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Addressing cultural determinants of health for Latino and Hmong patients with limited English proficiency: Practical strategies to reduce health disparities

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Abstract

We explored how addressing culture may improve patient-provider relationships and reduce health disparities for racial and ethnic individuals with limited English proficiency (LEP). We analyzed qualitative data collected to explore health disparities in preventive cancer screenings for Hmong and Spanish-speaking LEP patients in a large Midwest healthcare system. We interviewed 20 participants (10 from each group) and the audiotaped interviews were transcribed verbatim, then back translated focusing on meaning. Data was analyzed using content analysis. Two themes are: conversation is relational and quality time is valued. Good communication skills involve the amount of conversation, clear explanations, and engaging with the patient. Quality of time meant physical time spent with patient and the task-oriented nature of the encounter. Cultural literacy in healthcare practice helps to understand the whole patient rather than focusing on the symptoms of illness. Patients should not be treated in isolation of their culture. A patient-centered approach to care means physicians should not remain culturally neutral but be more culturally sensitive. We propose steps to reduce disparities by increasing the awareness of cultural literacy for physicians to improve patient-provider relationship.

Keywords

health disparities; cultural literacy; patient-provider relationship; patient-centered; limited English proficiency; health literacy

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Conflict of Interest

The authors (Park, Schwei, Xiong, and Jacobs) declare that they have no conflict of interest.

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards and the research protocol was approved by the University of Wisconsin-Madison Health Sciences Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. I also confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

Introduction

Racial and ethnic individuals who speak English “less than well” or “not at all”, referred to as limited English proficient (LEP), are more vulnerable to significant health disparities due to their limited ability to understand and communicate health information compared to English-proficient patients [1–5]. Providing equitable quality health care to the LEP patient presents challenges beyond language in our healthcare system. For immigrant and refugee populations, health disparities result from a combination of language and cultural barriers [3–4, 6–10]. Although culture is recognized as an important component of human behavior, it is not seen as a primary variable influencing health, resulting in continued health disparities for certain racial and ethnic groups [11–14]. This paper aims to draw attention to the importance of addressing cultural determinants of health by introducing the concept of cultural literacy into healthcare as a way to reduce health disparity.

In 2013, 41% of the immigrant population was considered LEP and experienced an 80% growth since 1990 from almost 14 million to 25 million—much faster than the 66% growth in the English-proficient population [15]. Latinos and Asians are the two fastest growing and the two largest populations with over 60% in each who are LEP [3, 6, 15]. The interdependency of language and culture means limited English proficiency restricts the ability of immigrants and refugees to assimilate or culturally adjust and integrate into a new host society because they are unable to comprehend the culture around them [4, 16]. Not understanding American culture (including western medicine) because of language and culture barriers, LEP patients have significantly lower health literacy and poorer health compared to English-proficient patients [3–5, 17]. Health literacy is the ability to understand health information in English [18]. Having limited English proficiency was found to have a greater effect on communication [3, 9, 19], which in turn affects patient-provider relationships.

In recent years, the healthcare system has moved towards implementing culturally competent practices including the provision of interpreters and materials in a language that patients can understand. Even with culturally competent practices, the burden for increasing health literacy continues to fall on the patient rather than on the healthcare provider (herein, provider). One way to counterbalance this burden on the LEP patient and deliver equitable care is to increase the *cultural literacy* of providers by helping them understand that language and culture are intrinsically related and mutually inclusive. This aligns with the *Healthy People 2020* “goal to use communication strategies to improve health care quality, population health outcomes, and achieve health equity [1]. Cultural literacy embraces cultural competence but includes a critical reflection of one’s own culture in relation to another culture [9; 20]. Culture is often unnoticeable to those living on the “inside” and only becomes apparent in comparison to another culture [13–14, 21]. For providers, cultural literacy will help them understand the complex relationship between language and culture of their patients compared to their own understanding of “American” culture and western medicine. This complex relationship, called *cultural orientation* (or sometimes worldview), influences the way individuals define their relationship with others, their communication patterns, and their sense of time orientation [22–24].

At the broadest level, cultural orientation has two domains: low-context (*individualism in western societies*) or high-context (*collectivism in non-western societies*)—bearing in mind there is no clear division and that individuals from different cultures fall on a spectrum within these domains due to the historical context of imperialism [22–24]. Of the many factors cultural orientation influences, this paper focuses on *communication patterns* and *attitude towards time* as it relates to interpersonal relationships. Communication patterns (task-centered or relationship-centered—see Table 1) can affect how trust and respect are understood and conveyed [22]. How time is valued as being future/goal-oriented or present-oriented (see Table 1) can affect how relationships are understood and established [17; 22–23]. For instance, the provider (low-context) may want to begin the medical encounter with the reasons for seeking care (task-centered) while the LEP patient (high-context) may want to spend time on pleasantries before “talking business” (relationship-centered). Core differences focus on how relationships are conceptualized (see Table 1). In high-context cultures, relationships are heavily dependent on trust, are interdependent, and are deeply reliant on group identity, more so when compared to low-context cultures [17, 22, 25]. For instance, Koreans use phrases emphasizing “our home” or “our country” rather than “my home” or “my country,” even when the situation is about the individual, reflecting strong group identity norms within that culture [26]. Conversely, in low-context cultures, relationships emphasize independence while identity is rooted in oneself and one’s accomplishments [24]. Mainstream U.S. ideology is based on individualistic or “pull yourself up by your bootstraps” mentality in contrast to the collectivistic group norms of many other countries. When the LEP patient and provider are from different cultural orientations, these distinctions are critical because of how each perceive and understand each other. Another complication is that the healthcare system and the providers are part of the dominant culture of the U.S. based on western cultural norms [14]. Attention to cultural literacy in health, where recognition of culture (and language) as determinants of health and patient health literacy, has been limited [4, 11–12, 14, 17, 21, 27–28].

Cultural literacy enhances evidence-based findings that positive patient-provider relationship improves patient health outcomes [8–9, 12, 29–31]. Although the patient-provider relationship is an intrinsically valued goal in healthcare, when providers encounter an LEP patient, the challenges of language barriers may overshadow this goal [32]. This challenge can hinder building trust. Patient trust in their provider is more likely to result in better adherence to treatment and health outcomes [33–38]. Studies on diverse chronic health conditions show that racial and ethnic minority groups tend to have less trust in the healthcare system compared to non-Hispanic whites [34–36]. Studies also found that lack of trust contribute to health disparities [34, 38]. Given that LEP patients tend to have lower health literacy compared to English-proficient patients, they place more importance on establishing trust and also regard their provider as a person of authority (see Table 1) [7, 17, 39]. This relationship building is core to practicing cultural literacy.

The purpose of this paper is to help providers expand their awareness of cultural literacy and to propose steps towards improving the patient-provider relationship, which could reduce health disparities for racial and ethnic LEP patients. This paper focuses on two components of cultural orientation: communication patterns and attitudes toward time. Because cultural orientation is internally consistent and serves as a source of constancy to many patients in a

new culture [24, 40], being consciously aware of these differences can serve as a starting point for providers to understanding their patients and help reduce the disparities existing between LEP and English-proficient patients. This paper unpacks the lived experiences of some Hmong (Southeast Asian refugees) and Spanish-speaking LEP patients living in the Midwest and how their cultural orientation influences their expectations towards their provider.

Methods

This paper is a secondary analysis of data from a study conducted to explore barriers and facilitators to preventive cancer screenings for Hmong and Spanish-speaking LEP patients in a large Midwest healthcare system. We recruited participants from clinic sites, community settings, and direct mail with language appropriate materials. Using snowball sampling, we asked participants to refer family and friends about participating in the study. We received verbal assent from all participants. The Health Sciences Institutional Review Board at the University of Wisconsin-Madison approved this study and ruled it exempt.

Eligibility criteria included: (1) self-identification as “not speaking English well” or “not at all” (limited English proficiency), (2) native Hmong or Spanish speaker, (3) eligible for preventive cancer screening (women 18 and men 50), (4) no previous cancer diagnosis, (5) had visited their primary care provider in the past year, and (6) willingness to participate in one interview in a location of their choice. Final sample size (n=20, 10 participants in each group) was reached once the research team determined theme saturation was met where responses became redundant and attempts to uncover new themes failed to reveal novel data for each group. All participants received \$50 in appreciation for their time.

Data Collection

At least two bilingual study team members proficient in Hmong or Spanish and English conducted semi-structured interviews in locations convenient for participants (their homes, primary care clinics, public libraries, and office meeting rooms). The interview guide was written in English, then translated into Hmong and Spanish by bilingual study team members based on meaning rather than literal interpretation [41]. For example, one Hmong researcher translated the interview guide from English to Hmong. Then another Hmong student back translated the interview guide written in Hmong to English to ensure the accuracy and meaning of the questions remained intact. Afterwards, the Hmong study team members reviewed and discussed any discrepancies in translation. All noted discrepancies and changes made were using group consensus. Translation of the Spanish interview guide used the same process. The interview guide consisted of a series of open-ended questions with supplemental probing questions.

All interviews had at least two bilingual study staff present. A bilingual and bicultural Hmong woman conducted the Hmong interviews and a bilingual white woman conducted the Spanish interviews. Audiotaped interviews averaged 70 minutes in length. All interviews were transcribed verbatim and translated focusing on meanings rather than literal interpretation as both Hmong and Spanish had terminology with no English equivalent [41]. Two bilingual study team members of each language reviewed all translated transcripts to

ensure quality and accuracy. Before selecting translations that best fit the message the participants were conveying, discrepancies in interpretation were resolved during group meetings where all possible interpretations were deliberated.

Data Analysis

Data was analyzed using content analysis [42–43]. Themes identified during the interview process became the preliminary codebook. Each study team member used the preliminary codebook to code two interviews and then met to review their codes and add new codes. A revised codebook with categorized themes based on pre-established categories arising from the semi-structured interview guide. At least two study team members independently coded each interview. Disagreements or discrepancies were resolved through group consensus. Code definitions were refined and agreed upon by study team members using an iterative process to create a final codebook, which was used to code all transcripts. The codes then informed emerging themes. NVivo was used to code the data.

Results

The final sample size was 10 Hmong and 10 Spanish-speaking participants with equal gender distribution across both groups. The age range of participants was 33 to 75 years with a median age of 54. Patients had been in the US for an average of 18 years, ranging from 8 to 33 years (see Table 2).

While all patients place great value on their relationship with their provider, LEP participants in particular depend on this relationship because of their unfamiliarity with the western healthcare system and their perception of their provider as a person of authority (see Table 1). Two themes emerge in our data that potentially influence the patient-provider relationship: 1) conversation is relational and 2) quality time is valued.

Conversation is relational

Relationships require communication. Participants identified that good communication skills involve the amount of conversation, clear explanations, and engaging with patients.

Amount of conversation—Often times, besides exchanging information, conversations are necessary for relationship building. The limited amount of conversation in a healthcare encounter was a concern for some participants, as evidenced in this statement from a female Hmong participant,

“I know that Americans are not like our Hmong people... there are some [*providers*] that come and say a few words and [*the patient*] didn't even finish talking. [*The provider*] said ‘We are only doing our job so we won't talk to you a lot.’ This is it.’ So that's how I know that those [*providers*] are not like our Hmong people where we like to talk a lot endlessly.”

The power of simple pleasantries also had an impact on relationships. Both Hmong and Spanish-speaking LEP patients placed great emphasis on the pleasantries in the form of greeting and recognition. One Hmong participant commented that when her provider smiles and

“speaks nicely then it’s like you are not scared of [*the provider*]...and you have a good relationship. That [*provider*] is a good person and there isn’t that part where you are scared of [*the provider*] that [*the provider*] doesn’t like you or that.”

This Hmong participant was sensitive to simple pleasantries as a way of acknowledging her presence despite obvious racial differences. One Spanish-speaking woman related her experience with a medical resident who did not say hello to mean, “You feel like “oh, it [*he*] is ignoring me, does it [*he*] like me or not like me? That’s how you feel.” Or as this male Spanish-speaking participant stated,

“I know in our culture that to say hello is very important. Sometimes I arrive at the house of my daughter’s friends, they’re Anglos, and no, they don’t say ‘hello’. They don’t even say ‘Hello, how are you?’, right...it is more cold so that’s how I feel with the, some doctors too.”

Participants acknowledge that the lack of simple pleasantries and conversations leave them feeling disregarded.

Clear Explanations—Participants expressed concerns with their providers regarding the lack of information regarding procedures. For instance, this Hmong female stated,

“Yeah, because I want doctors, who if they are going to do anything, they have to ask you that ‘I am going to do this to you. I am going to check this. I will be doing this. I need this to check for if you have this illness like this. Are you willing to?’”

Another Hmong female also confirmed this sentiment,

“After the check up, I was kind of mad at that doctor too. I said that ‘if you are going to do anything to my body, you have to ask me. If I am happy for you to do then you will. Because what if you scrape too deep and it bleed a lot and it hurts. You have to tell me that ‘I am going to scrape your tissues and I need some blood sample from your cervix for a check-up’ then you have to say that to me so that I know.”

One of the Spanish-speaking participants stated, “I think that is first thing to ask them, ‘Would you like to have this done, look-‘ I mean, explain to them the why...So it’s a very, very important question.”

But when a provider takes the extra time, despite time constraints, to explain the illness and treatment, LEP patients gain more confidence. As this Spanish-speaking female explained, “they [*providers*] are good, there are things that happen to me and he helps me...I like how he treats me: I feel that I am part of his family...” This Spanish-speaking male patient was resistant to getting a preventive cancer screening but after some clear explanation he said, “if you go, this is for this and like this like this...we were talking of all that and I said, ‘ahh okay, thank you.’” This Hmong participant’s statement parallels the sentiment, “yea, like I said, they have to be willing to work with family. Make sure that Hmong people understands...” Many participants expressed a desire to know what was happening in a healthcare encounter and described situations where this did not occur. When positive health

encounters include clear explanations, LEP participants feel more confident in the relationship established with their provider.

Engage with patient—Providers should take extra time to listen and engage with their patients [42–43]. One Spanish-speaking participant stated his disappointment because “They [*providers*] let me down because they don’t accept, they don’t accept suggestions.” Or as this female Spanish-speaking participant related, “No, you can tell the doctors, ‘I think it could be this,’ but they won’t accept it. Because of course, they are the ones who studied, not us.” This particular participant had researched her own symptoms but when attempting to explain this, she perceived that the provider dismissed her. Another Spanish-speaking participant expressed similar experiences, “Yes, they are, they are very respectful in truth, but like I told you, sometimes they need to listen more.”

However, when a provider engages with the patient and takes the time to talk about the patient’s health concerns, the results are quite positive as this male Hmong participant described his relationship with his provider, “That my doctor respects me and it [*provider*] loves me. We, as an older married couple, go and see it [*provider*], if there is anything, it [*he*] helps.” A Spanish-speaking participant also related her positive experience, “I felt that...well what happened to me was important to him, and, well he always listened to me, he was there to listen to me...He [*specialist*] would try to understand me...” The providers’ efforts to “hear” their patients resulted in strengthening the trust factor.

Quality time is valued

Differences in attitude and concept of time between provider and LEP patient was another theme expressed as the value in quality time spent with their provider in terms of physical time spent with patient and the task-oriented nature of the encounter. Several Spanish-speaking participants specified the providers’ lack of time to spend with them. For instance, “But, but you can’t speak too much with the doctor, because of the time” and “I know that their time is really short. Because I even told her, ‘listen, I think I have menopause because...’ [*Provider’s response*] ‘We will discuss that in a different appointment.’ Like that. ‘I only have little bit of time.’ Half hour for you and period, it’s over.” Another participant also shared,

“I go to the consultation only about diabetes and this and that. And sometimes it’s something else that I have, “look doctor, I have this.” But it’s fast. So no, no, they give too little time.”

Or as this Spanish-speaking participant stated about time with his provider, “one of the main reasons is the time that they give the doctor to examine you. That’s one of the reasons. I don’t know how long twenty minutes, thirty minutes, I don’t know.”

Regarding the task-oriented nature of the provider, this participant quoted his provider, “Look, here are the results of your blood test that you got done, you are okay regarding this and that...” but his feelings was full of “doubts because you don’t know exactly what in truth one needs to have checked.” This Hmong participant voiced his opinions on the task-oriented nature of his provider behind the amount of time spent in a health encounter: “and there are some doctors that do not have time to talk to you a lot. So then they speak

quickly...” Others noted that there are times when providers rush through the examinations and consultation. This male Hmong participant asserted, “If you [*provider*] speak too fast and examine me too fast because I have a big illness and so if they do that, then it is not good for me.”

Although some of the participants recognized the issue of quality time was a systemic problem as in the length of time for an appointment, the rushed nature of the health encounter was perceived negatively, especially when participants felt their voices were not heard.

Discussion

While all patients, English-proficient included, consider relationships with their providers to be important, we conclude that the Hmong and Spanish-speaking LEP patients in this study consider relationships with their provider more essential. LEP patients’ statements reflect the significance of relationships that are central to those from high-context cultural orientations. Conversation and quality of time spent were cultural orientation factors, which may influence trust or distrust in the patient-provider relationship.

LEP patients stressed that the value of conversation was integral to building relationship. Results illustrate how the bidirectional nature of communication between the LEP patient and the provider is often missing, resulting in negative medical encounters for the LEP patient [9, 44]. LEP patients seek an understanding from their provider in a way that allows them to feel comfortable during their health encounter. Although the patient and provider do not speak the same language, cultural literacy can be the link between patient and provider for negotiating an effective relationship and a way to create a more hospitable environment in which the patients can comfortably talk about their health issues. These conversations potentially increase the health literacy for LEP patients [3].

For the LEP patient, differences in time perception and management affect expectations around communication. Time orientation in high-context cultures (*polychronic*) is different compared to low-context cultures (*monochronic*) (see Table 1). In monochronic cultures, time is linear and highly organized to do one task at time with a focus on the “product” rather than the “process” [22]. Thus, where the LEP patient is focused on the relationship, the providers is focused on the task-at-hand. Although language barriers are not an isolated situation, it is often the focal point resulting in a tendency to overlook other cultural barriers when studying patient health outcomes [45–49]. Providers using cultural literacy to understand their patients can improve adherence to treatment, patient care, and clinical outcomes.

Practice Implications

Cultural literacy gives providers an opportunity to understand how cultural barriers for LEP patients—more than linguistic barriers alone—conflict with the western healthcare system their LEP patients must live in. The following are ideas to implement cultural literacy:

Relationship building is critical—When the patient-provider relationship involves two different cultural orientation contexts, inherent imbalances sometimes exist between the provider and the LEP patient due to status hierarchical positioning. Status hierarchy is often recognized and respected in high-context cultures [25] resulting in the LEP patient positioning the provider in a higher status due to his education and career (see Table 1). Conversely, in low-context cultures, the provider may be trying to create a sense of equality and not recognize status hierarchy. Being aware that honoring status hierarchy may cause a patient to be more passive, the provider can try to convey that in the US, the provider and patient can have a more egalitarian relationship allowing the patient to speak more openly.

Remember patient-centered communication—LEP patients require more time to ensure they understand what is going on. This is a daunting task when interpreters are involved because of time constraints. Being more patient-centered may get more patients participating during the health encounter [9]. Awareness of cross-cultural differences in cultural orientation can improve how providers communicate with their LEP patients. Patient-centered communication means engaging with their patient, which can lead to a positive perception of care [26, 32]. To be truly patient-centered, the provider cannot remain culturally neutral but rather needs to be more culturally sensitive, which can be done by increasing one's cultural literacy [11].

Conclusion

Shifting demographics in the U.S. include different interpersonal customs creating a need to understand and adapt to new ways of looking at communication, especially in healthcare. Western healthcare operates from the lens of the dominant culture (*individual-focus*) often times overlooking the role culture plays in the lives of racial and ethnic groups [14]. In this paper, we examined cultural literacy as a strategy to improve patient-provider relationship, which could reduce health disparities for racial and ethnic LEP patients. This paper is not about attaining culture-specific knowledge but to introduce the concept of cultural literacy and bring awareness of how foundational differences in cultural orientation can influence the patient-provider relationship. In doing so, this paper brings attention to the assumption in the universality of human behavior from the dominant culture perspective of the U.S. [14]. The goal in bringing this awareness will allow providers to adapt their communication patterns and understand their patients better. Although we recognize some providers already apply cultural competence in their practice and take time to converse with their patients, understanding cultural literacy will prove to be a valuable tool towards patient outcomes. Applying cultural literacy in healthcare practice is a more comprehensive way to understanding the whole patient rather than just focusing on the symptoms of illness [20]. Language and cultural barriers are only a part of the picture, meaning patients should not be treated in isolation of their culture [11, 21].

Immigrants and refugees migrating to the U.S. come from the three-quarters of the globe considered to have high-context cultures (Africa, Asia, Middle East, Central and South America, and parts of Europe) [25]. Participants in this study come from two Southeast Asian countries (Laos and Thailand) and four Spanish-speaking countries (Dominican Republic, Ecuador, Mexico, and Peru)—see Table 3. While there is diversity across Spanish-

speaking ethnic groups, many came from countries historically colonized by Spain resulting in some overlap over time between the indigenous and Spanish cultures. Moreover, while there are unique features in their language, essentially they can understand each other. Empirical studies have compared how cultural orientation affect perception in terms of what people see, understand, and think about the world around them [50–53]. Understanding how LEP patients *value trust to a higher degree* and how things get done *depends on the relationship* can help providers approach patients differently, which may improve healthcare service delivery.

The themes presented in this study illustrate cross-cultural differences often present when patient and provider are from different cultural orientations. Providers cannot always be language concordant with their patients but they do have an opportunity understand how cultural barriers—more than linguistic barriers alone—conflict with the western healthcare system the LEP patient must assimilate (or acculturate) to. When providers can enhance their cultural literacy skills, the exponential effect for the LEP patient could lead to stronger patient-provider relationships and positive long-term health outcomes. Findings from this study warrant future research to continue exploring cultural determinants on health as a way to reduce health disparities among racial and ethnic populations.

A major strength in this study is the access to LEP patient voices and the ability to capture their lived experiences. Another strength is the interdisciplinary connections (e.g. psychology and anthropology) to health. A third strength and possibly more valuable is the focus at the broader level on cultural orientation rather than culture specifically. This allowed us to explore and discuss the similarity of experiences in two very different immigrant/refugee populations that fall within the spectrum of high-context orientations rather than comparing the differences between different cultures. Because cultural orientation connects more cultural groups together, a fourth strength is not having to focus on one specific racial or ethnic group. However, limitations also need to be acknowledged. Findings are not designed to be generalizable and data was limited because the larger study focus was to explore factors contributing to disparities in preventive cancer screening. Also, because this study was conducted with participants who have a primary care provider, it is difficult to know whether or how different responses would be from patients who do not have a primary care provider. Lastly, while it may add value descriptively, we did not include reasons for immigration due to the sensitivity of this question.

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Table 1

Differences in Cultural Orientation

HIGH-CONTEXT (COLLECTIVISM)	LOW-CONTEXT (INDIVIDUALISM)
<i>Relationship depend on trust</i> , builds slowly	<i>Relationship begin and end quickly</i>
<i>Self is integral</i> to the group; identity rooted in group structure (family, culture, work, etc.)	<i>Self is independent</i> of the group; identity rooted in oneself and one's accomplishments
" We "—conscious, Interdependency	" I "—conscious, individual uniqueness
<i>Relationship and team-oriented</i>	<i>Task and individualistic-oriented</i>
<i>Status</i> highly valued; social structure and authority are centralized	People treated as <i>equals</i> ; social structure is decentralized
Focus on <i>context</i> and <i>process</i>	Focus on <i>content</i> and <i>outcome</i>
<i>Indirect</i> communication style	<i>Direct</i> communication style
<i>Time is a process</i> ; belongs to others and to nature. Polychronic	<i>Time is a commodity</i> to be spent or saved. One's time is one's own. Monochronic

Hofstede (2011), Triandis (2001)

Table 2

Demographic Variables—Hmong and Spanish-speaking Participants

	Overall (N=21)	Hmong (n=11)	Spanish-speaking (n=10)
Age (years, range)	54 (33,75)	55 (34,70)	53 (33,75)
Female (percent, absolute)	52 (11)	55 (6)	50 (5)
Reading Native Language (percentage)			
Very well	43 (9)	0 (0)	90 (9)
Well	33 (7)	55 (6)	10 (1)
Not well	14 (3)	27 (3)	0 (0)
Not at all	10(2)	18 (2)	0 (0)
Writing in Native Language			
Very well	29 (6)	0 (0)	60 (6)
Well	48 (10)	55 (6)	40 (4)
Not well	14 (3)	27 (3)	0 (0)
Not at al	10 (2)	18 (2)	0 (0)
Education			
None	33 (7)	64 (7)	0 (0)
Less than high school	14 (3)	18 (2)	10 (1)
High school	19 (4)	9 (1)	30 (3)
2 year degree	10 (2)	0 (0)	20 (2)
College or above	24 (5)	9 (1)	40 (4)
Insurance			
Private	29 (6)	18 (2)	40 (4)
Medicaid/Medicare	52 (11)	82 (9)	20 (2)
No insurance	14 (3)	0 (0)	30 (3)
Length of stay in the US (percent, range)	18 (8, 33)	20 (8, 33)	16 (9, 26)

Table 3

Participant Country of Origin

	Overall (N=21)	Hmong (n=11)	Spanish-speaking (n=10)
Dominican Republic	10 (2)	0 (0)	20 (2)
Ecuador	5 (1)	0 (0)	10 (1)
Laos *	48 (10)	91 (10)	0 (0)
Mexico **	5 (1)	0 (0)	10 (1)
Peru	5 (1)	0 (0)	10 (1)
Thailand *	5 (1)	9 (1)	0 (0)
United States **	5 (1)	0 (0)	10 (1)

* All participants grew up in their country of origin except for 2 people. One was born in Laos* but grew up in Thailand and the other was born in the US** but grew up in Mexico.