

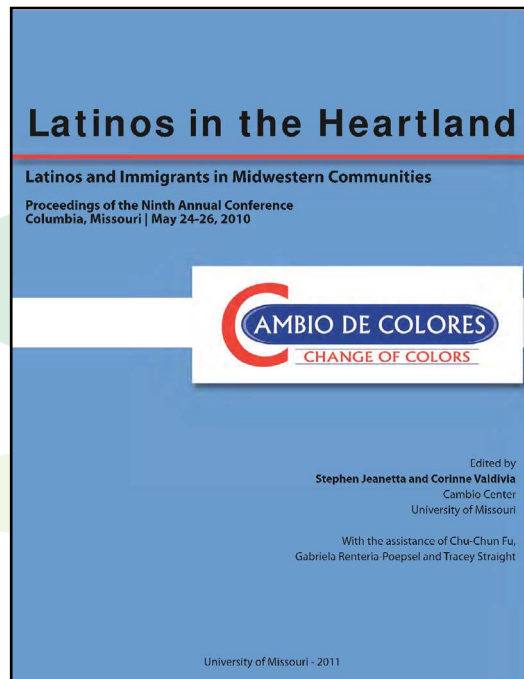


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Casa de Salud: A Community and University Partnership

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Saint Louis University



Keywords: immigrant access to care, Latino health, immigrant health care

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► Casa de Salud: A Community and University Partnership

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Abstract

DuBard and Gizlice (2008) reported that Spanish language preference is a marker for poorer access to care and preventive health services. Carr (2006) cited fear of detection and cultural/language barriers to care as major factors influencing access to care by the immigrant population. When La Clinica in St. Louis closed its doors in the spring of 2009, there was a void left for the immigrant population seeking health care. Just as the Guadalupe Centers in Kansas City are community-based social service agencies, bridging the gap between the newly arrived Hispanic immigrants and the health care system, so too Casa de Salud seeks to bridge that gap in St. Louis by providing community-based health and wellness services. Casa de Salud, on the Saint Louis University campus, opened its doors on January 18, 2010. Championed by Father Biondi, President of Saint Louis University, and Bob Fox, Chair of the Casa de Salud Board of Directors, Casa de Salud is committed to welcoming the immigrant community in Saint Louis and integrating them into the existing and larger preventive health and primary care services provided by primary care homes of local community health centers. The aim of this presentation is to give an overview of the care processes involved in accomplishing this purpose:

- Describe the St. Louis context for the development of pre-access to primary care
- Provide abstractions of Casa's referral experiences
- Reflect upon the experiences
- Articulate and illustrate the current Casa referral template

Methods include four steps: context, experience, reflection, and action. The context in which Casa de Salud exists sets the stage for the article. Experiences accrued during the first three months since Casa's opening illustrate the learning that has occurred as well as the services provided. Reflection upon the experiences provides an opportunity to extract principles that guide the referral process. The lessons learned from our experiences resulted in the development of an action plan.

Introduction

The Hispanic immigrant community is heterogeneous, varying by nationality, culture, socioeconomic status, and occupation, with professionals, technicians, and those in sales or administration comprising about 75% of the total Hispanic workforce (http://www.fiscalpolicy.org/20100123_ElDiario.pdf). At the same time, the number of uninsured is three times that of the non-Hispanic white population (HRSA Office of Minority Health, <http://www.raceandhealth.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=5>). In our society, lack of health insurance inhibits access to care.

Access to care is even more difficult for the uninsured, recently arrived immigrant, often separated from his or her family and disenfranchised within the United States. The barriers to care are several. DuBard and Gizlice (2008) reported that Spanish language preference is a marker for poorer access to care and preventive health services. Carr (2006) cited fear of detection and cultural/language barriers to care as major factors influencing access to care by the immigrant population.

When *La Clinica* in St. Louis closed its doors in the spring of 2009, a void was left for the immigrant population seeking health care. Just as the Guadalupe Centers in Kansas City are community-based social service agencies, bridging the gap between the newly arrived Hispanic immigrants and the health care system, so too *Casa de Salud* seeks to bridge that gap in St. Louis by providing community-based health and wellness services. *Casa de Salud*, on the Saint Louis University campus, opened its doors on January 18, 2010. Championed by Father Biondi, President of Saint Louis University, and Bob Fox, Chair of the *Casa de Salud* Board of Directors, *Casa de Salud* is committed to welcoming the immigrant community in Saint Louis and integrating them into the existing and larger preventive health and primary care and primary care services provided by patient-centered medical homes, such as local federally qualified and community health centers. *Casa de Salud* is an independent 501(c)(3) non-profit organization that emerged through collaboration between Saint Louis University, Washington University, the Hispanic Leadership group, and others in the metropolitan St. Louis area.

Casa's initial outreach to the community is through its clinical services. Unlike primary care, however, *Casa's* services represent a portal of entry into the health care system. Metropolitan Saint Louis has seven Federally Qualified Health Centers (FQHCs) and a set of regional community health centers. For the Hispanic immigrant, access to these services is important, but the barriers often seem insurmountable. What *Casa de Salud* provides is pre-access to care. This pre-access is a simple but often unarticulated aspect of care, familiar to all health professionals. The key elements in pre-access are contextual knowledge, language and contacts.

A simple example will suffice to explain pre-access. A family member, let's say, Jeff, calls his nurse practitioner (NP)-sister, Anne. Jeff is seeking advice because he has just been told his aortic valve is leaking and about 50% of his blood is flowing back into the heart. Anne realizes that, at some point, her brother is likely to need aortic valve surgery. She next translates her brother's lay language into medical language. Next, she contacts the chief of an appropriate department within an academic health science center. The chief says to send him the medical record. After review, he will schedule Jeff with the proper specialist within a week or two. Jeff did not have additional exams or tests performed to gain access. He merely had access to someone who knows how to work the health care system. Working the system requires medical/nursing/health professional knowledge, medical language skills, and contacts. Anne was the link to her brother's access to high-quality care. Anne's role in linking her brother to specialty care is analogous to *Casa's* role in linking the Hispanic immigrant community to the larger health care system.

In the above example, Jeff already had primary care and a diagnosis before he called Anne, his NP sister. That is one major difference between Jeff and the immigrant Hispanic community. Often the immigrant patient does not have access to primary care, and to gain access requires a knowledge base the patient does not possess. So, patient-centered pre-access services for the Hispanic immigrant must also include the provision of basic medical services akin to a continual, systematic medical triage system, with the goal of establishing the patient in a patient-centered medical home or, if needed, emergency medical care.

The *Casa de Salud* model draws upon two basic principles. Health care is a right, and the best health care system is a patient first system. The *Casa* model draws upon knowledge accumulated by experts in care access, interprofessional practice, community resources, referral processes, case management, and primary care. As previously mentioned, the model is not unique. Health care professionals utilize it all

the time in facilitating access for family and friends. Its articulation as a patient-centered pre-access to care model is unique and represents a “new” template only to the extent of its formal organization and utilization as a first stop in the health care journey of the Hispanic immigrant in St. Louis. The specific aims of this article are to:

- Describe the St. Louis context for the development of pre-access to primary care
- Provide abstractions of Casa’s referral experiences
- Reflect upon the experiences
- Articulate and illustrate the current Casa referral template

Literature Review

In earlier studies, DuBard and Gizlice (2008) reported that Spanish language preference is a marker for poorer access to care and preventive health services. Carr (2006) cited fear of detection and cultural/language barriers to care as major factors influencing access to care by the immigrant population. The purpose of this review of recent literature is to present a brief overview on the initial referral or initial access to primary care by the Hispanic immigrant and the related barriers and facilitators of that care. PubMed was selected as the search engine. All searches were saved in PubMed’s MyNCBI.

The search used the filter terms (*case management OR referrals OR access OR pre-access*) AND *Hispanics AND primary care*. This search yielded 1999 citations, of which 23 were written between 2009 and the present. Of these, the closest resemblance to the model employed by *Casa de Salud* is the Boston University model, named The Latino Health Insurance Program. It employs community health workers to enroll Latinos in a locally developed health insurance plan to educate and link Latinos with needed health services. A total of 230 adults and children were enrolled with a 100% retention rate after one year (Abreu & Hynes, 2009). While the purpose of the health insurance plan is like Casa’s, to link the Hispanic population to services, the methods differ. The Boston University plan is an insurance plan and *Casa de Salud* used a service model.

Factors cited as barriers to access included racial discrimination (Sorkin, Ngo-Metzger, & De Alba, 2010) and limited English proficiency (Seiber, Smith, & Tanenbaum, 2010). Facilitators included culturally competent care that was congruent with the cultural needs of those served (Costantino, Malgady, & Primavera, 2009). Religion was found to have no relationship to health care service utilization (Gillum, Jarrett, & Obisesan, 2009).

Of the remaining 19 articles, 16 addressed access to specialty care such as eye care (Morales, Varma, Paz, Lai, Mazhar, Andersen, & Azen. Los Angeles Latino Eye Study Group); mental health (Sorkin, Pham, & Ngo-Metzger, 2009); and diabetes (Link & McKinlay, 2009). Two of the articles referred to the use of GIS tracking systems (Bazemore, Diller, & Carrozza, 2010; Dulin, Ludden, Tapp, Smith, de Hernandez, Blackwell, & Furuseth, 2010) in locating highly mobile patients. Although one of the articles addressed health literacy, it did so assuming that it facilitated access to services and provided literacy enhancement and information (Britigan, Murnan, & Rojas-Guyler, 2009).

Productivity was limited in the two remaining advanced searches. The filter search *access AND barriers AND Hispanics AND primary care*, yielded 43 citations of which 6 were from 2009 to 2010. Of these, five had already been captured by the above search. The remaining citation addressed those with limited English proficiency and found that they tended to seek care from services serving the uninsured (Seiber et al. 2009). The filter search *access AND “facilitating” OR facilitators AND Hispanics* yielded 16 articles, of which 3 were written between 2009 -2010. Of these, two addressed specialty concerns: exercise during pregnancy (Marquez, Bustamante, Bock, Markenson, Tovar, & Chasan-Taber, 2009) and school-based

coping interventions (Garcia, Pintor, & Lindgren, 2010). The remaining articles cited employment, health care access and social support as factors facilitating health, in general, and mental health, in particular (Shobe, Coffman, & Dmochowski, 2009).

Although recent literature is sparse on the barriers and factors that facilitate access to primary care services among the immigrant Hispanic community, the literature is clear-cut (Table 1). *Casa de Salud* is designed specifically to decrease the barriers and to enhance those factors that facilitate access to basic medical services and referral to primary care.

Table 1. Barriers and factors that facilitate access to primary care services among the immigrant Hispanic community.

Barriers to Primary Care Access	Factors Facilitating Access to Primary Care
Language, limited English proficiency, Spanish language preference Cultural barriers Fear of detection Racial discrimination	Community health workers Culturally competent care Addressing the cultural needs of those served Health literacy Employment Social Support

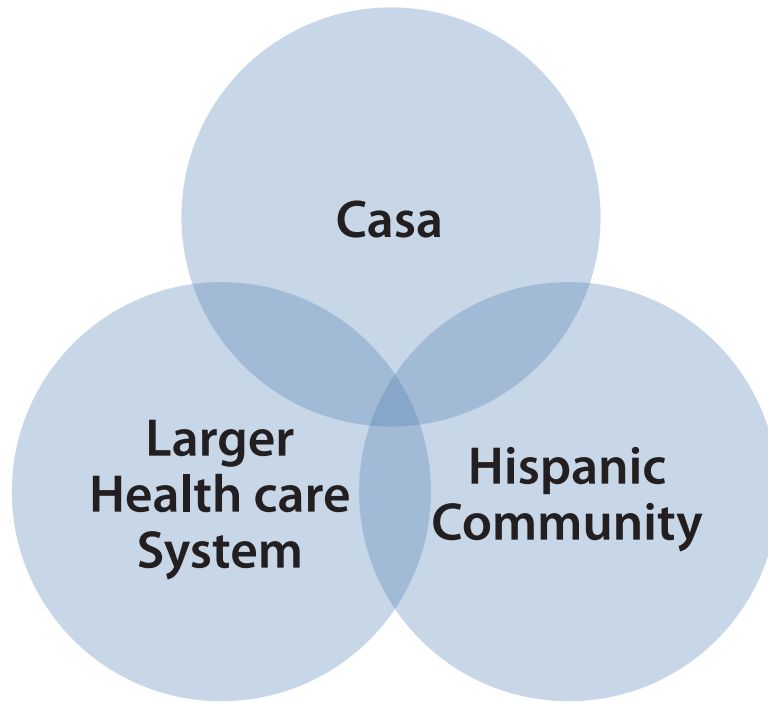
Methods

The methods used in this presentation rely heavily upon an experiential-reflective model used in Jesuit education for more than 450 years. It relies upon the presentation of the *context* and the *experience* followed by a *reflection* upon the experience, and the development of an *action* plan and its *evaluation*. Contextually, *Casa de Salud* is described in terms of its relationships with other systems in the community dedicated to achieving improved access to care by the immigrant Hispanic population. *Casa de Salud's* infrastructure was designed to make its mission a reality; by establishing a small clinic staffed with mostly primary care providers, with the goal of integrating clients into the existing safety net of St. Louis. Insights gained from referrals made are presented. From these experiences, steps in the referral process were reflected upon (the reflection stage) and a template was developed (the action phase). The action phase concludes the development of a referral template, illustrated as a referral decision tree. The Jesuit pedagogic model includes an evaluation step as well; this evaluation is currently underway as our program is only in its fourth month of operation.

Results

The context: Interaction of Casa with the Larger Health care System and the Hispanic Community. *Casa de Salud* provides a regional service that covers eight counties in Missouri and eight in Illinois. Within these counties *Casa de Salud* interacts with the larger health care system, and the Hispanic community (Figure 1). The St. Louis Metropolitan area has a Hispanic community estimated at nearly 100,000 people (Sandoval, 2010).

Figure 1. Venn diagram illustrating interactions among the Hispanic community, the larger health care system, and Casa de Salud.



Casa de Salud could not exist without its more than 25 corporate sponsors and strong institutional support. Table 2 presents its institutional sponsors. The involvement of the Hispanic community, central to the foundation of Casa de Salud, continues to increase, with Table 3 presenting the partnerships to date. The larger health care system includes partnerships with a host of institutions within the community (Table 4).

Table 2. Casa de Salud’s institutional support.

<ul style="list-style-type: none"> • Saint Louis University (FOUNDING AND SUSTAINING SPONSOR) • Barnes-Jewish Hospital Foundation • Ladue Chapel • Missouri Foundation for Health 	<ul style="list-style-type: none"> • Saint Louis University Hospital Auxiliary • St. Louis Children’s Hospital • Sal Mirowitz Day School • Washington University School of Medicine • Women’s Club of the SLU School of Medicine
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Table 3. Hispanic community partnerships.

<ul style="list-style-type: none"> • Hispanic Chamber of Commerce of Metro St. Louis • Hispanic Leaders Group • Interfaith Partnership • International Institute of St. Louis • Professional Latino Action Network • Puerto Rican Society • St. Cecelia Parish and other parishes and churches serving the Hispanic community • STL TV
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Table 4. Health care system partners.

<ul style="list-style-type: none"> • Barnes-Jewish Hospital • Cardinal Glennon Children’s Medical Center • Cohen Eye Associates • Crider Health Center • Family Care Health Centers • Goldfarb School of Nursing • Grace Hill Neighborhood Health Centers • Health Literacy Missouri • Myrtle Hilliard Davis Comprehensive Health Centers • O’Donnell Eye Institute • People’s Health Centers 	<ul style="list-style-type: none"> • St. John’s Mercy Neighborhood Ministry • St. Louis Children’s Hospital • St. Louis City Department of Health • Saint Louis County Department of Health • Saint Louis University Doisy College of Health Sciences, Schools of Medicine, Nursing, Social Work and Public Health • Saint Louis University Hospital • South Side Catholic Charities • South Side Day Nursery • Washington University School of Medicine and Brown School of Social Work
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Casa Infrastructure: Supporting Patient-Centered Access to Primary Care. *Casa de Salud* provides a service with a patient-first care philosophy. It is composed of two complementary services: community and clinical. Clinical services are managed by an administrative services director and a clinical services director, who work together as a team. The former provides community outreach, access to community support services, and the coordinating of volunteers to provide this support for our clients. The latter coordinates clinical services, tracks client’s diagnostic tests, referrals, measures outcomes, and directs quality improvement. Thus, *Casa* is able to provide clients with services utilizing the knowledge and skill in clinical health services administration, public health, community development, and health and wellness care. Salaried staff includes a full time director of administrative services, a part time director of clinical services, a medical assistant, and a receptionist. Volunteer clinical services are currently provided by 17 physicians, one psychologist, three registered nurses and one nutritionist. The physicians represent family medicine, general internal medicine, gynecology, dermatology, psychiatry, and family counseling.

Casa de Salud clinical services operate on less than a 40-hour per week schedule. Its relatively complex schedule averages 32 hours/week devoted to clinic visits. The evening and Saturday hours are an attempt to meet the work needs of the people served:

- Monday 9 – 1
- Tuesday 1 – 5, 6 – 8
- Wednesday 9 – 5 weekly, 6 – 8 monthly
- Thursday 9 – 1 biweekly, 1 – 5 monthly
- Friday 1-5 weekly
- Saturday 9 – 2 weekly

Between January 18 (opening) and April 17, the number of clinical visits totaled 566. This yields an average of about 50 visits/week, with 70 visits having been recorded during the last week. Because the mission of *Casa de Salud* is not to provide on-going primary care, but to integrate the patient as seamlessly and quickly as possible into the larger health care system, the number of referrals given of 50 patients/week is higher than the number of referrals within a typical primary care office.

Casa de Salud administrative services complement its clinical services. The director of administrative services is responsible for establishing the referral network (Table 4) and its navigator function. The role of the navigator is two-fold. Primarily, the navigator will help to integrate the patient into primary care

services offered by community health partners by scheduling appointments for them and accompanying them to their first visit. The navigator can also assist the patient in obtaining specialty care, if needed. As they do with primary care visits, the navigator can schedule necessary specialty care appointments, accompany the patient to the appointment, and assist with any translation or filling out of forms. Casa staff/navigators use the system in Table 4, Casa referral system to guide action. All navigators are volunteers, primarily from health-related graduate programs at local universities.

With only four full-time employees, Casa relies heavily on volunteers in addition to the medical professionals. Casa has a six-person volunteer board, and an advisory board that consists of approximately 25 community members. Advisory board committees include the sustainability committee—which helps to identify and secure potential forms of funding, the community outreach committee—which focuses on public relations with the community that Casa serves, the volunteer committee—which identifies and helps to organize potential volunteers, the patient advocacy committee—which works to insure that programming remains focused on/driven by the population that Casa serves, and the programs committee—which oversees the development and implementation of Casa’s many clinical and community programs. As many patients do not speak English, volunteer interpreters are often required for Casa’s day-to-day services. As part of this model, Casa has put strict quality control measures into place to insure that quality of care remains high. All volunteers who are interested in working with patients as interpreters are required to submit background checks and complete a Spanish proficiency test. All medical care, nursing and other professional providers are credentialed using standard credentialing processes.

Experience

Perhaps our experience is best illustrated using stories:

Scenario 1. Even though Casa de Salud does not provide pediatric care, unaware parents bring to Casa a child requiring same day care. The director of clinical services seeks expert pediatric advice through the Physician Access Hotline. The child, accompanied by a navigator, is met by a professional translator, seen, and treated the same day.

Scenario 2. An acute abdomen trumps transitioning a patient into primary care. The patient requires emergency surgery and must be sent to an emergency department. Accompanied by a navigator and met by a professional translator, the patient is assessed by forewarned emergency department staff at noon, is seen by a physician within an hour, has surgery that afternoon and is discharged the following morning. Hospital billing and physician group billing staff work with Casa staff to obtain discounts and payment plans on the related charges.

Scenario 3. An adult with a complex health problem requires the intervention of multiple agencies and professionals, the health department, an FQHC and multiple medical specialties. This complex case calls for transitioning the patient through multiple institutions and multiple specialties with sequencing decisions made on the basis of care priorities. Keeping close track of the patient until all transitions are made is mandatory. This is precisely the kind of patient who must not fall through the cracks.

Scenario 4. A patient requires urgent but minor ophthalmologic surgery. A private practice ophthalmologist is willing to accept a certain number of free or low-cost patients per month. After coordinating with the office staff, Casa sent this patient for treatment. The patient and his family were delighted with the service received.

The Casa experience requires trust and determination on the part of the patient, Casa staff, and the agencies receiving Casa patients. Patient trust and determination are manifested in various ways. For example, a patient phones Casa from outside a community health center. He says he cannot keep the appointment as directed, even though he is driving around the building. When asked why, he replied, “*Hay policia enfrente del edificio!*” Unbeknownst to the Casa staff, the facility was located across the street from a police station. He trusted Casa enough to phone and was determined enough to seek help, that he shared with us his fear of detention and allowed us to redirect him to another facility.

Interagency cooperation builds upon trust and determination. Casa has been most pleased with the warmth and efficiency of those with whom it is working. Occasionally, however, trust is tested, especially if Casa is perceived as trying to teach others. Such perceptions may prompt a “we know how to care for Hispanic patients” response in either Spanish or English. As with interprofessional practice, interagency trust requires mutual respect, effective communication, and acknowledgement that all are committed to patient well-being.

Reflection

As mentioned in the introduction, medical knowledge, medical language and contacts are critical when helping family, friends or patients through the health care system. The purpose of this reflection is to articulate how these elements converge in developing Casa de Salud’s referral system.

Implicit for each patient is a health care goal and desired outcome. As in the case of the child in the first scenario, some diagnoses require referral, are easily treatable, but carry a high risk for the patient, if untreated. The goal was to refer quickly to prevent poor outcomes. Primary care was not needed, rather a quick specialty intervention. However, for the patient with complex medical problems ongoing primary care is critical, and the relationship between Casa and our primary care safety net is what gets needed services to the patient. The navigator who accompanies the patient to the primary care visit becomes the vehicle that bridges the initial entry into the health care system (the pre-access visit) and the patient’s connection to ongoing primary care.

When speaking of referrals, acuity of the diagnosis controls the window of time within which the referral must be made for a successful outcome to occur. As in the case of the patient with an acute abdomen, referral speed is essential so that the time-to-surgery is quick enough to prevent life-threatening complications. Some referrals must be complete within minutes, an hour or so, a day or two, or a week or two.

When working with non-emergent situations among English-speaking, health literate population, the patient may often be given the responsibility for obtaining his/her own referral. For example, the physician may say, “I want you to go to the emergency department now and I will call ahead.” When working with a non-English speaking population, with or without health literacy, the patient is not capable of communicating his or her needs. Casa de Salud assumes responsibility for this care coordination to increase the probability that a successful outcome will be achieved.

Some referrals are more complex than others. Case complexity, therefore, refers to the number of referral agencies and the number of specialties involved in accomplishing such a goal. For example, let’s look at the third scenario. The patient’s diagnosis requires notification of the health department in addition to referral to at least one other agency capable of caring for the health needs of the patient and multiple specialties within that agency. A successful outcome is not only that the patient achieves health but the disease is not communicated to the family and broader community. A more traditional model than that of Casa de Salud might simply transfer or refer the patient to another agency and assume that the other agency will follow-through appropriately. This may be appropriate in a simpler, less bureaucratic

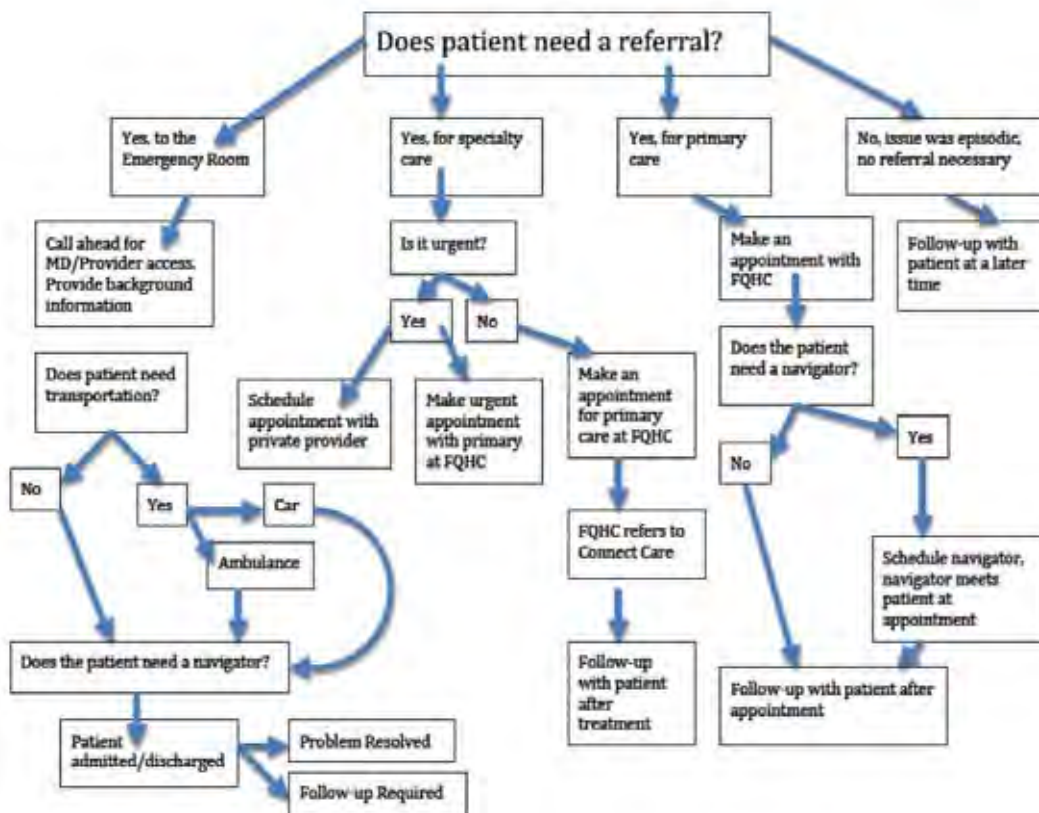
and more resourced world where all involved speak English and finances do not matter. It is becoming increasingly difficult in today's world, however, where even highly-intelligent and resourced individuals feel the need for a patient advocate when faced with a multi layered and highly-fragmented health care system. Even more so this is true for the Hispanic immigrant expected to successfully traverse several systems and specialties.

All referrals require good will on the part of the referring and referral agencies. While never to be taken for granted, good will in caring for the medical under and uninsured is intrinsic to the mission of non-profit health care organizations. The ability of private practice providers to care for this same population is limited, however. Therefore, the good will generated by their generosity, as in the fourth scenario, must not be taken for granted. Their continued availability requires that their limited resources not be exceeded and their good will not exhausted.

Action

Lay people may underestimate the difficulty of the referral process because professionals make difficult processes appear simple or routine. Ease is facilitated by translating difficult processes into relatively simple action plans. Action requires decision-making. Figure 2 outlines the major decision points within a referral decision tree. The four pathways outlined in the decision tree accommodate the four cases presented in this article. Several elements are critical to its successful implementation. Most importantly are pre-planning with each agency involved, steadfastness to the mission of integrating the Hispanic immigrant into the larger health care system, and an organizational flexibility that keeps insisting on a patient first philosophy when faced with conflicting priorities.

Figure 2. Case de Salud Referral Tree



Discussion and Conclusion

If Casa de Salud is to succeed in its mission of integrating Hispanic immigrants into the larger health care system, then the success of its referral process is key. If the referral process succeeds, its success is not due to Casa de Salud alone, but to the good will and teamwork of a myriad of agencies and people to come together to achieve the same goal. In his 17th century meditation, John Donne spoke of the interconnectedness of each in his poem, *No Man is an Island*. During the first half of the 21st century, interdisciplinary or interprofessional education, practice and road maps will need to address the interconnectedness of professionals in delivering care. Given the magnitude of the problems facing society today, inter- or cross-organizational education, practice and road maps will be required to meet the needs of large groups in or segments of our society. Organizations are likely to be judged not on their ability to build empires but on their ability to work together with other organizations to achieve common goals. The *Casa de Salud* provides one model or template for organizational interconnectivity.

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► Human, Social, and Cultural Capitals among Latino Gardeners in Denison and Marshalltown, Iowa

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Abstract

This paper explores different community capitals among Latinos participating in community gardens and farmer starter programs in Denison and Marshalltown, Iowa. Using the community capital framework, this study describes what makes it possible for Latinos to become gardeners in two rural Iowa communities and the circumstances that facilitate the process. For the methodology of this study, four in-depth interviews were carried out in Denison and four in Marshalltown, with Latino gardeners who have different backgrounds and purposes for their participation in farming. In addition, participatory observation at people's homes and garden plots was used to understand the programs. This research analyzes how human, social, and cultural capitals are essential elements for Latino gardeners and how the interaction between this three capitals build the structure for their motivation to become farmers, be civically engaged, and have access to food. This study also describes how the participants have previous knowledge related to agriculture, fresh food and local marketing, which is a result of not only their original countries, but also as a consequence of their migration patterns among rural communities in the US. This study concludes with some recommendations for Latino gardener programs and initiatives.

Introduction

From 1990 to 2000 the Latino population in the U.S. grew 57.9%, and in 2001 Latinos were 12.5% of the total population in the country (Guzmán, 2001; Díaz & Guzmán, 2002). The growth was even more rapid in the Midwest (Díaz & Guzmán, 2002), particularly in rural towns with meat packing plants like Denison and Marshalltown, Iowa. Labor markets and local enterprises in both towns were affected by the new immigrants.

Beginning in 2005, Latinos in those two towns participate in farming and gardening programs organized by Iowa State University Extension, the Leopold Center for Sustainable Agriculture, Iowa Valley Community College in Marshalltown (MCC), National Center for Appropriate Technology (NCAT), National Immigrant Farming Initiative (NIFI), and M and M Resource Conservation and Development Council in Carroll and the Prairie Rivers of Iowa RC&D Marshalltown.

Latino gardeners and beginning farmers in these programs opened new opportunities of social, economic, and cultural integration in local agriculture and local food systems. In Marshalltown, two Latino gardeners and farmers were chosen from "COMIDA"¹ and its related course, Start Your Own Diversified Farm² at Iowa Valley Community College in Marshalltown, and two from the Community Gardens at the same college. In Denison, four respondents were chosen from Latino gardeners participating in the Denison Community Gardens.

I used the Community Capitals Framework (CCF) to identify elements that facilitate Latino/a involvement in these enterprises, the challenges, and the implications that these farming and gardening initiatives have within the Latino community and the larger community. The CCF includes seven types of