The Response of Local Health Care Systems in the Rural Midwest to a Growing Latino Population

Working Paper Series

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EXECUTIVE SUMMARY

The purpose of this study is to provide an in-depth assessment of the response of local rural health care systems to the needs of a growing Latino population in rural Midwest communities. The project used a qualitative case study approach to assess health care access issues for Latinos in rural communities in Iowa, Kansas, and Nebraska, and to document successful strategies that could be adopted by other communities facing similar challenges. Two-day site visits were conducted in Marshalltown, Iowa; Great Bend, Kansas; and Norfolk, Nebraska between September 2001 and April 2002. Each visit included interviews with key informants and focus groups conducted in Spanish with Latino community members.

In the site visit communities, committed individuals, hospitals and other health care providers have developed health care safety net programs for Latinos and other low-income residents, using state and federal grants, local donations, and volunteer time from health professionals and community members. These programs and strategies include: 1) clinics that provide free or low-cost health care services to Latinos and other low-income residents; 2) school health programs that are connecting families to health care; 3) outreach by public health, social services and religious organizations to Latino residents; and 4) health care providers' efforts to communicate with patients in Spanish**.**

Despite these efforts, Latino populations still have many unmet needs for health care services. High rates of uninsurance, along with language and cultural barriers to care, have contributed to difficulties accessing health care in these communities. The lack of ongoing, stable funding for safety net services is a major problem. Communities are spending much time and effort seeking additional support, and some programs have already been eliminated or cut back because of a lack of long-term funding.

Many of the health care access problems experienced by Latino populations in these rural communities are the result of income, language and cultural barriers related to their recent immigrant status, difficulties which are also faced by Latinos in urban settings. At the same time, the health care access problems of rural Latinos also reflect larger systemic problems in rural health care, including shortages of physicians and other health care professionals, including qualified medical interpreters, and reluctance on the part of many dentists and some physicians to participate in Medicaid and S-CHIP programs.

Local providers currently bear a large share of the responsibility for meeting the health care needs of immigrants in rural communities. Approaches for allocating new funding or redirecting existing funding for targeted safety net services for immigrants in rural communities need to be examined. Transitional funding for these services would help bridge the gap between immigrants' arrival and assimilation, when it is anticipated that they will obtain private health insurance coverage through their employers.

Finally, the results of these case studies indicate that more attention needs to be focused on health care disparities and access to care issues for diverse populations in rural communities. Continued documentation and sharing of information about innovative rural programs and services will assist other rural communities experiencing a similar influx of immigrants.

INTRODUCTION

Most community studies of health care access for Latino immigrants have focused on metropolitan areas and the states where immigrants first arrived, e.g., Texas, California, and Florida (Hubbell, et al., 1991; Treviño et al.,1996; Halfon, et al., 1997; Flores et al., 1998; Ku and Freilich, 2001). A review of the literature on health status and health care access among rural minorities found little research on rural Latinos; research on rural Latinos living in the West North Central Census Division (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) was particularly lacking (Mueller et al., 1999). Yet, many rural areas in the Midwest are seeing an unprecedented growth in their Latino populations.

The rural Midwestern communities where new Latino immigrants are settling have experienced rapid growth both in the overall size and proportion of their Latino populations. As of 2000, one third of all rural counties in the 12 state Midwest Census Region had more than 300 Latino residents; 179 rural counties (21.5%) had more than 500 Latino residents; and 98 rural counties (11.8%) had more than 1,000 Latino residents. Latino residents accounted for more than 5% of the total population in 68 rural Midwest counties, and more than 10% of the total population in 25 rural counties (U.S. Bureau of the Census, 2000a).

The growth in rural Latino populations represents more than traditional migrant workers who have decided to relocate. The new immigrants are long-stay residents who are moving to rural Midwestern communities to work in light industry, meat packing, poultry and other processing plants (Huffman and Miranowski, 1996; Gouveia and Stull, 1997). These demographic changes are challenging rural health care systems to ensure access to care for a population that has low rates of health insurance coverage, limited financial resources, language and cultural differences, and special health care needs.

Latinos have the highest uninsurance rates among racial and ethnic groups in the U.S.; 37% of non-elderly Latinos are uninsured (Kaiser Commission, 2000). They are much more likely than non-Latinos to work for an employer who does not offer health insurance, and immigrant Latinos are much more likely than U.S. born Latinos to work in jobs where health insurance is not available (Schur and Feldman, 2001). Many of the food processing plants that are major employers of Latino immigrants in the rural Midwest offer health insurance. However, they often have waiting periods of three to six months before an employee is eligible for coverage, along with very high employee turnover, which limits the number of employees receiving health insurance benefits (Grey, 1999).

Medicaid coverage among Latinos has declined in recent years as a result of welfare reform, which made legal residents who entered the U.S. after 1996 ineligible for Medicaid. Undocumented residents do not qualify for Medicaid, except for emergency care, and some eligible Latinos are reluctant to apply for Medicaid, fearing it may jeopardize their future citizenship (Kaiser Commission, 2000).

Interpreter services and culturally appropriate care are essential to the provision of quality health care services to Latinos (Flores, 2000; National Alliance for Hispanic Health, 2000; Ku and Freilich, 2001; Flores et al., 2003). Several studies have demonstrated that language difficulties negatively affect access to care and use of health care services by Latino children and adults, even after controlling for ethnicity and other factors that influence access and service utilization. Among Latino adults, those who only speak Spanish are less likely to have a usual source of care and to visit a physician (Schur and Albers, 1996). Latino children whose parents are proficient in English are significantly more likely to have a usual source of care than those whose parents are not proficient (Weinick and Krauss, 2000). Latino emergency

room patients with fair or poor English proficiency report having significantly fewer physician visits than English-speaking non-Latinos or Latinos who speak English well (Derose and Baker, 2000).

The health status of immigrant Latinos varies depending on a variety of factors, including country of origin, occupation, living conditions, and lifestyle. Overall, Latino adults have a higher prevalence of diabetes, HIV/AIDS, hypertension, and obesity than non-Latinos in the U.S. (Holland and Courtney, 1998; National Alliance for Hispanic Health, 2000). Workers in meatpacking plants have high rates of occupational injuries, and the incidence of communicable diseases such as tuberculosis is high among some Latino populations. Latino children have a higher prevalence of dental caries, diabetes and obesity than their non-Latino counterparts (Flores et al., 2002).

The purpose of the current study is to provide an in-depth assessment of the response of local rural health care systems to the needs of a growing Latino population in rural Midwest communities. The project used a qualitative case study approach to assess health care access issues for Latinos in rural communities in Iowa, Kansas, and Nebraska, and to document successful strategies that could be adopted by other communities facing similar challenges. The study expanded upon initial work conducted on the rural Latino population in Minnesota (Ulrich, 1999; Brasure et al., 1999; Blewett et al., 2003).

STUDY DESIGN

Using 200 Census data, we identified 36 rural counties in the Midwest Census Region that met the following three criteria: 1) at least 1,000 Latinos were living in the county in 2000; 2) Latinos represented at least five percent of the county population in 2000; and 3) the county's Latino population grew 50% or more from 1990 to 2000 (U.S. Bureau of the Census, 2000b).

Ten counties were in Kansas; five each in Iowa, Indiana, Minnesota, and Nebraska; two each in Illinois and Missouri; and one each in Michigan and Wisconsin. To identify the specific communities for the case studies, we contacted several organizations that are knowledgeable about rural communities, health care resources, and the Latino population in their respective states, and asked them to help us identify rural communities within the 36 counties that had successfully implemented programs to increase access to health care and improve the health status of their Latino residents.[1] Based on the input from these organizations, the communities selected for the site visits were Marshalltown, Iowa; Great Bend, Kansas; and Norfolk, Nebraska.

Two-day site visits were conducted to each community between September 2001 and April 2002. Each visit included interviews with key informants and focus groups conducted in Spanish with Latino community members. A total of 55 key informant interviews were conducted with health care providers; social services, public health, education, community, and religious leaders; and business representatives.[2] The interviews focused on changes in local health care systems resulting from the growth of the Latino population; programs, services and strategies being used to address the health care needs of the Latino population; unmet needs; and future plans. Two focus groups were held in each community, for a total of six focus groups with 54 participants, to better understand the health care experiences and concerns of the Latino

[1] These organizations included the State Offices of Rural Health and State Primary Care Offices in Iowa, Kansas and Nebraska; the Statewide Farmworker Health Program in Kansas; State Workforce Development Offices in Iowa and Nebraska; the Iowa Division of Latino Affairs; the Mexican American Commission in Nebraska; the Kansas Advisory Committee on Hispanic Affairs; and the University of Nebraska Rural Health Research Center.

[2] The interviewees included mayors, a city council president, physicians, clinic directors and staff, public health directors and staff, hospital staff, county Medicaid directors and staff, directors and staff of social services and religious organizations, an assistant school superintendent, English as Second Language/English Language Learner program directors and staff, principals, a teacher, school nurses and health aides, and a family support specialist. The business representatives were a chamber of commerce director, and human resources directors and owners of several companies that employ Latino workers, including two meatpacking plants, a construction company, a small manufacturing company, and a motel. Representatives of two meatpacking plants, the Great Bend Packing Plant in

population in each community, from their own perspective. State and local contacts helped to identify key informants for the interviews, and local Spanish-speaking contacts recruited focus group participants. Semi-structured interview protocols, focus group protocols, and consent forms in English and Spanish were approved by the University of Minnesota Institutional Review Board.

SITE VISIT COMMUNITIES

Table 1 provides an overview of the demographic characteristics of the three site visit communities, Marshalltown, Iowa; Great Bend, Kansas; and Norfolk, Nebraska.

Marshalltown, Iowa

Marshalltown (population 26,009) is located in Marshall County in central Iowa, about 30 miles from Ames, 55 miles northeast of Des Moines, and 100 miles northwest of Iowa City. Marshalltown is the county seat and largest population center in Marshall County. Between 1990 and 2000, the Latino population in Marshall County grew 1,110%. As of 2000, Latinos comprised over 12 percent of the population in Marshalltown, and nine percent of the Marshall County population. In 1999, the median household income for Marshall County was $38,268; 10.2% of the population had incomes below 100% of the poverty level (U.S. Bureau of the Census, 2000a and b).

The Marshalltown Medical and Surgical Center, a 176 bed acute care hospital, is the locus of the local health care system. The hospital provides a range of inpatient and outpatient services to residents of Marshalltown and surrounding communities. The hospital-owned home health agency, Home Care Plus, provides public health services through a contract with Marshall

Great Bend and the IBP plant in Norfolk, refused to participate in interviews for the study.

County. The internists, general surgeons, pediatricians, and almost all the family physicians in Marshalltown are part of the McFarland Clinic, a multi-specialty physician group that is based in Ames, and has sites in 23 communities in central Iowa. Several single specialty groups also

TABLE 1

Characteristics of Site Visit Communities

	Marshalltown Marshall County Iowa	**Great Bend Barton County Kansas**	**Norfolk Madison County Nebraska**
City Population Number/Percent Latino	26,009 3,265 (12.6%)	15,345 2,025 (13.2%)	23,516 1,790 (7.6%)
County Population Number/Percent Latino	39,311 3,523 (9.0%)	28,205 2,344 (8.3%)	35,226 3,042 (8.6%)
Growth in Latino Population 1990-2000	1,110%	188%	440%
Median Household Income (2000)	$38,268	$32,176	$35,807
Percent of Population Below Poverty	10.2%	12.9%	11.2%
Distance to Metropolitan Area	Ames-30 miles Des Moines-50 miles Iowa City-92 miles	Topeka-188 miles Wichita-114 miles	Sioux City (IA)-86 miles Omaha-123 miles Lincoln-128 miles

Data Source: U.S. Bureau of the Census, 2000
Distances calculated using Yahoo mapping software.

practice in Marshalltown, including obstetrics/gynecology, orthopedic, opthamology and otolaryngology groups.

Economic activities in the Marshall County area include manufacturing, services, agriculture, wholesale and retail trade. The area has 41 manufacturing plants. The Swift Con-Agra meatpacking plant, with over 2,000 employees, is one of the largest employers in Marshalltown and a major employer of Latinos. Other large employers include Fisher Controls and Lennox Industries, which each employ over 1,200, and the hospital, with 700 employees.

Great Bend, Kansas

Great Bend (population 15,345) is located in Barton County in central Kansas, approximately 188 miles southwest of Topeka and 114 miles northwest of Wichita. The overall population in Barton County has declined since 1980. Between 1990 and 2000, the Latino population in Barton County grew 188%. As of 2000, Latinos comprised 13.2 percent of the population in Great Bend, and 8.3 percent of the Barton County population. In Great Bend, births to Latino mothers accounted for 23% of births at the hospital in the first half of 2001. In 1999, the median household income for Barton County was $32,176; 12.9 % of the population had incomes below 100% of the poverty level.

The health care system in Great Bend includes the Central Kansas Medical Center, a 121 bed acute care facility. The primary campus is in Great Bend; a second campus is located in Larned, 20 miles southwest of Great Bend. Hospital resources include a Level II emergency room, skilled nursing care, respite care, long-term care, and home health and hospice care. Approximately 35 physicians practice in Great Bend. The local primary care practices include a family physician practice and an internal medicine practice owned by the hospital, an independent family medicine practice, and a pediatric clinic. Specialists come to the hospital to

provide oncology, orthopedic, pulmonology, cardiology, and nephrology outpatient clinics. A for-profit surgery center is owned by local physicians.

The largest employers in Barton County include the hospital, the school district, and the community college, which employ over 600 employees each. The Great Bend Packing Plant has a workforce of about 350 employees, including many Latinos.

Norfolk, Nebraska

Norfolk (population 23,516) is located in Madison County in northeastern Nebraska, about 86 miles from Sioux City, IA, 123 miles from Omaha, NE, and 128 miles from Lincoln, NE. Between 1990 and 2000, the Latino population in Madison County grew 440%. As of 2000, Latinos comprised over 7.6% of the population in Norfolk, and 8.6% of the Madison County population. Births to Latino mothers accounted for 20% of the births in 2000 in Madison County. In 1999, the median household income for Madison County was $35,807; 11.2% of the population had incomes below 100% of the poverty level.

The local hospital, Faith Regional Health Services, is a 166 bed regional referral center, with a regional cancer center, dialysis center, radiology, physical rehabilitation and cardiac rehabilitation services. Hospital emergency services include an emergency department and an urgent care center. The health system has a home care program, ambulatory surgery center, nursing home, and assisted living. Approximately 65 physicians practice in Norfolk. Physician specialties in the community include cardiology, neurology, and orthopedics, as well as consulting specialists from Omaha.

Norfolk is a regional economic center for a six-county area, and the major retail trade center for northeast Nebraska. Thirty-nine manufacturing plants employ a total of more than 3,500 people. Other economic activities include agriculture, services including retail and

wholesale trade, education, and health care. IBP meatpacking plants in Norfolk and nearby Madison employ over 2,000 workers; a significant proportion of the workforce in both plants is Latino.

PRINCIPAL FINDINGS

- **Rural communities have implemented many programs and strategies to improve access to health care for Latino residents.**

The programs and strategies that have been implemented to improve access to health care in the site visit communities include: 1) clinics that provide free or low-cost health care services to Latinos and other low-income residents; 2) school systems that are connecting families to health care; 3) public health, social services and religious organizations that are reaching out to Latino residents; and 4) health care providers who are making an effort to communicate with patients in Spanish.

Clinics Are Providing Free or Low-cost Health Care Services

In the site visit communities, several clinics provide free or low-cost health care services to Latino patients, including the WeCare Clinic in Great Bend, the Norfolk Community Health Care Clinic, the Marshalltown Free Clinic, and the maternal and child health clinic in Marshalltown.

WeCare started in 1989 as a volunteer effort that provided vouchers for medical care and prescriptions to uninsured persons, using a small local grant and contributions from hospital employees. Over the next several years, the project expanded, using funds from a state primary health care grant, a United Methodist Wesley Health Foundation grant, the Kansas Farmworker Health Program, and a federal Rural Health Outreach grant. The local hospital donates about $100,000 annually to WeCare in ancillary services like x-rays, mammograms, and lab tests. In September 2001, WeCare was awarded a federal Community Health Center (CHC) grant.

The WeCare clinic is open five days a week, and also provides care one day a week at the health department in nearby Larned. Clinic staff include a full time nurse practitioner, an LPN, a bilingual health promoter, and a volunteer RN diabetes educator. The clinic collaborates with the Barton County Health Department and a local obstetrician to provide prenatal care, and has a network of eye doctors, dentists, and specialists in Wichita and Hutchinson that agree to take vouchers from WeCare. In the first year of CHC funding, WeCare planned to hire a family physician, a case manager, and a social worker. Future plans for the third year of the grant include hiring a dentist and dental hygienist to provide on-site dental care.

The WeCare clinic had a total of 2,185 patient visits in 2000. About 98% of patients were uninsured. The CHC funding will allow the clinic to continue to care for patients who are uninsured on a sliding fee scale basis, along with patients who have Medicaid, Medicare, and private insurance. About 70% to 80% of patients are Latino, with women aged 20 to 44 being the largest group of patients. WeCare has a diabetes support program for Latino patients that focuses on diabetes, high blood pressure, and high cholesterol, mainly for women in the 40 to 60 year old range. WeCare takes an integrated team approach to diabetes care, providing medical care, patient education, exercise, and a support group.

The Norfolk Community Health Care Clinic opened in October 1999. Most of the initial expenses for setting up the clinic were covered by a Maternal and Child Health Title V grant obtained as a cooperative effort with the Norfolk Public Schools, as well as community donations. A state Rural Health grant provided infrastructure development funds. Currently, the majority of clinic expenses are covered by grant funds and donations. The clinic facility and utilities are provided by the local hospital, and area physicians have donated equipment and supplies. State tobacco funds through the Cash Fund Project provide direct patient care services

to patients with diabetes and hypertension. The IBP meatpacking plant in Norfolk provides funding to the clinic for a part-time interpreter position. The clinic asks patients for a donation of $5 if they are able to pay.

The Norfolk clinic is open one evening and one morning a week, for a total of 8 hours. Care is provided by several part-time employees, including a nurse practitioner who is the clinic coordinator, a health assistant, an RN, and interpreters, along with volunteer physicians, mid-level providers, nurses, interpreters, and clerical support. The clinic provides primary care, but does not provide any obstetrical care, womens' health, mental health or emergency care. Referrals are made to other community resources for services the clinic does not provide.

The clinic had 1,052 patients in 2001, and 504 patients from January through April 2002. About 85% of patients were adults, and 53% were Latino. All patients are uninsured; the clinic does not accept patients with public or private insurance. The clinic sees about 10-20 IBP employees a month; they are not eligible for health insurance for the first 90 days of employment.

The Marshalltown Free Clinic started in November 1995. The clinic is held one evening a week for two hours, in a local church basement. It is funded primarily through in-kind contributions from the local hospital, volunteer time from physicians, nurses, and community members, and contributions from local churches and foundations. The program serves uninsured and underinsured individuals, and patients who are insured but cannot get an appointment with local providers.

In 2000, the free clinic served 599 patients; from January through March 2001, 340 patients were served. Ninety percent of the patients are uninsured, and about 40% are Latino. The clinic cares for all types of conditions; the most frequently seen conditions are urinary tract

infections, upper respiratory infections, diabetes, back pain and carpal tunnel. Many patients are workers at the local Swift Con-Agra meatpacking plant who are not yet eligible for health insurance because of the six-month waiting period.

The maternal and child health clinic in Marshalltown started providing prenatal care in1992. At that time, the local OB/GYN practice was short staffed. It had stopped taking uninsured patients, who had to go to Iowa City or Des Moines for prenatal care and delivery. In 1997, the OB/GYN practice added a new obstetrician and started doing deliveries for clinic patients again. Nurse practitioners staff the clinic, and the clinic contracts with the obstetricians to see patients early in pregnancy, at the end, and if there are problems. The clinic is open full time. In 2000, the clinic had a total of 6,644 prenatal and pediatric visits. About 49% of prenatal patients and 90% of child patients were Latino. Many clinic patients are uninsured, while others have Medicaid, and some, primarily meatpacking plant employees and their families, have private insurance.

In addition to Medicaid and a small amount of private insurance, funding for the maternal and child health clinic has come from several sources, including Mid Iowa Community Action, federal Title V funds, and the local hospital. In Fall 2001, Marshalltown was approved for federal Community Health Center grant funding as an expansion site of Primary Health Care, Inc., a CHC based in Des Moines. The Marshalltown CHC incorporated the maternal and child health clinic, and expanded to provide prenatal, pediatric, and adult primary care services. As of February 2003, the CHC had a staff of two nurse practitioners, a family physician, a physician assistant, and a three-quarter time pediatrician, and over 1,600 patient visits per month. Future plans include adding a dentist and dental hygienist to provide dental care.

After the CHC was established in Marshalltown, the Free Clinic closed and referred its

acute care patients to the CHC. The remaining patients had chronic illnesses and needed assistance obtaining medications, so the Free Clinic transitioned its volunteers and resources to MED ASSIST, a hospital program that helps individuals apply for free and reduced price medications from pharmaceutical companies.

Schools Are Connecting Rural Latino Families to Health Care

The proportions of public school students who are English Language Learners (ELL) in the site visit school districts reflect the large number of Latino families with young children in these communities. In the 2001-02 school year, 26% of elementary school, 21% of middle school, and 18% of high school students in Great Bend were ELL students. In Marshalltown, as of May 2002, 30% of elementary school, 20% of middle school, and 18% of high school students were ELL students. The overall Latino population in the Norfolk Public Schools was 16% in 2002.

These rural school systems are being challenged to provide sufficient space, staff, and resources to meet the educational needs of their rapidly growing and highly mobile immigrant student populations. The schools also are playing an important role in identifying immigrant children with health problems, and linking their families to the health care system. School nurses in these three communities perform traditional functions such as measuring growth, conducting vision and hearing screens, and monitoring students' illnesses and immunization status. Each nurse covers multiple schools, which limits the time to provide services beyond the basics. However, the schools, working in partnership with health care providers and using a combination of federal and state grants and local donations, have established successful programs to obtain much needed care for students and families.

In Marshalltown, the hospital funds two school-community nurses who serve as liaisons

between school health programs, medical providers, and families. The nurses serve a case management function on children's health issues that are identified at school, for example, arranging medical and dental appointments. Initially, Marshalltown had federal funding to provide school-based health care in four elementary schools, but the funding ran out two years ago. The program continues to function on reduced funding of about $80,000, from the United Way, the Bush Foundation, the hospital, and some Title V funds.

The funding is used for a local voucher program, which pays for student physicals, prescriptions, and dental care, through negotiated agreements with providers. Physicals are provided by local primary care practices. Nine local dentists participate in the dental component of the program, agreeing to take five appointments each month. The dentists bill Medicaid for children with Medicaid coverage, and the voucher program pays Medicaid rates for those who are uninsured. Once a month, the school-community nurse also takes a busload of 25 children, about 80% Latino, to the University of Iowa dental school in Iowa City for dental care. A family member usually comes along to interpret, and recently, some adults have also gone for dental care. Dental students and dentists provide the care. Medicaid covers some of the care, and the rest is free care from the University.

The Norfolk Public Schools have a student health fund, which is funded by the United Way and contributions. The fund, which started about 10 years ago, uses vouchers to cover some costs of emergency medical and dental care for students without other means of paying for the care. The district added a home school liaison nurse a year ago, using grant funding. She works with the school nurses and health technicians, who can contact her to follow up with families on health care issues, such as hearing and vision problems identified through screening.

Partnerships between the school systems, health care providers, and county public health

agencies have successfully increased immunization rates and obtained eye care for students. The Norfolk school district, which has made improvement of student immunization rates a priority, refers families to public health immunization clinics and to the Norfolk Community Health Care Clinic for immunizations. The Marshalltown school nurses administer vaccines from Vaccines for Children, a federal program that provides free vaccines for children who are uninsured or on Medicaid. The schools work with local optometrists in each community who volunteer to provide free eye care and with Lions Clubs that provide glasses for students who need them.

The schools also provide information about Medicaid and State Childrens' Health Insurance Programs (S-CHIP) to families that might be eligible for the programs. The Norfolk school district includes information about Kids Connection, the Nebraska S-CHIP program, in the information packet that is given to new families enrolling in the district, and Great Bend schools have Medicaid and Health Wave (the Kansas S-CHIP program) forms available in Spanish and English.

Although the school nurses in these communities are not bilingual, they have access to other school staff who are bilingual, including ELL teachers and tutors, as well as two bilingual family liaisons in the Norfolk school district. The nurses sometimes ask these staff to make phone calls to set up dental and medical appointments; occasionally school staff also go with students to appointments to interpret.

Public Health, Social Services and Religious Organizations Are Reaching Out to Latino Residents

In the site visit communities, public health and social services agencies are reaching out to Latino residents through several programs that improve access to health care, including public health nursing, the Women, Infants, and Children (WIC) nutrition program, lead screening, Head Start and Medicaid. The target population for a number of these programs is families with young

children, who comprise a large proportion of Latino residents in these communities. Many new immigrants find out about the programs from more established Latino residents who have benefited from the programs, while others respond to outreach efforts by bilingual staff, or informational materials in Spanish provided in community settings such as schools. Churches in these communities are also reaching out to Latino residents through Hispanic Ministries that provide immigrants with assistance in many areas, including accessing needed health care services.

In Great Bend, the Barton County Public Health Department provides family planning, maternal and child health services, WIC, public health education, and monitoring of communicable diseases. The department's total case load is approximately 25% to 30% Latino, and 38% of WIC participants in 2001 were Latino. The department has two bilingual staff members, and all of its brochures are available in Spanish. Having bilingual/bicultural staff members has clearly helped the department be more effective in serving Spanish-speaking public health clients. The bilingual staff have also helped link these clients with health care resources in the community, for example, by accompanying patients to physician appointments. However, the need for interpreters in other community settings is so great that the department has had to limit the time staff spend interpreting so that they have time to do their own work.

Goldenrod Hills Community Services, the community action agency for the 14 county service area that includes Norfolk, provides a number of health-related programs, including immunization, lead screening, public health nursing, breast and cervical cancer screening, maternal and child health services, and WIC. About 40% of their program participants are Latino, and the agency has a full time interpreter. Clinics to provide WIC, immunizations, lead screening, and well child checks are held in five locations every month, with the staff interpreter

and volunteer interpreters present.

All three communities have several social service agencies that are serving Latino residents. In Great Bend, for example, bilingual/ bicultural staff serve pre-school children and their families in the Head Start program that covers Barton County and two nearby counties; one-third of the children enrolled are Latino. Bilingual/ bicultural staff at Harvest America's office in Great Bend provide low income and migrant families with information, referrals, emergency assistance, and interpreter services. At the Family Crisis Center, which provides services to victims of domestic violence, about 10-12% of the caseload is Latino. The Center works with many Latinos who are undocumented, which does not affect their access to Center services, but has implications for the kinds of legal services the staff can draw on. The Center does not have any bilingual staff, but has four interpreters who are on-call, as well as bilingual board members. Using grant funds, the Center had all of their brochures and forms translated into Spanish.

County social services agencies in the three communities, which administer the Medicaid program, have some bilingual staff, and signs, application forms and educational materials in Spanish. County officials indicate that Latino families do not usually apply for cash assistance programs, as most families have one or more employed adults, but are more likely to need health care coverage through the Medicaid program. Some families who have employer-sponsored health insurance, e.g. meatpacking plant insurance, also qualify for Medicaid, because their incomes are low enough, and Medicaid covers more than their employer-sponsored insurance.

Religious organizations that are reaching out to new Latino immigrants include the Catholic churches in Marshalltown and Norfolk, which both have Hispanic Ministries. These ministries are staffed by bilingual nuns who provide multiple services for immigrants, including

interpretation, help with employment and immigration papers, assistance in making medical appointments, and rides for patients to appointments.

Health Care Providers Are Making An Effort to Communicate with Patients in Spanish

In the three communities, health care providers are making an effort to communicate with Latino patients in Spanish, although the availability of bilingual staff and interpreters varies by type of health care provider and community. The three hospitals have informational signs, forms, and patient education materials in Spanish. The Marshalltown hospital has had some type of interpreter services for the past ten years, including part-time on call interpreters, and using the AT&T phone interpreter service. The hospital established a full time interpreter position in September 2001 to help meet ongoing needs for translation in departments throughout the hospital, and also will continue to have "on-call" interpreters. A Spanish teacher at the local high school evaluates the competency of the interpreters the hospital uses, and the interpreters receive an orientation to the hospital and the position.

The hospital in Great Bend started employing a full-time bilingual employee in their Admissions office in 2001 to assist patients with health insurance coverage options. Hospital management hired this employee because they discovered that a lot of Latino patients were eligible for charity care or public programs only after the hospital spent time billing them, and decided that it would be better to determine eligibility earlier in the process to facilitate appropriate coverage and payment. The admissions employee describes the programs available to citizens and non-citizens, e.g., Medicaid, SOBRA emergency Medicaid coverage, HealthWave, and helps patients fill out application forms. The hospital's patient advocate and a few nurses also are bilingual. The Norfolk hospital contracts with several individuals to provide on-call interpreter services during the day, and uses the AT&T line when needed in the evening.

A special birthing class with an interpreter is offered for Spanish-speaking expectant parents. In all three hospitals, bilingual staff who work in non-interpreter positions at the hospital are sometimes asked to help with interpretation if an interpreter is not available.

The clinics that provide free or low-cost health care services in these communities have interpreter services. The MCH clinic in Marshalltown and the WeCare clinic both have bilingual staff and are planning to expand their interpreter services with the federal CHC funding. The Norfolk Community Health Care Clinic also has part-time interpreters on staff, while the free clinic in Marshalltown uses volunteer interpreters.

Three bilingual Spanish-speaking physicians practice in Norfolk. In the other communities, some physicians have studied Spanish in high school or college, and some have taken medical Spanish courses; the McFarland Clinic in Marshalltown, for example, offers medical Spanish courses. The pediatric practice in Great Bend hired a technical writer to translate all of their materials, including forms and information to Spanish. They purchase patient education materials in Spanish, and always ask drug representatives who give them informational materials to give them copies in Spanish.

- **Although the site visit communities have implemented several programs and strategies to improve access to care, Latino populations still have many unmet needs for health care services. High rates of uninsurance, along with language and cultural barriers to care, have contributed to difficulties accessing health care in these communities.**

Rural Latinos Have High Rates of Uninsurance

The results of surveys conducted by schools and community organizations in the site visit communities, along with information from the interviews and focus groups, indicate that a large proportion of Latinos in these communities are uninsured. A survey conducted by school nurses in Marshalltown in 1999 indicated that 29% of the students in the local elementary school with the highest Latino enrollment lacked health insurance (Marshalltown Community School

District, 1999). In a needs assessment conducted of Madison County residents, 64% of Latino respondents reported that not having insurance was a problem for them in getting health care (NeNOM Diversity Committee, 1998). The growing number of Latino patients who only have emergency Medicaid coverage or who qualify for charity care in the three hospitals are additional indications of the high rates of uninsurance.

The meatpacking plants, which are major employers of Latinos in these communities and throughout the rural Midwest, typically offer health insurance. However, new employees have a three to six month waiting period before they qualify for coverage, and some workers chose not to purchase coverage when it is offered because of the costs, particularly for family coverage. Among other businesses that employ Latinos, the availability of employer-sponsored health insurance varies by type of employer and whether the employee works full-time, year round, or on a part-time or seasonal basis.

Although many Latino families meet the income guidelines for Medicaid or S-CHIP programs, their participation in these programs is limited. Key problems are the inability of legal immigrants who have entered the U.S. since passage of the 1996 federal welfare reform law to qualify for Medicaid; lack of documentation, i.e., parents who do not have valid social security numbers, which are required on program applications, and fear among many Latinos of jeopardizing their immigration status. There is also a generalized distrust of government agencies that administer public programs, even among legal immigrants with appropriate documentation, and concern about being reported to the Immigration and Naturalization Service and/or deported. Additional barriers to S-CHIP participation cited by interview respondents and focus group participants were the inability to afford copayments, and difficulties with complicated forms and eligibility rules, especially in the Iowa Hawk-I program.

Language and Cultural Barriers to Care Still Exist

Despite efforts on the part of health care providers in the site visit communities to communicate with Latino patients, language and cultural barriers to care still exist, and affect access to care. A limited number of bilingual and bicultural health care professionals practice in these communities. At the time of our site visits, Marshalltown and Great Bend did not have any bilingual physicians, and all three communities had few bilingual health care professionals other than physicians.

The limited supply of bilingual health professionals reflects the general difficulty of recruiting physicians and other health care professionals to rural settings. The WeCare clinic in Great Bend, for example, wanted to recruit a bilingual physician, but had difficulty recruiting a physician, without limiting their search to bilingual physicians. In rural Nebraska, it has been difficult to recruit bilingual workers who have good written and oral language skills in both English and Spanish, as well as a college degree, for social worker positions. The state social services agency has tried to recruit for these positions in Texas, with limited success, since wages are not sufficiently high to motivate professionals to make the move, and to stay in the position over the long term.

The supply of trained interpreters is insufficient to meet the need for interpretation in these rural health care settings. Lack of reimbursement for interpretation services and competition from non-health care agencies such as law enforcement and the courts, which pay interpreters higher wages than health care providers feel they can afford, limits the availability of interpreters in health care settings.

The private physician practices in the site visit communities do not provide interpreter services. Focus group participants and interviewees reported that Latino patients usually bring

friends, family members, or bilingual staff from a social services or religious organization to medical and dental appointments to interpret for them. Some families rely on children to interpret, although this is discouraged by medical providers who question the appropriateness of having a child perform that function, and by school officials who do not want to have the children missing school.

Rural Latinos Have Unmet Health Care Needs

Key informants and focus group participants in the site visit communities identified several unmet health care needs in the Latino population. Non-emergency care for adults, especially for men and older non-working adults, was widely acknowledged to be a major unmet need. Respondents indicated that emergency care is available through hospital emergency departments, and that job-related injuries are treated by private physicians, clinics and hospitals, and covered by employers as required by law. Children's medical needs are generally being met through a combination of child health clinics, school health programs, and Medicaid-covered services. Pregnancy-related care for women is also typically available through maternal and child health clinics, and Medicaid-covered services provided by hospitals and private physicians, including emergency Medicaid coverage for deliveries. Latino residents identified preventive health care services as a particular area of unmet need, even among some families with health insurance, because of coverage limitations, large deductibles, and copayments. Continuity of care for Latino adults with chronic health problems such as diabetes was an additional concern.

Multiple respondents in each community identified dental care as a huge unmet need for Latinos and low income patients in general. The majority of local dentists are unwilling to take Medicaid or S-CHIP patients. In some cases, they also refuse to allow patients to make payments over time, and do not take insurance, requiring patients to pay up front and then be reimbursed

by the insurance company. In one community, a pediatrician described treating children with abscessed teeth, and trying not to overwhelm the one dentist who accepts Medicaid patients with referrals, because of fear that he will stop taking patients. Because of the lack of access, the dental care that is being provided is primarily emergency care.

Mental health care, and drug and alcohol prevention and treatment, were identified as additional areas of unmet need for the general population, and especially for Latinos because of language and cultural barriers and lack of insurance. High rates of lead poisoning among Latino children results from a scarcity of safe, affordable housing for low-income families in these communities. Another area of unmet need is prescription drugs. The free and low cost clinics in the three communities provide some prescriptions to patients who cannot afford to purchase them. The free clinic in Marshalltown uses samples from pharmaceutical companies and medications donated by physicians; it also purchases generic drugs in bulk, for distribution to patients when donated drugs are not available. In Norfolk, emergency medications for children are purchased through the Norfolk Public Schools student health fund, and staff at the Norfolk Community Health Care Clinic help patients obtain medications from patient assistance programs of pharmaceutical companies. The WeCare clinic provides patients with vouchers for prescriptions. The rising costs of prescription drugs are a concern for these clinics; the Marshalltown free clinic, for example, paid more than $900 in prescription costs in a recent month.

CONCLUSIONS

In the three site visit communities, committed individuals, hospitals and other health care providers have developed health care safety net programs for Latinos and other low-income residents, using a combination of state and federal grants, local donations, and volunteer time

from health professionals and community members. While they are meeting some of the community need, these safety net services are under considerable strain due to the lack of ongoing and stable funding. The pressures on local providers are significant. Communities are spending much time and effort seeking additional support, and some programs have already been eliminated or cut back because of a lack of long-term funding.

In Marshalltown and Great Bend, recently obtained federal Community Health Center funding should provide a stable source of financial support to help cover the costs of medical care for uninsured Latinos and other low-income community residents. Unfortunately, not all rural communities with underserved Latino populations will qualify for CHC funding. It is unclear how long safety net services can be maintained in these communities without additional financial support. The primary reason for the pressure on safety net services is the lack of health insurance coverage for new Latino immigrants and their children. Throughout our site visits, many interviewees and focus group participants voiced concerns about the difficulty low-income individuals and families face paying for health care, and the high costs of health insurance. Focus group respondents indicated that lengthy waiting periods and the cost of health insurance premiums, particularly for family coverage, are barriers to obtaining coverage from local food processing plants. Many families do not qualify for public insurance programs. Others have younger children who are covered, while older children in the same family who were born outside of the U.S. are ineligible. A Chamber of Commerce official indicated that local employers were experiencing uncontrolled inflation in health insurance premium costs, and that his own small business was paying more for employee health insurance than for advertising. Small employers who offer health insurance to full-time employees noted that many do not take the insurance because it is too expensive. Other respondents noted that individual insurance was

prohibitively expensive for those who do not qualify for employer-sponsored insurance.

Many of the health care access problems experienced by Latino populations in the rural site visit communities are the result of income, language and cultural barriers related to their recent immigrant status, difficulties that are also faced by Latinos in urban settings. At the same time, the health care access problems of rural Latinos also reflect larger systemic problems in rural health care, including reluctance on the part of many dentists and some physicians to participate in Medicaid and S-CHIP programs, and shortages of physicians and other health care professionals, including qualified medical interpreters.

Extensive problems with access to dental care for low-income persons, especially those on Medicaid, have been documented in several recent studies (GAO, 2000a, 2000b; USDHHS, 2000). The limited number of dentists in rural communities means that reluctance on the part of many dentists to participate in Medicaid and S-CHIP programs puts a large burden on the few local dentists who will take these patients. Shortages of Medicaid providers in rural areas often result in uninsured and publicly insured persons having to seek dental care a long distance away from their homes.

Shortages of physicians and other primary care providers in a rural community may make existing providers reluctant to take on new patients, especially publicly insured or uninsured patients. They may even close their practices to all new patients, a situation that has occurred with some practices in Great Bend. Provider shortages also put pressure on existing practices to spend less time with each patient, and may make physicians and other primary care providers less willing to see patients who need interpreters, since patient visits take longer when an interpreter is used. Provider shortages also mean that health care professionals have limited time available to learn another language; for example, one physician we interviewed indicated that

she was interested in learning more Spanish to communicate with her patients and their families, but she is on call so many evenings per week that she does not even have one evening a week for a Spanish class.

Physicians in the site visit communities were reported to be much more likely to take Medicaid or S-CHIP patients than dentists, but a few respondents also expressed concerns about the continued willingness of local physicians to take publicly insured patients. A physician whose practice is a certified rural health clinic indicated that the availability of cost-based Medicaid reimbursement was an incentive to care for Medicaid patients, but the much lower reimbursement for S-CHIP patients had necessitated a limit on S-CHIP patients in their practice.

Problems with access to medical interpretation services have serious implications for the quality of care provided to Latino patients who are not proficient in English (Ku and Freilich, 2001; Flores et al., 2003). Federal law requires all health care providers who receive federal funds, including Medicaid and Medicare, to provide language assistance services to patients with limited English proficiency (U.S. Department of Justice, 2002). However, the American Medical Association argues that private physician practices should not have to pay for interpreter services (AMA, 2002). Federal enforcement of language assistance requirements has been lax, but stricter enforcement may be counterproductive, if it discourages physicians from seeing Medicaid or Medicare patients. Only five states take advantage of federal matching payments for interpretation services provided to Medicaid and S-CHIP enrollees by having language assistance as a covered service under their state Medicaid plans (Youdelman and Perkins, 2002).

Local providers currently bear a large share of the responsibility for meeting the health care needs of immigrants in rural communities. Approaches for allocating new funding or

redirecting existing funding for targeted safety net services for immigrants in rural communities need to be examined. Transitional funding for these services would help bridge the gap between immigrants' arrival and assimilation, when it is anticipated that they will obtain private health insurance coverage through their employer.

Finally, the results of these case studies indicate that more attention needs to be focused on health care disparities and access to care issues for diverse populations in rural communities. Continued documentation and sharing of information about innovative rural programs and services will assist other rural communities experiencing a similar influx of immigrants.

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