	Sometimes,	Usually, or	Always?	REF	DK
15a. When you need an interpreter, how often is one provided for you?	1	2	3	4	7	8
15b. How often do you get the <u>same</u> interpreter when you go to the doctor?	1	2	3	4	7	8

	Would you say...					
	None,	A little,	Some, or	A lot?	REF	DK
15c. How much does having an interpreter help you understand what the doctor is asking you?	1	2	3	4	7	8
15d. How much does having an interpreter help the doctor understand what you are trying to tell them?	1	2	3	4	7	8
15e. How much does having an interpreter help you understand what is being done?	1	2	3	4	7	8
15f. How much do you worry your interpreter will not keep what you say private?	1	2	3	4	7	8

15g. Who do you usually have as your interpreter when you get health care? (DO NOT READ)

- Family member..... 1
 Friend..... 2
 Professional interpreter 3
 Someone else (Specify: _____)..... 4
 Refused 7
 Don't know 8

16. For each of the following, please tell me how important they are to keep you from getting sick.

What about...	Would you say that is...				
	Very important,	Somewhat important, or	Not important at all to keep you from getting sick?	REF	DK
a. Visiting a spiritual or traditional healer or shaman	1	2	3	7	8
b. Visiting a chiropractor	1	2	3	7	8
c. Visiting an alternative or complementary health care provider such as an acupuncturist or herbalist	1	2	3	7	8
d. Visiting a doctor or clinic for a <u>regular check-up</u> or physical exam	1	2	3	7	8

17. How often do you worry about going to the doctor or clinic for a check-up because you might get bad news? Would you say...

- Never,..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

18a. People differ a lot in their feelings about professional help for emotional problems. If you had a serious emotional problem, would you...

- Definitely go for professional help, 1
- Probably go,..... 2
- Probably not go, or 3
- Definitely not go for professional help? 4
- Refused 7
- Don't know 8

- 18b. How embarrassed would you be if your friends knew you were getting professional help for an emotional problem? Would you say...
- Very embarrassed, 1
 - Somewhat embarrassed,..... 2
 - Not very embarrassed, or 3
 - Not at all embarrassed? 4
 - Refused 7
 - Don't know 8

The next two questions are about the past year.

- 19a. Thinking about all of the experiences you have had with health care visits during the past year, have you experienced discrimination because of your race or skin color?

- Yes 1
- No 2
- Refused 7
- Don't know 8

- 19b. Thinking about all of the experiences you have had with health care visits during the past year, have you experienced discrimination because of your enrollment in a Minnesota Health Care Program?

- Yes 1
- No 2
- Refused 7
- Don't know 8

Your Health

20. Now thinking about your health, in general, would you say your health is...
- Above average, 1
 - About average, or..... 2
 - Below average?..... 3
 - Refused 7
 - Don't know 8

21. Are you limited in any way in any activities because of physical, mental, or emotional problems?
- Yes 1
 - No 2
 - Refused 7
 - Don't know 8

22. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
- _____ Days
- Refused -7
 - Don't know -8

The next two questions ask you to think about the past 2 weeks.

- 23a. During the past 2 weeks, how often have you been bothered by having little interest or little pleasure in doing things? Would you say...
- Not at all, 1
 - Some days,..... 2
 - Several days,..... 3
 - More than half the days, or 4
 - Nearly every day? 5
 - Refused 7
 - Don't know 8

23b. During the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?
Would you say...

- Not at all, 1
- Some days, 2
- Several days, 3
- More than half the days, or 4
- Nearly every day? 5
- Refused 7
- Don't know 8

24. Overall, how would you rate your **emotional** health? Would you say...

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or 4
- Poor? 5
- Refused 7
- Don't know 8

Finally, to help our staff interpret these results, I have a few questions about you.

25. ONLY ASK IF NEEDED: What is your gender?

- Male 1
- Female 2
- Refused 7
- Don't know 8

26. How old are you?

- _____ Years
- Refused -7
- Don't know -8

27. Are you currently...

Single, never married,.....	1
Living with a partner in a marriage-like relationship,	2
Married,	3
Separated,.....	4
Divorced, or	5
Widowed?	6
Refused	7
Don't know	8

28. Are you a member of any of the following groups? What about...

	Yes	No	REF	DK
a. Hispanic or Latino,	1	2	7	8
b. Hmong, or	1	2	7	8
c. Somali?	1	2	7	8

29. Which of the following best describes you? Would you say...

	Yes	No	REF	DK
1. White or European American,	1	2	7	8
2. Black or African American,	1	2	7	8
3. American Indian or Alaskan Native,	1	2	7	8
4. Native Hawaiian or Pacific Islander,	1	2	7	8
5. Asian, or	1	2	7	8
6. Or something else? (Specify: _____)	1	2	7	8

30. Which of the following best describes you? Would you say you are...

Retired,.....	1
Unable to work because of a disability,	2
A student,	3
Not currently working for pay,	4
Working part-time, less than 35 hours a week, or	5
Working full-time, 35 or more hours a week?	6
Refused	7
Don't know	8

31. Are you currently enrolled in one of Minnesota’s Health Care Programs such as Medicaid, Medical Assistance, MinnesotaCare, or GAMC? Would you say...

Yes, I am currently enrolled,	1
No, but I was enrolled in the past, or	2
No, I have never been enrolled?	3
Refused	7
Don’t know	8

32. What is the highest grade or level of school you have completed?

Never attended school.....	1
Elementary school (grades 1 through 8).....	2
Some high school (grades 9 through 12).....	3
High school graduate or GED.....	4
Technical or vocational school	5
Some college or Associate degree	6
Four year college degree (Bachelor’s).....	7
Graduate or professional degree	8
Something else(Specify: _____).....	9
Refused	-7
Don’t know	-8

33. Were you born in the United States?

Yes	(GO TO Q. 34).....	1
No		2
Refused	(GO TO Q. 34).....	7
Don’t know	(GO TO Q. 34).....	8

33a. How long have you lived in the United States?

_____ Years	
Refused	-7
Don’t know	-8

33b. What country were you born in?

_____ Country	
Refused	-7
Don't know	-8

34. What language do you usually speak at home?

English	1
Spanish.....	2
Hmong	3
Somali	4
Other (Specify: _____).....	5
Refused	7
Don't know	8

35. Other than the pre-notification letter we sent to you, where have you seen or heard about this study?
(Mark all that apply.)

Radio (Specify station: _____)	1
Local newspaper, (Specify: _____)	2
Flyer in the community or an announcement at community center or church, (Specify location: _____).....	3
Other (Specify: _____).....	4
Never heard about this study	5
Refused	7
Don't know	8

That was the last question. Thank you so much for taking the time to answer these questions.

If you have any further comments, I can note them now.

**Health Care In Minnesota
Child Survey**

Activity Code: 70911

May I please speak to (RESPONDENT NAME)?

My name is _____ and I'm calling from Wilder Research. We are working with the Minnesota Department of Human Services and the University of Minnesota School of Public Health on a study to help us better understand the problems people have getting health care. Your child was selected at random from a list of all people who have been enrolled in one of Minnesota's State Health Care Programs. You may remember receiving a survey in the mail about this – it had a \$2 bill in the envelope. We are following up because we did not receive a completed survey from you yet.

I would like to ask you some questions about your child's healthcare. This survey takes about 15 to 20 minutes depending on your answers. Would this be a good time or would another time be better?

Before we start, let me tell you that everything you say is completely confidential and will be seen only by the research team. Your answers will not affect the health care or health plan you receive or may receive in the future. The researcher in charge of this study is Dr. Kathleen Call; you may have her phone number if you wish to write it down (612-624-3922). If you have any questions as we go along, please feel free to stop me. Or if there is a question you don't want to answer, let me know and we can skip it.

If you have questions regarding this survey and would like to talk to someone other than the researcher, you can call the Research Subjects' Advocate line at 612-625-1650. You may call collect.

IF NEEDED: All individual responses will be kept at the University of Minnesota as secured research files identified with numbers, not names.

Before we begin, I would like to make sure I have the correct information about your child. Is your child's name _____?

IF YES: CONTINUE WITH SURVEY

IF NO: ASK IF RESPONDENT KNOWS CHILD OR WHO WE SHOULD CALL. IF NOT, "I'm sorry, we have called you by mistake. Thank you for your time."

**Health Care In Minnesota
Youth Survey**

Although you may have more than one child, please answer only for {CHILD}. First, I have just a few questions about your child’s health and use of health care services.

1. In general, how would you rate his/her overall health? Would you say it is...(DO NOT READ UNLESS NEEDED)

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or..... 4
- Poor? 5
- Refused 7
- Don’t know 8

2. About how long has it been since {CHILD} went to a doctor or clinic to get care for an illness or injury? (DO NOT READ UNLESS NEEDED)

- Within the past year 1
- More than 1 year, but less than 3 years..... 2
- 3 to 5 years..... 3
- More than 5 years 4
- Refused 7
- Don’t know 8

3. About how long has it been since he/she went to a doctor or clinic for regular or routine care? By regular or routine care, we mean things like physical checkups, vaccinations, or other types of preventive care.

- Within the past year 1
- More than 1 year, but less than 3 years..... 2
- 3 to 5 years..... 3
- More than 5 years 4
- Refused 7
- Don’t know 8

4. Was there anytime during the past year when he/she needed medical care but did not get it?
- Yes 1
- No 2
- Refused 7
- Don't know 8
5. Was there anytime during the past year that you delayed getting medical care you felt {CHILD} needed?
- Yes 1
- No 2
- Refused 7
- Don't know 8
6. During the past year, has he/she seen a psychiatrist, psychologist, social worker, psychiatric nurse, counselor, or, other doctor for an emotional or mental health problem?
- Yes 1
- No 2
- Refused 7
- Don't know 8
7. During the past year, did {CHILD} go to the dentist?
- Yes (GO TO Q. 7a) 1
- No (GO TO Q. 7b) 2
- Refused (GO TO Q. 8) 7
- Don't know (GO TO Q. 8) 8
- 7a. How much of a problem was it for him/her to get dental care? Was it...
- A big problem, (GO TO Q. 8) 1
- A small problem, or (GO TO Q. 8) 2
- Not a problem? (GO TO Q. 8) 3
- Refused (GO TO Q. 8) 7
- Don't know (GO TO Q. 8) 8

7b. What is the main reason your child did not go to the dentist during the past year? Would you say...

- You couldn't find a dentist who would accept your child as a patient, 1
- You couldn't get an appointment at a time your child could go,..... 2
- {CHILD} didn't need any dental care in the past year, 3
- You didn't know his/her Minnesota Health Care Program paid for dental care, (IF NEEDED: By Minnesota Health Care Program we mean Medicaid, Medical Assistance, MinnesotaCare, or GAMC), or 4
- Was there some other reason your child didn't go to the dentist in the past year? What was that reason: _____). 5
- Refused 7
- Don't know 8

8. People sometimes have problems getting health care. For each of the following items, please tell me if it is a big problem, a small problem, or not a problem for {CHILD} in getting the health care he/she needs.

What about...	Is that a...				
	A big problem,	A small problem, or	Not a problem for you and your child?	REF	DK
a. Difficulties with transportation such as getting to the doctor's office or clinic?	1	2	3	7	8
b. The doctors don't speak the same language as you or your child?	1	2	3	7	8
c. Getting an appointment as soon as your child needs one?	1	2	3	7	8
d. Knowing where to go?	1	2	3	7	8
e. Doctors don't understand your child's culture?	1	2	3	7	8
f. Work or family responsibilities make it difficult for you to get the health care your child needs?	1	2	3	7	8
g. The doctor's office or clinic isn't open when you or your child can go?	1	2	3	7	8
h. Doctors don't respect your child's religious beliefs?	1	2	3	7	8
i. Finding someone to take care of your other children makes it difficult to get the health care {CHILD} needs?	1	2	3	7	8
j. {CHILD} can't see the doctor you want him/her to see?	1	2	3	7	8
k. You worry that your child's insurance won't cover the care {CHILD} might receive?	1	2	3	7	8

	In that a...				
	A big problem,	A small problem, or	Not a problem for you and your child?	REF	DK
l. You worry that you will have to pay more for your child's care than you expect, such as charges besides co-pays?	1	2	3	7	8
m. You worry that doctors are not trustworthy?	1	2	3	7	8
n. You worry that your child's prescription medications will cost too much?	1	2	3	7	8
o. You think the place your child goes to get health care is not very welcoming?	1	2	3	7	8
p. You are not sure from month to month whether your child might have been dropped from his/her Minnesota Health Care Program?	1	2	3	7	8
q. You do not know what services your child's health plan covers?	1	2	3	7	8
r. You do not know where to go for help when you have questions about your child's health care?	1	2	3	7	8
s. You worry that you will have to pay more for your child's care than you can afford?	1	2	3	7	8

The next two questions are about older children, but please answer them regardless of the age of your child.

8t. When {CHILD} goes to the doctor or clinic, how often do you go with him/her? Would you say...

- Never..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

8u.

When you go with {CHILD} to the doctor or clinic, how often do you go with him/her into the examination room? Would you say...

- Never..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

Your Child's Usual Source of Care

The next questions ask about the place your child usually goes for health care. While there are many types of health care, in this survey we are referring to care provided by doctors or physicians, as well as nurse practitioners, physician assistants, and nurses.

9. Which of the following places best describes where {CHILD} usually goes for health care? (CIRCLE ONE) Is it...

- A doctor's office or clinic,..... 1
- An emergency room,..... 2
- An urgent care center,..... 3
- A hospital,..... 4
- An outpatient clinic in a hospital, 5
- A community health center,..... 6
- An Indian health center, or 7
- Something else? Specify: _____)..... 8
- Refused-7
- Don't know-8

10a. Thinking about the place your child usually goes for health care, how would you rate how well the doctor or other health care provider explained things in a way you or your child could understand? Would you say their explanation was...

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or..... 4
- Poor? 5
- Refused 7
- Don't know 8

10b. Thinking about the place your child usually goes for health care, how often did your child’s doctor or other health care provider really find out what the concerns about your child’s health are? Would you say...

Never,..... 1

Sometimes,..... 2

Usually, or..... 3

Always? 4

Refused 7

Don’t know 8

10c. Thinking about the place your child usually goes for health care, how often did your child’s doctor or other health care provider spend enough time to address concerns about your child’s health? Would you say...

Never,..... 1

Sometimes,..... 2

Usually, or..... 3

Always? 4

Refused 7

Don’t know 8

10d. Thinking about the place your child usually goes for health care, how often did his/her doctor or other health care provider treat you or your child as a partner in making health care decisions? Would you say...

Never,..... 1

Sometimes,..... 2

Usually, or..... 3

Always? 4

Refused 7

Don’t know 8

11. Is the doctor or health care provider that your child usually goes to the same race or ethnicity as your child?

Yes 1

No 2

Volunteered: No Usual doctor or health care provider..... 3

Refused 7

Don’t know 8

Still thinking about the doctor or health provider your child usually sees, for each of the next statements, please tell me if you agree or disagree.

12a. I trust that my child’s doctor or other health care provider has {CHILD} best interests in mind when making health care decisions. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don’t know	8

12b. I am afraid that {CHILD} provider might not do enough to find out what is really making him/her sick. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don’t know	8

12c. I am afraid that the health care {CHILD} receives might actually make him/her feel worse. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or..... 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don’t know	8

12d. I am afraid that the provider might tell me that {CHILD} has an illness he/she doesn't really have. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

12e. I am afraid that {CHILD} provider might not find an illness he/she does have. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

12f. I am afraid the provider might not do enough to help {CHILD} feel better. Do you...

Agree, or.....	Would you say you...
	Strongly agree, or 1
	Somewhat agree? 2
Disagree?	Would you say you...
	Somewhat disagree, or 3
	Strongly disagree?..... 4
Refused	7
Don't know	8

Your Child's Overall Experience With Health Care

Now thinking about your child's health and health care providers in general...

13. Overall, how would you rate your child's health care? Would you say ...

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or..... 4
- Poor? 5
- Refused 7
- Don't know 8

14. For each of the following, please tell me how often you think it causes health care providers to treat your child unfairly.

	Would you say this causes health care providers to treat him/her unfairly...					
	Never,	Sometimes,	Usually, or	Always?	REF	DK
a. Your child's race, ethnicity, or nationality?	1	2	3	4	7	8
b. Your ability to pay?	1	2	3	4	7	8
c. Your child's sex or gender?	1	2	3	4	7	8
d. Being enrolled in a Minnesota Health Care Program? (IF NEEDED: By Minnesota Health Care Program we mean Medicaid, Medical Assistance, MinnesotaCare, or GAMC)	1	2	3	4	7	8

15. Do you or your child ever need an interpreter to help speak with doctors or other health care providers due to language difficulties?

- Yes..... 1
 No(GO TO Q. 16)..... 2
 Refused(GO TO Q. 16)..... 7
 Don't know(GO TO Q. 16)..... 8

	Would you say...					
	Never,	Sometimes,	Usually, or	Always?	REF	DK
15a. When you or your child need an interpreter, how often is one provided for you?	1	2	3	4	7	8
15b. How often do you get the <u>same</u> interpreter when your child goes to the doctor?	1	2	3	4	7	8

	Would you say...					
	None,	A little,	Some, or	A lot?	REF	DK
15c. How much does having an interpreter help you or your child understand what the doctor is asking?	1	2	3	4	7	8
15d. How much does having an interpreter help the doctor understand what you or your child are trying to tell them?	1	2	3	4	7	8
15e. How much does having an interpreter help you or your child understand what is being done?	1	2	3	4	7	8
15f. How much do you worry your interpreter will not keep what you or your child say private?	1	2	3	4	7	8

15g. Who do you or your child usually have as your interpreter when your child gets health care?

- Family member..... 1
 Friend..... 2
 Professional interpreter 3
 Someone else (Specify: _____)..... 4
 Refused 7
 Don't know 8

16. For each of the following, please tell me how important they are to keep your child from getting sick.

What about...	Would you say...				
	Very important,	Somewhat important, or	Not important at all to keep your child from getting sick?	REF	DK
a. Visiting a spiritual or traditional healer or shaman	1	2	3	7	8
b. Visiting a chiropractor	1	2	3	7	8
c. Visiting an alternative or complementary health care provider such as an acupuncturist or herbalist	1	2	3	7	8
d. Visiting a doctor or clinic for a <u>regular check-up</u> or physical exam	1	2	3	7	8

17. How often do you worry about taking {CHILD} to the doctor or clinic for a check-up because you might get bad news about him/her? Would you say...

- Never,..... 1
- Sometimes,..... 2
- Usually, or..... 3
- Always? 4
- Refused 7
- Don't know 8

18a. People differ a lot in their feelings about professional help for emotional problems. If your child had a serious emotional problem, would you...

- Definitely go for professional help, 1
- Probably go, 2
- Probably not go, or 3
- Definitely not go for professional help? 4
- Refused 7
- Don't know 8

18b. How embarrassed would you be if your friends knew your child was getting professional help for an emotional problem? Would you say...

- Very embarrassed, 1
- Somewhat embarrassed,..... 2
- Not very embarrassed, or 3
- Not at all embarrassed? 4
- Refused 7
- Don't know 8

The next two questions are about the past year.

19a. Thinking about all of the experiences {CHILD} has had with health care visits during the past year, has he/she experienced discrimination because of his/her race or skin color?

- Yes 1
- No 2
- Refused 7
- Don't know 8

19b. Thinking about all of the experiences {CHILD} has had with health care visits during the past year, has he/she experienced discrimination because of his/her enrollment in a Minnesota Health Care Program?

- Yes 1
- No 2
- Refused 7
- Don't know 8

Your Child's Health

Now, thinking about your child's health...

20. In general, would you say that {CHILD} health is...

- Above average, 1
- About average, or..... 2
- Below average? 3
- Refused 7
- Don't know 8

21. Is {CHILD} limited in any way in any activities because of physical, mental, or emotional problems?
- Yes 1
- No 2
- Refused 7
- Don't know 8
22. Thinking about your child's physical health, which includes physical illness and injury, for how many days during the past 30 days was his/her physical health not good?
- _____ Days
- Refused -7
- Don't know -8

The next two questions ask you to think about the past 2 weeks.

- 23a. During the past 2 weeks, how often has {CHILD} been bothered by having little interest or little pleasure in doing things? Would you say...
- Not at all, 1
- Some days, 2
- Several days, 3
- More than half the days, or 4
- Nearly every day? 5
- Refused 7
- Don't know 8
- 23b. During the past 2 weeks, how often has {CHILD} been bothered by feeling down, depressed, or hopeless? Would you say...
- Not at all, 1
- Some days, 2
- Several days, 3
- More than half the days, or 4
- Nearly every day? 5
- Refused 7
- Don't know 8

24. Overall, how would you rate your child's **emotional** health? Would you say...

- Excellent, 1
- Very good, 2
- Good, 3
- Fair, or..... 4
- Poor? 5
- Refused 7
- Don't know 8

About Your Child

25. ONLY ASK IF NEEDED: What is your child's gender?

- Male 1
- Female..... 2
- Refused 7
- Don't know 8

26. How old is your child?

_____ Years

- Refused-7
- Don't know-8

27. Is your child a member of any of the following groups? What about...

	Yes	No	REF	DK
1. Hispanic or Latino,	1	2	7	8
2. Hmong, or	1	2	7	8
3. Somali?	1	2	7	8

28. Which of the following best describes your child? Would you say...

	Yes	No	REF	DK
1. White or European American,	1	2	7	8
2. Black or African American,	1	2	7	8
3. American Indian or Alaskan Native,	1	2	7	8
4. Native Hawaiian or Pacific Islander,	1	2	7	8
5. Asian, or	1	2	7	8
6. Something else? (Specify: _____)	1	2	7	8

29. Is {CHILD} currently enrolled in one of Minnesota’s Health Care Programs such as Medicaid, Medical Assistance, MinnesotaCare, or GAMC? Would you say...

- Yes, my child is currently enrolled,..... 1
- No, but my child was enrolled in the past, or 2
- No, my child has never been enrolled?..... 3
 - Refused 7
 - Don’t know 8

About You

Finally, to help our staff interpret these results, I have a few questions about you.

30. ONLY ASK IF NEEDED: What is your gender?

- Male 1
- Female..... 2
 - Refused 7
 - Don’t know 8

31. Are you now...

- Single, never married,..... 1
- Living with a partner in a marriage like relationship,..... 2
- Married, 3
- Separated,..... 4
- Divorced, or 5
- Widowed? 6
 - Refused 7
 - Don’t know 8

32. Which of the following best describes you? Would you say you are...

- Retired,..... 1
- Unable to work because of a disability,..... 2
- A student,..... 3
- Not currently working for pay, 4
- Working part-time, less than 35 hours a week, or 5
- Working full-time, 35 or more hours a week? 6
 - Refused 7
 - Don’t know 8

33. What is the highest grade or level of school you have completed?

- Never attended school..... 1
- Elementary school (grades 1 through 8)..... 2
- Some high school (grades 9 through 12) 3
- High school graduate or GED..... 4
- Technical or vocational school 5
- Some college or Associate degree 6
- Four year college degree (Bachelor's)..... 7
- Graduate or professional degree 8
- Something else (Specify: _____) 9
- Refused-7
- Don't know-8

34. Were you born in the United States?

- Yes.....(GO TO Q. 35)..... 1
- No 2
- Refused (GO TO Q. 35).....7
- Don't know (GO TO Q. 35).....8

34a. How long have you lived in the United States?

- _____ Years
- Refused-7
- Don't know-8

34b. What country were you born in?

- _____ Country
- Refused-7
- Don't know-8

35. What language do you usually speak at home?
- English 1
 - Spanish..... 2
 - Hmong 3
 - Somali 4
 - Something Else (Describe: _____)..... 5
 - Refused 7
 - Don't know 8
36. What is your relationship to {CHILD}?
- Parent, step-parent, or foster parent 1
 - Grandparent 2
 - Other relative 3
 - Guardian 4
 - Refused 7
 - Don't know 8
37. Other than the pre-notification letter we sent to you, where have you seen or heard about this study?
(Mark all that apply.)
- Radio (Specify station: _____) 1
 - Local newspaper, (Specify: _____) 2
 - Flyer in the community or an announcement at community center or church,
(Specify location: _____)..... 3
 - Other (Specify: _____)..... 4
 - Never heard about this study 5
 - Refused 7
 - Don't know 8

That was the last question. Thank you so much for taking the time to answer these questions.

If you have any further comments, I can note them now.
