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ABSTRACT (100-200 WORDS):

Numerous qualitative studies have identified a variety of barriers faced by Hispanic patients when accessing healthcare, but there has been minimal research completed on healthcare providers’ perspectives of these barriers. The present study was created to investigate current healthcare providers’ perspectives to gain new insight into the factors influencing accessibility of care. In this qualitative study, five healthcare providers were selected as participants through snowball sampling techniques. Data collection occurred through face-to-face interviews, and, with utilization of the Glaser and Strauss constant comparison method of data analysis, four major categories emerged. Findings showed that the barriers identified by healthcare providers are no different from those identified by Hispanic patients; however, the providers’ perspective also uncovered new data on underlying factors influencing accessibility of care. This includes educational deficits, social isolation of patients, and an inability to secure referrals to specialists for undocumented, uninsured, and low income patients. However, due to low sample size of this study, additional research should be conducted to ensure data saturation is reached prior to proposing new theory based on this data.
Barriers to Healthcare in the Hispanic Population of DeKalb County: A Healthcare Provider Perspective

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Abstract

Numerous qualitative studies have identified a variety of barriers faced by Hispanic patients when accessing healthcare, but there has been minimal research completed on healthcare providers’ perspectives of these barriers. The present study was created to investigate current healthcare providers’ perspectives to gain new insight into the factors influencing accessibility of care. In this qualitative study, five healthcare providers were selected as participants through snowball sampling techniques. Data collection occurred through face-to-face interviews, and, with utilization of the Glaser and Strauss constant comparison method of data analysis, four major categories emerged. Findings showed that the barriers identified by healthcare providers are no different from those identified by Hispanic patients; however, the providers’ perspective also uncovered new data on underlying factors influencing accessibility of care. This includes educational deficits, social isolation of patients, and an inability to secure referrals to specialists for undocumented, uninsured, and low income patients. However, due to low sample size of this study, additional research should be conducted to ensure data saturation is reached prior to proposing new theory based on this data.

Introduction

According to the KishHealth Systems Community Needs Assessment (2015), DeKalb County has been designated as Health Professional Shortage Areas in primary care and mental health specialties, leading to a medically underserved community. This designation is significant in that community members are unable to access preventative health care services as frequently as needed, and the services available may not be fine-tuned to specific population demographics. In addition, the Community Needs Assessment gathered data on characteristics of uninsured patients between years 2008-2010, noting that 45% of uninsured patients were foreign born or
not a U.S. citizen, with 26.9% identified as Hispanic. Per the 2011-2013 American Community Survey, 10.5% of the population of DeKalb County is of Hispanic descent, with Mexican ancestry being the primary ancestry noted, and between the years of 2009-2013, the percentage of population in poverty, as noted by race/ethnicity, was 38.2% Hispanic (KishHealth System, 2015).

Numerous published studies have created a large quantity of data on the causes and effects of healthcare disparities and their detrimental effect on accessibility of healthcare. It is well-known that there has been tremendous growth within minority groups residing in the United States, with 50 million census respondents (16% of the total population of the United States) claiming to be of Hispanic origin (U.S. Census Bureau, 2011). Over half of the growth of the U.S. population between 2000-2010 is attributed to the Hispanic population, with Chicago, Illinois ranking fourth highest in terms of number of Hispanic or Latino citizens (U.S. Census Bureau, 2011). DeKalb, Illinois, only sixty miles west of Chicago, has also seen an increase in its Hispanic population, reporting an increase from 6.6% in 2000 to 10.1% in 2010 (KishHealth System Community Needs Assessment, 2015).

The Hispanic population is the fastest growing minority group in the United States (U.S. Census Bureau, 2010); however, new immigrants to the United States are likely to have low English-speaking capabilities, and may arrive with minimal familial support (Riffe, Turner, & Rojas-Guyler, 2008). Minimal time spent in the U.S. is related to a lower level of acculturization, in which a new immigrant becomes familiarized with and adapts to the new culture. In addition, health education programs in the United States are designed with a Westernized culture in mind, and reflect those specific values, attitudes, and behaviors- all of which may be vastly different from healthcare practices in countries with a primarily Hispanic or
Latino population (Rojas-Guyler, L., Britigan, D.H., Murnan, J., King, K., & Vaughn., 2013). Educational items translated from English into Spanish may assume a certain level of health literacy exists when it does not (Cristancho, S., Peters, K., & Garces, M., 2014), while lack of familiarity with the culture and values of the U.S. further contributes to lower health literacy (Rojas-Guyler, L., Britigan, D.H., Murnan, J., King, K., & Vaughn., 2013).

Studies also showed that Hispanic individuals are at high risk of experiencing health disparities and experience more chronic conditions than other population groups, largely due to communication barriers, lack of resources such as healthcare insurance, high cost for services, low income, and insufficient knowledge of the resources available within their community (Cristancho, S., Peters, K., & Garces, M., 2014). Hispanic individuals face difficulties in obtaining insurance due to lack of required documentation, high premiums, low insurance, lack of employer-provided plans, and lack of understanding in terms of options, while others are unable to obtain insurance due to legal status. Multiple studies cite discrimination by healthcare providers who are unwilling to accept Medicare and Medicaid. (Cristancho, S., Garces, D.M., Peters, K.E., & Mueller, B.C., 2008; Harari, Davis, & Hester, 2008). Lack of health education and little or no health insurance, when paired with poverty, leads to poor health outcomes and less access to necessary health services (Riffe, Turner, & Rojas-Guyler, 2008), with one study also citing that lack of knowledge of available services is a greater barrier for patients than lack of available services (Raffaelli, M. & Wiley, A.R., 2012).

Language barriers lead to a variety of issues: patients reported avoidance of healthcare due to an inability to properly communicate, inability to ask healthcare-related questions without causing confusion, and inadequate translating services (Harari, N., Davis, M., & Heisler, M., 2008). These issues have been found to cause dissatisfaction in Hispanic patients, leading to
noncompliance with the treatment plan (Rojas-Guyler, L., Britigan, D.H., Murnan, J., King, K., & Vaughn., 2013). Patients also reported that interpreters are not always readily available, or that they are unaware they qualify for an interpreter. Use of untrained interpreters in place of qualified individuals can result in misinterpretation or omission of information, and patients unable to communicate or who suffer from interpretation issues inevitably lose trust in their providers (Cristancho, S., Garces, D.M., Peters, K.E., & Mueller, B.C., 2008). Language difficulties also contribute to social isolation. One study cited that Hispanic citizens often feel isolated from their community because they are unable to communicate and lack strong social and informational networks (Harari, N., Davis, M., & Heisler, M., 2008).

While extensive research has been conducted into the existence of health disparities faced by the Hispanic population of the United States, few studies have focused on rural or semi-rural communities, and disparities have been analyzed only from Hispanic patients’ perspectives. Very little data is available on healthcare disparities as viewed from the healthcare provider perspective. This study aimed to expand the existing data by analyzing providers’ views about the causative factors of barriers to healthcare services for Hispanic patients in the semi-rural communities in DeKalb County, Illinois.

Method

Procedure

This qualitative study utilized snowball sampling, in which participants recruit or refer potential participants from their personal acquaintances. This technique is utilized in populations which are hard to find or difficult to access under other sampling techniques. As a non-probability sampling technique, potential participants do not have equal odds of being selected; instead, they are privately recruited by acquaintances or associates (Oregon State University,
The initial participant may be recruited by the researcher if a prior relationship exists which would allow access. The initial participant is then asked to recruit or refer from their own acquaintances, and those participants asked to recruit from their own acquaintances, and so forth (Oregon State University, 2010).

**Sample**

The following criteria was used for inclusion: current healthcare provider in good standing, employed by one or more facilities within the limits of DeKalb County. A total of five participants were recruited into this study. Among the five, three were nurse practitioners (NPs), one was an associate degree nurse (ADN), and the fifth worked in case management. The exact ages of participants is unknown; however, none were under age 20, and none were over age 65. Four out of five participants stated they provided only basic healthcare services, while the fifth had more access to specialized care. Two NPs and the ADN stated they provided healthcare to patients within an age range of 0-100, while the other participants stated their caseloads were primarily patients under age 55; however, all participants reported daily provision of healthcare to Hispanic patients within DeKalb County.

**Data collection**

After discussion with the IRB and approval to proceed, participants were recruited. After obtaining informed consent from each participant, separate consent was obtained to utilize audio recording. Four participants consented to audio recording. One participant did not consent, and instead, notes were taken during the interview with a laptop computer and Microsoft Word software. Face-to-face interviews were scheduled at a location of the participants’ choosing. Four participants chose to interview at their workplace office, and one chose to interview at their home. Interview questions were as follows:
• In your experience through interactions with the Hispanic population, what do you think are some of the difficulties faced in their attempts to access healthcare services?
• What makes it difficult for you to provide healthcare to the Hispanic population in DeKalb?
• In your opinion, what makes it easier for you to provide healthcare for Hispanic patients that come to this clinic?
• What would make it easier to provide healthcare to this population?
• Have any steps already been taken by your facility to address these issues?
• Have these changes led to improvement?
• In your opinion, what is the biggest challenge faced by the Hispanic population when attempting to access health care in DeKalb?
• What can the School of Nursing do to help your facility or the Hispanic population to facilitate access to care?
• Is there any other relevant information you would like to add?

The interviews were transcribed by the principal investigator, followed by data analysis and coding using the Glaser & Strauss constant comparative method of qualitative analysis, in which data coding and data analysis occur simultaneously during a line-by-line reading of the text (Glaser & Strauss, 1967). Major codes were determined based on participant responses. The coded data were then reviewed and assigned into categories and significance attributed to each category through exhaustive description.

Results

The purpose of this study was to investigate the barriers to healthcare as defined by healthcare providers, as most previously published data on this subject arises solely from perceptions of Hispanic patients. Data analysis revealed four major categories, which support the existing data and provide additional insight into the cause of existing barriers to healthcare.

Educational deficits

The primary barrier to care defined by healthcare providers is a lack of education, leading to diminished continuity of care. Low health literacy is an ongoing problem in the United States, with immigrants, older adults, minority groups, and low income populations being at special risk (National Network of Libraries of Medicine, 2017). Low health literacy leads to several
unfavorable outcomes, such as increased risk of improperly taken medications, poorer health status, lower incidence of preventive care, and poor disease outcomes (National Network of Libraries of Medicine, 2017). Providers stated that due to lack of education, many patients did not understand that disease was present even when they were asymptomatic, and thus did not seek out preventive care. Low health literacy also translated into an inability to read or understand discharge instructions, leading to lack of follow-up care and improper disease management.

Health literacy is also influenced by cultural background and beliefs, which can affect how information is received and understood (The Joint Commission, 2007). Healthcare providers reported a variety of cultural beliefs that interfered with the delivery of healthcare, including fear that medications or implantable technology could destroy the body’s normal function, and reliance upon naturalistic remedies such as tea or herbs in place of visiting a physician. Culture heavily influences the significance of food, leading to difficulties in understanding the importance of adherence to dietary changes or restrictions. It also influences patients’ level of respect for authority: two providers reported that many Hispanic patients trusted the authority of their physicians without question, and did not advocate for themselves or seek out second opinions. These patients were described as passive participants in their own care and unaware of their rights.

**Accessibility of available resources**

The second-most prevalent barrier to care was identified as a lack of accessibility to available resources. Difficulties accessing available resources are compounded a lack of reliable transportation, leaving many available resources unused. Providers acknowledged that many families had only one car to share amongst all family members, so patients could not get rides to
their appointments. In addition, public buses and Trans-vac are under-utilized because these services often take up a large portion of the day during which patients would otherwise be spent at work. Patients were reported as unwilling to miss work to attend an office visit, resulting in no-show appointments and lack of regular preventive care. Lack of preventive or follow up care causes delays in necessary treatment to the point of severe illness or disability, at which point they require more facility resources to achieve wellness.

The KishHealth System Community Needs Assessment (2015) reports that 38.2% of those in poverty in DeKalb County are of Hispanic descent. Patients with low income must often prioritize their expenditures, and cannot always afford medications or equipment. Compounding this issue is lack of insurance. Undocumented citizens do not qualify for health insurance, with the exception being pregnant women, who qualify for Medicaid coverage only during the pregnancy. Those who do qualify for insurance may not be able to afford it, or their employers do not offer it. Providers also stated that even those with insurance often refuse treatment because they cannot afford the deductible or co-pay, and instead visit local emergency departments, where they know they can be treated despite an inability to pay.

Providers described offering free equipment and low-cost medications to patients who otherwise would be unable to afford their care. They stated that patients often took prescriptions to Mexico, where medication is cheaper. In addition, sliding-fee scales for services were instituted so patients could receive care, and facilities began offering their services as a “one-stop shop” where all basic care for a family could be received in a day. However, all providers discussed difficulties in securing referrals for their patients when specialized care was required. These difficulties were due to specialists refusing to accept patients who are low income, those who have no insurance, or those who have Medicare or Medicaid. Inability to access specialists
Language barriers

All providers described language as a significant barrier when Hispanic patients access healthcare services, with one provider stating, “If a patient can’t communicate, they can’t do anything”. Patients and providers who cannot communicate are at risk for misunderstanding each other. Patients may be unable to properly convey their questions and concerns or dictate their medical history and current symptoms. Attempts to schedule appointments may be unsuccessful if the appointment desk employees do not speak the same language or do not have access to a translator.

Steps have been taken by facilities to address communication, such as purchase of video and telephone translators, utilization of in-person translators, and translation of informational signs; however, many challenges still exist. Facilities only employ translators during standard daytime hours, leaving providers on evening or night shifts without access to face-to-face assistance. Any translator, whether it be video, telephone, or in-person, may encounter difficulties if a patient has altered mental status due to drugs, alcohol, or brain damage, forcing providers to rely on family members for assistance.

Regardless of mental status, providers often utilize other staff members to translate, even though this is not a legally reliable source, or choose to utilize family members. Family members not preferred for translation because they may add or remove imperative information when communicating with their relative, they may not know medical terminology, and their emotions may get in the way of an objective translation of information. However, two providers stated that they have witnessed other healthcare workers (mostly older physicians) judge patients for their
use of Spanish, demanding that family (including small children) translate for them. These same physicians were heard telling patients that because they have lived in the United States for one or more years, they should just speak English.

**Social isolation**

Providers described Hispanic patients as reliant on word of mouth regarding which resources to utilize or where to go for services. These patients are seen by providers as segregated from the greater community, spending most of their time with family and others of Hispanic descent because of shared language and culture. Those without social or familial support systems are often less aware of the services used by others, such as public transportation, translators, food pantries, and free clinics, or don’t know how to access the services.

Providers discussed that patients are afraid to access healthcare because of their legal status. They reported seeing colleagues stigmatizing Hispanic patients because of legal status and language issues. Other providers noted that building trust between patients is a gradual and time-consuming process, and that some colleagues did not put time or effort into forming mutually respectful relationships. This behavior can further isolate patients by making them feel unworthy of adequate care.

Finally, one provider discussed that most her female Hispanic patients struggle with depression and anxiety. This causes difficulties for providers because of these patients’ lack of motivation to make lifestyle changes, return for follow-up visits, or exercise. In addition, these patients may be unable to cope adequately with a new disease diagnosis. Female Hispanic patients were also described as being the primary caregivers for not only their children but also their parents and other family members, leading to overwhelming stress, caregiver burnout, and worsening depression.
Discussion.

This study, which aimed to expand upon healthcare providers’ perspectives of barriers to healthcare for Hispanic patients, served to confirm the accuracy and continued relevance of previously published studies. These studies listed a variety of causative factors contributing to difficulties in accessing healthcare, such as language and communication barriers, lack of knowledge of availability of resources, high cost of healthcare, and low acculturalization of new immigrants leading to cultural barriers. This study confirmed these factors remain a large part of the problem; however, providers have labeled the United States health system as a major culprit.

The format of the current health care system is one of independent care, with the expectation that most health education will occur on one’s own time rather than in the physician’s office (Cristancho, S., Peters, K., & Garces, M., 2014). The study participants noted that providers are spending less time with their patients, leading to diminished relationships and no formation of trust between provider and patient. These providers all discussed setting aside extra time for patients to provide disease education, and discussed building trust as a gradual process; however, they also noted that their facilities provide only basic care, causing them to frequently refer to other providers for specialized care. Furthermore, it was noted that some specialist providers of DeKalb County are unwilling to accept patients who are low income and have little or no health insurance.

Differences also existed in the factors attributing to social isolation. A previous study described social isolation due to lack of visitors, unawareness of available resources, and lack of strong social and informational networks (Harari, N., Davis, M., & Heisler, M., 2008), factors which were reiterated by the participants of this study. However, participants in this study also described social isolation from a mental health standpoint, raising not only the question of the
adequacy and availability of mental health services in DeKalb County, but also the question of healthcare providers’ overall ability to recognize signs of mental illness.

Limitations

The most obvious limitation of this study is the small sample size, which was not likely to be fully representative of providers in DeKalb County. Without an adequately sized and representative sample from the provider population, data saturation cannot occur and new theory cannot be formed. It is recommended that further studies be conducted with larger sample sizes to confirm data saturation has been reached, prior to proposing new theory based on this data.
References


