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Impact of a Case Management Program On Immigrants' Health Status and Access to Care

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Executive Summary

Problem. Immigrants are among the fastest growing populations in the United States (U.S.). Today, they comprise approximately eleven percent of the total U.S. population. Approximately forty-three percent of them are without health insurance. Reports also show higher numbers of untreated medical conditions, fewer interactions with the health care system, and receipt of health care services through emergency departments (ED). Essentially, there are increases in costs of care, changes from preventive care to emergency treatment, delays identifying illnesses until later, and increase the level of disease within the community. A case manager frequently faced with immigrants' concerns regarding access to care, and poor health status responded to these issues by implementing a community health program. The evidenced based practice question about population, intervention, comparison, and outcome was: Do immigrants who receive case management interventions have better access to care and improved health status than those who have no case management interventions was formulated?

Purpose. The purpose of the study was to evaluate the effects of a case management program to a group of immigrants served at the Immigration Outreach Service Center (IOSC).

Goal (s). The goal of the study was to establish findings that would help establish a program that would effectively help immigrants demonstrate improved health status, have increased access to health care services, and have increased knowledge of disease processes.

Objectives. The study focused on a free health clinic program that: provided health education on disease prevention and access to health care services, provided care to each immigrant and evaluated health services provided to meet their needs. It also reviewed successful care models and partnered with area health care facilities and education programs to develop a collaborative community based health care practice for immigrants seeking health care services.

Plan. A systematic assessment and literature review of immigrants in the U.S. were used to identify the population, health needs interventions and outcomes. Data were obtained from a sample of seventy two immigrants (*N* = 72) served at the IOSC. Participants were eighteen years and above, uninsured, and immigrants. All participants signed an informed consent, then completed health questionnaires that included self-reports of overall health status, access to care, and well-being; The Ryff and Reyes Scale of Psychological Well-Being measured their well-being. The logic model and The Public Health Nursing Practice Model were utilized as a guide to reach the intended outcomes. The study involved completion and approval of the Institutional Review Board application. The reliability and validity of all scales was measured in the study. The quantitative, comparison group, post-test design analyzed the measure of health care access and health status. Descriptive analyses of averages and percentages were used to characterize the study participants. Statistical Package for the Social Sciences software was utilized to organize, search, and retrieve the collected data.

Outcomes and results. During the initial visit, participants reported higher incidence of being uninsured, poor health status, and lack of health services. After being case managed, subjects reported reduced number of visits to the ED, improved functional status and quality of life, and increased knowledge of disease. Immigrants who received case management services were four times more likely to have access to health care services, with decreased health problems and reported improvement in health status than immigrants who did not receive any services.

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Problem Recognition and Definition

Problem Statement

The United States (U.S.) is a diverse nation with a complicated health care system. According to the U.S. Census Bureau (2010), the population of the U.S. grew by nine percent between 2000 and 2010 and has continued to increase in diversity at a greater rate. Immigrants are among the fastest growing of all communities in the country. Today, they comprise approximately eleven percent of the total U.S. population (Humes, Jones, & Ramirez, 2011).

The recent population changes are associated with continued inquiries as to whether these numbers contribute in any way to the crisis that the U.S. health care system is facing. One of the arguments is that data on health status point to the fact that there is significant evidence of poor health outcomes among immigrant populations with respect to premature death and preventable diseases (Lundy & Janes, 2001). This is probably due to poor access to health services. Access to care is defined as “the timely use of personal health services to achieve the best health outcomes” (Agency for Healthcare Research and Quality [AHRQ], 2011, p. 26). Access to health care has a significant effect on health disparities. There is substantial evidence that access to the health care system varies by socioeconomic factors and geographic location. Individuals with limited or no access to care (uninsured and underinsured people and those without a usual source of care) experience poor health outcomes, as well as worse quality of care (AHRQ).

Statement of Purpose

At the Immigration Outreach Service Center (IOSC), a study was implemented by a Regis University Doctorate in Nursing Practice (DNP) student for the purpose of examining disparities in care related to insurance status, usual source of care, and barriers to health care. In addition, this study evaluated the impact of case management services offered to a group of immigrants from various parts of the world who were seeking immigration services at the IOSC.

Purpose of the Project

Immigrants share common risk factors that impact their health outcomes. According to the World Health Organization (WHO), health is “a state of complete physical, mental, and social well-being (Lundy & Janes, 2001, p. 7). An article by McDowell (2010) indicated that “Well-being [has become a common focus for outcome measures] as it reflects the expanded goals of treatment, from medical treatment toward broader health care” (p. 69). Well-being refers to “contentment, satisfaction, or happiness derived from optimal functioning” (McDowell, p. 69). Evidently the state of well-being was lacking in this particular group. Therefore, the purpose of the project was to launch an evidence based program that explored for interventions that establish missing well-being.

Population, Intervention, Comparison, and Outcome

A review of the IOSC population revealed that the organization serves a group of immigrants who come from over thirty countries outside of the U.S. (IOSC, 2011). Most of them come to the center to seek “the tools and resources necessary to improve their quality of life and adjustment in the community” (IOSC). Having recognized a population with multiple health needs, the investigator established an evidence-based practice (EBP) that closely observed and determined the effects of receiving or not receiving the services. A group of immigrants receiving case management services were compared to a group of immigrants who were not receiving case management services to evaluate the impact of the program to their health status and wellbeing. These addressed the question that read as follows: Do immigrants who receive case management services have better access to care and improved health status than those who have no case management services? Utilizing the PICO (Houser & Oman, 2011) format, the key elements of the questions were identified as follows:

P (which stands for population) was represented by a group of low income, uninsured, or underinsured immigrants.

I (which stands for intervention) represented those individuals who received case management services.

C (which stands for comparison) represented those individuals who did receive any case management services.

O (which stands for outcome) represented improved health status and increased access to care.

Project Significance, Scope, and Rationale

The decision to implement the project was influenced by several factors that included the clinical expertise and experience of the investigator, the need of the community, and also the need to establish a program that promoted quality, cost efficient care. The investigator, who worked as a case manager at a local hospital for many years, had encountered increasing numbers of immigrants who were utilizing the emergency rooms for their health care instead of visiting a health provider due to issues such as lack of health insurance. Eventually it became unbearable for the investigator to continue ignoring the constant queries as to whether the immigrants were associated with the failing health care system; she took the initiative to participate in finding answers to the existing problem.

In addition, poor health care outcomes and demand for providers who play a role in designing, implementing, evaluating, and ensuring that the services provided contributed to better outcomes (Kane & Radosevich, 2011) influenced the investigator to execute the project. Finally in meeting the consumers’ demand for quality care, there was need to evaluate whether utilizing EBP ensured sound and quality care. Allison (2004) stated that EBP is “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (p. 62).

Further literature review indicated that in implementing the EBP process, it is crucial that the clinician with the appropriate expertise is utilized (Houser & Oman, 2011). Despite the fact that different types of health professionals can be involved in health program planning and evaluation, the choice of a clinician who supported and demonstrated a commitment to EBP was a better choice. Throughout the case management practice, the investigator had utilized EBP that had resulted in sound actions and decisions. Also Houser and Oman wrote, “Professional practice requires knowledge of evidence upon which to base interventions that lead to positive, quality outcomes” (p. 246). Therefore, utilization of a DNP clinician and case manager who was educated to apply current best evidence when caring for their patients was more beneficial in completing this study.

Theoretical Framework

During this project, the Public Health Nursing Practice Model (Smith & Bazini-Barakat, 2003) was utilized as it was known to provide a systematic model through which public health nursing is understood and practiced. In the project, the case manager played the role of a public health nurse who needed a framework that encompassed public health values, health determinants, practice priorities, types of interventions, and an understanding of the interplay of these at all levels. Following the values of the model that were interlaced in the circular depiction of the public health nursing process (Smith & Bazini-Barakat), the case manager assessed, diagnosed, planned, implemented, and evaluated all the processes in the project

The model was very appropriate for this project since it showed all the roles of a public health nurse. According to Zaccagnini and White (2011), these roles are highlighted as “an activist, is resourceful, priorities prevention, considers the client as an equal partner” (p. 424). Therefore, when the case management process was placed at the center of the three circles, it surrounded the needs of the individual. Eventually when all the activities collaborated with each other, a common goal or outcome was achieved.

The model also supported the role of a community case manager. The case manager in the project followed the same principles in the model to complete a systematic process that assessed the health needs of the population to identify community needs, current individuals’ knowledge, available resources, agency purpose, and objectives. Then developed a plan of interventions considering the identified needs taking into account the available resources and the range of activities that contributed to health and prevention of illness, disability and premature death (Lundy & Janes, 2001).

The model identified three main concepts of community and public health nursing. These included “an assessment, policy development, and assurance” (Zaccagnini & White, 2011, p. 299). In this particular project, the assessment focused on a community that was suffering from increased number of immigrants with limited access to health care and poor health status. As the project continued, the changes were made by carefully making sure that they were evidence and community based. Finally, the case management program assured that access existed for essential services and personnel were available to provide the services. Appendix C summarizes all the concepts and activities of the model.

Review of Evidence

Background of the Problem

The number of immigrants in the U. S. continued to increase at a fast pace. According to a report by The Urban Institute (Capps, Passel, Perez-Lopez, & Fix, 2003), by 2000, the foreign-born population, as measured by the Census, exceeded thirty one million, or about eleven percent of the total U.S. population. It was projected that by 2050, thirty percent of the population would be foreign-born (U.S. Census Bureau, 2004). The recent trend was that states and communities that had seen few immigrants as recently as 1990 were now welcoming new arrivals in exceedingly high volumes (Altarum Institute, 2011). Such increases were usually associated with poor health status, which became a big concern especially for health care leaders who know the impact associated with such health problems.

According to Federation for American Immigration Reform ([FAIR], 2009), immigrants were of greatest consequence because they were responsible for a disproportionate share of serious public health problems, were living in the community for extended periods of time, and often were dependent on U.S. health care services**.** A report by the Altarum Institute (2011) supported this argument by indicating that immigrants of all ages often have worse health status than other individuals in similar economic circumstances.

In addition to poor health status, immigrants were also more likely to face barriers to accessing healthcare than the citizen population (Lundy & Janes, 2001). These barriers included lack of adequate health care insurance, inability to pay for services, language and cultural barriers, no transportation, inconvenient hours to attend clinics or health centers, difficulty finding providers who speak their language and provide culturally-sensitive care, as well as ineligibility for many government-sponsored programs (Lundy & Janes).

It was possible that such barriers were the causes of poor health outcomes. Such outcomes were usually reflected in individuals with incidences of health disparities. Some of the health disparities that were identified by the investigator at the IOSC included lack of health insurance, poor access to care, and higher prevalence and incidence of chronic diseases. Also, literature review indicated that Federal laws generally bar undocumented immigrants from qualifying to programs such as Medicaid and Medicare (Kaiser Commission on Medicaid and the Uninsured, 2011).

As a result of these factors, it is essential for individuals, especially leaders in health care, to form partnerships and create innovative mechanisms that enhance health planning for immigrants and increase community capacity to meet the multiple needs of the immigrant community (Altarum Institute, 2011). One of the ways to take part in unraveling this puzzle is by looking at the disparities that exist among such individuals. Causes of health disparity among the immigrants are discussed in the next few paragraphs.

Causes of Health Disparity

After thorough review of literature from several sources, it was evident that for Americans with good access to health care it was easier to benefit from the nation’s health care system. Unfortunately, others faced barriers that made it difficult to obtain basic health care services. A report by the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services ([AHQR], 2006) indicated that racial and ethnic minorities and people of low socioeconomic status (SES) were disproportionately represented among those with access problems. Health insurance was the most significant contributing factor to poor quality of care for some of the core measures, and many were not improving (AHQR). Uninsured people were less likely to get recommended care for disease prevention, such as cancer screening, dental care, counseling about diet and exercise, and flu vaccination. They also were less likely to get recommended care for disease management, such as diabetes care management. Poor access to health care came at both a personal and societal cost. For example, if people did not receive vaccinations, they might become ill and spread disease to others. This increased the burden of disease for society overall in addition to the burden borne individually (AHQR). The main disparities identified during the project were briefly discussed in the next few paragraphs.

Lack of health insurance. Issues such as lack of health insurance made a real difference in when, where, and whether a person got health care when they need it. Largely due to their higher uninsured rate, non-citizens were much less likely than citizens to have a usual source of care, to have had any recent contact with a health professional, or to have received preventive or primary care (Henry J. Kaiser Family Foundation, 2011).

A population-based study of immigrants and health care that was completed by the Henry J. Kaiser Family Foundation (2011) indicated that immigrants and their children were less likely to have health insurance and a regular source of care and had lower use of health care resources than the U.S. born citizens. Inadequate access and poor quality care for immigrants could have serious consequences for their health and that of the United States' population (Henry J. Kaiser Family Foundation).

Community isolation. Conversation held by the investigator noted that when immigrants arrived to the U.S., they often expressed feeling isolated with few friends and little social support from the community. They also voiced having little or no understanding of the healthcare and social service system in the U.S. A report by the Henry J. Kaiser Family Foundation (2011) indicated that economic, linguistic, and cultural barriers played a big role on accessing needed health services. Furthermore, access to health and social services was difficult for immigrants because of adverse health policies and fragmented service delivery systems.

Lack of community providers. In most cases, health and social service providers who deliver essential services for immigrant families were difficult to locate. Immigrant health issues were mostly those of a young population with preventable or curable health problems if provided with early detection, health education, and access to primary care and social services (Henry J. Kaiser Family Foundation, 2011). The health issues experienced by such a group were representative of what is happening in various parts of the world. According to WHO (2008), "At the turn of the century the world faced a stark reality, millions were getting sick and dying from diseases such as tuberculosis, malaria, measles, diarrheal diseases and respiratory infections" (p. 2).

Environmental factors. Immigrants resided in resource-depleted environments which made them face multiple risks associated with chronic stressors such as frustrations over employment options, inadequate and unsafe housing conditions, repeated exposure to violence and crime, inadequate child care assistance, and insensitive attitudes of health and social service agencies (Lundy & Janes, 2001).

Barriers to Care and Role of Case Manager

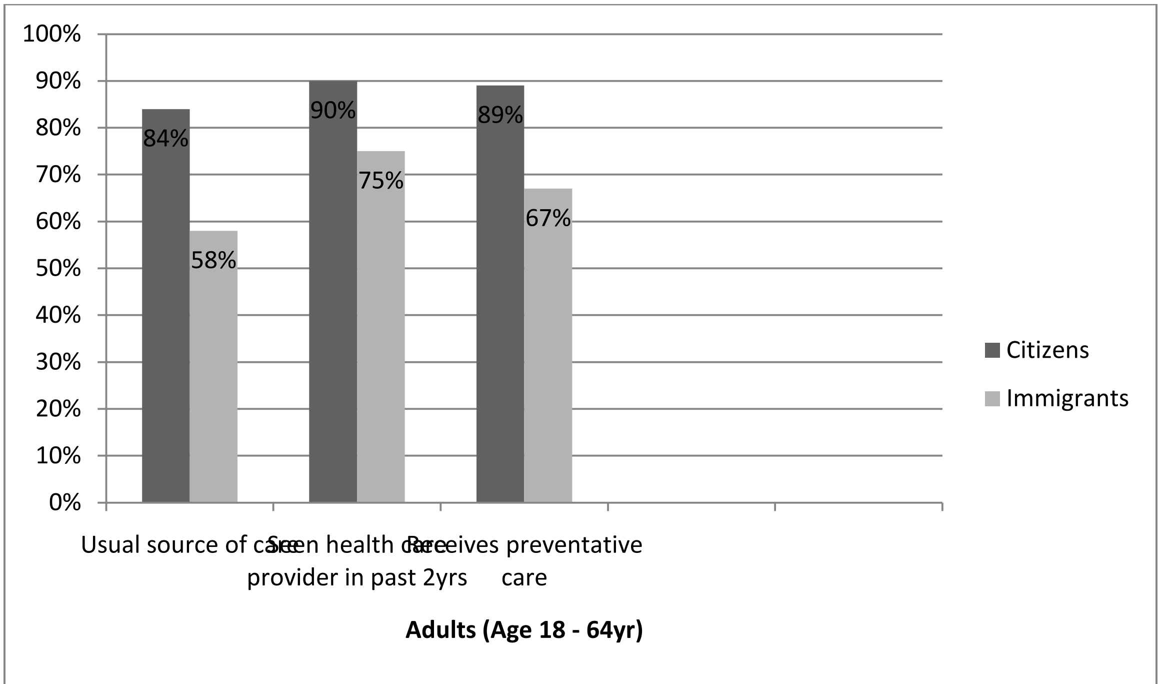
Overall, there were many barriers to care that kept large numbers of immigrants from accessing the healthcare system. As indicated in the discussion above, these barriers have a basis in finance, culture/language, and fear (Lundy & Janes, 2001). However, for the undocumented immigrant in particular, these barriers could seem even more overwhelming. Therefore, providers such as case managers with the appropriate training on such issues should be utilized. In addition to recognizing the barriers that impede access to care, it is also essential for the case managers to understand the fears that drive this population. This crucial step allows careful planning and effective coordination of patient care. Unfortunately, literature indicated that immigrants had a hard time getting access to such providers. In addition, these immigrants were less likely to have a regular source of primary care and were less likely to receive preventive care (Migration Policy Institute, 2011).

Systematic Review of the Literature

Data utilized in the study was retrieved from various sources including previous studies and surveys, medical journals, and databases that addressed health issues affecting immigrants in the U.S. The investigator focused on issues that affected immigrant's health status and access to care. Even though there were numerous sources from which to choose, the investigator narrowed the search to sources that were less than ten years old, avoided any political debates, and paid more focus to the adult population. All sources were carefully analyzed, including data type, sample design, and primary content. Appendix A gives a detailed summary of at least thirty of the journals, books, studies, and articles that were reviewed by the investigator.

Of the thirty articles that were reviewed, it was clear that the number of people without insurance in the U.S. was increasing. Compared to the citizens, the immigrants represented a higher percentage within the population of uninsured persons. According to Footracer (2009), immigrants represented 43.8% of the uninsured. The review also showed a difference in the way immigrants and native-born utilized health care resources. In general, immigrants had less interaction with the health care system than the citizens. Figure 1 shows a brief comparison of health care access among immigrants and citizens.

Figure 1



Source: Henry J. Kaiser Family Foundation (2011)

The Loch Raven and Woodbourne communities (location of the study) encountered a significant number of immigrants who came to the U.S. for various reasons including school or work. A review done by the investigator recognized that 81.3% of the population in these communities was minorities and 3.5% were foreign-born (U.S. Census Bureau, 2010). Immigrants were classified as “a group at increased risk for poor physical, psychological, and social health outcomes and inadequate health care” (U. S. Department of Health and Human Services, 2012, p.?).

A study conducted at the University of North Texas Health Science Center at Fort Worth, School of Public Health (Marshall, Urrutia-Rojas, Mas, and Coggin, 2005) reported that undocumented women were less likely to report having health insurance and a regular health care provider and reported lower education and income. These results supported the need for providing immigrant women with health services such as health fairs, affordable health insurance programs, community health services, and increased opportunities for participation in federal and state programs (Marshall et al).

The review also indicated that immigrants who received or had adequate access to health services seemed to have better health outcomes than those who did not have access to health care services. The situation could be corrected by increasing access to and use of evidence-based preventive services. Providing clinical preventive services prevented illness by detecting early warning signs or symptoms before they developed into a disease, and helped to detect a disease at an earlier, and often more treatable, stage (U. S. Department of Health and Human Services, 2012).

Another interesting finding was that most immigrants, at least those who came to the U.S. at a young age, are relatively healthy and often experienced better health outcomes, including lower mortality, than their U. S.-born counterparts (U. S. Department of Health and Human Services, 2012). However, over a period of time, the immigrants' health appeared to deteriorate with increasing cultural behavior, and with poor health indicators than those of native-born populations (U. S. Department of Health and Human Services). Several factors may account for this, including adoption of unhealthy habits, living in unhealthy environments, and regression to the mean of a group that had better-than-average health upon arrival to the U. S. However, the most common factor was poor access to care. This included reduced access to both personal medical services and public health services and programs such as immunizations programs (U. S. Department of Health and Human Services).

Poor access to care was associated with immigrants and their children facing serious implications to their health, and ultimately, for the health of the nation. According to a Healthy

People 2020 report, “Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone” (U. S. Department of Health and Human Services, 2012, p.?). Literature indicated that lack of access to health care impacted the overall physical, social, and mental health status, prevention of disease and disability, detection and treatment of health conditions, quality of life, preventable death, and life expectancy (U. S. Department of Health and Human Services).

Project Plan and Evaluation

Market/Risk Analyses

Moving on with implementing a new program, it was crucial to conduct an assessment of the organization’s performance. McNamara (2011) suggested that the use of tools such as comprehensive questionnaires, strengths, weaknesses, opportunities, and threats (SWOT) analysis, diagnostic models and the like, along with results to various best practices or industry standards make this assessment more complete. Therefore, the following section gives an analysis of the U.S. health care system and the IOSC case management program.

Health care industry in the United States description and outlook. During the planning phase of the program, the organization took a close look at the health care industry as a whole to include the types of care, payments, and organizations and individuals served so that the organization could choose and establish quality, personalized, high-value care needed by the clients. According to Lundy and Janes (2001), the health care delivery system refered to a multilevel industry that transforms various resources into essential services designed to meet the health care needs of a population. The health care system has changed drastically in the last 200 years. Prior to the 1850s, families took care of the ill and disabled at home with physicians making visits as needed. Treatment involved herbs and comfort measures. Medical knowledge was limited, and most medical practitioners in the U.S. lacked a standardized education. Few hospitals that existed served indigent clients. After this period came the years between 1850 and 1930 where significant gains in medical knowledge occurred. Technological advances necessitated an increase in the number of hospitals and nurses. These increased the number of surgical procedures and treatment of disease. Then between the 1930s and the 1980s, health care became more organized. Insurance became available, so people were more likely to go to hospitals for care. Finally, from the 1980s to the present, soaring costs resulted in reorganization, restructuring, reallocation of scarce resources, and difficult ethical decisions (Lundy & Janes).

The healthcare industry is made up of about 595,800 establishments (Bureau of Labor Statistics, U.S. Department of Labor [BLS], 2010). According to the BLS, despite the fact that there were advances in technology and increases in health care costs, compared to other countries in the world the clinical outcomes were not always better. The United States paid roughly twice as much per capita for health care as Canada, France, and the United Kingdom, yet experienced slightly lower life expectancy than those countries and significantly higher infant mortality (BLS).

The IOSC is a part of and shared some similarities with the U.S. health care system. The center serves a group of immigrants who are usually uninsured, underinsured, or underserved. They represent forty-three percent of noncitizens under 65 who have no health insurance. In addition, they include the 9.4 million uninsured immigrants, a majority of whom are in the country illegally. In most cases, the cost of the medical care of these uninsured immigrants was passed onto the taxpayer, and strained the financial stability of the health care community (FAIR, 2009).

A common trend among this particular group was the use of hospital and emergency services rather than preventative medical care. As a result, the costs of medical care for immigrants were staggering. For example, in California, the estimated cost of unreimbursed medical care was about $1.4 billion per year in 2004. In Texas, the estimated cost was about $.85 billion, and in Arizona the comparable estimate was $.4 billion per year (FAIR, 2009)**.**

Project Strengths, Weaknesses, Opportunities, Threats

The investigator utilized the SWOT analysis (Brandt et al., 2009) to analyze the organization. According to Brandt et al., SWOT analysis is a method for analyzing a business, its resources, and its environment to develop a strategic plan. It looks at internal strengths, internal weaknesses, opportunities in the external environment, and the threats in the external environment. It assists the organization in setting goals that reinforce and strengthen the facility's mission, vision, and values. The IOSC clinic is not different from any other business as it has its own strengths, weaknesses, opportunities and threats that are discussed in the next section.

Strengths. The following points were the factors that made the organization more competitive and successful than its competitors in an ever changing health care market:

1. In order to establish convenient hours for the providers to see the patients, the center was available to patients every other Thursday, and every first Saturday, and Sunday of every month.
2. Interdisciplinary collaboration of care was provided by a multidisciplinary team of medical doctors, nurses, social workers, educators, a priest, and nuns. The investigator’s professional experience verified that effective case management processes involved continued communication, coordinated service delivery,

comprehensive scope, and client-centered approaches that involved professionals from different disciplines. Therefore, the availability of such an interdisciplinary team made the program, stronger and with better patients' outcomes of care.

3. Accessibility to services remained open to all participants to make sure that all the clients' needs were addressed. The clinic offered multiple health services that included client education, screenings of chronic diseases, providing clients with resources, making referrals, and completing health assessments.
4. Location was a very important aspect in establishing the program. The center was surrounded by various hospitals, nursing homes, pharmacies, and rehabilitation centers. Also, the clients could easily access the center by either using the bus line or driving to the center.
5. Marketing was done through multiple advertisement channels that included the church website; flyers and brochures were utilized. The clinic staff visited common neighborhood meeting places such as the library, supermarkets, schools, and colleges to make community members aware of the services provided at the clinic. The clients usually communicated among themselves regarding the services offered at the clinic.

Weaknesses. Unfortunately, there were certain characteristics that contributed to the downfall of the program. These included the small size of the clinic, limited funding and resources, insufficient practitioners, volunteers and providers to provide care needed, limited working hours, limited diagnostic tools, and lack of services for children.

Threats. Despite the fact that the IOSC clinic portrayed a strong market opportunity, it also experienced a big threat from one of the area clinics known as People Community Health Centers. Just like the IOSC clinic, Peoples Community Health Centers is a non-profit, community based health center that provided comprehensive primary and preventive health care and social services to medically underserved individuals and families regardless of their ability to pay. The center has been in existence since 1970 (Peoples Community Health Centers, 2011). Unlike the IOSC, Peoples Community Health Centers had more services to offer to their clients.

Opportunities. Even though the center had been in existence for only a few months, there were a lot of positive achievements that took place that predicted its success. The investigator associated this success to various factors that included the center's realistic goals and objectives, special attention to the value of the customers, recognition of market trends and competitors, strong marketing strategies, the offering of free services, the continuous increase in number of immigrants, and its relationship with its customers.

Need and Sustainability

By evaluating the needs of the community, available resources, and sustainability, the program was able to find ways to measure their performance in the market and to improve the market share. Some of the findings are discussed in the next section.

Potential market growth, attraction and retention of customers. Most of the clients came from referrals made from the IOSC and the St. Matthews church. The staff personally made contacts with the area libraries, churches, and immigrants' stores to discuss the services offered at the center. Flyers and brochures were distributed in the Loch Raven community and all surrounding immigrants' meeting areas or gatherings. Emails and phone calls were made to the entire IOSC and St. Matthews' directory. In addition, the clinic utilized the IOSC and St. Mathews and other community's websites such as the Diaspora Messenger to advertise their services. The clinic's principles of treating every one with respect, dignity, cultural competence, individualized care, collaborative care, flexibility, and creativity attracted the clients to the clinic. The number of clients seen on a weekly basis continued to increase.

Excellent collaboration with community health providers. Since the clinic is a small nonprofit organization with limited resources, partnership with health care providers was established to ensure that the clients received the care they need. The staff collaborated, coordinated, and communicated with different health care providers in the community to identify and establish scarce health resources. As compared to a health fair that was hosted by the clinic last year, more providers participated in the 2012 health fair. Some of the main providers included Good Samaritan Hospital that is located two miles from the clinic. The hospital's cardiovascular unit supplied the clinic will all the educational materials that addressed issues on heart disease, diabetes, exercise, and nutrition. Maryland General Hospital, located about ten miles from the clinic, was also a big contributor to the health needs of the clinic. The hospital family practice doctors and residents offered free health assessments and primary care to the clients at the center. The Baltimore City Health Department has been a major provider in various areas of care to include: free immunizations, HIV testing, cholesterol testing, free mammograms, and free vision and dental checks. Other providers such as the Giant Pharmacy and Rite Aid have at times helped the clients receive discounted medications and medical equipment.

Stakeholders and Project Team

Clients. The immigrants served at the center were the main stakeholders in the project. The identification of the variables and the outcomes of the project would help determine how their health needs could be eliminated in the future. Additionally, if health providers failed to address the health issues facing the immigrants, it would be likely that the problems with access to care and poor health status would continue to deteriorate. Additionally as the mission of the IOSC was to provide the immigrants, refugees and asylum seekers the tools and resources necessary to improve their quality of life and adjustment in the Baltimore community by ways of organizing social change and collaborating with community based organizations (IOSC, 2011), the project also honored the same mission by focusing on the clients' health needs.

Administrative services. The role of Program Manager (PM) was performed by a DNP student from Regis University. As supported by Zaccagnini and White (2011), "The DNP is in the best position to effect and assess change within the clinical setting" (p. 90). The formal education, experience, and the translation, application, and evaluation of research in practice give the DNP the expert skills to implement change that improves practice and outcomes (Zaccagnini & White). In addition, the PM was a licensed Registered Nurse who worked as a community case manager at a local acute care teaching hospital. Therefore, the advanced clinical skills and knowledge of this candidate was a big contribution to the outcomes of the program.

The PM oversaw and evaluated all the services provided at the center. Other roles included orienting all the providers and volunteers to the IOSC community, evaluating the need for specific training on functions of all staff, and conducting all training sessions. The PM also compiled and developed all the operational manuals, assessment forms, policies, and procedures. During the final stages of the project, the PM established and implemented all the methodologies, evaluation, and analysis tools, completed comprehensive health assessments of all clients, and professionally documented and reported the results as needed. The PM utilized the results of the assessment to determine health care needs and the need for referral to primary care. The PM was also involved in organizing and advertising for health fairs quarterly, seeking partnership from the community providers, searching for grant opportunities, establishing the marketing strategies, and overseeing budgeting and finance processes.

The role of clinical mentor was performed by Dr. Joanna Basuray, a professor at Towson University. Her many years of experience as a community nurse and IOSC board member was a huge contribution to the success of the program. The mentor served as the local preceptor of the DNP student's clinical hours and facilitated access to resources required for the student to complete the program. Other roles included assisting the DNP student in selecting realistic and specific goals that supported the framework and objectives of the Regis University DNP program, guiding the student in development and acquisition of key leadership skills required of the project, meeting with the DNP student on a regular basis and providing feedback accordingly, and facilitating completion of application to practice clinical hours and the capstone project (Kruschke, 2011).

The role of the Capstone Chair was taken by a Regis University professor, Dr. Lora Claywell, who assisted the student to accomplish all the steps of the project such as applying for the Institutional Review Board (IRB) review. In collaboration with Dr. Claywell, other administrative staff such as the course instructors assisted the investigator to address all the components of the capstone project. The student approached the instructors through email and telephone on as needed basis to seek the assistance with course materials needed to complete the assignments.

Clinical services. A case manager was chosen and trained to work with and serve the immigrant population. Since organization was non-profit, the selected individual did not receive any kind of compensation for services provided to the clients. The individual demonstrated culturally competent care and functioned fully and independently as a community nurse. Also, the case manager demonstrated accurate use of the assessment tools chosen for the program and maintained complete confidentially of records on each client seen at the center.

In collaboration with the program manager, the case manager participated in introductory activities to begin relationship and build trust with members of St. Matthew's parish and those from the IOSC. Other activities included conducting comprehensive head to toe assessment of all clients who come seeking health care services, assisting with health screen and education sessions including health fairs offered on a quarterly basis, maintaining records of those who attend the clinic, intervening to meet the client's needs, and documenting results of interventions.

Barbara Metz, a longtime member of this community, continued to serve the role of outreach and service coordinator. Her qualification as a social worker gave her intense knowledge of community services and providers. In collaboration with the program manager, she assured that the needs of the clients were meet more effectively. Her services were compensated by the St. Matthews church. Therefore by utilizing her services, the program saved costs of employing a social worker.

Three local health care physicians agreed to offer free services to the clients. One of the doctors practiced as a general family practice physician at a local hospital. Therefore, he was accustomed to seeing such clients on a daily basis and thus is in a better position to understand and cater to their needs. His services included performing health assessments, writing prescriptions, and performing minor procedures such as incision and drainage. The other two physicians were endocrine doctors also practicing at a local hospital. They offered free endocrine consultations and teachings.

Volunteer services. The center invited both graduate and undergraduate students from Towson University to utilize their clinical skills in a community service learning project. The current theory and clinical expertise brought new skills and energy to the program. The experience gave the program manager the opportunity to incorporate her leadership skills in mentoring and evaluating these students. The students also assisted and participated in a research project performed by the program manager.

Nurses with a variety of clinical backgrounds offered their services on a volunteer basis. Their roles included assisting the program manager and case manager to perform health teachings and services to the clients. The nurses also performed noninvasive procedures such as blood pressure checks and weights. Their qualifications included licensure from Maryland State Board of Nursing and a current driver's license. They also had to pass a criminal background check performed upon entering this community.

Support services. The program utilized the housekeeping and maintenance services of the St. Matthews and IOSC's maintenance personnel to perform general services such as keeping the facility clean and organizing and arranging the chairs and tables.

Cost-Benefit Analysis

In today's cost conscious health care environment, health programs or interventions must prove their economic value as well as their impact on clinical outcomes. According to Santerre and Neun (2007) cost benefit analysis was a tool that can be used to judge the economic value of case management activities. Cost benefit analysis was a method for measuring the net benefit of an intervention in which costs and benefits are both expressed in the same monetary terms (dollars), allowing comparison of different interventions or decision alternatives (Santerre & Neun).

Case management benefits. According to Lundy and Janes (2001), case management was a collaborative process of assessing, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes. The benefits of the IOSC program included the following:

1. Increased participants’ access to care and removed barriers related to health, education and social services through direct services, advocacy, and leadership from the program staff.
2. Mobilized resources to participants. Ensured a match between the available resources and the clients’ needs, making the best use of what was available.
3. Provided free primary and preventive care services.
4. Educated participants on disease processes, available resources, and ways to improve health status.
5. Empowered community members to invest and get involved in their health.
6. Assisted participants in reducing the time it took to obtain a service time through more coordinated scheduling.

Benefits of capstone project. By completing the capstone project, the project facilitator accomplished the following:

1. Identified ways to reduce the use of more expensive interventions to achieve the same expected outcome.
2. Improved the clinician's ability to make choices concerning interventions, based on cost effectiveness and cost utility information provided by the study.
3. Improved the ability to assess the cause of adverse outcomes and inefficient processes, and the degree to which treatments, devices, procedures, and interventions were comparatively effective.

4. Identified ways to eliminate health care delivery service redundancies by improving labor efficiency through enhanced information at the point of care.
5. Redesigned inefficient processes to optimize personnel, space, and materials.
6. Enhanced clinical quality through continuous management of process variation, feedback, group process, ownership, and delivery system coordination.

Case management costs. Costs are usually recognized as direct, indirect, fixed or variable costs (Cleverley, Song, & Cleverley , 2011). These costs are discussed in the next few paragraphs.

Fixed Costs. These were the costs which did not vary but remained constant within a given period of time and a range of activity in spite of the fluctuations in production (Cleverley et al., 2011). Some of its examples included rent, insurance charges, and management salary. Table 1 is an overview of the fixed costs at the IOSC.

Table 1: IOSC Health Clinic’s Fixed Costs

Rent	$20,000.00
Clerical support	$1,200.00
Cleaning services	$300.00
Financial services (banking, accounting fees)	$375.00
Maintenance and technical support	$1,450.00
Legal insurance fees	$500.00
Licensing and registration fees	$100.00
Totals	$23,925.00

Variable Costs. These were the cost which vary directly in proportion with every increase or decrease in the volume of output or production (Cleverley et al., 2011). Table 2 represents some of these costs at the IOSC.

Table 2: IOSC Health Clinic’s Annual Variable Costs

Office supplies; pens, pencils, planners, calculators	$500.00
Transportation	$1,350.00
Refreshments	$600.00
Equipment (BP cuffs, thermometers, gloves, scale)	$10,000.00
Paper goods; cups, plates, balloons, forks, spoons	$500.00
Media; press release, internet, radio shows	$1,500.00
Printing materials and photocopying fees	$2,000.00
Promotional materials	$1,500.00
Totals	$17,950.00

Direct Costs. These were resources utilized in the delivery of a service (Cleverley et al., 2011). In the process of producing services at the IOSC, materials are printed, volunteers are interviewed and if it was not for the company been a nonprofit organization, wages would be paid. Therefore wages and salaries of staff providing the intervention were a direct cost, as are materials or supplies used with clients.

Indirect costs. These were costs incurred on those items which are not directly associated with the delivery of the service (Cleverley et al., 2011). During this project, such costs were generally related with supporting the program. For example the salary of the maintenance man, groundskeepers, and clerical support staff were indirect costs.

In the above discussion, it was clear that the start- up cost for the project was very minimal since most of the services and resources were obtained from its volunteers, sponsors, and stakeholders. Also the clinic did not have a pricing structure since all the services were free. This was one of the ways that the center attracted its customers. Also, since the clinic was run as a non-profit organization, the resources received from the different sponsors or donors helped the clinic offer free services. The overall benefits of implementing the program outweighed the cost of running the program. The program benefited both the individual client as well as the system as a whole by reducing client dependence on funded supports and maximizing independence where possible. Appendix F gives a clear an overview a budget that included the program's expenses and income.

Project Goals

The main goal of the project was that the immigrant population served at the IOSC would demonstrate a better understanding of their health problems, restore balance by properly managing the diseases as evidenced by a 25% decrease in the number of immigrants hospitalized due to preventable illnesses, and increase knowledge and adaptation in their new environments. Therefore by April, 2012 the immigrant population served at the IOSC would:

1. Demonstrate increased trust with the providers as evidenced by willingness of the individuals to discuss their health needs.
2. Have increased number of subjects making follow up visits to the IOSC health clinic or other referral clinics.
3. Demonstrate improved functional health status and self-reported improved well-being and quality of life.
4. Demonstrate a shift in the perception of disease as a terrible thing but as a way to early prevention and treatment.
5. Have increased use of health care facilities and resources provided at the IOSC center.
6. Have improved self-reported knowledge of disease, transmission, prevention and treatment.
7. Have increased access to providers as evidenced by the number of referrals made.

Objectives

To achieve the goals of the program, the team offered counseling, made referrals, and helped the clients with follow-up care and other services designed to assist the clients establish eligibility or programs that provided health assistance. Through a collaborative process, a team of volunteers assessed the needs of the clients then formulated plans on how to facilitate and advocate for options and services to meet individual's health needs through communication and available resources to promote quality, cost-effective outcomes. The program also increased access and removed barriers to health, education and social services through direct services, advocacy, leadership and community development. It also helped mobilize resources to clients, provided primary care, education, and empowered community members to invest and get involved in the client's health needs. Additionally the program ensured a match between the available resources and client's needs, making the best use of the available resources. [I would bullet the objectives as you have done with the goals above. That will make it easier to list the objectives when reporting on the findings.]

Vision and Mission Statements

In meeting the above goals and objectives, the clinic followed the vision to be the program of choice that strived to be recognized as a community program that ensured that immigrants served at the center could access timely and high quality healthcare from a team of experienced and caring staff in a culturally sensitive and fiscally responsible manner.

In achieving this vision, the organization held the mission statement of being the free community-based case management program that was committed to enhancing the health care needs of immigrants served at the IOSC. The program made sure that immigrants accessed quality healthcare by utilizing volunteers and by partnering with providers to provide prevention, education, medication access, case management services, and making specialty referrals as needed. The center offered free health services regardless of the client's capability to pay for the services

Process/Outcomes

The center responded to the needs of the clients by providing preventive and primary care services. The center offered a thorough, well established, systematic, and organized community case management program that provided services directed at reducing the potential for a disease through continuous, coordinated, and comprehensive care. The specific services included counseling, making referrals, helping with follow-up care, and other services designed to assist patients in establishing eligibility for programs that provided financial assistance. Through a collaborative process, a team of volunteers assessed the needs of the clients and then formulated a plan on how to facilitate and advocate for options and services to meet individual's health needs.

Logic Model

In addition to identifying the health problems among the immigrants, a strategic framework for improving immigrant's health status and increase access to care was identified. The framework helped to guide, organize, and coordinate the systematic planning, implementation, and evaluation of the project's efforts (Bordage, 2009). Additionally, successful, professional, and systematic studies called for the strongest planning and evaluation methods that clearly identified the outcomes at the early stages of the project. Early planning and evaluation "provides accountability to the stakeholders, demonstrates quality improvement, demonstrates effectiveness in the population involved in the study, and provides clarity of purpose to the progress" (Zaccagnini & White, 2011, p. 477). Therefore, the next sections discuss the use of the conceptual and theoretical models for development and evaluation of the project.

The Logic Model (W. K. Kellogg Foundation, 2004) was utilized as a road map to the activities needed to accomplish the intended outcome. The systematic and visual representation of the model made it easy to display and explain the relationship of the resources used to run the program, the planned activities, and the results that the investigator intended to achieve. In this study, the model clearly identified the resources that were utilized. These items included the personnel, funds, supplies, equipment, facilities, time, and cost. The availability of the resources was determined by available funding, aggressiveness of the program personnel, support from the stakeholders, and the strength of the project proposal. In this particular project, a grant was submitted to the Rotary Club (an organization that supported the project before), CVS Pharmacy, Towson University, and Regis University. Both universities had service learning grants that supported community service.

Next, the main activities were also highlighted in the model. They helped to support the goals, objectives, and outcomes of the project. During the implementation of the program, the activities included events that took place as well as training and education provided to the staff and volunteers, such as cultural diversity training, data collection processes, and the like. The immediate results were shown as the outputs, such as the number of participants and the hours of service. This was then followed by the intended results of implementing the program. Even though the main outcomes included improved health status and increased access to care, the model also provided a quick visual guide of all the possible outcomes that might have occurred in the study. Appendix B gives a visual display of the model that was developed by the investigator.

Population/Sampling Parameters

The target population was drawn from a group of immigrants served at the IOSC. The clients represented a vulnerable, uninsured, and underinsured population. Most of them did not carry any insurance and did not qualify for any type of public assistance such as Medicare or Medicaid. Further demographical data of this particular group is highlighted in the next few paragraphs.

Gender and age. The project included clients of varying ages, specifically adults eighteen and above. Due to the limited expertise and technology in children services, children under the age of 18 years were not serviced at the center. The children were referred to outside collaborating providers.

Ethnicity. This population was by nature composed of minority groups, primarily classified as black or Asians, originating from over forty-two countries, mostly from Africa and the Caribbean Islands.

Education. Data collected by the DNP student showed that the client's educational background varied. During the health screening sessions, the writer noted that 85% of the clients could read and write, 10% could read but not write, and 5% could neither read nor write. The levels of education varied from those that had no education to those that held degrees in higher levels such as the master's level.

Income. Despite the fact that immigrants spend long hours working, they remain a low-income earning population. The correlation between low income and being an immigrant was not clearly explained in any of the literature that was reviewed by the investigator.

Inclusion/Exclusion Criteria. The case management services were offered to everyone in the group who requested for care at the IOSC, whether or not they were participating in the study. The population that meet the inclusion criteria included everyone who was an immigrant, underinsured or uninsured, and eighteen years and over. Most of the clients who visited the IOSC matched the inclusion criteria. No clients were included in the study who were not immigrant or who were covered by health insurance. An additional exclusion criterion was determined by the capability of the facility to serve the needs of the clients. Therefore, since the facility was not well equipped to serve the needs of children, all the children were excluded from the study.

Recruitment. The case manager invited all clients to participate in the study. Since the IOSC immigration office had an encounter with most of the clients, the team approached the office to recruit any clients seeking health care services. Thus most of the participants were recruited from the IOSC office.

Population/sampling size. Based on the number of days the clinic was open and the number of clients historically seen on a day, the available sample size was approximately 72 clients (*N* = 72). Due to the fact that the clinic saw at least six clients on the Thursday sessions and about 10 clients on Saturday or Sunday visits, with at least two professional who were fully trained for the research project, the team decided to include seventy-two subjects in the study. This allowed the team to complete thorough systematic assessment, interviews, and surveys within the allocated time. All individuals who met inclusion criteria from point of approval of the study to the end in April of 2012 were included in the sample.

Setting

The Thursday sessions were offered at the basement of the IOSC office, while the Saturday and Sunday sessions were offered outside the St. Matthews Church. The IOSC and St. Matthew Church are all located in the same grounds. On certain occasions, the team approached different organizations such as local churches and restaurant in an attempt to reach more immigrants in the community by hosting educational and screening sessions.

EBP Methodology

Variables. Data on the outcome variables, health status, and access to care were obtained from visit records and self-reports scales administered by trained volunteers and the case manager every month during clinic visits or phone contacts. In the study, health status was defined as the impact of disease on patient function as reported by the patient (Rumsfeld, 2002). According to Rumsfeld, health status included patients' symptoms, functional limitation, and quality of life, in which quality of life was the discrepancy between actual and desired function. Therefore the subjects' health status was measured by a case manager by performing an assessment and then rating the individual along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease, and overall health. In addition, the subjects' health status was measured by asking the subjects to report their health perceptions in the domains of interest, such as physical functioning, emotional well-being, pain or discomfort, and overall perception of health. More specifically, the dependent variables included the subject's self-report of reduced number of visits to the emergency room, improved functional status, improved wellbeing, improved quality of life, knowledge of disease, transmission, prevention, and treatments, and the shift in the perception of disease as a terrible thing to a method of early prevention and treatment.

The main independent variable in the study was whether or not the study participants received the case management interventions. The case management program was assessed for number of services, referrals for other services, length of time in the program, increased use of health care facilities and resources provided by the program. The study also gathered a variety of descriptive data that included the client’s demographic data: age, ethnic background, marital status, income, health status, and barriers to access to care. The Ryff and Reyes Scale of Psychological Well-Being ([RPWB], Springer & Hauser, 2003), which showed the clients’ quality of well-being, was another variable assessed in the study.

Levels of Measurement

Nominal measurement. Also known as categorical variables, nominal measurement involved the use of numbers to show the attribute and to classify them into categories (Polit, 2010). In the study, the investigator looked into participants’ race, marital status, gender, or health status. Table 3 shows the nominal-level variable coding that the investigator utilized to identify the different categories assessed in the study.

Table 3: Nominal Measurement Variables

<table>
<tr><th>VARIABLE</th><th colspan="4">CODES</th></tr>
<tr><td>Sex</td><td colspan="2">Female = 1</td><td colspan="2">Male = 2</td></tr>
<tr><td>Group</td><td colspan="2">Experimental = 1</td><td colspan="2">Control = 2</td></tr>
<tr><td>Marital Status</td><td colspan="2">Married = Yes</td><td colspan="2">Unmarried (single, divorced, or widowed) = N0</td></tr>
<tr><td>Health Status</td><td colspan="2">Healthy = Yes</td><td colspan="2">Not Healthy = No</td></tr>
<tr><td>VARIABLE</td><td colspan="4">CODES</td></tr>
<tr><td>Race/Ethnicity</td><td>African = 1</td><td>Asian = 2</td><td>Hispanic = 3</td><td>Other = 4</td></tr>
</table>

Ordinal measurement. Ordinal measurement represented categories that “may have verbal labels such as small, medium, and large” (Polit, 2010, p. 7). The investigator was looking for the participant’s educational and income status; see Table 4.

Table 4: Ordinal Measurement Variables

VARIABLE	CODES			
Education Level	High School Diploma = 1	Some College, no degree = 2	College Degree = 3	Graduate = 4
Annual income	Under $15,000 = 1	$15,000 – 30, 000 = 2	$30,000 - $45,000 = 3	≥ $45,000 = 4

Ratio measurement. For this measure, the study looked at ages of the participants. Participant’s ages were categorized as ages 18 to 34, 35 to 54, 55to 74, and equal to or greater than 75. The study looked at how many participants were within each range. The investigators asked the question how old the clients were and then analyzed the age range of study participants

[This table is not really needed since you thoroughly described in the narrative.]

Interval measurement. Interval measurement provided “information about the magnitude of difference between different numeric values" (Polit, 2010, p. 7). The attributes of psychological well-being were measured in the study. The application of this measurement method was selected based on the fact that the investigator was assessing broad, comprehensive interventions that affect multiple aspects of health-related functions of daily life for a group of individuals (Kane & Radosevich, 2011). Also, the study was looking at the “patient’s perspective of the impact of program on relevant aspects of patient experience" (Kane & Radosevich, p. 87).

Protection of Human Rights Procedure

The Institutional Review Board (IRB) process. During the project, as with many other institutions, the student was required by Regis University to complete a review by an IRB. This included completing an application to the school as well as completing an online training known as the CITI training. After successful completion of the training, the student received a certificate shown in Appendix H. The IOSC board members reviewed the project proposal and approved for the study to take place at the agency.

Application of IRB at the IOSC. At the beginning of the study, the investigator was a novice with the processes involved in the study. Thus she had little or no knowledge of how to complete the IRB process. After reviewing the guidelines set forth by the National Research Act Public Law 99–158 and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (Colt & Mulnard, 2006), the investigator realized that the review was necessary. Since the study was going to be a systematic investigation including research development, testing, and evaluation designed to develop or contribute to general knowledge of human subjects and potentially getting funding or grants by organizations such as the National Institutes of Health (NIH).

Of the identified ethical issues; "autonomy, beneficence, non-maleficence, and justice" (Colt & Mulnard, 2006, p. 1605), during this project the investigator faced several ethical issues that required immediate attention before proceeding with the project. The main ones discussed include obtaining the informed consent and maintaining client's confidentiality.

Informed consent. As expected by the IRB, each participant received an informed consent which showed the agreement and willingness to voluntarily participate in the study based on a full disclosure of what constituted participation in the study and what were the risks and benefits involved in participating in the study. The contents of the consent were simple but included all the required details. Due to language barriers among the subjects, the research team created the consents in English and Spanish languages and also utilized interpreters to make sure that the clients clearly understood the contents of the information been provided. This was a very complex process as some of the subjects misunderstood the information provided and automatically declined to participate in the study.

Participants received a copy of the consent form for their records. Contact information for the researcher and the IRB were located on the consent form. For participants' protection and after the completion of the study, the signed consent forms are planned to be retained for three years in a locked file under the control of the researcher. At the end of three years the consent forms will be shredded. Appendix D-3 shows the informed consent that was utilized during the study.

Confidentiality. Another common issue is that of protecting the client's personal information. As mandated by Health Insurance Portability and Accountability Act ([HIPAA], Wiener & Gilliland, 2011), the project team members took special steps to protect personal identifier information, including getting written permission to share personal information with others. As most of the subjects were illegal immigrants, they were hesitant or scared that their information would be shared with outsiders causing them to experience immigration issues and/or deportation by the Immigration Naturalization Services (INS). Therefore, the investigator had to make sure that the center maintained exclusive restriction of the client's information. If any of the information was to be utilized outside the center, an informed consent had to be obtained. As part of the normal patient record, the health history questionnaire, and the specific health data sheet fell under the regulations governing HIPAA medical documents. Other important issues included safe storage and protection of participant information. The following sections give detailed information of how the two were maintained at the IOSC.

Safe storage/de-identified. The results of the health history, the physical assessment, and the scores on the standardized assessment tools were recorded by the nurse. A chart was compiled on each client and was kept under lock and key. Additionally the targeted/planned enrollment tables for reporting race and ethnicity data for subjects in clinical research were completed. Access to protected individually identifiable health information was limited to the researcher.

Participant protection. To protect the identity of the clients, the participant protection guidelines developed specifically for this study were followed. Each participant was assigned a randomly generated number that could not be traced back to the participant. This master list was kept in a locked and restricted storage area. The master list collected data from the Access to Care/Services survey form, the Health History Questionnaire, and the Specific Health Data sheet. Once the data collection was finished, the master list was destroyed by shredding. Appendix D-2 shows how each participant was assigned a randomly generated number that could not be traced back to the participant.

The Health History Questionnaire shown in Appendix D-5 and the Specific Health Data sheet shown in Appendix D-6 were part of the patient’s treatment (medical) record. Providers were also coded to prevent any possible linkage of participants to the Access to Care/Services survey forms as shown in Appendix D-4. Each provider was assigned a provider number by utilizing the following method:

1. What are the first two initials of your high school's name? ____

2. What day of the month were you born? ____
3. What is the last letter of your first name? ____
4. Combine your responses from 1-3 in order here (e.g., FA19A) : _____ (this is your provider study ID)
5. The provider study ID will then be into the health assessment and survey forms.

Timeframe

The processes of the capstone prone began in September 2010. The first step involved conducting a thorough systematic review of the community's health needs. Although this was an ongoing process, the initial assessment gave the writer an idea of what was lacking in the community of interest. It was with this idea that the writer started to collect resources and approached different organizations to inquire or request participation in the program.

By December, 2010, the writer had approached the IOSC and the clinical preceptor who was willing to work with the DNP to initiate the program. The process was slow at the beginning, but by January 2011, the team had developed the program's goals and objectives. By February 2011, the team had launched their first health teaching and screening session. Despite the fact that the team had tried to launch the services every other Tuesday and Thursday of the month, the sessions were not structured until April 2011 in which after completing a major health fair the team completed their first evaluation.

The evaluation demonstrated to the team that the program was not successful and thus demanded restructuring and more organization. It was at this time that the program manager started a strategic plan for running of the program. This plan involved conducting the organization's performance analysis, developing well established policies and procedures and mission and vision statements, recruiting and training staff/volunteers/ providers, developing new marketing strategies, and looking for funding sources.

Despite the fact that the program had been up and running and heading in the right direction, the DNP forgot that this was an EBP project that required and involved applying for an IRB review. Thus the IRB application was delayed until December 2011, which delayed the collection of data and evaluation of the outcomes. The IOSC IRB approved the student's application in October 2011, while the Regis University IRB approval was delayed until March 2012. The delay in receiving the Regis approval set back the investigator's plan to start the study by January 2012 through April 2012. Instead, the data collection process took place from March 2012 to April 2012, giving the investigator only a month to implement the interventions, collect the data, and complete a thorough analysis of the findings. Appendix E gives a detailed schedule of the events that took place throughout the study.

Instrument Reliability/Validity

As part of a research study, the investigator carefully verified validity, reliability and applicability of the measures used in the study. Therefore, all the methods and tools utilized in the study to measure the expected outcomes were carefully selected and analyzed. For instance, to evaluate the degree of dependability or accuracy of the RPWB scale, the investigator reviewed the ratings of the scale in previous research studies. A study by Ryff as reported by Springer and Hauser (2003) indicated that by utilizing the Cronbach's alpha method "the internal consistency coefficients were quite high (between 0.86 and 0.93) and the test-retest reliability coefficients for a sub sample of the participants over a six week period were also high (0.81-0.88)" (p. 4-5). Therefore, since the reliability coefficients of .80 or higher are more desirable (Polit, 2010), the reliability of the scale was confirmed.

According to various studies, the RPWB scale instrument has frequently been used due to its simplicity and ease of use by multiple clinicians. For example, an analysis of self-administered RPWB data from three major surveys, Midlife in the United States (MIDUS), National Survey of Families and Households II (NSFH), and the Wisconsin Longitudinal Study (WLS), yielded a Cronbach's alpha validity of score of 98% (Springer & Hauser, 2003). The findings of the surveys had strong evidence that RPWB did not have too many factors that could confuse or distract the researchers in collecting and interpreting its data. As with any other self-report assessment, there were limitations of using the scale. Since the subjects were self-reporting their well-being, it was possible that they responded in ways that were socially desirable rather than reveal their actual response to each statement.

In addition, to evaluate the validity of the access to care/services survey, the investigator verbally re-asked several key questions to a group of six volunteers. After a period of fourteen days, the same volunteers were then invited to complete the identical instrument. Statistical analyses of these data were performed to assess the properties of the instrument. The measure of internal consistency was calculated using the Cronbach's alpha on all subscales which ranged between .45 and .81 Measurement of construct validity using the Cronbach's alpha was adequate, with measures of sensitivity, specificity, positive and negative predictive values ranging from moderate to high. Based on these analyses, the team in the study decided to use the shortened version of the instrument originally developed by Ryff (Springer, et al, 2003). Additionally, the investigator was sensitive to the causes of validity and reliability of data in the study by considering some the followings factors:

Establishing a causal relationship. In the study, since one of the groups was receiving the case management and the other was not, selection bias was a big possibility. To avoid the possibility of the positive outcomes of the study been determined by the characteristics of the selected group, strong inclusion and exclusion criteria were utilized to make sure that all subjects were suitable for the study.

Missing data. In the study, informant interviews were utilized. Due to the subjects' language barriers and cultural beliefs, there was possibility that clients could have answered the questions inappropriately since they might have failed to understand the question or might have chosen not to answer the question as it might have jeopardized their cultural beliefs or legal status. For instance, some of the clients declined to reveal their demographics. This could have been the possible cause of inaccurate data or missing information needed to identify the relationship of the variables. Therefore, the team established trust between the interviewers and the subjects early and throughout the study and used a simple questionnaire, The RPWB had a proven record of been simple and yet addressed all components of overall well-being. Also, trained interviewers and interpreters were utilized at all times.

Confounding variable. In the study, there was a chance that variables other than the ones that were compared could have contributed to the outcomes. For instance, the study was excluding children in the study, but there was a possibility that children were the cause of poor health status among the immigrants instead of the adults. The logic model was used to show the immediate results of the study (outputs) such as the number of participants and the hours of service, the intended results of implementing the program (improved health status and increased access to care), and all of the possible outcomes that might occur in the study. The model helped to identify all possible variables, even the ones that were not compared as the causes of the outcomes.

Other measures that were utilized to avoid any validity or reliability issues included thorough review and edit of collected data to eliminate any issues such as researcher’s bias, missed data, or other issues that affect validity and reliability of the data. In further addressing any statistical issues that might threaten validity and reliability of the data, the investigator assessed to see whether the data meet certain assumptions for advanced analyses. For example, the investigator looked for and examined disconfirming, negative, and deviant cases and attempted to provide possible explanations for why the data varied.

Data Collection and Treatment Protocol

Informant interviews. Interviews were conducted on the monthly program visit or telephone contact between March 2012 and April 2012. Trained interviewers conducted the interviews in English and Spanish. On rare occasions in instances that the client did not understand either English or Spanish, volunteer interpreters were utilized. Health care access and use were based on the questions shown on the health status and access to care survey form. These included questions such as during the past one month, how many times did the participant see a health provider. In addition, every client who visited the IOSC, regardless of whether they were participating in the study or not, were interviewed by the nurse who asked questions related to their health history. The community nurse also conducted a head to toe physical assessment including a skin assessment, vision test using a Snellen eye chart, height, and weight. All the information from the assessment was recorded in the specific data form. The choice of utilizing interviews was due to the fact that most of the participants are unable to read and write.

Secondary analysis. Current records were assessed for further details of the participants. For instance, the sign-in sheets were reviewed to analyze clients’ attendance. Also, available records were utilized to review client’s compliance with the treatments and recommended regimens. The collected data was assessed for presence or absence of case management services, whether the clients experienced some connection with a case manager, assessed level of trust, agreement on the goals of treatment, and confidence in the clinician's ability.

In measuring the client's well-being, the RPWB (McDowell, 2011) was utilized. This scale was selected because it clearly and inclusively included the components of psychological well-being as a part of the overall health status. Even though this form came in the long, medium, and short form, due to time constraints the team decided to include twenty of the possible fifty questions included in the medium form. The form consisted of a series of statements reflecting the six areas of psychological well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (McDowell). The same components included in the scale were measured in the study. Respondents were asked to rate statements on a scale of one to six, with one indicating strong disagreement and six indicating strong agreement. In addition to its reliability and validity, the other advantage of using the form was that there was no charge to use it. Appendix D-1 shows the RPWB form utilized in the study.

Choice of statistical test. To analyze the data, the comparison group, post-test only design was utilized. Data was collected from participants as they completed the program as well as from a group of nonparticipants from the sample. The decision to utilize this design was due to the limited numbers of study participants and time to complete the project.

Statistical program. After the study variables were measured, the investigator utilized the most appropriate software known as the Statistical Package for the Social Sciences ([SPSS], Polit, 2010) to analyze the quantitative data. The decision to utilize the software was influenced by the fact that the investigator had utilized the program several times before and was most familiar and confident with how it functioned. The software was utilized to organize, search, and retrieve the collected data. In addition, its use provided more consistent and reproducible analysis and access to analytic methods not available by hand.

Interpretation of results. In the data analysis phase, the quantitative design was utilized. Descriptive statistics (Issel, 2009) were employed to analyze statistics collected from the quantitative data such as categorical variables (age, gender, ethnicity, income, education, and marital status). These included the percentages, averages, and ranges of the data. Simple comparative analyses were conducted to assess the relationship between the receipt of case management services and each health access and status variable.

Analysis documentation. The investigator utilized tables to report the findings. An audit trail was maintained to show documentation of all the analytic decisions. This included memos about insights at different points in the process, the regularly updated coding schemes with definitions and properties described, and analytic decisions made through the process. The goal was to provide sufficient detail so that if another researcher could analyze the same data in the same way, they could essentially come to similar conclusions (Curry, et al., 2009).

Project Findings and Results

The sample included seventy two immigrants served at the IOSC clinic; fifty-two of them were legal immigrants who arrived to the United States between 1986 and 2012, as either students or visitors. The rest of the group was made up of illegal immigrants who either entered the country legally but lost their immigration status when they extended the stay, or had entered the country illegally. There were twenty-nine males and forty three females. There were eighteen participants between the ages of 18 and 34, thirty-two between the ages of 35 and 54, eighteen between the ages of 55 and 74, and only four older than 75 years of age. Using the SPSS, the mean age was 44, and the standard deviation (SD) was 16.18. More than 75% of the group were

African from Kenya and Nigeria, 15% were Hispanic, 5% were Asian, and the other 5% represented other race/ethnic groups from such as Caribbean and European descents. Fifty-one percent of the participants reported that there were still married and 49% were single either through divorce, death of the spouse, or separation. An interesting finding was that some of the participants reported that they were single because their spouses were still residing outside of the United States.

The issue of income was very sensitive for most of the participants. The investigator noticed that most of the participants who were in the country illegally reported that they had no source of income due to the restrictions imposed by the immigration laws that they are not allowed to work. These values were represented by the missing data which was about two percent of the sample. Others refused to answer the question, indicating that this was a very personal matter. For those who agreed to answer this question, 25% reported making under fifteen thousand dollars, 10% reported making between fifteen and thirty thousand dollars, 20% made between thirty and forty-five thousand and 43% reported making at least forty-five thousand dollars or more. The reliability of this information was difficult to verify; the investigator depended on what the participants reported. As compared to other health agencies that require the clients to bring their proof of income, in the IOSC clinic this information was not required of the participants.

The next demographic element was the level of education. Interestingly, a majority of the participants (44%) reported that they had college degree, 30% were currently enrolled in a college, five percent reported having completed graduate studies, and 21% reported having a high school diploma.

In terms of health status in the experiment group, 20 subjects reported that they were healthy and 16 indicated that they were unhealthy. In the control group, 16 subjects reported they were healthy and 20 indicated that they were unhealthy. A two tailed t test for independent groups was used to test the differences in outcome (health status) among immigrants in the experimental and control groups. The t test revealed a small F statistic of .000 and the p value of 1.000 which was greater than the standard (.05). The test revealed a small test statistic of -.935, and a p value of .353 which was greater than the standard of .05. [Null hypotheses are not used in Capstone Projects, PICO statements are used.] The mean difference (--.11111) between the two groups was also small, and the confidence interval (CL:-34802 - .12579) for the mean difference had a negative on one end and a positive on the other. This meant that the mean difference included a zero. Therefore there was no difference in health status between the immigrants in the experimental and control groups (CL:-34802 - .12579).

In terms of well-being, the independent samples t test revealed a small F statistic of 0.366 and a p value of 0.547, greater than the standard (.05). The test statistic of 2.036 was a moderately large score, and the p value was .046. Utilizing means of equal variance assumed, the p value of 0.046 was lower than the standard of 0.05, so it was demonstrated that there was a significant difference between the immigrants in the experimental and control groups (cl: .01472 - .1.42972). Additionally both ends of the confidence interval were positive indicating that immigrants receiving case management services had on average higher levels of well-being than immigrants not receiving case management services.

Results Discussion

After completing the analysis the results, the investigator was surprised to find out that there was no difference between the health status of immigrants in the experiment and control groups. On the other hand, the results indicated that there was a great difference in access to care for immigrants who received case management services compared to those who did not receive those services. The findings were almost similar to the findings the investigator had identified in the literature review. A review of the demographic factors also indicated there was a relationship between the variables and group type. Therefore, when trying to determine the outcome, each of the variables should be analyzed as a possible cause for the outcome. This meant that most of the variables were equally important in identifying the impact of case management on immigrants' health status and access to care.

Limitations, Recommendations, Implications for Change

Due to the nature, behavior, and the characteristics of this population, the investigator encountered numerous limitations such as time, selection bias, availability, and missing data. The biggest problem was the failure of the clients to complete all project assessments. For instance, due to their work schedules, they failed to keep up with the follow-up sessions. Also due to the misunderstanding of the purpose of the project, some clients declined the invitation to participate thus there was lack of full representation of the group, resulting in a possible false outcome. The language barrier that existed among the clients contributed to missing important data from the clients who wanted to provide their personal perceptions but were misunderstood by the investigators. Lack of resources, personnel, and flexible times contributed to limited hours to run the program giving a possible false representation of the program's result. In addition, the IRB approval shortened the data collection time to only a one month period instead of a three month period.

Despite the limitations encountered in the study, the investigator feels that more research is urgently needed to facilitate greater access to health care for immigrants. In order to implement a change for immigrants, effective health care policies and programs should be implemented. This implementation requires an understanding of the specific needs and patterns of health care utilization among this population.

Overcoming barriers to improved health status and increased health care access requires expanding and providing timely services and increasing the number staff that are linguistically and culturally competent of immigrants' health beliefs and practices. In terms of access to care the IOSC study demonstrated that community-based programs rather than hospital-based could be more beneficial since a substantial proportion of immigrants do not enter the health care system regularly. Health care providers serving immigrant communities should work in concert with community groups, as well as with public health, social service, and school systems. For example, health care providers and researchers developed culturally appropriate educational materials and workshops to promote oral health among immigrants served at the IOSC. They discovered through surveys that the population served knew very little about available health services. As another example, when the staff at the IOSC worked with immigrant communities to correct cultural misunderstandings about diseases such as diabetes, hypertension, cancer, HIV and tuberculosis, it lessened the fear of being stigmatized by the disease and increased participation in their care.

Conclusion

In conclusion, in this study the immigrant community was facing a health crisis involving factors such as poor health care access and health status. Also, the lack of health resources or access to care implied that the community health nurses must be involved in implementing and strategizing ways to design appropriate programs that helped to eliminate those barriers. In response to a community health need, the writer implemented a community case management program with the goal of improving the health status, coordination of services, and eventually improving the quality of care for a group immigrants being served at a community based organization.

The writer presented a strong argument that a case management program was the ultimate solution in this community. In collaboration with other health providers and organizations, the DNP who worked as a case manager was identified as key player in facilitating care. Role functions such as assessment, planning, cultural sensitivity, and advocacy empowered the case manager in the efforts to improve access to care and health status while continuing to monitor cost. The market analysis of the IOSC case management program supported the fact the program was beneficial and productive to the identified group, the community, and eventually even the entire U.S. health care system. The study supported this analysis by revealing that there was a significant relationship between access to care and availability of health care interventions or providers. The immigrants who received case management services showed increased access to care than the ones who did not receive the interventions. Surprising, the study did not support the fact that their health status would improve with such interventions.

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Appendix A: Systematic Review of the Literature

Systematic Review Evidence Table					
	1	2	3	4	5
Article Title and Journal	Perceived Quality of Care, Receipt of Preventive Care, and Usual Source of Health Care Among Undocumented and Other Latinos. *Journal of General Internal Medicine*	Differences between immigrant and non-immigrant groups in the use of primary medical care; systematic review. *BMC Health Services Research*	Health status and access to health care of documented and undocumented immigrant Latino women. *Health Care for Women International*	Barriers to health care access in 13 Asian American communities. *American Journal of Health Behavior, 34 (1), 21-30.*	Health care expenditures of immigrants in the United States: a nationally representative analysis. *American Journal of Public Health 95(8), 1431-1438*.
Author/Year	Rodriguez, M., Bustamante, A., & Ang, A., (2009),	Uiters, E., Deville, W., Foets, M., Spreeuwenberg, P. & Groenewegen, P. (2009).	Marshall, K., Urrutia-Rojas, X., Mas, F., & Coggin, C., (2005).	Lee, S., Martinez, G., Ma, G., Hsu, C., Robinson, E., Bawa, J., & Juon, H., (2010).	Mohanty, S., Woolhandler, S., Himmelstein, D., Pati, S., & Carrasquillo, O., Bor, D., (2005).
Database and Keywords	CINAHL; Latinos, immigrants, preventive care	CINAHL; Immigrant, health care	CINAHL; Immigration, Health Care, insurance	CINAHL; access, Asian Americans, underrepresented, qualitative study, health care	CINAHL; Immigration, United States, Health Care Costs. Resource Utilization, Health Services Accessibility
Research Design	Cross-sectional Data	Systematic Review	Cross-sectional Study	Focus group study	Cross sectional study

Study Aim/Purpose	To determine the relationship between nativity/immigration status and self-reported quality of care and preventive care. 2. To assess the impact of a usual source of health care on receipt of preventive care.	A systematic overview of the existing research on differences in primary care utilization between immigrant groups and the majority of the populations.	To examine socio-demographic, migration, health status, and access to health care characteristics of immigrant documented and undocumented Latino women in North Texas.	To obtain and discuss in-depth information on health care use in Asian Americans (AAs).	Comparison of the health care expenditures of immigrants residing in the United States with health care expenditures of US-born persons
Population Studied/Sample Size/Criteria/ Power	4,013 Latino adults; ages ≥ 18 yrs.; US-born Latinos vs. Foreign-born Latino permanent residents and undocumented Latinos	37 original, quantitative, peer-reviewed papers were performed. Also had to have use primary care use, and with immigrant reference	325 Latino adults (ages 18 years of age or older) both male and females, born in a Spanish -speaking country in Fort Worth, Texas.	174 adults from 13 Asian American Communities in Montgomery County, and Maryland	18398 US-born persons and 2843 immigrants.
Methods/Study Appraisal/ Synthesis Methods	Survey; telephone interviews (Computer Assisted Telephone Interviewing) system. Variables; self-reported health care access and quality of care received.	A review of Pub Med, PsycInfo, Cinahl, Sociofile, Web of Science and Current Contents was completed.	Secondary data of a cross-sectional study of Latino adults. Data analysis was done using a SPSS v.11.5.	19 Focus groups, MAX QDA software was used for analyzes of qualitative data. Data collected through a moderator's guide, between May, 2007 and August, 2007.	Focus study of immigrants and non-immigrants

Primary Outcome Measures and Results	37% of undocumented Latinos had the lowest percentages of insurance coverage, 58% had usual source of care, 67% had blood pressure checks, 56% had cholesterol checks, and 76% reported excellent/good care in the past year. Undocumented Latinos reported the highest percentage receiving no health/health-care information from their provider.	Only studies concerning the actual use of primary medical care were included.	Undocumented women were less likely to report having health insurance and a regular health care provider, and reported lower education and income. Variables; language spoken, age, marital status, education attainment, unemployment, income	Financial, physical, communication, and cultural attitudes were four major barriers to accessing health care	Immigrants accounted for $39.5 billion in health care expenditures. After multivariate adjustment, per capita total health care expenditures of immigrants were 55% lower than those of US-born persons ($1139 vs. $2546). Similarly, expenditures for uninsured and publicly insured immigrants were approximately half those of their US-born counterparts. Immigrant children had 74% lower per capita health care expenditures than US-born children. However, ED expenditures were more than 3 times higher for immigrant children than for US-born children.

Author Conclusions/ Implications of Key Findings	1. In this sample, undocumented Latinos were less likely to report receiving health care, and had less quality of care, and more likely to receive no health/health care information from providers. 2. Differences in nativity/immigration status should be taken into consideration when discussing perceived quality of care among Latinos.	There is need for careful design in studies of differences in health care use between immigrant groups and the majority population. Studies concerning differences between immigrant and the majority population in primary health care use performed within the US might be interpreted as a reflection of a weaker primary care system in the US compared to Europe and Canada	There is need to provide immigrant women with health services such as health fairs, affordable health insurance programs, community health services, and increased opportunities for participants in federal and state programs.	Future studies, public health policy, and funding resources should consider including underrepresented AA subgroups and reflect their needs.	Health care expenditures are substantially lower for immigrants than for US-born persons. Our study refutes the assumption that immigrants represent a disproportionate financial burden on the US health care system

Strengths/ Limitations	1. Study focused only on one measure of perceived quality of care. 2. Due to the stigma associated with being undocumented, accuracy and /or reliability response could be adversely impacted. 3. Inclusion of barriers to health-care quality linked only to inability to pay, racial/ethnic background, and ability to speak English.	The studies met the quality indicators identified in the study, gave clear definitions of the variables, excluded bias, adjusted the outcomes as needed, and used the same source population for all immigrant groups.	1. The study was a nonrandom, purposeful sample, and the results may not be representative of the entire immigrant Latino Women population in Fort Worth, Texas, or the United States. 2. All of the data were self-reported and therefore were not collaborated by a medical professional.	Study had to be limited to residents of Montgomery County and Maryland due to the funding source jurisdiction. Possible overrepresentation of populations with stronger social capital than typical community members, thus underestimating the results.	1. The 1998 MEPS did not ask about immigration or citizenship status, therefore the study could not distinguish between naturalized citizens and other immigrant groups. 2. study could not capture health care expenditures outside the United States, where some immigrants may travel to obtain care or prescription drugs
Funding Source	Supported by the Network for Multicultural Research on Health and Healthcare, Department of Medicine-UCLA David Geffen School of Medicine, funded by the Robert Wood Johnson Foundation.	The Netherlands Organization for Scientific Research (NOW) Social cohesion Programme; subprogramme; the Dutch Multicultural and Pluriform Society (MPS), grant 261-98-618.	None	Asian American Health Initiative, Montgomery County Department of Health and Huam Services, Maryland	Institutional Health Resources and Services Administration research award, US Department of Health and Human Services (grant 5 DO8 HP 50018).

Comments	Excellent journal to support the population in my capstone project.	Complicated journal but with extensive studies and scientific results.	Too long but information is very sufficient with excellent explanations and definitions of the variable and the findings	Excellent context, in-depth context	This study received institutional review board exemption from the University of Southern California

Systematic Review Evidence Table

	6	7	8	9	10
Article Title and Journal	Breast Cancer beliefs and mammography screening practices among Chinese American Immigrants. *Journal of Obstetric Gynecologic & Neonatal Nursing.*	Mortality trends and disparities among racial/ethnic and Sex subgroups in New York City, 1990 to 2000, *Journal of Immigrant and Minority Health*	Immigration and selected indicators of health status and healthcare utilization among the Chinese. *Journal of Immigrant & Minority Health,12 (4), 470-479*	Only the best class of immigration. *American Journal of Public Health, 94(6), 932-939*	Implications for case management: ensuring access and delivery of quality health care to undocumented immigrant populations. *Lippincott's Case Management: Managing The Process Of Patient Care, 11 (4), 195-204; quiz 205-6*
Author/Year	Lee-lin, F., Menon, U., Pett, M., Nail, L., Lee, S., & Mooney, K. (2007).	Freeman, K., Zonszein, J., Islam, N., Blank, A., & Strelnick, A. (2011)	Chou, C., Johnson, P., & Blewett, L. (2010)	Abel, K. (2004).	Carr, D. (2006)
Database and Keywords	CINAHL: health beliefs, immigrants, models, screening	CINAHL: Mortality, mortality ratio, Disparities, Immigration	Academic Search Premier; Medical care, utilization immigrants, health status indicators, Immigrant effects on health	EBSCOhost. SPORTDiscus: immigrants, case management, health; healthcare, effects	CINAHL: Case Management, cultural diversity, immigration, statistics, health services accessibility quality of health care

Research Design	Descriptive study guided by the Health Belief Model		Multivariate logistic regression to estimate the adjusted odds of perceived poor health, having ever smoked, and past year emergency room visits according to immigration status.		Review
Level of Evidence					
Study Aim/Purpose	To explore knowledge and beliefs (perceived risk factors, susceptibility, benefits, common barriers) in relation to mammography screening practices among Chinese American women.	To identify possible factors that may contribute to differences in trends in mortality among race/ethnicity groups.	To examine the indicators of health status and healthcare utilization according to immigration status to assess the healthy immigrant effect for Chinese adults	Article helps to broaden our perspective by examining policies toward Filipinos and Mexican immigrants in Los Angeles.	Addresses the undocumented population, and identifies opportunities to encourage and promote access to healthcare while providing effective care management interventions

Population Studied/Sample Size/Criteria/ Power	One hundred Chinese immigrant women, 40 years or older in the Metropolitan area in the Northwestern United States.	Persons 35 years and older	15,549, Chinese in Taiwan, 964 U.S.-born Chinese and 253 Chinese Immigrants in the U.S.		Undocumented immigrants
Methods/Study Appraisal/ Synthesis Methods		Theoretical Model.	Review of the 2001 Taiwan National Health Interview Survey (NHIS), and the 1998–2004 U.S. National Health Interview Survey.		
Primary Outcome Measures and Results	The percentage of Chinese American women ages 40 and older whoever received a mammogram and who received a mammogram within the past year. Although 86% of the respondents reported that they had a mammogram, only 48.5% had a mammogram within the past year.		For Chinese immigrants, more years in the U.S. were associated with lower odds of reporting poor health and past-year emergency room use.		

Author Conclusions/ Implications of Key Findings	Nurses may influence the mammogram rates among Chinese American women by providing health education to family members of patients with breast cancer, reducing perceived barriers to mammogram, and seeking alternative payment mechanisms for patients who do not have insurance.	Reductions in HIV, cancer, CVD, CHD, AMI, and stroke-related mortality were found citywide for both men and women. However, disparities exist with regard to trends in HIV-related mortality, with Black, Hispanic, and Asian men having notably higher rates when compared to White men. Diabetes mortality rates rose dramatically citywide affecting mainly Hispanic and Asian men. Additionally, the increase in diabetes-related mortality among Asian women was more than twice that of White women. Changes in mortality among Asians were dramatic and exceeded those of other minority groups. Public health officials need to consider immigration patterns along with race/ethnicity and sex in designing, implementing, and evaluating interventions to prevent disease-related mortality, with a goal to eliminate disparities.			Undocumented immigrants living in the U.S. face tremendous obstacles while trying to navigate the healthcare system. The case manager can play a pivotal role in facilitating care in culturally complex situations. Role functions, which include skills such as assessment, planning, cultural sensitivity, and advocacy, empower case managers in their efforts to improve access and quality, while continuing to monitor cost. Planning care can be time consuming and a team effort, requiring the collaborative intervention of many other members of the healthcare team. As the number of undocumented immigrants continues to grow and impact the US healthcare system, the case management community has a responsibility to remain proactive in facilitating access to healthcare and to use its skills and capabilities to empower these

Strengths/ Limitations	The study utilized self-reported measures of MMG screenings that could have been over or under reported. Report was vulnerable to socially desirable behavior biases. Chart review was not cost effective. The results cannot be generalized to the general population since they were taken from Chinese community in a single northwestern city.	1. Aggregate groupings for race/ethnicity treat highly heterogeneous populations as homogeneous groups. 2. Rates of preventive screening and health insurance status vary substantially among Asian American subgroups			

Funding Source	Supported by American Cancer Society, Oncology Nursing Society, Sigma Theta Tau, and National Cancer Institute training grant	NIH grant 5 P60 MD000514-06, National Center on Minority Health & Health Disparities Comprehensive Center of Excellence in Health Disparities Research, Bronx Center to Reduce and Eliminate Ethnic and Racial Health Disparities. NIH grants P60 MD000538 and R24MD001786, National Center on Minority Health & Health Disparities, and CDC grant 1U48DP001904.		A grant from the UCLA Institute for American Cultures helped to fund the research.	
Comments	Complex and very detailed article.	.			Excellent journal that addresses all the needs and topics in the cap stone project. Very Thorough yet easy to understand.

Systematic Review Evidence Table

	11	12	13	14	15
Article Title and Journal	The impact of using nursing presence in a community heart failure program. *The Journal of Cardiovascular Nursing,22(2),89-94*	All-cause and cause-specific mortality of immigrants and native born in the United States. *American Journal of Public Health 91(3), 392-399*.	Communicating with pictures: Perceptions of cardiovascular health among Asian immigrants. *American Journal of Public Health, 99(12), 2147-2149.*	Expanding the universe of universal coverage: the population health argument for increasing coverage for immigrants. J*ournal of Immigrant & Minority Health, 11(6): 433-6*	Health of America's newcomers. *Journal of Community Health Nursing*.18(1): 53-68
Author/Year	Anderson, J. (2007).	Singh, K. & Siahpush, M. (2001).	Fitzpatrick, L., Steinman, E., Tu, S., L, Kyiet, T., Thanh N., Yip, M., & Sin, M., (2009).	Nandi, A., Loue, S., & Galea, S. (2009).	Smith, L. (2001).
Database and Keywords	CINAHL: heart failure, interventions, nurse-patient relationship, nursing presence	SPORT Discus; health, mortality, Immigration, immigrants	PsycINFO; Cardiovascular diseases; health perception; Asian immigrants; ethnicity	CINAHL; Health Care Reform, United States, Immigrants, Insurance Coverage, Health Care Costs, Health Services Accessibility, Health Status; Medically Uninsured, Preventive Health Care, Public Health	EBSCOhost. CINAHL; Immigrants, United States Health, Refugees, Diseases, Risk Factors, Health Services Accessibility, Health Services

Research Design	Case Studies review and discussion	Cohort study of 5 current population survey	Qualitative Study	Peer review	Descriptive study
Level of Evidence	High	High	Medium	High	High
Study Aim/Purpose	To evaluate the impact of nursing presence in a community health program.	Examined whether US-born people and immigrants 25 years or older differ in their risks of all-cause and cause-specific mortality and whether these differentials, if they exist, vary according to age, sex, and race/ethnicity	To see what a targeted group sees to understand how they view specific topics if one intends messages to relate to them.	To determine the relationship between nativity/immigration status and self-reported quality of care and preventive care. 2. To assess the impact of a usual source of health care on receipt of preventive care.	Discussion of the role of federalism on the interplay among policymakers regarding newcomer health. Also, the newcomer health policy, including immigration policies, and newcomer health issues such as infectious diseases and questionable health care.
Population Studied/Sample Size/Criteria/ Power	Chronic heart failure patients	HISPANIC Americans	23 Chinese, Vietnamese, and Korean immigrants with limited English-speaking proficiency, mean age 72 years.	4,013 Latino adults; ages ≥ 18 yrs.; US-born Latinos vs. Foreign-born Latino permanent residents and undocumented Latinos	Newcomers in the United States

Methods/Study Appraisal/ Synthesis Methods	Discussion and review of case studies	Using data from National Longitudinal Mortality study (1979 - 1989), derived mortality risks of immigrants relative to those of U.S. born people by using a Cox regression model after adjusting for age, race, ethnicity, marital status, urban/rural residents, education, occupation and family income.	Survey of older Asian immigrants on their views on cardiovascular health using Photo voice.	Critical review of the public health literature concerning the health status and access to health services among immigrant populations in the US. Using examples from infectious and chronic disease epidemiology	Review of existing policies, cases and health issues regarding new comers

Primary Outcome Measures and Results	1. Case study one illustrated the power of presence and how it can provide a safe place for the patient to share his/her innermost thoughts and feelings touching both the patient and nurse. 2. Case study two illustrated how patient education and monitoring of adherence, all underpinned by using presence, positively influenced self-management. 3. Case study illustrated how nursing presence may increase adherence, decrease hospitalizations, and facilitate healing.	Immigrant men and women had, respectively; an 18 % and 13 % lower risk of overall mortality than their US-born counterparts. Reduced mortality risks were especially pronounced for younger and for Black and Hispanic immigrants. Immigrants showed significantly lower risks of mortality from cardiovascular diseases, lung and prostate cancer, chronic obstructive pulmonary diseases, cirrhosis, pneumonia and influenza, unintentional injuries, and suicide but higher risks of mortality from stomach and brain cancer and infectious diseases. Mortality patterns for immigrants and for US-born people vary considerably, with immigrants experiencing lower mortality from several major causes of death.	Outcomes: Population's perceptions of cardiovascular risk factors, and aspects of subject's lives that promoted cardiovascular health. RESULTS: affordability is crucial to making healthy purchasing decisions, loneliness was identified as a risk factor, and there is importance of family in varying for and keeping older adults healthy.	Access to health services is at the intersection of the health of uninsured immigrants and the general population and that extending access to healthcare to all residents of the US, including undocumented immigrants, is beneficial from a population health perspective. Furthermore, from a health economics perspective, increasing access to care for immigrant populations may actually reduce net costs by increasing primary prevention and reducing the emphasis on emergency care for preventable conditions	Cost shifting and enormous consequences for newcomers and the community health nurses who promise them care.

Author Conclusions/ Implications of Key Findings	It is the contention of this author that the success of the program, while resting on expert multidisciplinary care, is also influenced by the spirit of a long-term therapeutic relationship that develops between the nurse, patient, and the patient's loved ones.	Future research needs to examine the role of socio-cultural and behavioral factors in explaining the mortality advantage of immigrants.	Issues related to poverty, heath care access, and quality of care greatly impact rates of disease once immigrants arrive in this country. It is important to see what a targeted group sees, to understand how they view specific topics if one intends messages to relate to them		Newcomers need and deserve appropriate health care. Communities need and deserve newcomers who are free of communicable disease, and hospitals need and deserve clients who can pay for services. Community health nurses play a vitally important role in promoting healthy people, healthy families, and healthy environments.
Funding Source	None	Unknown	Unknown	Unknown	Unknown
Comments	Clear and precise article	Clear and straight to the point	Very colorful but insightful discussion. The pictures made the concepts more understandable.	Organized	Very complicated article, difficult to understand

Systematic Review Evidence Table						
	16	17	18	19	20	21
Article Title and Journal	HIV education needs among Sudanese immigrants and Refugees in the Midwestern United States. *AIDS and Behavior, 10(3): 319-323.*	Barriers to health care access in 13 Asian American communities. *American Journal of Health Behavior, 34(1):21-30*	Establishing the public's trust through community-based participatory research; A case example to improve health care for a Rural Hispanic community. *Annual Review of Nursing Research. 238-259.*	Hospital admission rates for a racially diverse low-income with cohort of patients with Diabetes; The Urban Diabetes study. *American Journal of Public Health, 96(7), 1260 - 1264.*	How Do Older Chinese Women View Health and Cancer Screening? Results from Focus Groups and Implications for Interventions. *Ethnicity & Health, 9 (3), 283 -304.*	Immigrant children's reliance on public health insurance in the wake of immigration reform. *American Journal of Public Health, 98(11), 2004-2010.*
Author/Year	Tompkins, M., Smith, L., Jones, K., & Swindells, S. (2006).	Lee, S., Martinez, G., Ma, G., Hsu, C., Robinson, S., Bawa, J., & Juon, H. (2010).	Shelton, D. (2001)	Robbins, J., & Webb, D. (2006).	Liang, W., Yuan, E., Mandelblatt, J. S., & Pasick, J. (2004).	Pati, S., & Danagoulian, S. (2008).
Database and Keywords	CINAHL: HIV/AIDs, immigrants, education, beliefs, behaviors.	CINAHL: Access, immigrants, vulnerable, health care, study	CINAHL: community-based programs, health disparities, immigrants	EBSCOhost: Costs, access, health, immigrants	EBSCOhost: Immigrants, diseases, screening, cultural view	EBSCOhost: immigrant; health access, status

Research Design					Qualitative Study and Cross-sectional study	
Study Aim/Purpose	To evaluate knowledge, attitudes, and beliefs about HIV/AIDS as well as risk behavior in the Sudanese immigrant and refugee population of Nebraska.	To obtain and discuss in-depth information on health care use in Asian Americans.	Discussion of the changing nature of rural populations and implications for rural health care and nursing research.	To determine the frequency and costs of hospitalization and to assess possible racial ethnic disparities in a large cohort of low-income patients with diabetes who had received care at municipal health clinics	To qualitatively assess Chinese American women's views of health and illness and the potential influences of culture and language on cancer screening behavior.	To determine whether the reversal of the public charge rule of the Illegal Immigration Reform and Immigrant Responsibility Act, which may have required families to pay for benefits previously received at no cost, led to immigrant children becoming increasingly reliant on public health insurance programs.
Population Studied/Sample Size/Criteria/ Power	N = 47; Men and women aged 19 years and above, born in Sudan residing in Nebraska.	Nineteen focus groups for 174 adults from 13 AA communities in Montgomery County, Maryland.		18800 patients with Diabetes from March, 1, 1993 - December 31, 2001.	Chinese women residing in Washington, DC Metropolitan area, N=54 women, Five focus groups each consisting of 9 -12 Chinese American women aged 50 and older	675701 individuals, 105016 of whom were children, 18 years or younger.

Methods/Study Appraisal/ Synthesis Methods	Surveys collected in the months of November and December in 2003.		Review of community-based participatory research, review of rural CBPR literature documenting the work by nurses, presented a case example of the community capacity building.	Tested differences in hospitalization rates and mean hospital charges by age, gender, and race/ethnicity by linking administrative data from Philadelphia Health Care Centers with discharge data from Pennsylvania hospitals for march 1993 through December 2001.	Data generated responses from participant's to open-ended questions. Allconversations were tape-recorded and analyzed in the context of PRECEDE frameworkconcepts of predisposing, enabling, and reinforcing factors.	Used a multinomial logistic regression models to account for the substantial differences in socioeconomic status between foreign-born and US-born children. A secondary data analysis focusing on low-income children sampled in the 1997 through 2004 versions of the National Health Interview Survey.

Primary Outcome Measures and Results	A significant proportion of individuals were poorly educated about HIV infection, exhibit attitudes and beliefs that may increase their risk for disease acquisition, and create barriers to HIV prevention and care, and engage in high-risk sexual behaviors.			There were 30528 hospital admissions, a rise with age, and with the interaction of male gender and age. Rates for non-Hispanic whites were higher than those for African Americans, whereas those for Hispanics, Asian-Americans, and others were lower. Patients who were hospitalized at least 5 times made up 10.5% of the study population and accounted for 64% of hospital admissions and hospital charges in this cohort.	Assessment of perceptions to health and illness, knowledge about cancer, beliefs about andbarriers to cancer screening, and screening and healthcare experiences in the USA.	Between 1997 and 2004, public health insurance enrollments and the numbers of uninsured foreign-born children in the United States increased by3.1% and 2.7%, respectively. Low-income US-born children were just as likely as foreign-born children to have public health insurance coverage(odds ratio [0R] = 1.16; 95% confidence interval [Ci]=0.89, 1.52) and that, after 2000, foreign-born children were 1.59 times (95% CI = 1.24, 2.05) more likely than were US-born children to be uninsured.

Author Conclusions/ Implications of Key Findings	Appropriate educational materials are lacking, and there is a pressing need for improved access to culturally appropriate HIV education for this vulnerable population.		The use of community - based participatory processes is an important strategy for nursing and nursing research	Hospitalization rates for this low-income cohort with access to primary care and pharmacy services were comparable to those of other diabetic patient populations, suggesting that reducing financial barriers to care may have benefited these patients.	Traditional Chinese beliefs, such as those pertaining to fatalism, self-care, and the hot and cold balance, influence the perceptions of older Chinese women regarding health, illness, and use of preventive healthcare.	In the wake of the reversal of the public charge rule, immigrant children are increasingly likely to be uninsured as opposed to relying on public health insurance.
Strengths/ Limitations	1. Establishing a relationship of trust with the community leaders required a time investment of several weeks. 2. HIV/AIDS is not openly discussed in the Sudanese population, so it required considerable time and patience to ensure cultural				1. Due to the use of a small group, and the cross-sectional study design the results from this study may not be generalizable to all olderChinese American women. 2. Because of the cross-sectional data and the ways focus group questions were asked, we cannot establish casual relationships between factors and screening behaviors.	1. The finding that foreign-born and mixed status children were less likely than were US born children to have chronic conditions could be explained by differences in health insurance coverage and, access to health care services. 2. NHIS did not include consistent data on use of health care services across all of the years covered in these immigrants, and undocumented children are likely to be

	sensitivity and to avoid offensive wording in the construction of the survey. 3. Sample size was small and the sample was not randomly selected thus did not know the extent to which survey respondents represented the target population.					underrepresented. 3. NHIS is a cross-sectional survey, and therefore causal inference is limited.4. NHIS tightly controls access to state-level data, limiting the ability to examine the effects of state-funded public health insurance programs for immigrants. 5. Unable to examine the influence of other important linguistic and cultural factors (e.g., English proficiency, length of stay in the United States) on health insurance trends among immigrant children.
Funding Source	None	None	None	None	Supported by the Susan G. Komen Breast Cancer Foundation Race forthe Cure for the National Capital Area (#00DC2018).	National Health InterviewSurvey.

Comments	Appropriate study to represent the behavior of the population I assessed for my capstone project.				Organized, detailed study with very good analyzes of the discussion. Susan Komen is one of the sponsors in my project.	Well organized and detailed

Systematic Review Evidence Table						
	22	23	24	25	26	27
Article Title and Journal	Immigration and Health Care Reform: Shared Struggles. *Nursing Economic, 25(4), 235-237*.	The U.S. Health System and Immigration: An Institutional Interpretation. *Sociological Forum,24(3), 487-514*	Outcomes from a community-based, participatory lay health adviser HIV/STD prevention intervention for recently arrived immigrant Latino men in rural North Carolina. *AIDS Education and Prevention, 21(Suppl B), 103-108*.	Gender, ethnicity, and cardiovascular disease. *Journal of Cardiovascular Nursing, 20(1), 1 - 6*.	Emergency preparedness: knowledge and perceptions of Latin American immigrants. *Journal of Health Care for the Poor & Underserved, 18(2): 465-481*	Transnational Mothers Crossing the Border and Bringing Their Health Care Needs. *Journal of Nursing Scholarship; (43)1,64-71*
Author/Year	Gardner, B. (2007).	Portes, A., Light, D., & Fernández -Kelly, P. (2009).	Rhodes, D., Hergenrather, C., Bloom, R., Leichliter, S., & Montaño, J. (2009).	Allen, J. & Szanton, S. (2005).	Carter-Pokras, O., Zambrana, R., Mora, S., & Aaby K. (2007).	Sternberg, R. & Barry, C. (2011).
Database and Keywords	EBSCOhost; healthcare, immigrants, health	EBSCOhost; Health, healthcare, immigrants, institutions, policy, poverty	CINAHL; community based programs, immigrants, diseases, models, interventions	CINAHL; Gender, ethnicity, cardiovascular disease, immigrant.	CINAHL; Immigrants, health education, health Knowledge, Maryland; motivation; perception, risk factors	Academic Search Premier. Immigrants, health care, resources
Research Design	Discussion	Case studies	Cohort study	Cross-sectional epidemiological study	Focus groups	Qualitative research

Level of Evidence	Low	High	Low	High	High	High
Study Aim/Purpose	To identify the connection between health care and immigration share overlapping key areas in policy reform.	To examine the institutions that comprises the U.S. health system and their relationship to a surging immigrant population.	To evaluate the efficacy of a pilot lay health adviser (LHA) intervention designed to increase condom use and HIV testing among Latino men.	1. To distinguish between the constructs of gender versus sex, and ethnicity versus race. 2. to highlight a sampling of the substantial contributions of cardiovascular nurse researchers related to gender and ethnicity in the areas of symptoms of CVD, risk factors and prevention, delay in seeking care, diagnosis, and treatment, recovery and outcomes, and cardiac rehabilitation. 3. Propose recommendations for research.	Describes the level of public emergency knowledge and perceptions of risks among Latin American immigrants, and their preferred and actual sources of emergency preparedness information	To explore the experiences of transnational Latina mothers who immigrated to the United States without legal documentation or their children.
Population Studied/Sample Size/Criteria/ Power			Fifteen LHAs (mean age = 35.6; range 23-60 years) from 15 Latino soccer teams were trained and worked with their teammates for 18 months. Another 15	529 African Americanwomen older than 40 years	Five Latino community member focus groups, and one focus group of community health workers, were conducted in a suburban county	Eight transnational Latina mothers from South Florida during the summer of 2009

			teams served as the control group.		of Washington D.C. (N=51).	
Methods/Study Appraisal/ Synthesis Methods			Data were collected at baseline and at 18 months post-LHA training from a random sample of teammates from intervention and control teams. At baseline, descriptive statistics were summarized socio-demographic variables, psychosocial determinants of risk, and sexual and testing behaviors. Potential differences between conditions were assessed using t-tests and chi-square analyses. Multivariable logistic regression model using a generalized linear mixed modeling was used to test the efficacy of the intervention to increase condom	Used the principles of community-based participatory research.		Data were collected using open-ended questions in one-on-one, in-depth interviews that lasted 1 to 2 hr. A hermeneutic phenomenological analysis was used to analyze the data.

			use and HIV testing while adjusting for baseline scores, relationship status, and within team clustering.			
Primary Outcome Measures and Results			Relative to the control condition, participants in the intervention were more consistent condom use in the 30 days preceding follow-up (unadjusted analysis, intervention, 65.6% vs. control, 41.3%; p < .001). Participants in the intervention were more likely to report condomuse (adjusted odds ratio [AOR] = 2.3; confidence interval [CI = 1.2-4.3) and HIV testing (AOR = 2.5; CI = 1.5-4.3).	There were significant changes in the favorable direction for 11 of the 13 risk factor outcomes in the active intervention group versus only 1 out of 13 in the self-help group. A logistic regression analysis showed that the significant independent predictors of the most successful weight loss participants were to be higher number of sessions attended (P = .001), older age (P - .03), having a higher BMI (P < .001), and being included in the active intervention group (P = .001).	Participants had difficulty defining emergency and reported a wide range of perceived personal emergency risks: immigration problems; crime, personal insecurity, gangs; home/traffic accidents; home fires; environmental problems; and snipers. Few participants had received information on emergency preparedness, and most did not have an emergency plan.	A hermeneutic phenomenological analysis of the data yielded seven essential themes from the participants' stories: living in extreme poverty, having hope, choosing to walk away from poverty, suffering through the trip to and across the border, mothering from afar, valuing family, and changing personally.

Author Conclusions/ Implications of Key Findings	Nurses must take action by clearly stating the importance of ensuring the basic needs including health care of new immigrant groups are met. Raising the bar to improve the rights of one group can be a step toward ensuring them for everyone.		LHA interventions for Latino men that are developed in partnership with community members, rely on male centered intrapersonal networks, and are culturally congruent can enhance preventive behaviors and may reduce HIV infection.	The study demonstrated that church-based interventions can significantly benefit the cardiovascular health of African American women. Spirituality is also an important component of the intervention Women actively incorporated more spirituality than was originally included in the session materials and protocols. Church "ownership" of the program was also key.	Findings regarding key messages and motivating factors can be used to develop clear, prioritized messages for communication regarding emergencies and emergency preparedness for Latin American immigrant communities in the U.S	The results indicate that transnational Latina mothers find meaning in mothering from afar through embodied sacrifice, suffering, hopingfor a better life for their children, and family reunification. These results have implications for healthcare providers, social workers, policy makers, and educators whose professional responsibility is to advocate for, and to enhance the health and social well-being of, transnational mothers.
Strengths/ Limitations			Nonrandom assignment, the use of self-reported data and the lack of biomarker data, and the potential lack of generalizability of findings.			The study only identifies only one type of population and might be bias on other communities.

Funding Source	Through the generous support of individuals and corporations.	Senior Investigator Award from the Robert Wood Johnson Foundation.	Cooperative agreement from the CDC through the Association for Prevention Teaching and Research (APTR, formerly the Association of Teachers of Preventive Medicine) to Dr. Rhodes.		Supported by Cooperative Agreement Number (U50/ CCU302718 from the Centers for Disease Control and Prevention (CDC)	
Comments	Excellent debate but not a systematic review of the issues in my capstone project.					Excellent article, detailed and organized

Systematic Review Evidence Table			
	28	29	30
Article Title and Journal	Parental awareness of health and community resources among immigrant families. *Maternal and Child Health Journal, (9)* 1	Health insurance coverage and medical expenditures of immigrants and native-born citizens in the United States. *American Journal of Public Health. (99)7.*	Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey. *American Journal of Public Health 2006, (96)7, 1300*.
Author/Year	Yu, S., Huang, Z., Schwalberg, R., and Kogan, M. (2005).	Ku, L. (2009).	Lasser, K., Himmelstein, D., & Woolhandler, S. (2006).
Database and Keywords	CINAHL; immigrants; support services; children.	CINAHL; Health Resource, utilization, Statistics; immigrants, United States Insurance, Health	SPORTDiscus; Access; Health and Human Resources
Research Design		Quantitative research; Survey	
Level of Evidence		Strong	

Study Aim/Purpose	To examine the association between parental immigrant status and awareness of health and community resources to help address common family problems.	Examined insurance coverage and medical expenditures of both immigrant and US-born adults to determine the extent to which immigrants contribute to US medical expenditures.	Compared health status, access to care, and utilization of medical services in the United States and Canada and compared disparities according to race, income, and immigrant status.
Population Studied/Sample Size/Criteria/ Power	35,938 children younger than 18 years old	Nonelderly adults (19-64years old)	3505 Canadian and 5183 US adults
Methods/Study Appraisal/ Synthesis Methods	Using 1999 National Survey of America’s Families, bivariate and multivariate analyses were conducted to examine the relationship between parents’ immigrant status (U.S.-born citizens, naturalized citizens, and noncitizens) and their responses to questions about their awareness of specific health and community resources.	Data from the 2003 Medical Expenditure Panel Survey to perform 2-part multivariate analyses of medical expenditures, controlling for health status, insurance coverage, race/ethnicity, and other socio-demographic factors.	Controlling for gender, age, income, race, and immigrant status, we used logistic regression to analyze country as a predictor of access to care, quality of care, and satisfaction with care and as a predictor of disparities in these measures.

Primary Outcome Measures and Results	Compared to U.S.-born citizens, noncitizens were at the highest risk of not being aware of health and community resources for most outcomes, followed by naturalized citizens. The services of which noncitizens were most likely to be unaware were places to get help for family discord, child care issues, and family violence. Multivariate analyses indicate that parental race/ethnicity, education level, employment status, and child age were other significant independent risk factors.	Approximately 44% of recent immigrants and 63% of established immigrants were fully insured over the 12-month period analyzed. Immigrants' per-person unadjusted medical expenditures were approximately one half to two thirds as high as expenditures for the US born, even when immigrants were fully insured. Recent immigrants were responsible for only about 1% of public medical expenditures even though they constituted 5% of the population. After controlling for other factors, I found that immigrants' medical costs averaged about 14% to 20% less than those who were US born	In multivariate analyses, US respondents (compared with Canadians) were less likely to have a regular doctor, more likely to have unmet health needs, and more likely to forgo needed medicines. Disparities on the basis of race, income, and immigrant status were present in both countries but were more extreme in the United States

Author Conclusions/ Implications of Key Findings	Immigrant parents are at particularly high risk of alienation from systems of health care and support services that are available to low-income and other vulnerable populations in the United States. These findings clearly document disparate awareness among parents of different immigrant status. Community and health resources should reach out to immigrant populations, in linguistically and culturally appropriate ways, to alert them to the availability of their services.	Insured immigrants had much lower medical expenses than insured US-born citizens, even after the effects of insurance coverage were controlled. This suggests that immigrants' insurance premiums may be cross-subsidizing care for the US-born. If so, health care resources could be redirected back to immigrants to improve their care.	United States residents are less able to access care than are Canadians. Universal coverage appears to reduce most disparities in access to care
Strengths/ Limitations	The NSAF is conducted in English or Spanish and not in any other languages. Immigrant respondents whose primary language is not English or Spanish may therefore tend to be more educated and fluent in English than their peers, thus resulting in a possible underestimate of risk for the actual immigrant populations in the United States. Undocumented immigrants who may be at the highest risk of being not aware and not able to utilize health and community resources are likely not to participate in the	MEPS, like other national data sets, does not include data on legal or citizenship status of immigrants. However, census data do indicate that recent immigrants are primarily undocumented or legal noncitizens and that established immigrants are primarily naturalized citizens or legal noncitizens. Recent or undocumented immigrants may be under-sampled in MEPS, although the distributions of recent and established immigrants and US-born adults are similar to those found in census data. Data on medical	

	survey due to fear of exposing their illegal status; however, the survey contained no information about immigrant respondents' legal status. Also limited to the series of questions asked in the survey, which may not be adequate or complete in providing answers to other areas of interest, such as awareness of specific health care resources or health insurance programs. Also, the level of need for each of the services analyzed: data are not available to assess whether respondents would take advantage of these services if they did know about them. In addition, estimates for Asians were not significant likely due to small numbers, although the direction of the risks in these populations is evident.	expenditures are subject to measurement error, and aggregate national medical expenditures in the 2002 MEPS were about 13.8% below those reported in the National Health Expenditure Accounts	
Funding Source		None	None
Comments			

Appendix B: Logic Model

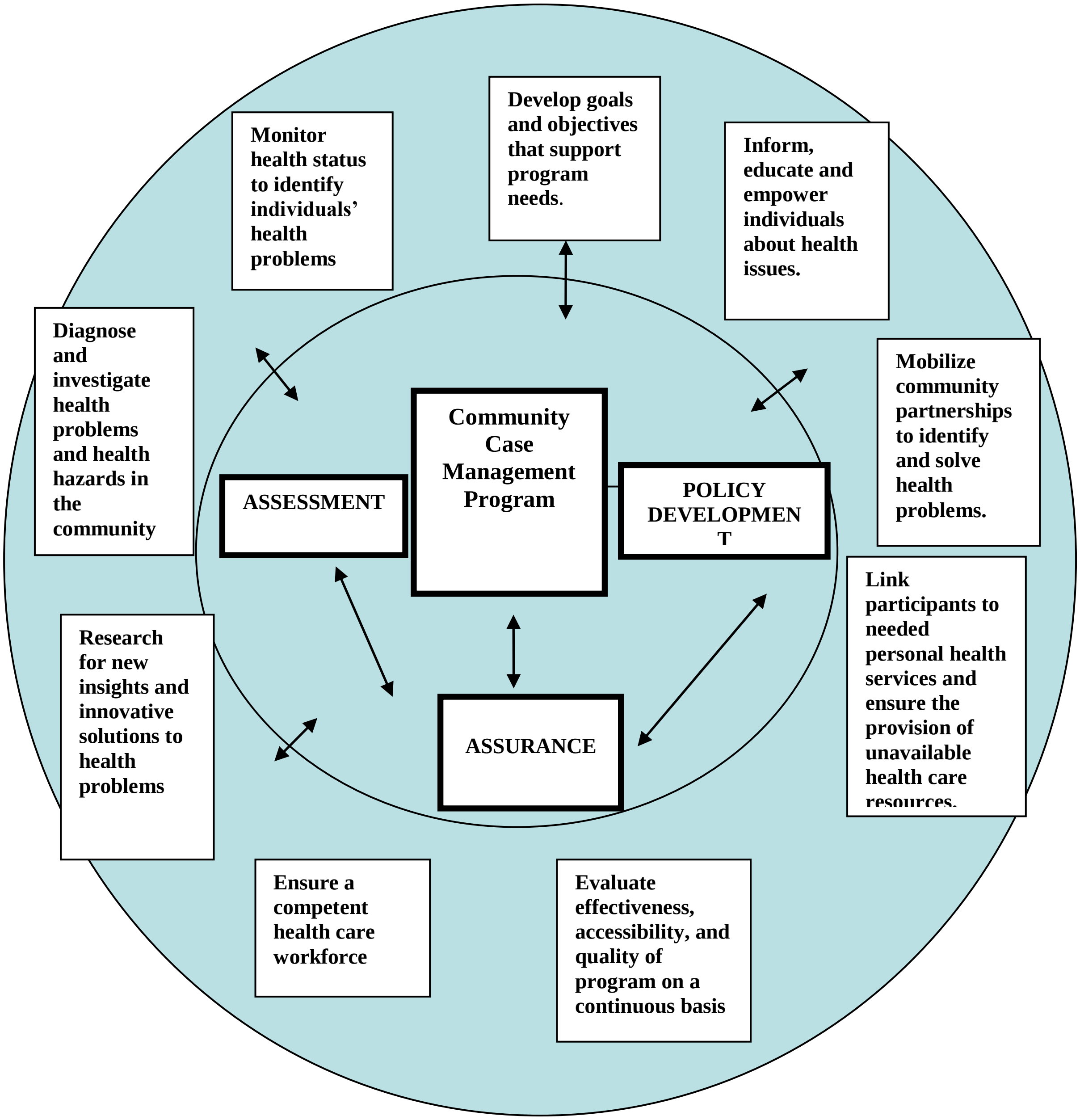
IOSC Community Case Management Program Logic Model

Resources-Inputs	Activities	Outputs	Outcomes	Impacts
Potential grants from Rotary Club, Towson University and Regis University.	Seek grant funding to seed health projects; acquire supplies, support for education	Amount of approved funds and grants	Money to finance project	Continuous funding of community based health organizations programs and grants from government and State funding agencies such as Medicaid, Medicare and INH.
Program Staff: Volunteers from St. Matthews church (multiple nurses, practitioners), IOSC (one lawyer, one director, and one social worker), Good Samaritan and Maryland General hospitals' staff, maintenance person.	Comprehensive Case Management Services (needs assessment, health screenings, resource finding, referral empowerment, and education programs	Reports from IOSC board members.		N = 40 individuals in April 30th. 2011 N = 72 individuals in April 30th. 2012.
Technical support: sparks (one website developer), Cozion media (events photographer and videographer).	Seek partnership with area free community health providers, facilities and education programs.	Patient satisfaction surveys	Increased trust with the providers as evidenced by willingness of the individuals to discuss their health needs.	Ongoing close collaboration between IOSC and the community
Space: St. Matthews church hall and IOSC classroom.	Educate, train and orient all volunteers and sponsors to population, cultural differences and health needs of immigrant populations served by IOSC.	Participation in educational and screening sessions	Increased number of subjects making follow up visits to the IOSC health clinic.	Increased productivity benefits to the Community
Two family practice medical doctors, one Endocrine doctor, and two medical students from Maryland General Hospital	Establish free health screenings and education sessions at the IOSC center.	Number of sponsors and providers willing to participate in the program.	Improved functional status and self-reported improved wellbeing and quality of life. Shift in the perception of disease as a	Increased provider participation in National community-based health programs

			terrible thing but as a way to early prevention and treatment.	
One PhD nurse/educator (preceptor), two Masters students from Towson university, and one Masters graduate nurse/acute care Case Managers. All actively involved in the program	Participate and co-sponsor seasonal health fairs for immigrant populations.	Reports from sponsors /providers and area facilities detailing number of referrals and appointments from IOSC clients.	Increased use of health care facilities and resources provided at the IOSC center.	Advocate for development of policies and plans that support community health efforts
Ready Access to Immigrant Population	Submit report of activities to the IOSC board.	Number of referrals and follow up appointments made by the program individuals.	Improved self-reported knowledge of disease, transmission, prevention, and treatments.	Increased community awareness of prevention efforts
Established reputation in the Community Regarding Care of immigrants at IOSC and St. Matthews church.	Plan a free health clinic program by reviewing successful models and continue to seek ongoing and permanent funding source for a free health service center.	Insurance status (ability to obtain Medicaid, SSI, private insurance)	Increased number of sponsors and providers participating in the program.	Establish and advocate research programs for insights and innovative solutions to health problems
Free services from sponsors	Develop goals and objectives for providing health care to immigrant population.	Completion of goals and objectives every three months (phases one, two, and three)	Increased support of the health programs by volunteers and program staff.	Increased number of immigrants without health insurance in the United States.
Health education flyers, handouts, booklets and brochures	Apply guidelines for applicants seeking collaboration or conducting research activity.	Comprehensive evaluation of each program participant every three months (phases one, two and three).		
Supplies	Conduct research and literature reviews for effective methods of establishing and evaluating community case management programs.	Satisfaction scores from IOSC board members	Increased satisfaction scores from IOSC members regarding the program’s activities.	

Appendix C: Conceptual Diagram

IOSC Public Health Nursing Practice Model
Adapted from the Public Health Nursing Practice Model (Lundy & Janes 2001)



Appendix D: Measurement Tool/Instrument

Appendix D-1: Ryff Scales of Psychological Well-Being (RPWB) Adapted from Springer and Hauser (2003)

The following set of statements deals with how you might feel about yourself and your life. Please remember that there is neither right nor wrong answers.

Circle the number that best describes the degree to which you agree or disagree with each statement.	**Strongly Disagree**	**Disagree**	**Disagree Slightly**	**Agree Slightly**	**Agree**	**Strongly Agree**
1. In general, I feel I am in charge of the situation in which I live.	1	2	3	4	5	6
2. I am not afraid to voice my opinion, even when they are in opposition to the opinions of most people.	1	2	3	4	5	6
3. I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
4. My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
5. The demands of everyday life often get me down.	1	2	3	4	5	6
6. I don’t want to try new ways of doing things—my life is fine the way it is.	1	2	3	4	5	6
7. In general, I feel confident and positive about myself.	1	2	3	4	5	6
8. I often feel lonely because I have few close friends with whom to share my concerns.	1	2	3	4	5	6
9. I do not fit very well with the people and the community around me.	1	2	3	4	5	6
10. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
11. I don’t have many people who want to listen when I need to talk.	1	2	3	4	5	6
12. I tend to be influenced by people with strong opinions.	1	2	3	4	5	6
13. I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6
14. I generally do a good job of taking care of my personal finances and affairs.	1	2	3	4	5	6
15. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	1	2	3	4	5	6
16. It’s difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6
17. For me, life has been a continuous process of learning, changing, and growth.	1	2	3	4	5	6

18. I am an active person in carrying out the plans I set for myself.	1	2	3	4	5	6
19. I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
20. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6

Key: Below are the items listed by scale.

Autonomy – the extent to which students view themselves as being independent and able to resist social pressures

1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.
2. My decisions are not usually influenced by what everyone else is doing.
3. I tend to worry about what other people think of me.
4. Being happy with myself is more important to me than having others approve of me.
5. I tend to be influenced by people with strong opinions.
6. I have confidence in my opinions, even if they are contrary to the general consensus.
7. It's difficult for me to voice my own opinions on controversial matters.
8. I often change my mind about decisions if my friends or family disagree.
9. I judge myself by what I think is important, not by the values of what others think is important.

Environmental Mastery – the extent to which students feel in control of and able to act in the environment

1. In general, I feel I am in charge of the situation in which I live.
2. The demands of everyday life often get me down.
3. I do not fit very well with the people in the community around me.
4. I am quite good at managing the many responsibilities of my daily life.
5. I often feel overwhelmed by my responsibilities.
6. I generally do a good job of taking care of my personal finances and affairs.
7. I am good at juggling my time so that I can fit everything in that needs to be done.
8. I have difficulty arranging my life in a way that is satisfying to me.
9. I have been able to build a home and a lifestyle for myself that is much to my liking.

Personal Growth – the extent to which students have a sense of continued development and self-improvement

1. I am not interested in activities that will expand my horizons.
2. I don't want to try new ways of doing things—my life is fine the way it is.
3. I think it is important to have new experiences that challenge how you think about yourself and the world.
4. When I think about it, I haven't really improved much as a person over the years.
5. I have a sense that I have developed a lot as a person over time.
6. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.

7. For me, life has been a continuous process of learning, changing, and growth.
8. I gave up trying to make big improvements or changes in my life a long time ago.
9. There is truth to the saying that you can't teach old dog new tricks.

Positive Relations with Others – the extent to which students have satisfying, trusting relationships with other people

1. Most people see me as loving and affectionate.
2. Maintaining close relationships has been difficult and frustrating for me.
3. I often feel lonely because I have few close friends with whom to share my concerns.
4. I enjoy personal and mutual conversations with family members or friends.
5. I don't have many people who want to listen when I need to talk.
6. It seems to me that most other people have more friends than I do.
7. People would describe me as a giving person, willing to share my time with others.
8. I have not experienced many warm and trusting relationships with others.
9. I know that I can trust my friends, and they know that they can trust me.

Purpose in Life – the extent to which students hold beliefs that give life meaning

1. I live one day at a time and don't really think about the future.
2. I tend to focus on the present, because the future always brings me problems.
3. My daily activities often seem trivial and unimportant to me.
4. I don't have a good sense of what it is that I am trying to accomplish in my life.
5. I used to set goals for myself, but that now seems a waste of time.
6. I enjoy making plans for the future and working to make them a reality.
7. I am an active person in carrying out the plans I set for myself.
8. Some people wander aimlessly through life, but I am not one of them.
9. I sometimes feel as if I’ve done all there is to do in life.

Self-Acceptance – the extent to which students have a positive attitude about themselves

1. When I look at the story of my life, I am pleased with how things have turned out.
2. In general, I feel confident and positive about myself.
3. I feel like many of the people I know have gotten more out of life than I have.
4. I like most aspects of my personality.
5. I made some mistakes in the past, but I feel that all in all everything has worked out for the best.
6. In many ways, I feel disappointed about my achievements in my life.
7. My attitude about myself is probably not as positive as most people feel about themselves.
8. The past had its ups and downs, but in general, I wouldn't want to change it.
9. When I compare myself to friends and acquaintances, it makes me feel good about who I am.

Appendix D-2: Master Data Cross List for Participants and Providers

Provider Name	**Study Reference Number**
Patient Name (Last Name, First)	**Study Reference Number**
1.	166.248.33.201
2.	166.248.33.202
3.	166.248.33.203
4.	166.248.33.204
5.	166.248.33.205
6.	166.248.33.206
7.	166.248.33.207
8.	166.248.33.208
9.	166.248.33.209
10.	166.248.33.210
11.	166.248.33.211
12.	166.248.33.212
13.	166.248.33.213
14.	166.248.33.214
15.	166.248.33.215
16.	166.248.33.216
17.	166.248.33.217
18.	166.248.33.218
19.	166.248.33.219
20.	166.248.33.220
21.	166.248.33.221
22.	166.248.33.222
23.	166.248.33.223
24.	166.248.33.224
25.	166.248.33.225
26.	166.248.33.226
27.	166.248.33.227
28.	166.248.33.228
29.	166.248.33.229
30.	166.248.33.230
31.	166.248.33.231
32.	166.248.33.232
33.	166.248.33.233
34.	166.248.33.234
35.	166.248.33.235

36.	166.248.33.236
37.	166.248.33.237
38.	166.248.33.238
39.	166.248.33.239
40.	166.248.33.240
41.	166.248.33.241
42	166.248.33.242
43.	166.248.33.243
44.	166.248.33.244
45.	166.248.33.245
46.	166.248.33.246
47	166.248.33.247
48.	166.248.33.248
49.	166.248.33.249
50.	166.248.33.250
51.	166.248.33.251
52.	166.248.33.252
53.	166.248.33.253
54.	166.248.33.254
55.	166.248.33.255
56.	166.248.33.256
57.	166.248.33.257
58.	166.248.33.258
59.	166.248.33.259
60.	166.248.33.260
61.	166.248.33.261
62.	166.248.33.262
63.	166.248.33.263
64.	166.248.33.264
65.	166.248.33.265
66.	166.248.33.266
67.	166.248.33.267
68.	166.248.33.268
69.	166.248.33.269
70.	166.248.33.270
71.	166.248.33.271
72.	166.248.33.272

Appendix D-3: IOSC Consent Form

Immigration Outreach Service Center Health Clinic's Consent Form

You are being asked to take part in a research study of how participating in a case management program would increase your access to health care and improve health status. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of this study is to evaluate the effectiveness and impact of applying case management interventions to a group of immigrants served at the Immigration Outreach Service Center Health Clinic.

What we will ask you to do: If you agree to be in this study, we will conduct an interview with you. The interview will include questions about your basic demographics, how old are you, any medical problems, any types of medicines you take, social and leisure activities, your connection with a care provider, whether or not you have any type of insurance, and how much you sleep. The interview will take about 30 minutes to complete.

Risks and benefits: There is the risk that you may find some of the questions about your health conditions and life style to be sensitive. Otherwise it is not anticipated that there will be any other risks to you participating in this study other beyond those encountered in day-to-day life.

All the subjects are welcome to receive case management services (free access to health care, free screening, medication/s services and education on health issues) whether or not they are willing to participate in the study.

Compensation: You will not be able to receive any kind of money or earnings by participating in the study. Refusal to participate will not affect your access to care.

Your answers will be confidential. The records of this study will be kept private. In any sort of report that is made public we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with Immigration Outreach Service Center Health Clinic. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researchers conducting this study are Nelly Kangethe RN, Dr. Joanna Basuray, Sonia Galvan RN and Maureen Craig. Please ask any questions you have now. If you have questions later, you may contact Nelly Kangethe at kange560@regis.edu or at 443-844-6001. You can reach Dr. Basuray at jbasuray@towson.edu or 410-704-4210, you can reach

Sonia at soniamgalvan@gmail.com or 443-834-2425, and finally you can reach Maureen at mcraig3@students.towson.edu or 443-824-5712. If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Regis University Institutional Review Board (IRB) at 1.800.388.2366 or email at irb@regis.edu.

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature ____________________________________ Date _________________________

Your Name (printed) ____

Signature of person obtaining consent: _______________________________ Date: ___________

Printed name of person obtaining consent ________________________

Appendix D-4: Immigrants' Health Status and Access to Care:

Immigrants' Health Status and Access to Care: Survey Questions 1 of 3

1. On a scale of 1 (agree) through 2 (do not agree), 3. (no idea) please tell me about each of the following statement

HEALTHCARE	
a. I am able to access a primary care physician or other health care provider (family doctor; general practitioner; internist; pediatrician).	1. Yes 2. No 3. Don't know
b. I have an access to a medical specialist (ophthalmologist, optician, oncologist, cardiologist, optician, dentist, nephrologists)	1. Yes. 2. No. 3. Don't know
c. I have access to a dentist when needed.	1. Yes 2. No 3. Don't know
d. I have access to transportation for medical appointments	1. Yes. 2. No. 3. Don't know
e. Is there sufficient number of physicians willing to see people without health insurance in your area?	1. Yes. 2. No. 3. Don't know
f. Do you have problems or concerns with accessing prescriptions, medical equipment?	1. Yes. 2. No. 3. Don't know
g. Would you say there are sufficient number of bilingual physicians and other health care providers in your community?	1. Yes. 2. No. 3. Don't know
h. Do you have sufficient resources to navigate your health care /concerns?	1. Yes. 2. No. 3. Don't know
i. Would you say health prevention, screening and wellness are promoted well in your community?	1. Yes. 2. No. 3. Don't know
j. Do you have access to emergency / trauma services?	1. Yes. 2. No. 3. Don't know
k. Do you have access to mobile clinic services?	1. Yes. 2. No. 3. Don't know

Immigrants' Health Status and Access to Care: Survey Questions 2 of 3

KEY HEALTH ISSUES

2. By answering 1. For Yes, 2. For No, or 3. For Don't Know, please indicate where you have any of the following health problems.

a. Diabetes	1. Yes	2. No	3. For Don't Know
b. Cancer	1. Yes	2. No	3. For Don't Know
c. Heart Disease	1. Yes	2. No	3. For Don't Know
d. Stroke	1. Yes	2. No	3. For Don't Know
e. Obesity	1. Yes	2. No	3. For Don't Know
f. Mental / Behavioral Health	1. Yes	2. No	3. For Don't Know
g. Substance Abuse (alcohol, prescription drugs, recreational drugs, illegal drugs)	1. Yes	2. No	3. For Don't Know
h. Asthma	1. Yes	2. No	3. For Don't Know

QUALITY OF LIFE

3. On a scale of 1. (Very poor) through 5 (excellent), 6. Don't know, please tell me how you would rate quality of in your community.

Very poor ← → Excellent

NEIGHBORHOOD/ENVIRONMENT						
a. Recreational activities for children / youths/adults.	1.	2.	3.	4.	5.	6. Don't know
b. Neighborhood safety	1.	2.	3.	4.	5.	6. Don't know
c. Availability of fresh produce and other healthy foods.	1.	2.	3.	4.	5.	6. Don't know
d. Availability of goods and services	1.	2.	3.	4.	5.	6. Don't know
e. Availability of public transportation	1.	2.	3.	4.	5.	6. Don't know
f. Availability of child care /elder care	1.	2.	3.	4.	5.	6. Don't know

Immigrants’ Health Status and Access to Care: Survey Questions 3 of 3

WELLNESS & PREVENTION

4. On a scale of 1. (Strongly disagree) through 5. (Strongly agree), and 6. Don’t know, please rate each of the following statements.

Strongly disagree ← →Strongly agree

a. Healthy lifestyle (nutrition, exercise) education programs are in your community.	8. 2. 3. 4. 5. 6. Don’t know
b. Substance Abuse (alcohol, prescription drugs, recreational drugs, illegal drugs) prevention/education programs are available in your community.	1. 2. 3. 4. 5. 6. Don’t know
c. Smoking cessation programs / support is available in your community.	1. 2. 3. 4. 5. 6. Don’t know
d. Diabetes: all services needed for this disease process are available in your community	1. 2. 3. 4. 5. 6. Don’t know
e. Cancer: all services needed for this disease process are available in your community.	1. 2. 3. 4. 5. 6. Don’t know
f. Heart disease: all services needed for this disease process are available in your community	1. 2. 3. 4. 5. 6. Don’t know
g. Arthritis: all services needed for this disease process are available in your community	1. 2. 3. 4. 5. 6. Don’t know

Study Participant Number: ___________
Study Provider Number: ___________

[Adapted from Springer and Hauser (2003)]

Appendix D-5: Health History Questionnaire 1 of 3

Today's Date:
Follow up Date/s:
Provider's Number: **1.** **2.**

Immigration Outreach Service Center
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your Health Assessment record.

Participant's Number	☐ M ☐ F	**Age:** ☐ **18-30** ☐ **31-40** ☐ **41-50** ☐ **51-60** ☐ **61-70** ☐ **>71**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Family:** Children? _ Parents living? _ Living with family? _By self? _ With friend? _	
Date of last physical exam:		**Name of previous physician:**	

HEALTH HISTORY

I. Client Based data

BP: **P:** **R:** **WT:**
Client's Primary and Secondary Language:
Childhood illness:
Immunizations:

Health Interview	1. What do *you* call the problem?	
	2. What do *you* think has caused your problem?	
	3. Why do *you* think it started?	
	4. What does your sickness do to you?	
	5. How severe is it? Is it a short or long course?	
	6. What worries you the most about your sickness?	
	7. What are the major problems your sickness has caused you?	
	8. What kind of treatment do you think you should receive?	

List any medical problems that other doctors have diagnosed		
1. 2.		
Surgeries		
Year	Reason	Location: country/state
Other hospitalizations		
Year	Reason	Location: country/state

Provider's NOTES:

Summary of Major Concerns:

1. Oxygenation:

2. Circulation:

3. Integument:

4. Gastrointestinal:

5. Muscular-skeletal:

6. Neurological:

7. Immunity

8. Personal - Developmental:

9. Cultural - Spiritual

10. Awareness - environmental

RECOMMENDATIONS:

REFERRALS:

FOLLOW-UP:

Appendix D-6: Specific Health Data

Participant’s Number:
Health Provider’s Number:
Date:

SPECIFIC HEALTH DATA
(***This information will be part of your*** Health Assessment record.**)**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise) ***Comments:***			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x per week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x per week for 30 minutes)			
Diet	Are you dieting? ***Comments:***	☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet? ***Comments:***	☐ Yes	☐ No	
	# of meals you eat in an average day?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Rank fat intake	☐ Hi	☐ Med	☐ Low
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	☐ Yes	☐ No	
	Have you considered stopping?	☐ Yes	☐ No	
	Have you ever experienced blackouts?	☐ Yes	☐ No	

	Are you prone to “binge” drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Weight **Management & Related Health Concerns**	Would you like to know more about healthy nutrition?	☐ Yes	☐ No
	Do you high Blood Pressure? ***Comments:***	☐ Yes	☐ No
	Do you have Diabetes? ***Comments:***	☐ Yes	☐ No
	Have you been checked for cancer? ***Comments:***	☐ Yes	☐ No
	Would you like to know more about weight related health problems? ***Comments:***	☐ Yes	☐ No
Personal Safety	Do you live alone? ***Comments:***	☐ Yes	☐ No
	Do you have frequent falls? ***Comments:***	☐ Yes	☐ No
	Do you have vision or hearing loss? ***Comments:***	☐ Yes	☐ No
	Do you have a Living Will or *equivalent*? ***Comments:***	☐ Yes	☐ No
	Do you drive a vehicle? ***Comments:***	☐ Yes	☐ No
	Do you frequently use public transportation? ***Comments:***		
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		GENDER	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐M ☐ F			☐ M ☐ F	
	☐M ☐ F			☐ M ☐ F	

	☐M ☐F		**Grandmother** *Maternal*		
	☐M ☐F		**Grandfather** *Maternal*		
	☐M ☐F		**Grandmother** *Paternal*		
	☐M ☐F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY (Use as Appropriate)

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY (Use as Appropriate)

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times ______		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have not had any symptoms in the following areas to a significant degree and briefly explains.

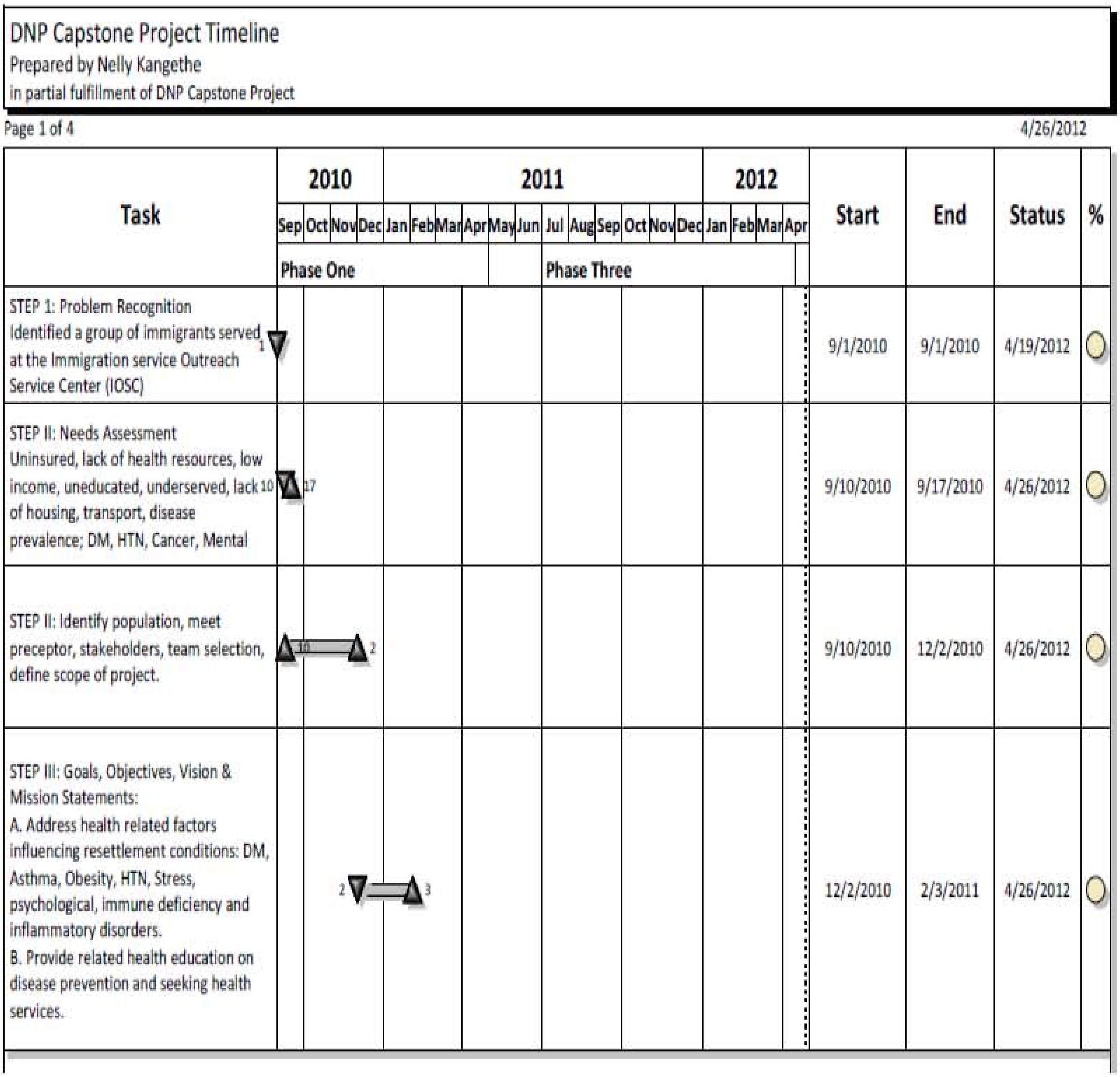
☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

RECOMMENDATIONS:

REFERRALS:

FOLLOW-UP:

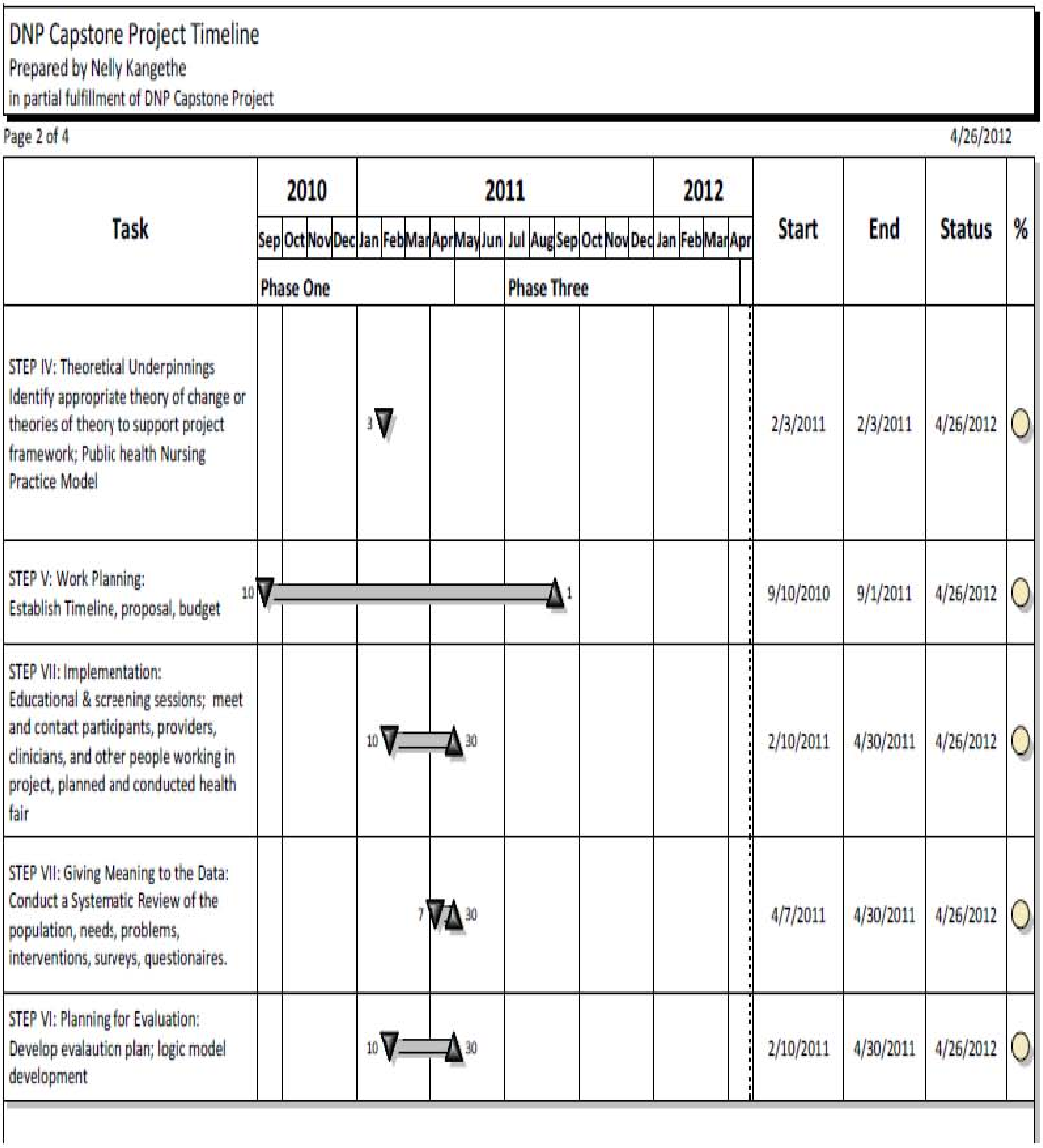
Appendix E: Timeframe



DNP Capstone Project Timeline
Prepared by Nelly Kangethe
in partial fulfillment of DNP Capstone Project

Page 1 of 4 4/26/2012

Task	Start	End	Status	%
STEP 1: Problem Recognition Identified a group of immigrants served at the Immigration service Outreach Service Center (IOSC)	9/1/2010	9/1/2010	4/19/2012	○
STEP II: Needs Assessment Uninsured, lack of health resources, low income, uneducated, underserved, lack of housing, transport, disease prevalence; DM, HTN, Cancer, Mental	9/10/2010	9/17/2010	4/26/2012	○
STEP II: Identify population, meet preceptor, stakeholders, team selection, define scope of project.	9/10/2010	12/2/2010	4/26/2012	○
STEP III: Goals, Objectives, Vision & Mission Statements: A. Address health related factors influencing resettlement conditions: DM, Asthma, Obesity, HTN, Stress, psychological, immune deficiency and inflammatory disorders. B. Provide related health education on disease prevention and seeking health services.	12/2/2010	2/3/2011	4/26/2012	○



DNP Capstone Project Timeline
Prepared by Nelly Kangethe
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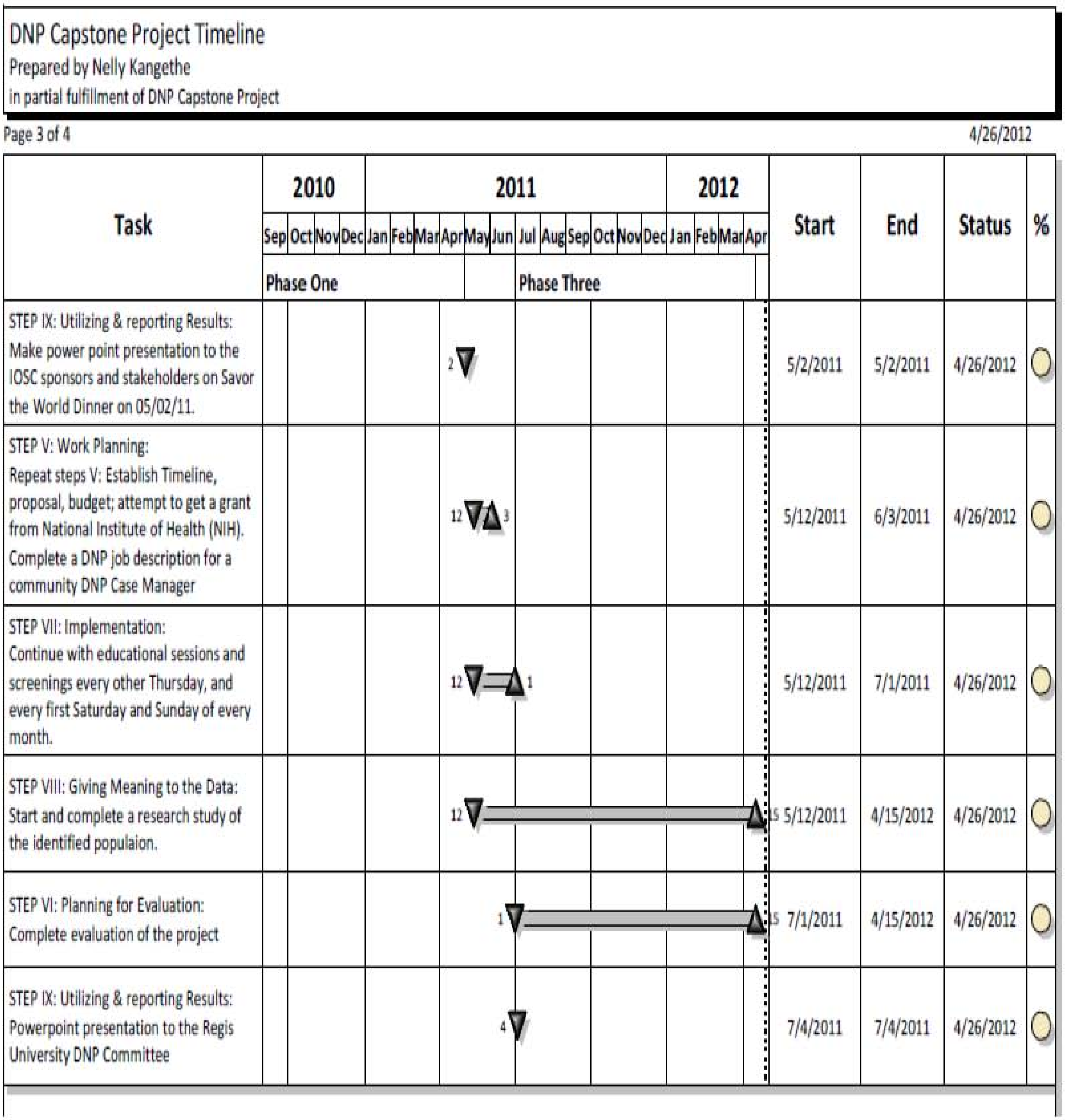
4/26/2012

Task	Start	End	Status	%
STEP IV: Theoretical Underpinnings Identify appropriate theory of change or theories of theory to support project framework; Public health Nursing Practice Model	2/3/2011	2/3/2011	4/26/2012	○
STEP V: Work Planning: Establish Timeline, proposal, budget	9/10/2010	9/1/2011	4/26/2012	○
STEP VII: Implementation: Educational & screening sessions; meet and contact participants, providers, clinicians, and other people working in project, planned and conducted health fair	2/10/2011	4/30/2011	4/26/2012	○
STEP VII: Giving Meaning to the Data: Conduct a Systematic Review of the population, needs, problems, interventions, surveys, questionaires.	4/7/2011	4/30/2011	4/26/2012	○
STEP VI: Planning for Evaluation: Develop evalaution plan; logic model development	2/10/2011	4/30/2011	4/26/2012	○



DNP Capstone Project Timeline
Prepared by Nelly Kangethe
in partial fulfillment of DNP Capstone Project

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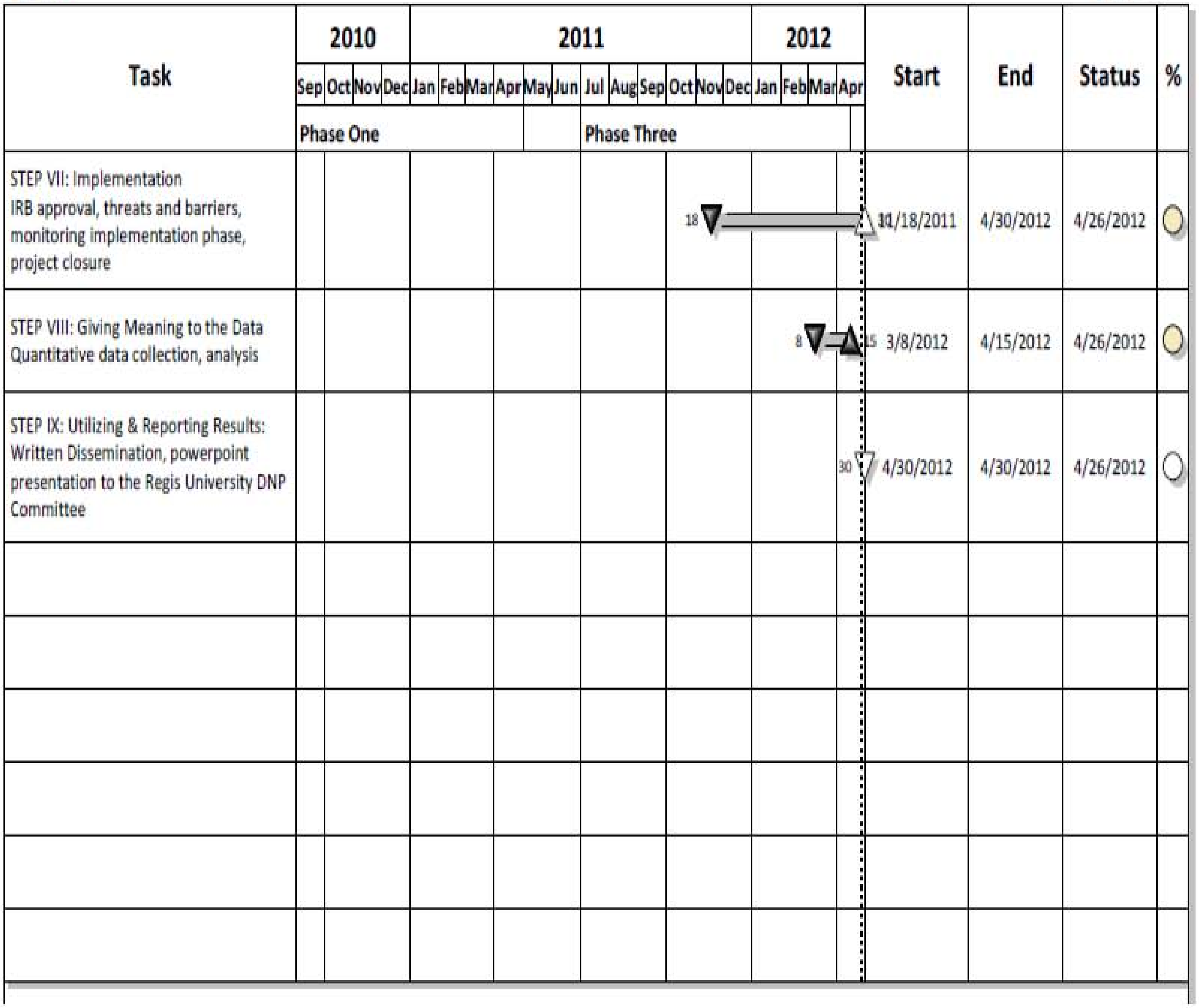
4/26/2012

Task	Start	End	Status	%
STEP IX: Utilizing & reporting Results: Make power point presentation to the IOSC sponsors and stakeholders on Savor the World Dinner on 05/02/11.	5/2/2011	5/2/2011	4/26/2012	○
STEP V: Work Planning: Repeat steps V: Establish Timeline, proposal, budget; attempt to get a grant from National Institute of Health (NIH). Complete a DNP job description for a community DNP Case Manager	5/12/2011	6/3/2011	4/26/2012	○
STEP VII: Implementation: Continue with educational sessions and screenings every other Thursday, and every first Saturday and Sunday of every month.	5/12/2011	7/1/2011	4/26/2012	○
STEP VIII: Giving Meaning to the Data: Start and complete a research study of the identified populaion.	5/12/2011	4/15/2012	4/26/2012	○
STEP VI: Planning for Evaluation: Complete evaluation of the project	7/1/2011	4/15/2012	4/26/2012	○
STEP IX: Utilizing & reporting Results: Powerpoint presentation to the Regis University DNP Committee	7/4/2011	7/4/2011	4/26/2012	○

DNP Capstone Project Timeline
Prepared by Nelly Kangethe
in partial fulfillment of DNP Capstone Project

Page 4 of 4 4/26/2012



Task	Start	End	Status	%
STEP VII: Implementation IRB approval, threats and barriers, monitoring implementation phase, project closure	11/18/2011	4/30/2012	4/26/2012	○
STEP VIII: Giving Meaning to the Data Quantitative data collection, analysis	3/8/2012	4/15/2012	4/26/2012	○
STEP IX: Utilizing & Reporting Results: Written Dissemination, powerpoint presentation to the Regis University DNP Committee	4/30/2012	4/30/2012	4/26/2012	○

Appendix F: Budget and Resources

Appendix F-1: IOSC's Balance Sheet 1

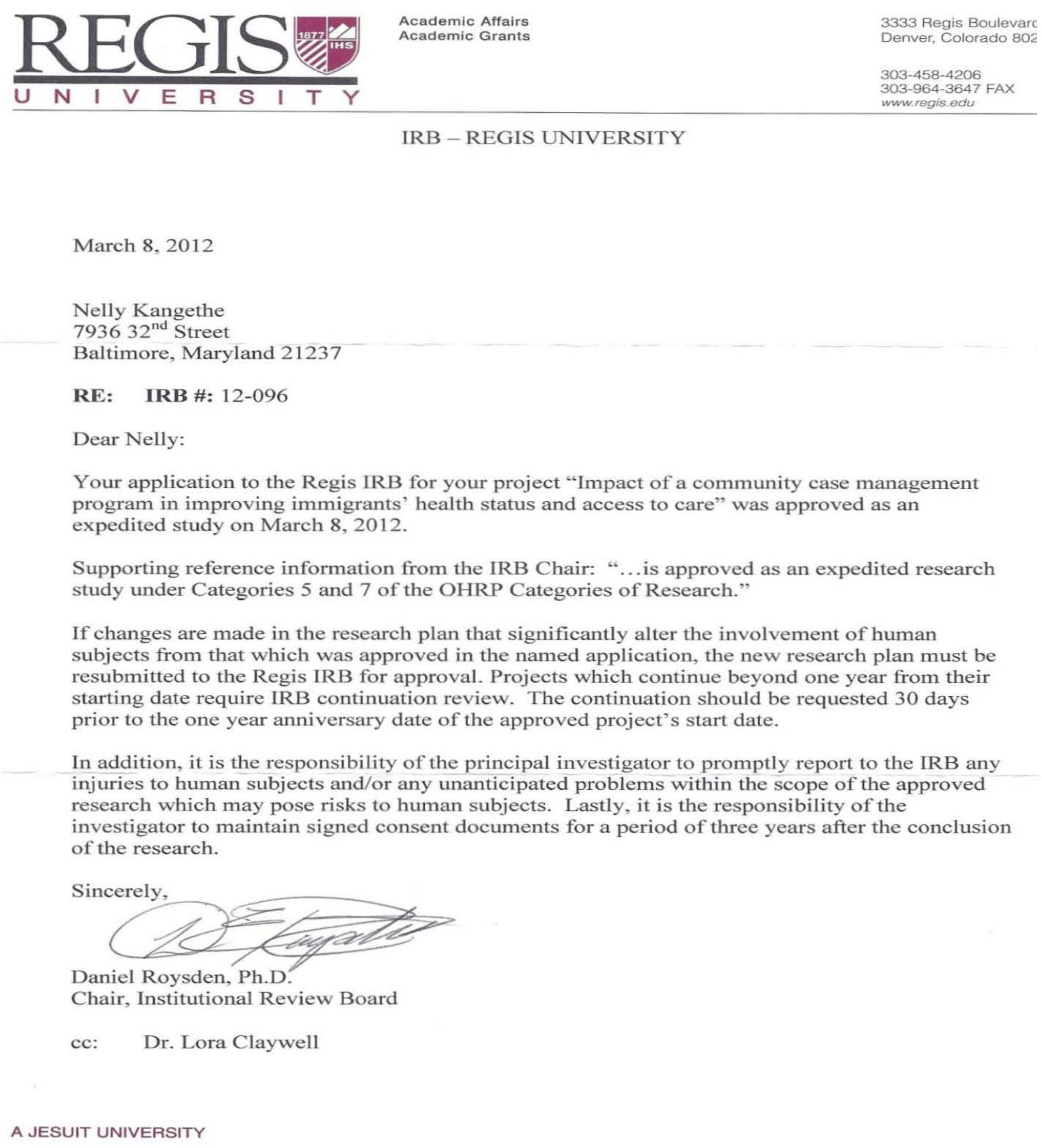
IOSC Health Clinic
Balance Sheet
January 31, 2011

Assets	
Cash (Donations)	$300
Accounts Receivable	0
Equipment	2,500
Supplies	3,800
Building Less: Allowance Depreciation	30,000 6,000 24,000
Total Assets	$30,600

Liabilities	
Accounts Payable	$ 3800
Notes Payable	2,500
Total Liabilities	6,300
Net Assets	24,300
Total Liabilities and Net Assets	$30,600

Appendix G: IRB Approval Letters

Appendix G-1: Regis IRB Approval Letter



REGIS UNIVERSITY

Academic Affairs
Academic Grants

3333 Regis Boulevar
Denver, Colorado 802

303-458-4206
303-964-3647 FAX
www.regis.edu

IRB – REGIS UNIVERSITY

March 8, 2012

Nelly Kangethe
7936 32nd Street
Baltimore, Maryland 21237

RE: **IRB #:** 12-096

Dear Nelly:

Your application to the Regis IRB for your project "Impact of a community case management program in improving immigrants' health status and access to care" was approved as an expedited study on March 8, 2012.

Supporting reference information from the IRB Chair: "…is approved as an expedited research study under Categories 5 and 7 of the OHRP Categories of Research."

If changes are made in the research plan that significantly alter the involvement of human subjects from that which was approved in the named application, the new research plan must be resubmitted to the Regis IRB for approval. Projects which continue beyond one year from their starting date require IRB continuation review. The continuation should be requested 30 days prior to the one year anniversary date of the approved project's start date.

In addition, it is the responsibility of the principal investigator to promptly report to the IRB any injuries to human subjects and/or any unanticipated problems within the scope of the approved research which may pose risks to human subjects. Lastly, it is the responsibility of the investigator to maintain signed consent documents for a period of three years after the conclusion of the research.

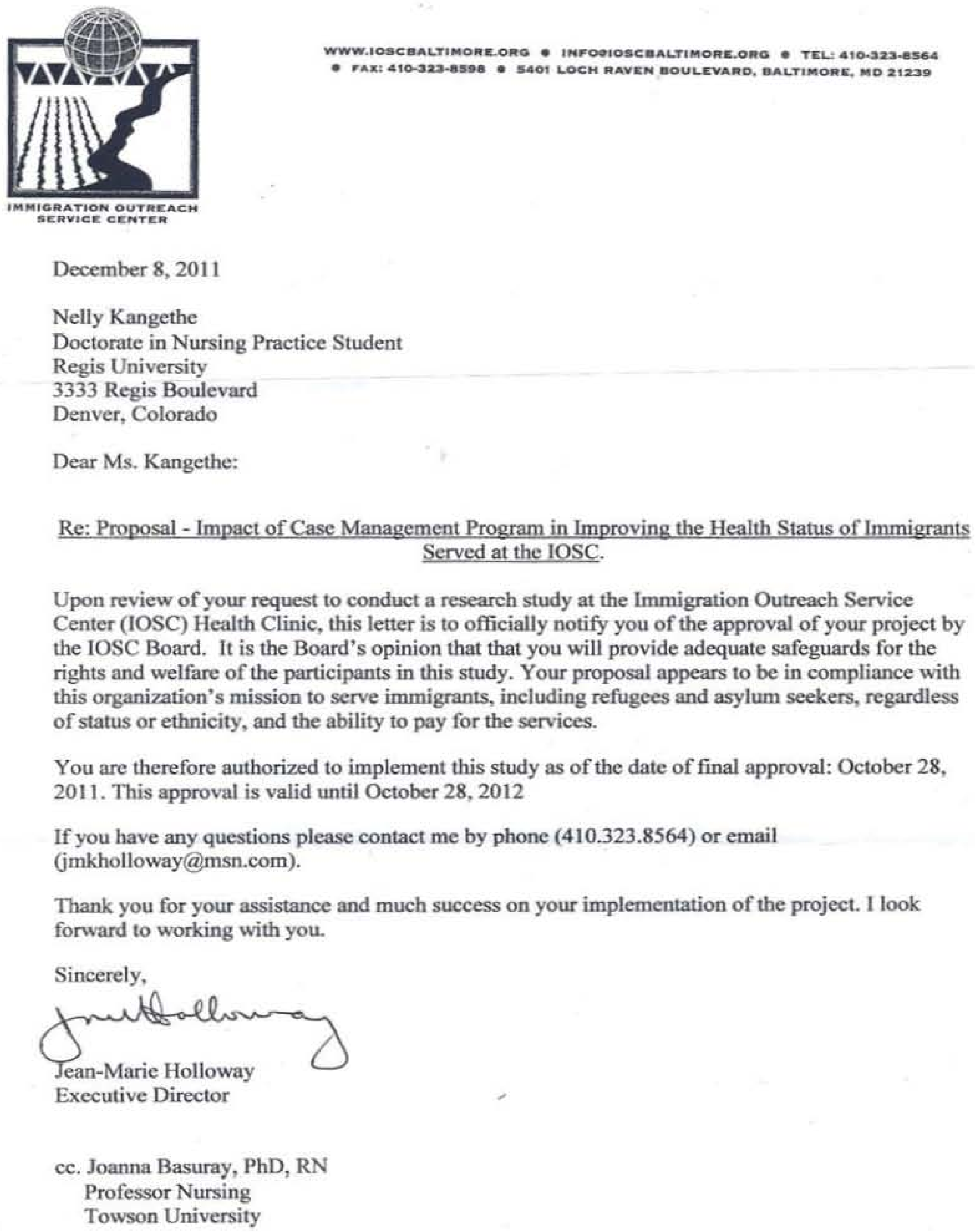
Sincerely,

Daniel Roysden, Ph.D.
Chair, Institutional Review Board

cc: Dr. Lora Claywell

A JESUIT UNIVERSITY

Appendix G-2: IOSC Letter of Support



IMMIGRATION OUTREACH
SERVICE CENTER

WWW.IOSCBALTIMORE.ORG • INFO@IOSCBALTIMORE.ORG • TEL: 410-323-8564
• FAX: 410-323-8598 • 5401 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239

December 8, 2011

Nelly Kangethe
Doctorate in Nursing Practice Student
Regis University
3333 Regis Boulevard
Denver, Colorado

Dear Ms. Kangethe:

Re: Proposal - Impact of Case Management Program in Improving the Health Status of Immigrants Served at the IOSC.

Upon review of your request to conduct a research study at the Immigration Outreach Service Center (IOSC) Health Clinic, this letter is to officially notify you of the approval of your project by the IOSC Board. It is the Board's opinion that that you will provide adequate safeguards for the rights and welfare of the participants in this study. Your proposal appears to be in compliance with this organization's mission to serve immigrants, including refugees and asylum seekers, regardless of status or ethnicity, and the ability to pay for the services.

You are therefore authorized to implement this study as of the date of final approval: October 28, 2011. This approval is valid until October 28, 2012

If you have any questions please contact me by phone (410.323.8564) or email (jmkholloway@msn.com).

Thank you for your assistance and much success on your implementation of the project. I look forward to working with you.

Sincerely,

Jean-Marie Holloway
Executive Director

cc. Joanna Basuray, PhD, RN
Professor Nursing
Towson University

Appendix H: CITI Training Certificate

CITI Collaborative Institutional Training Initiative

Human Research Curriculum Completion Report

Printed on 11/2/2011

Learner: Nelly Kangethe (username: kange560)
Institution: Regis University
Contact Information Department: Nursing
Email: kangnell@msn.com

Social Behavioral Research Investigators and Key Personnel:

Stage 1. Basic Course Passed on 06/13/11 (Ref # 6168404)

Required Modules	**Date Completed**	
Introduction	06/12/11	no quiz
History and Ethical Principles - SBR	06/12/11	4/4 (100%)
The Regulations and The Social and Behavioral Sciences - SBR	06/12/11	4/5 (80%)
Assessing Risk in Social and Behavioral Sciences - SBR	06/12/11	4/5 (80%)
Informed Consent - SBR	06/12/11	5/5 (100%)
Privacy and Confidentiality - SBR	06/13/11	5/5 (100%)
Regis University	06/13/11	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator