

Asset Mapping and Focus Group Usage: An Exploration of the Russian-Ukrainian Population's Need For and Use of Health-Related Community Resources

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Abstract

Community resources are an important aspect of preventive medicine and can also provide support to individuals with existing medical conditions. However, resources may not address all population groups within the community equally, and immigrants, who frequently face cultural and language barriers, are often unable to access the full range of healthcare resources available in the community. The purpose of this study was to gain insight on healthcare needs, attitudes, and access of a Ukrainian immigrant population in a large town in northern Indiana. Focus groups were conducted as a first step to creating connections upon which a community-based participatory research project could be built. Findings revealed cultural barriers (lack of understanding of health insurance options or value, belief that similar services were less expensive in the Ukraine) and language issues (lack of translation services or resources written in languages other than English or Spanish) were key barriers to accessing healthcare resources in the community. Concerns about dental care and its expense were also voiced. Future efforts might build on these findings by exploring policies and practices that affect various immigrant groups' access to community healthcare resources. Recommendations for such efforts are also discussed.

Introduction

Value of Community Healthcare Resources

An individual's health is not only determined during a visit with his or her clinician. Lifestyle choices and decisions that affect health are also shaped by factors outside the clinic walls. Due to the power of the sociocultural environment, patients' health decisions and outcomes can be either won or lost at the community level.

According to the Centers for Disease Control and Prevention (CDC, 2008), people see their primary care provider an average of four times per year. Given that most appointments last approximately 10 minutes (Gottschalk & Flocke, 2005) that computes to approximately 40 minutes per year in which a person is directly involved with their primary provider. Taking this into consideration, it is not likely that good health can be properly maintained through patient-clinician interaction alone.

Healthcare-related community resources are both available and positioned to assist in educating and supporting people with a myriad of opportunities. Also, according to the Community Preventive Services Task Force (2016), a highly regarded group of professionals who make evidence-based recommendations and gap analyses, community resources are recommended to address multiple health conditions. However, Porterfield, Hinnant, Kane, Horne, McAleer, & Roussel (2012) reported

that patients receive less than half of the preventive services recommended to them, highlighting an area ripe for improvement in the delivery of healthcare-related resources.

Previous efforts to engage with immigrant communities have resulted in improved capacity for communities to address health threats. For example, faculty from East Carolina University partnered with the Hispanic Community Development Center to address threats to the health of Latinx immigrants, an engagement effort that resulted in bilingual educational programming, extensive testing for HIV, and the securing of funding through grant-writing efforts (Larson & McQuiston, 2012). Efforts of a public health department in Charlotte, NC, through partnership with faith-based organizations, were successful in engaging Russian immigrants in physical activity programs, although participants did not achieve targeted weight loss (Slisenko, 2018). As demonstrated by these and other efforts, working with (as opposed to in or for) immigrant communities is the best approach to addressing threats to the health of vulnerable populations, including Slavic immigrants.

Overview of Barriers to Immigrants Accessing Healthcare Resources

Given the limited participation in community-based preventive and education services related

to health among the general population, the presence of other impediments to access (e.g., language barriers, lack of familiarity with the area) can have significant negative effects on individuals accessing such resources. When newly immigrated to a community, it is likely that people will be unfamiliar with or hesitant to use the recommended services simply because of their lack of familiarity with the community. Compounding this fact, newly arrived immigrants are likely to suffer from culture shock and language barriers. Furthermore, “minority groups are especially likely to have a different understanding of health...” (Benisovich & King, 2003, p. 135), due to practices in their native countries, which may include no preventive health measures. In addition, the Slavic population studied here stated their culture prefers naturopathic and alternative medicine interventions before seeing a physician. These unique and deeply ingrained practices can easily result in lack of compliance with medications and provider recommendations.

Since the passing of the August 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), studies have shown how immigrants arriving even legally into the United States are at risk for healthcare disparities (Derose, Escarce, & Lurie, 2007). The vulnerability of immigrant groups is compounded by delays and restrictions due to political mandates and immigration laws. Undocumented immigrants are summarily denied financial assistance, but even those immigrants who enter the United States legally (after the August 1996 passing of PRWORA) are ineligible for federal assistance such as Medicaid for five years after entering legally (Levinson, 2002). This ruling remains for the state of Indiana, which allows lawfully permanent residents to be eligible for emergency Medicaid assistance for five years. After the five year period, these citizens are eligible for full Medicaid coverage (Indiana Family and Social Services, 2019).

Multiple studies have delved into the mysteries of acculturation with immigrant groups. Some studies found immigrants to be vulnerable, to be resistant to acculturation, and to feel isolated as they adjust to their new normal (Benisovich & King, 2003; Katigbak, Foley, Robert, & Hutchinson, 2016; Martin, 2009). With cultural differences abundant, it is necessary for a community to recognize the differences and internal challenges faced by different cultural groups. As the world’s melting pot, it is the responsibility of communities in the U.S. to take cultural and language differences as

well as religious and acculturation factors into account, particularly as immigrant groups are often underrepresented and their “voices have been...muted” (Quintanilha, Mayan, Thompson, & Bell, 2016, p. 1).

Just one of the disparities of U.S.-born citizens and legal immigrants, such as language barriers or healthcare insurance, has been shown to impact the health of immigrants negatively (Larson & McQuiston, 2012), but rarely are disparities a single source of impact to an immigrant community. According to Derose et al., (2007), disparities in health care result in a lack of consistency of health care. This situation leads to decreased preventive care, communication with healthcare staff, understanding of a disease, and carrying through with medical recommendations, medications, and treatments. Some work has been done to identify strategies to addressing such issues caused by the challenge of immigrants accessing health care. For example, Meyer, Martinez, Mauricio, & Ip, (2013) published a handbook for training volunteers to serve as community health workers to focus on medication management with immigrants; yet, how immigrants approach the health system in their new country is not well understood.

In 1964, Title VI of the Civil Rights Act mandated that federally funded health organizations provide interpreters at the patient’s request (Derose et al., 2007). However, as a result of limited English proficiency from many immigrants, this right is not known of or followed through with. When combined with a busy physician’s office and a challenging or unknown process to obtaining a credible interpreter, this valuable connection can be overlooked, resulting in more disparities of health in the immigration population.

Looking specifically at Russian-Ukrainian (Slavic) immigrants, they, too, show special needs as they go through the acculturation process. In the Ukraine, medical practices remain underfunded since that country’s independence from the Soviet Union in 1991, and, according to Marya Dmytriv, MD, MPH, the “Ukraine is probably about 50 years behind the U.S.” in technology and treatment (Human Practice, para. 3, 2014). Also, due to the still-developing healthcare system in the Ukraine, Dmytriv said, “Illnesses aren’t validated if they’re not symptomatic” (Human Practice, para. 9). Thus, Slavic people may be used to living with silent diseases such as hypertension or high cholesterol untreated until a major health event occurs, such as a heart attack or stroke.

Although not an overwhelming percentage of the population, Slavic residents have unique healthcare desires and requirements that need to be addressed. To the best of our knowledge, no research has been done on Slavic immigrant health needs, but this is an important topic as research indicates that, “immigrants are a subset of the ethnic minority population with myriad health risks and health needs that are poorly understood” (Katigbak et al., 2016, p. 211). Therefore, the goal of the current study was to capture the stories of the Slavic population and to understand their wants, needs, and barriers to obtaining community healthcare resources.

Framework for This Study

To help situate this project, we provide here a brief description of how the first author established the necessary foundations for implementing this study. This project was the perfect marriage of two interests of mine; I am interested in the availability, accessibility, and impact of community resources, and I have always been fascinated by other cultures and traditions. When I first moved to the county where this study was conducted, I lived next to a first-generation Ukrainian immigrant family. Meeting the Ukrainian family piqued my interest in their culture and traditions. The son of the family spoke English, and we developed a friendship. This unplanned intersection of my interests and my social circle helped to create this project, as the subject of accessing healthcare resources came up with my neighbors. Together, we developed a plan to implement this study.

A little background research helped set the stage for our approach: According to the Center for Disease Control and Prevention, heart disease is the leading cause of death in Elkhart County, where the current study was conducted (CDC, 2014). The other leading causes of death include stroke, lung disease, and cancer (CDC, 2014). Addressing the underlying health conditions of obesity, physical inactivity, lack of social support, and tobacco usage can decrease deaths from these largely preventable diseases. There are community resources available to assist primary care providers’ interventions to address and support residents. Unfortunately, newly arrived immigrants may have barriers in accessing this help.

Our first objective was to create a database of health-related community resources and to prepare asset maps of these resources, stratified by categories: fitness, nutrition, social support groups,

prevention, and education. The methods used for developing the directories and asset mapping were grounded on the logic of the asset-based community development (ABCD) model (Kretzman & McKnight, 1993). The ABCD process focuses not on deficiencies of a community, but rather on the community’s assets and skills within individuals, associations, and institutions that can be shared to build and strengthen the area and its people. “In the ABCD approach, a community explores, describes, and maps its assets and then uses the assets to develop solutions to a specific social issue within the community such as: homelessness, hunger, access to healthcare, or poverty” (Lightfoot, McCleary, & Lum, 2014, p. 59). By focusing on the strengths already existing within the community, the people in the community can be empowered and can develop a sense of healthcare self-efficacy.

Following the creation of the healthcare resources database, our second objective was to better understand the health needs and barriers to accessing available community resources through focus groups. As the U.S. is home for many first-generation Slavic immigrants, we thought that data gathered from this population could provide a unique perspective on the health interests and needs that currently may or may not be addressed locally and more broadly.

The long-term aim of this study is to connect immigrant patients with resources needed to make a positive change in these residents’ health, well-being, and self-efficacy.

Methods

Participants

Members of a primarily first-generation Slavic church were invited to participate in focus groups. Three different dates were announced, and church congregants were encouraged to sign up for one of the dates if they were interested in participating. A target of eight to ten participants was set for each of the three focus groups. A total of 19 participants joined the three focus groups with an average of six per focus group. The pastor of the church plus the primary researcher’s neighbor encouraged congregants to participate to give them an opportunity to discuss their perspectives, desires, and concerns. The church was chosen because many first generation Slavic immigrants have a strong faith, making the local church a safe and common location for congregating and sharing information.

Table 1. Demographic Survey Questions Each Participant Answered

Survey Questions – Please answer below
Питання опитування – Дайте, будь ласка, нижче

1. What is your age, in years? _____
Ваш вік, в найближчі роки?
2. Are you male or female (circle one)?
Ви чоловік або жінка?
a. Male (чоловік)
b. Female (чоловік)
3. What is the highest level of education you have completed (circle one)?
Який найвищий рівень освіти Ви закінчили?
a. Less than high school
(Менш середньої школи)
b. High school graduate (середнє)
c. Some college (гр. середньо-технічна)
d. College graduate (випускник коледжу)
e. Post-graduate degree
(ступінь фундаментальну наукову)
4. In what year did you move to the United States? _____
В якому році ви переїхали до Сполучених Штатів?
5. How good would you say your spoken English is (circle one)?
Як добре ви сказали б ваш курси розмовної англійської мови є?
a. Very good (Дуже добре)
b. Good (добре)
c. Fair (гр. ярмарок)
d. Poor (бідних)
6. How good would you say your written English is (circle one)?
Як добре ви сказали б ваш письмову англійську мову?
a. Very good (Дуже добре)
b. Good (добре)
c. Fair (гр. ярмарок)
d. Poor (бідних)
7. How would you rate your overall health?
Як би ви оцінили ваш загальний стан здоров'я?
a. Very good (Дуже добре)
b. Good (добре)
c. Fair (гр. ярмарок)
d. Poor (бідних)

Table 2. Discussion Questions Presented to Each Focus Group

The following questions will be asked for discussion.
Наступні питання будуть задані для обговорення.

1. What does being healthy mean to you?
How do you know you're healthy?
Що означає бути здоровим для вас означає?
Як ви знаєте, ви здорові?
2. How would you compare your definition of health to other Americans?
Як би ви порівняли ваше визначення здоров'я для інших американців?
3. What are some health concerns of Ukrainian-Americans living in Goshen?
Які проблеми зі здоров'ям українських американців, що живуть в Гошен?
4. How do you get information about health-related issues?
Як отримати інформацію про проблеми, пов'язані зі здоров'ям?
5. What is your opinion of the community resources providing healthcare support or preventive services to residents of Goshen?
Яка ваша думка про ресурсах спільноти, які надають підтримку медичних або профілактичних послуг жителям Гошен?
6. What healthcare community resources are you aware of in the Goshen area?
Які медичні ресурси громади вам відомі в області Гошен?
7. Have you ever used any of those healthcare community resources?
Ви коли-небудь використовували будь-який з цих медичних ресурсів спільноти?
8. Why/why not?
Чому / чому ні?
9. What resources would you be interested in having available?
Які ресурси ви були б зацікавлені в тому, щоб доступно?
10. How likely are you to go to an English-speaking community resource?
Як ви, ймовірно, ви піти на англійській мові спільноти ресурсів?
11. How likely would you be to go to a healthcare resource if the time, location, and topic was of interest to you?
Як ви, ймовірно, буде йти до ресурсу охорони здоров'я, якщо час, місце і тема для вас інтерес?

Measures

This project was a mixed-methods case study with a heavy focus on qualitative data. Data gathering in focus groups began with a brief paper survey to capture basic demographic information, such as age, years lived in the U.S., and comfort levels with reading and speaking English (see Table 1 for a complete list of survey questions). The survey was in English with a Google-translated version following in Russian. The appropriateness of the questions and the accuracy of the translation was reviewed and approved by a first-generation Slavic-American (the first author's neighbor).

Qualitative data was then acquired by facilitating open-ended and in-depth discussion with Slavic-American residents focusing on: awareness of community healthcare resources, needs for resources, health concerns, and barriers to accessing healthcare resources in the community. These open-ended questions were also written in English and Russian and approved for appropriateness and translation accuracy (again, by the first author's neighbor; see Table 2 for a complete list of focus group questions). While the focus group sessions were held in spoken English with participants who were only fairly comfortable speaking

English, the language barrier was mitigated by having the questions written in both English and Russian. In addition, some participants were fluent in English and were able to help with translation when appropriate.

Procedures

Data collection occurred via three focus groups. Focus groups can be successful with minority populations for several reasons. First, the researcher can learn from the interaction between the participants. Also, the interviewees are likely to be more open and share thoughts with others from the same background and can build trust in discussing health topics. In addition, people are typically more comfortable around peers (Quintanilha et al., 2016). Therefore, every effort was made to ensure that the focus groups entailed a comfortable and enjoyable open discussion between participants and the researcher. If an interviewee was uncomfortable with any question, he or she was advised not to answer it. It was understood that the primary researcher, not being a part of their cultural group, might raise some suspicion and reluctance, as “researchers have historically encountered challenges to accessing and recruiting those from under-represented groups” (Katigbak et al., 2016, p. 211). By using focus groups with pilot-tested questions, it was hoped that the participants would be more comfortable talking about issues with other people who share their own customs and language. Each focus group was led by the primary researcher with an interpreter available as needed. Pilot-tested questions were asked and discussions easily formed. Participants were excited to share their needs, attitudes, and insights on health care.

The phenomenological method was the basis for the qualitative data collection in this study. Creswell (2003) defines this phenomenology as describing “the meaning of the lived experiences for several individuals about a concept or the phenomenon” (p. 14). The concept under examination was health-related community resources. Focus groups were conducted until saturation of results was achieved. Data saturation—met once no new information or data was being expressed—is imperative for quality and validity (Creswell, 2003).

At the start of the focus groups, it was explained that the goal of the project was to develop a partnership in speaking and listening in order to hear needs and barriers. The aim was to recognize the group as a unit of identity and offer members the

opportunity to be heard. Focus groups were employed as a democratic process between the experts (those being interviewed) and the research techniques used by the researcher. The two parties remain co-owners of the discussion, data, and results.

Each focus group began with reading the consent form, which had also been translated into Russian for participants’ convenience. After reading the consent forms and providing time for questions and answers regarding the focus groups, each participant signed the form. All study procedures were reviewed and approved by the Institutional Review Board at Indiana State University.

Analysis

The results of the focus groups were analyzed using QSR NVivo software, version 11. Using this software, it is possible to organize large quantities of qualitative data for analysis. Themes were brought forth by coding, or labeling, the data. By segmenting the data provided by the participants of the focus groups, relevant themes were discovered and documented.

The quantitative data was analyzed using Microsoft Excel, version 10. Information from the demographic survey was entered, and graphic representations were created for visual displays of the quantitative data.

Findings

Initial Findings from ABCD Community Resource Search

In Goshen, Indiana, where the study took place, there is a wide variety of healthcare resources available. However, minimal resources were available to people who do not speak English or Spanish (see Figure 1). A language category of “N/A” was created for those resources where language was not necessarily needed to use the resource. For

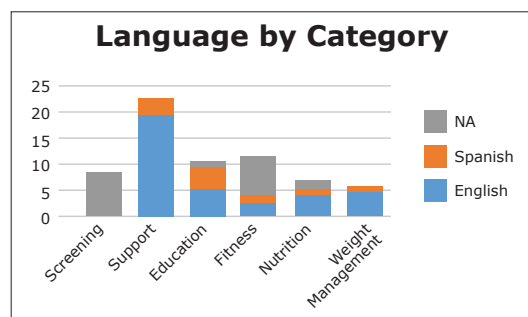


Figure 1. Languages of resources by category. Chart shows resource categories and languages in which these resources are provided in available target area.

example, screening resources are all listed as “N/A” as these include community blood pressure machines in chain retail stores and screenings provided by hospitals, which are required to provide translation upon request. Fitness was also a category with a large number of “N/A” resources, as the city studied has many miles of walking and bicycling trails available to the community for fitness and enjoyment.

Another approach to examining the available resources was to consider what programs were available based on various health conditions (see Figure 2). Educational opportunities most frequently existed for people with diabetes, where, due to the multitude of fitness opportunities with the parks and recreation department, there are a high number of potential opportunities for fitness for all residents.

Findings from Focus Groups

Three separate focus groups were held with representatives from the Slavic population. Data saturation occurred as themes were reoccurring at all events. A total number of 19 participants joined the focus groups and spoke freely about existing healthcare resources in the community, barriers to accessing those resources, and the wants and needs of the Slavic population in regard to health care.

Among the participants (n=19) were 13 women (68.0%) and 6 men (32.0%). Ages of participants ranged from 20 to 77 years of age (M=46, SD=18.5), and the total number of years in the U.S. ranged from 2 to 23 years (M=14, SD=4.8). Table 3 contains other demographic information of the participants.

Analysis of qualitative data showed common themes demonstrating needs, desires, fears, and concerns regarding healthcare community resources (see Figure 3).

Table 3. Results of the Demographic Survey

Variable	Mean (SD) or n(%)
Sex	
Male	6 (32.0%)
Female	13 (68.0%)
Age	46.4 Years (±18.5 years)
Education	
Less than high school	0 (0%)
High school	6 (33.3%)
Some college	4 (22.2%)
College graduate	6 (33.3%)
Post-graduate degree	2 (11.1%)
Years in the United States	13.9 Years (±4.9 years)
Comfort with speaking English	
Very good	6 (31.6%)
Good	3 (15.8%)
Fair	6 (31.6%)
Poor	4 (21.1%)
Comfort with reading English	
Very good	3 (15.8%)
Good	3 (15.8%)
Fair	2 (10.1%)
Poor	9 (47.4%)
Self-rated health	
Very good	5 (26.3%)
Good	9 (47.4%)
Fair	3 (15.8%)
Poor	2 (10.1%)

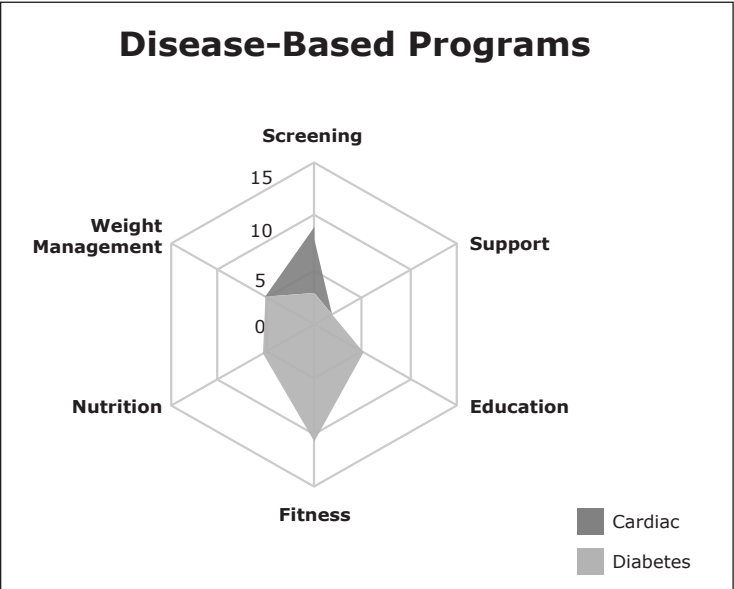


Figure 2. Resource category based on disease. This chart shows disease-based programs for cardiac and diabetic residents. Of the need demonstrated in the Slavic community, screening, weight management, nutrition, and fitness are of minimal want. Support and education are the key areas of need but these resources are the least abundant.

There is a significant lack of education/support groups, especially regarding diabetic and cardiac issues. However, translation services and education in Russian is a need, as even participants with fair to good spoken English skills are more confident speaking in their native language. Participants identified many challenges to their engagement in the medical system in this community. They were uncomfortable accessing emergency services because of a lack of awareness of urgent care services and because of high fees associated with such services. As one participant reported, “Urgent care? We are not aware. We won’t go to emergency because it costs too much.” Another participant similarly expressed that, “Russians and Ukrainians don’t know about urgent cares.”

Health insurance (or lack thereof) also served as a barrier to accessing healthcare resources among the participants. As one participant indicated, “The majority of us don’t have insurance. If it’s required for work, we have it.” Health insurance may be particularly problematic for newer immigrants: “But the Ukrainians who just get here and don’t speak English, they don’t understand. They go without insurance because they think it’s a waste of money. And it is.”

As indicated in the previous quote, cost is also a significant barrier to accessing health care among this population. Both high costs of health care and concerns regarding how exactly to pay those costs were reported. One participant said, “How do bills work? The bills keep coming. The bills come from so many places for one doctor visit. So many things for one visit. There are a lot of hidden fees.” Another

participant indicated that, “We like to pay in cash,” which can be challenging when a bill is delivered later. Some participants were aware that there are lower cost healthcare options, but they were not aware of how to locate or access those options: “What clinics can we go to if we don’t have a doctor, clinics that doctors volunteer at that are less? We don’t know where we can go to see a doctor who is less expensive.”

When discussing needs and desires, participants also focused on education and support in the Russian language. One participant with diabetes stated, “I don’t have education, and I don’t know where to get education. I get insulin at the doctor, but I still don’t know anything about it.” Medicare and Medicaid services are misunderstood, and the Russian-speaking population is in need of education on what is available and how to enroll. Five of the 19 participants were age 65 or older, meaning they are eligible for Medicare. Each focus group revealed questions on which Medicare offering(s), A, B, C, and/or D, participants needed. Furthermore, some were eligible for Medicaid, but unaware of how to go about enrolling in those services.

Aside from needing education and struggling with insurance and payment issues, one specific medical specialty that was discussed often was dental care. The cost of dental care in the U.S. is very high, especially when compared with costs in the Ukraine. According to one participant, “It’s expensive here and it’s hard to find dentists here. It costs one tooth per ticket [back to the Ukraine]. You can buy ticket and go [to the Ukraine] and fix all your teeth as much as you can fix one tooth

[in the U.S.].” In a couple of extreme cases, participants reported pulling their own teeth due to lack of an available, affordable dentist when needed. Again, translation and access are paramount in situations such as these, so no human being is suffering.

Finally, cultural beliefs also affected the Slavic population’s access to health care. The fact that they look to home remedies first keeps the population out of a medical clinic...unless the home remedy doesn’t work. First generation immigrants are used to raising and growing organic food, hard manual labor,

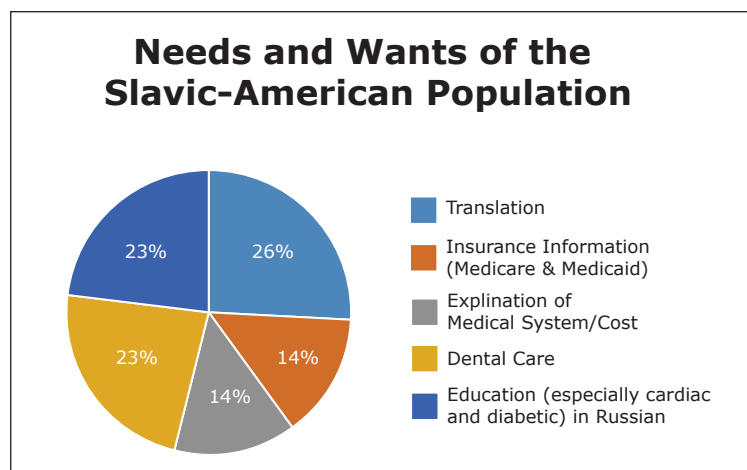


Figure 3. This chart shows the top needs and wants of the Slavic population that participated in the focus groups. Calculations are based on the number of times a participant initiated a discussion in one of these categories.

and a strong spiritual life. Thus, participants deemed some health factors such as dietetics, fitness, mental health, and weight management as not necessary or inappropriate. Preventive care, such as vaccinations and well visits are also not sought out, "...unless it is needed for papers or our job." Thus, the medical system in the U.S. plays a minimal role in Slavic-American life for most immigrants. However, when appropriate, they are in need of an entry point to care, translation, and explanation of payment.

Discussion and Future Directions

This study applied mixed methods to address the questions of what health-related resources were available in a small Midwestern community with a large Ukrainian immigrant population as well as the perceived health-related needs of that population. Findings may inform future efforts to address the healthcare needs of immigrant populations as these groups may be particularly vulnerable to health threats, while simultaneously facing significant barriers to accessing community resources for health. Community-based participatory research (CBPR) principles informed the study design, and asset mapping followed by focus groups was essential to the success of this study.

The Slavic community, contrary to barriers other researchers have encountered when desiring to work with an under-represented group (Katigbak, 2016), was very accessible in this study. A key reason for this accessibility was the first author's personal connection with members of the Slavic community. Others interested in working with immigrant populations should build on personal ties that may evolve outside of a professional context (e.g., health care or research). Forming meaningful connections with community members, relying on the expertise of the target population, and following through on suggestions provided by participants helped to build the necessary relationships for this project. Others should work to build similar connections with members of the target population in future efforts to address the health needs of immigrants. Tinkler (2010) shares a variety of strategies for building successful partnerships as well as identifying issues that disrupt such efforts, noting that a direct connection with the community strengthened a successful partnership (and was lacking in a less successful effort).

Relying on focus groups for data collection provided an outlet for participants to share similar

experiences, reinforce others' thoughts, and build off each other's stories. The lived experiences shared by participants provided the phenomenological foundation and reinforced previous literature that first-generation immigrants can feel isolated as they go through the acculturation process (Benisovich & King, 2003; Katigbak et al., 2016; Martin, 2009). The current project facilitated establishing meaningful relationships, which is the crux of any effort to develop effective community interventions.

The key findings of the current study revealed that the Slavic population has needs and wants in regard to health care, and that they face barriers in obtaining the information they want and need. Barriers facing this population are categorized into two areas: language and financial.

As expressed in both literature (e.g., Larson & McQuiston, 2012) and focus groups, language is the most significant of all barriers immigrant populations face. The language barrier alone identifies the Slavic population in the U.S. as a vulnerable population, meaning that they are "...at increased risk for poor physical, psychological, and social health outcomes and inadequate healthcare" (Derose et al. p. 1,258). Language barriers can delay medical care until a life-threatening event occurs. The survey portion of the current study provided similar evidence that language barriers are obstacles to healthcare access and can negatively affect the health of the Slavic population. Medical clinics and immigrant advocacy groups should be tasked to promote health among immigrant populations and should focus on identifying available translators and educating providers and the public about the mandate that federally funded health organizations are required to provide interpreters at patients' request (Derose et al., 2007).

Finally, the complexity of the U.S.'s managed care system is a hurdle to gaining access to care. As revealed by participants in the current study, misunderstandings of Medicare, Medicare Part D, and Medicaid can prevent or delay access. Multiple questions were brought up in all focus groups as to which Medicare plan was needed and how to obtain Medicaid. With most Slavic immigrants uninsured, except for Medicare when they turn 65 years old, medical care is out of reach financially for many members of this population. The participants deemed commercial health insurance as an unnecessary waste of money. A few immigrants did have commercial insurance

through employers but, "...immigrants have poor access to medical care, even when they are insured" (Migration Policy Institute, 2013, p. 7) as, per the focus group, they are unaware of the process of seeing a clinician especially due to language barriers. Interventions to address this barrier to healthcare access might incorporate trained volunteer community health workers, as suggested by Meyer et al., (2013). Helping immigrants understand what resources are available (both free of charge and on a fee basis), as well as benefits of and sources for procuring health care, may help immigrants increase access of healthcare resources. Furthermore, these volunteers might be trained through the Centers for Medicare and Medicaid Services' National Training Program (n.d.), which helps people "better understand and educate others about Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the federally facilitated health insurance marketplace" (para. 2).

McClelland, Ingram, Caballero, Garcia, & McCarville, (2011) developed a toolkit (vetted through Community Partnerships for Health) to support immigrant women accessing available resources in their communities. While that project focused on women experiencing domestic violence, the lessons learned may apply to immigrants seeking to access healthcare resources as well. The McLelland group recommends as a first step that community agencies be familiarized with the needs of immigrants, and that all relevant agencies be identified and brought into efforts to meet the target population's needs. They then recommend that referral roles and responsibilities be identified and that trainings be implemented to coordinate community efforts. Also, efforts to address the needs and wants of immigrants related to accessing health care might follow a similar path of familiarizing providers with immigrants' needs, identifying relevant agencies (as was done here through ABCD asset mapping), then establishing referral protocols and coordinating agency efforts.

The Slavic community is a close-knit and faith-based community. Information of interest to the community will spread via word of mouth, as did the request for focus group participants. This community is a hard-working and thriving group of people who come from a background much different than most other U.S. citizens. This community comes from a land of conflict, tension, and war. They enrich the U.S. landscape, though their quiet lifestyle might go unnoticed. It is, therefore, the duty and privilege of communities in the

U.S. to make sure this population's needs and wants do not go unnoticed, and that action be taken in order to accommodate their healthcare wants and needs. Education is the simplest action a community can do, once the need has been identified, as in the current study, to promote health, healthy lifestyles, and medical coverage. By supporting these basic human rights, communities will be healthier and more productive, and self-efficacy will be a norm of all of the citizens.

As with all research efforts, there were both strengths and weaknesses associated with the current study. Some of the strengths included the full involvement of the focus group participants. They were open and appreciative to have someone, even an outsider, care enough to want to listen and help with their health care. The participants and translation assistant were tremendous assets to make sure that participants' stories were heard and understood. Weaknesses of the study included the limited number of participants who were able to join the focus groups. Although saturation of data was achieved, everyone has a different story. More personal stories may have further strengthened the identification of the needs of this community. Another weakness was that the primary researcher did not speak Russian. Although excellent translation was provided, there remains a gap in understanding of the feelings and nuances of the participants' stories.

In conclusion, this study lays the groundwork for addressing the healthcare needs and wants of the Slavic population in Goshen. Moving forward, CBPR practices may be best suited to addressing the needs identified through the current study. CBPR can reduce disparities to health care by meshing the invaluable first-hand information of the population with the knowledge and guidance of a researcher. The spokespeople from the population and the researcher become partners while identifying key challenges as they learned from each other with the common goal of reducing healthcare disparities. The information gleaned through this study can be used as researchers and members of the Slavic population work together to develop and implement strategies to improve access to and utilization of community healthcare resources for Slavic immigrants.

Development of a solid, evidence-based set of community resources and services along with volunteer community health workers would be assets to immigrants and the communities in which they live and work (both the county in

which the current study was conducted and beyond). Although some areas of needs, such as dentistry and cost of dental health, are not going to be remedied by this study, it does underscore the importance of future advocacy efforts for immigrants. The needs and wants were stated and validated through three focus groups, and the resources are available. Once the educational and language barriers between the needs and wants are addressed and a bridge to the existing resources is built, a healthier community can be achieved with this population, whose members quietly co-exist in the community.

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