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HUMPHREY INSTITUTE OF PUBLIC AFFAIRS

Improving Access to Minnesota Health Care Programs for Hispanic/Latino Communities

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Final Report to the Minnesota Department of Human Services, Division of Health Care Eligibility and Access

- August 2008 -

This report was prepared as part of the Humphrey Institute of Public Affairs course PA8002 Synthesis Workshop under the guidance of Professors Gary DeCramer and Thomas Walkington in fulfillment of the Master of Public Affairs degree requirement.

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Improving Access to Minnesota Health Care Programs for Hispanic/Latino Communities

Executive Summary

The Minnesota Department of Human Services (DHS), Division of Health Care Eligibility and Access partnered with Master of Public Affairs student consultants from the University of Minnesota, Hubert H. Humphrey Institute of Public Affairs (Humphrey Institute) to identify and examine potential barriers facing Hispanic/Latino populations in accessing Minnesota Health Care Programs (MHCP). The goals of the project were to:

- Identify potential primary barriers that create disparity in service access facing Hispanic/Latino populations when accessing MHCP based on input provided by identified stakeholders in seven metropolitan county offices and the MinnesotaCare operations office; and

- Research national and local promising practices that address barriers facing Hispanic/Latino populations in accessing public health care programs.

Data collected by the Minnesota Department of Health and University of Minnesota School of Public Health (2008) shows that Hispanic/Latino populations currently have the highest rate of uninsurance in Minnesota compared to any other racial or ethnic group. According to the 2007 Minnesota Health Access Survey, 7.2 percent of the state's population did not have health insurance (approximately 374,000 people). For Hispanics/Latinos the rate was 19.0 percent compared with 14.7 percent for African Americans, 16.0 percent for Native Americans and 6.4 percent for whites (Minnesota Department of Health & University of Minnesota School of Public Health, 2008). Hispanic/Latino populations make up approximately

3.6 percent of the state's total population and are expected to grow faster than any other racial or ethnic group in the state—nearly triple by 2030 (Minnesota State Demographic Center, 2005).

The consultant team relied primarily on applicant data from the MMIS and MAXIS eligibility systems and stakeholder interviews with 12 staff from the MinnesotaCare operations office and Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington Counties. Quantitative and qualitative data analysis showed some general trends across the counties:

- Applications are growing disproportionally among Hispanics/Latinos and primary Spanish speakers.
- Requests for Spanish interpreters is growing across all programs and all counties, however suburban counties (e.g., Anoka, Dakota and Washington) have seen an increase in interpreter requests of more than 70 percent from 2003 to 2007.
- The MHCP application process and eligibility determination is complex for all populations, however for Hispanic/Latino populations it is often more difficult due to immigration status, employer documentation and language.
- County offices generally do not regularly have access to or review aggregate data on Hispanic/Latino clients to determine changes in program demands or quality improvement.
- Nearly all of the counties are doing some kind of outreach specifically for Hispanic/Latino communities, however urban counties have more culturally-specific resources available within the community for outreach and assistance.
- Stakeholders perceive that many Hispanic/Latino populations do not apply for MHCP due to fear and mistrust of government institutions.
- Spanish is the most requested language, however most county offices believe they have adequate language resources to meet demand.

Based on the available data, the following actions were recommended to improve access to MCHP for Hispanic/Latino populations:

- Collect reliable and valid baseline data for state and counties to use in program planning and ongoing quality improvement.

- Expand collaborative outreach opportunities within Hispanic/Latino communities to raise awareness, offer application support, increase trust and dispel myths about program eligibility.

- Seek opportunities to simplify and streamline programs and processes for Hispanic/Latino populations.

- Ensure all communications with primary Spanish-speaking clients is in Spanish.

- Implement a multi-stakeholder strategy to gather additional information about access barriers and opportunities, with emphasis on involving Hispanic/Latino communities.

Project Overview

The Minnesota Department of Human Services (DHS), Division of Health Care Eligibility and Access partnered with Master of Public Affairs student consultants from the University of Minnesota, Hubert H. Humphrey Institute of Public Affairs (Humphrey Institute) to identify and examine potential barriers facing Hispanic/Latino populations in accessing Minnesota Health Care Programs (MHCP). Reducing ethnic and racial disparities in service access has been identified as one of six priority areas for DHS. Data collected by the Minnesota Department of Health and University of Minnesota School of Public Health (2008) shows that Hispanic/Latino populations currently have the highest rate of uninsurance in Minnesota compared to any other racial or ethnic group and the population as a whole is expected to grow faster than any other group over the next 30 years. Given the high rate of insurance disparity and anticipated population growth, DHS determined they needed more information on barriers Hispanic/Latino populations may face in accessing MHCP. The goals of the project were to:

- Identify potential primary barriers that create disparity in service access facing Hispanic/Latino populations when accessing MHCP based on input provided by identified stakeholders in seven metropolitan county offices and the MinnesotaCare operations office; and
- Research national and local promising practices that address barriers facing Hispanic/Latino populations in accessing public healthcare programs.

Background

DHS is Minnesota's largest state agency with approximately 7,200 employees and an annual budget of nearly $11 billion, about a quarter of the state's expenditures. More than 90 percent of the DHS budget is spent on health care, long-term care and related services for mental health and chemical dependency. Other DHS programs include Minnesota Family Investment Program, General Assistance, Subsidized Child Care, Food Support and other social services. DHS staff partner with employees in Minnesota's 87 counties to serve seniors, parents with children, people with disabilities and others to help them live independently with dignity (Minnesota Department of Human Services [DHS], 2008).

Overview of Minnesota Health Care Programs (MHCP)

The State of Minnesota offers three publicly-funded basic health care programs grouped under MHCP: Medical Assistance (MA) (the state's Medicaid program), General Assistance Medical Care (GAMC) and MinnesotaCare (DHS, 2008). MinnesotaCare is primarily administered by DHS although some county offices also process applications. DHS also oversees MA and GAMC, which are administered by counties. An estimated 666,000 state residents receive health care through these three programs, approximately half of whom are children under 21. MHCP comprises nearly 73 percent of DHS's total budget. The state pays all or part of enrollees' medical bills for:

- Families with children under 21
- Pregnant women and newborns
- Adults without children
- Adults with disabilities

- Children with disabilities
- People age 65 and older
- People living in a nursing home
- Home and community services

Medical Assistance: As the largest of the three health care programs, MA provides health care and prescription medication coverage. According to DHS (2008), an estimated 507,000 low-income seniors, children and families, and people with disabilities received coverage each month during the last fiscal year. The majority of those eligible for MA are children, parents and pregnant women.

General Assistance Medical Care: GAMC primarily covers low-income adults without children between the ages of 21 and 64 who are not eligible for MA or other health care programs. During the last fiscal year, an average of 33,000 Minnesotans each month received GAMC (DHS, 2008).

MinnesotaCare: As part of Minnesota's welfare reform strategy, MinnesotaCare offers publicly-subsidized health coverage to residents who do not have access to affordable health insurance. In general, Minnesotans are not eligible if their employer offers insurance and pays at least half the monthly premium. Enrollees pay premiums based on family size and income. The program is funded through a combination of health care provider taxes, federal Medicaid matching funds and enrollee premiums (DHS, 2008).

Health Insurance Enrollment Rates

Statewide, Hispanic/Latino populations are the least likely of any racial or ethnic group to have health insurance coverage (Minnesota Department of Health & University of Minnesota

School of Public Health, 2008). In the 2007 Minnesota Health Access Survey, 7.2 percent of the state's population did not have health insurance (approximately 374,000 people). However, all nonwhite racial and ethnic groups had a rate of uninsurance higher than the statewide total. For Hispanics/Latinos the rate was 19.0 percent compared with 14.7 percent for African Americans, 16.0 percent for Native Americans and 6.4 percent for whites. However, the rate of uninsurance for Hispanics/Latinos did drop from 31 percent in 2004 to 19 percent in 2007. During that same time period the statewide uninsurance rate remained relatively constant. Results from the 2007 survey did not show a significant difference in insurance rates for U.S. born residents versus foreign-born Minnesotans (Minnesota Department of Health & University of Minnesota School of Public Health, 2008).

The Minnesota Department of Health and University of Minnesota School of Public Health (2008) speculate that the overall decrease in the Hispanic/Latino uninsurance rate may be due to two factors that "positively correlate with higher insurance coverage" (p. 3). The first factor is income. Fewer Hispanics/Latinos were living below 100 percent of the federal poverty level in 2007 than in 2004 (31.2 percent compared to 39.4 percent). The second factor is length of time living in the U.S. The 2007 Minnesota Health Access Survey found that compared with 2004, the Hispanic/Latino population in 2007 was more likely to have been in the U.S. for 10 or more years (Minnesota Department of Health & University of Minnesota School of Public Health, 2008).

Population and Growth

According to the 2005 Census estimate, there are approximately 186,912 Hispanic/Latino residents in Minnesota, or 3.6 percent of the state's total population (Minnesota State Demographic Center, 2005). The highest numbers of Hispanic/Latino residents are in the seven county Twin Cities Metropolitan area, however Hispanic/Latino populations make up a greater percent of total population in some of Minnesota's southwestern counties. Currently, Hispanic/Latino populations make up a small percent of the total population in each of the seven Metropolitan counties, however this is expected to change over the next 30 years. Table 1 shows the population estimates for each of the Metropolitan counties for 2005.

Table 1: Hispanic/Latino Population Estimates by Metropolitan County, 2005

County	Latino Population Estimates	Percent of County Total Population	Percent of Total Latino Population
Anoka	7,879	2.4%	4.2%
Carver	2,844	3.4%	1.5%
Dakota	15,272	4.0%	8.2%
Hennepin	61,969	5.5%	33.2%
Ramsey	29,535	6.0%	15.8%
Scott	4,237	3.5%	2.3%
Washington	5,687	2.6%	3.0%

Source: Minnesota State Demographic Center, 2005.

According to the Minnesota State Demographic Center (2005), Hispanic/Latino populations are the fastest growing racial or ethnic group in the state, and Hispanic/Latino and nonwhite populations are younger than whites. This trend is expected to continue.

Hispanic/Latino populations will nearly triple by 2030 (Minnesota State Demographic Center, 2005). While the total statewide population is expected to grow by 27 percent between 2000 and 2030, the Hispanic/Latino population is expected to grow 184 percent, from an estimated 143,382 individuals in 2000 to 406,700 by 2030 (Minnesota State Demographic Center, 2005). This anticipated increase will likely be the result of immigration, migration from other states and increasing birth rates. Table 2 shows the projected increase in Hispanic/Latino populations in the Metropolitan county area.

Table 2: Hispanic/Latino Population Growth Projections by Metropolitan County, 2000 – 2030

County	2000	2010	2020	2030	% Change
Anoka	4,961	8,100	10,700	13,000	162.0%
Carver	NA	NA	NA	NA	NA
Dakota	10,459	17,400	23,300	28,400	171.5%
Hennepin	45,439	80,400	109,300	134,500	196.0%
Ramsey	26,979	39,200	48,800	56,900	110.9%
Scott	2,381	5,400	8,900	12,400	420.8%
Washington	3,892	5,900	7,600	9,100	133.8%

Source: Minnesota State Demographic Center, 2005.

Snapshot of Hispanic/Latino Populations in Hennepin County

More than a third of the state's Hispanic/Latino populations live in Hennepin County—an estimated 61,969 residents in 2005—and that number for Hennepin County alone is expected to double by 2030 (Hennepin County, 2007). Hispanic/Latino populations contribute significantly to the economic, social and cultural vitality of the county and the state. In 2007, Hennepin County Department of Research, Planning and Development prepared a brief

demographic overview of overall social and economic well-being of Hispanic/Latino populations. While the profile focuses on only one county, it demonstrates potential trends for Hispanic/Latino populations across the state.

In general, Hispanic/Latino adults in Hennepin County are less likely to be citizens while their children are more likely to have been born in the U.S (Hennepin County, 2007). According to Hennepin County (2007), an estimated one fourth of Latino adults are known to be citizens while approximately three-fourths of Latino children are citizens. Among foreign-born residents in the county, the majority come from Mexico, followed by India and Laos. However, Hennepin County has seen an increase of Latino immigrants from Ecuador, El Salvador, Guatemala and Guyana among other Central and South American countries over the past six years (Hennepin County, 2007).

School enrollment for Hispanic/Latino children is increasing at a higher rate than growth in the overall population (Hennepin County, 2007). Between 2000 and 2006, the total Hispanic/Latino population in Hennepin County grew by 46 percent (Hennepin County, 2007). During that same time period, public school enrollment for Hispanic/Latino children in the county grew by grew by 82 percent; however the high school graduation rate for Hispanic/Latino students was lower than any other ethnic or racial group at 41 percent in 2006 (Hennepin County, 2007).

Economically, Hispanic/Latino populations are not faring as well as their counterparts in the general population. In 2005-2006, the median family income for Hennepin County was $63,933, however the median family income for Hispanics/Latinos was $28,324 (Hennepin County, 2007). Per capita income was $27,857 for all residents compared with $12,611 for

Hispanics/Latinos (Hennepin County, 2007). Approximately 11 percent of individuals in Hennepin County lived below the federal poverty level (FPL), compared with 19 percent of individual Hispanic/Latinos (Hennepin County, 2007). For families, 7 percent of the total population lived in poverty compared with 18 percent of Hispanics/Latinos (Hennepin County, 2007). Among low-income families with children receiving cash or food assistance from the Minnesota Family Investment Program (MFIP), Hispanics/Latinos, compared to other ethnic and racial groups in Hennepin County, received assistance for a shorter period of time and had a slightly higher rate of employment than the overall population (Hennepin County, 2007).

Immigration status is the most common barrier for Hispanics/Latinos in accessing resources for health insurance, employment, college financial aid and public assistance (Hennepin County, 2007). Hennepin County (2007) further reported that Hispanics/Latinos are least likely to have health insurance compared to other ethnic and racial groups. The Hennepin County SHAPE 2006 survey found that nearly 40 percent of Latinos between the ages of 18 and 64 lacked health care coverage, and 29 percent of Latino children were without insurance (Hennepin County, 2007).

Research Methodology

The research approach for this project consisted of four main parts: a review of current literature, analysis of applicant data, stakeholder interviews and identification of promising practices. The team conducted a review of current literature pertaining to cultural barriers for Hispanic/Latino populations in accessing health care services and programs, and identified promising practices published by local and national organizations.

The primary method for qualitative data collection consisted of stakeholder interviews with representatives from MinnesotaCare operations and seven Twin Cities Metropolitan counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington. These counties were chosen based on the total number of residents identified as Hispanic/Latino, although other Minnesota counties have a higher proportion of Hispanic/Latino residents. DHS and the student consultant team jointly developed an inventory of questions pertaining to Spanish language resources, community outreach, applications and case management. See Appendix B for the list of questions. The team then met with staff from each of the county human service departments and MinnesotaCare. The student consultant team analyzed quantitative data on MHCP applicants reported from each of the seven counties in the statewide DHS eligibility system, MAXIS, as well as information on statewide MinnesotaCare applicants processed by the MinnesotaCare operations office and reported in MMIS.

The overall objective of DHS is to reduce disparities for Hispanic/Latino populations in accessing MHCP. This project represents an initial step towards identifying specific barriers that affect Hispanic/Latino populations based on feedback from a limited pool of county and state employees in areas with high concentration populations. This was not an exhaustive data gathering process involving broad representation of county staff, community members, health care providers or consumers. Further research and analysis is needed to fully understand the cultural, linguistic and systemic barriers Hispanic/Latino populations may face in learning about or potentially enrolling in MHCP.

Review of the Literature

The consultant team conducted a review of current practice-based literature specifically addressing issues Hispanic/Latino populations may face in accessing health care programs and services in Minnesota. Most of the literature on disparities focuses on access to health care services, not health care programs. However, there appears to be good research from the vantage point of Hispanic/Latino populations and community organizations that provide services to these populations.

> *"… the literature review demonstrated that Latinos are a unique population in Minnesota, and should be examined separately from other populations of color. For example, in addition to language and cultural differences, Latinos have high rates of employment and family formation, low rates of welfare dependency, and relatively strong health indicators compared to other populations of color. As a result, many of the policies intended to improve the health and health care access of underserved populations are not meeting the needs of Latinos"* (Ulrich, 1999, pp. 23, 61, 78).

The literature also suggested the importance of explaining the diversity within the Hispanic/Latino communities. According to Lillie-Blanton, Leigh and Alfaro-Correa (1996, p. 8), "the Hispanic population of the United States consists of persons of any race who are members of one of the five major Spanish-origin subgroups: Mexican Americans, Puerto Ricans, Cubans, Central and South Americas and "other Hispanics." Chong (2002, p. 4) also uses these subgroup distinctions, noting that "58 percent of the nation's Latinos are of Mexican origin, 10 percent

are from Puerto Rico, 3.4 percent are of Cuban origin and the remaining 28.5 percent are Central and South American, Dominican and of other Hispanic origins." This research emphasizes that there is not a typical Hispanic/Latino group, but several subgroups; each with its own traits and characteristics. However, these subgroup distinctions are often not reflected in research and data on Hispanics/Latinos as a whole. Currently, Hispanic/Latino populations are the largest minority in the United States at approximately 13 percent of the total population (Chong, 2002).

Eight recurring themes were drawn from the literature related to barriers for Hispanic/Latino populations when accessing public health services:

1. Data collection
2. Financial resources and access to employer-sponsored health insurance, affordable health care and disposable income
3. Knowledge about health care systems and processes, insurance program requirements, public programs and information resources
4. Outreach and information
5. Culturally competent and appropriate health services and programs
6. Language and interpretation
7. Immigration status, documentation, program eligibility, and fear and mistrust of government systems
8. Logistical support for transportation, child care and flexibility to schedule appointments

Data Collection

According to Ulrich (1999) data gathering and research on health care access for Hispanics/Latinos in Minnesota has been limited. Studies have only targeted this population in the last 20 years and much of the data that has been collected has not been sufficiently analyzed due in part to the small sample sizes in the 1980s and the definition dilemma that occurred in the 1990s. However with the sample size growing and with clearer definitions it is a matter of funding and time to have accurate data.

> *"Improve existing data collection systems to increase the quantity and quality of health and health care access data available on Minnesota's Latino Populations. In addition to the proposed study, existing data collection systems need to be improved to collect information about Latinos and other populations of color in Minnesota on a regular, on-going basis. Although there are several potential sources of health and health care access information about Latinos in Minnesota, some such as MHHP hospital discharge data and HMO claims data do not collect information on race and ethnicity. As much of the information currently available about Latinos in Minnesota is in unpublished reports, accessing information about Minnesota's Latino population can be difficult and time consuming. Moreover, many of the studies done in the past have not been widely disseminated, and the information gathered has gone unused"* (Ulrich, 1999, p. 25).

Financial Resources and Access to Insurance

According to Davidoff, Ulrich, Carrizales and Blewett (2000), of the Hispanic/Latino populations in Minnesota with health insurance, coverage is either through employer-sponsored or publicly-subsidized programs. Private insurance through employers often requires expensive premiums, co-pays and deductibles, or can require a waiting period for coverage. The Minnesota Department of Health (2007) reported that private health insurance premiums rose an average rate of 7.6 percent each year for the last twelve years. More importantly, this rate of increase far outpaced growth in inflation, per capita income, and average weekly wages during the same period (Minnesota Department of Health, 2007; America's Health Insurance Plans, 2006). For workers in low-wage industries these plans may be out of reach.

Public programs also have limitations for Hispanics/Latinos. Davidoff et al. (2000) found that Hispanic/Latino populations generally do not enroll in public health insurance programs because they do not know where to sign up, are unsure of eligibility requirements, or do not have enough information about the plans. Fear and mistrust of government systems and lack of culturally-sensitive health services also present barriers for some Hispanics/Latinos in seeking out publicly available health resources.

In general, Hispanic/Latino populations have high employment rates. However, this does not necessarily correspond to high wages. Ulrich (1999) noted that in the Twin Cities in 1995, 88 percent of Hispanics/Latinos reported having at least one working adult in the household. Although they also noted that Hispanics/Latinos tend to work in industries that are more likely to not have employer-sponsored health insurance than other economic sectors. Ginzberg (1991) also found that the diverse Hispanic/Latino population contains large numbers

of working poor, whose jobs offer few or no health insurance benefits, thus limiting their access to health care. A report from the Robert Wood Johnson Foundation (2007) found that only 47 percent of parents in families earning less than $40,000 a year are offered health insurance at their jobs – a 9 percent drop since 1997. Smaida, Blewett, Carrizales and Fuentes (2002, p. 2) found that "many [Hispanics/Latinos] said they have to make difficult decisions and must weigh the need for health care against other basic needs. This leads to access problems and infrequent use of clinics and providers unless absolutely necessary."

Knowledge of Health Care Services and Programs

Research by Smaida et al. (2002) found that for many Hispanics/Latinos the U.S. health care system and programs appears complex and confusing.

> *"Many Latinos find it difficult to understand the dynamics of the U.S. health care system and the concepts of health insurance. We found a lack of understanding of the difference between Medicare and Medicaid, as well as confusion over such concepts as deductibles, co-pays and insurance. Maneuvering the health care system is difficult and at times overwhelming. Several participants said that they or others they know inadvertently decide that they were not eligible for services. These decisions are based on rumors, eligibility requirements of other states where they previously lived, as well as expectations about income qualifications. Several individuals said that they expect to pay nothing even on Minnesota Care, a program designed for the working poor with a monthly premium based on income and family size. Our focus group findings show that current insurance*

coverage for the participants is diverse and fragmented mix of public and private programs. This was especially the case in families, where it was not uncommon to find more than one health insurance plan and a mix of public and private programs" (Smaida et al., 2002, p. 2).

Outreach and Information

Hispanic/Latino communities tend to be closely connected and reliant on each other for support, both concrete and physiological. Smaida et al. (2002, p. 15) found that "while some participants said that Latinos find out about public programs by word of mouth, it seems that the presence and availability of a community social service improved access to health care and health insurance for several of our focus group participants."

Cultural Competency

The literature points to great strides in cultural sensitivity, however cultural competence raises the bar for organizational accountability and calls for ongoing development. The notion of cultural competence is further complicated by taking into consideration the cultural values and characteristics common within diverse Hispanic/Latino subgroups. According to Lillie-Blanton et al. (1996, p. 7), "an additional barrier for African American and Hispanic patients, not only in the initial search for health services but also in their continuation and compliance with treatment, is a health provider with low cultural competence; that is, one who lacks an understanding of sensitivity to cultural differences and patient needs associated with these differences."

Language and Interpretation

Language remains a significant barrier for primary Spanish speakers. Research disputes the perception that by making interpreter services available or hiring bilingual staff, this barrier can easily be dealt with. According to Chong (2002, p. 6), "the complexities and richness of the Spanish language add to the difficulties of developing proficiency. People from every country and region in Latin America use distinctive idiomatic speech patterns." Ulrich (1999, p. 15) cites a 1995 study conducted in Minneapolis in which language barriers were identified as the second greatest barrier for Hispanics/Latinos in accessing health care. The research suggests that those receiving services continue to see language as a barrier even though service providers may not view this as a significant issue or at least one that has been improved and no longer needs resource investments. It's also important to note that limited-English proficient Hispanics/Latinos as a subgroup face even greater disparities and inequities in access to health care than English speaking Hispanics/Latinos (Saha, Fernandez, & Perez-Stable, 2007).

Immigration Status

The literature outlines some of the complexities of immigration status and eligibility for public services. Documentation requirements are complex and for some immigrants, immigration or refugee status can change over time, making it even more difficult to determine eligibility for different programs. Smaida et al. (2002, p. 9) state that "undocumented immigrants find themselves in an even more complicated situation - they risk their health by not seeking health care when needed, or they risk their chance of survival here in the U.S. by

possibly being reported as undocumented. Even if a person had legal status, there is concern about the role of the U.S. government and fear of deportation."

Logistics

Ulrich (1999) points out that logistical issues can serve as barriers for Hispanics/Latinos in accessing health care, particularly for workers who need to get permission to take time off to go to appointments or parents with young children. "Other barriers that can prevent Latinos from accessing health care include long waiting times, inconvenient hours and loss of pay from work, not knowing where to go, and lack of transportation and child care" (Ulrich, 1999, p. 16).

Analysis of Applicant Data

DHS relies on two statewide eligibility determination systems for data gathering. The MinnesotaCare operations office relies on MMIS when determining applicant eligibility, while county offices use MAXIS to determine eligibility for MA, GAMC and other county health care programs.

A note about the data: All data collected reflects information reported on the Minnesota Health Care Programs Application (HCAPP) for head of household only, regardless of eligibility or acceptance status. Information on other members of a family group is not reflected in these data. All total calculations are based on total number of applications received and may reflect duplicate applications from the same head of household within a given calendar year (CY). Approvals reflect those applications in which any member of the household was approved

for coverage (not limited to head of household). Denials reflect only those applications in which all members of the household were denied coverage.

The consultant team reviewed data specific to Hispanic/Latino and primary Spanish speaking heads of household, however applicants are not required to provide information on their race, ethnicity or primary language. Data provided on Hispanic/Latino heads of household is based on information reported on the HCAPP and may be underreported. Applicant information on primary Spanish speakers reflects only head of household if the language field was completed. Applications received in Spanish or Spanish speakers who were assisted in completing the application in English but did not indicate on the application their primary language was Spanish will not be reflected in the total numbers. Additionally, data provided on Hispanic/Latino and primary Spanish speaking heads of household are not exclusive. These data may reflect the same applicant.

Statewide MinnesotaCare Applicants Reported in MMIS

Data reported in MMIS for the past five years shows an overall increase in MinnesotaCare applications of 26.5 percent from 2003 to 2007. However, total applications from heads of household who identified as Hispanic/Latino grew by 40.6 percent and total applications from heads of household who identified Spanish as their primary language grew by 43.1 percent from 2003 to 2007. This indicates that the rate of growth for Hispanic/Latino and primary Spanish speaking heads of household during this time is noticeably higher than overall growth in applications. In 2007, applications from Hispanic/Latinos made up 4.8 percent of the statewide total while applications from primary Spanish speakers made up 2.3 percent. This

was not a significant increase in the percentage of the statewide total over 2003. Population growth from 2003 to 2006 (the last year for which data is available) shows a disproportionate increase in Hispanic/Latino populations. The total state population grew by 2.1 percent while the statewide Hispanic/Latino populations grew by 18.9 percent (Minnesota Department of Health, 2008).

In addition to an increase in applications between 2003 and 2007, the rate of approvals for Hispanic/Latino and primary Spanish speaking heads of household grew as well. Of the total applications submitted by Hispanic/Latino heads of households, the approval rate grew 38.6 percent from 2003 to 2007. The approval rate for primary Spanish speaking heads of household grew by 43.3 percent. Overall, the percent of approvals for MinnesotaCare applications processed by the MinnesotaCare operations office from Hispanics/Latinos and primary Spanish speakers remained relatively low at less than one quarter of total applications in those categories. This could potentially be due to a variety of factors ranging from incomplete application forms, applicants that were eligible but did not pay the first premium, higher rates in ineligibility among applicants, or applicants were unwilling or unable to get an employer to sign required documentation about employer-sponsored insurance. Further data analysis is needed to fully understand why the approval rate for Hispanic/Latino and primary Spanish speaking heads of household appears low. Requests for interpreters also grew over the previous five years. Tables 3 and 4 show the total number of applications reported in MMIS from heads of household identified as Hispanic/Latino and primary Spanish speakers from calendar years 2003 to 2007.

Table 3: Statewide Total of MinnesotaCare Applicants with Head of Household Identified as Hispanic/Latino, CY2003 to CY2007

	CY2003	CY2004	CY2005	CY2006	CY2007
Approved	417	407	374	359	578
Denied	1,517	1,599	1,954	2,196	2,132
Total	1,934	2,006	2,328	2,555	2,720*
Unduplicated	1,843	1,914	2,238	2,445	2,528
Percent Unduplicated	95.3%	95.4%	96.1%	95.7%	92.9%
Percent of Total Approved	22.6%	21.3%	16.7%	14.7%	22.9%
Interpreter Request	34.2%	35.9%	38.8%	42.8%	45.0%

Source: DHS, MMIS Statewide Data, July 2008
**10 applications were pending in CY2007*
Notes: Data voluntarily reported on application form and reflects head of household only. Approvals reflect only those applications in which the head of household was approved. Denials reflect only those applications in which all members of the household were denied. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Table 4: Statewide Total of MinnesotaCare Applicants with Head of Household who Identified Spanish as Primary Language, CY2003 to CY2007

	CY2003	CY2004	CY2005	CY2006	CY2007
Approved	104	115	95	111	149
Denied	800	819	1,046	1,205	1,141
Total	904	934	1,141	1,316	1,294*
Unduplicated	876	911	1,119	1,284	1,248
Percent Unduplicated	96.9%	97.5%	98.1%	97.6%	96.4%
Percent of Total Approved	11.9%	12.6%	8.5%	8.6%	11.9%
Interpreter Request	68.1%	73.5%	73.6%	75.8%	77.9%

Source: DHS, MMIS Statewide Data, July 2008
**4 cases were pending in CY2007.*
Notes: Data voluntarily reported on application form and reflects head of household only. Approvals reflect only those applications in which the head of household was approved. Denials reflect only those applications in which all members of the household were denied. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Statewide MHCP Applicants Reported in MAXIS

Each Minnesota county uses MAXIS to determine eligibility for MA and GAMC applicants processed by the county office. A review of statewide data for calendar years 2003 to 2007 show a 21.1 percent increase in applications overall across the state. Total applications from heads of household who identified as Hispanic/Latino and total applications from heads of household who identified Spanish as their primary language grew at similar rates—20.4 percent and 20.5 percent respectively—between 2003 and 2007. Applications from Hispanic/Latinos made up 9.6 percent of the statewide total in 2007 while applications from primary Spanish speakers made of 6.0 percent.

In general, approval rates for Hispanic/Latino and primary Spanish speaking heads of household remained fairly constant near 75 percent for the previous five years. The approval rate for MA and GAMC applications is significantly higher than that for MinnesotaCare applications processed by the MinnesotaCare operations offices. However, no definitive conclusions can be drawn from this difference. Each program has different eligibility and income requirements. Of the total applications received by Hispanic/Latino heads of households, the approval rate grew 14.0 percent from 2003 to 2007. The approval rate for primary Spanish speaking heads of household grew by 16.0 percent. Tables 5 and 6 show the total number of applications reported in MAXIS from heads of household identified as Hispanic/Latino and primary Spanish speakers from calendar years 2003 to 2007.

Table 5: Statewide Total of MHCP Applicants with Head of Household Identified as Hispanic/Latino, CY2003 to CY2007

	CY2003	CY2004	CY2005	CY2006	CY2007
Approved	18,508	19,060	20,154	20,701	21,107
Denied	5,898	6,694	7,529	8,241	8,275
Total	24,406	25,754	27,683	28,942	29,382
Unduplicated	19,692	19,667	20,973	21,701	22,022
Percent of Total Approved	75.8%	74.0%	72.8%	71.5%	71.8%

Source: DHS, MAXIS Statewide Data, July 2008
Notes: Data voluntarily reported on application form and reflects head of household only. Approvals reflect only those applications in which the head of household was approved. Denials reflect only those applications in which all members of the household were denied. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Table 6: Statewide Total of MHCP Applications with Head of Household who Identified Spanish as Primary Language, CY2003 to CY2007

	CY2003	CY2004	CY2005	CY2006	CY2007
Approved	11,486	11,825	12,588	13,015	13,323
Denied	3,726	4,058	4,514	5,002	5,009
Total	15,212	15,883	17,102	18,017	18,332
Unduplicated	11,574	11,971	12,833	13,349	13,605
Percent of Total Approved	75.5%	74.5%	73.6%	72.2%	72.7%

Source: DHS, MAXIS Statewide Data, July 2008
Notes: Data voluntarily reported on application form and reflects head of household only. Approvals reflect only those applications in which the head of household was approved. Denials reflect only those applications in which all members of the household were denied. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Metropolitan County MHCP Applicants Reported in MAXIS

Each of the seven Metropolitan counties showed an increase in applications for the three major health care programs (MA, GAMC and MinnesotaCare) from 2003 to 2007.

However, suburban counties—particularly Anoka, Dakota and Washington—showed a higher percentage increase in the number of applications from the general population compared to the other metropolitan counties in 2007 over 2003, and they showed a significantly higher percentage increase in applications from Hispanic/Latino and primary Spanish speaking heads of households. Hennepin and Ramsey Counties showed consistent increases across all three groups. Table 7 presents the difference between the number of MHCP applicants in 2003 compared to the number of MHCP applicants in 2007 reported in MAXIS for all applicants, Hispanic/Latino heads of household, and primary Spanish speakers.

Table 7: Percent Change of Metro County MHCP Applicants for All Applicants, Hispanic/Latino Heads of Household and Primary Spanish Speaking Heads of Household, CY2003 to CY2007

County	All Applicants			Hispanic/Latino Heads of Household			Primary Spanish Speaking Heads of Household		
	2003	2007	% Change	2003	2007	% Change	2003	2007	% Change
Anoka	12,602	16,931	34.3%	624	1,148	84.0%	387	753	94.6%
Carver	1,976	2,454	24.2%	247	325	31.6%	170	194	14.1%
Dakota	11,633	15,930	36.9%	1,413	2,179	54.2%	802	1,380	72.1%
Hennepin	65,747	74,924	14.0%	8,215	9,416	14.6%	6,959	8,042	15.6%
Ramsey	29,220	33,789	15.6%	3,251	3,652	12.3%	1,892	2,137	12.9%
Scott	2,785	4,148	48.9%	347	493	42.1%	270	365	35.2%
Washington	4,451	6,240	40.2%	210	353	68.1%	73	146	100%

Source: DHS, MAXIS Statewide Data, July 2008
Notes: Data voluntarily reported on application form and reflects head of household only. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Table 8 shows changes in total population and Hispanic/Latino populations by county between 2003 and 2006 (the last year for which data is available).

Table 8: Population Change, by County, between 2003 and 2006

	Percent of Total Population 2003 for Hispanic/Latino	Percent of Total Population 2006 for Hispanic/Latino	Percent Change from 2003 to 2006	Percent Change from 2003 to 2006 for Total Population
Anoka	2.0%	2.5%	31.0%	4.1%
Carver	2.8%	3.4%	31.7%	10.9%
Dakota	3.4%	4.2%	27.7%	3.9%
Hennepin	4.9%	5.9%	20.0%	0.1%
Ramsey	5.7%	6.1%	5.2%	-2.6%
Scott	3.2%	3.6%	28.3%	14.3%
Washington	2.2%	2.7%	28.8%	5.4%
Statewide	3.3%	3.8%	18.9%	2.1%

Source: Minnesota Department of Health, 2008

While the numbers of applicants have been increasing, the annual application acceptance rate in each county has remained consistent for both Hispanic/Latino and primary Spanish speaking heads of household. In general, applicant acceptance rates range between 62 and 77 percent across the seven counties.

Overall, the number of applicants increased during each of the previous five calendar years. However, there was no indication of a disproportionate increase in the percent of applicants identified as Hispanic/Latino or primary Spanish speaking heads of household as a total of all applicants in any of the counties. Table 9 shows the percent of Hispanic/Latino and primary Spanish speaking heads of household as a percent of the total MHCP applications for calendar year 2007 reported in MAXIS by county.

Table 9: Percent of Total MHCP Applicants for Hispanic/Latino Heads of Household and Primary Spanish Speaking Heads of Household, by County, for CY2007

County	Hispanic/Latino Heads of Household	Primary Spanish Speaking Heads of Household
Anoka	6.8%	4.4%
Carver	13.2%	7.9%
Dakota	13.7%	8.7%
Hennepin	12.6%	10.7%
Ramsey	10.8%	6.3%
Scott	11.9%	8.8%
Washington	5.7%	2.3%

Source: DHS, MAXIS Statewide Data, July 2008
Notes: Data voluntarily reported on application form and reflects head of household only. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Requests for Interpreter Services

The HCAPP contains a check box for heads of household to indicate if they need interpreter services. The MAXIS data reflects only those applicants who formally requested interpreter services. The data below does not reflect applicant use of Spanish language lines, assistance from bilingual staff or applications received in Spanish in which the interpreter request was not checked. Additionally, the data field is not required to be updated and total requests may be underreported. Many of the county representatives who participated in the stakeholder interviews did have information on the number of requests for contracted interpreter services and language line usage. The tables below compare MAXIS data on interpreter requests from heads of households identified as Hispanic/Latino and those identified as primary Spanish speakers. These data may be duplicative for applicants identified

as Hispanic/Latino and primary Spanish speakers. The data is presented to look at trends across year and county.

Anoka, Dakota and Washington Counties saw the greatest increases in heads of household identified as Hispanic/Latino and primary Spanish speaking from 2003 to 2007. The same is true for interpreter requests. Hennepin and Ramsey Counties receive more actual interpreter requests; however the percent change from 2003 to 2007 remained stable. For all of the counties, there was a similar rate of interpreter requests compared between Hispanic/Latino and primary Spanish speaking heads of household. However, there were noticeable differences when comparing the percent of interpreter requests from all Hispanic/Latino heads of household applicants and all primary Spanish speaking heads of households. This indicates that race and ethnicity is not a predictor of interpreter requests. It also shows that not every applicant who identified Spanish as their primary language requested interpreter services. Table 10 shows the number and percent change of MHCP applicant interpreter requests by county from calendar year 2003 to 2007. Table 11 shows the interpreter requests as a percent of total applicants identified as Hispanic/Latino and primary Spanish speaking by county for each of the previous five years.

Table 10: Number and Percent Change of MHCP Hispanic/Latino and Primary Spanish Speaking Heads of Household Applicants Requesting Interpreter Services, by County from CY 2003 to CY 2007

County	Number of Interpreter Requests in CY2003	Number of Interpreter Requests in CY2007	Percent Change
Anoka			
Hispanic/Latino	323	649	100.9%
Spanish Speaker	318	578	101.6%
Carver			
Hispanic/Latino	142	154	8.5%
Spanish Speaker	141	158	7.8%
Dakota			
Hispanic/Latino	733	1,248	70.3%
Spanish Speaker	701	1,135	70.8%
Hennepin			
Hispanic/Latino	6,366	7,164	12.5%
Spanish Speaker	6,315	7,120	13.7%
Ramsey			
Hispanic/Latino	1,672	1,874	12.1%
Spanish Speaker	1,613	1,789	10.9%
Scott			
Hispanic/Latino	211	316	49.8%
Spanish Speaker	210	315	50.0%
Washington			
Hispanic/Latino	54	128	137.0%
Spanish Speaker	52	122	134.6%

Source: DHS, MAXIS Statewide Data, July 2008

Notes: Data voluntarily reported on application form and reflects head of household only. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Table 11: Percent of Total MHCP Hispanic/Latino and Primary Spanish Speaking Heads of Households who Requested Interpreter Services, by County and Calendar Year

County	CY2003	CY2004	CY2005	CY2006	CY2007
Anoka					
Hispanic/Latino	51.8%	55.8%	54.7%	54.2%	56.5%
Spanish Speaker	82.2%	85.2%	84.4%	85.6%	85.1%
Carver					
Hispanic/Latino	57.5%	57.7%	54.6%	48.1%	47.4%
Spanish Speaker	82.9%	84.1%	76.7%	79.0%	78.4%
Dakota					
Hispanic/Latino	51.9%	53.3%	56.5%	57.8%	57.3%
Spanish Speaker	87.4%	86.4%	87.9%	88.8%	86.7%
Hennepin					
Hispanic/Latino	77.5%	77.7%	75.9%	76.2%	76.1%
Spanish Speaker	90.7%	90.5%	89.5%	89.0%	89.3%
Ramsey					
Hispanic/Latino	51.4%	53.2%	50.8%	51.0%	51.3%
Spanish Speaker	85.3%	87.2%	84.5%	84.5%	83.7%
Scott					
Hispanic/Latino	60.8%	62.2%	67.4%	65.5%	64.1%
Spanish Speaker	77.8%	82.9%	86.4%	85.8%	86.3%
Washington					
Hispanic/Latino	25.7%	30.6%	31.5%	33.0%	36.3%
Spanish Speaker	71.2%	77.8%	76.0%	72.7%	83.6%

Source: DHS, MAXIS Statewide Data, July 2008
Notes: Data voluntarily reported on application form and reflects head of household only. Numbers may have been underreported. Multiple applications may have been submitted by same head of household in a given calendar year and reflected in the total.

Stakeholder Interviews

The consultant team conducted interviews with a total of 12 staff from seven Metropolitan counties and the MinnesotaCare operations office to gain their perspectives on how the current MHCP application process may work for Hispanic/Latino populations and any

barriers individuals may face in accessing the programs. See Appendix A for a list of stakeholders. The interviews were also intended to provide insight into how some of these barriers may be addressed in the community. County Administrators in each of the seven counties were asked to identify appropriate representatives to participate in the interviews. The stakeholder interviews were conducted with individuals who administer MHCP such as financial services, eligibility and outreach supervisors. The roles at the county offices vary slightly but include such activities as determining eligibility for the programs, assisting with the applications when there are questions, requesting interpreter services, and, in some cases, providing outreach to Hispanic/Latino communities.

The general format of the interviews consisted of approximately 25 questions in a conversational style rather than a strict question/answer format in order to build trust with the interviewees and to create a safe environment in which to discuss difficult issues. In addition to the standard questions, interviewees were asked a few more open-ended questions about their current application processes for general understanding and also asked their opinion on barriers, opportunities, and other topics that may not have been covered in the interview. The opinions of this stakeholder group were particularly important since this group had voiced their concern over being excluded in the past. The expert opinion of these service providers is key to the success of reducing barriers for Latinos/Hispanics to access MHCP. By engaging in the process this group is empowered to make change, feels some ownership in the process, and can influence the next steps on the findings of this report.

Barriers Identified by Stakeholders

Each county handles applications and administers programs differently. All of the county offices administer other social service programs such as cash assistance, food stamps and subsidized childcare, however each office has a different system for processing applications and interacting with clients. Certainly there was variation in volume of annual and monthly applications across the counties. The fact that there are many programs administered through these county offices does mean that there may be some systemic barriers that exist for the counties overall in administering their programs that cannot be tied specifically to be barriers to accessing MHCP specifically.

Many counties, especially the larger ones have screeners who do a pre-interview of sorts to determine what programs an applicant may be eligible for and guide them to the appropriate process. This can be viewed as a sort of triage process that also helps to prioritize the needs of the individual. Most counties have financial workers who are cross trained to know something about all of the programs while other counties have teams who handle specific types of applications, e.g. families versus single adults, Spanish, etc. A broad knowledge of program eligibility rules is especially important for the smaller counties.

The stakeholder interviews highlighted common barriers to MHCP access for Hispanic/Latino communities. Some of these barriers apply to all MHCP applicants, however there are some dynamics that are unique to or more challenging for Hispanics/Latinos based on culture and language.

Application Process: Stakeholders discussed the challenge of navigating the overall application process for all potential enrollees. Applicants are not required to have an in-person

interview as part of the MHCP application unlike other social services such as cash assistance and food support. Applicants for MHCP are encouraged to submit forms via mail; however, staff suggested that applicants who do not fully understand the documentation requirements or experience language difficulties may not always submit completed forms by mail. If an applicant has questions about the application process, options for assistance are not always clear. Stakeholders also expressed difficulty in sometimes reaching applicants over the phone and through the mail, which can be further compounded by language barriers. Some stakeholders indicated that when an applicant comes in person to discuss questions, there is often a faster resolution and the application can be submitted correctly. Suburban county stakeholders felt they were able to provide some in-person assistance to help individuals complete the application forms. Stakeholders from larger counties did not feel they had the additional staff needed to provide that level of support, however they have partners in the community who have been able to accommodate that need. In general, stakeholders thought that the lack of support for completing applications presented some challenges, particularly for those who were not able to provide additional documentation or needed language services.

Eligibility Determination: Overall, MHCP eligibility rules are very complex and difficult to navigate. This level of complexity is true for any applicant and is compounded for Hispanic/Latino communities where citizenship, immigration status and documentation for individuals as well as among family groups are often in flux. Stakeholders voiced concern over the ability for county workers to support the application process because the eligibility rules and criteria are different depending on an individual's needs and life circumstances. Some stakeholders discussed the amount of time and training workers need to understand all of the

programs rules. One idea mentioned involved using simpler, target applications to help alleviate the complexity for applicants and for staff determining eligibility. It may be easier for applicants and county staff to complete and process applications that are more specific to needs such as families, single adults, workers, those with special needs and others. Doing this would mean different types of applications but would alleviate some of the need for all financial workers to know and understand all of the eligibility rules and program requirements. Another benefit is that the applicant could choose the application that best is best suited to their particular situation.

Data: Most of the counties did not have easy access to aggregate data on clients served or specific population demographics. Each county is required to report information on each client in the statewide information system, however there is no regular feedback mechanism for county staff to see reports or more importantly use this information for ongoing quality improvement or outcome measurement. In general, county staff did not know how the data was used or if it was regularly reviewed at the state level.

Outreach and Education: Many more individuals are eligible for MHCP than actually apply. Education and outreach to communities is a key area of focus for the entire population eligible for health care programs. Also, part of outreach and education includes de-mystifying and dispelling myths around the programs. Some county staff expressed concern over who really should be doing outreach to Hispanic/Latino communities, however nearly every county had some form of outreach, through collaborations with clinics and outreach staff, co-located staff at schools or hospitals, participation in health fairs or regular participation in Hispanic/Latino cultural events.

One concern raised was over funding. Current funding for outreach staff based in the community comes from sources dedicated to health care access. Some communities did have access to grant funding to help seed outreach efforts in the community. There is no funding for outreach to enroll participants in health care programs. Some thought DHS would need to fund this separately with the counties. Another issue discussed was whether or not outreach really belonged in the county domain or whether that belonged to some of the community clinics and other community organizations that directly serve Hispanics/Latinos. One county saw doing outreach as a conflict of interest with providing financial services support.

Cultural Considerations: Stakeholders discussed specific barriers that pertain to Hispanic/Latino communities regarding culture. Many of these barriers surround issues of trust, fear and relationship building. Some stakeholders discussed a general lack of trust among Hispanics/Latinos for government institutions, particularly for those without citizenship or documentation who may fear being reported to Immigration and Customs Enforcement (ICE). Additionally, some applicants are reluctant to reveal sources of income, particularly if they are working for cash or without documentation. Stakeholders said that many individuals in Hispanic/Latino communities fear of being reported to the IRS was often as big a concern as being reported to ICE.

Many of those interviewed mentioned the strong relationships and close ties that those in Hispanic/Latino communities form with those in their immediate network. This includes information sharing through word of mouth and from trusted leaders. Family relationships tend to be very strong and a key for building informal networks outward to the larger community. Stakeholders stated that that because of these strong informal networks, programs with the

best chance for success are those that involve outreach to the communities. The one-on-one and face time aspects are more important to this community because there is often fear that government officials are connected in some way and that what is said in one place may be communicated more broadly. There are some conditions such as pregnancy that allow eligibility to some programs regardless of documentation status. However, many in Hispanic/Latino communities are unwilling to take the risk of applying for the programs because they fear becoming too visible within the community. Connecting with clinics or other community resources specifically serving Hispanic/Latino communities helps to alleviate this problem by building relationships and trust between individuals and agencies.

Language: In general, stakeholders did not believe language was a particular barrier for primary Spanish speaking clients. Those interviewed suggested that while Spanish applications are on the increase there is enough language support available through contracted interpreter services, bilingual staff and language lines. However, it appears that language becomes a barrier generally due to misinterpretation of already complex rules and also due to some efficiency loss and perhaps additional time required whenever there is a need for Spanish interpretation. Nearly all counties were clear that they do not encourage minor children to serve as interpreters for their parents. The literature, however, indicates that language may continue to be an issue from the perspective of primary Spanish speakers.

Logistics: Stakeholders discussed some of the general barriers related to logistics, such as daytime office hours, transportation and childcare. For working adults or parents with young children in Hispanic/Latino communities, these factors can create additional challenges if they need to meet with a county representative to complete application forms or have an

interpreter present. Some county offices do provide evening appointments and child care. However, suburban counties were more attentive to transpiration barriers due to the lack of public transportation.

Prioritization of Identified Barriers

Stakeholders identified the complexity of the application process and eligibility requirements as the highest priority barrier. While many respondents suggested streamlining the application process, they recognized the legislative requirements for this process. Some counties have developed specialized teams to handle specific aspects of program eligibility for different populations.

The perception of fear and lack of trust of government institutions among Hispanic/Latino populations was heard in many counties. Outreach and education were identified as mechanisms for building relationships in communities to dispel myths about programs and services. Because many individuals within Hispanic/Latino communities rely on relationships with family, church groups, schools and other social networks, it is important to connect with individuals where they congregate. Some counties discussed the importance of additional funding for outreach, education, and public awareness efforts.

In addition, county staff identified resource constraints that impact services and supports for all clients. Certainly budget reductions have led to decreased dollars for direct assistance to clients and resulted in staff reductions. Many counties said they had either lost a number of positions or were unable to fill existing vacant roles.

Opportunities

The county stakeholders interviewed identified several ways to address the barriers outlined above. Many of the ideas involve improving outreach and cultural competency. Some of these ideas have been implemented through pilot programs with the aid of grant money or are being administered through partnerships with community organizations. For example, Hennepin County has established the Office of Multicultural Affairs which helps cultural and immigrant communities with interpreter services and with general outreach. La Clinica in Ramsey County has grant funding for a full-time outreach worker who helps Hispanic/Latino clients access health care services and programs. In addition, Carver County has received grant money for a Navigator program to help provide information and resources so individuals can navigate the health care system. Outreach is also very effective in dealing with many of the fears of many in Hispanic/Latino communities. Stakeholders mentioned staff placed in the community as their key liaison for outreach. However, these roles tend to be funded by grant monies and many counties rely on specific individuals who are doing outreach informally without creating permanent paid positions to do this work. Some stakeholders voiced concern that the counties themselves should not be responsible for outreach at all since their role is to process the applications and offer services specifically surrounding this process. There was also concern that if outreach is a priority for the counties then dedicated funding should be allocated for this.

Spanish was identified as the most requested language service in the counties. This indicates there may be enough demand to justify hiring bilingual Spanish speakers who can help with language needs. Currently, there is a heavy reliance on workers who speak Spanish to

pitch in and provide ad-hoc services above and beyond their current job responsibilities without additional compensation. Some stakeholders indicated a need to improve efficiencies regarding the use and functionality of the language line. Each county is required to have a Limited English Proficiency (LEP) plan as a way to help ameliorate language barriers. However, it was unclear in the interviews the various factors that were used to determine these annual plans.

Promising Practices

Many of the promising practices highlighted in this report come from research that has examined the disparity in access to health care delivery rather than access to publicly funded health care programs. While there may be some subtle differences, these practices can be applied to the disparity in access to MHCP for Hispanic/Latino populations. This is not intended to be an exhaustive list of promising practices but rather the primary examples from Minnesota and around the country. Research suggests that any effort to reduce the number of uninsured Hispanics/Latinos must consider alternative and complementary approaches to existing programs as a necessary component to increasing access to the MHCP and will require a comprehensive, multi-stakeholder strategy (Davidoff et al., 2000).

Data on Race, Ethnicity and Language

Research suggests that efforts to reduce racial and ethnic disparities in access to publicly funded health care programs must begin with valid and reliable baseline data on race, ethnicity and language preference. There is currently limited data available to understand or monitor access and health issues for immigrant populations and other communities of color (Davidoff et

al., 2000). While collecting these data alone cannot reduce or eliminate disparities, understanding the data is a necessary first step in identifying disparities and targeting strategies to address inequities. Without such data, the state and counties cannot effectively define the problem or devise targeted, meaningful solutions (Angeles & Somers, 2007).

Medicaid is the largest provider of health insurance for minority populations in the United States, covering at least one in five non-elderly Hispanics/Latinos and African Americans compared to one in 10 whites (Angeles & Somers, 2007). State and county Medicaid (Medical Assistance) agencies in Minnesota that collect race, ethnicity and language information can use these data to identify disparities and appropriate interventions. Data on race and ethnicity can also be used to plan programs, set priorities, determine translation and interpretation needs and identify and explain performance differences among county human service offices. Additionally, these data must be easily accessible for state and county human service staff to use in a timely manner for quality improvement. It is important to recognize that the process of gathering information impacts the quality of the data when studying variables such as health care access in Hispanic/Latino communities. If state and county agencies and staff do not take the time to understand Hispanic/Latino cultures, there is evidence that clients will report false or incomplete information (Davidoff et al., 2000).

Outreach, Education and Community Involvement

Barriers to health care coverage and solutions to eliminating inequities for Hispanics/Latinos can vary widely by location. There is no one-size-fits-all solution that works across all communities. Interventions must be tailored to the community's specific needs and

must reflect the community's demographic and socioeconomic make up, cultural values, as well as existing infrastructure and supports (Angeles & Somers, 2007). Engaging Hispanic/Latino communities through community-based activities and programs is an important strategy to effectively reduce disparities in access to public health care programs.

Outreach and education initiatives can help Hispanic/Latino consumers find out about health care programs and better understand their eligibility for and the level of benefits and services. Methods to achieve this outreach may include using bilingual and bicultural community health workers, Hispanic/Latino community newspapers, Hispanic/Latino television and radio programs and disseminating information at Hispanic/Latino community events. Outreach efforts should not only target potential Hispanic/Latino enrollees but also social service agencies, community-based organizations, clinics and hospitals working with individuals from Hispanic/Latino communities. Trusted organizations and leaders from within the community may be better able to inform individuals about health care programs than state or county staff given the fear and mistrust some Hispanics/Latinos have towards government institutions (DHS, 2003). In a survey of state and county enrollment and eligibility workers by the Minnesota Health Care Connect Project (2007), 20.1 percent of respondents indicated that the state and counties could become more efficient in their eligibility and enrollment work by "better utilizing non-governmental entities in the eligibility process" (p. 9).

The survey also showed that 71.8 percent of state and county respondents indicated that "easy to use client screening tools available at county offices and outreach sites" would make it easier for clients to access all of the programs for which they might be eligible (Minnesota Health Care Connect Project, 2007, p. 11). Eligibility-screening tools such as Bridge

to Benefits (http://www.bridgetobenefits.org/) or The Benefit Bank (http://www.thebenefitbank.com/) are being used by community-based organizations in Arkansas, Florida, Kansas, Minnesota, Mississippi, Montana, Ohio and Pennsylvania to screen clients for eligibility in public health care programs and other public support programs. Community-based organizations using these eligibility-screening tools not only help clients find out about the programs for which they are eligible but can also help clients enroll in these programs. One public program that has been associated with an increase in insurance enrollment and access to health care services is the Women, Infants and Dependent Children Food Supplement Program (WIC) (Davidoff et al., 2000). By enrolling in the WIC program, clients are exposed to needed health care information for their children and themselves and are more likely to enroll in a public health care program.

Research shows that lack of insurance in Hispanic/Latino communities is perpetuated by the difficulty in filling out forms as well as general lack of knowledge of programs and program eligibility (Davidoff et al., 2000). One promising practice to deal with this barrier is culturally competent community-based organizations that provide application assistance. These organizations provide one-on-one application assistance and help clients obtain verifications to make it easier and more efficient for state and county agencies to process their applications. Portico Healthnet, St. Cloud Area Legal Services, Western Minnesota Legal Services, Olmsted Community Action Program and Lake Superior Community Health Center are examples of community-based organizations that provide application assistance in multiple languages to clients in Minnesota applying for the MHCP. They are all part of an outreach initiative funded by the Minnesota Council of Health Plans to assist people throughout Minnesota apply for MHCP.

Community-based case management organizations like these have been shown to be more effective than traditional Medicaid/SCHIP outreach and enrollment in insuring uninsured Latino children (Flores, Abreu, Chaisson, Meyers, Sachdeva, Fernandez, Francisco, B. Diaz, A. Diaz & Santos-Guerrero, 2005). According to the Minnesota Health Care Connect Project (2007), "greater assistance obtaining verifications" and "greater assistance filling out the application" were also the top two ways that state and county respondents indicated that they could improve the experience of their customers in applying for and being enrolled in MHCP (p. 5).

Cultural Competency

Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by clients (Cross, Bazron, Dennis, & Isaacs, 1989). As Hispanic/Latino populations in Minnesota continue to grow, having a culturally competent workforce and processes becomes more important, especially given the history of fear and mistrust of government institutions among many Hispanic/Latino communities.

The Commonwealth Fund (2007) has identified a number of states that have used the legislative arena for addressing cultural competency in health care. New Jersey and Washington State have passed legislation that requires cultural competency training for certain health care

professionals. The legislation establishes an "ongoing multicultural health awareness and education program" (Commonwealth Fund, 2007, Overview section, ¶ 1). The program aims to educate health care professionals "regarding the knowledge, attitudes and practice skills necessary to care for diverse populations to achieve a greater understanding of the relationship between culture and health" (Commonwealth Fund, 2007, Overview section, ¶ 1). Vickie Ybarra, chair of the Washington Governor's Interagency Council on Health Disparities, states that "Our state will learn much from this process that we are confident will help address health disparities in our increasingly diverse state" (Commonwealth Fund, 2007, Overview section, ¶ 3). California and Maryland have also passed legislation involving cultural competency training for health care professionals and providers. Similar bills have been proposed in Arizona, New York, Illinois and Ohio.

The U.S. Department of Health and Human Services' Office of Minority Health (OMH) has developed cultural competency guides and resources as well as established a Center of Cultural and Linguistic Competence in Health Care and the National Partnership for Action to End Health Disparities. OMH has also released national standards for culturally and linguistically appropriate services (CLAS) in health care. These standards contain three main themes – culturally competent care, language access services and organizational supports for cultural and linguistic competence (Angeles & Somers, 2007). They also provide a comprehensive approach to addressing the needs of racial, ethnic and linguistic population groups that experience unequal access to health care (Angeles & Somers, 2007). The CLAS standards could be modeled upon and adapted to create similar standards for state and county human service workers. Other culturally competent practices include providing interpreter services, hiring bilingual and

bicultural staff, making information available in languages other than English and ongoing staff training and education in cultural competency.

Recommendations

The following recommendations are based on the intersecting themes from the interviews, the data analysis and the literature review. When fully implemented, these recommendations can help reduce the disparity in service access to MHCP for the Hispanic/Latino populations. However, these are only preliminary steps towards the ultimate goal of equity in access to MHCP for all racial and ethnic groups across the state.

Data Collection, Analysis and Use

Reducing racial and ethnic disparities in access to MHCP must begin with valid and reliable baseline data on race, ethnicity and language preferences. While collecting these data alone cannot reduce or eliminate disparities, gathering these data is a necessary first step in identifying disparities and targeting strategies to address inequities. Data on race, ethnicity and language can also be used to plan programs, set priorities, determine translation and interpretation needs and identify and explain performance differences among county human service offices. These data should be easily accessible for state and county staff to use in a timely manner for quality improvement.

It is important for all staff to understand why they are collecting these data and how the data will be used. Several interviewees suggested that there is some confusion around who is tasked with collecting and analyzing data for the purposes of recognizing barriers.

Communication between the state and counties should be improved to allow for more transparency and visibility about what each other are doing. Doing so would allow the state and counties to work more collaboratively to streamline processes and workflow.

It is also important to recognize that the process of gathering information from clients impacts the quality of the data. If state and county agencies and staff do not take the time to understand Hispanic/Latino cultures (i.e., cultural competency), there is evidence that clients will report false or incomplete information (Davidoff et al., 2000). However, one piece of data that could provide quality improvement information is regular feedback from Hispanic/Latino clients. This information could help inform the state and counties about their strengths and limitations when it comes to serving the Hispanic/Latino communities. One piece of data that was not available and therefore not included in this report is information about why Hispanic/Latino and Spanish speaking applicants were denied access to MHCP. A second piece involved authorized representatives and identifying under what circumstances applicants use a third party for support. We recommend analyzing these data to see if there are any undiscovered barriers in the application process.

Outreach

Outreach strategies to effectively reduce disparities in access to the MHCP must begin with partnerships and/or relationships between county agencies, community-based organizations and Hispanic/Latino communities. Outreach and education initiatives can help Hispanic/Latino clients find out about MHCP, better understand their eligibility for and the level of benefits and services covered and fill out applications and renewal paperwork. Methods to

achieve this outreach may include using bilingual and bicultural health care "navigators," Hispanic/Latino community newspapers, Hispanic/Latino television and radio programs and disseminating information at Hispanic/Latino community events. Outreach efforts should not only target potential Hispanic/Latino enrollees but also social service agencies, community-based organizations, cultural organizations, clinics and hospitals working with individuals from Hispanic/Latino communities. Trusted organizations and individuals from the Hispanic/Latino communities may be better able to inform individuals about the MHCP than state or county staff given the fear and mistrust some Hispanics/Latinos have towards government institutions (DHS, 2003). The stakeholder interviews touched many times on how important it is to mitigate the fears that many individuals in Hispanic/Latino communities have when dealing with government agencies. County administrators mentioned the importance of having someone "in the field" to act as a liaison or connection between the counties and Hispanic/Latino communities. Culturally competent community-based organizations can also provide one-on-one application assistance and help clients obtain verifications to make it easier and more efficient for state and county agencies to process their applications.

Simplify and Streamline Programs and Processes

Program and application complexity was a reoccurring theme during our interviews with state and county eligibility and enrollment staff. Many felt that the MHCP requirements are difficult to understand due to many different programs with a myriad of eligibility rules. The scope of program rules makes it challenging for the counties to administer and hard for many in the Hispanic/Latino communities to understand. This complexity makes it time consuming and

expensive to train eligibility staff and may result in more errors and inefficiencies during the eligibility and enrollment process. Because of the program complexity, eligibility and enrollment staff need regular program updates in a timely manner.

The MHCP application and process can be a daunting task and may be a deterrent for many Hispanics/Latinos applying for the programs. Some stakeholders suggested having separate application forms for different family types to make the application process more specific to individual needs. This may make the forms easier to complete and process since they are not trying for a "one-size-fits-all" solution. While we recognize the DHS does not have the ability to change every eligibility rule, we still recommend trying to simplify and streamline application, eligibility and enrollment processes wherever possible.

Communication with Clients

DHS and the counties must ensure that their external communication mechanisms meet the needs of Spanish speaking clients. This includes Spanish application materials, phone messages and signage. We also recommend that all follow up materials and information that is sent to the client be communicated in their preferred language. These are just a few ways that the state and counties can be more culturally competent when dealing with Hispanic/Latino clients.

Multi-Stakeholder Strategy for Additional Information Gathering

In order to gain a truly comprehensive understanding of the barriers faced by many Hispanics/Latinos in accessing MHCP, a comprehensive, multi-stakeholder strategy involving a

broader array of experiences is needed to gain clarity around barriers and to validate assumptions. Additional stakeholder interviews and focus groups should be conducted with Hispanic/Latino enrollees and prospective applicants, as well outreach workers, community-based organization, health care providers and leaders within Hispanic/Latino communities. Conducting a comprehensive assessment gives a greater voice to Hispanic/Latino communities by hearing first-hand perspective on the application and enrollment process, and the factors that often prevent many Hispanics/Latinos from applying for assistance. A collaborative effort is needed to truly understand and determine how to improve access to health care programs for Hispanic/Latino populations.

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Appendix A: List of Stakeholders

Anoka County
Miriam Kopka, Family Programs Manager, Income Maintenance Department

Carver County
Darla Wulf, Financial Assistance Supervisor

Dakota County
Deb Bercier, MA Supervisor
Laura Pelkola, Health Advocate

Hennepin County
Susan Bongaarts, Outreach Supervisor
Ernie Neve, Supervisor
Jackie Poidinger, HSPHD Managed Health Care Supervisor

Ramsey County
Shannon Kennedy, Human Services Manager, Financial Assistance Services
Deborah Krech, Supervisor, Financial Services

Scott County
Michelle Weber, Financial Assistance Supervisor

Washington County
Mary Farmer-Kubler, Supervisor, Financial Assistance

MinnesotaCare Operations Office
Todd Keller, Enrollment Manager

Appendix B: Stakeholder Interview Questions

Demographics

1. How long have you been working in your current role?

2. Could you provide a short overview of your job description in your County?

3. How many staff in your county are responsible for addressing outreach or service to the Hispanic community?

4. Do you help people in the office fill out the application? Do you have staff available to help people fill out the application in other languages?

5. Are there intake workers or financial workers available to speak to clients in Spanish?

Finding Information in Spanish

1. Do you collect language and ethnicity data about the clients seeking services? If yes, do you analyze that data and use it to provide services to clients? If no, what prevents you from collecting that data?

2. Does the lobby of the county building have signage in both English and Spanish?

3. Does the phone system have Spanish instructions on the voice mail?

Outreach to the Hispanic/Latino Community

1. How do Hispanic/Latino clients typically learn about MHCP? What are the specific outlets in the community where information is made available about MHCP in Spanish? Do you have data on this?

2. Does your county have any outreach programs in place that target the Hispanic/Latino community?

3. Do you know about any other community based outreach programs in that target the Hispanic/Latino community?

Application and Case Management

1. What is the monthly volume of applications submitted by clients indicating they are Hispanic/Latino?

2. Has anyone submitted a Spanish application in the past month? If so, how many?

3. Do you think that the number or percentage has changed over the last 5 years in terms of Hispanic/Latino applicants and in terms of Spanish applications? If so, how has it changed?

4. How many Hispanic/Latino clients come into the office versus return application by mail? Are there other pathways for applications? How about Spanish speakers? Do you have any data on percentage or numbers from each pathway?

5. How many Hispanic/Latino clients come into the office with an advocate? How many Spanish speakers come into the office with an advocate?

6. What happens when an application is submitted in Spanish? Is it translated into English? If so, how long does that take? If not, what is the application path? How does the handling of a Spanish application compare to an English application?

7. If applications are translated (see above question), how many translators do you have to translate applications?

8. If a client indicates their primary language is Spanish and they need a translator or interpreter, do all notices and follow up calls go out in Spanish? How are Spanish speaking clients notified when they are accepted to the program or if follow-up is needed?

Opinion

1. What practices do you think are working well in the county to help the Hispanic/Latino community or Spanish-speakers specifically in accessing MHCP?

2. Based on your experience, what, if any, barriers may limit the county in helping the Hispanic/Latino community or Spanish-speakers specifically in accessing MHCP?

3. What would you identify as the top 3 barriers that the Hispanic/Latino community or Spanish-speakers specifically face in accessing the MHCP?

4. What opportunities do you see for addressing the barriers?

5. What would you like to add to this topic that we haven't asked about?