

Challenges of Providing Healthcare

to Montana Migrant Workers

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Abstract

The purpose of this grounded theory qualitative research study was to gain understanding of the challenges facing healthcare providers when caring for Montana migrant workers. Healthcare providers from the state of Montana were interviewed regarding personal beliefs on the healthcare provided to migrant workers in rural clinics. The participants were also asked for their opinions regarding migrant care for the near future. Data were collected via audio taped interviews, field notes and theoretical memos. Analysis through classic grounded theory was used to establish categories and identify the social process. The core category of this study is “Establishing a Common Ground” with the following supportive categories: (a) Accessing Health Care (b) Allocating Resources and (c) Provider Initiatives. Findings suggest that the participants of this study are dedicated to providing quality medical care to Hispanic clients in rural Montana using limited resources. The research identified the challenges encountered when serving this population and how these challenges were being addressed. Participants expressed how optimal utilization of minimal resources is imperative to sustaining quality care. In addition, the social process of establishing common ground when working with culturally diverse clients is important to health promotion. Researchers can use and modify these categories to fit their clinical practices and create further research in cultural understanding and rural clinical medicine.

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Dedication

I would like to dedicate this senior honors thesis to the Montana migrant workers and the participants in this study. They have given so greatly of themselves to their work. One day healthcare may be seen as a universal right.

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Chapter I

Background

A disparity within the American healthcare system has been identified; the minority populations' inability to access healthcare is increasing (Healthy People 2020, 2011). Healthy People 2020 is a government funded, science-based initiative to improve the healthcare of everyone in America. One overarching goal of Healthy People is to “achieve health equity, eliminate disparities, and improve the health of all groups” (Healthypeople.gov, 2011 para 4.).

In response to the healthcare disparity dilemma, as well as many others, Healthy People 2020 created specific goals to promote quality healthcare in this nation. One of the primary objectives of the coalition targets the disparities in healthcare for marginalized populations and seeks to decrease it by the year 2020 (Healthypeople.gov, 2011). Other healthcare goals include creating coverage for more people, bettering available services, providing more services, instituting more timely care, and increasing the healthcare workforce. With the institution of new policies, these key objectives will address the challenges of providing healthcare so the disparities may be diminished or eliminated by the year 2020 (Healthypeople.gov, 2011).

The three major components associated with eliminating disparities in healthcare, according to Healthy People 2020, are (a) gaining access to the healthcare system (b) accessing healthcare in the location where services are needed and provided and (c) finding a healthcare provider with whom the client can communicate and trust. The Healthy People 2020 perspective is that, “Disparities in access to health services affect individuals and society. Limited access to healthcare impacts people’s

ability to reach their full potential, and negatively affects their quality of life” (Healthypeople, 2011. para 2).

Cultural Competence: A Legal Mandate

In the year 2000, a mandate was issued that healthcare institutions must provide culturally and linguistically competent care to individuals in hospitals. The Federal Office for Minority Health issued the *National Standards on Culturally and Linguistically Appropriate Services (CLAS)* Act, which stated that all health care facilities must have culturally competent care, access to language services, and an organized support service for people of other cultures. The federal law made it obligatory to provide linguistically isolated populations, such as those living in rural communities, with communication resources and services. This point is also represented in the United States Constitution, which states that all people have the right to “reasonable, timely, and appropriate language care” described in Title VI of the 1964 Civil Rights Act (Human Health Services, Civil Rights, 2001. para 2).

Research has revealed that accessing the healthcare system in America can be difficult for many ethnic groups (Aday, 2001). The challenges experienced by Hispanic agricultural migrant workers in Montana are just one example (Montana Primary Care Association (MPCA), 2010). The term *Hispanic* will be used throughout this text to describe individuals who have roots in Latin America or the Iberian Peninsula (Therrien & Ramirez, 2000).

Hispanic Population in the United States

In 2010 it was estimated that nearly 50.5 million individuals living in the United States were Hispanic or of Hispanic decent; the statistic is regardless of citizenship status. This estimate makes up nearly 16 percent of the total population.

The Hispanic population has grown by 15.3 million individuals or 43 percent since the year 2000 (census.gov, 2011).

It is currently noted that the ratio of Spanish speakers to Spanish speaking healthcare providers in the U.S. is significantly unbalanced (Torres, 2008 & Aday, 2001). One reason barriers in healthcare may exist for the Hispanic population relates to the lack of bilingual/bicultural doctors, nurses, and trained medical interpreters (Torres, 2008). The Census status reports that there are currently 4,700 bilingual doctors of the 819,000 currently practicing, equating approximately to one bilingual doctor for every 8,787.2 Spanish speakers. There are even fewer bilingual nurses, only 3,900 of the 2,449,000 currently practicing. The statistic reveals that for every 10,589.7 Spanish speaking clients, there is approximately one nurse that speaks the same language (U.S. Census Bureau, 2004).

It is projected that by the year 2020 that there will be close to 60 million Hispanics living in the U.S. The number of bilingual healthcare providers, however, is not speculated to accommodate this population growth (Pew Hispanic Center/Kaiser Family Foundation, 2005).

Hispanic Population in Montana

As of the year 2000, 5.2% of Montana's population spoke a language other than English. Today, the Montana Hispanic population makes up well over half of all Montana's non-English speakers. In the year 2010, Montana's total Hispanic population grew by nearly 33,000 individuals, making up 3.1% of the total population (U.S. Census Bureau, 2010 & Pew Hispanic Center, 2008). An estimated 12,953 of the 31,000 Hispanic individuals in Montana speak primarily Spanish and have been reported to have low competency in English, described by the U.S. Census Bureau as "less than proficient" (2000).

The majority of Montana's Hispanic population is considered transient, i.e. "migratory farm workers." There is an estimated 10,400 Hispanic migrant working individuals living in Montana; it is often challenging to provide care for these individuals. Most of the Hispanic men, women, and children live primarily in rural settings where sufficient medical treatment and facilities may not be available, which creates a barrier to healthcare.

Migratory workers are consistently in contact with dangerous pesticides, long hours of manual labor, constant sun exposure, and poor nutritional and living situations. Therefore it is priority to provide Hispanic individuals working and living in Montana with an opportunity to receive healthcare (Montana Primary Care Association, 2011). Likewise, healthcare institutions across Montana are in favor of supporting cultural training programs; such as language assistance services, guidelines for interpreter services, and telephone-language lines for limited English speaking patients (Montana State Hospital Policy and Procedures Manual, 2009).

Vulnerable in Montana

The Hispanic population in Montana has been identified as a vulnerable and at risk population for contracting disease and preventable illnesses. Hispanics have also been noted to continue living with these illnesses without the ability to obtain affordable, quality healthcare (U.S Health and Human Services, Community Health Status Indicators, 2011). The challenge for Montana's healthcare professionals is how to provide care to Hispanic individuals when cultural, communication, and financial barriers inhibit this process (MPCA, 2010). "Culture" is the term used to describe a pattern of learned values, practices, and beliefs within a group; also the group customs, views of relationships, communication style and language (Betancourt, 2004).

These cultural and communication discrepancies between clients, providers, and healthcare systems are encountered on a regular bases. Many of these encounters have resulted in significant misunderstandings between healthcare providers and clients, leaving a negative impact on the care available to the Hispanic minority; such as Hispanic clients being turned away from needed services and increased incidences of bias towards Hispanic clients from providers (Torres et al, 2008). These discrepancies will be referred to as barriers for the remainder of this thesis.

As a part of American society, cultural barriers exist for many Hispanics. These barriers are regarded as individual, organizational, structural, societal, and/or provider based (Cristancho; et al. 2008). Barriers to healthcare include: being uninsured, lacking resources needed to reimburse healthcare institutions, and/or language differences which bar communication with providers. All of these factors subsequently lead to an increased rate of noncompliance in treatment, referrals, and follow-up appointments, which leads ultimately, to frustration on behalf of the healthcare providers, and a further decline in healthcare status of Hispanics in America (Flores, 2002).

Healthcare Disparities: The Goal

A disparity is defined as an “inequality or gap that exists between two or more groups” (DHHS, 2001, p.3). Research provides evidence that indicates that healthcare disparities are increasing for the Hispanic population living in the U.S. rather than declining as in most other minority groups (Agency for Healthcare Research and Quality (AHRQ), 2006). Currently, a focus of the U.S. Department of Health and Human Services (DHHS) is to eliminate health disparities in the U.S. by the year 2020 (DHHS, 2010).

This research revealed the disparities in healthcare for Hispanic migrant workers as perceived by their health care providers in Montana. The research also shows how the healthcare system in Montana is compensating. The most common disparity found affecting the Hispanic population in Montana is the inability to access affordable and reliable healthcare.

Public programs and services that promote the prevention of chronic illness; such as cardiovascular disease, cancer, diabetes, mental health problems, and prenatal care to prevent infant and maternal mortality and morbidity, are often inaccessible to marginalized populations (Cristancho, 2008, & Institute of Medicine, 2003). Although much research continues to focus on the clinical parameters of healthcare disparities, there is little evidence to show how healthcare disparities affect migrant farm workers in Montana.

Only a few studies have investigated how healthcare professionals provide care to ethnically diverse clients in rural settings. None have taken place in Montana. Innovative means to distribute care to this underserved population are currently being developed and utilized to help minimize the disparity throughout the nation (AHRQ, 2006). The purpose of this grounded theory research is to explore the problem and gain understanding of the challenges of providing healthcare to the migrant Hispanic population in Montana.

Chapter II

Review of the Literature

In Grounded Theory, most of the review of literature section is completed after the research is concluded, based on the fact that the researcher must remain unbiased and constantly compare data during the investigation (Glaser & Strauss, 1967). However, a review of literature is included for the purposes of this honors thesis project.

Introduction

The misunderstandings produced by cultural barriers have been noted to leave a considerable negative impact on public health. Lack of understanding can lead to severe health problems, complications, and even death. Examples include; individual difficulties following through with treatment schedules, recommendations, and follow-up consultations. These complications often result in decreased health status, more extensive hospital visits, and increased expenditure on the part of the individual and the institution (Pheils & Saul, 2009).

Systematically, tax dollars are spent to pay for healthcare which cannot be reimbursed by the individual. The extra expenses accumulate and are therefore reimbursed by the institution or the government, resulting in increased taxes or decreased Medicare/Medicaid reimbursement (Jacobs, 2004).

Communication barriers lead to unnecessary diagnostic tests, procedures, and emergency room visits resulting in higher charges (Hampers et al. 1999). Clients lack the ability to communicate problems and are therefore less likely to be helped by medical treatment (Torres et al. 2008). In addition, the inability to communicate problems with healthcare providers leaves providers liable for medical error and thus creates clinical bias when clients do not speak English (Cristancho et al. 2007).

The psychological reduction of trust and respect has been found, as well as a diminished amount of disclosure on the part of client, as related to cultural incompetence (Julliard et al. 2008). Cultural understanding and humility are qualities which have been related to maintaining client safety and satisfaction. In the worst case scenario, the lack of trust can lead to negligent harm or death (Collins, 2004).

These circumstances are unfortunate and sadly have increased over the last decade. The number of documented medical errors resulting from cultural diversity is significant. Smaller rural hospitals usually have even fewer resources utilized prior to serving limited English proficient clients (Torres et al, 2008).

Issues Facing Healthcare in Rural America

Hispanic immigrants are residing in rural communities more frequently than ever before (Cristancho et al., 2008). The article, *Listening to Rural Hispanic Immigrants in the Midwest: A Community-Based Participatory Assessment of Major Barriers to Health Care Access and Use* suggests just that fact. The study identified the specific barriers which cause the majority of the problems in healthcare for Hispanics. The following factors were identified by participants: a) a lack of health insurance or limited coverage, b) minimal availability of public programs, c) a tremendously high costs of healthcare services, d) communication conflicts, e) legal status discrimination, and f) a lack of transportation.

Although studies have shown that rural communities are often strengthened economically by immigration (Dalla & Christensen, 2005), rural towns may find it difficult to accommodate the population's needs with existing public assistance programs. Mass influxes of diverse populations visit healthcare centers putting pressure on the care providers to accommodate their needs. Limitations in healthcare services and lack of resources contribute to the health disparities for Hispanics, and

create the “poor health” health trend seen in minority populations living in rural settings (Cristancho, Graces, Peters, & Mueller, 2008).

A qualitative research study, completed by members of the University of Illinois at Chicago and University of Illinois College of Medicine, evaluates perceived healthcare barriers of Hispanics living in rural areas of Illinois. A conceptual vulnerability model was used to guide participation in nineteen focus group interviews. The purpose of the study was to determine whether accessing and/or utilizing the healthcare system was a challenge for Hispanic individuals in rural communities.

Through focused small group interviews, specific priority health needs were assessed regarding the targeted areas of difficulty. Results of this study found 181 individuals living in three rural Illinois communities, who were more vulnerable to receiving poor healthcare (Cristancho et al., 2008).

The framework of this model was multidimensional, which allowed for individual and community based risk factors for poor health to be evaluated. The researchers attempted to find out why the healthcare status of the Hispanic minority was deficient in rural communities. Participants from the focus groups shared their perceptions of barriers to healthcare and how the barriers affected the quality of care they received. Data shows that these barriers led to an increased frequency of hospital visits, diminished health status, increased health concerns, and difficulty accessing health care services (Cristancho et al., 2008). One mother described her experience,

My son suffers from asthma. His doctor didn't explain to me very well about this disease because he didn't have the time to tell the interpreter about my son's problem. It has been very difficult for me to find information in Spanish

about this problem... At this point, I don't know if I am giving him his treatment, nor do I understand how to prevent his asthma attacks.

In this example, two problems regarding medical interpretation are identified. First, the amount of time needed from the provider to communicate with medical interpreters is often not adequate and second, the current medical interpreter's ability to deliver information is also inadequate (Cristancho et al., p. 9, 2008).

Other participants expressed their frustrations concerning the lack of interest on the behalf of their providers to ensure that proper medical interpretation services were available for the community. Identifying the problems is the key to correcting them, stated one researcher in the discussion. The article concludes that in order to reduce barriers in healthcare, they must be identified and then addressed by the implementation of a health service policy, which includes the employment of staffed medical interpreters (Cristancho et al., 2008).

Rural Communication

Research has provided evidence which shows that when rural hospitals do not staff full time, medically-trained interpreters, communication discordances between clients and providers occur. In one research article, the importance of staffing interpreters in healthcare settings was assessed. When language discordance arose, it was analyzed and was found to be associated with decreased health education, poor personalized care, and diminished patient satisfaction in healthcare settings. The study also suggested that proper transmission of health information can be facilitated by the presence of an interpreter; however, the study also states that an interpreter is not a substitute for a language component provider (Ngo-Metzger et al, 2007).

In another study, *Rural Hospitals and Spanish-Speaking Patient with Limited English Proficiency* (Torres et al., 2008), 841 hospitals in 544 rural communities were

surveyed to find out what tools were provided to help language communication needs. Three hundred and nine hospitals responded to the survey, with the conclusion providing evidence to indicate that nearly all the rural hospitals had tools available to aid clients.

The most common reported tools available to clients were brochures, language cards, and posters. Strengths of communication assistance in healthcare settings included support for language assistance programs, staff willingness to utilize interpreters, and telephone translator lines. Weaknesses in the hospitals included the lack of state agency support, language training programs, and funding for interpreters (Torres et al., 2008). One contributing factor to the high rate of consistency is that hospitals are mandated to continually reassess their policies and procedures related to language concordance, in order to comply with Joint Commission standards, because miscommunication can be detrimental to the healthcare provided to minorities (Torres, 2008).

In the same rural hospital study, the most commonly used interpretation services were reported. Bilingual employees, whose primary position was not interpretation, accounted for 79.0% of translations, 68.8% of the hospitals used telephone interpreter lines, and 47.8% used family or friends of the client to translate. Unspecified ad-lib interpreters can often be necessary in emergent situations. However, studies have shown that within these exchanges with casual individuals, 25-50% of the medical subject matter is misinterpreted or omitted, creating serious consequences for the client (Torres, 2008).

Medical errors are exponentially more common per medical encounter when family members or friends of the patient are used as interpreters. The reasons these errors are so common are that these individuals are most likely untrained in the

medical field and/or lack complete understanding of medical terminology. Research has also indicated that family member can be uncomfortable translating private or personal information. Primarily, lay people often do not understand the vocabulary presented in medical situations or they do not fully understand the information given by the healthcare provider. Or another example is when children are used as interpreters, they do not understand medical terminology relating to illness or anatomy, they have less developed abstract thinking, or they refuse to communicate with elder clients about specific health issues concerning private parts (Pheils, 2007). What is lost in translation results in twice the number of medical errors and confidentiality is lost for the individual (Collins 2004).

Several case studies obtained by anthropologist and doctor of nursing Geri-Ann Galanti's show the negative side effects of ineffective interpreters, and how poor communication affects healthcare. Many cases were reported in Galanti's study; these are only a few to exemplify the overall theme (Caring for Patients from Different Cultures, 2008).

A Hispanic woman was admitted to the hospital and diagnosed with problems concerning her reproductive organs and the need for a hysterectomy. When her bilingual son was used as an interpreter, he appeared to be translating the information accurately, indicating the right body parts. His mother signed the consent form willingly. However, the next day, upon learning from a translator that her uterus, and ability to conceive children, a major source of pride in Hispanic culture, had been removed, she became very angry and sued the hospital (Galanti, 2008).

In Hispanic culture, it is inappropriate for a male son to discuss the private parts of his mother; the son had been embarrassed and solely pointed in the general direction of the tumor. In Hispanic culture, often the number of children a woman can

have will give her high status in the community. Galanti argues that when dealing with any health issue that is remotely sexual in nature, family members should not be used as interpreters.

In one case study, a Mexican American woman came into the hospital complaining of severe abdominal pain. When an interpreter was not available, the patient was obligated to have her nine year old daughter translate her symptoms. The patient was discharged from the same hospital on three separate occasions with a simple medical diagnosis of a “stomachache.”

When the pain became too unbearable for the woman, she returned to the emergency room for the fourth time. On this occasion, an interpreter was provided for her. The patient was able to explain to the interpreter her symptoms and a wide-range of diagnostic testing was done. Ultimately the woman was diagnosed with a sexually transmitted infection or STI and treated. When confronted about her sexual history and as to why she had not disclosed her situation earlier, the patient explained that she had felt extremely uncomfortable discussing such issues with her daughter and therefore could not completely disclose her illness to the provider.

When a professional medical interpreter was not available for the woman in this case-study, she was obligated to communicate through her daughter with healthcare providers and therefore, was unable to be properly treated for an extended period of time. The consequences of miscommunication are prolonging time to treatment of a potentially serious illness, delaying needed hospital visits, and increasing costs for the hospital care (Galanti, 2008).

In another case-study reported by Galanti, the experience of another Hispanic individual has to do with the result of a lack of confidentiality for clients. An older Hispanic man was diagnosed with Human Immunodeficiency Virus or H.I.V. in 2008.

The man was admitted to the hospital for an opportunistic infection he had acquired when he received the H.I.V. diagnosis.

The man's bilingual nephew was used as a translator for his uncle's prognosis. The uncle's current health status is reported to have come as quite a shock to the nephew. Upon learning that his uncle had contracted this disease, the nephew immediately terminated all contact with his uncle. It was later discovered that the nephew had also reported his uncle's diagnosis to the rest of his family, who then, in the same manner as the nephew, terminated contact with the patient (Galanti, 2008).

The dilemma in this particular situation may be attributed to the fact that a proper interpreter was not utilized and there was a lack of cultural understanding regarding the negative association towards individuals with H.I.V. There is often severe stigmatization linked to those with H.I.V., and homosexual activity is discouraged in Hispanic culture (Galanti, 2008).

Another case-study gave the example of one patient who was prescribed a specific medication "once a day" and suffered a fatal overdose. After being prescribed the medication in the hospital, the patient took the prescription home. The Spanish speaker misread the drug label and took it, as he perceived it, "once a day." The overdose occurred when the Spanish speaker took the literal translation of the English word "once" as its Spanish equivalent "once" or eleven. The man took the medication eleven times that day, not once, and the outcome was death (Galanti, 2008).

In another study, Hispanic clients who had limited English proficiency (LEPs) were reported to be twice as likely to misunderstand prescription drug labels and instructions as English speakers. This puts LEPs at a high risk for serious complications as a result of preventable medication errors (Torres et al. 2008). The

accurate exchange of information is being addressed by including language specific prescription drug labels.

Negative consequences of language barriers also result in the need for more diagnostic testing for Spanish speakers. Results of the qualitative study *What Latina Patients Don't Tell Their Doctors* indicate that clients are less likely to disclose information to their providers when trust is not established, and it results in the need for extensive diagnostic testing (Julliard et al, 2008). The qualitative study indicates that building rapport with clients can better facilitate communication and disclosure is more common.

These are several studies which indicate untrained interpreters and poor understanding and communication in healthcare settings lead to adverse events. There are a wide range of cultural and communication barriers between providers and individuals. An increasing need for translation services and cultural competence grows in the United States. It has become essential to find more efficient means to care for minority patients as the population trend grows.

Offering interpretation services may be the first step to reducing the number of problems associated with healthcare barriers for Hispanics in the U.S. An innovative substitution for on-call staff interpreters in hospitals is the telephone translation line. The line can be called 24 hours a day and can aid the growing demand of rural American health care settings. The telephone translation line will help provide care to linguistically diverse clients when interpreters are unavailable (Galanti, 2008. Torres et al, 2008. Collins et al, 2006).

Bilingual Assessment Tools

Communication barriers have been reported to exacerbate the effects of pain when the nature and severity of it cannot be explained. Language barriers when a

person is in pain can increase patients' stress responses, exponentially extending healing time (Collins, 2004). In order to prevent poor pain assessment with LEP individuals, written tools have been developed.

When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that a patient has the right to have pain assessed and treated in all hospital settings, bilingual question/answer cards began appearing nationwide. Bilingual translation cards facilitate individuals' need to communicate pain and aid providers in their assessments (Collins, 2004).

A pain question-answer tool was created by the University of Alabama Spanish Department to help communicate the five elements of pain that individuals commonly experience. Questions regarding quality, intensity, duration, location, and associating factors were addressed on the cards, based on the American Pain Association's recommendations for assessment.

Within each question on the assessment, answers help providers pinpoint the cause and help attain accurate diagnose. The article concluded that making bilingual pain assessment a priority will aid limited English speaking individuals receive care, as pain is the number one reason many people make visits to the hospital (Collins, 2004).

Interpreter Services

In a before and after study, the cost of utilizing interpreter services in healthcare settings was evaluated. Medical Doctor Elizabeth Jacobs, an assistant professor of Medicine from the Division of General Medicine and Collaborative Research in Chicago, Illinois assessed the impact of interpreter services on hospital costs. The study also documented the extent to which interpreter services are utilized on a day by day basis (Jacobs, 2004).

One research study was conducted to measure the changes in delivery and overall cost of healthcare services before and after an interpreter was provided. The average cost per Health Maintenance Organization (HMO) member increased by only \$2.40 a member per year when translators were provided. Interpreter services increased the costs of hospital visits by only \$79 per implementation; however, it is noted that most interpreter services estimated cost significantly less, \$35 per visit, as opposed to the cost found in this study (Jacobs, 2004).

When comparing the cost of English speaking patients to clients utilizing interpreter services, a significant link to more preventive education was found (7.3% vs. 2.7%; $P=0.033$), more office visits were made (1.74 vs. 0.71; $P=0.014$), and prescriptions written (1.70 vs. 0.52; $P=0.001$) and filled (2.38 vs. 0.88; $P,0.001$). This research article indicates that increases in preventative and educational care have a positive relationship with increased proceeds for the hospital (Jacobs, 2004). The estimated cost for providing interpreter services was \$279 per person, per year. Therefore, providing these services was an economically feasible way to enhance the quality of health care for limited English proficiency clients (Jacobs 2004).

In the discussion section of this article, the access to interpreters increased the cost of health services. However, the services were reported to enhance the care received. If clients received preventative educational services, they were more likely to make hospital in-patient visits when necessary, they spent less time in the emergency room, and filled more prescriptions, which benefited both the individual's health status and the healthcare system as a whole (Jacobs 2004). In the movement to serve this population, research has been conducted to determine the advantages and disadvantages of using interpreter services.

Enhanced Interpreter Services

In a study performed to analyze the difference between utilizing trained medical interpreters vs. an arbitrary bilingual individuals, the conclusion suggests that individuals receiving information from trained medical interpreters report fewer complications in care. Enhanced interpreter intervention, however, did not have a significant impact on the hospital cost for the individual (Jacobs & Sadowski, 2007).

Hospital costs for utilizing trained interpreter services vs. non-medically trained ones has caused a controversy over whether or not it is worth the cost for health administrations to provide enhanced services. Researchers from the Stroger Jr. Hospital of Cook County and the Division of General Internal Medicine at Rush University Medical Center of Chicago, Illinois evaluated the pros and cons of utilizing enhanced interpreter services.

The setting for this prospective intervention study was an unidentified public inpatient hospital located in Chicago, Illinois. The purpose of the research was to identify the effects of enhanced interpreter services in relation to education and interpersonal communications between providers and Limited English Proficient (LEP) individuals. Researchers surveyed individuals based on their satisfaction with visits according to the services available to them and the monetary expense (Jacobs & Sadowski, 2007).

The “enhanced interpreter service” is composed of individuals who complete a yearlong course in medical competence and vocabulary. Bilingual students are certified to work with patients in the hospital (Jacobs, 2007). Throughout the enhanced training program students learn medical terminology, standards, ethics, legal issues involving confidentiality, and how to improve the triad of communication (interpreter, patient, & provider) for each case (Jacobs, 2007).

Results of this study indicated that enhanced interpreter services improved the perception of interpersonal care, and provided education on the behalf of the client. The results also showed little significant impact on the cost of enhanced interventions. Each enhanced interpreter service cost an estimated additional \$234. Spanish speakers paid 1.5% more on average for the enhanced interpreter service. Another interesting statistic that resulted from this particular study was that the cost for the hospital was reduced by \$92 (Jacobs, 2007).

The study reported that the decrease in emergency room visits could also be attributed to the availability of interpreters and better education for individuals (Jacobs, 2007). Additionally, patient satisfaction was improved when enhanced services were provided. The limitation of this study was that it did not determine the impact of enhanced interpreter services over a long term period. The nursing implications of this study further imply that good communication skills enhance the ability to educate individuals and improve healthcare experiences while lowering the costs of medical visits (Jacobs 2007).

Educating Hispanic Clients

Hispanics in America with limited English proficiency are more likely to have poorer health status when compared to those of other ethnicities. The U.S. Department of Health and Human Services [DHHS] (2000) found that social disparities contribute to the population's increased vulnerability to specific diseases. Knowledge of disease prevention and treatment are minimal. The diseases that the Hispanic population are most susceptible to include cardiovascular disease, cancer, diabetes, end-stage renal disease, and problems related to pediatric and maternal care, rehabilitation, and nursing home services (DHHS, 2000). The National Healthcare Disparities Report (NHDR) indicated that health disparities have diminished in the

recent decade for all other minority groups, except Hispanics (Agency for Healthcare Research and Quality [AHRQ] (2006).

Researchers have found that some medical disparities occur because providers are unable to educate their patients, with the end result being an increased occurrence of illness in the population (Pheils & Saul, 2009). Medical interpretation services facilitate individuals' ability to receive adequate information. However, an assessment of individual education levels is not necessarily done prior to physical assessment and therefore the education provided may not be adequate (Pheils & Saul, 2009).

Patient-Provider Relationships

The patient-provider relationship is multi-dimensional, as observed in the study, *What Latina Patients Don't Tell Their Doctors*. Among the most important facets of the provider-patient relationship is the amount of human compassion, care, trust, and kindness that are involved. Clients in healthcare settings can often feel uncomfortable disclosing personal information to providers, especially if these qualities are not present (Julliard et al, 2008).

In addition to language barriers, cultural incompetence can contribute to the poor quality of care provided. The problems that arise when the client does not trust the provider can be detrimental to the health outcome. Complex health problems, limited disclosure on the part of the client, and cultural/communication differences exponentially amplify the challenge to provide quality care (Julliard et al, 2008). Because most diagnosis and treatments are dependent on the information disclosed by the individual, trust and communication are imperative. If health care providers are incapable of facilitating their clients trust, there is an increased risk for health problems, adverse events, and dissatisfaction (Julliard et al, 2008).

Several Brooklyn physicians from the Department of Internal Medicine and Family Medicine & the AmeriCorps/Reach Out program asked twenty-eight women to participate in a study to determine how physician-patient relationships, language barriers, and cultural differences affect disclosure. The twenty-eight Latina women in the study replied based on their personal experiences in healthcare settings. Out of the total twenty-eight, twenty-six of women reported that complete disclosure with providers was based on mutual respect, trust, and compassion. Interference was caused by language or cultural misunderstanding and was reported from twenty-three of the twenty-eight women who participated in the study. Increased stress resulting from diminished trust contributed significantly to reduced disclosure (Julliard, 2008).

Cultural incompetence also led a number of the women to feel embarrassed, afraid, and vulnerable when addressing healthcare concerns. The inability to completely comprehend procedures, treatment plans, and diagnosis led to internal feelings of shame and fear. Participants also stated that cultural and language barriers often made them feel as if providers were reacting negatively to their concerns (Julliard, 2008).

In the cases where translators were available to the women in this study, even less disclosure was reported. The women felt uncomfortable speaking with interpreters and believed their right to confidentiality was being violated. In other cases, women were asked to supply their own personal interpreters. In one case a woman described her situation,

It is difficult because they (Doctors) don't speak Spanish, and I don't speak English. Then they often need to look for a translator, or if they can't find me one, I need to ask my relatives to go with me to the next appointment. That situation is really embarrassing (Julliard, 2008, p.546).

A compromise in confidentiality and respect for the client has been perceived by the participants in Julliard's study. Julliard makes the point that it is the ethical responsibility of the providers, as mandated by the United States Joint Commission standards, to ensure compliance with the Health Insurance Portability and Accountability Act [HIPAA] (Julliard, 2008).

In an attempt to bridge the gaps in healthcare from communication and cultural barriers of health delivery for Hispanics, hospital staff can be educated on proper translator protocol, active listening, and empathy to help aid concerns and facilitate disclosure. In conclusion, Julliard and her colleagues found that staff training programs in communication and cultural understanding techniques helped build trusting relationships. These relationships fostered better healthcare and satisfaction on the part of their Latina clients (Julliard, 2008).

Educating Providers to Deliver Better Care

In a before and after study conducted by researchers, Bischoff, an epidemiologist of public health, Perneger, a professor of health service evaluations, Loutan, an epidemiologist, and Stalde, a professor of community health, sought to assess the effectiveness of an intervention program to improve the quality of communication between physicians and "allophone" individuals. Allophone is the term used in this research article to describe an individual that speaks a language different from that of the language of the researcher (Bischoff et al., 2003).

Two consecutive samples of participants were evaluated to determine the effectiveness of a "communication work-shop" intervention (Bischoff et al., 2003, p. 542). The interactive workshop consisted of training sessions for physicians in enhancing communication skills while working with interpreters. Physicians were

given the opportunity to participate in interpreter-assisted consultations and given feedback based on perceived performance.

The intervention included ideas on how to better plan and schedule interpreter-assisted consultations, and manage the communication triad and cross-cultural communication. A five step structure was adopted to help physicians prepare for the consultation, initiate it, manage communication during the consultation, finish the consult, and obtain feedback from the interpreter after the patient leaves. Information was provided on the available interpreter services (languages, specialties), practicalities, and the payment plans for the translators (Bishoff, et al., 2003, p. 542-543).

The goal of the workshop was to improve the physician communication skills with allophone patients in order to better provide care and lessen health disparities. The post-workshop results were significant. Patients indicated an increase in respectfulness on the part of their physician. Patients also reported better satisfaction in the process of trans-language communication skills.

Doctors' responses to patients' needs increased from $P=0.37$ to $P=0.54$ post-workshop. After the intervention, interpreter use with allophone patients was increased from 46% to 67% from the previous year. The conclusion of this study determined that the effects of communication and cultural barriers can be decreased when enhanced training is aimed towards primary care providers (Bischoff, et al., (2003).

Perceptions of Clinical Time Management

In one study, physicians from all departments reported a perceived need to spend more time with LEP patients in order to provide quality care. This conclusion was derived from the study *Do Physicians Spend More Time with Non-English-*

Speaking Patients?. The study was conducted by the Department of Internal Medicine at the University of Washington. The purpose of the research was to determine if physicians actually do spend more time with patients who are non-English speakers (Tocher & Larson, 1999).

In a time-motion study, the duration of hospital visits were identified to see if time discrepancies existed between visits with Limited English Proficient (LEP) individuals and primary English speakers. Doctor Thomas Tocher and Doctor Eric Larson followed one-hundred and sixty-six patients throughout their clinical visits in order to evaluate time expenditures for both groups. Fifty seven non-English speaking patients were used as the experimental group while a control group of one-hundred and nine English patients were in the comparison group (Tocher & Larson, 1999).

The time expenditure was reported based on when individuals waited for medical providers, were in contact with medical providers, the total time spent in clinic, and providers' perceptions of time with the patient. No significant disparity was noted in the actual physical time spent with Hispanic clients; however, surprisingly physicians perceived that they "needed more time" with LEP individuals to provide quality care (Tocher & Larson, 1999). The importance of this study suggests the need for further studies to determine how to improve the quality care provided given, the minimal time with culturally diverse individuals.

Cultural Competence vs. Cultural Humility

Due to America's ethnically and culturally diverse population, philosophies have evolved on how to increase cultural awareness. Perspectives, beliefs, and practices vary between cultures and have significant effects on health and healthcare. In a country of ever increasing cultural, racial, and ethnic acceptance, it is important to educate healthcare providers to be culturally aware and implementing humility in

clinical practice can better the health outcomes for diverse individuals (Tervalon & Murray-García, 1998).

In recent research, it is becoming less common to use the term “cultural competence.” Rather, a new term has been designated to refer to cultural competence, ‘cultural humility’. Cultural humility suggests that through a humble acceptance of one’s own ideas and beliefs, one can actually further their knowledge of other’s through a similar learning and acceptance process. This process should never be considered fully complete but rather a lifelong dedication to understanding others, as well as ourselves (Tervalon & Murray-García, 1998).

Cultural humility calls for a mutual respect of differences in hopes of promoting more open-minded care. Being open to another’s values, beliefs, and culture helps stimulate therapeutic relationships and bridge gaps in cultural knowledge. A partnership between the healthcare provider and client to create better understanding will aid the individual-based clinical practice and health outcome (Tervalon & Murray-García, 1998).

Cultural humility is an advocacy model to promote better healthcare to culturally diverse clients. Teaching healthcare students, who will provide care to respect cultural difference, will better allow the effective providing of care. The Institute of Medicine defines *optimal primary care* as “an understanding of the cultural, nutritional, and belief systems of patients and communities that may assist or hinder effective health care delivery” (Tervalon & Murray-García, 1998. p. 118).

The study indicates that (a) self-reflection and lifelong learning, (b) patient-focused interviewing and care, (c) community-based care and advocacy, and (d) institutional consistency all lead to cultural humility (Tervalon & Murray-García, 1998. p. 118). It is essential to have a patient-focused interviewing systems and

cultural understanding that creates therapeutic client-provider relationships, which has already been shown to lead to increased trust and disclosure that leads to better health outcomes.

Delivery of Healthcare Services

In an article published by the Public Health Nursing Journal in 2007, The Farm Worker Family Health Program (FWFHP) reported that an intervention to increase healthcare for migrant farm workers was implemented. The program was successful in serving migrant farm worker and their families. The project was a collaborative effort by an interdisciplinary team that attempted to provide the healthcare to a population and area of need (Connor, Rainer, Simcox, & Thomisee, 2007).

In the community based partnership, ninety local college students and faculty members from Emory University visited one rural, low-resource location to assist the already existing program in providing healthcare to farm workers. Students and faculty members from the departments of nursing, physical therapy, dental hygiene, and psychology joined the Spanish-language students and the local health department to bring basic healthcare to migrants working in the rural setting. The responsibilities for each student member were different, depending on scholastic discipline. Student nurses were responsible for height, weight, body mass index, blood pressure, vision and hearing screens, and obtaining hemoglobin and glucose samples and results. Nurses also worked on referrals to primary care physicians that were available in the area (Collins, 2007).

The purpose of the partnership was to establish an enhanced healthcare facility that educates farm workers on preventative care, on how to better their health status. The program also sought to enhance the students' education through cultural

immersion. These experiences allowed students to incorporate knowledge of minimal resources available to marginalized populations in American society. The community partnership was inspired by another model where interdisciplinary teams focused on gaining professional skills by working with at-risk-populations in low-resource areas to promote better health within the community (Connor, et al., 2007).

The approach aimed to help future health care professionals gain an idea of social responsibility and leadership. The goal was to foster an understanding of how at-risk-populations in non-traditional settings receive healthcare with minimal resources. The relationship between being a migrant worker and poor health was observed by students (Collins, 2007). The immersion was an opportunity to enlighten students on environmental hazards which effect health status and healthcare.

Students were confronted with language discordance. The students were obligated to cooperate with interpreters in order to communicate with the clients and in this way they recognized the importance of public health work and the translating process. Working under unpredictable circumstances gave students the opportunity to learn flexibly, patience, and an appreciation for language concordance in the healthcare field (Conner, et al, 2007).

Montana Migrant Health Program

Migrant workers travel to Polson, Montana annually for the cherry harvest. Hispanic migrant workers find jobs in the area every August. They have also encountered a chance to receive affordable health care in this rural Montana town. A small temporary clinic is set up in Polson every year to offer free medical and dental care during the last week of July and the first weeks of August; this is known as the *cherry harvest* or *cosecha de la cerezas* (Montana Primary Care Association, 2010).

Hispanic migrant workers, a population often considered marginalized in American society. These are the individuals seen at the Flathead Migrant Clinic, where often as many as 800 people seek medical attention in the three week span. These reportedly large families often live on less than \$10,000 a year and are confronted with chronic illnesses such as “hypertension, obesity, and diabetes...” the very same chronic illnesses that plague the majority of Americans. The clients are in need of prescription medications and health treatments (B. Gibson, personal communication, August 1, 2010).

Providing healthcare to individuals who speak different languages can be difficult. Migrant workers in Montana are facing troubling medical maladies that go untreated every year due and to the inability to receive care. Claudia Stephens of the Montana Migrant Council (Montana Primary Care Association, 2010) reported that,

Even in these times of heavy mechanization, people still bend over hoes for long hours working in fields. People still stand on ladders to pluck cherries from the trees and lay them gently in heavy bags that cut into their shoulders.

The challenges faced by Hispanic migrant workers in Montana are difficulties with communication, poor or no housing, drinking from contaminated water sources or having no running water at all, little or no money to pay for insurance, expensive treatments and medications, and difficulty accessing the healthcare system in general (Montana Migrant Council, 2010).

The Montana Migrant Council (MMC) is a program established in 1971 to assist Hispanic migrant workers in Montana. The program provides primary healthcare to migrants and seasonal workers, as well as their families throughout the state year-round. The MMC provides primary and preventative health care, transportation to and from clinics, outreach translators, access to dental care,

pharmaceutical cost relief, occupational health and safety assessments, and healthcare through the Migrant Health Program (Montana Primary Care Association Inc., 2010).

The program utilizes extensively trained medical and bilingual personnel to aid in provision of primary healthcare to this minority population. Health professionals, bilingual translators, and culturally competent protocols assist the MMC to provide the highest quality care to this underserved population in non-traditional settings. Of the estimated 10,400 Hispanic individuals living in Montana, the MMC currently serves an estimated 6,000 individuals annually. This includes men, women, and children who normally would not have the opportunity to obtain affordable healthcare (Montana Primary Care Association Inc., 2010).

There are currently nine clinics located throughout Northeastern, South Central, and Western Montana where the migrant farm worker populations are the highest. Preventative healthcare professionals, nurses, nurse practitioners, a dental hygienist, outreach workers and case managers create the broad interdisciplinary network. Individuals receiving care must apply to qualify; however, occupational and legal status, and economic background make no difference (Montana Primary Care Association Inc., 2010).

As a proactive alternative to decrease the negative side-effects correlated with language and cultural barriers, the MMC works year round to provide healthcare to the Hispanic minority. The implementation of appropriate services that provide preventative health education and promotion are effective means to aid in inevitable healthcare visitation. The MMC program helps to relieve the societal burdens and barriers in caring for this population.

Summary

As this review of literature has shown, much research has been done in the area of understanding cultural barriers and competence. New programs have been implemented, such as enhanced interpreter services and rural community clinics to help bridge these barriers. There has been no research, however, conducted to evaluate the healthcare being provided to migrant workers in Montana. The purpose of this research is to fill in those gaps in the research and aid in the implementation of such programs in Montana.

The review of literature on this subject has indicated that the nurses in the United States are going to come into contact with clients of Hispanic descent at some point in their careers. How nurses and other healthcare providers distribute care to these individuals is subject to the education they receive. Increasing the knowledge of the culture of a client will aid healthcare providers distribute better healthcare. When the client's values and beliefs are understood, healthcare professionals, such as nurses, have a better means to provide quality care.

This research can be used to modify the current distribution of care to all migrant farm workers. With the application of the knowledge indicated by the research, a higher quality of care may be provided. The research has indicated the pros and cons of utilizing interpreter services, as well as its importance. The importance of how facilities will handle communication, healthcare access, assessment of education and pain must also be determined. Not only is it ethical but it is legally mandated by the U.S. Constitution and CLAS Act. The nursing implications of this study are to enhance the cultural context of nurses in order to provide higher quality care to diverse populations.

Chapter III

Methodology

This study was guided by the theoretical perspective of understanding the interactions between multiple individuals from culturally diverse groups (Glaser & Strauss, 1967). It examines how healthcare professionals view providing care to migrant workers. The research is composed of interviews on the personal experiences and interactions with migrant farm workers in rural healthcare settings. These data collected were used to develop views on culturally diverse healthcare and gain understanding of communication which facilitates healthcare for Hispanics in rural areas of Montana. The research involved intensive interviewing, inductive reasoning, constant comparative analysis of data, and general observation to develop a grounded theory (Glaser & Strauss, 1967). Interviews and analysis were done simultaneously until no new categories were identified and redundancy was reached.

Purposeful Sampling

Six participants were recruited from rural Montana clinics where healthcare is provided to migrant workers. The sample was purposive and selected based on participant's years of experience and ability to articulate their experiences in this area of study (Glaser, 1976; Glaser & Strauss, 1967). Six actively working health care providers volunteered to be participants for this study.

Inclusion criteria for each participant was that they must meet each of the following: (a) have worked with the migrant population in Montana for a minimum of two years, (b) be a least 18 years or older, and (c) have completed at least one seasonal rotation providing healthcare to migrant workers in rural areas. Prior to participant recruitment, the researcher protocol was approved by the Carroll College

Institutional Review Board and informed consent process was obtained from the individual.

Characteristics of Participants

Of the six participants, there were five female individuals and one male. Professions of these individuals ranged from; one general medicine doctor, one family nurse practitioner, one registered nurse, one case manager, one area service coordinator, and one outreach lay worker. All participants were actively employed with the Montana Migrant Council during the time period from July to August 2010.

To varying degrees, all participants worked directly with the Hispanic migrant workers in Montana. Each participant had a vast amount of individual experience working with this population and each with a personal perspective of the healthcare system. All were knowledgeable in different areas of providing care to the Hispanic population in Montana. None of the participants worked in the same area of care and each one therefore had different areas of focused knowledge.

Data Collection

Data was collected through ten, in-depth, open-ended interviews, each of which lasting approximately 45-60 minutes. The focus of this study was to identify main themes found in the individual experiences of those working with Hispanics in the rural Montana healthcare system. All interviews were conducted in private isolated areas; either in offices, converted Winnebago clinics, or in the cherry orchards of Polson, Montana. Observations of the clinical practices and operations were all recorded in the researcher's field notes. All interviews took place in the individuals' work space during working hours. No gratuity was paid to any participant.

During the initial interview process, informed consent was verbally obtained from participants and audio recorded for the record. Additionally, a written consent form was signed (See Appendix B). Individual interviews were conducted which were based on seven to ten-prewritten questions by the researcher (See Appendix C). The answers to each question led to more in-depth, focused questions based on individual responses.

Individuals were first asked to state their name and consent for audio-recording for the purposes of this study. Participants were asked how long and where they have worked with migrant workers. Participants were then asked to describe their job descriptions and typical interactions with the migrant worker population in relation to healthcare. Based on these responses, participants were asked to elaborate on the positive and negative aspects of these experiences. Preliminary interview questions remained open-ended but became more focused and specific as data was gathered and conceptual categories emerged.

Secondary interviews were conducted after the initial analysis of the primary interviews was complete. Five of the six participant's interviewed were available for secondary interviews. The second round of interviews was conducted in a similar fashion in order to fill in the gaps in the data and gain a more in-depth understanding of the themes presented in the first round of interviews.

Specific interviews of a secondary nature were conducted over the phone. The interval between the first and second interviews created an unexpected time for reflection on the part of the participants. Any "change" or "no change" in attitudes and/or perspective was identified and used to validate findings. Second interviews were used to gather further data as well as a form of validating credibility of the researcher's findings (Lincoln & Guba, 1985).

Data Analysis

All interviews were audio taped and later transcribed for the purposes of coding and analysis of data. Transcriptions were analyzed for content based on the constant comparative method by Glaser (1976). Data analysis was conducted both simultaneously and after data collection. A coding process was developed to aid in analyzing the mass amount of data collected and aimed to identify categories; however, a core category and supportive categories evolved. This form of open coding was used to divide the data into segments that could be scrutinized for common themes that were reflected in multiple individual experiences. Patterns emerged from the coding of collected data to conceptualize and categorize information in an organized manner. Similarities and differences were noted in all areas of research and analyzed thoroughly for continuity.

Observations were recorded as theoretical memos in the field journal during the coding process to track bias and ideas of the researcher. Theoretical memos were used to develop a basis for the grounded theory and will later be explained in the discussion of this research.

The classification of data helped saturate the categories with as much co-occurring information as possible. Each category holds as much data as the researcher was able to gather through the interview, open-coding, and theoretical coding processes. Any information that was found to be disconfirming led to further revisions and analysis.

Rigor

Credibility of data was validated by the use of secondary interviews. Each secondary interview was contrasted against the preliminary to determine any changes in findings. Also, constant observation, and persistent debriefing of the research

process in the field notes and with research mentor aided the researcher to maintain neutrality. Other, more expert qualitative researchers were consulted to explore and inquire about any forming biases on the part of the researcher. All levels of healthcare professionals as well as case managers, area services coordinators, and outreach workers were called upon to hear and reflect on the findings.

Chapter IV

Findings

The findings of this research indicate that there is a distinct social process that correlates with the distribution of care to minorities in Montana. Each one of the following categories and sub-categories are supported directly by the individual experiences, expressed through the transcribed quotes in each section. All categories were derived through the constant comparative analysis method based on the Glaser and Strauss prototype (1967). All outliers are illustrated as well in the findings section of this research.

Core Category: Establishing Common Ground

The participants described the importance of establishing “Common Ground.” The process of two parties reaching an agreement on a subject was considered by participants to be establishing common ground. This social process can be founded through either a mutual understanding of an issue or a negotiation where settlement occurs. Findings revealed that participants are continually assessing client interactions and how the participant may influence clients to obtain optimal health. Establishing common ground with the clients allows participants to promote health in a way that is pleasing to the client.

First of all, when establishing common ground, it was critical for participants to understand how cultural and individual beliefs affect the health perceptions of their clients. Participants recognize that clients from different cultural backgrounds from their own often have a different set of standards and values relating to health. Understanding that a number of influences affect how each client looks at health and healthcare is important in order to provide effective care. One participant stated that “The hardest part actually, is trying to have the clients return to their follow-up

appointments. It is very difficult because clients come to the United States, or anybody (immigrant workers, not only Hispanics), to work.” Another participant reaffirmed this:

Health is not for them, they have to work. So, even if you call them, even if the patient knows he is sick, that he needs to return for follow-up, he is not going to do it because he needs to work.

Clients express their attitudes about health and healthcare, which subsequently guides participants to better understand why clients’ make the choices they do. Participants often described the value of healthcare as diminished compared to the clients’ need to work and earn a living. One innovative way participants are addressing this problem and establishing common ground is that they literally “take the care to the client”.

One participant explained:

This time of year we know that people are coming for the sugar beet harvest. To work in the fields, so that’s when we go out and try to register people. And then if we see that there are enough people in the area to make a visit with the mobile clinic, then that’s what we do.

Participants understood the need to take the care to the client. Often, participants perceive the needs of the client are more monetarily based and little emphasis is based on health. Clients are focused on earning a living and feeding their families and therefore put little effort into coming into the clinic. It is at that point, that participants make it their responsibility to provide care in the areas in which it is needed.

The most common health trend amongst the migrant working population is, “The most common one, the most awful one, is of course the one that exist here [U.S.] too, as obesity.” Another participant stated:

I would say that only about 5% of the population we see is of normal weight; which leads to all sorts of other problems like hypertension, diabetes... A lot of it has to do with, number one, the traditional food that the population eats and then number two, is that they can't afford to buy healthy food. I think those are the two main reasons for them being overweight. And of course education too, they have no idea what is in the foods they are eating.

This participant identifies three key problem areas for the clients that ultimately result in poor health status and lead to preventable disease (a) Food choices, (b) Expense of healthy foods, and (c) Lack of education on healthy nutrition.

The participant must take the next step in establishing common ground; building a relationship of mutual understanding, "We address diet by basically using colors." The participant uses the "colors" of food as a way to objectively confront the health issue so that both parties can mutually understand:

Instead of using the word carbohydrate in diets we call those foods white foods. We ask them to stay away from white foods. We tell them they need to eat more colors. If you are eating more colors, you are eating more fruits and vegetables rather than, if you are eating more white floury foods, for instance, tortillas.

"Tortillas" are perceived by the participant to be a traditional food for Hispanic migrants. The participant and primary provider for the population in the area, understands that although tortillas may be a staple in migrant workers' diets, nutrition education will be ineffective if common ground is not reached. Another aspect that the participant described is that the "traditional" diet of Hispanics is rich in a wide variety of grains, fruits and vegetables. It is the poor person's U.S. diet that seems to be the reason problem.

To elaborate the notion of establishing common ground with clients, the word “carbohydrate” is usually not the most appropriate term to use when working with those with Limited English Proficiency and education. Common ground increases the chances for better health outcomes for the individual. “Eat colors, like fruits and vegetables such as salads. It is healthier. But white foods like rice and tortillas are good but they are not as healthy.” Instead of calling foods by their bio-molecular make-up, the participant uses the simplicity of colors to communicate the same point.

The ability of the provider to assess the knowledge level of the client and their aptitude to comply with recommendations gives the participants a better understanding of how to address the clients’ needs. This allows for an opportunity to promote better health through reliable education.

To establish common ground, one participant stated it is best to “educate the patient”. The participant stated, “Education works. I have learned through the years that education works.” When teaching clients how to maintain and promote health, the participant must understand clients’ education level and goals. Education creates an understanding and is a bridge to barriers.

Participants use education to promote healthcare, “If they completely understand that they actually need to follow-up on what we are telling them, then they are very compliant”. Through thoughtful consideration and education, participants have found that they can influence clients’ compliancy; however, for some participants, this influence can make patient-provider boundaries particularly difficult to maintain:

I call them, and I beg them, and I tell them what is going to happen and they still don’t come... I beg them and I tell them, and I scream at them the reasons why... I truly babysit them. I ask them, “Do you remember about how you

were before and how you are now? How you have become more obedient because you know that you are getting better because of everything you have done; because you are taking care of yourself.” And I tell them over and over.

The participant puts forth great effort to influence the client almost to the point of nullified autonomy. This participant is considered an outlying situation where the client is almost coerced into receiving care. The participant emphasized the need to receive care; however, how the client receives this message is unknown. In order to influence the clients to comply/agree with the healthcare standards, this participant does not attempt to establish common ground, but rather “begging” and “screaming” at them gets them to comply.

In essence, the value of the individual’s health must be recognized by the individual. Or if they do not understand that they are ill, they may not seek treatment. One participant stated, “You call them and you beg them and you tell them what is going to happen and they still don’t come.” The severity of future illness is evident to the participant, but not to the client in their perspective. Another participant described the frustration felt when perceptions of illness differ:

They don’t think that diabetes is big thing. If they feel ok, they’re ok. We had a man in Flathead whose blood sugar was like 700 and we tried to get him to go to the doctor. He said, “But I feel ok. There’s nothing wrong with me.” We couldn’t get him to understand that there *was* something wrong.

Health for some clients, although not all, is simply the notion that if a person “feels ok” that means they are “ok”. This theme was shared among participants and found to be common while working with migrant client population. “There are many who do not see the importance of health and there are others who know that they really need to take care of themselves. They know what they should and shouldn’t do. It all just

depends.” Participants understand that client needs differ by individual. It, however, remains essential to gain trust and respect while forming relationships with clients in order to provide quality care. The clients can then be considered responsible and able to access the care provided to them.

Supporting Category: Providing Access to Care

Accessing healthcare for Hispanic individuals has been described by participants as the “ultimate goal” to promote health and prevent disease. During the primary interview process, each participant was asked to describe what issues they perceived to most impact clients’ ability to access care. One participant described that this disparity came from the disenfranchisement of the population as a whole:

Any time that you have an immigrant population with a different language, with different customs, often they are the poorer of the society they are assimilating into.

You tend to see these trends that say, “Well, first and second generations of Hispanics often do not have the same standard of living as folks living in America for more time.” Often that is because of the language barrier. They are unable to secure jobs or education, and generally it is a result of the poverty and less of the culture. They don’t have health insurance. In many cases, the fact that some Hispanics are here illegally or undocumented also limits their access to health assistance programs from the government. So it is a compilation of those factors, really, I believe, that causes and perpetuates the disenfranchisement of the population.

The participant explained that cultural and socioeconomic adversities make healthcare difficult to access for clients considered to be in the “margins” of society.

Participants throughout the interviews four main barriers that prevent migrant workers from accessing health care were identified. These four barriers to access are (a) communication difficulties, b) fear and legal consequence c) inadequate transportation, and d) expense. These sub-topics can all be contained under the umbrella the sub-category of accessing care.

Communicating

In communication, information must travel from one party, considered the sender, to another, referred to as the receiver. The transfer allows for the sharing of data and re-interpretation of information by another individual (Galanti, 2008). In the case of the participants in this research, that information is often difficult to communicate. Complicated as communication can be, it becomes exponentially more complex when two languages are being used.

Participants in this study explained the importance of accurate communication related to providing healthcare for migrant workers. The complications and confusions that arise when concepts are lost in translation can be “devastating,” resulting in poor care management or no care at all. Communicating medical information can also be a source of frustration for participants. Some participants, primarily responsible for organization and administration, were asked to help translate for clients as well. The participant commented on medical terminology used in healthcare:

The doctor gets carried away with medical terminology and I have to stop him and say, “Now you will have to explain it to me in a way that I can explain it to them because I don’t understand some of those medical words.

The terminology used by medical healthcare providers can prove to be a challenge for some participants, even those who are bilingual. When participants were required

to translate for medical professionals, some had little or no medical background to recall from. Therefore, the participants must ask the medical providers to re-explain the information in a way they can understand it and then translate it to the client.

Another participant, trying to express concerns with clients who have no background in healthcare, stated:

The lack of education makes it very difficult to express diseases, origins of diseases, treatments, ect. How medications work. They need to understand everything, how to take medications, when they need to come back to the clinic, when their next follow up appointment will be.

This participant suggested that adequate time and appropriate communication leads to better health outcomes for clients. Clients must fully understand the instructions explained by the participants and the implications to their health or they may not comply with recommendations.

All participants, in order to be selected for this study, were required to work with specific Hispanic migrant client base for at least two years and therefore were presumed to have had the opportunity to work with Spanish speaking individuals during their occupation. Half of the participants interviewed were considered “fluent” in Spanish, while the other participants spoke little to no Spanish at all. One participant recalled, “At the time when I was growing up, . . . people really didn’t want their kids to speak Spanish.” In a time and culture where Mexican Americans were expected to learn English, this particular participant described the importance of non-natives learning English. Now, the participant works with a client base where the majority of clients seen speak only Spanish. One participant stated that:

I feel that it is so important for people to understand that some of these people really don’t speak English and don’t understand English. And how hard it is

for them when they have to go to the doctor and they can't speak English. It's so sad. It's a big deal. I think to myself, "How would I feel if I were in a different country and couldn't speak the language and there was no one around to help me." That would be a sad day.

The participant used empathy to help her understand the clients' inability to communicate results in fear; the fear of being in a foreign land, needing medical care, and being unable to tell anyone about it.

Another participant who regularly provided care to the migrant clients stated, "The language barrier makes it difficult. If they don't speak English... You must go through a translator. If they don't speak fairly fluent English then we always have a translator. This takes time and that means less time with the client."

Translators must then be available at times when clients need them. When official translators are unavailable a participant stated that "Sometimes they can speak enough English that I can manage or they have a child that speaks English, so I can have them translate for their parents." This participant uses family members to translate information to and from the client.

Participants use a variety of resources to help clients gain access to medical care and communicate with their healthcare providers. The use of translators, family members, and children, as described in by participants, are a means of facilitating to communicate with clients. A non-Spanish speaking participant confirmed that working with the migrant population and being unable to communicate "has definitely inspired me to learn Spanish."

Participants must find ways to ensure that clients understand the information presented to them in order to be compliant with the treatment desired. If the client

does not understand the treatment directions, they will have a hard time adhering to it. One participant explained how she ensures client understanding, “For one thing, we like to ask the patients to repeat what we have said, what we have told them whether it is through a translator or not, just to make sure they understand.” The reliability of assessing understanding by this method has not been researched for reliability when dealing with those from Hispanic or any other cultures.

Fear and Legal Consequence

A social needs-based assessment of clients allows participants to understand how legal discrimination against Hispanic migrant workers affects health outcomes. One participant shared his/her experience:

There is a lot of prejudices around when people are migrants—But I do understand the prejudice can make people feel like these people come here and take their jobs and do all these bad things, which isn’t true, but that’s the way they feel.

A common concern identified by participants is the recognition of an existing social prejudice against Hispanic immigrants living and working in the United States. One participant stated:

I love taking care of these people. I think they work really hard for America. Most Americans have no idea that these programs exist. These people come here to do jobs that no one else will do and they are very integral to our food supply and they need health care while they are here.

One participant inferred, “I think they don’t understand that they can still get a ‘work Visa’.” The participant described ways to obtain access to care when there is legal status pending in the U.S. When clients do not have the proof of legal status, then access to care becomes more difficult to obtain.

A conflicting viewpoint is that it may be equally as difficult to maintain the visa as it is to obtain care. The participant explained, “I think they don’t know that they can get a work Visa. They thought it would be more difficult because within nine months they have to go back home. It’s expensive to go back home.” The participant explained that the point of the work Visa is so that the client can work legally. What happens when the visa is more trouble to obtain and maintain than it is worth is that they do not apply for it. It is described as too “expensive” and “dangerous” to go back and forth between countries thus creating a conflict to obtain legal status.

Transportation and Expense

Participants agreed that transportation and healthcare are expensive. First of all, the client must have access to or a means of transportation. Next, the client must be able to afford the gas it takes them to get to and from the clinic. Ultimately, once the client arrives at the healthcare facility, they must be able to afford the care provided.

The migrant workers have been described as living “far below the poverty line,” making it difficult for clients to take off from work “without the possibility of compensation” (Hellman, 2010). Clients seeking healthcare are obligated to make the choice to postpone working as they visit clinics. Participants explained that clients are expected to come in for check-ups, follow up appointments, and to refill prescriptions in a timely matter “without any regard to what the client is losing on the other end”. Clients must pay for most visits to see a provider making the journey “too expensive to consider”. One participant described it this way:

The most difficult barrier for migrants is transportation. We have one family who has a diabetic, hypertension, and asthma. They are unable to come because they need to go find jobs, because there is no farm work right now.

They know they need to come in but they cannot come in. They don't have the money for gas, and they don't have the money to spend on their kids, and then whenever they have time or money left over, they will come.

The price each client must pay is raised exponentially when the various factors are taken into account, such as gas, multiple medications, and wages lost.

The compounding difficulty decreases the probability of migrant workers to seek access to care. It can appear impossible and impractical for migrant clients to seek healthcare.

Participants, however, are finding ways such as "voucher systems" and volunteers to help clients access care. One participant stated:

We use a voucher system. If we need to refer them to a specialist we can voucher them out. We pay Medicaid rates. We have pharmaceutical vouchers for medications under fifty dollars. There are all kinds of patient prescription programs, and even the pharmaceutical companies will help out certain patient income brackets.

The voucher system was considered by most participants in this study to be an effective means to provide affordable medication and referral options to primary care providers.

Participants indicated the importance of finding resources for clients. Programs which provide assistance to meet priority needs of the clients are not common and therefore, must be thoroughly researched. The availability of quality resources are investigated by participants. This inquiring includes accessing the voucher system set up by pharmaceutical companies to distribute affordable drug medications to those in need. Expectations on the part of the client, however, should not be great. One participant stated, "It usually takes from 2-4 weeks to get

medication the first time.” Programs, such as the prescription voucher assistance, take longer to provide services. Clients must often wait for extended periods of time before they receive their medications.

Participants explain that clients are expected to “get by” on what is available to them at the time and for the most part they do. One participant stated:

I think the programs available are affecting it in a positive way. I think the emphasis on treating acute illness is very good. In some cases where there is a long term presence of the Hispanic population, I have seen the benefits of such programs as the voucher system. What is being implemented is necessary and I think it is a positive development.

The participant recognized that the available programs are not perfect, but they are a good resource that should be utilized. Access to such programs provides services that have positive effects on the clients.

The voucher system and programs like it are considered by participants as a step forward in the direction of eliminating disparities in healthcare for minorities. Programs are developed based on levels and areas of need, when utilized; they allow the participants to provide better care.

Supporting Category: Allocating Resources

One challenge for participants working with the migrant population is to identify the areas of need for the clients. Once problems are identified, participants then were asked to share ideas as to how to create solutions. Participants recognized their disadvantages and inability to accomplish their goals were directly related to the availability of resources. Participants recognized how minimal resources must be utilized effectively in order to provide quality care. All participants in this study

identified challenges in providing healthcare to migrant working clients, especially those working in rural settings.

One participant stated that migrants are:

A population in America that has been marginalized in the health care system and I am interested in learning about how they have been marginalized, what their needs are, and then maybe how to fix that situation.

There are several ways these questions have been answered; however, first identifying the challenges facing the population is necessary. One participant stated, “The most challenging part of what I do is the amount of time we are allotted for the services that we need to provide.” The participant described a typical day in Polson:

Just imagine, you find yourself with many patients in the waiting room, which is actually just a tent, and it’s a hot summer day, and you are trying to get this family registered. So the challenge comes when you realize that five of the eight people have diabetes and one is pregnant. How do you help them? It can be very overwhelming and sad. These people are here working in the sun and get little opportunity to receive care. That is what we are here for and we do our best, but we don’t have much.

The challenge for this participant was often the need and inability to provide the care needed in a short period of time.

When asked to describe their particular role when working with clients, the participant stated, “I am an outreach worker. The outreach worker position is really a catch-all position.” The time efficiency of an outreach is necessary and can be challenging; the same participant goes on to say, “Do you adequately have enough time to obtain the health history and do you have time to adequately provide education and at the same time the nurse or the doctor may need your assistance to

translate for them?” The outreach worker is responsible for registering clients, collecting health history information, and translating for the medical providers. The participant expressed a sense of difficulty and frustration when fulfilling all of these responsibilities.

All participants in this study concurred that the number of human resources available to provide care to migrant clients is insufficient. One participant said, “We typically see upwards of 800 clients in the span of a three week period. And to have a staff of a full time Nurse Practitioner and a few part-time RN’s and five outreach workers is not enough, it is absolutely not enough.” Another healthcare participant added, “To see upwards of twenty-five people in a day and do all the follow-up while working in a field, it’s hard to do it all.” The participant later continued, “We are so short staffed. I don’t know how the nurses do it. How they can even handle and they don’t say anything. Nurses are very resilient. We do just fine with very little.” And another participant: “There are not enough providers to see all the clients.”

Beyond the amount of providers available, physical resources can also be in short supply in rural healthcare settings. One participant discussed the difficulties of working with minimal physical resources at rural sites, “We rented the basement of a church and used green sheets just like a M.A.S.H. unit to make privacy. We used chalk boards as walls of exam rooms.” Another participant, working out of a 1980’s Winnebago, recalled client visits, “It’s not the best for confidentiality. When you receive care next to your neighbor and you don’t know if they can hear you, it limits disclosure, but we gave the most reasonable confidentiality we could.” The word “reasonable” is used by participants’, as well as the ability to “get by” to give an idea of what rural clinical care for migrant workers is like.

While interviewing one participant in their work space under a small four walled canopy tent, the participant was asked what they believe would help solve the challenges faced by the rural clinic. The participant explained, "I just think we need bigger tents to give people more room to do their jobs, 'cause it is sweltering in here." Other resources are unavailable in rural setting as well. Consider the expenses of diagnostic testing. The same participant stated:

Having tests available doesn't mean that you find better answers. You learn to get by. I may not have the money to do a CT of someone's sinuses but I can do a plain film. And every time the radiologist says, "Well, you know a CT scan would be better." I say, "You told me what I needed to know on this." But the next thing they always say is, "Well, you really should consider a CT." and I say, "Well, I would consider it but this person can't afford it.

The participant weighed obtaining the more accurate diagnostic tests versus the ones the client can afford. In this case, the affordable test is the only one that will be provided. The participant stated, "When people need tests that you wish you could get but they can't afford it, you don't have that option. That would wipe out their budget very quickly. It becomes frustrating" Again, the theme that expenses and lack of resources prevent participants from providing quality care. Clients have to get by with what is available to them and providers must utilize the knowledge of the population in order to provide quality care. One participant's perspective was, "They seem to do just fine."

Participants were asked to compare mobile clinics with permanent ones, "At a mobile clinic, you can do anything in there that we can do in our permanent clinic. They can do PAP's, they can do blood work, everything that we can do here in our clinic they can do. It's incredible." There are instances where creativity and

innovation must make up for lacking resources. Another participant states about the rural clinic, “My cabinets are two metal file cabinets that we also set the centrifuge on and when you centrifuge on a metal cabinet, it is very noisy.” The participant explains, “The money doesn’t go into the building or the equipment. The Council puts all their money into the client.” Minimal funds equates to minimal resources. This can lead to providers facing more challenges. Another participant stated:

Physically the Winnebago’s do not represent a sterile, private environment to see patients in. It is not particularly welcoming. What is the final goal? I would say that the final goal is a *nice* RV that is slightly more modern and with air conditioning. We always have to go back to what is the ultimate goal and we have to live up to that goal. We have a ways to go.

A participant explained that a priority goal for one rural clinic was to obtain computerized technology, “We just got computers... We never had computers. It is hard to be in a society where everyone wants to e-mail and send you things by computer when you don’t have one, but now we do.” Ability to access and recall on electronic medical records is important for healthcare providers in rural settings. Other rural clinics are attempting secure resources to attain the same goal. Another participant stated the need for electronic medical records is one of highest priority:

This isn’t a question of just having 21st century technology because it’s snazzy and it seems like a cool thing. This is something that would absolutely improve the health care delivery at the clinic, reduce duplication, and control accuracy. Because often, as you know, patients are not the best at remembering exactly what they have had in the past, what procedures they’ve had, what medication they have taken. I know it is a difficult thing but I think it is very feasible and clearly benefits the patients which makes it such that

even though it may not be as feasible as it should be, it should absolutely be accomplished without reservation.

Another participant added:

With electronic medical records I believe helping these people would be a feasible goal. I understand that the biggest barrier to that is the one time cost. That stuff doesn't cost a lot to maintain but the one time purchasing cost can be a barrier for a non-profit, but it is a barrier, that I think you ultimately have to get past.

Electronic medical records serve as an instrument to keep track of health over time.

Another participant stated that, "If we could have a pool where this patient is being tracked at the location where they visit year round, it would speed up the process by cutting down duplication." The participant adds that electronic medical records will result in "Spending less time hunting down the pharmacy and hunting down what medication they are taking, I could spend more time giving health education instead of duplicating information that was taken six months ago in a different location."

Electronic medical records are just one way participants see that could promote higher quality of care provided to clients in rural settings.

Providers

Participants in this study regard the building and the equipment to be less important than the care itself. One participant stated, "It is certainly in my opinion the facilities are far less important than the providers." Participants have revealed their opinions the clinics' weaknesses. The interview process, minimal human and physical resources, time restraints, outdated systems and equipment have all been considered challenges; one of the highest priorities is the limited competence of the providers themselves:

I have some reservations about the depth of experience of some of the providers here. Many are not familiar with treating illnesses such as chronic diabetes. There are a lot of gynecological issues, a lot of patients who are pregnant or in some stage of pregnancy or are in the early stages of child rearing and to my knowledge; I have never seen a pediatrician or an OBGYN. Another participant described other areas of care where there is a lack of experienced providers for migrant clients, “Many of the patients have eye problems, to my knowledge, I have never seen an ophthalmologist that was willing to stop by.” Some of the main areas of client complaints are not being addressed due to the inexperience or lack of knowledge by the healthcare professionals working in rural settings.

Problem Solving

When asked whether or not resolutions seem possible amongst all of the challenges presented through participant interviews, one participant stated, “The challenges can absolutely be met and they can absolutely be met by passionate caring people.” Paralleling another participant statement, “To get the changes that we desire is by continuing to pursue, without fail, to meet these challenges. If we fail, if we drop the ball, if we throw our hands up, then nothing is going to improve. Then we fail, and we fail our patients.”

Participants described a sense of ethically responsibility to advocate for clients regarding the provision of quality care. A participant stated, “You know this is a population where there is no one else to count on besides us.” The participant was asked to explain the relationship with the clients, “We are the last line of defense for them.” Participants hold themselves responsible for improving the health of their clients. They cannot “fail” clients because clients have little ability to advocate for themselves.

Supporting Category: Provider Incentives

Each participant was asked why and how did they come to work with the migrant workers in Montana. A reoccurring theme throughout all of the participant interviews was their “incentive” to provide healthcare to the underserved came from the relationship and bond created by the extreme circumstances. One participant said:

While the clinic’s main charter is for medical services, the primary care aspect affords us the ability to be so much more to our patients. Reflecting on my work at the clinic, it has been a blessing. I have seen many people for the past three years and this permits me to be a part of their lives. The opportunity has afforded me the ability to see the growth of the children as they face life’s challenges. For example, one of the regular patients is a 14 year old boy who aspires to go to college, to leave behind the migrant life, and cycle of poverty. I have counseled him about his diabetes, helped his family maintain and promote good health, and helped encourage him to pursue a college education.

Another participant stated, “I like working with the clients because I can see the need.”

The desire for participants to provide healthcare to migrant workers is considered a calling. One participant stated, “Medicine is a vehicle for justice. A more fair and equal society, in which everyone enjoys the promise of a better life, requires good health. This is what I have been called to do.”

A participant explained that working with migrant workers is a “beautiful” experience. The participant stated, “When you see what you can do and how they appreciate what you are doing... When you get to see them through the year, it is truly beautiful.” Reflecting on all of the challenges presented when working with this population, one participant stated, “Its long hours but the people there are so nice. The

clients bring us cherries. They are so appreciative of what we do.” Another participant stated, “The translating, filing the paperwork, whatever we can do for them, they just really do appreciate it. They are just those kinds of people. They would do anything for you if they could.” Another participant said, “They will always come back and say thank you.”

One participant described the best part of working with the migrant population, “meeting the people and knowing how appreciative they are of what we do.” And another, “Well, really it is that they are really, really thankful for receiving any kind of care. It really helps them a lot. It is just something you don’t see in the traditional western world.” The world of healthcare is deeper than it appears, “Every time we help a client, it’s rewarding.” Clients will often return to the clinic in Montana to receive care. One participant said, “When a client comes back and you may not think it is a big thing but to them, it really is a big thing.” The clients that return from year to year create relationships with the providers. One participant said:

Getting to know them from year to year. When they come and you don’t see them for a whole year, it’s kind of nice. Just knowing the people. They are not just a client or a number. We make them feel comfortable while they are here for a little while. Clients will call and say, “I moved to Colorado, or Idaho and the migrant clinic down that isn’t like the one in Billings.” That makes a big difference. That makes you feel good.

Another participant described a particular family:

We have one big family that never liked to get their check-ups. And then for the past three years the first thing they do, when they come, they get registered, they get their check-ups, they get their follow-ups for all their ten. So that is really good. They are really good at health. So that is rewarding.

The clients continue to return to the Montana clinic because, “They could see that we were really helping them and that we were really trying to help them. In any other office they don’t do that, but here... We do all the tests. We really want to help.”

One client recalled similar situations:

I was on the front line when a mother had struggled with depression, when a child has had an asthma attack, and when a father of five had an epileptic seizure. I was the only person to help provide refuge at our clinic for a wife fleeing from an abusive husband while crying “somebody help me!” in Spanish. These are my experiences and why I am called to work with the underserved.

The opportunity for the participants to care for clients of differing cultures from their own awarded them the sense of accomplishment and purpose. Each participant describes the thankfulness and gratefulness of the population they served as unprecedented in the typical western clinic/hospital atmosphere. Many participants described the migrant health clinic as the only way their clients can receive healthcare and therefore it is the responsibility of the providers to give care to the “marginalized” population. Healthcare is used as a “vehicle for peace” between clashing cultures. Each participant gave insight into their personal incentives for caring for these individuals.

Chapter V

Discussion

The Hispanic migrant workers in Montana have been shown to be a vulnerable population due to the healthcare disparities they encounter and the entrenched, cyclic poverty they have become accustomed to. The word, *marginalized*, Vasas pointed out, are those individuals that “fall within the margins of society” are often forgotten and are impoverished, discriminated against, or are functionally impaired (as quoted in Anderson, 2011, p. 320). Stone mentions that Hispanics in America frequently receive far worse care than the majority white population (as cited in Anderson, 2011). The preceding research has depicted this insight as well.

Individuals from different ethnic groups or areas establish values, lifestyles, health practices, as well as means of interpersonal communication, considered their culture (Anderson, 2011). The research presented here provides evidence that cultural differences can create problems for those distributing healthcare. In rural settings where resources are minimal, providers have found independent incentives which aid them in this difficult distribution of care. The differences illustrated through quotations and experiences of the participants in this study show the need for more culturally competent and language coordinated care in the United States. Many of the problems presented in the research are based on the misunderstanding between groups which lead to healthcare disparities and poorer quality of life.

In the rural healthcare setting, Connor et al, identified a multidisciplinary approach has been identified as a means to combine knowledge and enhance the quality of care provided (2007). Non-traditional or resource deprived clinic/hospital settings have been shown to create problems for healthcare providers distributing

care, such as the areas in this study. Rural settings lack resources and comfort measures that are often available in large institutional hospitals (Anderson, 2011).

The term “rural” can be defined as a small population density or geographic location. In the case of this research, the term “rural” in healthcare, was both. Establishing healthcare accessibility in such an area for the underserved has proved to be a difficult task for all those involved.

Many people come to the United States to find jobs and provide services that are temporary in nature, including the migrant workers in Montana. Seasonal agricultural workers have healthcare needs that are not being addressed. Usually it is because they cannot access the healthcare system for a variety of reasons as described by the participants in this study. In the case where access has been denied, it is very seldom that migrant workers will contact authorities (Anderson, 2011).

American healthcare providers understand that Westernized healthcare implies healthier living. Eating the right foods, exercising daily, and visiting the doctor annually, can lead to better a health status for the individual. Individuals who practice healthy lifestyle measures have better odds of combating and preventing disease (Healthy People 2020, 2011). What about those who do not have the same access or knowledge of healthcare? These individuals suffer higher probabilities of becoming ill and contracting preventable diseases (Human Health Services, 2011). This may be the case for many migrant workers in Montana.

That is why with the knowledge and understanding gathered through providing healthcare to the migrant Hispanic population is so important to future care. Healthcare workers can become more culturally competent and better able to provide quality care to these individuals based on that knowledge.

For one participant at the clinic, medicine has become a “vehicle for justice.” This participant pointed out, “A more fair and equal society, in which everyone enjoys the promise of a better life, requires good health.” Rural migrant clinics offer a way to connect with this “marginalized” population or the “forgotten of our society” and they aid them to “obtain and maintain” the health standards they need in order to work to provide for their families and America (B. Gibson, personal communication, February, 2011).

Educating the client was deemed a way to empower individuals to take accountability for their own health. A professor at Carroll College once said that by educating clients, we give them the power to change the outcome of their illness, or at least their attitude (D. Greenwood, personal communication, January, 2011). Education is instrumental for the participants in this study to ensure quality care is provided. Over the course of the interview process, themes emerged based on the needs of clients as they are perceived by the participants providing the healthcare. The theme that was most surprising was the incentives for the participants.

The code of ethics for healthcare providers assures that the distribution of healthcare reach all populations as widely and justly as physically possible and especially to those that are most in need. However, there are barriers holding up the access to healthcare which are affecting the availability of care for minority populations (Partners in Health, 2009). This problem has been show to exist in Montana.

In this grounded theory research, common barriers were identified by healthcare workers. They included faulty communication between patients and providers, transportation problems, monetary reimbursement or financial distress, educational issues, legal documentation, and basic discrimination. These problems

create the great disparity in care which was identified by the participants in the interviews. Many Hispanic immigrants residing and working in rural areas and communities in Montana are feeling the impact of, and they suffer the consequences of common preventable diseases such as hypertension and diabetes.

Rural Montana hospitals are having a difficult time accommodating this new population with translators and affordable services. As a consequence, the Hispanic minority is finding it economically impossible to receive care needed. There are few public programs that are set up that will help Hispanics get the care they need. That is why federally funded programs like the Montana Migrant Clinic have been created, to make it possible for migrant workers to find care. The clinics are set up to find a middle ground between affordability and quality of care for those who cannot afford it (Montana Primary Care Association Inc., 2011).

Further research could lead to the development of practical resources for better healthcare. Interventions in rural healthcare settings can lead to better health for individuals, cutting costs for unneeded treatments in hospitals, and decreasing health disparities for populations in Montana. Nursing students, as well as students from other occupational disciplines, could work together to take care of the individuals in this research. Adequate translation and enhanced services, service- oriented projects, and better physical assessment tools provided by nurses could help decrease the disparity in healthcare for the Montana migrant worker.

APPENDIX A

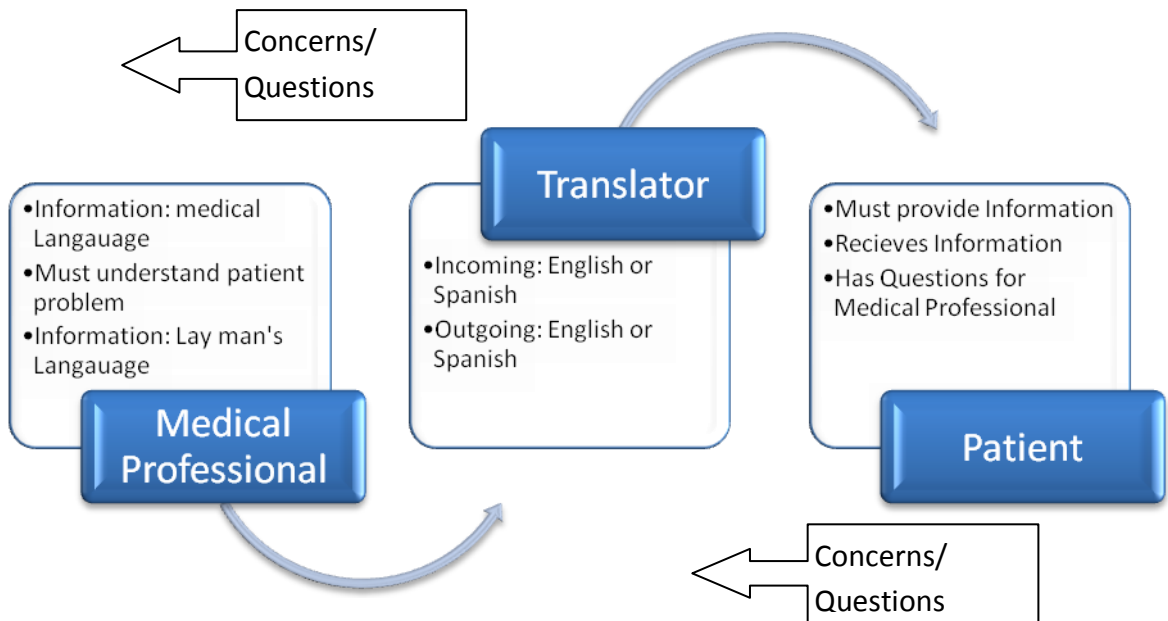


Figure 1:1 by Jade Johnstone 2011, Illustrates the complicated process of communication between provider, translator, and participant.

APPENDIX B
Consent Form for Participant

Purpose and Procedures: This study is intended to assess Montana Migrant Council (MMC) employees and volunteer's feelings and attitudes in regards to administering healthcare. If you agree to take part in this research, you will be asked to complete a one-on-one interview with the researcher that will be audio-recorded and a follow-up questionnaire. You will be given feedback after data has been collected. Location and time of interview is flexible. This will take about 45 minutes.

Voluntariness: Your participation in this research is voluntary. You may refuse to participate, discontinue participation, or skip any questions you don't wish to answer at any time without penalty or loss of the benefits to which you are otherwise entitled. Your identity and answers will remain confidential.

Risks and Benefits: You may experience some mild, temporary discomfort relating to the one-on-one interview process, about your personal answers to questions, or if your answers to questions will affect you in any way, as they concern your feelings and attitudes. Other than helping to identify the needs of the MMC, you will probably not receive any direct benefits from participating in this research. However, your participation may help researchers and clinicians understand certain barriers in healthcare and need for improvement within the system.

Compensation: There will be no compensation

Confidentiality: Only the principal researcher will have access to research results associated with your identity. In the event of publication of this research, no personally identifying information will be disclosed. A code will be assigned to the themes of consistent needs and barriers, not individual identities.

Who to Contact with Questions: Questions about this research study should be directed to the primary investigator and person in charge, Jade K Johnstone., or her supervisor, Dr. Joni Walton. They can be reached at (406)788-4837 or jjohnstone@carroll.edu. You may also reach them at 5001 27th St. SW. Great Falls, MT 59404. Questions about your rights as a research participant should be directed to the Carroll College Institutional Review Board Office at 447-4300; irb@carroll.edu. You will receive a copy of this consent form.

I certify that I have read this form and volunteer to participate in this research study.

(Print) Name

Signature

Date: _____

APPENDIX C
Sample Questions for Participants

1. Please state your full name; spelling included.
2. Do I, the researcher have your permission to audio record this interview to be used later, anonymously, for research in the field of nursing?
3. Explanation of research and purpose.
4. How long have you been working with the Montana Migrant Council (MMC)?
5. How exactly would you describe your job here at the MMC?
6. At what locations have you worked with the Hispanic population? Mobile clinics and/or permanent clinics?
7. Are you fluent in Spanish? How do you communicate with Spanish speakers?
8. What first got you interested in working with this population, or why?
9. What is the most challenging aspect of working in this area?
10. What is the most rewarding aspect of working in this area?

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