

Disparities and Barriers to Utilization among Minnesota Health Care Program Enrollees



Final Report

December 2003



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Utilization Among Minnesota
Health Care Program Enrollees
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Executive Summary

Across a wide variety of measures of health outcomes, racial and ethnic minorities fare worse than their European American counterparts in the United States. Even in Minnesota, which is consistently ranked as one of the healthiest states, there are wide gaps between racial and ethnic groups on measures of access and health outcomes.

This report presents findings from a statewide survey of 4,902 Minnesota Health Care Program (MHCP) enrollees designed to assess racial and ethnic disparities in the use of preventive and other health services, as well as barriers that discourage the use of those services. The sample included American Indian, African American (US born), Hispanic/Latino, Hmong, and Somali enrollees, as well as a representative sample of all enrollees. To understand barriers to service use for children and adults, the sample included randomly selected children and adult enrollees of the health care programs. When a child was chosen, an adult member of the household, hereafter referred to as a parent, answered the questions about the child. The survey was conducted either by mail or by telephone between April and July 2003 and measured demographics, health status, health care utilization, and barriers to the use of services.

The following are some major findings from the study:

General

- Overall, people of color enrolled in MHCP, whether adults or children, experience more barriers to access and utilization of health services than do their European American counterparts.
- Among the racial and ethnic populations included in the study, the groups most likely to be immigrants (Hispanic/Latino, Hmong, and Somali) generally report the greatest number of barriers, followed by African Americans, American Indians, 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 parents of child enrollees.
- The study assessed the influence of access barriers, discrimination, being suspicious of doctors in general, lack of trust in one's own doctor, and having access to quality interpreters. Adults experiencing problems or having concerns over provider behavior, including discrimination, are less likely to have sought preventive health care in the past year. Children's use of services is less sensitive to barriers.

Use of Services

- While the majority of enrollees report a preventive visit in the past year (just over 70% of adults and 80% of children), the rate of preventive care is quite low among Hmong enrollees, both young and old (approximately 60%).

Financial and Coverage Barriers

- Worry over having to pay more than expected or that insurance won't cover the health care received is a primary obstacle to seeking care for MHCP enrollees, regardless of race, ethnicity, and age, with more than 50% of adults and almost 40% of parents citing one or both of these barriers.

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 41% of adults and 32% of parents. Hmong identified this as a bigger concern (68% of adults and 61% of parents) than the other groups.
- Other access barriers that are often mentioned by enrollees include transportation problems, inability to see the doctor they want to see, and the hours that the clinic is open.

Family and Work Responsibilities

- Regardless of race, ethnicity, or age, most MHCP enrollees identified work and family responsibilities as important barriers to access and utilization of health services.

Trust and Confidence in Doctors

- The trustworthiness of doctors (as a group) stands out as a problem that hinders the use of health care services for parents of American Indian and African American children and Hispanic/Latino and Hmong adults and parents. Similarly, these same groups, in addition to Somali parents, are *less* trusting of and confident in their *own* doctor. Lack of confidence in one's own provider is associated with lower use of preventive services among adults.

Perceived Discriminatory Attitudes

- About 45% of all adults and 36% of parents think that their ability to pay or being enrolled in MHCP causes their doctor or other health care providers to treat them or their children unfairly.
- Among populations of color, approximately 30% of adults and 18% of parents think that their race, ethnicity, or nationality causes their health care providers to treat them unfairly.
- More enrollees perceived discrimination on the basis of being enrolled in MHCP than on the basis of race, ethnicity, or nationality.
- Among people of color, perceptions of discrimination are generally higher among African Americans and Hmong and lowest among Somali.

Language, Religion and Cultural Barriers

- Hispanic/Latino, Hmong, and Somali enrollees indicate that misunderstanding of their particular language, culture, or religious beliefs causes problems when getting health care services; these barriers are particularly important for Hmong and Somali enrollees. African American adults are also fairly likely to report problems with doctors not understanding their culture or respecting their religious beliefs.

Interpreter Availability and Quality

- Hispanic/Latino, Hmong, and Somali enrollees rated the availability and quality of interpreter services. Interpreters are least available for Hmong (59% of adults and 75% of parents report problems getting an interpreter when needed) with Somalis falling close behind (about 50% of adults and parents). Of the three groups, interpreters are most available for Hispanic/Latinos; however, as many as 33% report problems with interpreter availability.
- When asked how much having an interpreter helps them understand what the doctor is asking, what is being done during the visit, or helps the doctor understand what they are trying to say, Hmong are most likely to provide negative ratings (73% of adults; 53% of parents); Somalis are second (about 50% of adults and 35% of parents), and Hispanic/Latinos are third (30% of adults and parents).

Relationship Between Barriers and Use of Services

- The results suggest that adults who report barriers are less likely to report receiving care in the prior year. The relationships are particularly striking for use of regular and routine care. The relationship between use of health services and barriers seldom reaches significance for children.

Recommendations

Several recommendations follow from these findings. First, the worries over having to pay more than expected for care or whether insurance would cover costs suggests that there is a need to develop educational and outreach initiatives to help MHCP enrollees better understand the level of benefits and services covered by the programs. Second, initiatives to study and design solutions to access problems like scheduling and transportation are desirable. This should include educating consumers about transportation and interpreter services provided by health plans within MHCP. Difficulties related to work and family responsibilities might require outreach initiatives to inform MHCP enrollees about the availability of temporary day care options to assist them with family responsibilities while getting to appointments or taking a relative to health care appointments. Partnering with affected communities may lead to creative solutions and initiatives.

The findings associated with trust and perceived discrimination (both racial and socioeconomic) suggest the relevance of cultural sensitivity education across the health care system. DHS could work with the communities, MHCP providers and health plans, major health care educational institutions, and professional associations to develop programs such as diversity awareness workshops that include specific information about different cultures, customs and religion, and health beliefs.

The results point to significant problems with the availability and quality of interpreters. These problems are greatest within the Hmong and Somali communities but are also not trivial in the Hispanic/Latino community. Interpreter issues merit greater attention and members of these communities, professional interpreters, and MHCP providers are well positioned to both describe the subtleties of the problem and work toward creative solutions.

Addressing the barriers identified in the study requires not just the work of the State or the health plans and providers, but also requires that community members play an active role.

Introduction

Project goals:

The project was designed to understand barriers to preventive and other health care among Minnesota Health Care Program (MHCP) enrollees. The study focuses on disparities in the use of preventive and other health services, as well as factors that discourage the use of services among African American (US born), American Indian, Hispanic/Latino, Somali, Hmong, and European American children and adults. A second purpose of the study was to identify potential solutions to observed disparities with the goal of improving service delivery.

Background:

Across a wide variety of measures of health outcomes, racial and ethnic minorities fare worse than their European American counterparts in the United States (U.S. Department of Health and Human Services (USDHHS), 1985; Institute of Medicine (IOM), 2002). Even in Minnesota, which is consistently ranked as one of the healthiest states, there are wide gaps between racial and ethnic groups on measures of health status and outcomes. For example, the infant mortality rate for African Americans and American Indians is twice that of European Americans; Asians, American Indians, and African Americans in Minnesota have between 3 to 5 times higher rates of cervical cancer; Hispanic/Latino and African American children are more than three times as likely as European Americans to be uninsured (Minnesota Department of Health 2002). Similar disparities are found over a number of other health measures, such as breast cancer, immunizations, and injury rates.

It is encouraging that the elimination of racial and ethnic disparities in health is one of the two central objectives of Healthy People 2010 (USDHHS 2000) and is also a priority in Minnesota. In 2001, the state legislature passed the Eliminating Health Disparities Initiative, which provided funding to community organizations to target racial and ethnic disparities in health and health care. Most would agree that the elimination of racial and ethnic disparities in health outcomes is a worthwhile goal based on principles of social justice. It must also be recognized that such disparities bring very tangible costs to society. These include a less healthy and productive workforce, with poor health further hindering disadvantaged populations' opportunity to gain economic stability and independence (IOM 2001).

Eliminating disparities in health, however, is a difficult public health challenge. Previous research suggests that disparate health outcomes are partially due to differences in access to care and the quality of care received by racial and ethnic groups in the population. A growing body of research suggests that racial and ethnic minority groups face potential barriers to good health care in a number of areas, including socio-economic disadvantage, problems accessing care, mistrust and difficulty in relationships with providers, and linguistic and cultural differences that make navigating the U.S. health care system difficult.

This report examines disparities in the use of care and the types of barriers experienced by adults and children in MHCP when using health services. We examine disparities between American Indians, Hispanics/Latinos, African Americans born in the United States, Somali, Hmong, and European Americans. The choice of these racial and ethnic groups was based on enrollment numbers (groups with larger representation in the MHCP were selected) as well as disproportionately high immigration rates (e.g., Hispanic/Latino, Hmong, and Somali) because barriers to care may be greater among those less familiar with the US health care system.

Our examination of the importance of race and ethnicity in shaping health care recognizes that race and ethnicity are social factors (as opposed to biological). Identification with a specific racial or ethnic group is associated with differential access to economic opportunities such as having a stable income, well-paying satisfying work, decent housing in safe neighborhoods, political power, and differential experience of discrimination and exclusion (Kawachi & Kennedy 1999; LaViest 1994).

What are Minnesota Health Care Programs?

Minnesota has three main public health care programs and they 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 (MnCare). 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, MnCare 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 income.

Project Design and Methods

Research process:

This study represents a collaborative effort between the Minnesota Department of Human Services, Stratis Health, the University of Minnesota, and community-based researchers. Our research model uses a community-based participatory research method that promotes active involvement of community members in all stages of the research process, a process we believe is critical to improving population health. This multidisciplinary project team was established to design and implement all aspects of the study.

The research utilized focus groups and a survey of enrollees of Minnesota Health Care Programs. The focus groups gathered qualitative data about individuals' views of preventive care and perceived barriers. These results also informed the development of the survey instrument. The survey gathered quantitative information about patterns of use, health status, and barriers to receiving health care.

Phase I: Focus groups

The first phase of the study was a series of focus groups in each of the six communities, sponsored and facilitated by community-based organizations. The results provided insight into how health and health care are articulated and into barriers to preventive care.

The results from these focus groups highlighted the wide variety of practices that individuals use to keep themselves and their children healthy. Many of the practices (for example, good hygiene, consulting religious and spiritual leaders, and accessing family and community experts and support) fall outside of the traditional medical definitions of "prevention" (for example, vaccinations, exams, screening) but are vital to how members of these communities view their health and health care.

Discussions during the focus groups also emphasized the significant barriers that individuals face when they seek health care and preventive services. The most prevalent is discrimination toward immigrants, those of other races, and MHCP enrollees in general; mistrust of health care providers; financial concern that MHCP benefits will not cover the entire bill; time it takes to secure an appointment and time spent waiting at the clinic; transportation issues; and lack of physical symptoms (feeling healthy), which translates to a lack of perceived need for health care services. (See *The Disparities in Minnesota Health Care Programs: Focus Groups with Communities*, April 2003 at <http://www.dhs.state.mn.us/HealthCare/pmqi> for the full report.)

Phase II. The Survey

Who was surveyed?

The intended population for this study is all enrollees in MHCP living in Minnesota. Unfortunately, an error was made in accessing the administrative data to create the sampling frame (the list of enrollees from which the sample was drawn); the list includes all enrollees in managed care but only about one-third of enrollees in fee-for-service. Fortunately, the error does not seem to have seriously biased the fee-for-service component of the sample. The differences between the distributions of those in the sampling frame and those not in the sampling frame are relatively minor (see Appendix A for details). Thus, although the sampling frame, and hence the sample, disproportionately represent enrollees in managed care, they seem to do an otherwise good job of representing the population of MHCP enrollees.

The project team selected a stratified random sample of enrollees in public health care programs in Minnesota from the sampling frame. In addition to a random sample of the MHCP enrollee population, African Americans, American Indians, Hispanic/Latinos, Somali, and Hmong were over-sampled to ensure that there were enough respondents to be able to draw conclusions from their answers.

Because the project team wanted to understand barriers to service use for children and adults, the sample included randomly selected children and adult enrollees of the health care programs. When a child was chosen, an adult member of the household answered the questions about the child. Children (less than 18 years old) were not interviewed.

The data were weighted to correct for unequal selection probabilities of individuals and post-stratified to match population controls.

What was asked?

The questionnaire included measures of demographics, health status, utilization, and barriers to the use of services. Where possible, we chose questions that have been used in national surveys. The team also designed some questions because appropriate measures were not available (such as those about unfair treatment due to public program enrollment) for some concepts that the focus group results indicated may be important barriers to accessing health care.

How was the survey conducted?

The Cities' Institute for Public Health Research (CIPHR – the survey center housed in the Division of Health Services Research and Policy, University of Minnesota School of Public Health) conducted the survey between April and July 2003. It included both mail and telephone surveys to increase participation of sample members. If the mail survey was not returned, we offered to interview the respondent by telephone. Telephone interviews were conducted in Hmong, Somali, Spanish, and English.

A number of measures were taken to maximize the response rate, including sending pre-notification letters, distributing flyers, having telephone lines dedicated for Spanish, Hmong and Somali messages, and responding promptly to messages left on the project’s answering machines. Table 1 describes the targeted number of completed surveys, the actual number of completed surveys, and the response rate per stratum. A total of 3,284 persons completed the mail survey, and 1,669 the telephone survey for a total of 4,953 completes. The overall response rate was 54%, with a cooperation rate of 80%, which is similar to or exceeds other studies of this population. (See the Technical Appendix for a detailed description of the sample design and weights.)

Table 1: Response Rates by Sampling Stratum

Sample Stratum	Targeted Completes	Completed Surveys	Response Rate
Simple random sample	1400	1856	63.0%
American Indian	600	528	42.9%
African American	600	581	46.7%
Hispanic/Latino	600	663	54.5%
Hmong	600	697	56.5%
Somali	600	628	50.4%
Total	4400	4953	54.0%

Phase III. Developing Recommendations

Community members reviewed preliminary survey results; this is an important part of the community-based participatory research approach adopted throughout the project. In a facilitated small group review and discussion session, individual meetings, and conference calls, community members were asked to react to the preliminary findings. They were asked to indicate which results were expected and which were surprising, given their knowledge of the community generally and, for some, their involvement in the qualitative focus group component of the study.

Based on the discussion of the preliminary survey results, community members shared ideas and recommendations for improving access and use of health care services, especially preventive services. Recommendations offered by community members are integrated into this report.

Survey Results

Characteristics of MHCP Enrollees in the Sample

In contrast to Table 1, which presents the raw number of respondents in the sample by race and ethnicity, Table 2 shows the weighted sample (See the Technical Appendix for a description of the weighting methodology). Consistent with the MHCP population, enrollees are primarily non-Hispanic European Americans (68%) (referred to as European Americans), with African Americans born in the US (referred to as African Americans) comprising the second largest racial/ethnic group (11.4%). Compared to adults, children are much more likely to be Hispanic/Latino (14.1% vs. 2.9%) and African American (16.5% vs. 8.7%), which is consistent with their representation in the enrollee population.

Table 2. Weighted Distribution of Enrollees by Race and Ethnicity

	Adult %	Child %	Total %
Hispanic/Latino	2.9	14.1	6.8
American Indian	3.4	3.5	3.5
Hmong	2.2	2.0	2.1
Other Asian/Pacific Islander	3.9	3.8	3.9
US born African American ¹	8.7	16.5	11.4
Somali	2.6	2.7	2.6
Other Foreign Born African	2.3	1.8	2.1
European American	74.0	55.7	67.7

¹For child enrollees place of birth refers to the parent's place of birth

While Asians and Pacific Islanders (who are not Hmong) make up about 4% of the enrollee population, there are too few individuals in the sample (53 adults and 24 children) to make precise estimates of service use or barriers for this population. Similarly, among children there are too few foreign-born (non-Somali) Africans to make reliable estimates for this group (N = 53). Further analyses, therefore, exclude presentation of estimates for these groups.

Table 3 shows the socio-demographic characteristics of the adults. Not surprisingly, significantly fewer Hmong (10%) and Somali (2%) adults are born in the US compared to the total population (86%). Almost one-half of Hispanic/Latino enrollees are born in the US. The average time in the US significantly differs among immigrants: on average, Somali enrollees have been in this country ten fewer years than Hmong immigrants, and more than eight fewer years than Hispanic/Latino enrollees. Over one-half of Hispanic/Latino, Hmong, and Somali enrollees report speaking a language other than English at home. Among the Hmong and Somali adult populations, the proportions speaking other languages are particularly high, approximately 90%.

Table 3. Socio-demographic Characteristics of Adults

	European American	American Indian	African American	Hispanic /Latino	Hmong	Somali	Total
% US born	97	99	100	49	10	2	86
Mean years since immigration	14.3	NA	NA	13.7	15.7	5.3	11.9
% Non-English language at home	3	0	1	53	89	92	12
Mean age	47.0	39.4	40.0	34.7	48.5	34.9	45.5
% Female	70	65	72	71	70	63	69
% Greater Minnesota	52	35	5	35	4	25	43
% Married	25	10	10	38	34	38	24
% Employed	45	40	33	41	20	23	42
% High school graduate	79	70	69	50	26	32	74

NA: not applicable

Females are disproportionately represented among the population of MHCP enrollees, and this holds true for each community within the program. Compared to the total population, Hmong and African Americans are much less likely to live in Greater Minnesota. Almost one-quarter of the adult MHCP population are married; although the proportion married is higher in the Hmong (34%), Somali (38%), and Hispanic/Latino (38%) communities, and lower among American Indians (10%) and African Americans born in the US (10%).

Finally, the data suggest that some communities in MHCP may be more socio-economically disadvantaged than others. Hmong and Somali are significantly less likely to be working than the total population of enrollees. Adults from these communities are also significantly less likely to have graduated from high school than the total population.

As shown in Table 4, the patterns for children in many respects echo those found among adults: 1) Hmong, Somali, and Hispanic/Latino children are more likely to have parents who were not born in the US; 2) among immigrants, Somali children’s parents arrived in the US more recently; 3) non-English languages are more likely to be spoken at home for Hispanic/Latino, Hmong and Somali children; 4) Hmong, African American, and Somali enrollees are less likely to live in Greater Minnesota; and 5) parents of American Indian and African American child enrollees are less likely to be married or employed.

Table 4. Socio-demographic Characteristics of Children

	European American	American Indian	African American	Hispanic /Latino	Hmong	Somali	Total
% Parent US Born	97	100	100	33	18	4	80
Mean years since parents immigration	18.4	NA	NA	8.4	16.1	6.3	10.9
% Non-English language at home	1	0	0	66	73	91	16
Mean age	7.8	7.0	8.0	4.8	9.5	6.4	7.3
% Female	49	47	44	41	51	48	47
% Greater Minnesota	58	29	11	29	8	9	41
% Parents married	54	16	22	43	71	61	46
% Parent employed	61	54	56	46	53	40	58
% Parent high school graduate	89	88	81	39	54	40	79

NA: not applicable

Adults and parents differ on marital status, employment, and educational level. In general, parents are considerably more likely to be married, employed, and have at least a high school education, although the latter does not hold for Hispanic/ Latino parents.

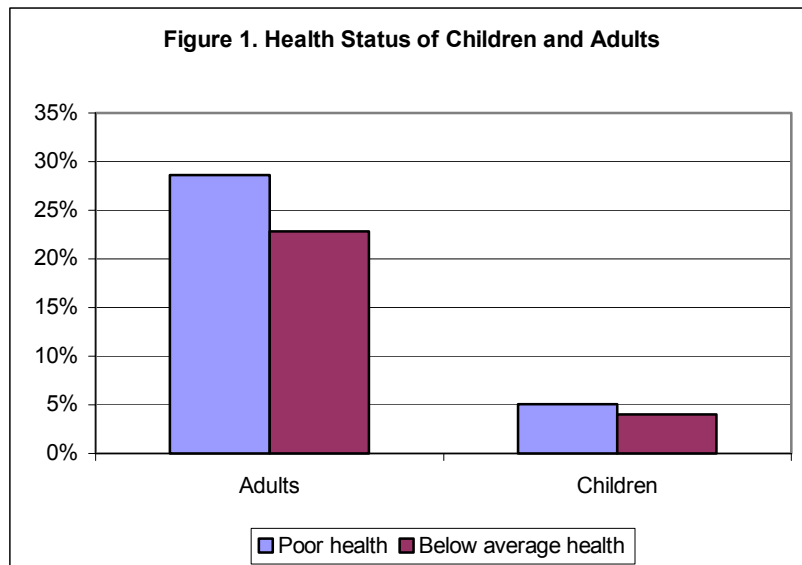
In sum, there are important socioeconomic differences across racial/ethnic groups among child and adult MHCP enrollees that are likely associated with health status, use of services, and experiences with the health care system. It will be important to take these factors into account when examining the influence of racial/ethnic 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), and whether they thought their current health was below average, average, or above average.

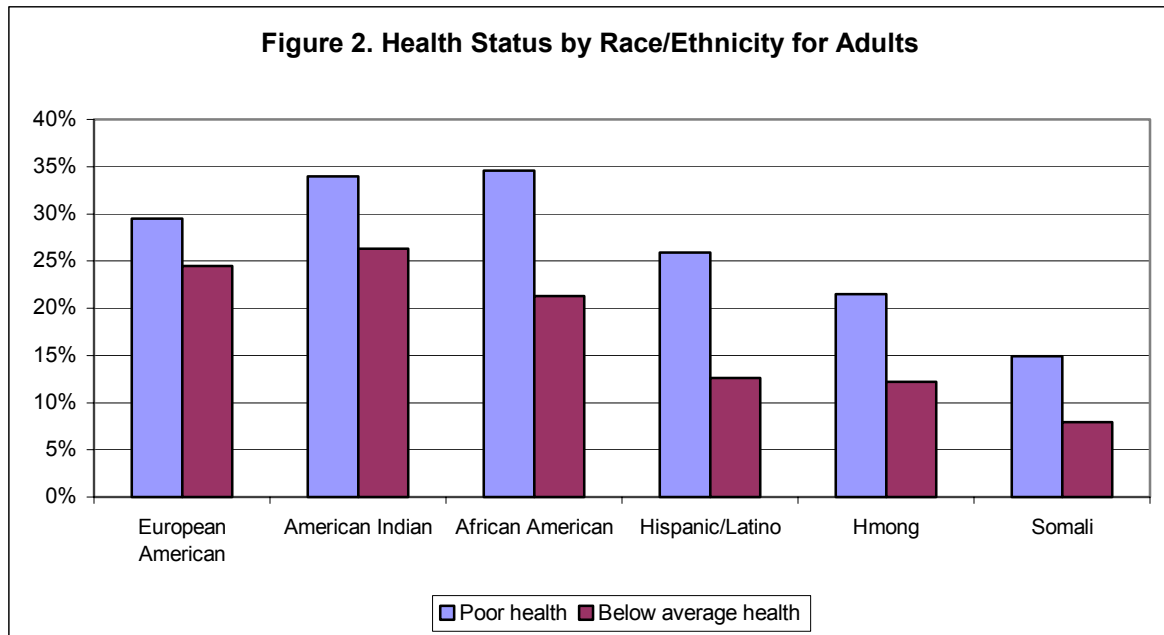
Based on these self-reports, the overall MHCP population can be characterized as fairly healthy. About 20% of MHCP enrollees indicated that they were in fair or poor health, 16% indicated that they were in below average health.

Not surprisingly, adults experience more health problems than do children. As shown in Figure 1, adults are about six times more likely to be in fair or poor or below average health than are children.



Does Health Vary by the Race and Ethnicity of MHCP Enrollees?

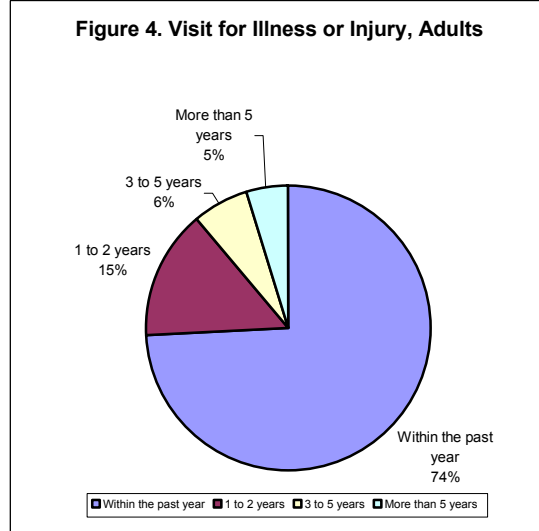
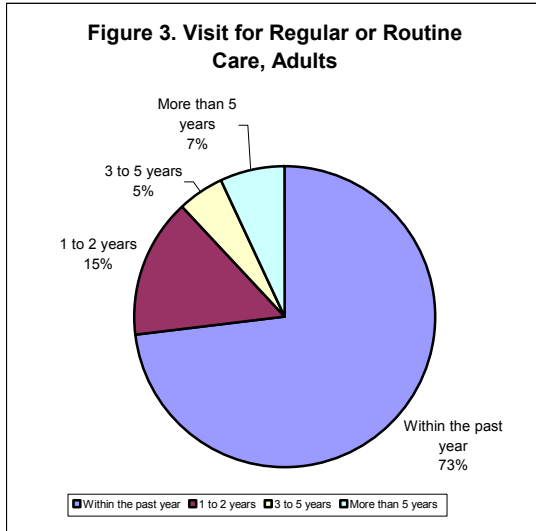
Among adults, health status is generally good among all racial and ethnic groups (Figure 2). However, there are distinct differences between groups with a larger portion of African Americans, American Indians, and European Americans reporting poor health on both measures.



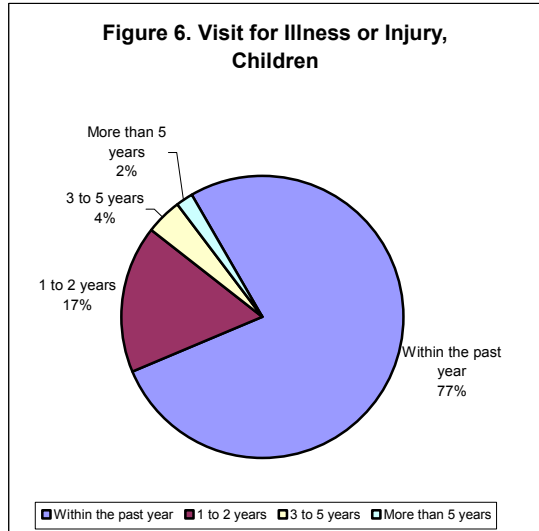
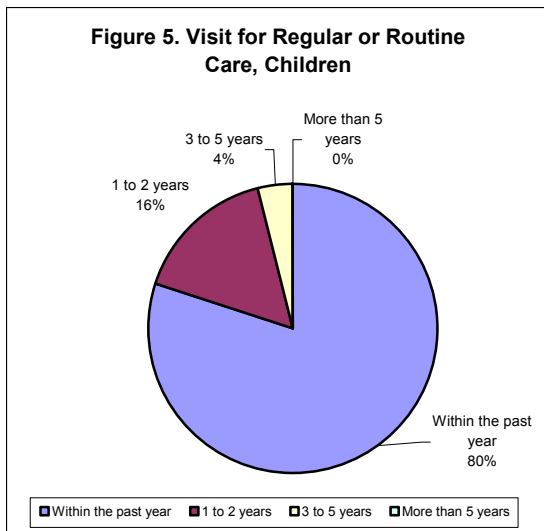
The health of children within MHCP is very good and similar across racial/ethnic communities: fewer than 9% of children overall are reported to be in fair or poor health; and 9% or less indicate below average health in any given community.

How Recently Did MHCP Enrollees Use Services?

As shown in Figures 3 and 4, most adults in MHCP report using services in the past year: 73% report a visit for regular or routine care (preventive care), and 74% report seeing a health professional for an illness or injury (acute care). Only a small proportion of adults have not sought any services for 3 years or more.

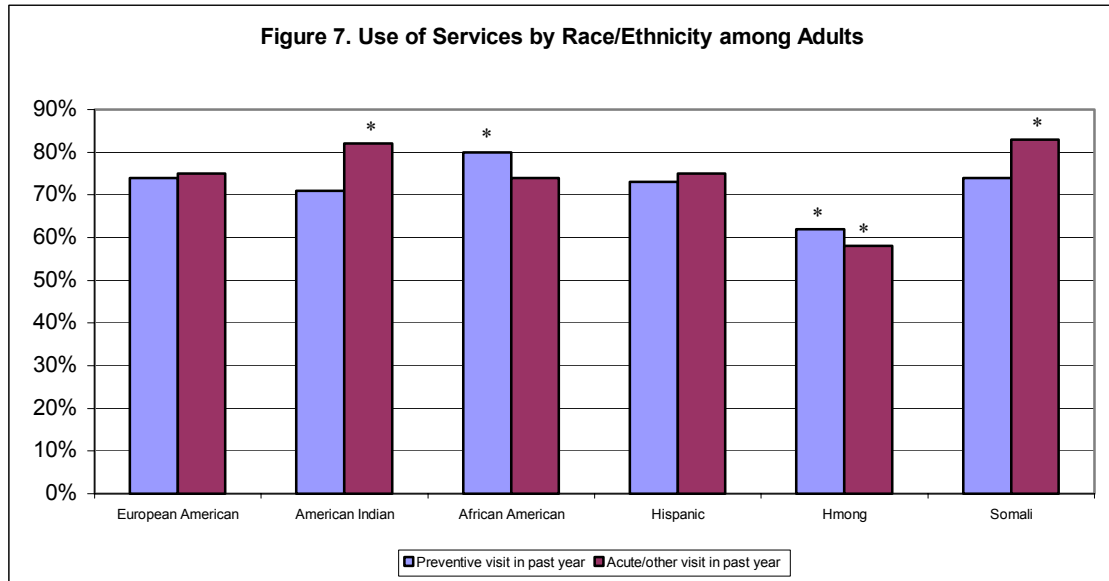


As shown in Figures 5 and 6, use of services in the past year is slightly higher among children than adults for both regular and routine care (80%) and care for illness or injury (77%). Only four percent had not had a preventive care visit in the last 3 years.



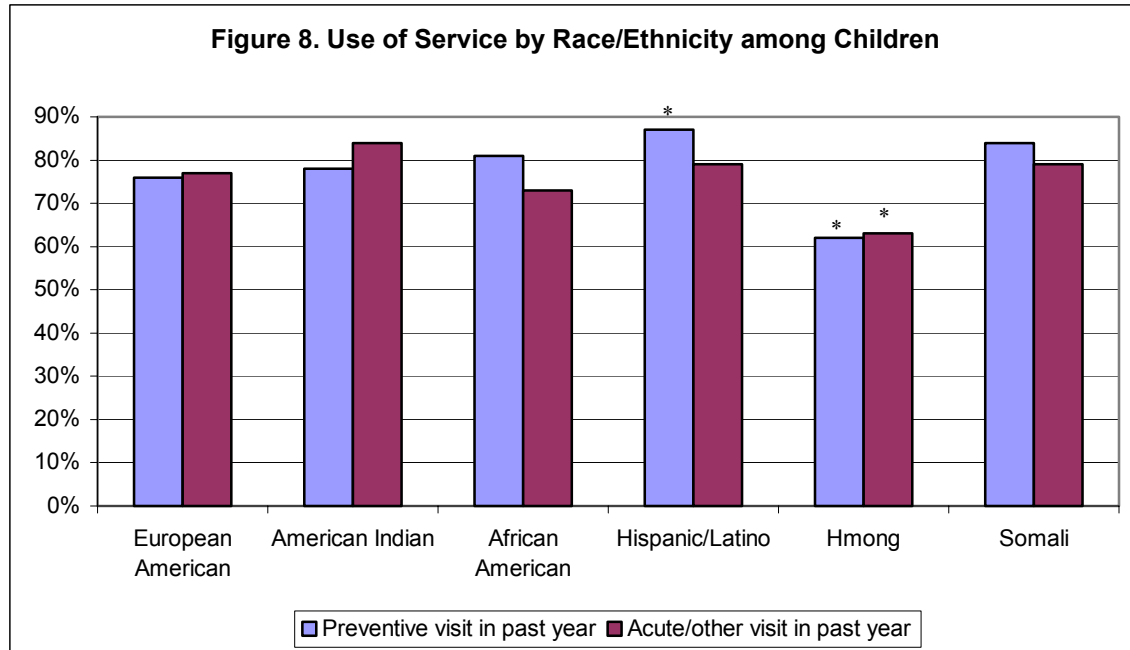
Does Service Use Differ Among MHCP Enrollees?

Figure 7 points to differences in service use in the past year among adult MHCP enrollees. More African American adults (80%) report regular or routine care in the past year; separate analysis of administrative claims data also shows African Americans to be among the highest users of preventive services (data not shown). Visits for illness or injury are highest among Somali adults (83%), whereas Hmong enrollees are less likely to report a visit for preventive care (62%) or an illness or injury (58%) in the past year.



* Indicates a significant difference in utilization compared to European American.

As shown in Figure 8, patterns of service use within racial/ethnic groups among child enrollees are similar to use among adults in that Hmong children are least likely to have either an acute or preventive care visit in the previous year. However, use of preventive care is highest among Hispanic/Latino children.



* Indicates a significant difference in utilization compared to European American.

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 barriers for children.

A series of 13 questions asked respondents about their experiences in five areas that may present problems¹ for people when they are trying to get needed health care: (A) financial barriers, (B) access issues such as clinic hours and transportation to the doctor’s office, (C) family and work responsibilities that might interfere with seeking help, (D) general trust in providers, and E) language and cultural issues that make it difficult to get care.

In addition, the survey included measures of (F) enrollees’ trust and confidence in their own doctor or health care provider, and (G) perceptions of discrimination. The (H) availability and quality of interpretive services were assessed for respondents who indicated they needed an interpreter during medical encounters.

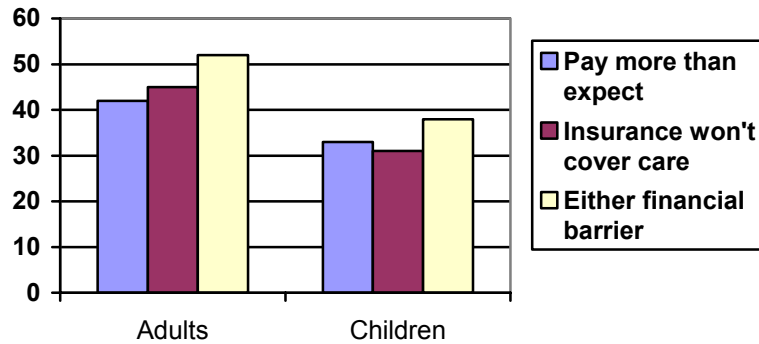
¹ Respondents perceiving a small or big problem in each of the 13 barrier questions were categorized as perceiving a problem, as opposed to perceiving “no problem at all.”

A: Financial and Coverage Barriers to Care

Respondents were asked whether worries that insurance would not cover the care received or that they would have to pay more than expected were problems for them when getting needed health care.

As shown in Figure 9, worry that insurance will not cover care and worry that one might have to pay more than expected are equally common problems, reported by just over 40% of adults and just over 30% of parents. Adults are more likely to report these problems than are parents of children.

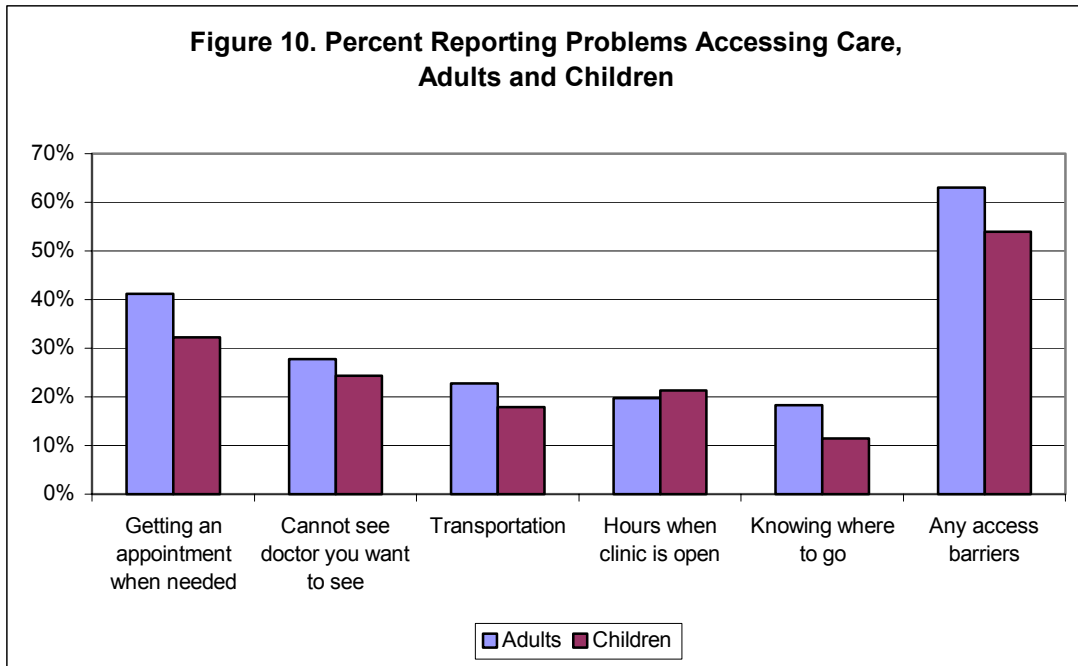
Figure 9. Percent Reporting Financial and Coverage Barriers



B: Access Barriers

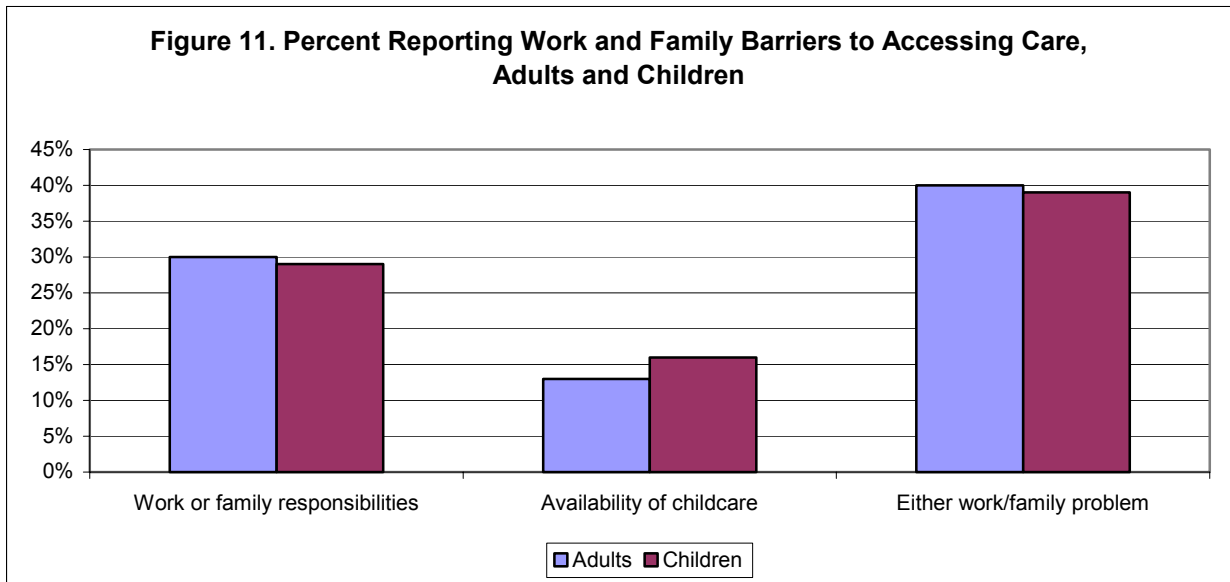
Access barriers include problems getting transportation to doctors, getting an appointment when needed, knowing where to go to receive care, inconvenient office hours, and inability to see the doctor they want to see.

As shown in Figure 10, getting an appointment when needed is the most commonly reported access problem experienced by adult and children. Knowing where to get care is mentioned least frequently. Overall, adults are more likely to experience one or more problems accessing care than are children.



C: Family and Work Responsibilities

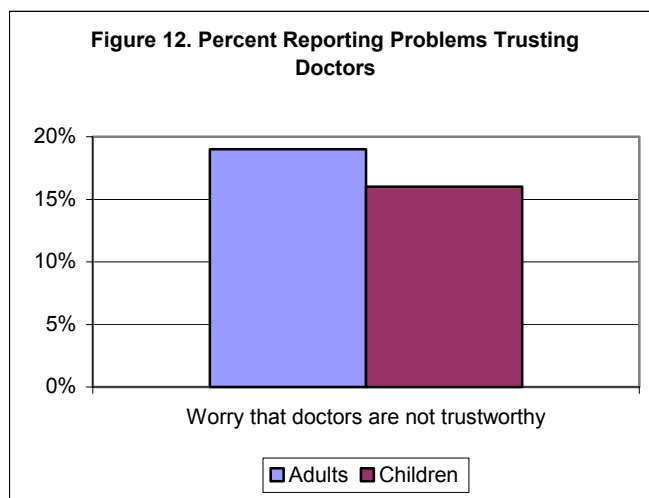
As shown in Figure 11, about 30% of adults and parents indicate that work or family responsibilities are a problem when trying to get the health care they need. Finding childcare presents less of a problem in accessing care. Parents of children and adult enrollees are about equally likely to report these problems.



D: Trust in Doctors

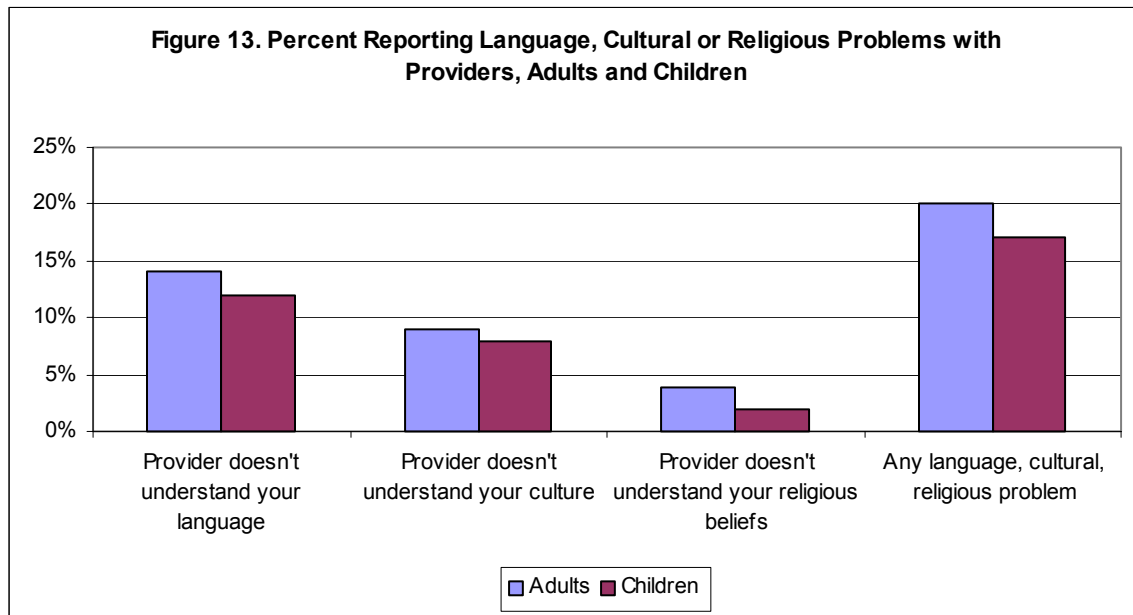
Respondents were asked whether they thought that doctors not being trustworthy is a problem when trying to get needed medical care for themselves or their children (in the case of child enrollees). This question is an assessment of whether trust in doctors, in general, is perceived as a problem when seeking care. We discuss enrollees' perception of their *own* doctor or health care provider in a later section titled "Trust and Confidence in Own Doctor or Health Care Provider."

The trustworthiness of doctors appears to present a greater barrier to getting care among adults than children (see Figure 12).



E: Language, Cultural, and Religious Barriers

The survey asked enrollees how big of a problem it was that doctors do not speak the same language, understand one's culture or respect one's religious beliefs. Of the barriers covered up to this point (financial and coverage worries, access, work and family responsibility, or trust) language, culture and religion are the least likely to be considered problematic. As shown in Figure 13, the fact that the doctor does not speak the same language is the most common of these problems, reported by 14% of adults, and 12% of parents.



Racial/Ethnic Differences Experiencing Barriers A through E

Table 5 shows the variation in the experience of barriers in areas A through E across racial and ethnic groups, with shaded cells representing the top five problem areas within each group for adult and child enrollees. Throughout this section of the report, European Americans serve as the comparison group in tests of differences by race/ethnicity.

MHCP enrollees of all ages, races, and ethnicities report concerns that the services received won't be covered by their insurance, and that they may have to pay more than they expect for services received. Although coverage and payment worries are common to all enrollees, Hispanic/Latino and Hmong are most likely to perceive problems in these areas.

Within the set of problems characterized as access barriers, getting an appointment as soon as needed is most pervasive, ranking at the top for all racial and ethnic groups, regardless of age. Transportation difficulties are reported by all enrollees, but are considerably more common among populations of color. Inability to see the doctor they want to see is listed among the top barriers for European Americans (both adults and parents), as well as for Hispanic/Latino adults and Somali parents. Difficulty getting needed care due to clinic hours is among the top barriers reported by American Indian parents. Finally, African American adults, Hispanic/Latino parents and Hmong adults and parents are more likely to report they don't know where to go to seek needed care.

Work and family responsibilities are also among the more frequently reported barriers to accessing services for all racial and ethnic groups, with European Americans being the least likely to experience this barrier. Difficulties getting childcare or babysitters pose a greater barrier to care among populations of color.

Doubt about the trustworthiness of doctors is a particularly important barrier to seeking needed care for Hispanic/Latino and Hmong. In the next section, trust and confidence in one's own doctor or health care provider, and the extent to which this differs across racial and ethnic groups, is explored in greater depth.

The last section of Table 5 presents the frequency of problems due to language, cultural, and religious differences. Language and cultural barriers to care are more often experienced among African American, Hispanic/Latino, Hmong and Somali enrollees. Furthermore, these are among the top five problems for Hmong enrollees, and Hispanic/Latino and Somali parents. Experiencing difficulties obtaining needed care because doctors do not respect one's religious beliefs is among the least frequently endorsed barriers although Hmong and Somali report it more often.

Clearly, no racial/ethnic group is sheltered from problems; each of the 13 barriers is considered a problem by at least 10% of the enrollee population. Consistent with the results for the population as a whole, experiences of barriers are more pronounced among adults. However, for the most part, the top ranking barriers to needed care among adults are similar to those reported by parents. This is not the case for Somalis, among whom adults and

parents only share two of the top five problems. It is interesting that, with few exceptions, Hmong are much more likely to report each type of barrier to accessing needed care.

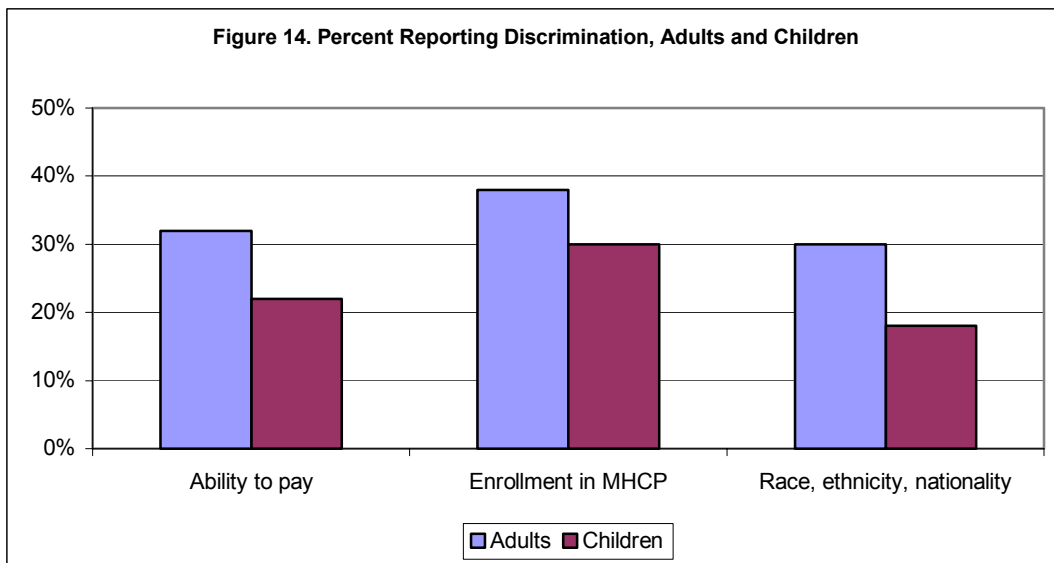
Table 5. Percent Reporting Barriers to Health Care Service Use by Race/Ethnicity among Children and Adults

% reporting the following problems:	European American		American Indian		African American		Hispanic/Latino		Hmong		Somali	
	adult	child	adult	child	adult	child	adult	child	adult	child	adult	child
Financial and coverage barriers												
Worry insurance won't cover care received	43%	30%	47%	33%	51% *	33%	55% *	37% ^a	63% *	51% *	52% ^a	33%
Worry you'll have to pay more than you expect	41%	30%	42%	38%	43%	26%	49% ^a	35%	65% *	39%	49%	24%
Access barriers												
Getting appointment soon as needed	38%	30%	44%	36%	48% *	32%	45%	34%	68% *	61% *	41%	52% *
Difficulties with transportation	18%	11%	39% *	24% *	37% *	23% *	37% *	29% *	47% *	24% *	32% *	48% *
Cannot see doctor you want to see	28%	27%	17% *	21%	27%	18% *	32%	19% *	44% *	34%	36%	35%
Office/clinic not open when you can go	18%	20%	22%	36% *	19%	22%	23%	19%	53% *	34% *	20%	31%
Knowing where to go	16%	9%	21%	18%	21% ^a	13%	22%	15% *	46% *	26% *	20%	12%
Family & work responsibilities												
Work or family responsibilities	27%	27%	40% *	30%	34% *	33% ^a	30%	28%	53% *	41%	37% ^a	28%
Availability of childcare or babysitter	11%	15%	22% *	15%	18% *	18%	25% *	14%	32% *	33% *	27% *	32% *
Trust in providers in general												
Worry that doctors are not trustworthy	18%	14%	19%	24% ^a	22%	17%	28% *	19% ^a	54% *	34% *	23%	14%
Language, cultural & religious barriers												
Doctors don't speak your language	10%	5%	8%	6%	12%	10% *	31% *	31% *	61% *	38% *	34% *	33% *
Doctors don't understand your culture	4%	2%	7%	9%	14% *	9% *	26% *	13% *	56% *	42% *	36% *	25% *
Doctors don't respect your religious beliefs	2%	1%	3%	7%	4% *	2%	6% ^a	2%	37% *	22% *	17% *	12% *
Shaded cells represent top 5 barriers per age and racial/ethnic group												
Indicates significant differences in barriers between European American and other groups: ^a p < .10; *p < .05 or better												

F: Perceived Discriminatory Attitudes

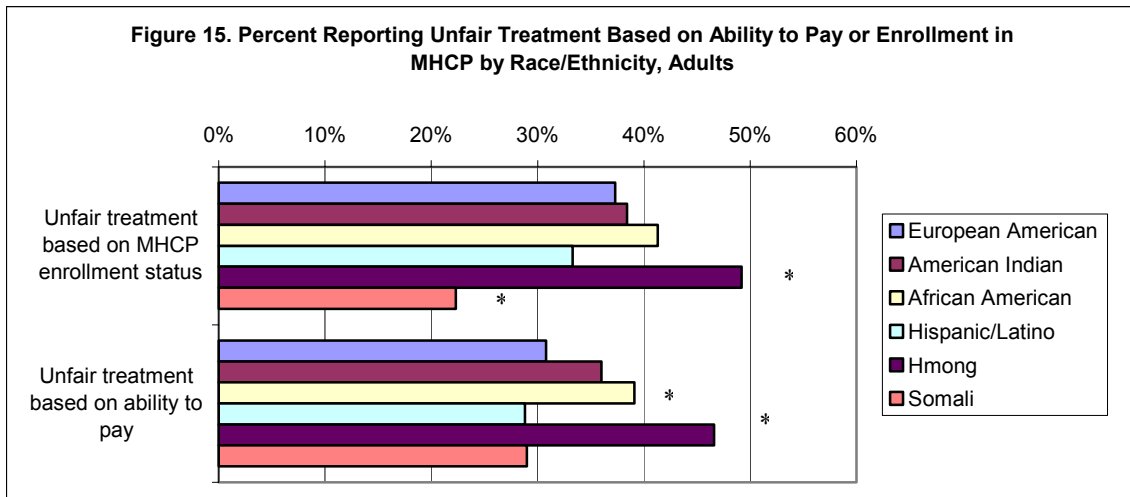
The survey included measures of perceived discrimination from health care providers. Respondents were asked if they felt they were treated unfairly by providers due to their ability to pay or being enrolled in a Minnesota Health Care Program. Respondents were also asked if they ever felt that providers treated them unfairly because of their 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 14, perceptions of unfair treatment due to enrollment in MHCP is the most common of these items, with more adults (38%) than parents (30%) reporting they sometimes or always feel this way. Almost one third of adults and 22% of parents feel that they are treated unfairly due to ability to pay. Among populations of color just under a third of adults and a fifth of parents report that they (their child) are treated unfairly due to race, ethnicity, or nationality.²

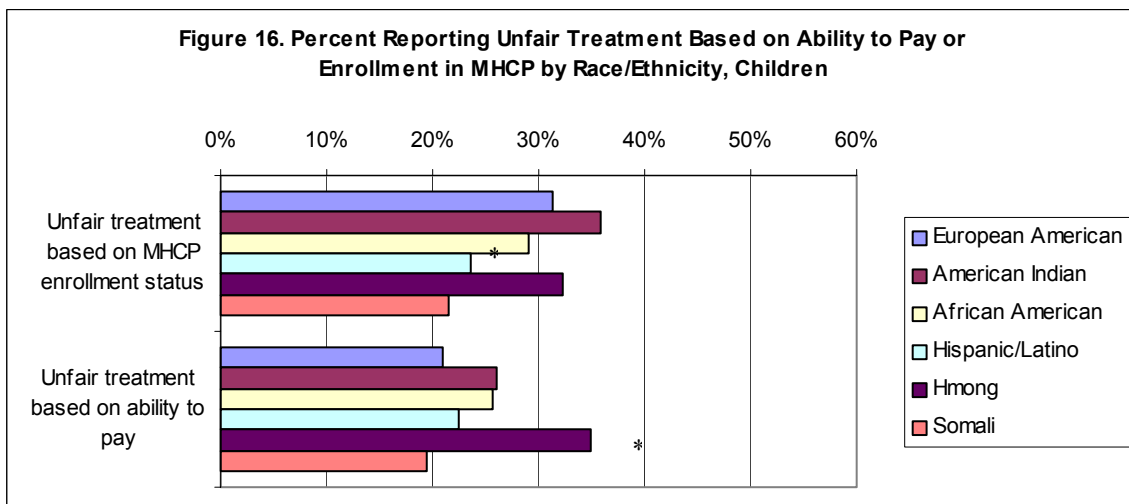


² European Americans are omitted from the analyses of discrimination by race, ethnicity or nationality.

As shown in Figures 15 and 16, feelings of discrimination based either on ability to pay or enrollment in MHCP are common in each racial/ethnic group. Among adults, African Americans and Hmong are significantly more likely to report that they are treated unfairly based on ability to pay or enrollment in MHCP. Somali adults are *less* likely than European Americans to report being treated unfairly because of ability to pay or enrollment in MHCP. Among child enrollees (Figure 16), Hispanic/Latino parents are less likely to perceive discrimination based on MHCP enrollment. Hmong parents are more likely to perceive unfair treatment due to perceived ability to pay.

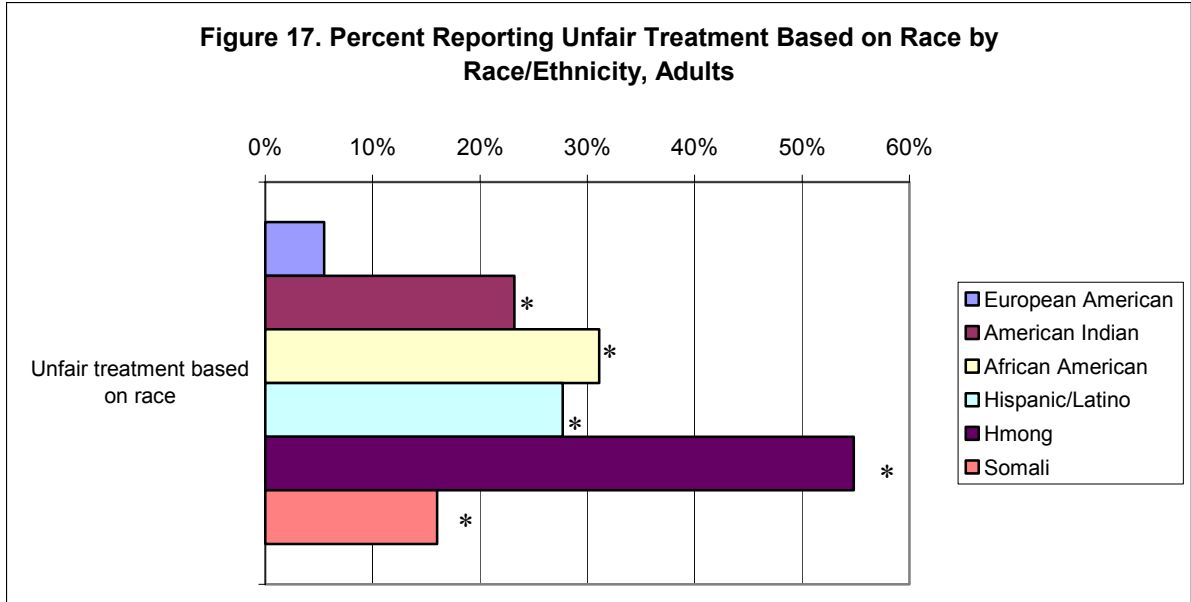


*Indicates a significant difference compared to European Americans.

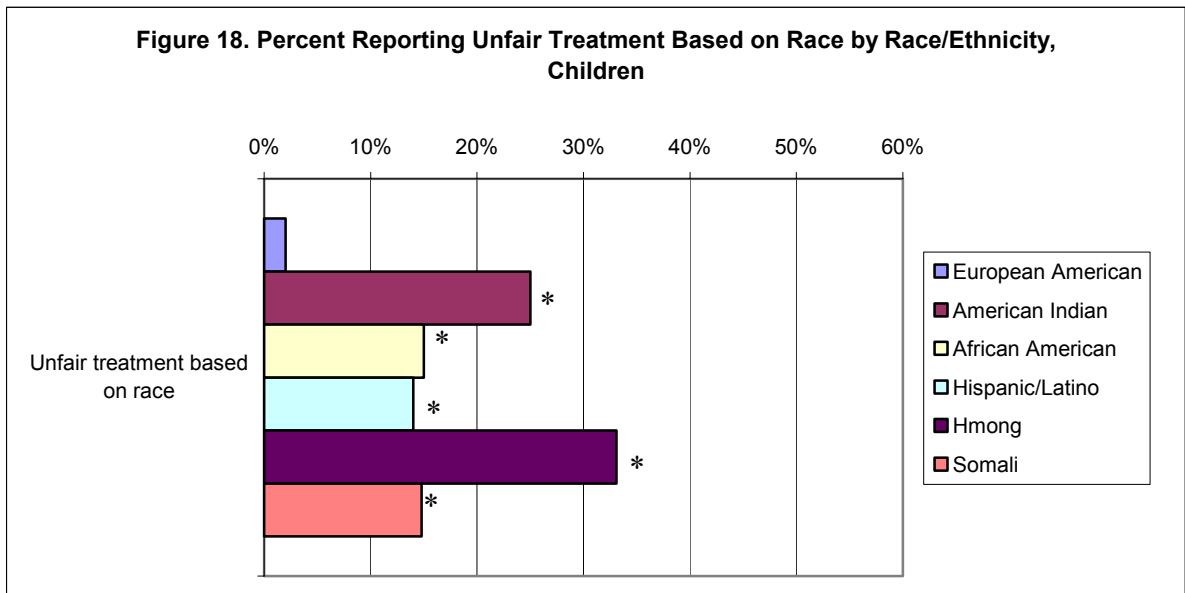


*Indicates a significant difference compared to European Americans.

Feelings of discrimination based on race, ethnicity or nationality vary considerably as shown in Figures 17 and 18. Consistent with earlier results, perceptions of discrimination are higher among adults and are particularly high among Hmong (more than one-half of adults, and one-third of parents).



*Indicates a significant difference compared to European Americans.



*Indicates a significant difference compared to European Americans.

To foster greater understanding of cultural issues on the part of health care providers, one of the national standards developed by the Institute of Medicine (IOM) to ensure delivery of Culturally and Linguistically Appropriate Services (CLAS) encourages health care organizations to, "...recruit, retain, and promote at all levels of the organization a diverse staff..." (Institute of Medicine, 2002, p. 182). To evaluate the extent to which MHCP enrollees encounter health care providers of their own race, they were asked if 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 90% of children) to see a provider of the same racial/ethnic background (Table 6). European Americans are followed by Hmong and American Indian in responding that their own (or their child's) provider is of the same racial/ethnic group.

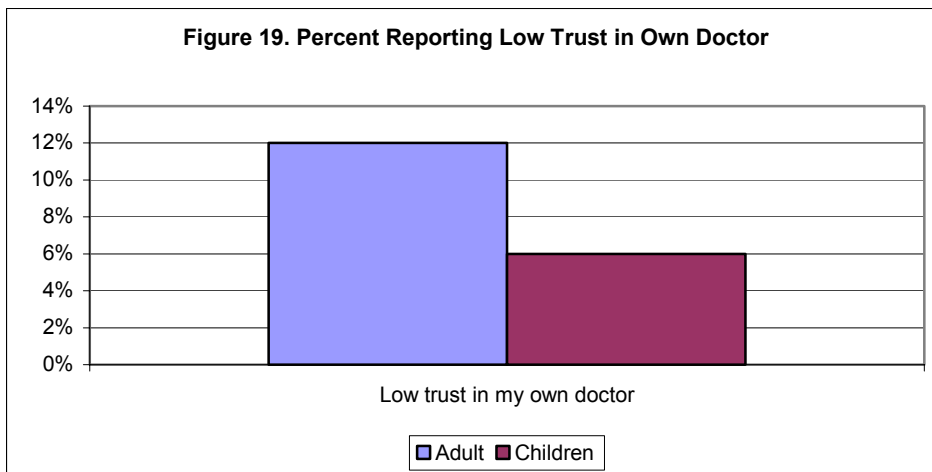
Table 6. Percent Reporting Having a Doctor of the Same Racial/Ethnic Group among Adults and Children

	European American	American Indian	African American	Hispanic/Latino	Hmong	Somali
Adults	85%	25%	8%	13%	28%	6%
Children	90%	19%	7%	16%	23%	9%

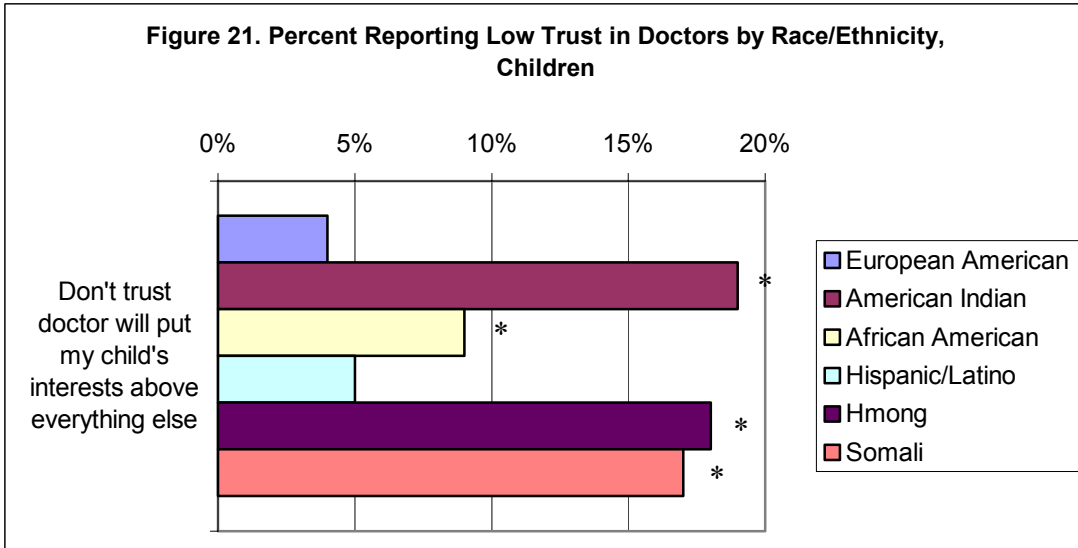
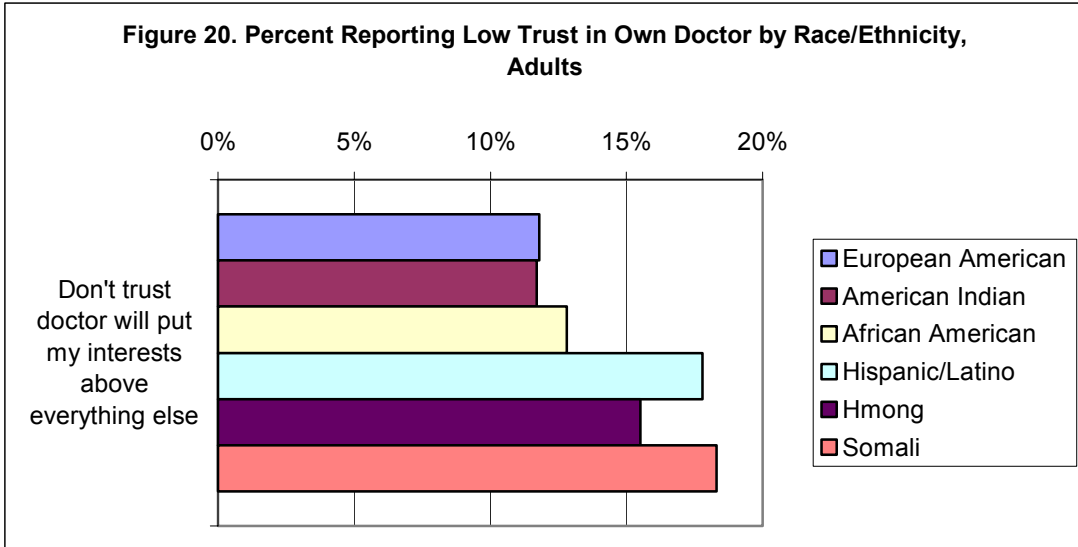
G: Trust and Confidence in Own Doctor or Health Care Provider

In addition to asking about general trust in doctors, enrollees were asked if they trusted their own doctor or health care provider to put their interests above everything else. The survey also included questions assessing 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 had an illness that they do not have, or that their provider might not find an illness they do have. Responses to these questions were combined, to create a measure of confidence with health care providers.

As shown in Figure 19, low trust in their *own or their child's* provider appears to be more problematic for adults than for parents. Fewer enrollees (12% of adults and 6% of parents) perceived a lack of trust in their own or their child's provider than reported that trustworthiness of doctors in general presented a barrier to getting care (see Figure 12).

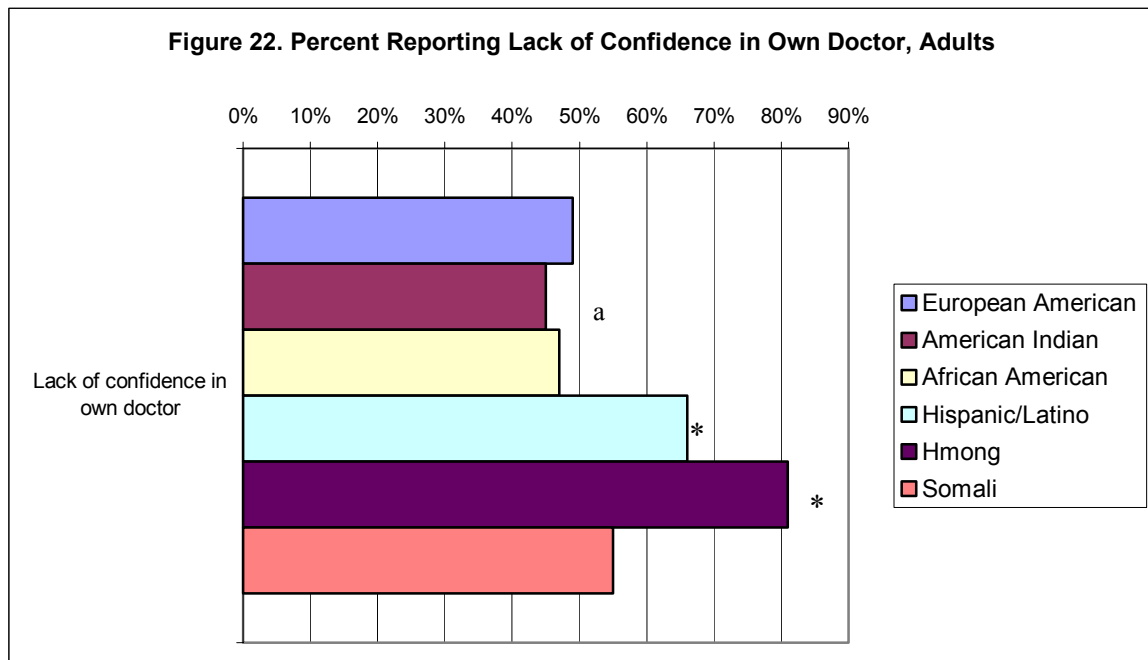


Among adults there is little variation in provider trust by race/ethnicity, whereas reports of mistrust in their child's own doctor are considerably higher among American Indian, African American, Hmong, and Somali parents (see Figures 20 and 21).



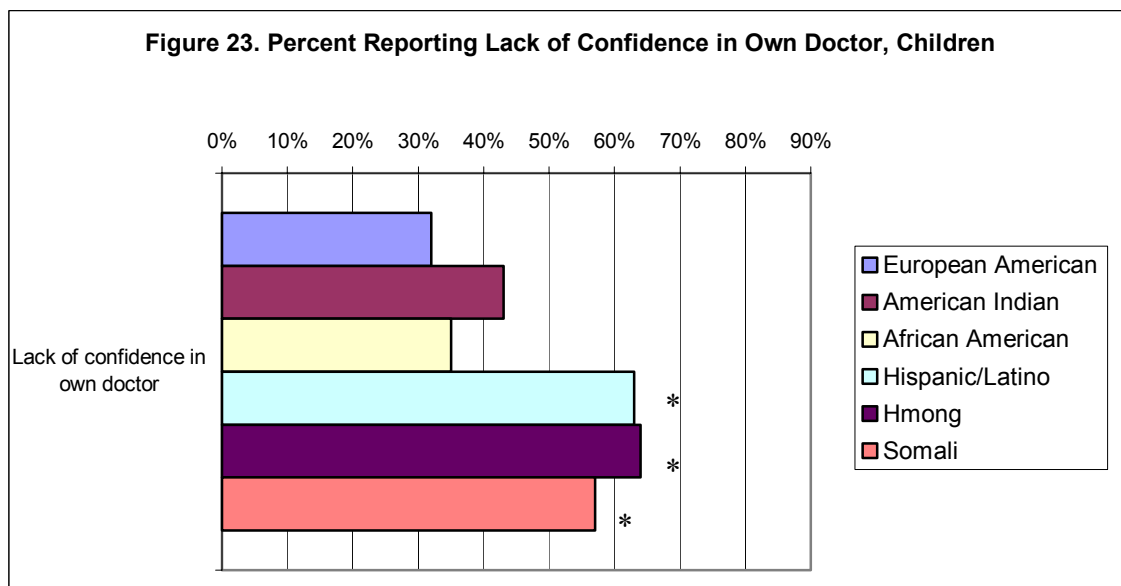
*Indicates a significant difference compared to European Americans.

Figures 22 and 23 show that lack of confidence in their own provider is more problematic among adults than parents. Lack of confidence is most common among Hispanic/Latino, Hmong, and Somali respondents, but it is also common among European Americans with 49% of adults and 32% of parents indicating that they worry their doctor might not do enough to find out what is making them (or their child) sick, that the health care received might make them feel worse, that their provider might tell them they have an illness that they do not have, or that their provider might not find an illness they do have.



*Indicates a significant difference compared to European Americans.

^a Indicates a significant difference between American Indians and European Americans.



*Indicates a significant difference compared to European Americans.

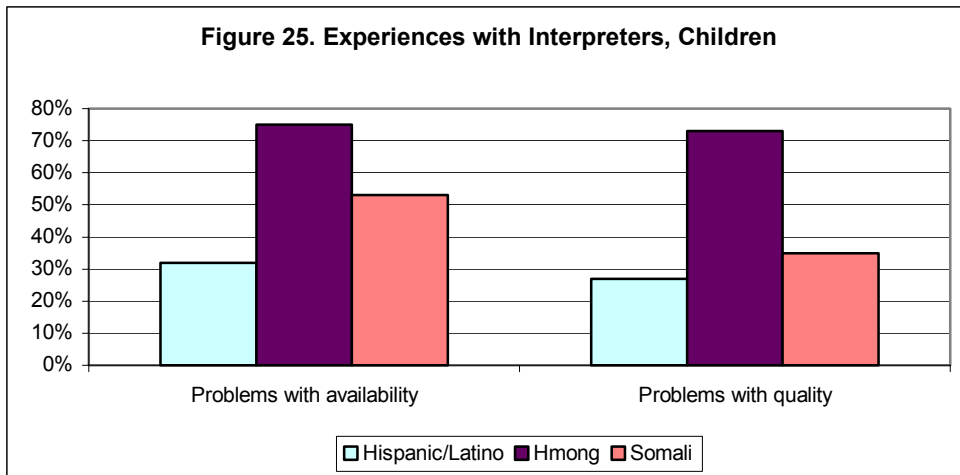
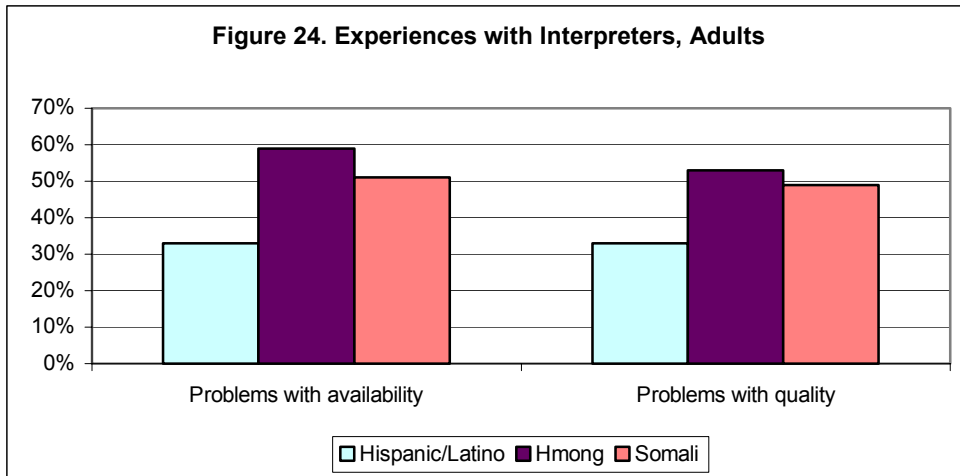
H: Interpreter Availability and Quality

We further explored the extent to which language differences between patients and providers present a barrier to care by asking about availability and quality of interpreter services. The analyses of these questions are restricted to Hispanic/Latino, Hmong, and Somali respondents. Among Hispanic/Latino, 40% of adults and 50% of parents reported needing an interpreter. Approximately 46% of Somali adults and parents need an interpreter to help them communicate with their doctors or other health care providers. Whereas 30% of Hmong parents report needing an interpreter, 64% of Hmong adults report this need. Hmong adults are significantly more likely than Somali and Hispanic/Latino adults to be in need of interpreter services. This difference among adults makes sense in light of the disproportionate share of Hmong adults in the 65 and over age group: 29% of Hmong adults in contrast to 6% of Hispanic/Latino and 11% of Somali.

Respondents needing an interpreter were asked how often this need was met; those who indicated that an interpreter was not almost always provided are characterized as having problems with availability of interpreters. Respondents were also 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 in 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.

Problems with interpreter services significantly vary by community. As shown in Figures 24 and 25, regardless of age, Hmong are significantly more likely than Hispanic/Latino to report problems getting an interpreter and problems with the quality of interpretation provided. However, even one-third of Hispanic/Latino adults report problems in these areas.

Within the Hmong community, problems with interpreter services are even more severe for parents; almost three-quarter report problems with availability and quality. Significantly more Somali than Hispanic/Latino parents report problems with interpreter availability; yet Somali parents experience significantly less problems than Hmong parents.



Are Barriers Related to Use of Health Services?

In this section, the relationship between the experience of potential barriers to health care and use of health care services is explored. We examine whether individuals who experience any barriers in each of the 11 areas (financial or coverage problems, access to care, family and work responsibilities, trust in providers in general, trust and confidence in one's own doctor, economic or race discrimination, language, religious and cultural issues, and interpreter availability and quality) are more (+), less (-), or as likely (indicated by "ns" or not significant) to report visiting a doctor for preventive care or for an illness or injury. The analyses can only indicate whether barriers and services use are positively or negatively related, not the causal ordering of the relationship.

As shown in the first two columns of Table 7, adults who report barriers are less likely to report receiving care in the prior year. The relationship is particularly striking for use of preventive care services. With the exception of language, religious and cultural barriers, and lack of quality interpreters, problems in each of the other areas are associated with lower rates of use of preventive care (as indicated by the minus sign). Individuals are more likely to make active choices about whether they will or will not visit a doctor for preventive care than for an illness or injury. It makes sense, therefore, that preventive care is more affected by problems in each domain than is care for an illness or injury.

Among children, the relationship between use of health services and barriers seldom reaches statistical significance. The findings are in the expected direction for use of regular or routine care; parents who report problems or difficulties are also less likely to report that their child received care in the last year. Child enrollees whose parents were unable to get an interpreter are less likely to use preventive and other care than those reporting always being provided an interpreter.

The relationship between barriers and use of care for illness or injury among children is not in the expected direction. Table 7 shows that those with worries about cost and coverage, and access barriers are more likely to visit for injury or illness in the prior year (as indicated by the + sign). A clear understanding of this relationship cannot be disentangled with the available data, but it seems likely that those who received care actually experienced the problem. If so, the pattern of results suggests that they may be less likely to obtain preventive care in the future.

Table 7. Relationship Between Barriers and Use of Services, Adults and Children

<i>Barrier Domain:</i>	Adults		Children	
	Visit for injury or illness in past year	Preventive visit in past year	Visit for injury or illness in past year	Preventive visit in past year
Financial, coverage barriers	-	-	+	ns
Access barriers	ns	-	+	ns
Family, work responsibilities	ns	-	ns	ns
Trustworthiness of doctors	ns	-	ns	ns
Trust in own provider	ns	-	-	ns
Confidence in own provider	ns	-	ns	ns
Economic discrimination	-	-	ns	-
Race discrimination	-	-	ns	ns
Language, cultural, religious barriers	ns	ns	ns	ns
Interpreter availability[^]	ns	-	-	-
Interpreter quality[^]	ns	ns	ns	ns

[^] Analyses of interpreter services are restricted to Hispanic/Latino, Hmong and Somali subpopulations

ns: not significant

"-" use is significantly lower among enrollees reporting this problem as compared to those with no problem, $p < .05$

"+" use is significantly higher among enrollees reporting this problem as compared to those with no problem, $p < .05$

Summary of Findings

This project was designed to assess racial and ethnic disparities in the use of preventive and other health services among MHCP enrollees and factors that discourage the use of those services. The information obtained by the study will help the Minnesota Department of Human Services improve care delivery to those enrolled in their programs.

Use of Services

The results show that most MHCP enrollees have annual contact with the health care system; overall, approximately three quarters of the respondents said they have used preventive health care services or services for illness or injury within the past year. The results of this study suggest that there are important racial/ethnic differences in the health care experiences of enrollees in MHCP, with use of services being quite low among Hmong, both young and old. Thus, it is with some relief that Hmong report being in good health.

Barriers to Getting Health Care

Some of the potential barriers to use of health care services investigated in the current study are not specific to any one racial or ethnic group but are observed in all communities. For example, worries over having to pay more than expected or that insurance won't cover the health care received are primary obstacles to seeking care for MHCP enrollees. These worries are particularly acute in the Hispanic/Latino and Hmong communities and among adults rather than children. Similarly, the inability to schedule a health care appointment in a timely manner emerged as an important barrier to care across all racial/ethnic and age groups. Transportation problems, ability to see the chosen provider, and work or family responsibilities also ranked high on the list of barriers identified by all groups.

The results also suggest that many enrollees in MHCP experience problems in their relationships with providers and the health systems. These types of barriers to care also vary across the different communities that participated in the survey. For parents of American Indian children and Hispanic/Latino and Hmong adults and children, the trustworthiness of doctors presents barriers to needed care. Furthermore, among African American parents, trust in their own doctor or other health care provider stand out as problems that hinder use of health care services.

Specifically, the parents of American Indian children, as well as Hispanic/Latino, Hmong, or Somali enrollees, regardless of age, are *less* likely to think that their doctor or other health care provider puts their interests above anything else. These groups are also *more* likely to fear that their providers are not doing enough to find out what is making them sick, that the care they receive might make them feel worse, that they will be told they have an illness they don't really have, or that an illness will not be detected.

Almost half of all MHCP adults and around a third of parents say that their perceived inability to pay or their enrollment in an MHCP such as Medicaid, Medical Assistance, or MinnesotaCare cause their doctor or other health care provider to treat them unfairly. African American adults, Hmong adults, and parents of Somali children tend to perceive this form of discrimination at heightened levels vis-à-vis European American enrollees. This finding is consistent with the research literature suggesting that the stigma of being associated with a public program or entitlement may cause differential and unfair treatment by their doctors.

Perceived racial discrimination is less common than perceived discrimination based on financial reasons or enrollment in MHCP. However, enrollees of color are likely to think that their race, ethnicity, or nationality cause their health care providers to treat them unfairly. The extent to which this was a problem in the American Indian and Hmong communities was somewhat unexpected. Roughly a quarter of American Indian adults and parents think they are treated unfairly due to their race, ethnicity, or nationality. For Hmong, the proportion jumps to over half of adults and a third of parents. Unfair treatment due to race is also a problem for adult African American and Hispanic/Latino enrollees with about a quarter to a third of respondents reporting some form of discrimination.

Finally, African American, Hispanic/Latino, Hmong, and Somali enrollees report doctors' misunderstanding of their particular language and culture causes problems when getting health care services. Provider's understanding of religious beliefs is the least important barrier among each racial and ethnic group (this is true among adults and parents).

Interpreter Availability and Quality

The availability and quality of interpreter services can influence the use of health care services. Analyses of questions on interpreter services focused on Hispanic/Latino, Hmong, and Somali enrollees. Of those three groups, interpreters are least available for Hmong enrollees where over half of the adults and almost three quarters of parents do not get an interpreter when needed. Somali enrollees do not fare much better; only about one-half indicate they are provided a needed interpreter. Finally, one third of Hispanic/Latino enrollees are not always provided an interpreter.

Judgments of the quality of interpreter services are also negative. When asked how much having an interpreter improves mutual understanding between doctor and patient or improves doctor-patient communication, Hmong are least likely to provide positive ratings; Somali, regardless of age, are not far behind. Again, Hispanic/Latino enrollees report better quality interpreter services than the other groups, yet one-quarter to one-third report problems in this area.

Relationships Between Barriers and Use of Health Services

It is important to document the extent to which access issues and discrimination, being suspicious of doctors in general, lack of trust and confidence in one's own doctor, and having access to quality interpreters are related to use of health services. The results indicate a complex relationship between these domains and the use of health care for illness and injury.

For adults, the relationship is rather straightforward -- the more problems one experiences, the less likely one is to seek care. However, among parents some of the barriers to access are not associated with reduced utilization of health care services. Parents who report worrying about their ability to pay or whether the insurance will cover the costs, as well as those who have trouble obtaining timely appointments or difficulty with transportation, are actually more likely to have had a health care visit for illness or injury in the past year. This positive association could be attributed to timing. For example, those who seek health care are in a position to offer opinions or ratings on such things as insurance worries or transportation issues.

The results for preventive care are more along expected lines. Adults who worry they will be unable to pay for care, experience access problems such as lack of transportation or not knowing where to go, have conflicting work or family responsibilities are less likely to have sought preventive health care in the past year. Adults, who mistrust doctors generally, as well as lack trust and confidence in their own provider, or experience discrimination of some form, are less likely to report regular or routine care within the past year. Use of preventive services for children is less affected by perceived barriers. As was the case with care for illness and injury, these associations did not differ demonstrably by race or ethnicity.

Recommendations

The results of this study clearly indicate that there are a number of barriers common to all MHCP enrollees. There are also important differences in the number and degree to which racial and ethnic groups perceive specific barriers. Finally, some differences in perceived barriers to access and use of services between the adult and child enrollees within the same racial and ethnic group are identified.

Several recommendations are provided below grouped thematically by type of barrier. These recommendations echo national standards developed to ensure delivery of Culturally and Linguistically Appropriate Services (CLAS) (Institute of Medicine, 2002). Briefly, these national standards call for care delivery that is respectful of and compatible with patients' health beliefs and practices, partnering with communities to develop and implement CLAS activities, setting strategic CLAS goals and self-evaluation systems to monitor progress toward reaching these goals, ongoing staff training and education in CLAS, hiring a diverse workforce, making information available in languages other than English that are prevalent in the local environment, and provision of competent interpreters. Although the CLAS standards provide a useful framework for fostering improvements within the current health care system more generally, the current study provides specific guidance on how DHS might address the particular concerns of its MHCP enrollees.

Financial and Coverage Barriers

Concern that insurance will not cover the care received or having to pay more than expected for care is among the top five barriers reported by all groups with the exception of parents of Somali children. The degree to which this is perceived as a barrier to access and use of services is consistently higher for adults than parents, and is associated with lower use of health care among adults. Recommendations within this domain include:

- Develop outreach and education initiatives to help enrollees better understand the level of benefits and services covered by MHCP such as transportation and interpreter services, as well as associated out of pocket costs. Methods to achieve this communication may include community newspapers, television and radio programs, and disseminating information at community events.
- Target outreach efforts not only to enrollees but also at social services agencies working with individuals from these communities. Trusted organizations and individuals may be better able to inform individuals about the services provided by DHS.
- Work with MHCP health plans to identify and engage culturally competent staff who can serve as point-of-contact resources and advocates for enrollees of diverse racial and ethnic groups.

- Review MHCP documentation provided to enrollees by DHS and participating health plans and work to increase the clarity of description of program benefits and services, potential out-of-pocket expenses, tailoring information to both adults and parents of children.

Access Barriers

Difficulties accessing health services represents one of the top five barriers for both adults and children in all racial and ethnic groups; these barriers are associated with lower rates of preventive care utilization among adults. The single most important factor in this domain is getting an appointment as soon as needed, followed by transportation issues and the inability to see the doctor or health care provider of choice.

With respect to getting an appointment as soon as needed, it is important to note that this finding is consistent with satisfaction surveys of public and private payer populations in the state and around the country (Farley Short et al., 2002; Minnesota Department of Human Services, 2001). For most patients, their health condition is immediate and will either get better or worse by the time they are able to schedule an appointment under most scheduling systems. If they are unable to get an appointment when needed, they may either seek care in other more expensive settings, such as urgent care centers or hospital emergency rooms or forgo care until their condition worsens and is more costly to the health care system and the individual (e.g., missed work and family responsibilities, quality of life).

Recommendations within this domain include:

- Work with MHCP health plans and providers to encourage and evaluate access and appointment policies that are more responsive to enrollees' health care needs.
- Explore the feasibility of designing and implementing pilot studies of same-day appointments for enrollees among providers with high MHCP patient loads.
- Work with communities to understand and resolve access barriers confronted by MHCP enrollees. This should include raising awareness of transportation services provided by health plans within DHS.

Family and Work Responsibilities

Across most racial and ethnic groups, work and family responsibilities are identified among the top five barriers to getting needed health services. Recommendations within this domain include:

- Collaborate with communities to create viable and trusted temporary day care or respite care options that allow enrollees to comfortably seek care for themselves or their children.

Trust and Confidence in Doctors, Perceived Discriminatory Attitudes, and Language, Cultural, and Religious Barriers

Trust in providers generally, trust and confidence in one's own provider, and perceptions of discrimination (specifically, unfair treatment based on ability to pay and MHCP enrollment, as well as race) are identified as barriers to needed services, and are associated with lower rates of service use among adults and children alike. Hmong and Somali enrollees and parents of enrollees also report barriers associated with language and cultural differences. The results point to a need to develop and offer sensitivity education across the health care system (providers, health plans, educational institutions and professional associations). Communities most affected by these barriers are uniquely positioned to work toward creative solutions to these problems, which may include:

- Diversity awareness workshops for providers that include specific information on customs, culture, and health beliefs developed by or with community members and organizations.
- Promoting, to the extent possible, training and hiring health professionals from communities of color. This would also resolve issues surrounding interpreter services described below.
- Developing strategies that prevent those actually delivering services from identifying the payer may reduce discriminatory attitudes based on enrollment status or perceived ability to pay.
- Developing mechanisms to monitor progress toward cultural and class sensitive service delivery, along with evaluating the outcomes of these health care system changes.
- Making a long-term commitment to developing a workforce of health professionals that is culturally diverse and inclusive of all of the racial and ethnic groups that it serves.

Interpreter Availability and Quality

The results point to problems with availability of interpreters, which is associated with lower use of services among adults and children, as well as issues with the quality of interpreter services. Studies show that patient satisfaction is lower between language-discordant patients and providers; miscommunication between patients and providers can increase the likelihood of medical error and/or inappropriate care, leading to higher costs; patients who cannot communicate with their providers may be less likely to comply with treatment and other physician recommendations; and language/cultural barriers may be associated with underutilization of health care services (Andrulis, Goodman, and Pryor, 2002; Collins et al., 2002).

Given the importance of the role of interpreters in access to and delivery of high quality health services, DHS can work with communities, professional interpreters, MHCP providers, and health plans to:

- Develop outreach programs to inform MHCP enrollees about the availability of interpreters, their rights to interpreters, and how to access these services.
- Explore the feasibility of engaging “cultural brokers” to assist in this process. Cultural brokers are both bilingual and bicultural and therefore are able to both interpret the words as well as the culture and customs essential to devising appropriate policies and procedures.
- Explore the feasibility of both engaging additional professional interpreters as well as mechanisms to evaluate the quality of interpreter services offered to MHCP enrollees.

Discussion

This project provides the first large-scale, statewide effort to understand the barriers to access and use of preventive health care services experienced by MHCP enrollees in six communities: Somali, Hmong, Hispanic/Latino, African American, American Indian, and European American.

The study addressed three important questions:

- What is the impact of race/ethnicity on the variation in use of services, when controlling for other variables?
- What is the impact of race/ethnicity on the variation in difficulties accessing needed services, when controlling for other variables?
- What relationships exist between barriers and use of services, and does that vary by race/ethnicity?

It is important to acknowledge that results from the study cannot explicitly reflect the health care experiences of other population groups enrolled in MHCP such as foreign-born European Americans (for example immigrants from Russia and other European countries); non-Hmong Asian Americans; and non-Somali foreign born Africans.

Addressing the barriers identified in this study requires the commitment and creativity of all actors: DHS, health plans, providers, professional associations, educational systems, community members and organizations. Solutions to these problems should be informed by those from the community and tailored to the needs of the community. The challenge is to engage communities in a manner that does not suggest or encourage competition for scarce resources across communities.

References

- Adelmann PK, Asche SE. *Minnesota behavioral health treatment needs assessment: Comparisons of health plans participating in the Prepaid Medical Assistance Program*. St. Paul, MN: Minnesota Department of Human Services Performance Measurement and Quality Improvement Division, 2002.
- Andrulis, D., Goodman, N., & Pryor, C. *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency*. Boston, MA: The Access Project, 2002.
- Collins, K.S., Hughes, D.L., Doty, M.M., Ives, B.L., Edwards, J.N., & Tenney, K. *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*. New York, NY: The Commonwealth Fund, 2002.
- Farley Short, P., McCormack, L, Hibbard, J., Shaul, J.A., Harris-Kojetin, L., Fox, M.H., Damiano, P., Uhrig, J.D., Cleary, P.D. (2002). Similarities and differences in choosing health plans. *Medical Care*, 40, 289-302.
- Harrison PA, Beebe TJ, McRae JA, Asche SE. *An Evaluation of Behavioral Health Services by Minnesota Medicaid Managed Care Enrollees: A Field Test of the Experience of Care and Health Outcomes (ECHO) Survey*. St. Paul, MN: Minnesota Department of Human Services Performance Measurement and Quality Improvement Division, 2001.
- Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academy Press, 2002.
- McRae, J.A., & Castellano, S. *Barriers to Preventive Care for Children*. St. Paul, MN: Minnesota Department of Human Services Performance Measurement and Quality Improvement Division, 2002.
- Minnesota Department of Health. Center for Health Statistics. *Populations of Color in Minnesota*, Fall 2002. Available at <http://www.health.state.mn.us/omh/healthstatus.pdf>.
- Minnesota Department of Human Services. *Medicaid and MinnesotaCare Health Care Quality Survey Results*. St. Paul, MN: Minnesota Department of Human Services Performance and Quality Improvement Division, 2001
- Parker, J. D., & Makuc, D. M. (2002). Methodologic Implications of Allocating Multiple-Race Data to Single-Race Categories. *HSR: Health Services Research*, 37(1), 203-215.

Technical Appendix A: Methodology

1. The Sample

The project team obtained a file from the Minnesota Department of Human Services (DHS) that contained all non-institutionalized public health care program enrollees in managed care and about one-third of enrollees in fee-for-service, as of the date that data were pulled (3/20/03). Table A-1 compares enrollees in fee-for-service who were included in the sampling frame with those who were mistakenly excluded. The index of dissimilarity quantifies the differences between the groups on each of the factors listed; it can be interpreted as the proportion of the sampling frame that would have to be recategorized for the distributions to be identical.

Fortunately, the error does not seem to have seriously biased the fee-for-service component of the sample. The differences between the distributions of those in the sampling frame and those not in the sampling frame are relatively minor. We compared the distributions of race, ethnicity, nationality, language, age, gender, education, employment, and several variables measuring the basis of eligibility in MHCP, and found differences (indices of dissimilarity) between the two groups of between 1 and 18%, with an average of 6.7%. The largest difference occurs for race, for which 18% of enrollees in the sampling frame are the “wrong” race. However, the difference is fortuitous in that the sampling frame is short of European Americans and those whose race is unknown, two groups to be undersampled for the survey. Furthermore, the sampling frame captures the vast majority, about three-fourths, of the minority groups being oversampled, in part because minority groups are disproportionately enrolled in managed care. In short, although the sampling frame, and hence the sample, disproportionately represent enrollees in managed care, they seem to do an otherwise good job of representing the population of MHCP enrollees.

Table A-1. Distributions of Various Factors for Enrollees in and out of the Sampling Frame.

Variable	Index of Dissimilarity	Category	In Sampling Frame	Out of Sampling Frame
Age	0.088	0-17	34.1%	33.4%
		18-65	60.1%	52.0%
		65 +	5.8%	14.6%
Race	0.176	Asian	6.4%	3.7%
		African American	21.0%	11.8%
		American Indian	7.5%	1.8%
		Pacific Islander	0.1%	0.1%
		Unknown	4.0%	13.1%
		White	60.9%	69.5%
Nationality	0.028	African	2.4%	1.6%
		C. American/Caribbean	1.0%	1.6%
		European	0.4%	0.3%
		SE Asian	3.2%	1.5%
		Other Non-US	1.4%	1.3%
		US	91.6%	93.8%

Language	0.028	English	85.8%	86.9%
		Spanish	2.1%	3.1%
		Hmong	3.2%	1.4%
		Somali	2.2%	1.2%
		Other/Unknown	6.7%	7.4%
Ethnicity	0.021	Hispanic	5.3%	6.6%
		Not Hispanic	93.8%	91.7%
		Unknown	0.9%	1.7%
Gender	0.009	Female	53.8%	54.7%
		Male	46.2%	45.3%
Education	0.046	< 12	67.4%	72.0%
		12	25.7%	22.7%
		> 12	6.9%	5.4%
Employed	0.121	Yes	9.9%	7.0%
		No	27.8%	18.5%
		Unknown	62.4%	74.4%
Eligibility	0.082	Aged	2.6%	5.3%
		Blind/Disabled	21.6%	14.1%
		MFIP	13.1%	12.3%
		Needy Child/Pregnant Woman	33.5%	36.7%
		Other Medical	2.8%	4.2%
		Other/Unknown	26.6%	27.4%
Disabled ^a	0.136	Yes	45.6%	32.1%
		No	54.4%	67.9%
Spenddown ^a	0.026	Yes	6.1%	8.7%
		No	93.9%	91.3%
Waiver ^a	0.045	Yes	6.2%	10.8%
		No	93.7%	89.2%

^a Specialized types of eligibility.

The enrollee file was de-duplicated by recipient identification number. To increase participation and minimize the effects of sample clustering, the remaining sample frame included only one person per household. From this data file, a total of 9,350 enrollees were selected to receive the survey so that a target of 4,400 surveys would be completed.

Because the principal focus of the current investigation was on disparities in the use of preventive and other health services, as well as factors that discourage the use of services among African American, American Indian, Hispanic/Latino, Somali, Hmong, and European American children and adults, the sample was stratified by race and ethnicity. In light of low enrollment rates in some racial/ethnic strata, the sample was further split into two random samples. In the first sample, the simple random sample (SRS), random sampling of the entire MHCP enrollee population was conducted with the expectation of 1,400 completions.

In the second sample, enrollees in certain strata were over-sampled to study barriers and service use within specific racial/ethnic groups. Random sampling within strata was done for a total of 3,000 expected completions in this sample. By dividing a heterogeneous population into relatively homogeneous subpopulations, precise estimates from any one stratum can be obtained with relatively small samples within that stratum. This approach preserves the

ability to calculate estimates for various strata as well as for enrollees as a whole with known statistical precision.

A total of 224 cases were ruled ineligible to participate in the survey once contact was made. Of the 9,350 cases that were eligible to participate, surveys were completed by 4,953 cases. Table A-2 provides target sample sizes and the actual number of completes by stratum. While the targets were exceeded in several strata (see Mail + Phone column), the targets were not met for the American Indian and African American strata.

Table A-2 also provides the upper and lower bound response and cooperation rates for each of the strata sampled for the current study. Essentially, the response rate is the ratio of completed interviews to eligible addresses or numbers dialed. The cooperation rate is the ratio of completed interviews to all eligible respondents contacted. The lower bound rates use a definition of eligible cases that excludes those respondents who moved out of state, or are in jail or any other institutional setting or group quarters. In addition to these exclusions, the upper bound rate excludes from the denominator those cases with bad contact information (e.g., non-deliverable address and no telephone number). The SRS stratum (Sample 1) obtained the highest response and cooperation rates, regardless of how the rates were calculated. Irrespective of stratum, the upper bound response rates approached or surpassed 50% and cooperation rates were in the 70-90% range.

Table A-2: Final Upper and Lower Bound Response and Cooperation Rates by Sampling Stratum

Stratum	Target	Completes			Lower RR	Upper RR	Lower Coop.	Upper Coop.
		Mail	Phone	Mail + Phone				
SRS	1400	1379	477	1856	63.0%	66.6%	84.6%	88.5%
American Indian	600	338	190	528	42.9%	49.1%	80.7%	86.0%
African American	600	354	227	581	46.7%	52.4%	78.0%	84.1%
Hispanic/Latino	600	324	339	663	54.5%	58.6%	85.0%	91.4%
Hmong	600	585	112	697	56.5%	57.6%	70.3%	92.2%
Somali	600	304	324	628	50.4%	54.5%	75.0%	90.1%

The response rates observed in Table A-2 surpass those seen in most recent DHS studies. For example, the recently completed DHS Minnesota Mental Health Needs Assessment Study that included a telephone survey of Prepaid Medical Assistance Program (PMAP) enrollees yielded a response rate of 29% (Adelmann & Asche 2002). The Experience of Care and Health Outcomes (ECHO) survey pilot completed by DHS in 2001 obtained a response rate of 45% using a mail/telephone mixed-mode approach for PMAP enrollees who used behavioral health care services in the preceding year (Harrison, Beebe, McRae & Asche 2001). Using a similar mixed-mode mail/telephone design for a Consumer Assessment of Health Plans (CAHPS) survey, the Minnesota Health Data Institute achieved a 42% response rate for the PMAP population and a 52% for MnCare enrollees (Minnesota Department of Human Services 2001). The sample and data collection methodology of the DHS CAHPS study most closely resembles that used in the current study, and the SRS stratum in

particular. The fact that response rates of over 60% are observed in that stratum is a testament to the effectiveness of the mixed-mode methodology employed in this study. It also comports with a recently conducted study of children enrolled in MHCPs where a 66% response rate was observed (McRae & Castellano, 2002).

2. Data Collection

The present study utilized a mixed mode methodology comprised of an initial contact by mail and a telephone follow-up to non-respondents. Mixed mode is common; for example, it was used with the CAHPS and the ECHO surveys.

An initial mail survey was attractive because it is the least costly method. The possible downsides of a mail-only approach include that they take 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. Using a mixed methodology approach, Gallagher et al. (2000) obtained response rates of 63% for children and 73% for adults enrolled in Massachusetts Medicaid.

In light of the above, we implemented the following steps for the survey data collection:

- We ran sample lists through an update-append process to clean contact information prior to first mailing.
- Several weeks prior to the first mailing of the surveys and periodically throughout data collection, formal notices were published alerting communities of the study. The notices served to inform prospective respondents that they might be surveyed on various health topics in the near future and to remind them to complete the survey.
- We sent the first questionnaire to sampled enrollees. The mailing envelope was sent with a “Forwarding and Address Correction Requested” instruction. When a mailing was returned with an address correction, the sample file was updated. If the mailing was returned as undeliverable, further address searches were attempted.
- About two weeks after the first mailing, a second questionnaire was mailed to nonrespondents.
- About three weeks after the first mailing, computer-assisted telephone interviewing (CATI) for non-respondents was initiated. Each telephone number in the non-responding sample was called until there was a minimum of 10 “no answer” dispositions. Another 10 attempts to interview were made once a contact was made. Interviews were attempted at various times of the day and on different days of the week. At this point, another attempt at searching for a better telephone number via directory assistance was made. Respondents contacted in this phase were encouraged to mail in their completed questionnaires or to complete a telephone interview. Those who preferred to respond by telephone were interviewed via the CATI system.

Collaboration with individuals and organizations that represent African American (including Somali), American Indian, Hispanic/Latino, and Asian American (including Hmong)

communities was key to increasing response rates. These individuals and organizations were essential for understanding barriers to participation and methods to reduce these barriers and therefore increase response rates.

The following adjustments and additions to the above protocol were made in an attempt to maximize contacts with prospective respondents:

- A pre-notification letter describing the purpose of the survey and informing them that prospective respondents would be contacted by mail in the near future was added to the protocol (see Appendix A: Prenotification Letters). Such pre-notification has been shown to significantly increase respondents' willingness to participate in a survey and overall response rates (Smith, Chey, Jalaludin, Salkeld, & Capon, 1995; Gibson, Koepsell, Diehr & Hale 1999).
- When mailings were returned with new addresses, we re-mailed to those new addresses. We received 336 undeliverable mailings with new address information. (An additional 1,179 were returned with no forwarding information available.)
- When the self-administered survey was designed, we included telephone numbers for respondents to call. We dedicated phone lines for Spanish, Hmong, and Somali messages. We kept logs documenting each call, then called those respondents back.
- When we attempted a telephone contact, if we were told the respondent no longer lived there, we asked for a new addresses and/or phone number.
- Answering machine messages were left explaining the study. Messages included the interviewer's name and affiliation, purpose of the call, and day and time when she or he would call back. Leaving such messages has been shown to increase the rate of reaching a household by as much as 15% (Harlow, Crea, East, Oleson, Fraer & Cramer, 1993). Overall response rates have been shown to be similarly increased (Koepsell, McGuire, Longstreth, Nelson, & LaBelle, 1996).
- The refusal rate was quite low (4% of the total cases available for telephone contacts). Refusal conversions were attempted with about 75% initial refusals because doing so has been found to increase final response rates by about 4% (Allison & Yoshida 1989). Some of the refusals were extremely firm and these were not called, however. There were a few angry refusals; the Managing Director called back to apologize for the call.
- The frequency of callbacks was increased to identify indeterminate numbers. The number of calls made per number (up to 58), is many more than are usually made in a survey of this type. The standard procedure in many cases is to finalize the status of a telephone call number after 8 calls (Allison & Yoshida, 1989).

3. Special Tracking Procedures

Searches were made on the name of the respondent, the address, the old phone number, and the last name if the name was unusual. We searched the white pages of the telephone book, conducted internet searches, and made additional searches when we found the original telephone number listed to someone else; we then searched on that name. We also made calls to the respondent if we found a name and address match or if we found the name with a different address, to the person at the address listed even if the name was different (not

including apartment addresses), and to people with the same surname (if the name was unusual) asking for the respondent. We focused this latter type of calling in the Greater Minnesota where we were more likely to contact a relative of the respondent and where we eliminated fewer names as being too common. Care was taken to insure that the correct person was contacted.

We also called respondents who returned the self-administered survey but omitted some questions. If we could not reach the person for any reason, we sent a letter asking the respondent to call us. This helped in completing many of the self-administered forms with missing items. Finally, DHS was provided a list of children in the sample because we did not have parent/guardian name and contact information for the child cases. DHS provided updated contact information for them.

4. Data Collection Timeline

Important events in the collection of data are noted in Table A-3. Initial mailing dates were staggered largely to accommodate the development and refinement of the different versions of the survey instrument. In the case of the Little Earth reservation, data collection did not start until we had an opportunity to meet with representatives of that community.

Table A-3: Data Collection Timeline

Activity	Population	Date(s)
Send pre-notification letters	Adult	4/23/03
Send pre-notification letters	Child	5/5/03
1 st Mailing	Adults	5/8/03 – 5/13/03
1 st Mailing	Child	5/15/03 – 5/16/03
1 st Mailing	Little Earth	5/21/03
2 nd Mailing	Adults	6/3/03 – 6/4/03
2 nd Mailing	Child	6/5/03 – 6/6/03
2 nd Mailing	Little Earth	6/12/03
Telephone Interviewing starts		
- English	Adult & Child	6/16/03
- Spanish	Child	6/17/03
- Spanish	Adult	6/20/03
- Somali	Adult	6/19/03
- Somali	Child	6/27/03
- Hmong	Adult	7/14/03
- Hmong	Child	7/15/03
Data collection ends		7/31/03

5. Weighting and Post-stratification

The data were weighted to correct for unequal selection probabilities of individuals and post-stratified to match population controls. Table A-4 provides the information used to construct the sample expansion weights. The probability of selection was calculated by dividing the number of completes by the total number of individuals eligible within each stratum. Individual weights in this first step are calculated by taking the inverse of the selection probability within each stratum.

Table A-4: Sample Expansion Weights for Sampling Strata

Stratum	Completes ^a	Universe	Probability of Selection	Individual Weights
SRS	1847	251048	.0074	135.14
American Indian	526	3575	.147	6.80
African American	579	30652	.0189	52.91
Hispanic/Latino	661	15378	.043	23.26
Hmong	696	4899	.142	7.04
Somali	622	5847	.1066	9.38

^a The total number of completes in Table A-4 (n = 4931) does not match the total number of completions provided earlier in Table A-1 (n = 4953) because prior to weighting, 22 cases were deleted because they were deemed to be only partially completed or completed in a suspicious manner (e.g., respondents chose only the first response option on all items).

The distribution of the race/ethnicity variable was generated once the individual weights were applied and compared to the population distribution to assess whether post-stratification to population controls was necessary. Comparisons of the differences in the two distributions demonstrated that post-stratification was warranted (see Table A-5).

Table A-5: Differences Between Sample Weighted for Unequal Selection Probabilities and the Population Distribution

Race/ethnicity	Weighted Sample (a)	Population Distribution (b)	Relative Difference (a-b)	Percent Difference
Hispanic/Latino	10.16	6.78	3.38	40%
Hmong	3.73	2.15	1.58	54%
Somali	3.46	2.60	0.86	28%
White non Hispanic	58.33	67.62	-9.29	-15%
African American	17.53	13.51	4.02	26%
American Indian	4.60	3.45	1.15	29%
Asian/Pacific Islander	2.19	3.90	-1.71	56%

Table A-6 shows the post-stratification adjustment factors for each of the seven racial and ethnic categories. The adjustment factor was calculated by dividing the population proportion by the comparable proportion in the weighted sample for each of the racial and ethnic categories.

Table A-6: Post-Stratification Adjustments

Race/ethnicity	Weighted Sample (a)	Population Distribution (b)	Adjustment Factor (b/a)
Hispanic/Latino	10.16	6.78	.667
Hmong	3.73	2.15	.576
Somali	3.46	2.60	.751
White non Hispanic	58.33	67.62	1.159
African American	17.53	13.51	.770
American Indian	4.60	3.45	.750
Asian/Pacific Islander	2.19	3.90	1.781

We used these individual level weights whenever analyses were conducted on the entire survey population and the strata were combined. Any analyses conducted within strata were done with unweighted data.

Finally, after weighting the data and as analyses were undertaken, it was discovered that for 29 cases, enrollees under 18 years of age were sent (and completed) a questionnaire due to inaccurate age information in the DHS administrative data, under-reporting of age in the survey, or both. Since the Institutional Review Board application and approval stipulated that minors were to be excluded from direct data collection, these cases were omitted from the analysis. Therefore, a total of 4,902 cases were included in the analysis file.

6. Measuring Race and Ethnicity

The primary classificatory variable used in the analyses was race/ethnicity. For purposes of the present study, race/ethnicity was categorized using the standards set forth by the Office of Management and Budget (OMB). Briefly, the OMB standards recommend that if two responses are chosen, and one is White/European American, the minority race can be assigned. This is consistent with the 'whole assignment, smallest group' strategy discussed in the literature (Parker & Makuc, 2002). Using this method, when a respondent selects multiple racial categories, the response is assigned to the smallest group. For example, if a respondent marked both African American and American Indian, the American Indian category would be assigned due to this group's smaller representation in the population. The respondent's ethnicity (Hispanic/Latino, Hmong, Somali) was assigned before race. Using these decisions rules, the race categories in this study were: non-Hispanic European American, American Indian, US born African American, Hispanic/Latino, Hmong, Somali, other foreign born African, and non-Hmong Asian/Pacific Islander. Unfortunately, the sample size for the latter two groups was too small to provide reasonably reliable estimates. The entire sample was included in all analyses, however estimates were not reported for other foreign born African and non-Hmong Asian/Pacific Islander respondents.

7. Recoding Primary Measures

In order to simplify data analysis and the interpretation of results, several of the primary measures utilized in the current study were dichotomized. A listing of the primary measures, their associated survey items (see Technical Appendix B: Questionnaires), and the manner in which they were recoded is provided in Table A-7.

Table A-7: Item Recoding

Measure	Survey Item(s)	Recoding
Use of preventive care	3	1 = Visit for regular/routine care in past year; 0 = Other
Use of acute care	2	1 = Visit for illness or injury in past year; 0 = Other
Financial and coverage barriers	8K, 8L	1 = Big or Small Problem; 0 = No problem
Access barriers	8A, 8C, 8D, 8G, 8J	1 = Big or Small Problem; 0 = No problem
Family and work responsibilities	8I, 8F	1 = Big or Small Problem; 0 = No problem
Trust in doctors	8M	1 = Big or Small Problem; 0 = No problem
Language, cultural, religious barrier	8B, 8E, 8H	1 = Big or Small Problem; 0 = No problem
Perceived discriminatory attitudes	17A – 17E	1 = Almost always, usually, sometimes; 0 = Never
Interpreter availability	19A	1 = Almost never, sometimes, usually; 0 = Almost always
Interpreter quality	19B – 19D	1 = None, a little, some; 0 = A lot

Other than the measures relating to use of medical services, each of the measures listed in Table A-7 was coded so that the higher value in the dichotomy (1) was indicative of a problem within that dimension. For example, if in answering the question, “How much does having an interpreter help you understand what is being done?” the respondent indicated anything but “a lot,” the response would be coded as “1” and interpreted as a problem.

8. Analytic Strategy

The analyses included computing univariate statistics to describe the distribution of the major variables, bivariate analyses to describe differences between groups unadjusted for covariates, and multivariate statistics to explore variation in barriers and utilization of preventive and other health services.

- **Univariate statistics:** Distributions of measures of utilization for preventive and other care and barriers to care were generated for the stratified random sample and the sub-populations. The central statistics included means for interval variables and proportions for categorical variables. Standard deviations (where applicable) and confidence intervals were computed.
- **Bivariate analyses:** These analyses tested for differences between groups in utilization of preventive and other care and differences in the experience of barriers. The two central grouping variables of interest were: **race/ethnicity** and **age** (child vs. adult). Because most of the measures were categorical, the significance of differences was tested by chi-square statistics. When appropriate to level of measurement, unadjusted odds ratios were computed.

- **Multivariate analyses:** The focus of these analyses was on explaining variation in the utilization of preventive and other health care, and variation in the experience of barriers. Dummy variables were computed to measure race/ethnicity, with European Americans typically comprising the reference category. Again, because the dependent variables were dichotomous, logistic regressions were computed. The multivariate analyses were always conducted separately for adults and children.

In the body of the report, most of the tests of significance rely on the results of the bivariate analyses described above. Only when the multivariate analyses offered a different interpretation of the findings did we highlight the results of the multivariate analyses.

Technical Appendix B: Adult and Child Questionnaires

ID LABEL

HEALTH CARE IN MINNESOTA ADULT SURVEY

May I please speak to (RESPONDENT NAME)?

My name is _____ and I'm calling from the University of Minnesota, School of Public Health. We're working with the Minnesota Department of Human Services on a study to help them better understand the problems people have getting health care. You were selected at random from lists of people who have been enrolled in one of Minnesota's health care programs.

This study takes about 9 to 12 minutes. 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. 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 or if there is any question you don't want to answer, please feel free to stop me.

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 research files identified with numbers, not names.

First, I have just a few questions about your health.

1. In general, how would you rate your overall health? Would you say it is excellent, very good, good, fair or poor? (Included in most national/state surveys)

- 1 EXCELLENT
- 2 VERY GOOD
- 3 GOOD
- 4 FAIR
- 5 POOR
- 7 DON'T KNOW
- 9 REFUSED

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 CHOICES) (Adapted from National Health Interview Survey; Shape II)

- 1 WITHIN THE PAST YEAR
- 2 1 TO 2 YEARS (MORE THAN 1, LESS THAN 3)
- 3 3 TO 5 YEARS
- 4 MORE THAN 5 YEARS
- 7 DON'T KNOW
- 9 REFUSED

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. (DO NOT READ CHOICES) (Adapted from the BRFSS)

- 1 WITHIN THE PAST YEAR
- 2 1 TO 2 YEARS (MORE THAN 1, LESS THAN 3)
- 3 3 TO 5 YEARS
- 4 MORE THAN 5 YEARS
- 7 DON'T KNOW
- 9 REFUSED

4. Where do you usually go for regular or routine care? Would you say, (CHECK ONE ONLY) (adapted from surveys that ask about respondent's usual place of care: National Health Interview Survey, Shape II, Commonwealth Fund)

- 01 a spiritual or traditional healer or shaman
- 02 a chiropractor,
- 03 an acupuncturist or herbalist
- 04 an emergency room at a hospital
- 05 an urgent care center
- 06 a community health center
- 07 an Indian health center
- 08 an outpatient clinic in a hospital
- 09 a doctor's office or clinic or
- 10 some other kind of place. What would that be? _____
- 97 DON'T KNOW
- 98 N/A: NO REGULAR CARE
- 99 REFUSED

5. How much regular or routine care have you needed in the past five years? Would you say a lot, some, a little or none?

- 1 A LOT
- 2 SOME
- 3 A LITTLE

} → GO TO QUESTION 6 BELOW

- 4 NONE

→ 5a. Is this because you have been healthy and haven't needed any care?

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 9 REFUSED

- 7 DON'T KNOW → GO TO QUESTION 6 BELOW
- 9 REFUSED → GO TO QUESTION 6 BELOW

6. How often in the past five years have you felt that you could get the health care you needed? Would you say almost never, sometimes, usually or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

7. During the past year did you go to the dentist?

1 YES



7a. How much of a problem was it for you to get dental care? Was it a big problem, a small problem or no problem at all? <input type="checkbox"/> 1 A BIG PROBLEM <input type="checkbox"/> 2 A SMALL PROBLEM <input type="checkbox"/> 3 NO PROBLEM AT ALL <input type="checkbox"/> 7 DON'T KNOW <input type="checkbox"/> 9 REFUSED

2 NO



7b. What is the main reason you did not go to the dentist in the past year? <input type="checkbox"/> 1 You couldn't find a dentist who would accept you as patient <input type="checkbox"/> 2 You couldn't get an appointment at a time you could go? <input type="checkbox"/> 3 You didn't need any dental care in the past year. <input type="checkbox"/> 4 You didn't know your State Program paid for dental care. By State Program, we mean Medicaid, Medical Assistance or Minnesota Care. <input type="checkbox"/> 5 Was there some other reason you didn't go to the dentist in the past year? What was that? <input type="checkbox"/> 7 DON'T KNOW <input type="checkbox"/> 9 REFUSED

7 DON'T KNOW
 9 REFUSED



GO TO QUESTION 8 BELOW

8. People sometimes have problems getting health care. For each of these, 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. (Adapted from unmet need sections of surveys such as SHAPE, National Health Interview Survey, the Invisible Child; response-set adapted from CAHPS)

8a. The first one is, difficulties with transportation such as getting to the doctor's office or clinic. Is that a big problem, a small problem or not a problem for you?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8b. The doctors don't speak the same language that you do. Is that a big problem, a small problem or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8c. Getting an appointment as soon as you need?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8d. Knowing where to go.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8e. Doctors don't understand your culture. Is that a big problem, a small problem or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8f. Work or family responsibilities make it difficult for you to get the health care you need?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8g. The doctor's office or clinic isn't open when you can go?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8h. Doctors don't respect your religious beliefs?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8i. Finding someone to take care of your children makes it difficult to get the health care you need?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 8 N/A NO CHILDREN
- 9 REFUSED

8j. You can't see the doctor you want to see?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8k. You worry that your insurance won't cover the care you might receive. Is that a big problem, a small problem or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8l. You worry that you will have to pay more for the care than you expect, such as additional charges besides co-pays?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8m. You worry that doctors are not trustworthy. Is that a big problem, a small problem or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

Now thinking about your last visit to a doctor or clinic,

7. What was the reason for that visit? Was it for... (Adapted from Community Tracking Survey)
- 1 (a) care for a chronic condition such as cancer treatment, heart problems, arthritis or so on
 - 2 (b) care for a new or acute illness or injury such as a cold, the flu or a broken arm or
 - 3 (c) regular or routine care such as blood pressure or cholesterol checks, a mammogram or a physical checkup?
 - 7 DON'T KNOW
 - 9 REFUSED

These next questions ask about your health care provider. While there are many types of health care providers, in this survey we are referring to doctors or physicians, as well as nurse practitioners, physician assistants, and nurses.

10. Which of the following places best describes where you last saw a doctor or health care provider? Was it in ... (Adapted from surveys that ask about respondent's usual place of care: National Health Interview Survey, Shape II, Commonwealth Fund)
- 1 a doctor's office or clinic
 - 2 an emergency room
 - 3 an urgent care center
 - 4 a hospital
 - 5 an outpatient clinic in a hospital
 - 6 a community health center or
 - 7 an Indian health center?
 - 97 DON'T KNOW
 - 99 REFUSED
11. Thinking of your last visit to a doctor or clinic, how would you rate how well your health care provider listened to you? Would you say their listening was... (Adapted from Community Tracking Survey)
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair or
 - 5 Poor
 - 7 DON'T KNOW
 - 9 REFUSED

12. During your last visit, how would you rate how well the health care provider explained things in a way you could understand? Would you say their explanation was... (Adapted from Community Tracking Survey)

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair or
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

13. During this visit, do you think that the health care provider did...

- 1 More than they should have done
- 2 About what they should have done or
- 3 Less than they should have done
- 7 DON'T KNOW
- 9 REFUSED

14. Still thinking of your last visit, how many days did you wait between when you made the appointment and when you actually saw the health care provider? (Adapted from Community Tracking Survey)

- 1 ___ ___ Days (If same day write 0)
- 2 ___ ___ Weeks
- 3 ___ ___ Months
- 7 DON'T KNOW
- 8 N/A: WALKED IN
- 9 REFUSED

15. About how long did you have to wait in the office before seeing a doctor or health care provider? (Adapted from Community Tracking Survey)

- 1 ___ ___ Minutes or 2 ___ ___ Hours
- 7 DON'T KNOW
- 9 REFUSED

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

16. Overall, how would you rate your health care? (Adapted from Commonwealth Fund; Community Tracking Survey)

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair or
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

17. For each of the following, please tell me how often you think it causes health care providers to treat you unfairly. (Adapted from California Health Interview Survey)

17a. Your race, ethnicity or nationality. Do you think this causes health care providers to treat you unfairly almost never, sometimes, usually or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17b. Your ability to pay. Do you think this causes health care providers to treat you unfairly almost never, sometimes, usually or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17c. Your sex or gender?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17d. Your age?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17e. Being enrolled in a Minnesota Health Care Program such as Medicaid, Medical Assistance or MinnesotaCare?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

18. Is the doctor or health care provider that you usually go to the same race or ethnicity as you? (Adapted from California Health Interview Survey)

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 9 REFUSED

19. Do you ever need an interpreter to help you speak with doctors or other health care providers due to language difficulties? (Adapted from Commonwealth Fund; CAHPS)

1 YES

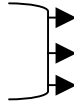


ANSWER QUESTIONS 19A-D

2 NO

7 DON'T KNOW

9 REFUSED



GO TO QUESTION 20, PAGE 12

19a. When you need an interpreter, how often is one provided for you? Would you say almost never, sometimes, usually or almost always?

1 ALMOST NEVER

2 SOMETIMES

3 USUALLY

4 ALMOST ALWAYS

7 DON'T KNOW

9 REFUSED

19b. How much does having an interpreter help you understand what the doctor is asking you? Would you say none, a little, some or a lot?

1 NONE

2 A LITTLE

3 SOME

4 A LOT

7 DON'T KNOW

9 REFUSED

19c. How much does having an interpreter help the doctor understand what you are trying to tell them? Would you say none, a little, some or a lot?

1 NONE

2 A LITTLE

3 SOME

4 A LOT

7 DON'T KNOW

9 REFUSED

19d. How much does having an interpreter help you understand what is being done?

- 1 NONE
- 2 A LITTLE
- 3 SOME
- 4 A LOT
- 7 DON'T KNOW
- 9 REFUSED

Now thinking again about the doctor or health care provider you usually see,

20. Overall, how would you rate that person? Would you say...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

For each of the next statements, please tell me if you agree or disagree.

21. I trust that my doctor or other health care provider will put my interests above everything else. (Adapted from Community Tracking Survey)

1 AGREE



Would you say you strongly agree or somewhat agree?

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

- 3 SOMEWHAT DISAGREE
- 4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22A – D, BELOW

9 REFUSED



GO TO QUESTION 22A – D, BELOW

22a. I am afraid that my provider might not do enough to find out what is really making me sick. Do you agree or disagree?

1 AGREE



Would you say you strongly agree or somewhat agree?

1 STRONGLY AGREE

2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

3 SOMEWHAT DISAGREE

4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22B – D, PAGE 14

9 REFUSED



GO TO QUESTION 22B – D, PAGE 14

22b. I am afraid that the health care I receive might actually make me feel worse.

1 AGREE



Would you say you strongly agree or somewhat agree?

1 STRONGLY AGREE

2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

3 SOMEWHAT DISAGREE

4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22C – D BELOW

9 REFUSED



GO TO QUESTION 22C – D BELOW

22c. I am afraid that my provider might tell me that I have an illness I don't really have.

<input type="checkbox"/> 1 AGREE	→	Would you say you strongly agree or somewhat agree? <input type="checkbox"/> 1 STRONGLY AGREE <input type="checkbox"/> 2 SOMEWHAT AGREE
----------------------------------	---	---

<input type="checkbox"/> 2 DISAGREE	→	Would you say you somewhat disagree or strongly disagree? <input type="checkbox"/> 3 SOMEWHAT DISAGREE <input type="checkbox"/> 4 STRONGLY DISAGREE
-------------------------------------	---	---

<input type="checkbox"/> 7 DON'T KNOW	→	GO TO QUESTION 22D BELOW
<input type="checkbox"/> 9 REFUSED	→	

22d. I am afraid that my provider might not find an illness I do have.

<input type="checkbox"/> 1 AGREE	→	Would you say you strongly agree or somewhat agree? <input type="checkbox"/> 1 STRONGLY AGREE <input type="checkbox"/> 2 SOMEWHAT AGREE
----------------------------------	---	---

<input type="checkbox"/> 2 DISAGREE	→	Would you say you somewhat disagree or strongly disagree? <input type="checkbox"/> 3 SOMEWHAT DISAGREE <input type="checkbox"/> 4 STRONGLY DISAGREE
-------------------------------------	---	---

<input type="checkbox"/> 7 DON'T KNOW	→	GO TO QUESTION 23, PAGE 15
<input type="checkbox"/> 9 REFUSED	→	

23. For each of the following, please tell me how important they are to keep you from getting sick. (Adapted from California Health Interview Survey)

23a. Visiting a spiritual or traditional healer or shaman. Would you say that is very important, somewhat important or not important at all in keeping you from getting sick?

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23b. Visiting a chiropractor, very important, somewhat important or not important at all?

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23c. Visiting an alternative or complementary health care provider such as an acupuncturist or herbalist.

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23d. Visiting a doctor or clinic for a regular check-up or physical exam?

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

24. 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

- 1 Almost never
- 2 Sometimes
- 3 Usually
- 4 Almost always
- 7 DON'T KNOW
- 9 REFUSED

25. Do you agree or disagree with the next statement? "There is little doctors can do to keep me from getting sick."

1 AGREE



Would you say you strongly agree or somewhat agree?

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

- 3 SOMEWHAT DISAGREE
- 4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 26

9 REFUSED



GO TO QUESTION 26

26. Now thinking about your health, in general would you say that your health is:
(adapted from Community Tracking Survey)

- 1 Above average
- 2 About average or
- 3 Below average
- 7 DON'T KNOW
- 9 REFUSED

27. Are you limited in any way in any activities because of physical, mental or emotional problems? (Adapted from BRFSS)

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 9 REFUSED

28. 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? (BRFFS, SHAPE)

1 ____ DAYS
 7 DON'T KNOW
 9 REFUSED

29. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (BRFFS, SHAPE)

1 ____ DAYS
 7 DON'T KNOW
 9 REFUSED

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

30. GENDER (IF CAN'T TELL, ASK) (all surveys)

1 Male
 2 Female
 9 REFUSED

31. How old are you? (All surveys have some version of age)

1 ____ YEARS
 7 DON'T KNOW
 9 REFUSED

32. Are you currently... (Adapted from Commonwealth Survey)

1 Married
 2 Living in a marriage-like relationship
 3 Widowed
 4 Divorced
 5 Separated or
 6 Never married
 7 DON'T KNOW
 9 REFUSED

33. Are you a member of any of the following groups? (Meets federal OMB standards for measurement of ethnicity)

- 1 Hispanic or Latino
- 2 Hmong or
- 3 Somali
- 4 NONE OF THE ABOVE
- 7 DON'T KNOW
- 9 REFUSED

34. Which of the following best describes you? (CHECK ALL THAT APPLY)
(Meets federal OMB standards for measurement of race/ethnicity)

- 1 White or Caucasian
- 2 Black or African American
- 3 American Indian or Alaskan Native
- 4 Native Hawaiian or Pacific Islander
- 5 Asian
- 6 Or something else?
What would that be? _____
- 7 DON'T KNOW
- 9 REFUSED

35. Which of the following best describes you: (adapted from SHAPE)

- 1 Retired
- 2 Unable to work because of a disability
- 3 A Student
- 4 Not currently working for pay
- 5 Working part-time, that is less than 35 hours a week
- 6 Working full-time, that is 35 hours or more a week
- 7 DON'T KNOW
- 9 REFUSED

36. Are you currently enrolled in one of Minnesota's Health Care Programs such as Medicaid, Medical Assistance, or MinnesotaCare?

- 1 YES, I AM CURRENTLY ENROLLED
- 2 NO, BUT I WAS ENROLLED IN THE PAST
- 3 NO, I HAVE NEVER BEEN ENROLLED
- 7 DON'T KNOW
- 9 REFUSED

37. What is the highest grade or level of school you have completed? (Adapted from BRFSS) (DO NOT READ CHOICES)

- 01 NEVER ATTENDED SCHOOL
- 02 ELEMENTARY SCHOOL (GRADES 1 THROUGH 8)
- 03 SOME HIGH SCHOOL (GRADES 9 THROUGH 12)
- 04 HIGH SCHOOL GRADUATE OR GED
- 05 TECHNICAL OR VOCATIONAL SCHOOL
- 06 SOME COLLEGE OR ASSOCIATE DEGREE
- 07 FOUR YEAR COLLEGE DEGREE (BACHELORS)
- 08 GRADUATE OR PROFESSIONAL DEGREE
- 09 OTHER
DESCRIBE: _____
- 97 DON'T KNOW
- 99 REFUSED

38. Were you born in the United States? (Adapted from California Health Interview Survey)

1 YES → GO TO QUESTION 39 BELOW

2 NO →

38a. How long have you lived in the United States?
____ years

38b. What country were you born in?

7 DON'T KNOW → GO TO QUESTION 39 BELOW

9 REFUSED →

39. What language do you usually speak at home? (DO NOT READ CHOICES)
(Adapted from Census to cover main languages in MN)

- 1 ENGLISH
- 2 SPANISH
- 3 HMONG
- 4 SOMALI
- 5 SOMETHING ELSE?
Describe: _____
- 7 DON'T KNOW
- 9 REFUSED

And that was my 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.

ID LABEL

HEALTH CARE IN MINNESOTA CHILD SURVEY

Hello, may I please speak to (CHILD NAME'S MOM)?

My name is _____ and I'm calling from the University of Minnesota, School of Public Health. We're working with the Minnesota Department of Human Services on a study to help them better understand the problems people have getting health care. CHILD's name was selected at random from lists of people who have been enrolled in one of Minnesota's health care programs.

I'd like to ask you some questions about his/her health care. This study takes about 9 to 12 minutes. 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. 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 or if there is any question you don't want to answer, please feel free to stop me.

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 research files identified with numbers, not names.

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

Although you may have more than one child, for this study, please answer only for CHILD.

And is CHILD a boy or a girl.

- 1 BOY (MALE)
- 2 GIRL (FEMALE)

First, I have just a few questions about CHILD'S health.

1. In general, how would you rate his/her overall health? Would you say it is excellent, very good, good, fair or poor?

- 1 EXCELLENT
- 2 VERY GOOD
- 3 GOOD
- 4 FAIR
- 5 POOR
- 7 DON'T KNOW
- 9 REFUSED

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 CHOICES)

- 1 WITHIN THE PAST YEAR
- 2 1 TO 2 YEARS (MORE THAN 1, LESS THAN 3)
- 3 3 TO 5 YEARS
- 4 MORE THAN 5 YEARS
- 7 DON'T KNOW
- 9 REFUSED

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. (DO NOT READ CHOICES)

- 1 WITHIN THE PAST YEAR
- 2 1 TO 2 YEARS (MORE THAN 1, LESS THAN 3)
- 3 3 TO 5 YEARS
- 4 MORE THAN 5 YEARS
- 7 DON'T KNOW
- 9 REFUSED

4. Where does your child usually go for regular or routine care? Would you say, (CHECK ONE ONLY)

- 01 a spiritual or traditional healer or shaman
- 02 a chiropractor
- 03 an acupuncturist or herbalist
- 04 an emergency room at a hospital
- 05 an urgent care center
- 06 a community health center
- 07 an Indian health center
- 08 an outpatient clinic in a hospital
- 09 a doctor's office or clinic or
- 10 some other kind of place. What would that be? _____
- 97 DON'T KNOW
- 98 N/A: NO REGULAR CARE
- 99 REFUSED

5. How much regular or routine care has your child needed in the past five years? Would you say a lot, some, a little or none?

- 1 A LOT
- 2 SOME
- 3 A LITTLE



GO TO QUESTION 6 BELOW

- 4 NONE



5a. Is this because he/she has been healthy and hasn't needed any care?

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 9 REFUSED

7 DON'T KNOW → GO TO QUESTION 6 BELOW

9 REFUSED → GO TO QUESTION 6 BELOW

6. How often in the past five years have you felt that CHILD could get the health care he/she needed? Would you say almost never, sometimes, usually, or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

7. During the past year, did CHILD go to the dentist?

1 YES →

7a. How much of a problem was it for him/her to get dental care? Was it a big problem, a small problem or no problem at all?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NO PROBLEM AT ALL
- 7 DON'T KNOW
- 9 REFUSED

2 NO →

7b. What is the main reason your child did not go to the dentist in the past year?

- 1 You couldn't find a dentist who would accept your child as a patient
- 2 You couldn't get an appointment at a time your child could go
- 3 CHILD didn't need dental care in the past year
- 4 You didn't know his/her State Program paid for dental care. By State Program, we mean Medicaid, Medical Assistance, or Minnesota Care
- 5 Or was there some other reason your child didn't go to the dentist in the past year? What was that?
- 7 DON'T KNOW
- 9 REFUSED

7 DON'T KNOW →

9 REFUSED →

GO TO QUESTION 8 NEXT PAGE

8. People sometimes have problems getting health care. For each of these, 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. (Adapted from SHAPE)

8a. The first one is, difficulties with transportation such as getting to the doctor's office or clinic. Is that a big problem, a small problem, or not a problem for you and your child?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8b. The doctors don't speak the same language as you or your child. Is that a big problem, a small problem, or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8c. Getting an appointment as soon as your child needs one?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8d. Knowing where to go.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8e. Doctors don't understand your child's culture. Is that a big problem, a small problem or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8f. Work or family responsibilities make it difficult for you to get the health care your child needs.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8g. The doctor's office or clinic isn't open when you or your child can go?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8h. Doctors don't respect your child's religious beliefs?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8i. Finding someone to take care of your other children makes it difficult to get the health care CHILD needs.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 8 N/A NO OTHER CHILDREN
- 9 REFUSED

8j. CHILD can't see the doctor you want him/her to see.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8k. You worry that your child's insurance won't cover the care CHILD might receive. Is that a big problem, a small problem, or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8l. You worry that you will have to pay more for your child's care than you expect, such as additional charges besides co-pays.

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8m. You worry that doctors are not trustworthy. Is that a big problem, a small problem, or not a problem?

- 1 A BIG PROBLEM
- 2 A SMALL PROBLEM
- 3 NOT A PROBLEM
- 7 DON'T KNOW
- 9 REFUSED

8n. We are interested in learning about the experiences of older children. When CHILD goes to the doctor or clinic, how often do you go with him/her?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

8o. When you go with CHILD to the doctor or clinic, how often do you go with him/her into the examination room?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

Now thinking about your child's last visit to a doctor or clinic,

9. What was the reason for that visit? Was it for...

- 1 (a) care for a chronic condition such as cancer treatment, heart problems, asthma and so on
- 2 (b) care for a new or acute illness or injury such as a cold, the flu, a broken arm, or strep throat.
- 3 (c) regular or routine care such as a physical checkup or vaccinations?
- 7 DON'T KNOW
- 9 REFUSED

These next questions ask about your child's health care provider. While there are many types of health care providers, in this survey we are referring to doctors or physicians, as well as nurse practitioners, physician assistants, and nurses.

10. Which of the following places best describes where CHILD last saw a doctor or health care provider? Was it in

- 01 a doctor's office or clinic
- 02 an emergency room
- 03 an urgent care center
- 04 a hospital
- 05 an outpatient clinic in a hospital
- 06 a community health center or
- 07 an Indian health center
- 97 DON'T KNOW
- 99 REFUSED

11. Thinking of your child's last visit to a doctor or clinic, how would you rate how well the health care provider listened to you or your child? Would you say their listening was...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair or
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

12. During your child's last visit, how would you rate how well the health care provider explained things in a way you or your child could understand? Would you say their explanation was...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair or
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

13. During this visit, do you think that the health care provider did

- 1 More than they should have done
- 2 About what they should have done or
- 3 Less than they should have done
- 7 DON'T KNOW
- 9 REFUSED

14. Still thinking of your child's last visit, how many days did CHILD wait between when the appointment was made and when he/she actually saw the health care provider? ...

- 1 ___ ___ Days (If same day write 0)
- 2 ___ ___ Weeks
- 3 ___ ___ Months
- 7 DON'T KNOW
- 8 N/A: WALKED IN
- 9 REFUSED

15. About how long did he/she have to wait in the office before seeing a doctor or health care provider? ...

- 1 ___ ___ Minutes or
- 2 ___ ___ Hours
- 7 DON'T KNOW
- 9 REFUSED

Now thinking about CHILD'S health and health care providers in general,

16. Overall, how would you rate CHILD'S health care?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair or
- 5 Poor
- 7 DON'T KNOW
- 9 REFUSED

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

17a. Your child's race, ethnicity or nationality. Do you think this causes health care providers to treat him/her unfairly almost never, sometimes, usually, or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17b. Your ability to pay. Do you think this causes health care providers to treat him/her unfairly almost never, sometimes, usually, or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17c. Your child's sex or gender.

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17d. Your child's age.

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

17e. Being enrolled in a Minnesota Health Care Program such as Medicaid, Medical Assistance, or MinnesotaCare.

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

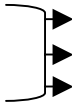
18. Is the doctor or health care provider that your child usually goes to the same race or ethnicity as your child?

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 8 N/A: NO USUAL CARE PROVIDER
- 9 REFUSED

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

1 YES → ANSWER QUESTIONS 19A-D

- 2 NO
- 7 DON'T KNOW
- 9 REFUSED



GO TO QUESTION 20, PAGE 13

19a. When you or your child need an interpreter, how often is one provided?
Would you say almost never, sometimes, usually, or almost always?

- 1 ALMOST NEVER
- 2 SOMETIMES
- 3 USUALLY
- 4 ALMOST ALWAYS
- 7 DON'T KNOW
- 9 REFUSED

19b. How much does having an interpreter help you or your child understand what the doctor is asking? Would you say none, a little, some, or a lot?

- 1 NONE
- 2 A LITTLE
- 3 SOME
- 4 A LOT
- 7 DON'T KNOW
- 9 REFUSED

19c. How much does having an interpreter help the doctor understand what you or your child are trying to tell them? Would you say none, a little, some, or a lot?

- 1 NONE
- 2 A LITTLE
- 3 SOME
- 4 A LOT
- 7 DON'T KNOW
- 9 REFUSED

19d. How much does having an interpreter help you or your child understand what is being done?

- 1 NONE
- 2 A LITTLE
- 3 SOME
- 4 A LOT
- 7 DON'T KNOW
- 9 REFUSED

Now thinking again about the doctor or health care provider CHILD usually sees,

20. Overall, how would you rate that person? Would you say...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor
- 7 DON'T KNOW
- 8 N/A: NO USUAL CARE PROVIDER
- 9 REFUSED

For each of the next statements, please tell me if you agree or disagree.

21. I trust that my child's doctor or other health care provider will put CHILD'S interests above everything else.

1 AGREE



Would you say you strongly agree or somewhat agree?

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

- 3 SOMEWHAT DISAGREE
- 4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22A – D, PAGE 14

9 REFUSED



GO TO QUESTION 22A – D, PAGE 14

22a. I am afraid that CHILD'S provider might not do enough to find out what is really making him/her sick. Do you agree or disagree?

1 AGREE



Would you say you strongly agree or somewhat agree?

1 STRONGLY AGREE

2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

3 SOMEWHAT DISAGREE

4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22B – D, PAGE 14

9 REFUSED



GO TO QUESTION 22B – D, PAGE 14

22b. I am afraid that the health care CHILD receives might actually make him/her feel worse.

1 AGREE



Would you say you strongly agree or somewhat agree?

1 STRONGLY AGREE

2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

3 SOMEWHAT DISAGREE

4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 22C – D BELOW

9 REFUSED



GO TO QUESTION 22C – D BELOW

22c. I am afraid the provider might tell me that CHILD has an illness he/she doesn't really have.

1 AGREE →

Would you say you strongly agree or somewhat agree? <input type="checkbox"/> 1 STRONGLY AGREE <input type="checkbox"/> 2 SOMEWHAT AGREE

2 DISAGREE →

Would you say you somewhat disagree or strongly disagree? <input type="checkbox"/> 3 SOMEWHAT DISAGREE <input type="checkbox"/> 4 STRONGLY DISAGREE

7 DON'T KNOW →

GO TO QUESTION 22D BELOW

 9 REFUSED →

GO TO QUESTION 22D BELOW

22d. I am afraid that CHILD'S provider might not find an illness he/she does have.

1 AGREE →

Would you say you strongly agree or somewhat agree? <input type="checkbox"/> 1 STRONGLY AGREE <input type="checkbox"/> 2 SOMEWHAT AGREE

2 DISAGREE →

Would you say you somewhat disagree or strongly disagree? <input type="checkbox"/> 3 SOMEWHAT DISAGREE <input type="checkbox"/> 4 STRONGLY DISAGREE

7 DON'T KNOW →

GO TO QUESTION 23 BELOW

 9 REFUSED →

GO TO QUESTION 23 BELOW

23. For each of the following, please tell me how important they are to keep your child from getting sick. (Adapted from California Health Interview Survey)

23a. Visiting a spiritual or traditional healer or shaman. Would you say that is very important, somewhat important, or not important at all in keeping your child from getting sick?

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23b. Visiting a chiropractor, very important, somewhat important or not important at all?

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23c. Visiting an alternative or complementary health care provider such as an acupuncturist or herbalist.

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

23d. Visiting a doctor or clinic for a regular check-up or physical exam.

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT IMPORTANT AT ALL
- 7 DON'T KNOW
- 9 REFUSED

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

- 1 Almost never
- 2 Sometimes
- 3 Usually
- 4 Almost always
- 7 DON'T KNOW
- 9 REFUSED

25. Do you agree or disagree with the next statement? "There is little doctors can do to keep my child from getting sick."

1 AGREE



Would you say you strongly agree or somewhat agree?

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE

2 DISAGREE



Would you say you somewhat disagree or strongly disagree?

- 3 SOMEWHAT DISAGREE
- 4 STRONGLY DISAGREE

7 DON'T KNOW



GO TO QUESTION 26

9 REFUSED



GO TO QUESTION 26

26. Now thinking about your child's health, in general would you say that CHILD'S health is: (Community Tracking Survey)

- 1 Above average
- 2 About average or
- 3 Below average
- 7 DON'T KNOW
- 9 REFUSED

27. Is CHILD limited in any way in any activities because of physical, mental, or emotional problems? (Adapted from BRFSS)

- 1 YES
- 2 NO
- 7 DON'T KNOW
- 9 REFUSED

28. 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?

1 _____ DAYS
 7 DON'T KNOW
 9 REFUSED

29. Thinking about your child's mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was his/her mental health not good?

1 _____ DAYS
 7 DON'T KNOW
 9 REFUSED

31. How old is CHILD?

1 _____ YEARS
 7 DON'T KNOW
 9 REFUSED

40. Is your child a member of any of the following groups?

1 Hispanic or Latino
 2 Hmong or
 3 Somali
 4 NONE OF THE ABOVE
 7 DON'T KNOW
 9 REFUSED

41. Which of the following best describes your child? (CHECK ALL THAT APPLY)

1 White or Caucasian
 2 Black or African American
 3 American Indian or Alaskan Native
 4 Native Hawaiian or Pacific Islander
 5 Asian
 6 Or something else?
What would that be? _____
 7 DON'T KNOW
 9 REFUSED

42. Is CHILD currently enrolled in one of Minnesota's Health Care Programs such as Medicaid, Medical Assistance, or MinnesotaCare?

- 1 YES, IS CURRENTLY ENROLLED
- 2 NO, BUT WAS ENROLLED IN THE PAST
- 3 NO, HAS NEVER BEEN ENROLLED
- 7 DON'T KNOW
- 9 REFUSED

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

43. GENDER (IF CAN'T TELL, ASK)

- 1 MALE
- 2 FEMALE
- 9 REFUSED

44. Are you now...

- 1 Married
- 2 Living in a marriage-like relationship
- 3 Widowed
- 4 Divorced
- 5 Separated or
- 6 Never married
- 7 DON'T KNOW
- 9 REFUSED

45. Which of the following best describes you:

- 1 Retired
- 2 Unable to work because of a disability
- 3 A Student
- 4 Not currently working for pay
- 5 Working part-time, that is less than 35 hours a week
- 6 Working full-time, that is 35 hours or more a week
- 7 DON'T KNOW
- 9 REFUSED

46. What is the highest grade or level of school you have completed?
(DO NOT READ CHOICES)

- 01 NEVER ATTENDED SCHOOL
- 02 ELEMENTARY SCHOOL (GRADES 1 THROUGH 8)
- 03 SOME HIGH SCHOOL (GRADES 9 THROUGH 12)
- 04 HIGH SCHOOL GRADUATE OR GED
- 05 TECHNICAL OR VOCATIONAL SCHOOL
- 06 SOME COLLEGE OR ASSOCIATE DEGREE
- 07 FOUR YEAR COLLEGE DEGREE (BACHELORS)
- 08 GRADUATE OR PROFESSIONAL DEGREE
- 09 OTHER
DESCRIBE: _____
- 97 DON'T KNOW
- 99 REFUSED

47. Were you born in the United States?

1 YES → GO TO QUESTION 48 NEXT PAGE

2 NO →

47a. How long have you lived in the United States?

____ years

47b. What country were you born in?
Please specify:

7 DON'T KNOW →

9 REFUSED →

GO TO QUESTION 48 NEXT PAGE

48. What language do you usually speak at home? (DO NOT READ CHOICES)

- 1 ENGLISH
- 2 SPANISH
- 3 HMONG
- 4 SOMALI
- 5 SOMETHING ELSE?

Please describe: _____

- 7 DON'T KNOW
- 9 REFUSED

49. What is your relationship to CHILD?
(DO NOT READ CHOICES)

- 1 PARENT/STEP-PARENT/FOSTER PARENT
- 2 GRANDPARENT
- 3 OTHER RELATIVE
- 4 GUARDIAN
- 7 DON'T KNOW
- 9 REFUSED

And that was my 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.
