



# **Experiencing the Health Care System: Insights from Multicultural Health Care Consumers**

**A Summary of Focus Group Results**

**Multicultural Health Task Force  
Multicultural Health Research Initiative  
Virginia Department of Health  
2001**

## FORWARD

The Virginia Department of Health's Multicultural Health Task Force (MCHTF) is pleased to present *Experiencing the Health Care System: Insights from Multicultural Health Care Consumers*- a summary of focus group findings specifically written for public health policy-makers, program personnel and providers serving multicultural populations. The purpose of this report is to assist agencies, organizations and individuals in creating more culturally and linguistically competent policy, programs and service delivery in an effort to eliminate racial and ethnic disparities in health.

In its effort to provide research-based information, MCHTF created the Multicultural Health Research Initiative. This initiative has expanded the knowledge base regarding the public health system's capacity to provide culturally and linguistically competent services to minority populations, best practices among public health and private agencies and identified consumer-identified access issues. *Experiencing the Health Care System: Insights from Multicultural Health Care Consumers* summarizes the access and utilization issues of 16 multicultural groups residing in Virginia. The experiences and findings outlined do not necessarily apply to every racially, ethnically or culturally diverse individual living in Virginia. Moreover, it is our expectation that these findings will be used in conjunction with other research and information to produce culturally and linguistically competent services and to highlight the importance of the elimination of health disparities.

I wish to thank the MCHTF Research Advisory Committee members, our multicultural facilitators and our communities, through whose diligence and commitment this report was produced. We all look forward to the extensive use of this information and the contributions we are confident this will make to the elimination of racial and ethnic health disparities.

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**Most importantly**, we especially thank our facilitators for without their active participation and hard work this effort could not move forward.

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The assistance and support of each of these individuals and organizations are very much valued and appreciated.

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# ABOUT THE MULTICULTURAL HEALTH TASK FORCE (MCHTF)

## **Purpose**

To strengthen statewide research efforts directed at the elimination of racial and ethnic health disparities.

## **History**

Over the course of the last 4 years, the Multicultural Health Task Force (MCHTF) has made significant inroads into efforts aimed at the elimination of racial and ethnic health disparities. Supported by a grant from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (State Systems Development Initiative SSDI MCJ-51T012-04), the task force initially functioned as a small cultural competency workgroup, providing training to more than 150 Virginia Department of Health (VDH) staff in the Office of Family Health Services. In 1998, the group evolved into the Multicultural Health Task Force (MCHTF) consisting of members from the offices of Family Health Services, Minority Health, Health Policy, Primary Care and Rural Health and Epidemiology. As an intra-agency task force working within VDH and with continued support through MCHB, this task force worked on numerous projects related to cultural competency and the elimination of racial and ethnic disparities in health. These include, but are not limited to cultural competency and research training, state and national presentations, collaborative efforts between MCHTF and AHEC, and the Multicultural Health Research Initiative. For more than 3 years, the Multicultural Health Research Initiative has been at the forefront of MCHTF priorities. This project has expanded the knowledge base regarding the public health system's capacity to provide culturally competent services to minority populations, and identified consumer-based access issues from perspectives of 17 different racial and ethnic communities in Virginia. Initiative findings have been presented at both the 1999 and 2000 American Public Health Association Annual Conferences, the 2000 Maternal, Infant and Child Health Epidemiology Workshop: Reducing Disparities in Maternal and Child Health Outcomes and at the 1999 Association of Maternal and Child Health Programs Annual Meeting. In addition to *Experiencing the Health Care System: Insights from Multicultural Health Care Consumers*, the following is a list of additional reports that have resulted from the Multicultural Health Research Initiative.

### *Research Reports*

- ***Cultural Competency in Public Health: Meeting the Health Care Needs of Virginia's Multicultural Populations, 2000***
- ***Cultural Competency in Public Health: Virginia's Response to Dental Trends and Issues among Multicultural Populations, 1999***
- ***Cultural Competency in Public Health: Virginia's Response to Children with Special Health Care Needs, 1998***

## **Statewide Task Force Expansion**

With increased emphasis placed on collaboration between agencies, MCHTF expanded into a statewide taskforce in May 2000. Current partners supporting MCHTF include the Department of Social Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Systems Management for Human Services in Alexandria, Virginia Center for Health Statistics, Opening Doors Program, Migrant Health Network, Area Health Education Centers (AHEC), National Foundation for Vietnamese-American Voters, Virginia Technical Institute for Community Health, Virginia Commonwealth University Survey and Evaluation Research Lab, University of Virginia Center for Improving Minority Health, James Madison University Department of Sociology and Anthropology, Eastern Virginia Medical School Center for Pediatric Research, Hispanic Committee of Virginia, voluntary refugee resettlement organizations such as the Ethiopian Community Development Council and the Virginia Council of Churches, and private health systems such as Bon Secours Richmond Health System and INOVA Healthsource. This new collaboration at the state level brings Health and Human Services (DHHS) funded partners together to respond to the national goal of 100% access and 0 disparities, by initializing a cross-cutting strategy to develop and implement a statewide coordinated research agenda that will effectively support all efforts to eliminate disparities.

## **Current MCHTF Activities**

MCHTF is working collaboratively to develop and implement a statewide research agenda aimed at the elimination of disparities in health. Components of current efforts include the identification of research gaps as they relate to Virginia's racial and ethnic communities, prioritization of research areas in which the development of strategies and interventions would yield the greatest impact, the identification of existing statewide data resources, including infrastructure, capacity, linkages and quality, the identification of funding sources and research, and education and information dissemination to health and human services providers and communities.

In addition to possessing skills in research and evaluation, many MCHTF members have extensive national experience providing technical assistance, training and consultation on issues related to cultural and linguistic competence. The task force will continue to serve as a valuable link to resources for all health and human services programs, health systems, educational institutions and communities.

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## INTRODUCTION

The current literature discusses the changing face of health care in the United States. Persons seeking care can no longer be described as simply patients, but consumers of health care. Consumers wish to be fully informed about their diagnosis and included in decisions about their treatment plan. Along with increased availability of health information, diverse ethnic populations are steadily increasing. These populations must seek health care from a western care system that may have little or no similarity to their respective health systems or treatment regimens (Chesanow, 1998). Respective studies documenting health care satisfaction among African-American and Spanish-speaking Americans reported that these groups were dissatisfied with care and were at greater risk for receiving low quality care and poor health outcomes when compared to non-Hispanic Whites. These studies reported Blacks felt White doctors treated them worse than doctors of other races, adding to the growing body of research that report ethnic differences between physicians and patients may act as barriers to communication (Johnson Publishing Co, 1999). Likewise, Spanish-speaking Americans reported clinicians treated them with less respect than their English-speaking patients (Moreles et al, 1999). The new health care consumer is educated about their condition, ethnically diverse and increasingly vocal about their care. The new consumer will motivate clinicians to reassess treatment styles and incorporate new consumer-focused techniques in the development of treatment plans.

Meeting Healthy People 2010 goals and overall health status improvements for Virginia's citizens largely depends on the ability to improve health indicators and outcomes among minority and multicultural populations. Recent birth certificate data reveal that one-third of Virginia resident live births are from a minority group. Hispanics and Asians each represent close to five percent of the maternal and child health population, while Blacks account for nearly one out of five citizens. In recent years, multicultural and minority populations have represented an ever-increasing proportion of the state's maternal and child health population. Virginia now ranks 9<sup>th</sup> among states with the largest immigrant resident population and 8<sup>th</sup> among intended residence for new arrivals. This growth has placed Virginia as having the 16<sup>th</sup> largest Hispanic and 9<sup>th</sup> largest Asian populations in the country.

Half of all Virginia resident infant deaths occur to a member of a minority group. State vital statistics reveal the Black infant mortality rate to be two and half times higher than the White infant mortality rate. While the difference in infant deaths resulting from congenital anomalies has narrowed among White and Black infants, gaps remain substantial in deaths from low weight births and Sudden Infant Death Syndrome (SIDS). Black neonates die at a rate nearly three times greater than White neonates. In the past five years, these disparities have persisted, and in some parts of the state have even increased. The disparities extend beyond infant mortality and reach into numerous other health indicators. As the cultural landscape of Virginia has become more diverse in recent years, these disparities have also emerged in other racial and ethnic groups. Recent data show that Hispanics in Virginia now have the lowest rate of first trimester prenatal care utilization, with close to three out of ten pregnant women entering care late.

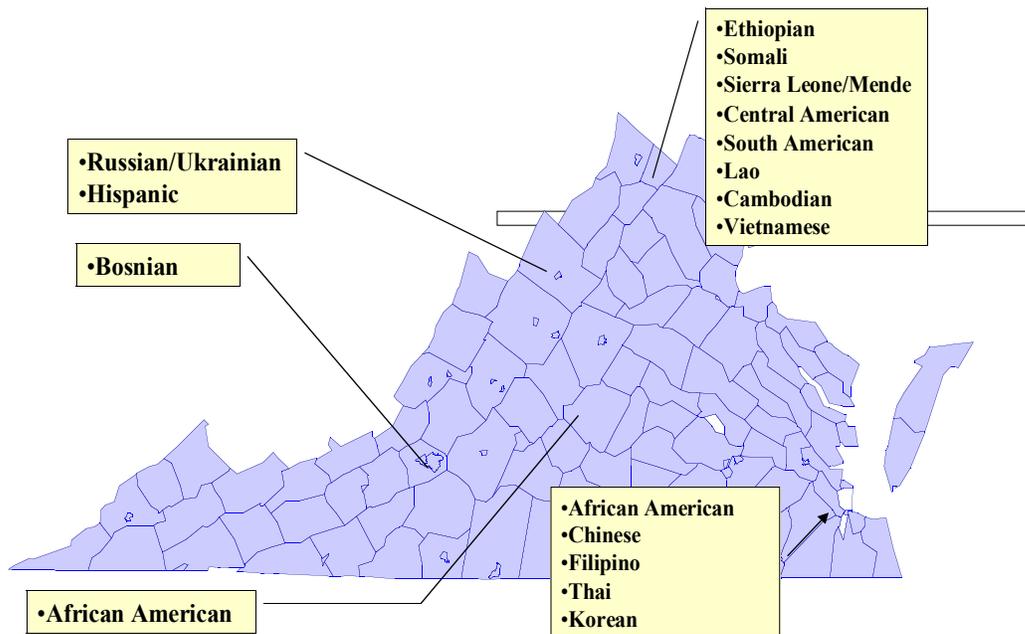
Understanding racial, ethnic, and geographic disparities presents a challenge, one that has become both a state and national priority. Within the Commonwealth of Virginia, focus groups were conducted to gain insight into the opinions, perceptions and expectations of multicultural health care consumers regarding their health care experiences. Seventeen focus groups were conducted with representatives of various ethnic and cultural populations in Virginia. Each

focus group represented one or two ethnic groupings and the sessions were organized and conducted by bilingual, bicultural facilitators. The racial and ethnic groups included:

**Table 1: Multicultural Focus Groups and Geographic Location**

<b>Multicultural Focus Groups Conducted by MCHTF</b>	<b>Geographic Location of Targeted Population</b>
<b>African American</b> (1 rural, 1 urban)	Buckingham County, VA: Rural Norfolk, VA: Urban
<b>Bolivian-Peruvian</b>	Northern Virginia
<b>Bosnian</b>	Roanoke, VA
<b>Cambodian</b>	Northern Virginia
<b>Central American</b>	Northern Virginia
<b>Chinese</b>	Norfolk, Tidewater, Virginia Beach, VA
<b>Ethiopian</b>	Northern Virginia
<b>Filipino</b>	Norfolk, Tidewater, Virginia Beach, VA
<b>Hispanic</b>	Harrisonburg, VA
<b>Korean</b>	Norfolk, Tidewater, Virginia Beach, VA
<b>Russian/Ukrainian</b>	Harrisonburg, VA
<b>Lao</b>	Northern Virginia
<b>Sierra Leonean</b>	Northern Virginia
<b>Somali</b>	Northern Virginia
<b>Thai</b>	Norfolk, Tidewater, Virginia Beach, VA
<b>Vietnamese</b>	Northern Virginia

## Geographic Location of Focus Groups



VDH recognizes the multitude of diverse populations residing in the Commonwealth. Due to resource constraints, only a specified number of focus groups were conducted. Focus group selection was based upon several established criteria such as geographic accessibility to resources, the impact of multicultural populations on health and human services providers in specific geographic areas, and provider feedback.

This report summarizes the findings of 203 focus group participants who were asked questions regarding their knowledge and understanding of the health care system, their use of the system, potential barriers to access, and their experience with the system and recommendations for improving the system. The issues that were raised by focus group participants richly detailed access and quality issues experienced by many of Virginia's multicultural populations when attempting to access and utilize health care services from both the public and private sector. Similarly, all consumers cited confusion navigating the U.S. health system, lack of coverage and inability to communicate effectively as barriers to access and deterrents to receipt of quality care. It is these issues that may potentially contribute to many of the underlying causes to racial and ethnic health disparities.

## METHODOLOGY

This report is based upon qualitative data gathered from focus group sessions and individual interviews conducted during 1999 and 2000. The primary purpose of these data are to provide a framework for understanding and applying cultural data in assessing how interventions could be developed successfully and how direct service utilization could be enhanced and promoted among multicultural groups.

Using a questionnaire developed by the *Cross Cultural Health Care Program* based in Seattle, Washington, the MCHTF Research Advisory Committee created a modified version which utilized a standardized series of questions to elicit individual responses within the context of a group. The questions were designed to solicit input on issues related to health care access, utilization, barriers and experience with the health care system from individuals who access care from both privately and publicly funded health services. Participants who do not access services were also included in the study.

Each question set was reviewed in a formal training session with each individual facilitator in order for that facilitator to understand the types of information we were seeking. This allowed for the facilitator to translate the question appropriately without losing sight of the question's goal. Additionally, the facilitator was allowed to modify or delete questions in order to enhance the tool's sensitivity. The facilitators conducted the focus group or interview in the language appropriate for the participants. This allowed participants to use their own vocabulary, language and communication styles to articulate their answers. Each session was taped and subsequently translated and transcribed by the facilitator.

In addition to participating verbally in the focus group, each respondent was asked to complete a participant information sheet in order to collect demographic data. Participants were asked basic demographic and health care coverage information about themselves and their children. Due to limited resources, the participant information sheet was not translated into the various languages spoken by participants. Facilitators assisted with the translation and completion of these forms.

A total of 203 men and women participated in 17 focus groups. The sample size of each group consisted of 12 individuals, however, in one instance, only 11 individuals participated.

The majority of facilitators were identified through community-based organizations. Each facilitator was trained by the MCHTF. Focus groups were conducted in a setting the facilitator thought would be most comfortable and appropriate for the project. Food or refreshments were provided at all sessions and incentives were given to all focus group participants by the MCHTF.

In several instances, modifications to the methodology had to be exercised. The Russian/Ukrainian facilitator felt that the most effective way of implementing the questionnaire would be to interview individuals separately. The Bosnian focus group was conducted in three different sittings with 4 participants in each. Given the diversity of facilitators and participants, methodology flexibility was necessary to execute the project. Since the project goal was not to test a hypothesis, but rather an information-seeking exercise, it was imperative to create a culturally sensitive and informally structured process.

## **FOCUS GROUP FINDINGS**

\*A distinction should be made between quotes made by either a “Hispanic Participant”, “Central American Participant” or a “Bolivian-Peruvian Participant”.

“Hispanic Participant” refers to an individual who participated in the Hispanic focus group conducted in Harrisonburg, VA. Members of this group may have come from Mexico, Central or South America.

“Central American Participant” refers to an individual who participated in the Central American focus group conducted in Northern Virginia. Members of this group originally came from one of several Central American countries.

“Bolivian-Peruvian Participant” refers to an individual who participated in the Bolivian-Peruvian focus group conducted in Northern Virginia. Members of this group originally came from either Bolivia or Peru.

## Knowledge and Understanding of the Health Care System

### What health care services are available for you to use in the area that you live?

In general, participants of all focus groups were knowledgeable about health care services available in their communities but there was a general lack of understanding regarding the types of services provided with the exception of their primary health care providers. A wide array of services were mentioned including hospitals, clinics, the military, urgent care, public health clinics, family physicians, HMOs, free clinics, emergency rooms and pharmacies. Many participants provided specific names of the service providers or organizations and were familiar with locations.

A few groups reported fewer sources of services in their communities. These included the Bolivian-Peruvian, Bosnian, Russian/Ukrainian, and Ethiopian groups. These groups reported fewer sources of care with private physicians, emergency care and free clinics being the primary sources mentioned. While these groups may not be as familiar with services it could also be that fewer health services are available in their respective communities. However, it should be noted that the Bolivian-Peruvian and Ethiopian focus groups participants reside in a resource-rich geographic area, and the Bosnian and Russian/Ukrainian focus group participants reside in smaller cities located in the Shenandoah mountain region.

Members of the Bosnian, Ethiopian, Sierra Leone, Thai, and Cambodian groups reported insurance coverage (public or private) as a factor in their use and choice of health services. For instance, the Ethiopian group members were familiar with local hospitals but used the free clinic for care because they do not have insurance.

Thai participants mentioned the use of free clinics for uninsured or underinsured and wanted more information on these clinics to share with others in their community. This group spoke in great detail about insurance coverage, co-payments, primary care physician referrals, and where to get immunizations for children and flu shots. Several groups were not aware of free clinics in their communities.

Somali group members listed sources that may be available in that particular community including university hospitals and a mobile health clinic. This group also mentioned the Multicultural Human Services Center and Social Services. It may be that these organizations provide links and referrals to health care services and health insurance information rather than actually providing health care services.

While some members of the Hispanic group had heard about clinics or services they did not have information and details about what kind of services are provided and where they are located so have not sought care from these sources. Likewise the Korean focus group members did not know what specific services were available from health care sources and they did not know about the local health department services in particular. Both Korean and Hispanic focus group participants believed that the hospital would take care of any health problem.

Several members of groups mentioned that they were not familiar with services in their community since they were healthy and had no need to seek health care services. In addition members from several different groups reported that they were new to the area and therefore not familiar with services.

## Use of the Health Care System

### Where do you and members of your household go to receive health care?

The majority of group members from all focus groups report that they and their family members go to private physicians or private, not public health clinics. A primary factor in their choice seems to be whether they have insurance that is accepted by the private physician (public or private insurance). Those who are uninsured or underinsured tend to go to free clinics, local health department clinics and use the emergency room more frequently (Somali, Sierra Leone, Ethiopian). Several groups mentioned specifically that they seek care through private physicians and do not use hospitals unless necessary (Cambodian, Bosnian).

Most Cambodian focus group members and several members of the Lao group reported going to private physicians who are Cambodian or Vietnamese and always seek care from a clinic or a physician before going to hospital. Several reported going to local health department clinics only when they cannot get services through private physicians. Some members of the Cambodian group indicated that they or family members have sought services at health department clinics because Medicaid is accepted for prenatal care and they also want to qualify for the WIC Program.

In the Cambodian focus group a number of members mentioned that they and family members use traditional methods or herbal doctors, a healer or a monk for health services. After several days, if the illness persists, they go to see the medical doctor or go to the hospital emergency room.

A few groups had members reporting that they used urgent care centers (e.g. *Patient First*.) or emergency rooms as frequently as private physicians (African-American, Somali, Filipino) for care. Chinese participants report going to urgent care centers in the evenings when their doctor's offices are closed but were concerned about the higher costs.

In the African-American group many use private physicians but a few go to urgent care for primary services. Among the Central American participants, use of clinics and private physicians who take Medicaid is common. They report using clinics if they do not have insurance with children being seen at pediatric clinic or by pediatrician. Several group members said they seek care for children but no regular care for themselves.

Members of a few groups (Bolivian-Peruvian, Sierra Leone, Bosnian) reported that except for emergencies, they usually do not seek primary care. Members of the Bosnian group said they have not needed care – “never sick” which suggests that routine preventive care is not being sought – only if emergency or acute illness. Members of the Ethiopian group also voiced their feelings that they do not get sick all that often so when they do, they go to emergency room or free clinic because they we do not have insurance. One member of the group said:

*“Thank God I never get sick. If so I do not know what to do.”*

While Filipino group members mentioned public health department, private hospitals, and urgent care centers (Patient First) they also mentioned traditional healers and chiropractors. Lao participants also reported using a Chinese acupuncturist, and an abbot of a Loa temple where they have sought care.

The Korean group members were most likely to report that they do not have regular physicians (one member was pregnant so has an OB/GYN and one has a Pediatrician for her child). Many members said they do not go for routine care but only as the need arises with one member saying that “Mostly not go anywhere unless we are dying.”

*“Mostly not go anywhere (health care services) unless we are dying.”*

## **Health Care Provider Used**

### **What kind of health care provider do you and your family members use?**

Many groups had members who saw a variety of providers including physicians, nurses, nurse practitioners, nurse midwives and specialists (OB/GYN, psychologist, surgeon, cardiologist, podiatrist, dentist, periodontist, chiropractor, ophthalmologist). The majority of respondents in all groups mentioned physicians first and then nurses as their usual provider.

In the Chinese group, a social worker assisting with home care and therapy for other family members was considered a health provider. Some participants know social workers that have helped patients get in touch with services that hospitals do not provide (home care, physical therapy). This group also reported that they go to see a nurse practitioner only when their doctors are not available. They feel doctors are more qualified than nurses.

Participants in the Bolivian – Peruvian group also mentioned seeing mental health providers. Participants in this group also commented on their belief that doctors can cure and calm pain. They believe in medical advances for sickness saying, “I believe in doctors, professionals. It’s medical science.”

There was discussion about natural healers and herbalists in several groups. Some Chinese group members mentioned that they go to acupuncture doctors and Chinese herbal medicine doctors. A member of the African-American group also reported using a “herb doctor” and indicated that natural herbs are used by family members instead of prescribed medications. No reason for using alternative remedies as a substitute for prescribed medications was provided. Several participants from the Cambodian focus group talked about self-care using a coin rub, tiger balm, Tylenol and sleep rather than doctors because “doctors always make us take off our clothes and ask too many silly questions.” Another Chinese member said that “I hate to go to the clinic, it makes me sicker just to wait for hours to see a doctor who see us for about 15 minutes”. There was general agreement from group on this comment.

Cambodian group members explained that when sick from work, they must see a doctor for a note. Several groups (Thai, Central American, Korean) specifically mentioned that they go to pediatricians for their children and obstetrician/gynecologists for their care.

Most Korean participants did not know about nurse practitioner’s services or function nor about public health clinic services or free clinics. The overwhelming majority of all focus group participants believed that the physician is truly the health care provider and the role of nurses is to assist physicians only. Members from the Korean group did mention pharmacists as a source of primary care. Group members explained that in Korea, health care is provided only by physicians, but more people see a pharmacist initially for minor health problems. In Korea

pharmacists are able to prescribe any type of medication and function as a first-line healthcare provider.

Finally, some members from the Korean, African-American and Bolivian groups felt strongly that religion and God play a significant role in their health care services and outcomes. For instance, in the Korean group, one member said they go to a church pastor for primary care. In the Sierra Leone group a member said “I believe in God for treatment – we just pray and we believe that God heals. But, when it is going bad or when we loose faith then we have to rush to the hospital or the clinic.” Another member of this group also said that “although I have insurance – I do not use clinic or see doctors.” A member from the Bolivian-Peruvian group said “I have been getting better with the help of doctors that God has put in my path at the clinic.”

## **Type of Provider Preferred**

### **What kind of health care provider do you like to use (prefer)?**

Virtually all members of all groups preferred seeing a family physician or specialist (gynecologist) for their health care. Many people voiced their preference for seeing “their” doctor and preferred to be seen by the same physician at each visit when possible.

*“My gynecologist is extremely good and knowledgeable she also understands my culture and beliefs.”  
Sierra Leone Participant*

A member of the Hispanic group also expressed feeling trustful and comfortable with her providers:

*“I just arrived in this country and when I found out I was pregnant, I went to a clinic recommended by a friend of mine, a free clinic. I use a nurse midwife and I feel really comfortable with her.”*

There were some specific comments regarding more negative interactions with physicians that illustrate some of the differences in cultural beliefs and how providers handle them. One female participant from the Sierra Leone group provided an example:

*“I had to change my doctor because she made me feel bad for undergoing a circumcision. She went on and on about the consequences and how bad it was.”*

Members of the African-American group expressed their preferences for providers by explaining the kind of behaviors and attitudes that they would like for any providers. An example of their comments include:

*“I like doctors who answer my questions – sometimes they think you don’t know anything. I like doctors that when you challenge them, they don’t mind.”*

*“Like doctors that will tell me what the medication is used for; what they do and where they come from – answer my questions.”*

Several groups had members who preferred male or female providers based on the nature of their visit. For instance, one member from the Sierra Leone group indicated that she prefers to see a female physician for her OB/GYN needs but sees a male physician for other concerns. A male member of this group would prefer a male nurse and physician, however there has never been one available at any of the clinics from which he has sought care.

There was less agreement on the preference of seeing nurses for care although acceptability of seeing nurse practitioners and nurse midwives seemed higher than for general nursing staff.

While most group members indicated a willingness to see nurses for their care, a few groups expressed mixed reactions to nurses and even voiced their distrust of some nursing staff (Sierra Leone, Bosnian). It has been their experience that nurses show neglect unless a doctor is around. Others say that nurses have been very kind. A member of the Bosnian group also indicated that they preferred “real doctors” and specialists because nurses did not help when her son was sick.

Another factor in expressing provider preferences comes from members of the Cambodian group. The group’s facilitator offered that once some of the members are in the hospital they might confuse nurses with doctors because all in white uniforms but once in the hospital all of them have a complete trust of the health care providers. This may be a common issue among other groups as well so establishing a clear preference for physicians versus nursing (or other support staff) might be difficult.

In the Bosnian group, student interns were discussed. Two respondents preferred student interns and said their experience was similar to physician. One respondent did not have the same trust level with students and felt they might give the wrong thing and then would have to go back to see real doctor and pay more money. They said it was cheaper in the end to have a doctor.

Some participants in several groups (Ethiopian, Hispanic, Sierra Leone, Somali Russian/Ukrainian, Vietnamese) expressed the fact that although they might prefer certain physicians and providers, their type of insurance or lack of insurance dictates their provider choices:

*“We do not have any choice but to use free clinic doctors. Would like to use other doctors but very expensive.”*

*Ethiopian Participant*

*“I am not choosy with whom I see. I cannot even afford to see one. I will be happy to see any health provider regardless of gender, ethnicity, or color”*

*Sierra Leone Participant*

Seeing providers who speak the patient’s language was important to members of the Cambodian, Central American, Hispanic and Chinese groups. As a Cambodian group member said:

*“Of course we like to go directly to the clinic or hospital when we are really sick. If they don’t let us wait too long we may go more often each time when we are sick, or if they have someone who speaks Cambodian there.”*

*“Would like to see nurse who speaks my language – that is the most important – communication. Put emphasis on doctors, social workers and nurses who speak Spanish.”*  
*Central American Participant*

*“I trust the place, they speak my language, treat me well”*  
*Central American Participant*

A Chinese group member expressed their feelings about providers and communication by saying:

*“It’s not that they (doctors) must speak Chinese – depending on their abilities.”*

Several groups discussed their preferences for seeing providers from their own or a similar culture (Chinese, Lao, Thai, Vietnamese). Based on the comments, this preference goes beyond having someone who can speak the patient’s language. For instance, some members of the Thai group sought care from a Thai doctor who spoke their language and understood them.

*“It is easy to talk to the doctors from our country, they understand our problems and our illness better, and the nurses are nice to us.”*

*“They do not rush us, or make us feel like poor people.”*

There was a clear preference among Lao participants for using Asian doctors. “Most insurance companies have Asian doctors available” “I go to an Asian doctor because I think they know about Asian diseases” – ...in my opinion American and Asian doctors are a little different. American doctors may not really understand what Asian patients like, how we live, etc” “Loa and Vietnamese health problems are more or less the same – I think my doctor knows well about the disease of Asian people.”

Several participants in the Chinese group said they liked to use medical doctors who are Chinese. “I feel more at ease with a Chinese doctor – they know the Chinese – they know more of the Chinese philosophy – he uses the same American medicine – his medicine works faster – maybe his dosage is heavier.”

A Chinese participant also explained that his (American) doctor said, “It’s no use taking Ginseng.” The participant indicated that he did not appreciate the disconcerting comment made by the provider, and further explained that Ginseng is a Chinese traditional tonic believed to have multiple healing functions on the human body. These examples illustrate a level of comfort with providers that know and respect the cultural aspects of health and wellness of a culture.

The preference for using a small versus a large medical office, clinic or hospital is evident in the comments for two of the groups. The African-American groups had members who voiced their preference for smaller offices:

*I’d rather go somewhere small – build rapport – not where they push you in and out. Because, if you are going to see a doctor, they know all this personal stuff about you. If you are being pushed in and out, you are just like another stranger.”*

In stark difference, members of the Korean group would prefer to use large hospitals because they all felt a large hospital provides comprehensive services and you could walk right in for care. As a group member noted, in Korea, anyone can walk in to a large hospital for any health care need and there is the perception that care at a large hospital is better.

## Utilization of Services

### Clinics

#### When do you or members of your household seek care from a clinic?

Based on a summary of responses, all groups use clinic services (local health department, free clinic, outpatient clinic, specialty clinics) although some groups report using clinic services more frequently. These include the African-American, Bosnian, Central American, Chinese, Cambodian, Filipino, Sierra Leone, Somali and Thai groups. Most members of these groups reported using clinic services within the last three months. Groups reporting that they use clinics less frequently include the Ethiopian, Russian/Ukrainian, Lao, Korean, Vietnamese, Hispanic and Bolivian groups. Participants from these particular groups were more likely to indicate or describe the presence of physical barriers to access such as coverage and confusion than had members from the other focus groups.

Several groups reported using local clinics for a variety of services from regular check-ups and immunizations to heart, skin cancer and prostate problems noting that they go to clinic regularly for checkups and said that this was preventive. For some groups (Central American, Bosnian, Korean) most clinic visits mentioned were related to their children.

*“I don’t see a doctor, but I take my children to their doctor regularly.”*

*Korean Participant*

Some participants reported infrequent clinic visits due to self-treatment of perceived minor illnesses. A few participants also indicated that they used a friend or family member’s medication if their own symptoms were similar.

Some respondents mentioned difficulty with insurance coverage and the lack of money as a reason for not going to clinics. There also seemed to be some confusion regarding the process for applying and maintaining public health insurance.

*“My sister went [to the clinic] last week to renew her card. There is a kind of status that they have that has to be renewed when it expires. It is for low income. She has to go and renew it because she started to have health problems again.”*

*Sierra Leone Participant*

Several participants remarked that they only sought care at clinics when their self-treatment did not work and when they cannot buy some medication without prescription. (Central American, Korean).

#### How were you treated by the staff at the clinic?

Overall, participants in all groups reported that clinic doctors and staff were courteous, nice, pleasant and friendly.

*“They were cordial with me. They treated me well and with respect.”*  
*Central American Participant*

*“I went to the clinic for my children’s vaccinations because insurance doesn’t cover them. I like the care my children receive from the nutritionist who measures their growth and development.”*  
*Hispanic Participant*

There were some participants (Ethiopian, Lao, Bolivian-Peruvian focus groups) who reported that they were treated badly or that staff was “very cruel.”

*“I went to my gynecologist. The staff is not so friendly. They are not so nice. But the doctor is good. But the nurse who calls me into the room is not nice. She never smiles.”*  
*Lao Participant*

Several members of the Bolivian-Peruvian group reported that one clinic had long waits and were treated rudely by staff (not doctors). They felt they were treated poorly for not speaking English. One participant said that it was her worst experience ever and several participants specified that the “black staff” in the reception were particularly unfriendly. A few participants described specific body language of doctors and staff members that were interpreted as hostility and anger towards them (the participants).

Members of the Hispanic group said that doctors and most nurses were caring but the front desk staff (receptionists) was often very rude. Many group members felt unwelcome and discriminated against due to the language barrier.

*“The only people who don’t treat you well are the receptionists at the front desk. They ignore you and act like they don’t know what you’re saying and then you just have to go and sit.”*  
*Hispanic Participant*

A few members noted that there had been a marked improvement over the past years in how they were treated by the staff:

*“When I first went there, people were always in a bad mood and treated me rudely, but now there are only a couple of people like that there.”*  
*Hispanic Participant*

Some participants cited the long wait to get an appointment scheduled as a frustration with clinics.

*“I felt that when you want to see urgently a doctor and you are very sick, the receptionist will tell you that the doctor is very busy today, but you can see a registered nurse, otherwise you have to wait two or three days.”*  
*Somali Participant*

Although many participants reported good treatment by staff many also mentioned long waits to be seen.

*“Good service only it takes a long time.”  
Filipino Participant*

*“Last time I went to the free clinic...I lost a whole day there...when I saw the doctor he wasn't happy because I did not bring an interpreter with me.”  
Cambodian participant*

*“I went there at 10 am and waited around 1 hour, but met with the doctor for just three minutes.  
Thai Participant*

### **Did you or members of your household need an interpreter at the clinic?**

Most groups reported needing an interpreter for their clinic visits but used family members or tried to do the best they could to communicate with clinic staff. A Russian participant explained that “Yes, we need interpreter but we didn't have him. So we try by ourselves, translate what we can understand.” Many participants reported bringing young children (sons, daughters or grandchildren) to interpret like the Cambodian participant who brought his 14-year-old grandson. A few group participants said that doctors spoke their language and some participants reported using an interpreter from AHEC, a social service organization or their church. A Chinese participant said, “*We would be in trouble if we can't find an interpreter.*” Some participants said that they can manage without an interpreter but it depends upon the health provider or staff member. Another participant in the Russian group said, “*We need interpreter, of course, but we live already here for a long time and we don't have right to ask for interpreter.*”

*“I went to see my doctor yesterday. He was very courteous. I didn't have an interpreter at the time. He used simple English so I could get by.”  
Chinese participant*

*The Virginia Department of Health requests that you bring your own interpreter. There is a sign on the front desk that says bring your own interpreter.”  
Hispanic Participant*

*“They have treated me well. Sometimes you have to understand them because they have their problems. Sometimes I teach them Spanish...I try to get on their good side.”  
Central American Participant*

Some group members expressed their concern that while they can understand simple words in English and can make it through an appointment, they are concerned that they cannot properly describe their symptoms or they will not understand information such as instructions for medications or follow-up and referral instructions.

*“I don't know how to describe things, such as pin poking pain.  
Korean Participant*

*“The first time I really needed an interpreter my English tutor at Wilson Education Center helped. Now I understand the process of the chemotherapy and the treatment can be done without an interpreter.”*  
*Vietnamese Participant*

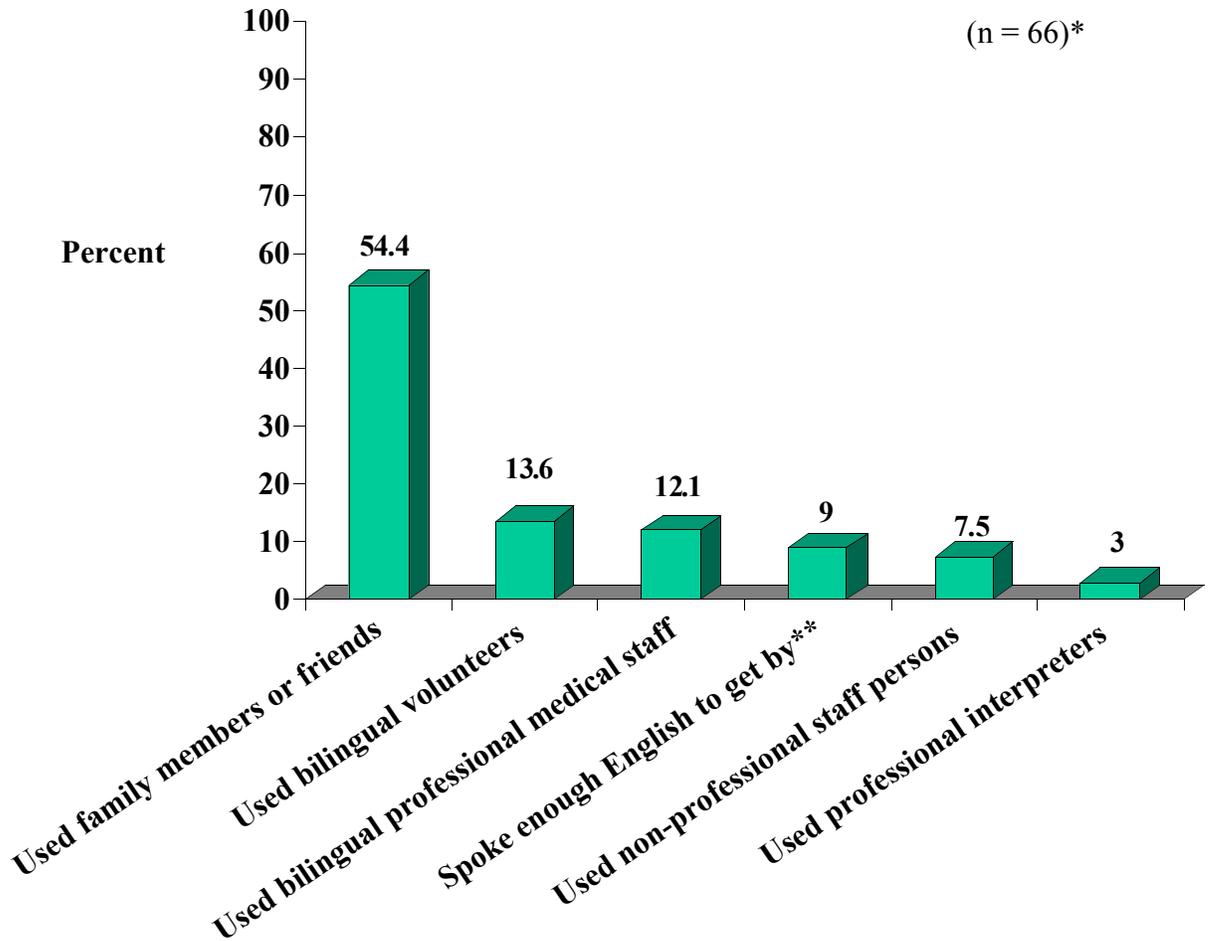
*Sometimes when I want to explain or ask something I cannot use medical terms. I cannot depend on my children. They don't speak our language very well. They cannot explain to be in good details.*  
*Loa Participant*

Likewise, several participants said they do not seek care because they cannot speak to them (doctors):

*“One of the reasons that I do not go to see a doctor is that I could not speak to them”*  
*Korean Participant*

Overall, the quality and accuracy of communication is affected by the lack of trained interpreters.

**Figure 1: Types of Language Assistance Utilized in Clinics**



\*Number of respondents who indicated that they needed or used language assistance services while visiting a clinic.

\*\*Although the participants indicated they “spoke enough English to get by” they also stated that they needed an interpreter.

### **Did you or their health improve because of this visit?**

Most members of all groups reported an improvement in their health after their clinic care. Some members expressed concern or confusion regarding some of the testing, medications or lack of referral related to their clinic visits:

*“The last time I went he (doctor) told me to go have a mammogram and pap. I am scared of it. I don’t think I have those diseases, no one in my family had that.”*  
Cambodian participant

*“To do mammogram or pap test my doctor never refer me to anyone, maybe I am too old or I don’t speak English.”*  
Cambodian participant

*“Yes, I feel better after the visit, he prescribed good medication for us and he also prescribes a big quantity. That I can take them next time I have the same symptoms.”*  
Cambodian participant

The participants who said they did not improve after treatment tended to have undiagnosed complaints or conditions that required them to seek further care.

### **Emergency Rooms**

#### **When do you or members of your household seek care from the hospital emergency room?**

Most focus group participants report using the emergency rooms when they have serious problems like asthma attacks, accidents, severe pain, poisoning, heart attack, serious bleeding, fainting, fingers cut off or broken bones. A few groups (Central American, Sierra Leone, Korean, Bosnian) specifically mentioned that they would be more likely to bring a child with an illness or injury (including a child with a fever) to the emergency room for care without waiting or using over-the-counter medications.

*“For child would go right away – for self if something just would not go away.”*  
Bosnian participant

*“When do I go? Only when pain to beyond control or only when child is ill”*  
Sierra Leone participant

Most also said they use the emergency room only if the clinic or regular physician’s office was closed (weekend, evening) and the symptoms and/or pain is uncontrollable. African-American discussed the benefits of using urgent care (e.g. *Patient First*) providers as a primary care provider (allowed on some health insurance plans) because there is extended access on weekends and evenings.

#### **When was the last time you sought care – at the emergency room?**

Most groups reported low to moderate use of emergency rooms with several members in each group saying they have never used emergency room care. In many cases, over half the members

of groups reported never using an emergency room or using emergency rooms over 2-4 years ago (Bolivian, Bosnian, Cambodian, Chinese, Hispanic, Russian, Sierra Leone). Again, most of these members reported going to the emergency room for accidents, severe pain, uncontrolled bleeding, automobile accidents, pre-term birth, ear infections, and heart conditions. Many members of each group said that they use the emergency room only in case of emergencies when their family doctor is not available (weekends, evening hours, when their doctors are not in the office).

Several groups tended to use emergency rooms more frequently with at least half of group participants reporting that they have used the emergency room with most of their visits within the last year. These include the African American, Lao, Korean, Ethiopian, Central American, and Somali groups.

### **When do you or members of your household seek care from the hospital emergency room?**

Some of the reasons they went or brought family members to the emergency room include kidney stones, home accidents, cut face at work, daughter has broken head, passed out, allergic reactions, shot (assume gun shot wound), alcohol poisoning, high fever, child stopped breathing, finger amputated, car accidents, back pain, asthma attack, serious bleeding, strong pain, a child with a fever.

Although it is difficult to interpret the nature of the illness and emergencies reported, it appears that perhaps the severity of the problems reported by these groups (more frequent users of emergency care) may actually be greater than compared to the nature of emergency room visits reported by those groups who use the emergency room less frequently. Another factor in emergency room usage may be the individual variability of hours and physicians through primary care physician offices and clinics. In some areas, primary care physicians may have extended hours and alternatives for care that provide alternatives to emergency room visits.

Similar to those groups reporting less frequent use, these groups also said that they used the emergency rooms when the clinic or their regular doctors were not available. One person reported using the emergency room while on vacation. In addition, some members of the Ethiopian and Somali groups reported their decision to use the emergency room was based on their lack of health insurance:

*“It (emergency room) was the only place to go, because we have no insurance.”*

*Ethiopian participant*

*“I go if illness is life threatening situation, serious, depends on severity of situation, but go to ER when you don’t have insurance.”*

*Somali participant*

### **How were you treated by the staff at the emergency room?**

All but two groups reported that they were treated well at the emergency rooms but most groups with the exception of two (Lao, Filipino), reported long wait times as a major complaint with some participants reporting wait times of up to 8 hours. Typical responses included:

*“Staff friendly and nice but long wait – over 4 hours”*

*Bolivian-Peruvian participant*

*“Not a lot of people – not a busy time but had to wait.”*  
*Bosnian participant*

Members of the Korean group said that their visits were positive, except for the prolonged waiting.

*“If an emergency, you expect speedy care, but it is not. I would say it is not emergency room, but a waiting room.”*  
*Korean participant*

*“Good care – no discrimination but long waits.”*  
*Sierra Leone participant*

*“Treatment OK but wait too long. The emergency room reminds me of parking lot – they will drop you anywhere”*  
*Somali participant*

Members of the Filipino and Lao groups reported good care but not long wait times.

*“Wonderful and fast response from staff.”*  
*Filipino participant*

The nature of injuries reported among the Lao participants (heart attack, car accident) and the fact that many arrived by ambulance may have made a difference in their waiting time at the emergency rooms.

A few group members were not a pleased with the care they received. For instance, in the Ethiopian group, most members said they staff was kind, friendly, and professional but a few said their care was fair, some staff members were nasty, or doctor very serious.

A Sierra Leone participant voiced concern that the emergency room was filthy saying:  
*“They did not clean up messes quickly and I’m concerned about blood and AIDS. You expect that blood would be cleaned up immediately.”*

In the Thai group, one member said that the provider did not provide information about what was wrong with the child or what they planned to do.

*“It made me feel worried because I don’t know what happened with my kid.”*

Several members of the Hispanic group had negative experiences in the emergency room with some members saying they felt discriminated against because could not speak English. In addition, they had many complaints about long waits, large bills and most were not pleased with treatment saying that the delay in treatment that they received caused other problems.

### **Did you or your family member need an interpreter for the emergency room visit?**

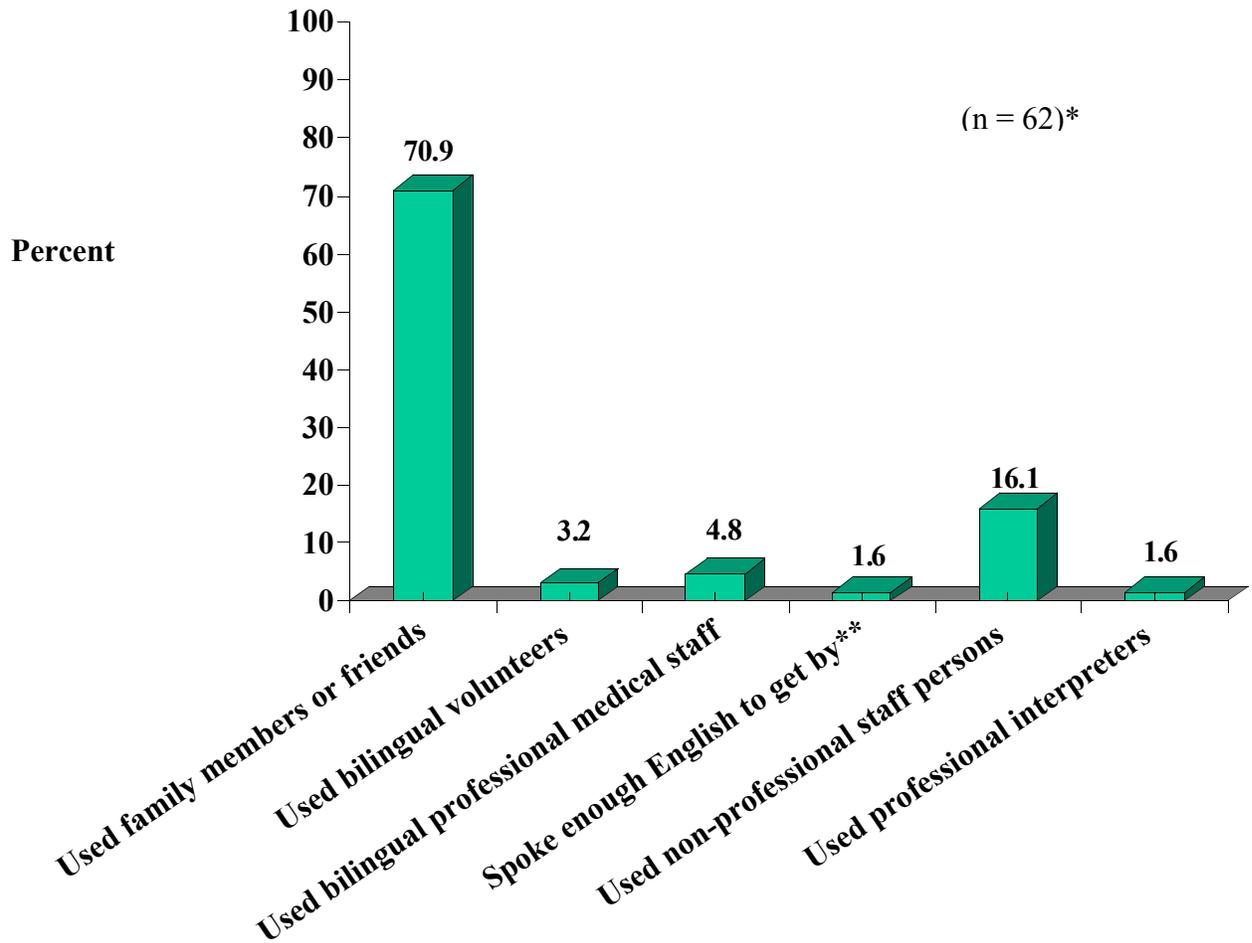
The groups with a large number of participants needing translation services include the Central American, Filipino, Korean, Lao, Russian, Ethiopian, and Somali groups. Almost all of the members in these groups needed interpreters. There were several groups with fewer group

members stating that they needed interpreters. These include the Bolivian-Peruvian, Bosnian, Cambodian, Chinese, Hispanic, Vietnamese, Thai and Sierra Leone groups.

Of those reporting a need for interpreters, most said they used a family members or friends (sister, spouse, father, daughter, a 12 year old neighbor, Refugee Resettlement Office staff member). A few members of the Central American group had members reported that interpreters provided by the hospital (doctor, nurse, staff). A Cambodian member even reported that a hospital janitor was used to interpret. Using children as interpreters was mentioned frequently in several groups.

A Filipino group member commented that it is most useful to have an interpreter to go through the whole process until dealings with hospital and doctors are over. Among the members of the Korean group, the elderly had the most need for interpretation services. Group members reported that because English speaking family members or friends accompanied them, the hospital did not ask them if they needed interpreters. A Russian group member said, "*When I can't find an interpreter I can't go to the doctor.*" An Ethiopian group member reported that there was an Ethiopian doctor when he went for emergency room care.

**Figure 2: Types of Language Assistance Utilized in Emergency Departments**



\*Number of respondents who indicated that they needed or used language assistance services while visiting a clinic.

\*\*Although the participants indicated they “spoke enough English to get by” they also stated that they needed an interpreter.

A member of the Bolivian-Peruvian group reported, *“For me it’s enough to say – no English, and somehow they bring a person that speaks Spanish.”* While another member of the same group said, *“Thank God, I don’t need an interpreter – I can speak English.”*

A Cambodian group member described the communication she had in a hospital emergency room when an interpreter was not available.

*“All hospital people were very nice to me, they talked to me very slowly and listened to me very patiently. They let me stay with her 9 days until she was discharged. They told us to come back in one week, but I never did because I couldn’t find any interpreter to help us.”*

In the Hispanic group, two members said they speak English and did not need an interpreter but one said that it would have been helpful - *“we had problems communicating and we could have used an interpreter.”*

Very few members of the Vietnamese, Thai, and Sierra Leone groups said they needed interpreters. However, it should be noted that participants felt that if they could communicate “somewhat” with providers that this was sufficient, and does not describe the quality or outcome of the encounter.

### **Did your health improve because of this visit?**

The majority of participants in all groups reported an improvement in their condition after their emergency room visit with only a few saying they needed to seek follow-up at a clinic. While most of the Thai participants said they and members of their household showed improvement from emergency room visits, 10 of 12 went back to family doctors for follow-up.

Some group members reported additional treatment was necessary after their initial emergency room visit. The secondary issues identified as needing treatment included tooth extraction, ulcers, and blood sugar.

While most members of the Ethiopian group reported improvement, one member could not find anyone to help buy medicine and another mentioned medicine was very expensive.

### **Traditional Healers**

#### **When do you or members of your household seek care from traditional healers?**

Most participants in all groups said they did not use traditional healers although some said that they would use them if they were available. Several participants reported that they used traditional healers for things such as acupuncture and herbs when they were in their native countries or living in other states. Although traditional healers are seldom used, participants reported using techniques and self-treatment remedies often used by traditional healers.

Most participants reporting past use of traditional healers said they went all the time and felt it was very effective. Several Chinese participants reported having been to traditional healers in the past 2 years for acupuncture, herbal medicine or massage when they suffered from minor illness.

In the Cambodian group a number of members mentioned that they and households use the traditional methods or herbal doctors, healer or monk for health services. After several days when the illness persists they go to see the medical doctor or go the hospital.

A member of the Lao group mentioned that they do not like or believe in black magic or traditional-alternative providers.

One person described going to a Shaman and receiving a blessing string around his arms. He explained, “I feel happy and feel recovered.” Another member spoke of knowing someone who “blows magic spells on sore spots – so she is kind of a spiritual doctor.”

Several groups spoke of traditional healers in a spiritual aspect and explained that these healers did not use remedies but recited religious readings while performing other rituals.

*“There is nothing like the Qura’an. It is like medicine.”*  
Somali Participant

*“I use spiritual healers when I feel mentally bad, sad, or depressed.”*  
Lao Participant

## **Self-Treatment**

### **When is self-treatment used?**

Most groups reported self-treatment for common illnesses and discomfort such as colds, sore throat, flu, headache, back pain, sunburn, stomach aches, tooth aches, minor illnesses and non-life threatening situations. Participants in all groups report using home remedies and over-the-counter medications for minor illnesses and to address symptoms. The most frequently reported over-the-counter medications included pain relievers, cough syrups, and cold medications.

Frequently mentioned home remedies included herbs, herbal teas, rubbing coins with tiger balm (Cambodian); asking a family member to massage their back, neck and temples (Cambodian); use of Nopal, a Mexican plant similar to cactus for treatment of diabetes (Central American); and food items such as cloves, raw garlic, honey, ginger, and lemons. Members of the Lao group also mentioned bitter melon tea and warm water and salt.

Many stated that they could treat themselves if they “know and understand their sickness.” Most all members of every group reported that they would seek medical attention if their illness persists or if symptoms got worse after self-treatment. In some cases, self-treatment does seem to be a factor of the expense of seeing a doctor.

Most groups reported they are less likely to take chances with using over-the-counter medications and home remedies with their children or grandchildren. Some group members reported that although they have health insurance they are more likely to use insurance for their children and not seek care for themselves using self-treatment instead. One Hispanic participant reported using the advice of their pharmacist in treating minor illnesses in their household.

Some members reported self-treatment for some conditions that might be considered more serious and likely to need medical attention or be symptoms of a more serious health problem such as herpes, toothaches, diarrhea and diabetes. A Sierra Leone participant voiced concern

that “Doctors in this country do not know what is Malaria or how to treat it. I will never go to the clinic if I have malaria but use over-the-counter drugs.”

## Barriers to Access

### Have you or members of your household ever had a hard time getting the care you wanted for any reason?

Some focus group participants reported that their doctors would not refer them to specialists or order blood tests or x-rays that the patients felt they needed. Most felt that the insurance system did not allow these referrals or tests and some believed that their physicians benefited from not referring them to specialists.

*“I had a doctor who didn’t want to make referrals. He wanted to treat me himself.” “So...I would say he wanted the money. Although he wouldn’t say that, he felt that he could treat me for that but you know I went to him because he was my assigned doctor. He didn’t want to make the referral out for what I needed.”*

*African-American Participant*

There was some discussion about physicians not listening to what patients need, some distrust of insurance system and frustration with the way the insurance programs work.

## Language and Interpreters

Members of several groups reported difficulty in receiving care due to language barriers and a lack of interpreters (Bosnian, Chinese, Hispanic, Korean, Somali, Russian, Vietnamese, Lao). Most reported not being able to explain their problem because they did not speak English and because they did not bring an interpreter with them.

*“I think many problems because of language. Because I don’t – we don’t know explain what is bothering us – what’s the point?”*

*Bosnian Participant*

*“Language, you go and try to speak in your best English and they look at you like you as if you were from Mars. It’s frustrating and that’s the problem.”*

*Hispanic Participant*

*“People cannot express their sickness in words so how will the doctors help them?”*

*Somali Participant*

*“I did not understand some medical terms and I am afraid that I could not interpret accurately.” Vietnamese Participant*

While some Chinese group members reported that a local hospital had a list of interpreters who could help you with language problems, most respondents reported having to use their own interpreters to arrange health appointments and go to the appointments with them.

A Russian participant explained the particular difficulty with using children as interpreters...“Biggest problem is language because when I took kids for interpreting they can’t to explain to the doctor my problem and can’t translate back what doctor said.”

### **Issues of Culture and Religion**

There were few focus group members who specifically reported culture or religion as issues in receiving care. One culturally related issue mentioned by a few participants was their discomfort with seeing a provider of the opposite sex.

*“It is difficult for me to have a physical examination because most of the doctors are men and young, and look at every part of my body. I never told my husband that, he may not let me to go again.”*

*Cambodian Participant*

*“The only problem is I don’t like to see a male doctor, especially when they check my private part.”*

*Lao Participant*

*“You go to a hospital, there is a woman, she asks you to undress, and she wants to touch all parts of your body. That’s a problem against my beliefs...There are cases where women refuse to see male doctors.”*

*Somali Participant*

One Ethiopian participant said that they did not believe in medicine...“My religious beliefs, for me to go and get a pap smear test is unheard of.” In addition, a Sierra Leone participant stated that they felt they had been discriminated against once and believed it was a result of the cultural differences.

*“...ignorance about our culture.”*

*Ethiopian Participant*

Three Thai participants state that they sometimes worry that a doctor does not have enough knowledge about some diseases that are found in Thailand, but not in America.

### **Money**

Almost all groups had members reporting lack of insurance and lack of money as barriers to receiving health care. Some mentioned the loss of work time for appointments and the resulting loss of pay to be a barrier to seeking medical care. Participants in the Sierra Leone and Somali groups also reported lack of money for childcare as a problem.

*“Everybody from Russia try not to go to doctors because it is much expensive.”*

*Russian Participant*

## Negative Attitudes and Bias

A handful of participants reported that they felt the negative attitudes of medical staff deterred them from seeking care with some identifying discrimination specifically as a problem.

*“I mean they just don’t listen much to what you would like to do and what your worries are and I think that’s the worst part...”*

*Bosnian Participant*

*“There are attitudes in the office.” “I think they were back there talking about someone and I didn’t appreciate that.”*

*African-American Participant*

## Transportation

Several members from the Cambodian, Central American, Ethiopian, Hispanic and Korean groups mentioned transportation as a problem both in keeping their appointments and arriving at their appointments on time. Several focus group participants reported that they regularly used taxis, buses and transportation offered by other agencies such as the Hispanic Committee.

## Experiences with the Health Care System

### What’s your or your family member’s best experience?

Many participants shared specific operations and procedures as their best experiences including procedures such as an ear operation for a child, a hernia operation, physical therapy, and treatment after a car accident. One participant said that a removal of a tumor and the coverage of cost was the best experience. For some, good care meant the feeling of a very clean medical environment, high technology of new medical equipment made them more trustful of healthcare services.

Several members of the Central American and Hispanic groups felt that their best experience was when they received help from the Hispanic Committee or a social worker in enrolling their children for Medicaid. Some group members also said that they had good experiences when they were enrolled as patients in local health clinics.

Hispanic, African-American, Filipino and Lao participants cited pregnancy and childbirth as best experiences.

*“When I found out I was pregnant I didn’t know what to because I was new to this county. I went to the clinic and they opened their doors to me.”*

*Hispanic Participant*

*“I was treated royally by staff.”*

*Filipino Participant*

Many participant said that their best experiences with they health care system are when they have had doctors who are patient, skilled, try to speak some words in the patients language and

have cured their problems without a long wait. Some participants said that they were pleased when they found a good physician who was available to see them when they needed it.

*“My best experience has been with my doctor. He always knows the right thing to say to me. He’s my advisor.”*

*Hispanic Participant*

*“I like when doctors try to speak some Spanish to you or make the effort to communicate with you and help you in your own language.”*

*Hispanic Participant*

*“...the white person I saw broke the barrier I had about white people discriminating against blacks. I am glad I met her. Also, I like my gynecologist, she always listens to me.”*

*Sierra Leone Participant*

Thai participants had best experiences when they had less waiting time, quick service, treated politely, and friendly staff and good care.

*“The best experience is going in, signing in and having the doctor see me in like 2 minutes.”*

*Lao Participant*

*“ Yes, I had a checkup and the doctor was absolutely so nice and he was in Farmville and I was surprised, and he talked to me, and he talked to me, and he talked to me and explained everything he was doing, you know. And he asked if I had any questions and he genuinely, you know, he was just genuinely nice and, you know, I thought this is the best one of these things*

*I’ve ever had to have and I felt like that when I left and I told him.”*

*African-American Participant*

*“Good doctor, This guy – he really understands, he helps me, he call me home if I do not understand something, he explains. He write me letter.”*

*Chinese Participant*

### **What was your/your family member’s worst experience in receiving health care?**

For many participants, problems with insurance and reimbursement represented their worst experiences receiving health care. The complicated process for getting Medicaid coverage and keeping the coverage was cited as a major frustration. Some said that non-coverage of some tests by insurance was their worst experience.

Some participants reported their lack of health insurance or money to pay medical bills as their worst experience.

*“To tell the front desk people I have no insurance.”*

*Ethiopian Participant*

*“My worst experience has not having the money to take my children to the doctor when they are sick. It’s a very helpless feeling.”*  
*Hispanic Participant*

Several members voiced frustration with trying to get appointment at clinic, not being able to see their family doctor, long waiting time in the office, less time spent with doctor, and impolite service.

*“My worst experience, now and always, is when I call the clinic and they always get distracted or forget about you or say call emergency or do this or do that.”*  
*Bolivian-Peruvian Participant*

*“The nurses in the hospital treated me rudely when my baby was born.”*  
*Hispanic Participant*

Some participants voiced frustration with procedures done without understanding why, such as a tooth extraction, x-rays and teeth cleaning. Participants felt especially displeased when they these services were not covered by insurance. Some said there were too many tests and blood work before you could get medicine.

Members of the Ethiopian, Korean, and Russian groups mentioned encounters with language barriers as their worst experiences. One Russian participant said that there was a difference in care and that it was easier to take medication and follow instructions in her native country. This could be due to the ease of communication in own language with Russian physician.

*“Sometimes a shortage of words to express how I feel”*  
*Ethiopian Participant*

A few members of the Sierra Leone and Somali groups said their worst experiences were related to lack of provider understanding of cultural practices such as female circumcision or diseases that are uncommon in the United States such as malaria.

*“GYN blamed me for undergoing circumcision. You would have thought I committed a crime.”*  
*Sierra Leone Participant*

*“Mine worst experience was malaria – they did not know what to do. I could not believe they put me in intensive care because of malaria.”*  
*Sierra Leone Participant*

### **Are you and the members of your household satisfied with your present health care services?**

Most members of all groups said that they were satisfied with their present health care services but mentioned specific concerns regarding frustration with persistent pain, undiagnosed conditions, lack of physician and hospital choice through insurance coverage, wait time, lack of extended hours, and language barriers. Several participants stated that they were satisfied with their doctors and clinics but not with Medicaid.

*“We are satisfied – when we have serious problems we know that we are in good hands. We are lucky to be here, our health care services are great.”*  
Cambodian Participant

*“All satisfied except one need interpreter especially for female health problems. This is most important to clarify things for treatment.”*  
Lao Participant

*“I am satisfied but too expensive and live in fear to become sick because of expense.”*  
Russian Participant

*“The healthcare system in the US is only good for those who are rich, who have a good health insurance coverage, or for those who work for big companies. The health care really becomes a burden for those who have no insurance.”*  
Vietnamese Participant

## **Consumer Input on Improving the System**

### **How can health care services be improved to better serve you and your community?**

Many participants said that services could be improved by hiring translators in hospitals, clinics and health departments of having a bilingual staff person who is available during all office hours. Some said that having more doctors and nurses who speak their language even if it is only a few words, would be an improvement.

Members of the Chinese and Cambodian groups suggested having more doctors of Chinese traditional medicine and having medical staff that know something about their culture.

Some participants recommended that providers and staff get a human relations course and learn to treat people better and that providers not use jargon but find non-medical terms to explain medical conditions.

Some recommendations related to restrictions of insurers. Some participants said they would like to have free choice of doctors including seeing specialists without a referral. Others were more concerned that Medicaid cover dental expenses and that all doctors should accept Medicaid.

Participants suggested less expensive private health insurance and expanded coverage especially for those whose employer does not provide health insurance. Some wished for coverage of immunizations under insurance plans. A few participants recommended low or no cost health care services for all.

Several participants suggested friendlier, more polite and culturally sensitive staff at offices. Decreased wait time, more time with spent with physicians, and more minor care clinics with expanded hours were also recommended.

### **Major conclusions**

Most cultural groups know where to access clinical and emergency services. Many focus group participants expressed confusion regarding system's navigation and structure, health insurance coverage (what is covered and costs). General sense of helplessness with regard to lack of health care coverage and the costs of paying for medical and emergency room visits, dental care and medications.

### **Recommendations for Improved Service Delivery: System's Improvements**

- Provide system's navigation education and assistance to clients.
- Improve clinic/ER intake staff knowledge and referral information for public health care coverage at point of contact.
- Provide referral information for local dentists accepting Medicaid/Medicare (Children's Health Improvement Plan) currently FAMIS insurance.
- Provide specific referral (telephone number, staff contact) for making application for Medicaid, Medicare, CHIP.
- Improve patient choice in scheduling appointments with same provider over time. Majority of focus group respondents reported preferring seeing the same doctor for clinic visits. Although this may mirror preferences in the general population, it may be even more important for culturally diverse patients to develop a relationship with one provider over time to build communications and enhance treatment & follow-up.
- Review and add/change policies to support exceptional communications and culturally appropriate care.
- Review and modify existing policies and procedures to achieve compliance with Title VI Civil Rights Act, 1964 45 C.F.R. Part 80 Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency.

### **Recommendations for Improved Service Delivery: Patient – Provider Encounter**

While many focus group participants said they prefer to see providers who speak their language and understand the cultural aspects of their illness or health conditions, many also reported that they found providers who, although they were not bilingual, they were able to provide culturally competent care due to exceptional cross-cultural communication skills. Also a large number (55%-70%) of patients needing an interpreter for a clinic appointment or an emergency room visit reported using a family member (many use young children) or friend as an interpreter.

The use of extended family and friends as interpreters can result in varying degrees of communication and outcomes. For some cultural groups, having the support and involvement of extended family for medical treatment and care plan can support better compliance and outcomes but this does not necessarily mean that the family member or friend should be relied on to provide interpreter services for the patient. Indeed,

providers should see extended family involvement as a positive factor in diagnosis and treatment but whenever possible, family members should not be used as interpreters.

The reliance on interpreters to communicate with limited English speaking patients is necessary for most health providers lacking in sufficient numbers of providers who are fluent in foreign languages. Thus, the use of an interpreter is not necessarily an indication of poor quality care. The lack of preparation of such interpreters and the degree to which plans rely on potentially biased communications such as family members and friends may be an indices of questionable quality of care. Family members may try to shield their loved ones from information given by the doctor on the patient's condition and/or treatment. In addition, many medical terms and instructions for medication and treatment may not be fully understood by family members, especially when young children are used as the primary interpreters.

### *Recommendations*

- Increase recruitment and hiring of bilingual staff members who reflect the composition of patients served.
- Increase staff training and skills in providing culturally competent services including enhanced communication skills.
- Provide/support staff learning conversational skills/health & medical terminology in languages reflecting patient caseload.
- Provide basic medical translator training for staff members (professional and non-professional staff members).
- Require enhanced training for staff on the cultural beliefs and practices that influence health and medical decisions.
- Improve skills in cross-cultural communications for all staff members including strategies for establishing rapport and identifying non-verbal communications that improve patient understanding, compliance and outcomes.
- Improve the effectiveness of communications from the patient's frame of reference. Provide cultural sensitivity training from the patients perspective (arrange for listening sessions with representatives from patients served to discuss aspects of care - confidentiality, using family members/friends as interpreters, gender-sensitive issues such as gender of providers different from patient and issues for difference cultures, health beliefs/practices that may influence/interfere with treatment, compliance, follow-up, issues of respect for difference ethnic groups).
- Focus on the "universal" communication skills and behaviors that can improve interaction and communications – patience, trying to speak some words in the patients language, paying close attention to the patient, listening carefully, limiting interruptions during the appointment, decreasing wait time and decreasing the number of staff contacts within one visit.

- Reinforce verbal communications with appropriate written materials designed for your patient caseload (not just translated from English). There are several sources for culturally and linguistically appropriate patient education and information materials.

Focus group participants had many negative comments about wait time for appointments and wait times in the clinic and emergency room waiting rooms. While this is not a culturally-specific customer service issue, there may be more frustration and perceptions that the wait time is longer due to the lack of ability to speak English, ask questions and “advocate” for themselves in the clinic or ER environment. Focus group participants also tended to dislike the rushed interaction and short time with their physicians and felt their ability to both express their health problem and concerns and fully understand the provider were diminished by the limited contact with their primary provider.

#### *Recommendation*

- Providers need to spend more time with patients to establish communication and trust. The provider should be taking measures to ensure that the patient understands both the instructions for treatment including important information like where to fill prescriptions, how often to take prescribed medications and plans for returning to the clinic for follow-up. Compliance and patient satisfaction can be improved through careful, patient provider behaviors and communication.

## References

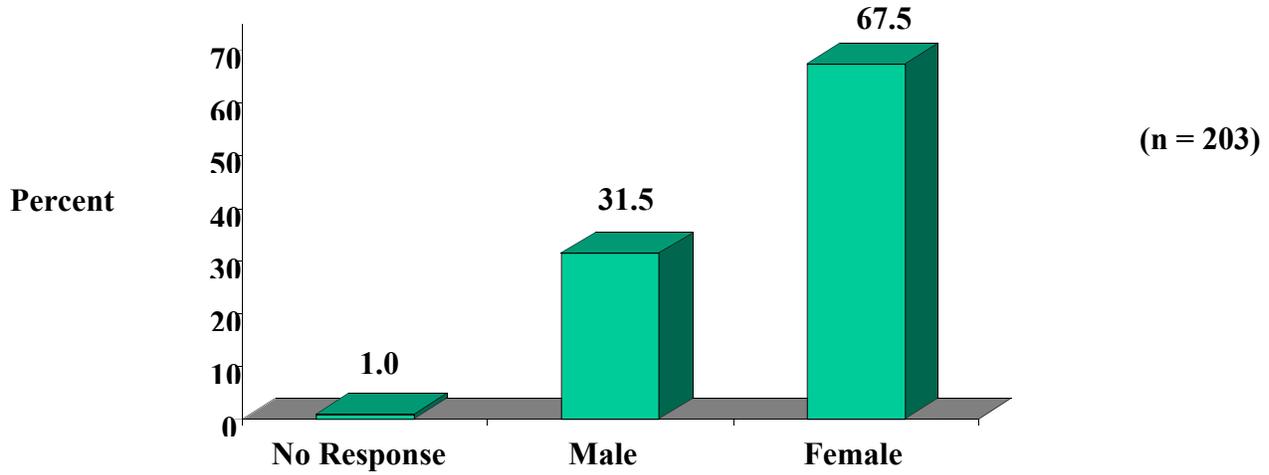
*New study finds that blacks say white doctors treat them worse. Jet*, Sept. 6, 1999 v96 i14 p. 16. Johnson Publishing Company.

Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. *Are Latinos less satisfied with communication by health care providers?* *Journal of General Internal Medicine*. (1999) Jul; 14 (7): 409-17.

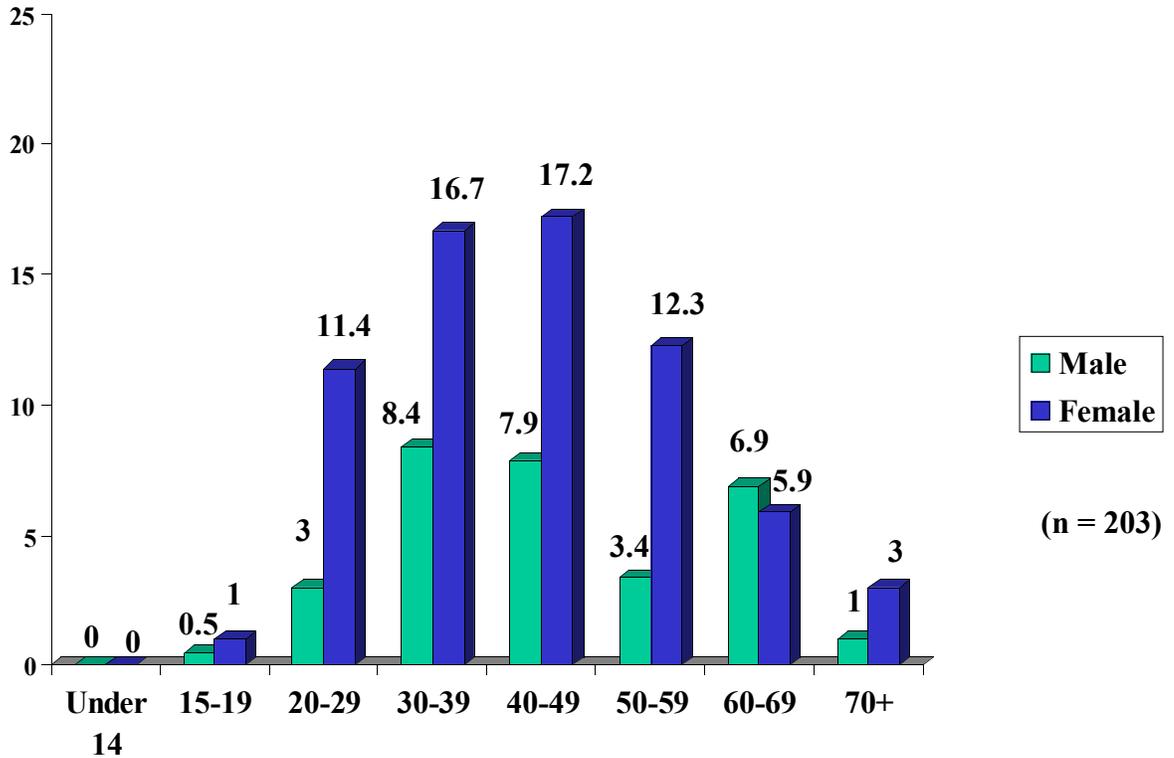
## **FOCUS GROUP DEMOGRAPHICS**

The following information is based on self-reported data from focus group participants. In some instances the data were presented as separate groupings “All Focus Group Participants,” “Immigrants (non African American participants)” and “African American Participants” in order to demonstrate the impact of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) on immigrants access to health services. In many instances, even legally present, long-time residents have lost health benefits under this law. Significant restrictions on health benefit eligibility prohibit immigrants and their children who entered the United States after August 22, 1996 from accessing care.

**Figure 1: Gender Distribution**



**Figure 2: Age Distribution by Gender**



## **Table 2: Race/Ethnicity**

**Participants recorded the following race/ethnicities**

African  
Asian  
Black  
Black, Mende  
Bosnian  
Cambodian  
Chinese  
Ethiopian  
Filipino  
Hispanic  
Irtra  
Khmer  
Korean  
Lao  
Somali  
Thai  
Vietnamese  
White  
Yugoslavian

**Table 3: Homeland**

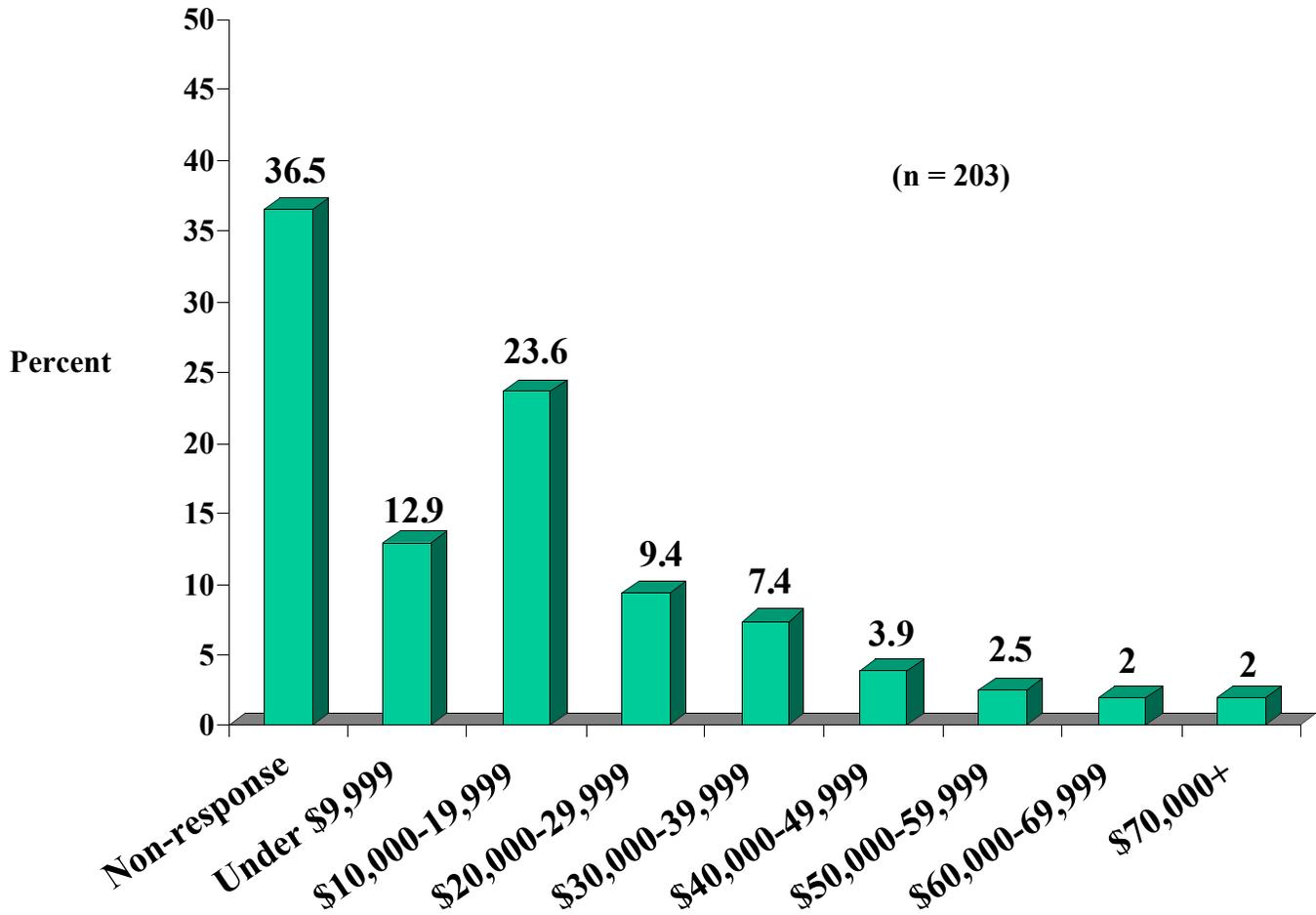
**Participants listed the following countries as their “homelands”.**

Asmera  
Bolivia  
Bosnia  
Cambodia  
China  
Cuba  
Dominican Republic  
El Salvador  
Ethiopia  
Honduras  
Hong Kong  
Indonesia  
Kampuchea  
Korea  
Laos  
Mexico  
Nicaragua  
Peru  
Philippines  
Russia  
Sierra Leone  
Somalia  
Taiwan  
Thailand  
Ukraine  
United States  
Vietnam  
Virginia  
Yugoslavia

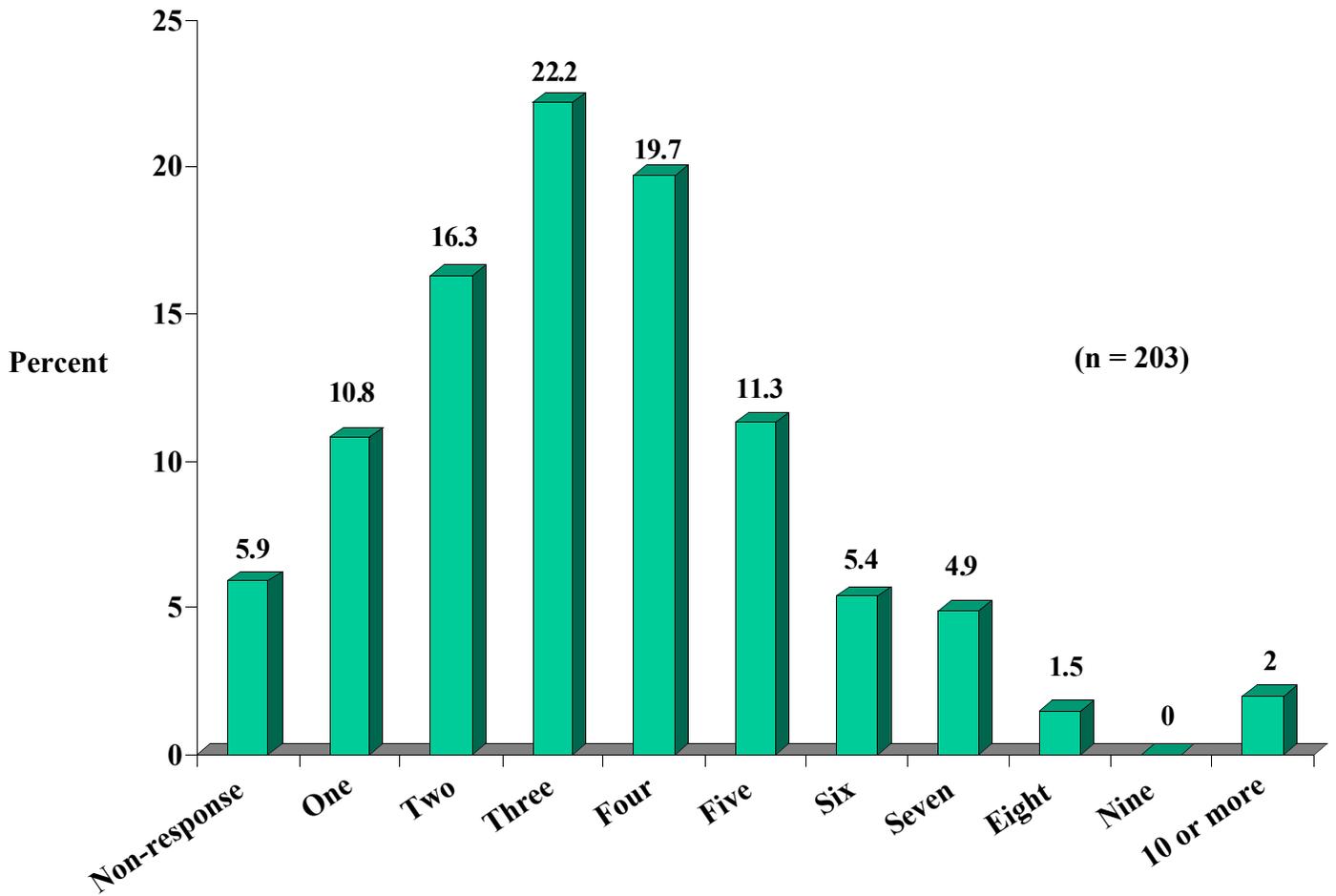
**Table 4: Primary Languages Spoken by Focus Group Participants***Languages spoken are self-reported by focus group participants*

<b>Language Spoken</b>	<b>Race/Ethnicity of Reporting Participant</b>
Amharic.....	Ethiopian
Arabic.....	Somali
Bosnian.....	Bosnian
Cambodian.....	Kmher, Chinese, Cambodian
Chinese.....	Chinese
Creole.....	Sierra Leonean
Croatian.....	Bosnian
Dutch-Creole.....	West Indian
English.....	African American
Filipino.....	Filipino
Khmer.....	Cambodian, Chinese
Korean.....	Korean
Laotian.....	Laotian
Llocano.....	Filipino
Mandarin.....	Chinese
Mende.....	Sierra Leonean
Rahaweyn.....	Somali
Russian.....	Russian
Serbo-Croatian.....	Bosnian, Yugoslav
Slovenian.....	Bosnian
Somali.....	Somali
Spanish.....	Bolivian, Cuban, Dominican, Honduran, Mexican, Nicaraguan, Peruvian, Salvadoran
Tagalog.....	Filipino
Temne.....	Sierra Leone
Thai.....	Laotian
Trigrigna.....	Itrea ( <i>Could not be further defined</i> )
Uisai.....	Filipino, Papau New Guinea
Ukrainian.....	Ukrainian
Vietnamese.....	Vietnamese
Visayan (dialect of Cebuano)	Filipino
Total Spoken Languages Reported: 29	

**Figure 5: Annual Income**



**Figure 6: Total Number of Individuals Residing in Participant's Household**



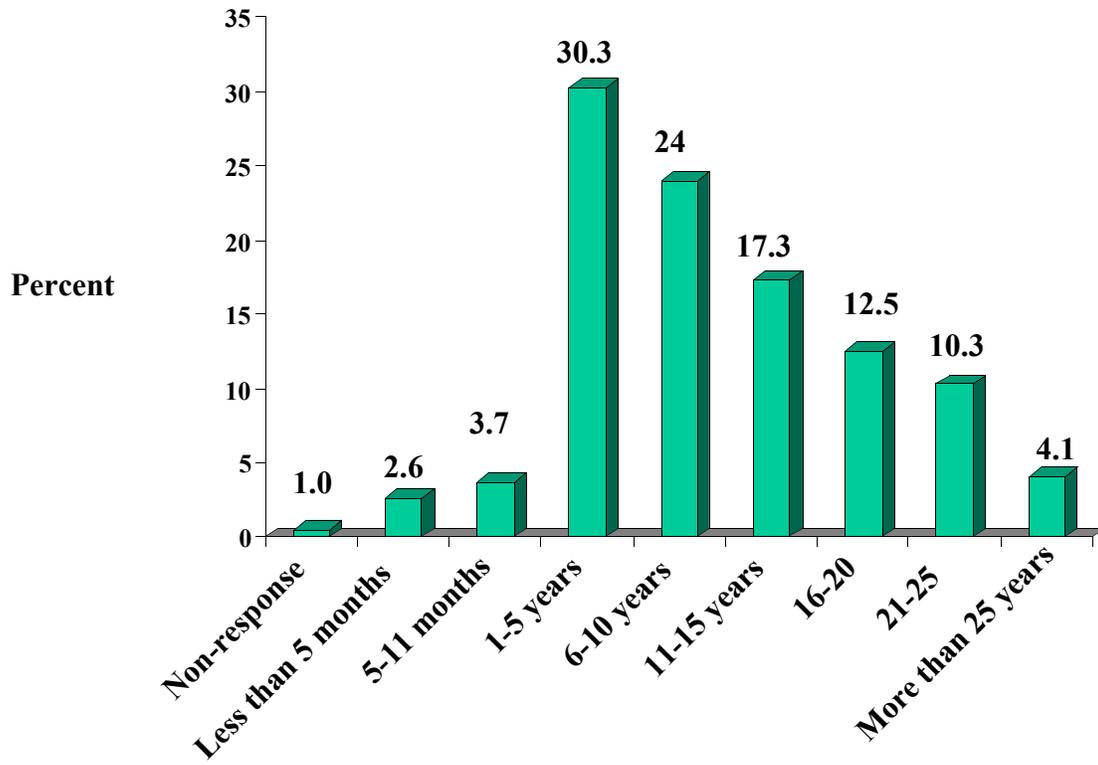
**Table 5: Years in U.S. (Non African-American Participants)**

<b>Years in U.S.</b>	<b>Nº. ans.</b>	<b>Percent.</b>
<b>Non -response</b>	1	0.5%
<b>Less than 5 months</b>	5	2.6%
<b>5-11 months</b>	7	3.7%
<b>1 year</b>	5	2.6%
<b>2 years</b>	9	4.7%
<b>3 years</b>	12	6.3%
<b>4 years</b>	22	11.5%
<b>5 years</b>	10	5.2%
<b>6 years</b>	11	5.8%
<b>7 years</b>	9	4.7%
<b>8 years</b>	10	5.2%
<b>9 years</b>	6	3.1%
<b>10 years</b>	10	5.2%
<b>11 years</b>	4	2.1%
<b>12 years</b>	8	4.2%
<b>13 years</b>	4	2.1%
<b>14 years</b>	9	4.7%
<b>15 years</b>	8	4.2%
<b>16 years</b>	6	3.1%
<b>17 years</b>	2	1.0%
<b>18 years</b>	3	1.6%
<b>19 years</b>	2	1.0%
<b>20 years</b>	11	5.8%
<b>21 years</b>	4	2.1%
<b>22 years</b>	0	0.0%
<b>23 years</b>	2	1.0%
<b>24 years</b>	1	0.5%
<b>25 years</b>	2	1.0%
<b>26 years</b>	0	0.0%
<b>27 years</b>	2	1.0%
<b>28 years</b>	0	0.0%
<b>29 years</b>	1	0.5%
<b>30+ years</b>	5	2.6%
<b>TOTAL OBS.</b>	<b>191</b>	<b>100%</b>

**Mean = 11.85 Standard deviation = 7.56**

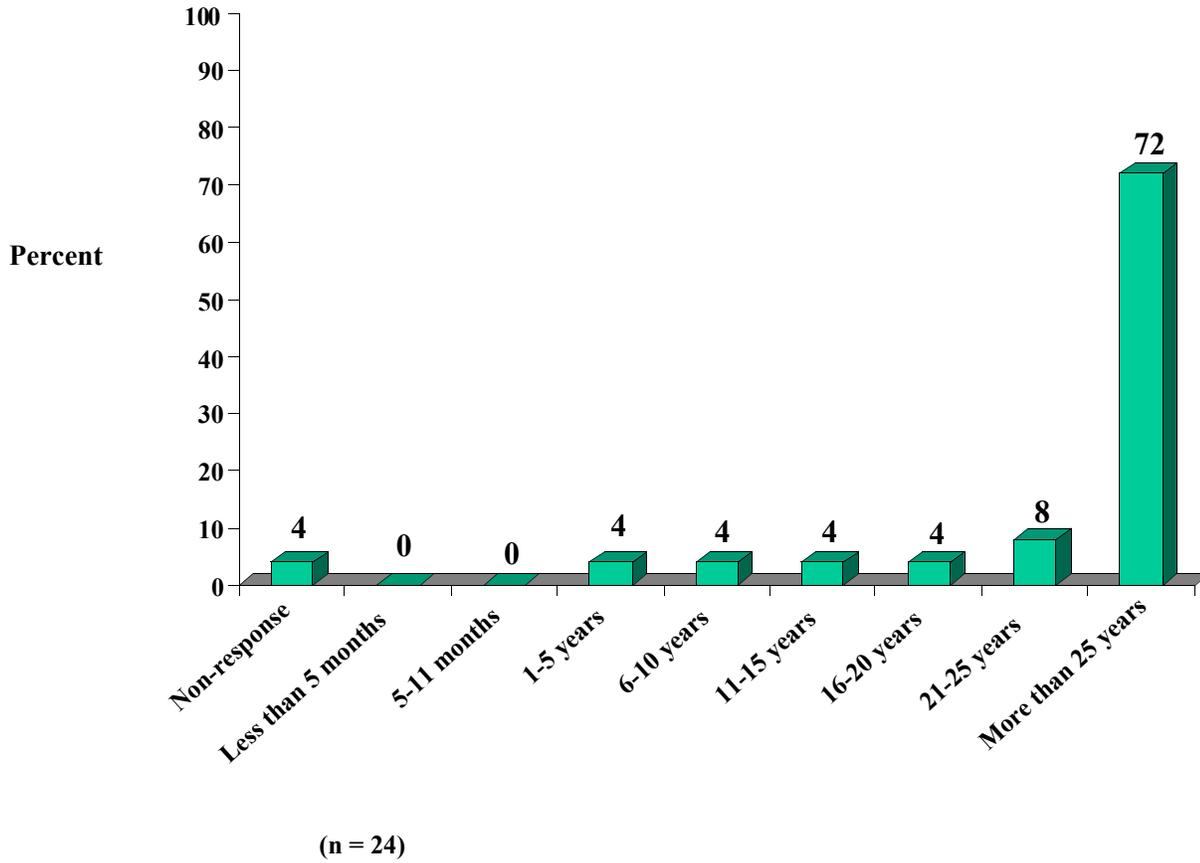
This question has a single, scaled response. Parameters rank from 1 (less than 5 months) to 32 (30+).

The mean and standard-deviation are calculated ignoring non-responses.

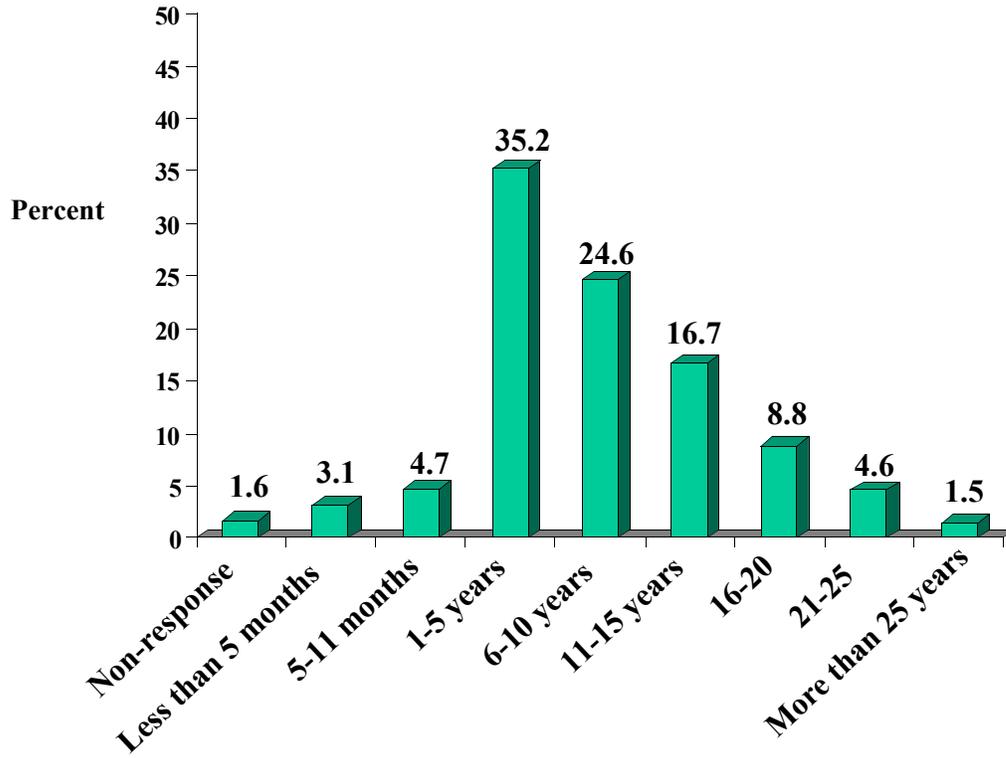
**Figure 7: Years in U.S. (Non African-American Participants)**

(n = 189)

**Figure 8: Years in Virginia (African American participants)**



**Figure 9: Years in Virginia (non African American participants)**

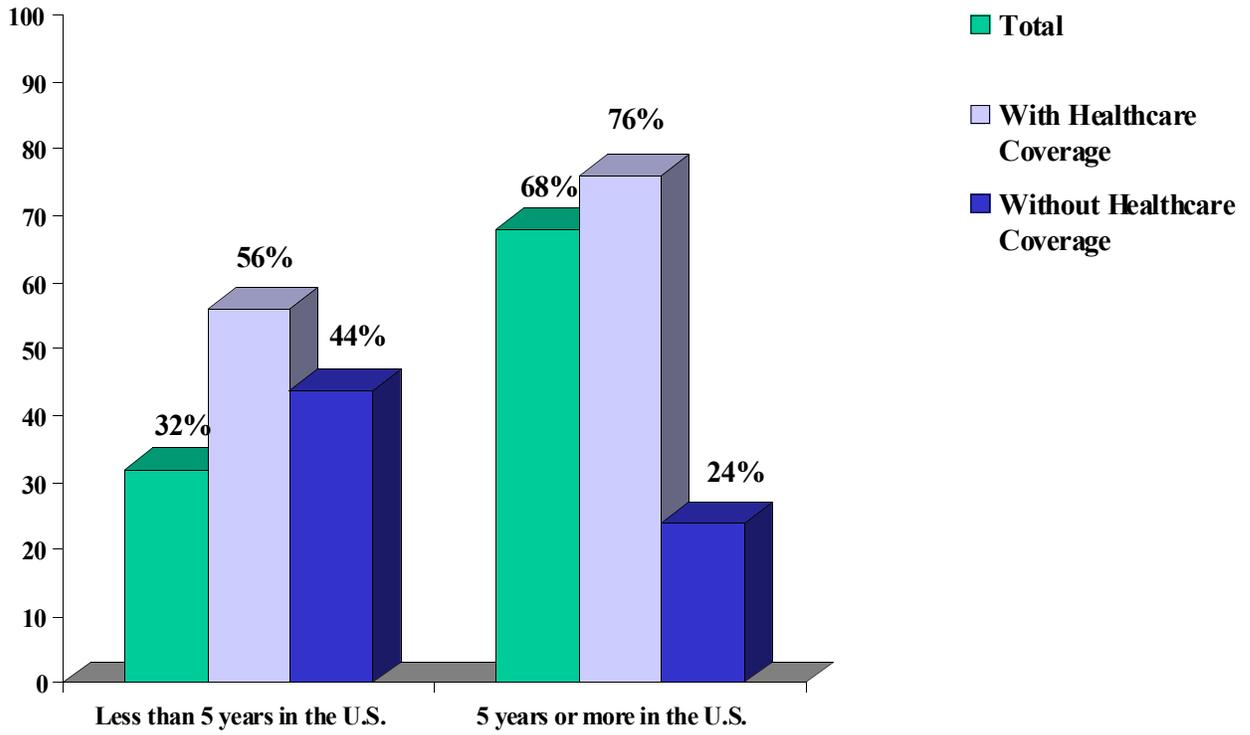


(n = 189)





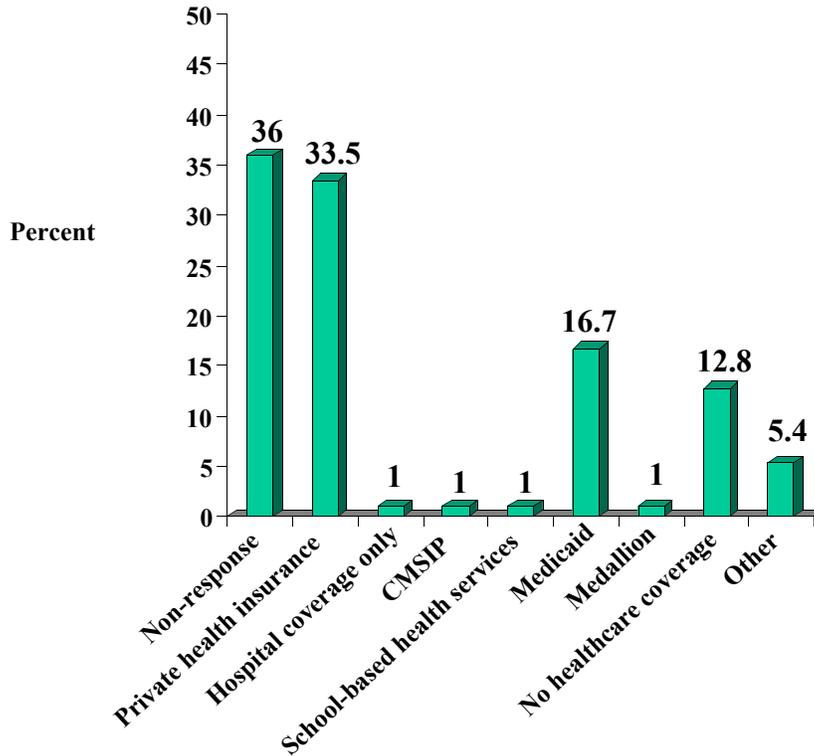
**Figure 12: Immigrant Healthcare Coverage by Years in the United States (non African American participants)**



(n = 189)

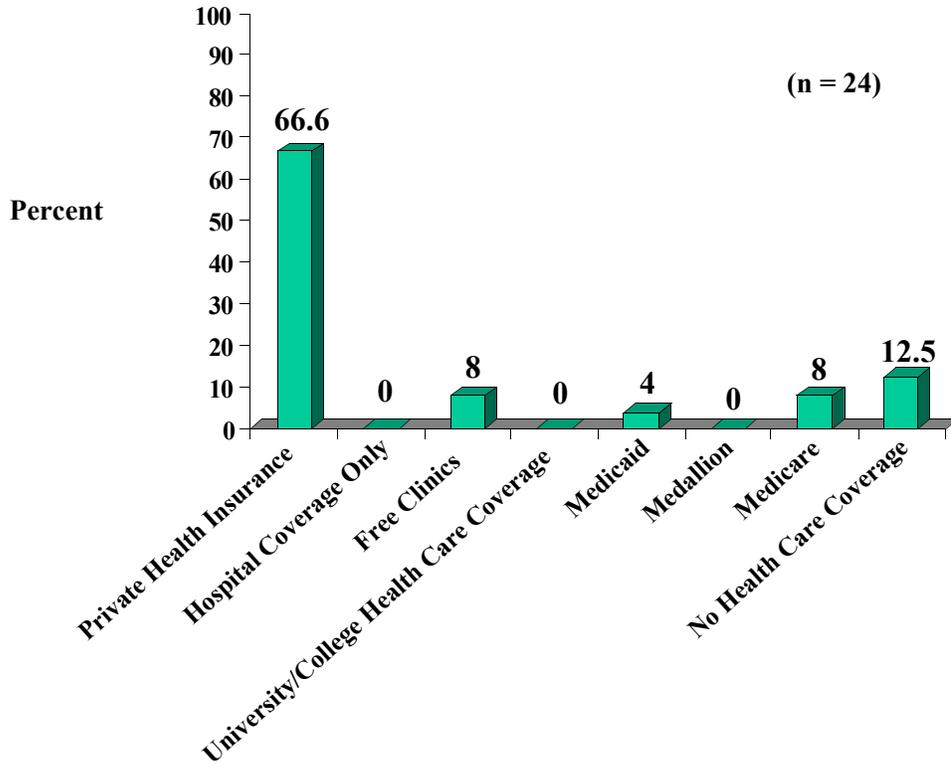


**Figure 14: Children's Health Care Coverage: All Focus Group Participants**



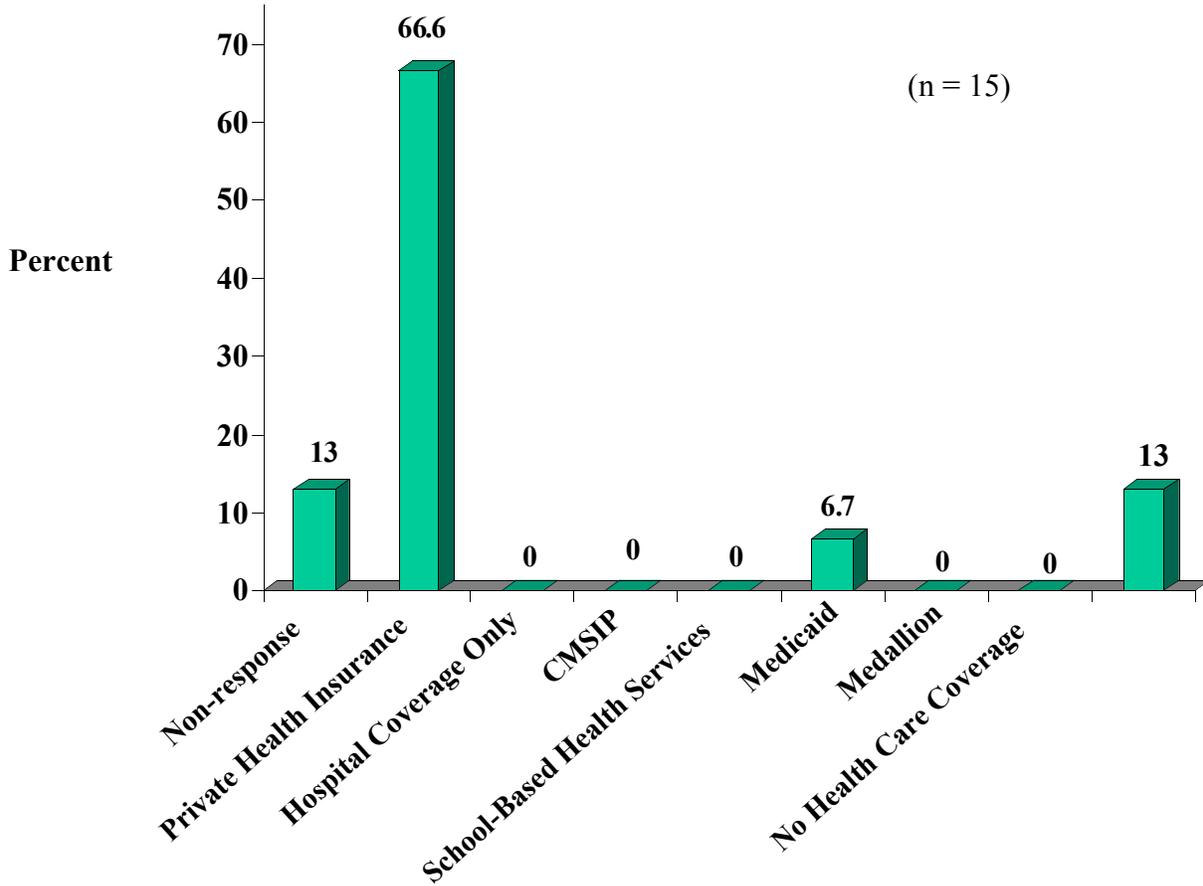

The number of responses is greater than the number of observations, due to multiple responses (maximum 8).

**Figure 15: Health Care Coverage: African American Focus Group Participants**



Healthcare Coverage	N°. ans.	Percent.
Non -response	0	0.0%
Private health insurance	16	66.6%
Hospital coverage only	0	0.0%
Free Clinics	2	12.5%
University/college healthcare coverage-students only	0	0.0%
Medicaid	1	8.0%
Medicare	2	4.0%
No health care coverage	3	12.5%
Other	0	0.0%
<b>TOTAL OBS.</b>	<b>24</b>	

**Figure 16: Children's Health Care Coverage: African American Focus Group Participants**



Children's insurance	N°. ans.	Percent.
Non -response	2	13.0%
Private health insurance	10	66.6%
Hospital coverage only	0	0.0%
CMSIP	0	0.0%
School-based health services	0	0.0%
Medicaid	1	6.7%
Medallion	0	0.0%
No health care coverage	0	0.0%
Other	2	13.0%
<b>TOTAL OBS.</b>	<b>15</b>	