Latino Health Care Collaborative (LHCC)

District of Columbia Department of Health (DOH)

Report on the Status of Latino Health in the District of Columbia, 2004

Funded by the Centers for Medicare and Medicaid Services (CMS)
Submitted to the Council of Latino Agencies, August 12, 2005

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH

ACKNOWLEDGEMENTS

Government of the District of Columbia
Anthony A. Williams, Mayor

Department of Health
Gregg A. Pane, MD, Director
Brenda J. Kelly, Senior Deputy Director, Policy, Planning, and Research

State Center for Health Statistics Administration
Fern Johnson-Clarke, Ph.D., Acting Director
Ligia Artiles, Project Coordinator
Biva Chowdhury, Statistician
Monica Davis, Research Assistant
Patricia Theiss, Public Health Analyst, Coordinator DC Healthy People 2010 Plan
Luz Vega, Prevention Specialist

D.C. Office of Planning, State Data Center
Robert R. Beasley, Analyst

George Washington University Department of Global Health
William Waters, Ph.D., Associate Professor, Senior Associate
Jennifer Cromwell, MA

Council of Latino Agencies
Eugenio Arene, Executive Director
Kristin Jerger, MD, Project Director
Heather McClure, Ph.D., Director of Research and Policy

National Center for Health Statistics
Wilbur Hadden, Ph.D., Statistician

Members of the Technical Advisory Board
Mohamed Akhter, Ligia Artiles, Odile Attiglah, Jackie Brown, Greg Chen, John O. Davies-Cole, Kay Eilbert, Ricardo Galbis, Maria Gomez, Muhuiddin Haider, Barbara Hatcher, Kristin Jerger, Fern Johnson-Clarke, Esther Kaggwa, James Kamau, Vijaya L. Melnick, Heather McClure, Juan Romagoza, Mark Rubin, Peter Tatian, Patsy Theiss, Luz Vega, Gustavo Velazquez, Bailus Walker, Will Waters, Henry Williams, Carl W. Wilson

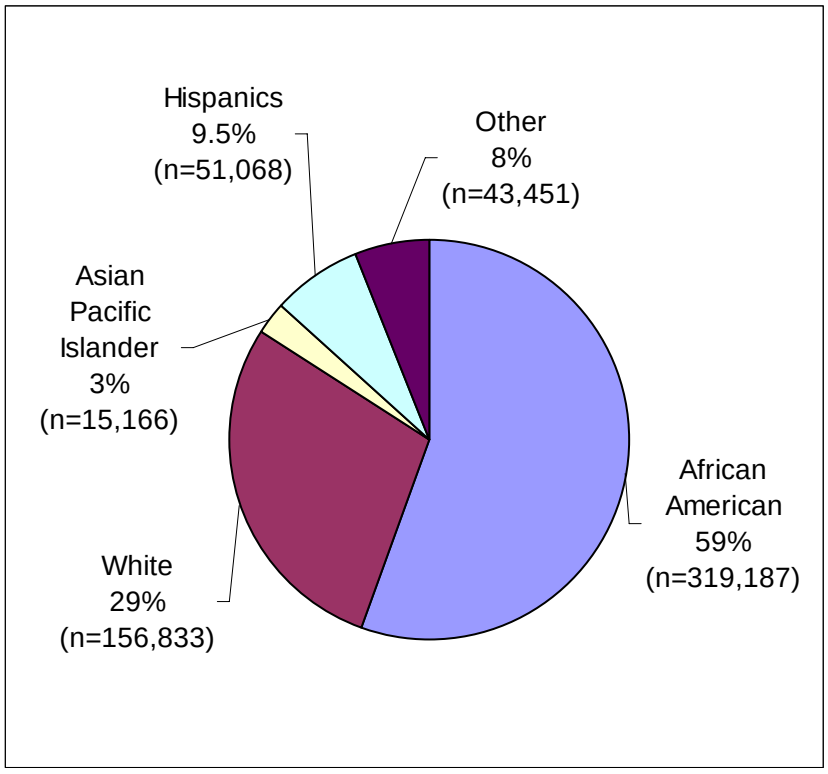
Special thanks go to the following individuals and institutions who made important contributions to the LHCC study and health intervention:
Richard Bragg, Community Ministries of Rockville, Julie Farkas, Lori Kaplan, Rodrigo Leiva, Ivor Livingston, Margaret O'Brien, Andrea Perez, Michael Quinn, Ivonne Rivera, Krishna Roy, Robert Santos, Manfred Sprinckmoller, Alex Taylor del Cid, Peter Thomas, Armando Trull, Gustavo Velazquez

Table of Contents

I. About the District of Columbia

As the nation's capital, the District of Columbia is characterized by a distinctive international stature and a diverse population. In its 63 square miles, the District is home to a population which represents many world cultures. The 2002 Census indicates that the District's population of 572,059 is 59 percent African American, 29 percent white, 3 percent Asian / Pacific Islander, and 8 percent Other (Figure 1). Residents of Hispanics ethnicity represent 9.5 percent of the total population. The challenge faced by the District's health system is to address the needs of all its residents, while recognizing the diverse health needs and health status of its numerous subpopulations.

Figure 1: Estimated Population by Race District of Columbia, 2002



In recent years, dramatic changes, in particular the advent of health care management organizations (HMOs), have occurred in the health care arena. These changes have affected the

delivery of health care and created new challenges for shaping public health policy. Nevertheless, the purpose for providing health care has not changed. There remains the need to continuously assess the impact of these changes on public health, on ensuring access to appropriate interventions, on monitoring the overall health system, and on developing appropriate public policy.

In the midst of this changing health care environment, the District of Columbia struggles with a number of health-related problems among its residents. The five leading causes of death in 2002 were heart disease, cancer, hypertension, cerebrovascular diseases, and homicide. Expressed in crude rates, these deaths occurred at rates of 244.6, 222.9, 61.4, 40.2 and 38.5, respectively. The infant mortality rate in 2002 was 11.5 per 1,000 live births compared with 7.2 nationally. Over the past ten years (1993-2002), there has been an overall declining trend in the infant mortality rate.

II. Introduction

In the late 1990s, the federal government released draft objectives for a comprehensive 10-year Prevention Agenda for improving the health of the nation by 2010. Named *Healthy People 2010*, this initiative (DHHS 2000) evolved from earlier Prevention Agendas, notably, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (issued in 1979) and the 1980 publication *Promoting Health/Preventing Disease: Objectives for the Nation.* Prior to the development of the 2010 Prevention Agenda, national health priorities and objectives were established in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (DHHS 1990).

The new 2010 Plan is science-based and is designed to measure specific areas of progress to be expressed as measurable objectives grounded in local baseline data. The 2010 Plan has two

defining characteristics. First, it has two overarching goals: (1) to increase quality and years of healthy life and (2) to eliminate health disparities. Second, it specifically and explicitly calls for a community-based approach to achieving its basic goals, meaning that local governmental agencies and non-governmental and community-based organizations should be full and active partners (DHHS 2000) in efforts to bring the strategies for disease prevention and health promotion to community residents.

The District of Columbia Department of Health (DOH), in an effort coordinated by its State Center for Health Statistics Administration (SCHSA), responded to the Federal initiative with its *DC Healthy People 2010 Plan: A Strategy for Better Health* (SCHSA 2000), modeled on the Federal plan, and its subsequent series of 2010 implementation plans with companion *Progress Reports:* the *DC Healthy People 2010: Annual Implementation Plan Year 2002* (SCHSA 2002), and the *DC Healthy People 2010 Biennial Implementation Plan 2003-2004* (SCHSA 2004). A *Mid-Course Revision to the DC Healthy People 2010 Plan* that will bring the health baselines up to 2000 from 1997-1998 is being finalized for release in the fall of 2005 (SCHSA 2005). The status of population health in the District of Columbia was also documented in the *DC Healthy People 2010 Plan* (DC DOH 2000). Following the lead provided at the federal level, the District's strategy is focused on the elimination of health disparities separating resident minority populations from the white population (Public Health Infrastructure Objective 10-3. Revised in 2003 to read as follows: Develop data on all racial/ethnic population groups – i.e., white, black/African American, Asian American/Pacific Islander (AAPI), American Indian/Alaska Native - residing in the District). However, in order to measure progress in the elimination of disparities, health baseline data on all resident minority populations must be available. To fill this gap in resident minority health baseline data, the SCHSA began work on a model for a targeted community health

assessment, the DC Community Health Assessment Initiative (DC CHAI) that had the potential to yield the desired minority health baselines. Unlike the standard city-wide community health assessment models such as Mobilizing Action through Planning and Partnerships (MAPP) and APEXPH, the DC CHAI model would provide a community health assessment based on small area analysis, followed by a community health education component with data-driven health messages.

The strategy was put into action when the SCHSA developed a successful application in 2002 to the Centers for Disease Control and Prevention (CDC) for a Prevention specialist who in her two-year assignment at the SCHSA was focused on the establishment of health baselines for resident minority population groups, Latinos and AAPI, unaccounted for in the existing health data reports and databases at the SCHSA. Early in 2003, the SCHSA convened a meeting with partners, including the George Washington University Department of Global Health (GWUDGH) and the Council of Latino Agencies (CLA), to formulate a plan to apply the DC CHAI model to gather accurate and reliable baseline data on health status of different minority population groups residing in the District of Columbia, specifically with reference to priority health areas previously identified in the *DC Healthy People 2010 Plan* (SCHSA 2000). In order to obtain these data, a pilot plan using the DC CHAI model was developed to conduct a randomized household survey of a representative sample of the District's Latino population and, based on experience gained in this pilot effort, to conduct household surveys of other minority population groups as defined in the U.S. Census.

Among the reasons for addressing health status in the Latino community first were: (1) it is a large, dynamic, and growing population in the District (and surrounding jurisdictions); (2) it differs from Latino populations in other parts of the country in terms of countries of origin and socioeconomic status; for that reason so much of the growing literature on Latino health and well-

being is not necessarily applicable; (3) approximately three quarters of District Latinos reside in a readily-identifiable and discrete central corridor in the center of the city, so that a household-based survey would be easily designed; and (4) an active network of community-based Latino organizations would be available for collaboration. The principal community-based organization identified for this purpose was the Council of Latino Agencies (CLA), along with three of its member organizations: Mary's Center for Maternal and Child Care, La Clínica del Pueblo, and Andromeda. Together, the partnering organizations formed the Latino Health Care Collaborative (LHCC), and a Technical Advisory Board (TAB) of experienced public health professionals from local universities and health organizations was established to guide the work of the partners (See Appendix 1 for TAB membership).

III. Health Priorities among Resident Latinos in the District of Columbia

Latinos are a population of increasing concern in the United States, and they merit special attention for a variety of reasons. First, there are now an estimated 41.3 million Latinos in the country, representing 14.1 percent of the total US population (U.S. Census Bureau 2005). The growth of the Latino population is dramatic; the 2000 U.S. Census counted 35.3 million Latinos, representing 12.5 percent of the total U.S. population, growth between 1990 and 2000 exceeded 5 percent, following increases of 61 percent between 1970 and 1980 and 53 percent between 1980 and 1990 (Council on Scientific Affairs 1991).

Second, Latinos have poorer socioeconomic status than the general population, particularly when compared to non-Hispanic whites. On average, educational achievement is lower. Fully 27.7 percent of Latinos in the United States had less than a ninth grade education in 2000, as compared to only 4.5 percent of the non-Hispanic white population, and while 56.1 percent of

Latinos had a high school education or more, the comparable figure for non-Hispanic whites was 87.7 percent. Moreover, 6.7 percent of Latinos at least 16 years of age are unemployed, compared to 3.6 percent among non-Hispanic whites. Consequently, Latinos are three times more likely to live below the poverty line than non-Hispanic whites (25.6 percent vs. 8.2 percent) and over a third of Latino children are poor (34.4 percent vs. 10.6 percent of non-Hispanic white children); (Council on Scientific Affairs 1991).

Third, the health status of Latinos is inferior to that of the general population in the United States in terms of both mortality and morbidity, especially among the poor (Lilly-Blanton, Rushing, and Ruiz 2003). Life expectancy at birth is lower, while rates of infant mortality, neonatal mortality, and low birth weight are higher (Berk et al. 2000; Morales, Reise, and Hayes 2000). It has been well known for more than a decade that compared to national averages, Latinos have higher rates of hypertension, tuberculosis, HIV/AIDS, diabetes, alcoholism, cirrhosis, gallstones, kidney and liver disease, occupational risk, and violent death (Council on Scientific Affairs 1991; Delgado et al. 1990; Jiménez and Jiménez 1992; Nickens 1991). They also have higher incidence and mortality rates from cancers of the stomach, liver, uterine cervix, and gallbladder, associated with exposure to infectious agents and lower rates of screening (O'Brien et al., 2003). In sum, while there is substantial variation among and within subgroups, research has long established a close link between Latino ethnicity and poor health status.

Poor health status is exacerbated by inadequate access to health care, and has been so for many years. For example, 31 percent of Latino children live in families that lack medical insurance coverage vs. 12 percent for non-minority children (Collins 1994). Undocumented Latinos are especially vulnerable; compared to other population groups they use fewer ambulatory services (Collins 1994) and have long been more dissatisfied with the care they receive (Scribner

1989). Dissatisfaction with care does not occur in a vacuum; recent evidence shows that under the same circumstances, members of minority groups, including Latinos, receive poorer care than others (Lilly-Blanton, Rushing, and Ruiz 2003).

Understanding the cultural and economic dimensions of health care among Latinos is particularly challenging because they are a heterogeneous population, differing not only in terms of country of origin, but also on the basis of duration of residence in the United States; levels of acculturation; and formal education; income, and other measures of socioeconomic status.

Understanding the health of Latinos in the Washington, DC area is especially challenging, because the Latino resident community is so diverse and dynamic. For example, while Washington, DC's total population declined between 1980 and 2000, its resident Latino population grew considerably. The 2000 U.S. Census counted 44,943 Latinos in the District of Columbia, representing 7.9 percent of the District's population, compared to 32,710 in 1990 (or 5.4 percent of the total), and 17,676 in 1980 (or 2.8 percent of the total). A large proportion of Latinos are from El Salvador, but Mexicans and other Central Americans, Puerto Ricans, Dominicans, and Cubans are also present in large numbers, as are South Americans, especially Bolivians and Peruvians. The District's Latino community is unique for several reasons (Aragon and Lillie-Blanton 2004):

- Duration of residence is longer than generally thought; the majority of Latino immigrants have been in this country for more than six years.
- Latino adults are three times more likely to be uninsured than other adults.
- Latinos have less access to health care, but are not more critical of the health care system than other adults.
- Compared to Latinos elsewhere in the U.S., those in the District of Columbia are more likely to be foreign born and primarily speak Spanish.

Among the priority issues identified by the District of Columbia Department of Health in its *Healthy People 2010 Plan*'s chapter on Nutrition and Overweight is obesity. The Federal government, through the *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (US DHHS, 2001) has already identified overweight and obesity as representing an "epidemic" in America. Approximately two thirds of American adults are now either overweight or obese, as measured by the body mass index (BMI), which is based on weight and height. The importance of this epidemic can hardly be overstated; voluminous literature links overweight and obesity with cardiovascular disease, diabetes, and even with the potential for decreasing longevity in the U.S. population (Oshansky et al. 2005; Wannamethee, Shaper, and Walter 2005). (For further details refer to Obesity Trends Among US Adults, 1990-2000, a Power Point presentation by Dr. David Satcher, a former U.S. Surgeon General).

Overweight and obesity in the U.S. have long been associated with poverty and minority status; and recent evidence (Goel et al. 2004; Kaplan et al. 2004) shows that immigrants' duration of residence in the United States is positively associated with higher body mass index. Moreover, the status of U.S. Latino health must be considered in a societal context; for example, Popkin (2001) shows that increasing overweight and obesity represents one of the most important trends in developing countries, and is associated with structural factors such as urbanization and changing diets and lifestyles. Specifically, as Uauy, Albala, and Kain (2001) demonstrate, Latin America is experiencing rapid demographic and nutritional transitions. Overweight and obesity are on the rise. And associated risk factors, especially cardiovascular disease and cancer, are also increasing. Thus, health status in the Latino community is not only in part a product of the environment in which immigrants find themselves, but also in part, a product of the lives they led prior to coming to the U.S.

IV. III. Methodology

A. Study Design

The information presented in this report is based on a stratified, probability-based sample survey of 819 adult Latinos living in Washington, DC, who were at least 20 years old at the time of the interview. With technical assistance from the National Center for Health Statistics and the District government's Office of Planning, a multistage sampling procedure was designed, beginning with the selection of Wards 1, 2, 3, and 4 for the study, because they represented 78 percent of resident Latinos according to the 2000 U.S. Census. City ward maps of Census tracts, Census blocks and household listings by race/ethnicity of residents that were provided by the Office of Planning were used to determine the sample frame for the study population (maps available only on hardcopy). The methodology for the determination of the sample frame and random selection of Hispanic or Latino households for interviewing purposes was based on procedures recommended by Robert Santos, a professional sampler with whom the SCHSA team consulted in several telephone conferences after having worked with the epidemiologist from the federal Centers for Disease Control and Prevention assigned to the Department of Health in the Bureau of Epidemiology and Health Risk Assessment. It should be noted that according to the federal Office of Management and Budget (OMB), Hispanic and Latino are interchangeable terms. In this paper, we will apply the OMB definition. The sampling strategy can be described as follows.

A multistage sampling methodology provided for the identification of Hispanic populated wards, census tracts and census blocks from which there followed the random selection of blocks in the designated wards using 2000 census maps. Within the selected blocks, interviewers began on the northwest corner and identified every other dwelling unit for screening. In the case of

multiple-story buildings, the team worked from top to bottom, and moved clockwise around the block until all dwelling units had been identified and screened. Selected dwelling units were first screened for Latino inhabitants, based on self-identification. The data collector listed all of the people living in the dwelling unit by first name and age.

From the list, the person next in numerical sequence to the last person interviewed was selected. If the first person on the list for the first household was interviewed, the second on the list for the second household would be interviewed. If the third person on the list in the next household was interviewed, and the fourth household consisted of only two persons, then the second or last on the list would be interviewed. When more than one person in the dwelling unit was eligible (Latino and 20 years of age or more) the one to be interviewed was randomly selected based on age and gender from the list of household members. After the selected individual provided informed consent, the interview was conducted (See Appendix 4d for Informed Consent form). If an eligible person was identified for the second module, that interview was continued with the application of the appropriate section of Module II. If the selected person was not home, an appointment was made and followed up on. When no one answered the door at selected dwelling units, up to two call-back attempts to arrange an interview were made; the call-backs were made on week days between 9:00AM and 5:00PM, evenings between 5:00PM and 8:00PM, and weekend days between 10:00 AM and 8:00PM.

Modifications to Sample Size Resulting from Experience in Ward 3

The desired sample size was determined to be 825 (number derived from a desired total of 750 plus oversampling by 10%), as described in the preceding section. At first, this number was to come from the four wards in which most of the Latinos in the District of Columbia reside.

However, the data collectors found that conducting the survey in Ward 3 was extremely difficult for the following reasons:

-First: the vast majority of Latinos in Ward 3 were not interested in participating in the study. We attributed this to the fact that Latinos in this ward have a higher income and social status and, on average, have better access to health care and a better quality of life (and thus, may have had less incentive to participate in the study);

-Second: most of the residences in Ward 3 are condos, and the data collectors were unable to gain access to the buildings to randomly select the dwelling units;

-Third: the census figures for Ward 3 Latinos may very well include people who are not permanent residents of the District, being either students or associated with diplomatic missions or international organizations.

It was decided to drop Ward 3 - after having made several unsuccessful attempts with letters to building managers and ward representatives describing the survey and its significance - and to increase the sample in the other wards; the increase was accomplished by increasing the number of persons to be selected from the target blocks by 20 percent, each ward was treated as a separate stratum. A Detailed Outline of the Sampling Methodology is in Appendix 2.

Development of Survey Instrument

The survey instruments consisted of two modules. A main module, Module I, was based primarily on the District's 2001 version of the Behavioral Risk Factor Surveillance System (BRFSS), that was designed to solicit information on demographics, access to health care, and health outcomes related to high-risk behaviors, with particular emphasis on preventable diseases. Additional questions on injury and access to health care were taken from the National Health Interview Survey to complete Module I. All of the questions included in the Module had

previously been tested and validated. The questionnaire was written in both English and Spanish and pre-tested in both languages. Respondents were given the option of answering in either language; ultimately, all 819 interviews were conducted in Spanish. This module was designed to be applied in approximately 45 minutes. (See Appendix 4a, 4b, 4c for Module I). A second module, to be discussed in a separate report, was designed to provide information on segments of the Latino community of particular interest to providers in the CLA: mother and children, adolescents and the elderly. The instruments were approved by the District of Columbia Department of Health Institutional Review Board for Public Health (IRBPH).

It should be explained that the BRFSS is a telephone survey of randomly selected adults living in households with telephones within the District of Columbia. In the District, the BRFSS is conducted by the DOH/ Bureau of Epidemiology and Health Risk Assessment with funding and guidance from the Centers for Disease Control and Prevention. However, respondents to the BRFSS are limited to those persons living in households with telephones and able to understand and communicate in English; thus the probability of including a representative sample of Latinos is low. A comparison of preliminary findings with the LHCC survey tool to Module I and the 2003 BRFSS is shown in a power point presentation in Appendix 7.

Pretesting of the instrument

Pretesting of the instrument and interviewing protocol was done on three separate occasions in nearby sites in Maryland. On two occasions, the survey and protocol for interviewing were pretested on a group of Latinos attending classes in English as a second language and on one occasion on members of a Latino church. Pretesting was conducted to identify and correct any language or interviewing procedures that were unclear, misleading or

culturally unacceptable. Prior to the fieldwork training, errors identified in the pretesting of the instrument and protocol for interviewers were corrected.

Training of the Data Collectors

A four-day training session was planned and completed as scheduled. A bilingual team of data collectors consisting of 15 native Spanish speakers, recruited from the Latino community participated in an intensive four-day training session. The training was conducted entirely in Spanish, and consisted of the following elements:

- The project's purpose and goals. This component allowed team members to understand and appreciate the project's importance and their role in contributing to its overall success.
- Project logistics and field work, including sampling methodology, identification of selected households and individuals within households, rules for call backs, and informed consent. This component provided the necessary skills for applying the questionnaires in the field in the most accurate and efficient manner possible.
- Interviewing techniques, including optimizing the interviewer-interviewee dynamic, obtaining informed consent, registering responses, handling skip patterns, and closing the interview. This component was designed to provide the skills that were essential for successful interviewing and accurate recording of information provided by the respondent.
- Introduction to the questionnaire, with a focus on each section and question. This component familiarized the interviewers with the specific elements of the questionnaire: design and layout, correct formulation of each question, skip patterns, and rules for addressing respondents' questions.
- Classroom-based practice. This component provided interviewers with the opportunity to formulate the questions in the questionnaire and to record responses to each question. In

general, it provided interviewers with greater familiarity with the questions, the management of skip patterns, and other features. It also gave the GW team trainers the opportunity to observe and evaluate the interviewers.

- Field-based training at the Nueva Esperanza Lutheran Church in Silver Spring, MD. It should be noted that the instruments had previously been pilot tested at the Community Ministries of Rockville, in Rockville, MD.

The training emphasized the following points: correct selection of households and eligible adults within households, correct techniques for completing questionnaires, skip patterns, presentation at the door, protecting confidentiality, how to ask questions, avoiding bias, repeat calls (morning, afternoon, evenings, weekends) and appointments, supervision and reporting, handling of completed questionnaires, transportation, cell phones, and other logistical matters. In addition, techniques for selecting households for the additional modules were reviewed.

During the training, the teams were formed on the basis of balancing skills, experience, and gender. Team leaders were also selected using similar criteria and were given additional information on selection of blocks and households, assigning team members to households, quality assurance, and submission of completed questionnaires to the Principal Investigator and project assistant at (at CLA) for submission to the project coordinator at the SCHSA.

The basic technique for the training was interactive discussion. Handouts consisted of blank questionnaires and reporting forms. Flip charts were used and placed on walls to record comments and further the discussion. Following the training, supervisors were interviewed and all interviewers completed a short questionnaire in which the different elements of the training were assessed. (See Appendix 6 for Evaluation of Training Report).

Practice Prior to Fieldwork

Monitored practice sessions were conducted both in house and in the field in order to standardize the application of the instrument. The practice sessions were conducted on a group of Latinos who were not District residents, so that the LHCC target population would not be biased. However, the participants selected for the pretesting were sociodemiographically comparable to the LHCC target population.

Preparations for Fieldwork

The data-collectors/interviewers were divided into five teams; for each, a team leader was selected based on experience and performance during the training. These individuals were responsible for team oversight, logistical decisions within selected blocks, and quality assurance for completed questionnaires. They also acted as interviewers. Each day, the teams were assigned to cover a certain number of households in designated blocks in the selected wards as indicated on small area maps of Census blocks provided by the PI and project coordinator. These maps were drawn from the ward maps provided by the Office of Planning. An important element of training and fieldwork was quality control, which was addressed by ensuring that interviewers fully understood how to fill out questionnaires and answer sheets and to review them before submitting them to the responsible team leaders. The team leaders, in turn, reviewed the survey answer sheets and submitted them to the PI and project assistant at the CLA who again reviewed the completed answer sheets before submitting them to the project coordinator for data entry at the SCHSA.

B. Data Entry

Data Entry Process

The data entry program was developed by a senior data entry clerk in the Research and Analysis Division (RAD) of the SCHSA, under the supervision of the Division Chief who also is the Director of the SCHSA. All data storage, data entry and data quality were done at this location. The project coordinator served as data manager. She also reviewed all answer sheets for completeness and quality before they were given to data entry clerks for entry.

Informed Consent forms that accompanied the survey answer sheets were detached from the corresponding answer sheets and stored in a locked cabinet on a separate file before being handed to the data entry clerks. Data entry process included daily quality assurance and verification for accurateness and completeness to a random selection of the daily entries. Data entry clerks were instructed to verify entries several times a day. The data manager also performed random checks to verify the accuracy of the data during each day. The senior data entry clerk also conducted periodic checks of the entries for errors.

Data entry was completed on its 94% after three weeks. A final data entry day was required to complete the last batch of answer sheets returned by data collectors two weeks later. After the data entry was 100% completed, more detailed data quality verification took place. The Chief of RAD completed the merging of data into one file and its exportation to Excel and SAS statistical software.

A preliminary run of frequencies for each variable on both Modules (i.e. Module I the core assessment tool, Module II with its three sections: A, B and C) was done on SAS statistical software. Using the frequency runs, the data manager verified each variable of Module I for any incorrect entries due to error in data collection or data entry. The necessary corrections were

made to the original Excel file and new frequency runs were done. At this point, Module I data are considered to be 100% clean.

Data Entry Program

The program used to enter data from LHCC assessment tool answer sheets was dBASE. The entries will be imported into Excel for final data quality assurance of the whole database, and then imported into SAS for data analysis.

Data Entry Clerks

A job description was circulated among LHCC partners and Technical Advisory Board (TAB) members. Four applicants who were students on summer break referred by a member of the TAB were interviewed. The interviews were conducted at the SCHSA by the project coordinator and her supervisors, including the program analyst who designed the community assessment model and the RAD Chief. The interview process included review of previous experience in data entry and ability to use computer programs, especially data entry programs. Some knowledge of the Spanish language was required. Applicants were also screened for recommendations. During the interview, the incumbents were debriefed on the purpose and significance of the study. They were also introduced to the data entry program and asked to demonstrate their computer literacy by entering data from a sample LHCC survey data answer sheet.

Of the four applicants, two were hired as data entry clerks to work at the SCHSA in positions funded by the CMS grant to the CLA. The data entry clerks were paid $4.00 per entered survey. Daily time sheets were submitted to the CLA as lead agency for the study funded by the CMS. Checks were mailed every week to the data entry clerks.

Training of the Data Entry Clerks

The data entry clerks were trained by the senior data entry clerk and the data manager in t the following areas:

1. Entering and negotiating the program menus
2. Saving on hard drive and backup
3. Browsing through the records
4. Quality verification based on answer sheets (records)
5. Finding common errors on records
6. Understanding the purpose and significance of the study
7. Reading through answer sheets to be entered
8. Entering data on separate files for Module I and Module IIA, IIB and IIC.

At the end of each day, data entry clerks went randomly through their saved records with data manager. They submitted a daily time sheet including the Survey ID No. of all records entered each day.

C. Data Analysis

The data from the 819 surveys were checked for errors and consistency using SAS statistical software. The National Center for Health Statistics provided technical assistance by calculating the appropriate weights to the sample size within each census block within each ward (See Appendix 3 for Memo from Dr. Wilbur Hadden). These weights would inflate the 819 sample respondents to the total Latino population in Ward I (13,097), Ward 2 (5,781), and Ward 4 (6,257). Descriptive, univariate, and bivariate analyses were performed using SAS.

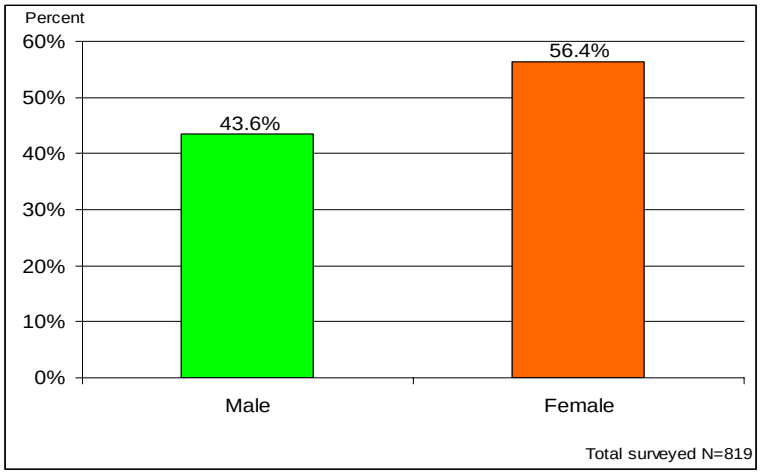
V. Findings and Discussion

This section presents the findings of the survey conducted by the LHCC in 2004. First, information is presented on the characteristics of the interviewees with respect to gender, age, marital status, country of origin, education, employment status, household income, duration of residence in the U.S., language ability, race, insurance coverage and general health status. The next section presents the findings on the five leading health conditions encountered in the Latino community. The section that follows contains information on access to health care and barriers; then data are presented on other health outcomes. Finally, conclusions are presented.

A. Latinos in the District of Columbia

The single characteristic that most typifies the District's Latino community is its diversity as measured by a variety of socioeconomic and demographic indicators. Figure 2 (below) shows that a little more than one-half of the respondents were females and just over 40 percent were males.

Figure 2. Gender of Respondents, 2004

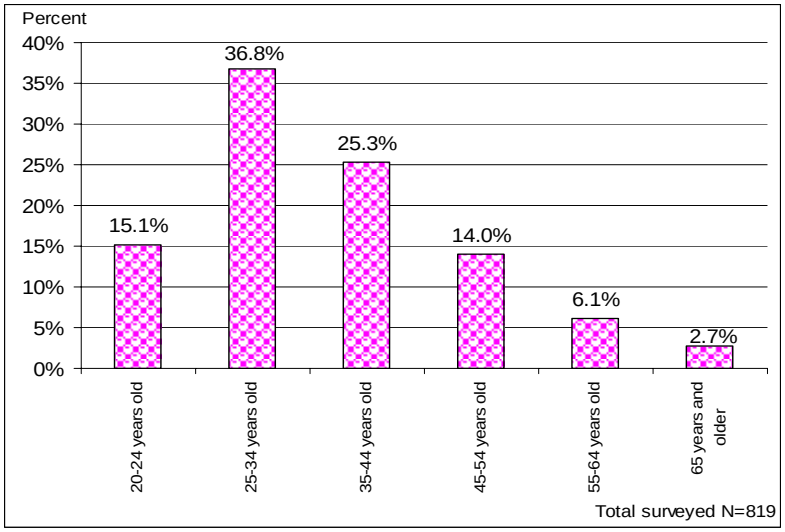


D.C. Department of Health, State Center for Health Statistics Administration

The survey results on age of respondents coincide with other studies that suggest that this is a relatively young population (Figure 3 below). Less than three percent of respondents were 65 years of age or older, compared with those in the younger age brackets: 20-24 years old (15.1

percent), 25–34 years old (36.8 percent), 35–44 years old (25.3 percent), 45–54 years old (14.0 percent) and 55–to more than 65 years old (less than 10 percent).

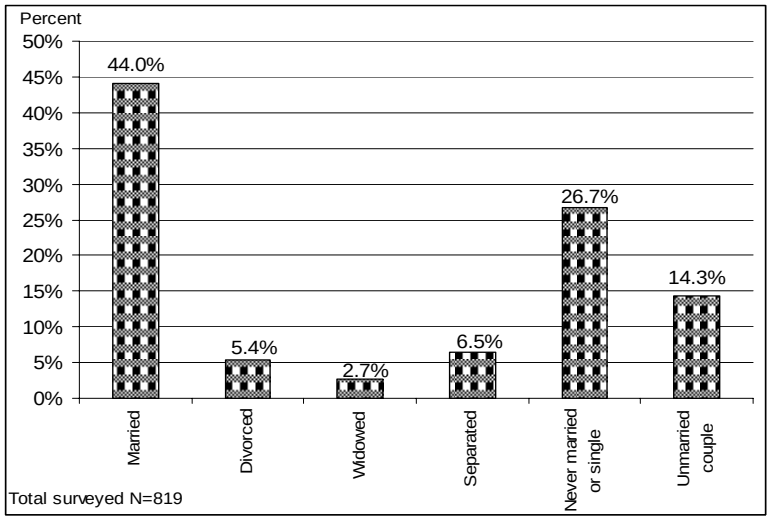
Figure 3. Self-Reported Age, 2004



D.C. Department of Health, State Center for Health Statistics Administration

As far as marital status, almost half of surveyed Latinos surveyed are married (44 percent), almost 30 percent are single or have never been married and 14.3 percent lives in an unmarried couple arrangement and 14.6 percent are divorced, widowed or separated. (Figure 4 below).

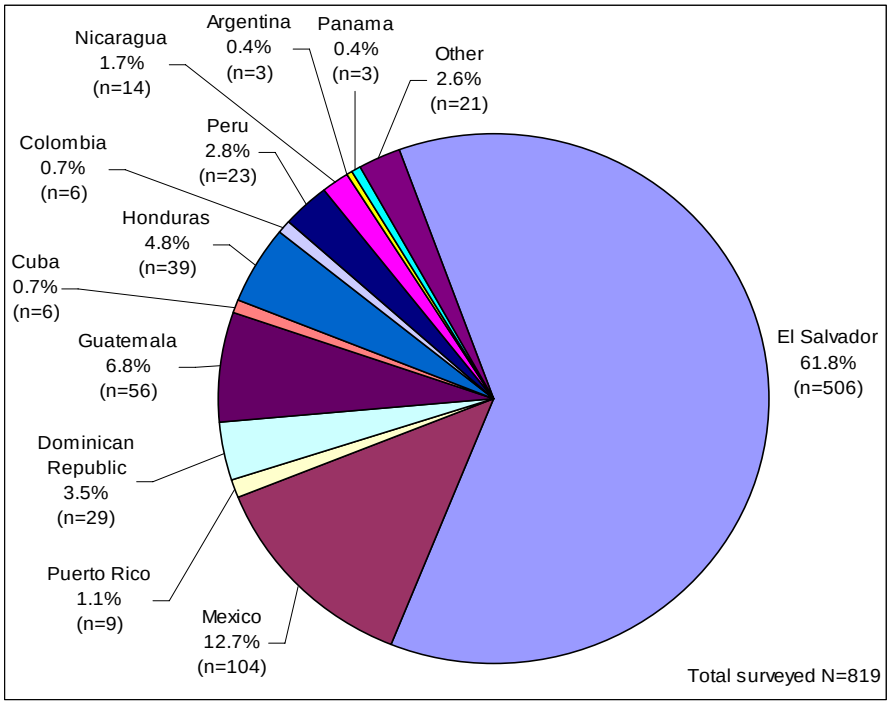
Figure 4. Self-Reported Marital Status, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Figure 5 (below) shows that natives of El Salvador represent more than half of the sample, but that many other countries are represented as well. Notably, a total of 12 percent of respondents came from El Salvador's Central American neighbors Guatemala and Honduras. Natives of Mexico, who represent around two thirds of Latinos at the national level, represent another 12 percent in the District, while the two other largest groups at the national level, Cuba and Puerto Rico, are much less represented in the District.

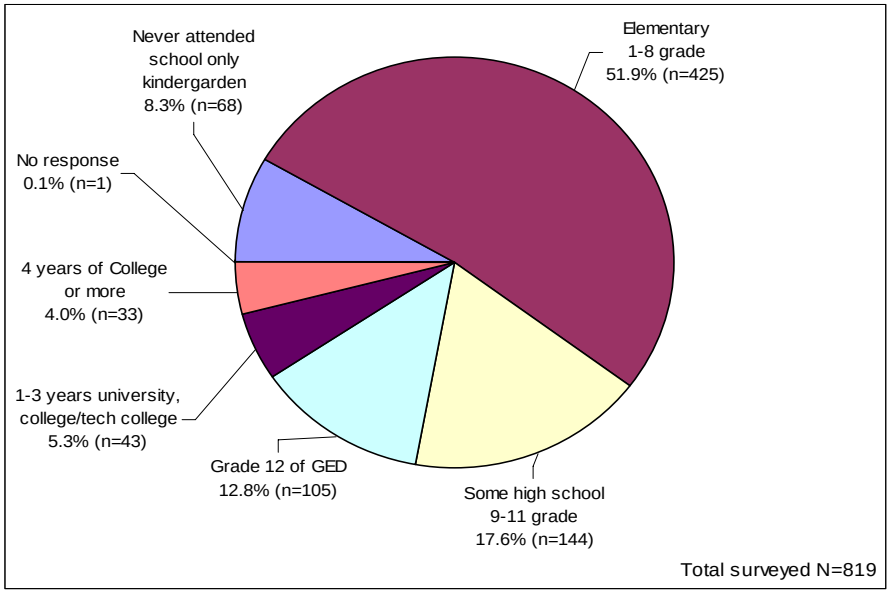
Figure 5. Country of Origin, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Figure 6 (below) shows that a very large proportion of the District's Latino community has relatively little formal education; eight percent have never attended school and just over half have only a primary school education. This finding has profound implications for the ability of members of this community to have access to high-paying jobs and to be able to navigate the health care system effectively.

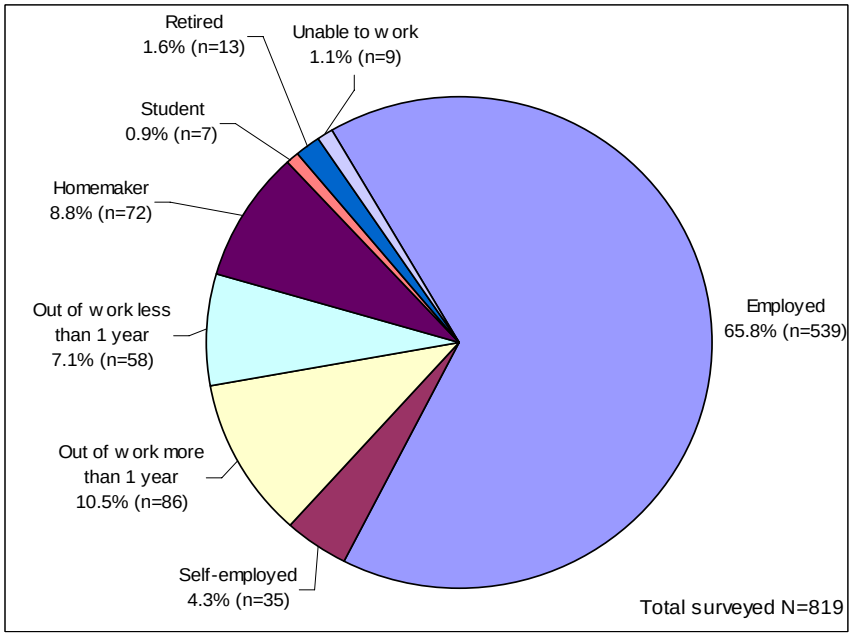
Figure 6. Educational Level, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Figure 7 (below) shows that two-thirds of respondents are employed for wages or salaries; another four percent are self-employed; on the other hand, about 18 percent are out of work. Note also that a very small proportion of respondents reported that they are retired.

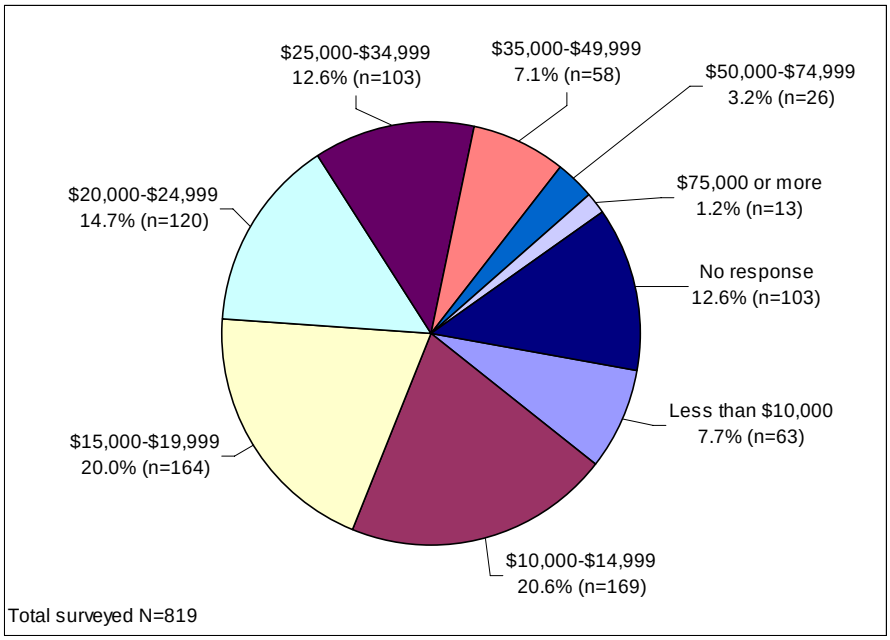
Figure 7. Employment Status, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Figure 8 (below) shows that the household income of a large proportion of the District's Latino community is extremely precarious; nearly two-thirds of respondents reported total household incomes of $25,000 per year or less, while only five percent reported total household incomes of $50,000 or more. About three in ten DC Latinos surveyed (28.3 percent) is poor based on income below 100% of poverty determined by the Federal Poverty Threshold for a family of three - $15,260 in 2003. (Kaiser Family Foundation, 2003).

Figure 8. Total Household Income, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Finally, as shown in Tables 1 & 2 (below), show two important indicators (language and duration of residence) that are often used to measure levels or degree of acculturation support the notion that the District's Latino community is different than those Latino communities found elsewhere in the United States and that it is more diverse. The tables also present an apparent paradox: while a large proportion of respondents speak only or primarily Spanish (59 percent), about two-thirds have been living in the United States for five years or more and only about a fifth report living here for less than two years.

Table 1. Duration of Residence in the US and Language Ability, 2004

A. Duration of Residence	Number	Percent
Total	819	100
Born in the United States	5	0.6
> 0 to < 2 years	103	12.6
2 to < 5 years	169	20.6
5 to < 10 years	199	24.3
> 10 years	342	41.8
Language Spoken		
Total	819	100
Only Spanish; no English	483	59.0
Spanish more than English	268	32.7
Spanish and English equally	63	7.7
English more than Spanish	3	0.4
Only English; no Spanish	0	0

D.C. Department of Health, State Center for Health Statistics Administration

Table 2. Duration of Residence in the US and Language Ability, percent, 2004

	Only Spanish	More Spanish than English	Spanish equal to English	More English than Spanish	Only English	Total (N)
Born in US	0.1	0.0	0.2	0.1	0.1	5
0-2 years	8.9	3.3	0.4	0.0	0.0	103
2-5 years	13.9	6.0	0.7	0.0	0.0	169
5-10 years	15.9	7.6	0.7	0.0	0.1	199
+ 10 years	20.2	15.8	5.6	0.2	0.0	342
No answer	0.0	0.1	0.0	0.0	0.0	1
Total (N)	483	268	63	3	2	819

Total surveyed N=819

D.C. Department of Health, State Center for Health Statistics Administration

Surveyed Latinos in the Washington, D.C. area were more homogeneous in their response to the question of race (Table 3). Respondents self-reported their race as "White" 10 percent, "Black or African American" 0.7 percent, "Asian" 0 percent, "Native Hawaiian or other Pacific Islander" 0.1 percent, "American Indian or Alaska Native" 1.0 percent, "Mixed" or "Other" 88.5 percent (having to specify). Among the specific answers given by respondents to the "Mixed or Other" options were: Hispanic or Latino/a (87.8 percent), Mestizo (of mixed parentage, especially Spanish and Indigenous, 7.2 percent), Mixed (3.1 percent), mentioned their country of origin (1.4 percent) and Moreno and Indigenous (both 0.2 percent each). This illustrates that the majority of people in this group think of Hispanic or Latino as a race and not as a cultural, linguistic or anthropological heritage. When looking at the combination of language spoken and duration of

residence of the 819 respondents, 20.2 percent who reported living in the U.S. for more than 10 years speak Spanish only, followed by those who live in the U.S. for 5-10 years (15.9 percent), and 2-5 years (13.9 percent). Thus, these numbers translate to 50 percent of D.C. Latinos surveyed reside in the U.S. for two years or more speak Spanish only and 65.4 percent who live in the U.S. for two or more years speak only Spanish or Spanish and some English (Table 2).

Table 3. Self-Reported Race, 2004

Race*	N	Percent
Total	819	100.0
White[1]	86	10.5
Black or African American[2]	6	0.7
Asian[3]	0	0.0
Native Hawaiian or other Pacific Islander[4]	1	0.1
American Indian or Alaska Native[5]	8	1.0
Mixed or other[6]	725	88.5
Hispanic or Latino/a	509	87.8
Mestizo	42	7.2
Mixed	18	3.1
Mentioned their country	8	1.4
Moreno	1	0.2
Indigenous	1	0.2
Did not know	1	0.2

D.C. Department of Health, State Center for Health Statistics Administration

1. White as having origins in any of the original peoples of Europe, the Middle East or North Africa.
2. Black or African American as having origins in any of the black racial groups of Africa.
3. Asian as having origins in any of the original peoples of the Far East, Southeast Asian or the Indian sub-continent**.**
4. Native Hawaiian or other Pacific Islander as having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.
5. American Indian, Alaska Native as having origins in any of the original peoples of North and South America and who maintains tribal affiliation or community attachment**.**
6. Mixed (any two races) or other.

*As defined by The Federal Office of Management and Budget (OMB)

As noted in Table 4 (below) respondents mentioned having health insurance coverage on more than half of the cases (58.2 percent), and a little less than a half reported not having health insurance. (See Health Care Access in Section D of Findings and Discussion for more details).

Table 4. Insurance Coverage, 2004

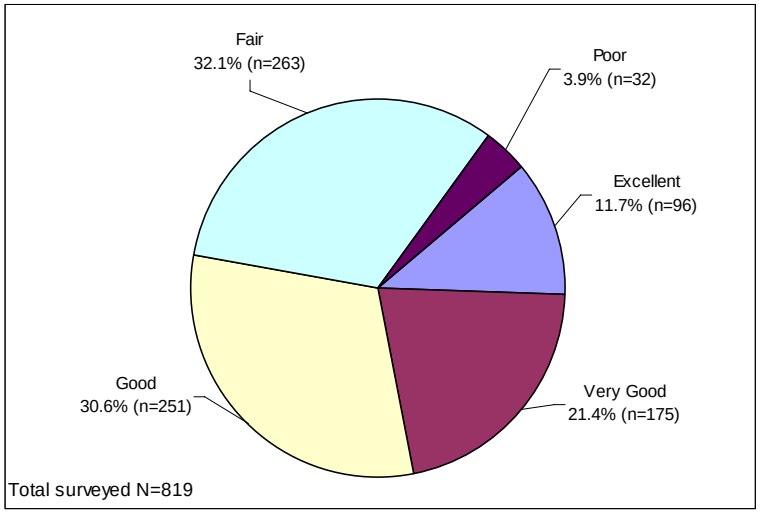
Insurance coverage	Number	Percent*
Total	819	100.0
Yes	477	58.2
No	340	41.5
No response	2	0.2

*Percentage may not add to 100 due to rounding. D.C. Department of Health, State Center for Health Statistics Administration

B. Self Reported General Health Status

Absent clinical examinations, the survey allowed respondents to self-report on their health status and functional disability. Figure 9 (below) shows that nearly two-thirds of respondents assessed their own health as excellent, very good, or good; at the same time, over a third view their health as only fair or poor. Women (39 percent) are more likely to describe their health as fair or poor (Table 29). The data also show that with increasing age more people tend to respond in similar terms. Income and educational levels are also important factors in the perception of the person's health status. With decreasing income and education, the proportion of respondents who reported fair or poor health increased across each level. Widowed persons (50 percent) and those unable to work (88.8 percent) had the greatest proportion of perceived fair or poor health. Residents who live more than 10 years in the U.S. (44.1 percent) and speak Spanish only (42.1 percent) also have the largest proportion of perceived fair or poor health. Table 5 (below) shows that few respondents reported extended periods of ill health (between 21-30 days); note that fewer respondents reported experiencing no days in which mental health (defined as stress and depression) (66.3 percent) was not good compared to physical health (defined as physical illness and injury) (70.6 percent). Also note that fifteen percent more respondents reported that bad health did not prevent normal activities than those who indicated there were no days in which health was not good (86 percent vs. 70.6 percent respectively). This may indicate that even when sick or when "health is not good" Latinos pursue their normal activities at a high rate.

Figure 9. Self-Reported Health Status, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Table 5. Number of Days in Month: Measurements of Health Status, percent, 2004

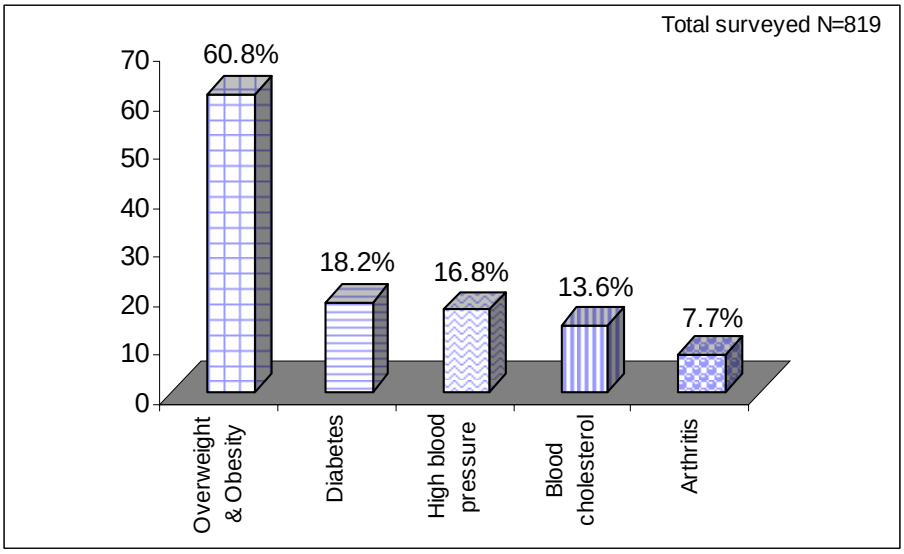
Health Status	Number of Days						
	0 days	1-5 days	6-10 days	11-15 days	16-20 days	21-25 days	26-30 days
Health Not Good	70.6	14.9	5.4	2.9	0.7	0.36	3.7
Mental Health Not Good	66.3	18.2	3.9	3.3	1.3	0.4	5.5
Bad Health Prevents Normal Activities	86.0	8.9	2.2	0.5	0	0.1	0.7

Total surveyed N=819
D.C. Department of Health, State Center for Health Statistics Administration

C. Five Leading Health Conditions

Figure 10 (below) shows that, the five leading health conditions encountered among respondents are overweight and obesity (60.8 percent), diabetes, including pregnant women diagnosed with gestational diabetes, (18.2 percent), high blood pressure (16.8 percent), blood cholesterol (13.6 percent), and arthritis (7.7 percent).

Figure 10. Most Prevalent Health Problems, percent, 2004



D.C. Department of Health, State Center for Health Statistics Administration

1. Overweight & Obesity Measured by Body Mass Index

As reported above, overweight and obesity represent one of the most important health problems in the country given both the association with other health problems and the increasing prevalence. As noted earlier, nearly 61 percent of respondents were either overweight or obese as measured by reported height and weight, which were used to calculate the body mass index (BMI), which was then compared to national standards. BMI is the weight in kilograms (kg) of the person without wearing shoes divided by the square of the person's height in meters (m^2) without wearing shoes ([weight in kg] / [height in meters]^2 or [weight in kg] / [height in cm]^2 x 10,000). BMI does not actually measure body fat, but generally correlates well with the degree of obesity. Overweight is defined as a BMI from 25.0 through 29.9. People who fall in this group are at a slightly increased risk of weight-related health conditions, such as high blood pressure, high blood cholesterol, heart disease, and adult-onset of diabetes. Obesity is defined as a BMI of 30 or more. The risk of heart disease, other weight-related conditions, and premature deaths greatly increases for people in this group. It is interesting to note (Table 6) that overweight is

slightly more prevalent in men (43.7 percent) than women (36.6 percent) while the opposite is true for obesity: 23.4 percent for women compared to 17.9 percent for men.

Table 6. Body Mass Index (BMI) by Gender, 2004

BMI	Female		Male		Total	
	Number	Percent	Number	Percent	Number	Percent
Underweight – BMI < 18.5	56	12.1	21	5.9	77	9.4
Normal – BMI 18.5 – 24.9	129	27.9	115	32.2	244	29.8
Overweight – BMI 25.0 – 29.9	169	36.6	156	43.7	325	39.7
Obesity – BMI ≥ 30.0	108	23.4	64	17.9	172	21.0
No response-weight unknown	0	0.0	1	0.3	1	0.1
Total surveyed	462	56.4	357	43.6	819	100.0

D.C. Department of Health, State Center for Health Statistics Administration

The prevalence or occurrence of overweight and obesity tends to increase with age (Table 31). This risk of being overweight and obese, however, increase from age 20 years until the age of 44, then it decreases. Overweight and obesity increase sharply from ages 20-24 years (37.1 percent) and peak at the ages of 35-44 (72.9 percent), then decrease at the ages of 45-54 (67.8 percent) and significantly at the ages of 55-64 (17.5 percent) but increase significantly with old age (65 years or older) (59.1 percent).

There is no significant relationship between income, employment status, education level and overweight and obesity in general ($p > .05$). Nonetheless, people who had an income between $10,000 - < $35,000 and between $50,000 - < $75,000 showed a higher occurrence of overweight and obesity. Homemakers and people who are unable to work tend to be less affected by overweight and obesity (54.2 and 55.6 percent respectively). Respondents who never attended school or only had a kindergarten level tended to be more overweight and obese (66.2 percent), in general, than people in other education categories, but were followed very closely by people who only had elementary ($1^{st} – 8^{th}$ grade) or some high school attainment ($9^{th} – 11^{th}$ grade) (63.3 and 62.5 percent respectively).

There is a statistically significant, though weak, inverse correlation between marital status and BMI ($p = .05$). Married (66.9 percent), widowed (68.2 percent), and separated (66.0 percent)

people are more likely to be overweight and obese than other people in the marital status classification.

The risk of being overweight and obese increases with the number of years Latinos lived in the United States. Latinos who spoke Spanish only (no English) were at greatest risk of being overweight and obese, which decreases as more English is spoken. There is little difference between Latinos who are overweight and obese with health care coverage than those who have no insurance.

When we look at the distribution of overweight and obese respondents by their ward of residence, the data show that 63.5 percent live in ward 1, followed by 60.6 percent in ward 2, and 55.3 percent in ward 4.

-Physical Activity and Diet as it Relates to Overweight & Obesity

Most of the strategies that can be brought to bear for weight control are reducing high caloric and fatty food consumption and increasing physical activity. It is interesting to note that only one in four respondents (24.8 percent) reported that a health care professional had advised him/her to lose weight and only 6.7 percent had been told to maintain their current weight.

-Monitoring and Controlling Your Weight

In spite of the level of overweight and obesity found in this sample, less than four in ten (37.2 percent) of all respondents reported that they were currently trying to lose weight, while nearly half (47.7 percent) were trying to maintain their current weight. Of those currently trying to lose weight, 74.1 percent of overweight and obese and 56.3 percent are trying to maintain their current weight.

Table 7 shows that less than one-half of all the respondents reported consuming fewer calories or less fat to lose weight or to keep from gaining weight; just over one in four reported

using physical activity to lose weight, and only three in ten reported using physical activity to maintain their current weight. Approximately 67 percent of Latinos surveyed who are overweight and obese are using physical activity or exercise to lose weight and 67 percent are using physical activity to maintain their current weight.

Most respondents who were employed or self-employed reported at least moderate physical exercise in the work place; 63.6 percent said that their work involves mostly walking or moving, while another 8 percent engage in mostly heavy labor or physically demanding work. At the same time, more than one in four respondents reported that his/her work involves mostly sitting or standing.

Table 7. Weight Control Activities, 2004

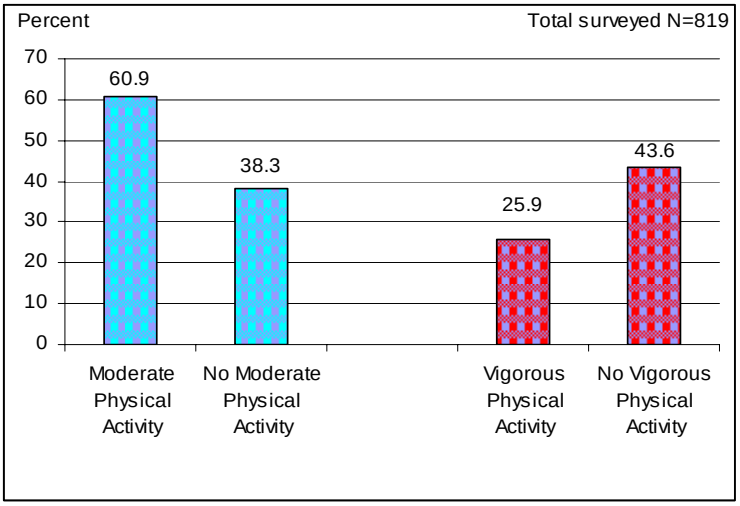
	Yes		**No**		**No Response**		**Total**	
Currently eating either fewer calories or less fat to:	N	%	N	%	N	%	N	%
• lose weight	316	40.0	469	59.4	5	0.6	790	100
- BMI ≥ 25	228	72.2	258	55.0	2	40.0	488	61.8
• keep from gaining weight	375	47.5	410	51.9	5	0.6	790	100
- BMI ≥ 25	261	69.6	226	55.1	1	20.0	488	61.8
Using physical activity to:								
• lose weight	207	26.2	578	73.3	4	0.5	789	100
- BMI ≥ 25	138	66.7	349	60.4	1	25.0	488	61.9
• keep from gaining weight	237	30.1	544	69.1	6	0.8	787	100
- BMI ≥ 25	158	66.7	327	60.1	2	33.3	487	61.9

D.C. Department of Health, State Center for Health Administration

The data presented in Figures 11, 11a and 11b (below) complement these findings. It can be seen that nearly four in ten respondents reported that they did not regularly engage in even moderate physical activity (defined as at least 10 minutes of activities such as brisk walking, bicycling, vacuuming, gardening, or any other activity that causes small increases in the breathing or heart rate) or work while over four in ten reported that they did not regularly engage in vigorous physical activities (defined as at least 10 minutes of activities such as running, aerobics,

heavy yard work, or anything else that causes large increases in breathing or heart rate). When asked about engaging in vigorous physical activities, 30.5 percent did not respond at all.

Figure 11. Daily Physical Activity, percent, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Fig 11a. Moderate Physical Activity by BMI

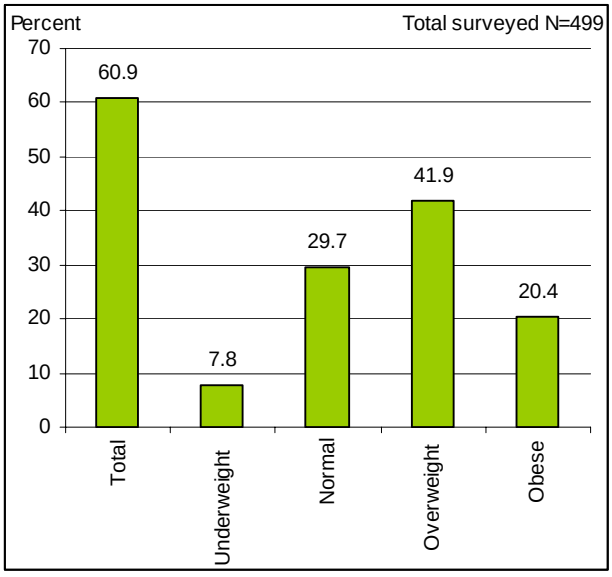
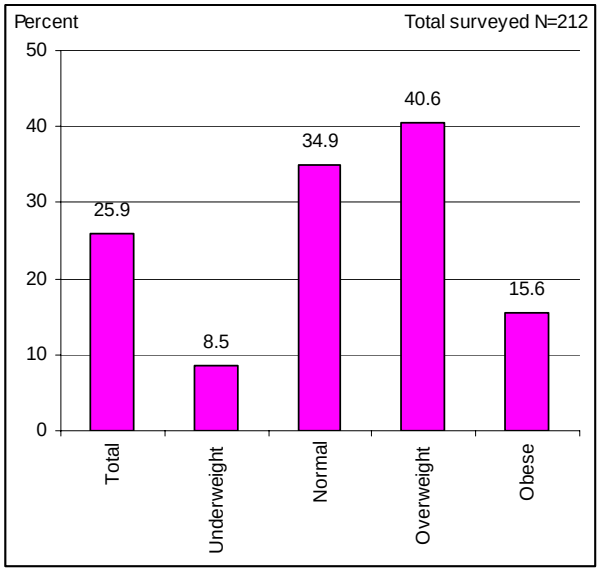


Fig 11b.Vigorous Physical Activity by BMI



D.C. Department of Health, State Center for Health Statistics Administration

Table 8 presents an interesting contrast to these findings. When asked how many days per week they exercised moderately or vigorously, a much smaller proportion of respondents reported

that they did not engage in these activities, while over one-half do so at least five days per week on average. This apparent contradiction clearly reveals the need for enhanced measures of physical activity that could minimize the inherent difficulties of self-reporting.

Table 8. Frequency of Physical Activity per Week, percent, 2004

Physical Activity	Days Per Week								
	0	1	2	3	4	5	6	7	No response
Moderate Physical Activity (N=525)	1.5	3.4	9.9	12.4	5.0	22.9	6.9	37.5	0.5
Vigorous Physical Activity (N=242)	8.7	5.8	11.6	12.8	5.4	31.0	7.0	17.4	0.4

D.C. Department of Health, State Center for Health Statistics Administration

Table 9 presents data on dietary consumption. It shows that consumption of fruits and fruit juices is well below the recommended five portions per day and that consumption of red meat averages less than one serving per day. Fewer than three in ten respondents (28.7 percent) reported that they are currently taking vitamin pills or supplements, and of those, seven in ten reported taking multivitamins. Overweight and obese respondents either consumed less (62.2 percent consumed 1-2 per day) or more than the daily recommended fruits and vegetables (78.6 percent consumed 5 or more per day).

Table 9. Weekly Consumption of Fruit Juice, Fruits, Vegetables, Red Meat, and Fiber, percent, 2004

	Servings Per Week							
	0	1-5	6-10	11-15	16-20	21-25	26-30	Unknown
Fruit Juice	9.3	39.3	37.2	8.7	0.2	4.0	0.9	0.4
Fruits	5.7	57.4	31.5	6.0	0.1	1.3	0.2	0.4
Vegetables	4.0	56.4	2.2	0.5	0	1.3	0.1	0.4
Red Meat	2.3	56.7	26.1	9.9	0.7	3.8	0.1	0.4
Grain or Fiber	2.3	19.7	41.2	22.7	1.3	12.2	0.5	0.1

D.C. Department of Health, State Center for Health Statistics Administration

2. Diabetes

As reported above (Figure 10), 18.2 percent of all respondents reported that they had been told by a health care professional that they have diabetes. Of these respondents, 13 percent (Table 10) were diagnosed with gestational diabetes (diabetes during pregnancy). Sixty-six male respondents were excluded from the analyses because the survey data collection sheet showed that they checked "diagnosed with diabetes during pregnancy."

Table 10. Prevalence of Diabetes, 2004

	Yes		Only While Pregnant		No		No Response		Total
	N	%	N	%	N	%	N	%	N
Diagnosed with diabetes	39	5.2	98	13.0	613	81.4	3	0.4	753

D.C. Department of Health, State Center for Health Statistics Administration

Table 11 shows that less than two in ten respondents diagnosed with diabetes are currently taking insulin, and less than one-half have been taught to manage diabetes.

Table 11. Treatments for Person Diagnosed with Diabetes, 2004

	Yes		No		Total
	N	%	N	%	N
Now taking insulin	6	19.4	25	80.7	31
Now taking diabetes pills	18	58.1	13	41.9	31
Ever been taught to manage diabetes	15	45.5	15	54.6	33

D.C. Department of Health, State Center for Health Statistics Administration

Nevertheless, women had the highest rate of diabetes (including gestational diabetes 27.1 percent) compared to men (4.1 percent). In the D.C. Latino community, rates for diabetes increase with age (Table 32). The highest rate of diagnosed diabetes is in the 65 years or older age group (33.3 percent). Those who earned between $10,000 - $14,999 (28.5 percent) were more likely to have diabetes, followed by respondents who earned less than $10,000 (25.9 percent). Marital status shows a pattern of an increased likelihood of diabetes. The data show that divorced respondents had the highest rate of diabetes (33.3 percent), followed by widowed (33.3 percent), and separated (20.0 percent) people.

Regarding employment status, retired (33.3 percent) Latinos, homemakers (33.3 percent), and those unable to work (88.9 percent) had the highest rate of diabetes. Only 15 percent and 10.5 percent of respondents diagnosed with diabetes engaged in moderate or vigorous physical activities, respectively. Sixty percent of respondents with diagnosed diabetes were born in the United States and 19.6 percent spoke Spanish only (no English).

Table 12 shows that 45.5 percent of interviewees with diabetes had not been checked for feet sores/irritations in the past 12 months; 31.3 percent had seen a health professional for diabetes; and 39.4 percent had not been checked for hemoglobin A1c, while 30.3 percent had been checked for A1c and had had 3-4 checks in the past year.

Table 12. Professional Checked for Diabetes-Related Condition, percent, 2004

Professional Check	Times in Past 12 Months									
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7-12**	**More than 12**	**No Response**
Checked feet for sores or irritations (N=33)	45.5	15.1	3.0	9.1	3.0	0.0	3.0	15.2	0.0	6.1
Seen health professional for diabetes (N=32)	18.8	6.3	6.3	9.4	31.3	3.1	6.3	6.3	9.4	3.1
Checked for Hemoglobin A1c (N=33)	39.4	6.1	0.0	18.2	12.1	0.0	0.0	6.1	0.0	18.2

D.C. Department of Health, State Center for Health Statistics Administration

3. High Blood Pressure (Hypertension)

Figure 10 shows that high blood pressure is the third most prevalent health condition in the Latino community. Eighty-four percent of respondents reported having blood pressure checked by a health care professional (Table 18). Approximately 17 percent of all respondents reported having been diagnosed with high blood pressure. Of those with a positive diagnosis, though, 40.9 percent are taking medication (Table 18).

In the District of Columbia Latino community, more women (21.6 percent) reported being diagnosed with high blood pressure compared to men (10.4 percent). Increasing age was also

associated with a higher risk of high blood pressure (Table 33). Income and educational status are inversely related to the risk of high blood pressure. Widows (38.1 percent) followed by divorcees (34.9 percent) and separated persons (24.5 percent) had the highest rate of high blood pressure. When looking at employment status, people who are retired (69.2 percent), are unable to work (66.7 percent), or are self-employed (25.7 percent) have the highest risk of high blood pressure. Almost 18 percent of people diagnosed with high blood pressure engaged in moderate physical activities, while 13.9 percent engaged in vigorous physical activities. Fifty percent consumed, on an average daily basis, 5 or more fruits and vegetables. Nearly 21 percent has health insurance, 28.5 percent live in the U.S. longer than 10 years, and 35.5 percent speak Spanish and English equally. Ward 4 (19.6 percent) has the largest proportion of residence with diagnosed high blood pressure, followed by ward 1 (16.5 percent), and ward 2 (11.6 percent).

4. High Blood Cholesterol

As reported above, high blood cholesterol is the fourth most prevalent health condition in the Latino community, having been reported by 13.6 percent of all respondents (Table 13). At the same time, 52.9 percent have had blood cholesterol checked, and of those, 68.9 percent reported having levels checked within the past year, and another 21.4 percent, between 12 and 24 months ago. Thus, checking their blood cholesterol within the past two years resulted in 90 percent of respondents.

Table 13. Preventive Health Care, 2004

Health Care	Yes		No		N.R.*		Total
	N	%	N	%	N	%	N
Ever had blood cholesterol checked	433	52.9	381	46.5	5	0.6	819
Told by health professional that blood cholesterol is high	107	13.6	676	86.0	3	0.4	786

*N.R. means No Response.
D.C. Department of Health, State Center for Health Statistics Administration

The data show that gender differences are important, since 17.6 percent of females are at risk compared to 8.3 of males diagnosed with high blood cholesterol. Increasing age is also

related to a higher risk of high blood cholesterol. Latinos in the District of Columbia who never attended school reportedly have the highest rate of high blood cholesterol. Like hypertension (high blood pressure), widows, divorcees, and separated respondents had the highest rate of high blood cholesterol. Retired persons (30.8 percent) and persons unable to work (33.3 percent) have the highest prevalence of high blood cholesterol. Only 12.5 percent who have high blood cholesterol are involved in moderate physical activity and 17.3 percent has health care coverage. Two in five persons with high cholesterol ate 5 or more fruits and vegetables daily. Fourteen percent of respondents with high blood cholesterol live in ward 1, 11.9 percent reside in ward 4 and 9.7 percent live in ward 2 (Table 34).

5. Arthritis

As discussed earlier, arthritis is one of the most prevalent health conditions in the Latino community, having been reported being diagnosed with arthritis by nearly eight percent of respondents. As shown in Table 14, substantial proportions of respondents currently suffer from arthritis symptoms and have sought health care for their condition (52.3 percent). A smaller proportion, less than three in ten, report limitations due to arthritis, however.

Table 14. Presence of Arthritis Symptoms, 2004

Arthritis Symptoms	Yes		No		No Response		Total
	N	%	N	%	N	%	N
During the past 12 months, had had pain, aching, stillness or swelling in or around a joint	150	18.3	659	80.5	10	1.2	819
Symptoms present on most days for at least one month	99	64.3	55	35.7	0	0.0	154
Now limited in any way in any activities because of joint symptoms	36	23.8	115	76.2	0	0.0	151
Have seen a doctor, nurse or other health professional for these joint symptoms	79	52.3	72	47.7	0	0.0	151
Currently being treated by a doctor, nurse or health provider for arthritis	43	29.5	102	69.9	1	0.9	146

D.C. Department of Health, State Center for Health Statistics Administration

More women (11.3 percent) than men (3.1 percent) reported being diagnosed with arthritis. The prevalence of arthritis increases with age. Respondents 55 or older are more likely to experience arthritis (Table 35). Widows (22.7 percent) and persons speaking Spanish only (8.9 percent) and living in the U.S. for over 10 years (12.6 percent) tend to have pain, aching, stillness or swelling in or around a joint. Latinos who are retired (53.8 percent), out of work for more than one year (12.8 percent) and live in Ward 1 (9.6 percent) reported having the highest prevalence of diagnosed with arthritis.

D. Health Care Access

Consistent with national trends, 41.5 percent of survey respondents reported that they do not have access to any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans like Medicare. In addition, as Table 15 shows, that 31.8 percent of respondents do not have any one provider whom they consider as their personal doctor. Nearly three-fourths (74.6 percent), though, have access to a specific clinic or doctor's office for their health care, while one-fourth (24.8 percent) has neither. Table 30 shows that more women (67.5 percent) than men (46.2 percent) have health insurance. People who are 65 years and older (81.8 percent), earn between $35,000-$49,999 (67.2 percent), college graduates (75.8 percent), widowed (72.7 percent), retired (100 percent), live in the U.S. longer than 10 years (65.8 percent), speak Spanish and English equally (71.4 percent), and reside in Ward 4 (64.6 percent) have the highest prevalence of having health insurance. Conversely, people ages 20-24 years (43.6 percent), who earn less than $10,000 (50.8 percent), have some high school education (53.5 percent), never been married or single (46.1 percent), out of work for less than one year (36.2 percent), live in the U.S. less than two years (33.0 percent), speak Spanish only (55.7 percent), and live in Ward 1 (54.8 percent) are more likely to be uninsured.

Table 15. Health Care Utilization, percent, 2004

	Yes	Yes, more than one	No	No Response	Total N
Do you have one person you think of as your personal doctor or health care provider?	53.5	14.5	31.8	0.2	819
Is there one particular clinic, health center, doctor's office or other place that you usually go to if you are sick or need advice about your health?	67.4	7.2	24.8	0.6	819

D.C. Department of Health, State Center for Health Statistics Administration

Almost seven in ten Latinos in the District of Columbia indicated that they would go to a clinic or health center if they are sick or need advice about their health. Going to a doctor's office or HMO (24.8 percent) is their second choice when seeking health care (Table 16).

Table 16. Type of Place Health Care is Sought, 2004

Type of Place	N	%
Total	819	100
Doctor's Office or HMO	150	24.8
Clinic or Health Center	416	68.8
Hospital Outpatient Department	24	4.0
Hospital Emergency Room	1	0.2
Urgent Care Center	2	0.33
Other	6	1.0
No Response	223	27.2

D.C. Department of Health, State Center for Health Statistics Administration

The use of traditional and complementary sources of health care and treatments among Latinos has been widely observed. This is a broad category that covers a wide range of situations and options that are not mutually exclusive. In Latin America it is common for people of virtually all socioeconomic levels to use different combinations of "modern" or "Western" medicine in combination with complementary methods such as herbal remedies, and those customs have found their way into the U.S. Latino community. Among the respondents to this survey, over 36 percent report using prayer to complement standard health care, which reflects the deep religious roots of this community (Table 17). In addition, nearly 20 percent report using herbal medicines, nine percent using chiropractic therapy, over four percent using other therapies, and over two percent seeing a spiritual doctor.

Table 17. Complementary and Alternative Medicine (CAM), 2004

CAM Therapy	Yes %	No %	Don't Know %	Total
Spiritual Doctor	2.4	97.3	0.2	819
Prayer	36.4	63.4	0.2	819
Herbal Medicine	19.5	80.1	0.4	819
Chiropractic Therapy	8.9	90.8	0.2	819
Other Therapies	4.4	94.8	0.9	819

Note: Percentage may not add to 100 due to rounding..
D.C. Department of Health, State Center for Health Statistics Administration

1. Routine Care and Preventive Health

Given the variability in access noted above (Table 15), it is not surprising that while over one-half (53.5 percent) of respondents reported that they have a health care provider, 63 percent reported having had visited a doctor for a routine checkup (defined as a general physical exam rather than a visit for a specific lesion or illness) within the past year and an additional 13.3 percent reported that they had received a routine exam more than a year ago but less than two years ago; 11 percent had not had a checkup in more than two years. Table 18 provides information on preventive health behaviors. As reported above, high blood pressure was one of the most prevalent health conditions encountered in the survey, and it is closely related to priority areas identified by the project. A high proportion of respondents reported having blood pressure checked by a health care professional; of all respondents, nearly 17 percent have been diagnosed with high blood pressure (Table 33). Of those with a positive diagnosis, though, less than one-half are taking medications (although in some of these cases medication may not be indicated). At the same time, just over one-half have had blood cholesterol checked; and of those, over two-thirds reported having levels checked within the past year, and another 21 percent, between 12 and 24 months ago. About 86 percent of respondents were told by a health care professional that they do not have high blood cholesterol, but this remains one of the more prevalent health problems in this community; a finding that is particularly notable given the relative youth of the population.

Table 18. Preventive Health Care Utilization, 2004

	Yes* %	No* %	Total N
Ever had blood pressure checked by doctor, nurse or health care provider	84.4	15.6	819
Told by health professional that has high blood pressure	16.8	82.2	819
Currently taking medicine for high blood pressure	40.9	58.6	198
Ever had blood cholesterol checked	52.9	46.5	819

*Percentage may not add to 100 due to exclusion of no response (yes + no+ no response = 100 percent).
D.C. Department of Health, State Center for Health Statistics Administration

2. Other Preventive Health Behaviors and Health Knowledge

Other important issues related to health behavior include immunizations, tuberculosis control, dental care, and consumption of alcohol and tobacco. The survey was conducted during a period of great concern about the flu; at the beginning of this period, the availability of vaccines was limited, but shortages were soon eased. Less than one in four respondents reported receiving a flu shot in the preceding 12 months; and fewer (12.8 percent) reported having ever received a pneumococcal (pneumonia) vaccine (Table 19). Persons receiving a flu shot increased with age, where those 65 years of age and older (63.6 percent) received the most flu shots.

Table 19. Immunization Shots, 2004

Type of Immunization	Yes* %	No* %	Total N
During the past 12 months, have you had a flu shot?	22.7	77.3	819
• 20-24 years	22.6	77.4	124
• 25-34 years	15.0	85.1	301
• 35-44 years	21.7	78.3	207
• 45-54 years	28.7	71.3	115
• 55-64 years	42.0	58.0	50
• 65+ years	63.6	36.4	22
Have you ever had a pneumonia shot?	12.8	86.4	813
• 20-24 years	15.7	82.6	121
• 25-34 years	9.0	90.3	299
• 35-44 years	14.6	84.5	206
• 45-54 years	13.9	85.2	115
• 55-64 years	20.0	80.0	50
• 65+ years	9.1	90.9	22

*Percentage may not add to 100 due to exclusion of no response (yes + no+ no response = 100 percent).
D.C. Department of Health, State Center for Health Statistics Administration

Tuberculosis (TB) is a growing concern both worldwide and in immigrant populations. Nearly sixty percent of respondents reported having received a skin test or X-ray for TB; and

about five percent reported having been told by a health care provider that they have TB (Table 20).

Table 20. Tuberculosis Awareness, 2004

	Yes* %	No* %	Total N
Ever had skin or X-ray test by doctor, nurse or health care provider	59.3	40.5	819
Told by health professional that has Tuberculosis	4.8	94.9	789

*Percentage may not add to 100 due to exclusion of no response (yes + no+ no response = 100 percent).
D.C. Department of Health, State Center for Health Statistics Administration

-Dental Care

More than four in ten respondents reported that they had seen a dentist or dental clinic for any reason in the past year; on the other hand; 10 percent had not done so in more than two years, and 12.2 percent in more than five years. Moreover, only about three in ten respondents (31.5 percent) reported that no permanent teeth had been removed because of tooth decay or gum disease, while nearly half (45.5 percent) had had between one and five teeth removed; 15 percent had had six or more teeth removed and 7.7 percent had had all of their permanent teeth removed.

-Alcohol Consumption

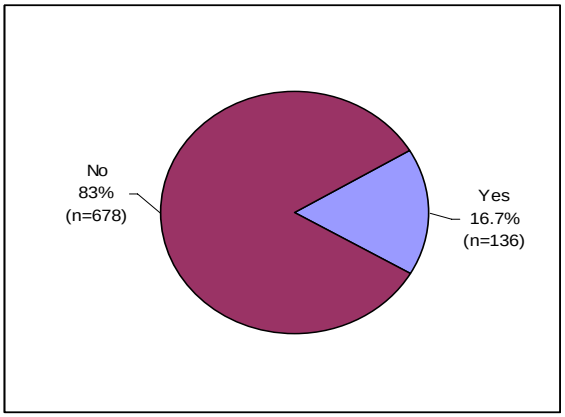
Alcohol consumption in the District of Columbia Latino community as reported by respondents is very low; 74 percent said that in the preceding 30 days, they had not had any alcoholic beverage and 13 percent reported having had a total of one or two. Patterns of drinking are complex: when asked how many drinks were consumed, 21.9 percent of respondents who had consumed alcohol in the past 30 days reported that they had one or two drinks, 28.8 percent had three or four drinks, 16.4 percent had five or six drinks, 15.1 percent had seven to ten drinks, and 22.8 percent had more than ten drinks. This pattern is confirmed by the finding that 21.8 percent of those who reported drinking alcohol in the past month had drunk five or more drinks in the same day once or twice in the past month, while 15.8 percent had done so three or four times.

This finding suggests that while most respondents do not report drinking alcohol, some of those who do engage in binge drinking (defined as having five or more alcoholic drinks on occasion).

-Tobacco Use

A similarly complex pattern was found for tobacco consumption. Figure 12 shows that most respondents were non-smokers, defined as having smoked less than 100 cigarettes in their lifetime.

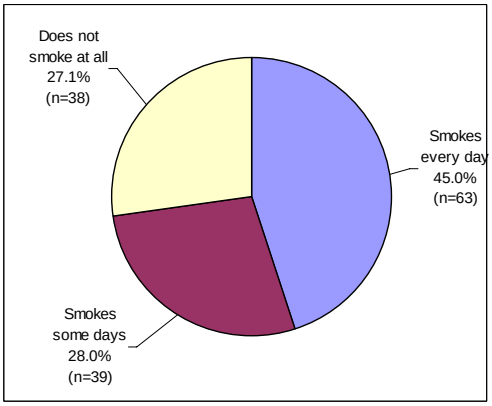
Figure 12. Smokers vs. Non-Smokers, percent, 2004. (Smoked 100 Cigarettes in Entire Life)



D.C. Department of Health, State Center for Health Statistics Administration

Of respondents who reported having smoked at least 100 cigarettes in their lifetimes, just over one in four stated that they do not now smoke; while 45 percent smoke every day, as seen in Figure 13.

Figure 13. Frequency of Tobacco Use, percent, 2004



D.C. Department of Health, State Center for Health Statistics Administration

Among current smokers, 41 percent of respondents reported smoking fewer than five cigarettes per day; and an additional 44.6 percent smoked five cigarettes or more, but less than a pack a day; 8.1 percent reported smoking a pack a day, but only 2.7 percent more than a pack a day. Also among smokers, 30.1 percent report having quit, while 24.1 percent tried to quit but failed. Fully 40.6 percent reported that they have not tried to quit. Of respondents who reported having quit smoking, nearly two in 10 (19.2 percent) report having quit less than a month ago; 15.4 percent quit between one and six months ago; 3.9 percent quit between six and 12 months ago, 20.5 percent quit between one and five years ago; and the rest quit six years ago or more. Further evidence that smoking is an intractable problem for a small proportion of respondents is the finding that 38.5 percent first smoked before the age of 16 (the youngest reported age of initiation of smoking was eight years), while 28.9 percent reported first smoking at the ages of 16 to 18 years. It is interesting to note, though, that only 30.9 percent of smokers reported that they had been advised to quit by a health care professional. On the other hand, at least six of ten smokers reported that they refrain from smoking to avoid indoor pollution when inside the home, to protect children from second-hand smoke, and to obey non-smoking policies in the work place.

Men have the highest percentage (79.4 percent) among current smokers, while 51.5 percent of women are current smokers (i.e., smoking every or some days). The percentage of current smokers decreases progressively among people in the 20-44 age group and then increases among those 45 years of age or older. Latinos who currently smoke are in the youngest age groups, 20-24 years (88.9 percent) and 25-34 years (84.4 percent).

3. Chronic Disease: Knowledge and Practice

The high reported levels of overweight and obesity suggest the particular importance of related chronic diseases, including cardiovascular conditions. Table 21 shows that more than half

of respondents are eating components of healthy diets and that this proportion exceeds that of respondents who were advised by a health care professional in the past 12 months to eat a healthy diet. Nevertheless, as suggested by findings reported earlier, fewer are engaged in physical activities; and only around four in ten report having been advised by a health care provider to engage in physical activities. Nevertheless, the frequency of severe coronary problems is very low; only 0.8 percent, 1.9 percent, and 1.2 percent of respondents report having been told by a health care professional that they had had a heart attack, angina or coronary heart disease, or stroke, respectively. At the same time, only 11.2 percent of respondents aged 35 or more take a low-strength aspirin daily or every other day to protect against heart problems.

Table 21. Knowledge and Practice of Cardiovascular Disease, 2004

	Yes %	No %	Total N
Doing the following to lower risk of developing heart disease			
Eating fewer high fat or high cholesterol foods	52.0	47.4	819
Eat more fruits and vegetables than before	54.6	45.1	819
Being more physically active than before	36.5	63.1	819
Within the past 12 months, a doctor, nurse or other health professional advised you to:			
Eat fewer high fat or high cholesterol foods	42.4	56.9	819
Eat more fruits and vegetables	44.8	54.5	819
Be more physically active	39.8	59.5	819

Note: Percentages may not add to 100 due exclusion of no response
[yes + no + no response (not reported) = 100 percent].
D.C. Department of Health, State Center for Health Statistics Administration

Asthma is a health condition of increasing concern in some segments of the U.S. population. Among respondents, 6.6 percent reported that they had been told by a health care professional that they had asthma, and of those, 32 percent report that they still have asthma. More women (64.8 percent) report being diagnosed with asthma compared to 35.2 percent men. Asthma affects both the 25-35 years olds and the 35-44 year olds equally (25.9 percent) who have the highest prevalence among all age groups. Ward 4 had the highest prevalence of asthma (8%) followed by Ward 1 (7.3%) and Ward 2 (3.2%).

4. Barriers

As shown in Table 22, the principal barrier to access to health care when it is needed is cost (30.5 percent); this finding is consistent with the high proportion of respondents who lack health insurance. A second economic barrier that is less recognized is the inability of many people to leave work in order to secure health care services (11.6 percent), reflecting the low occupational status that many respondents have: their jobs provide neither health insurance nor time off for health care. The high number of negative responses to these questions indicates that some of the reasons for not accessing health care were not listed in the questionnaire.

Table 22. Reason for not Accessing Health Care, 2004

Reason	Yes %	No %
Cost	30.5	69.4
Transportation/Distance	7.6	92.3
Lack of Time Off Work	11.6	88.3
Family Care/Family Responsibility	8.9	93.7

D.C. Department of Health, State Center for Health Statistics Administration

E. Other Health Outcomes

1. Cancer

While the Latino population in the District is relatively young on average, and would therefore be likely to have lower prevalence rates than older populations of such chronic diseases as cancer, this is an area of continued and increasing concern as the population ages, particularly given barriers to screening and care.

Reported levels of breast cancer in female respondents (3.1 percent) and prostate cancer in males (0.6 percent) are quite low based on reports of diagnosis by a health care professional. Reported family histories of cancer were also low; 6.8 percent of women and 4.7 percent of men said that they had close blood relatives with breast cancer and prostate cancer, respectively.

Patterns of preventive health measures including screening are complex (Table 23). Almost one-half of female respondents reported having ever had a mammogram, but more than eight in ten have had a clinical breast exam. Most reported that exams were part of routine preventive care (82.1 percent) while 14.1 percent were for diagnostic measures for problems other than cancer. Only 1.4 percent was screened because of a family history of breast cancer, and less than one percent was to monitor existing breast cancer. Data for women who reported ever having a mammogram by age indicate that 79.2 percent of those women were 40 years and older (Table 36). However, women in the 40-44 years of age category were the highest at risk for not having a mammogram. Women 40 years of age and older who are highest at risk of not having a mammogram earned less than $15,000 (52.9 percent), never attend school (24 percent), an unmarried couple (40 percent), out of work for more than one year (41.2 percent), has no health insurance (29.1 percent), live in the U.S. anywhere from two to ten years (52.8 percent), and speak Spanish only (24.1 percent). It is important to note when looking at vital records data, no Latino woman died from breast cancer in 2001 or 2002 (D.C. State Center for Health Statistics Administration, 2001, 2002).

In contrast, of all men who responded, less than two in ten men report having had either a digital rectal exam (DRE) or a prostate-specific antigen (PSA) test to detect prostate cancer (Table 23). However, the American Cancer Society recommends that men ages 40 years or older should have either a digital rectal exam or a prostate-specific antigen test to detect prostate cancer. The risk of not having a PSA or a DRE among men 40 years and older decreases with age (Table 37). Men who are 40-54 years are more likely to report not having a PSA or a DRE. It is interesting to find that 100 percent of men who earn between $50,000-$74,999 do not have a PSA of a DRE. Men, 40 years and older, who never attended school more likely will not have a

PSA (71.4 percent) of a DRE (85.7 percent). Single men, 40 years and older, tend not to have a PSA (81.8 percent) or a DRE (72.7 percent) and men who are out of work for less than one year have no PSA (84.6 percent) or DRE (76.9 percent). Men, 40 years and older, with no health insurance will not have a PSA (79.2 percent) or a DRE (80.9 percent). Men who speak Spanish only regardless of length of stay in the U.S. or where they live in the District of Columbia are more likely not to have a PSA or DRE.

Table 23. Preventive Health Care Utilization for Cancer, 2004

	Yes %	No %
Ever had a mammogram	46.7	53.3
Ever had a clinical breast exam	80.8	19.3
Ever had a Pap smear	94.5	5.3
Ever had a blood stool test using a home kit (HBS)	8.1	91.7
Ever had sigmoidoscopy or colonoscopy	9.0	90.5
Ever had a Prostate Specific Antigen (PSA) test	13.9	85.3
Ever had a digital rectal exam	16.8	83.2

Dept. of Health, State Center for Health Statistics Administration

With respect to colorectal cancer, fewer than one respondent in ten (both male and female) reported having had a fecal occult blood test (FOBT)/Home Blood Stool Test (HBS) or having had either a sigmoidoscopy or colonoscopy. On the other hand, those respondents who reported having had these preventive tests generally have done so within the past year or in more than nine cases in ten, within the past three years (Table 24). The highest rate of non-response for this question was for the FOBT/HBS and the sigmoidoscopy or colonoscopy (Table 23). The former probably reflects confusion as to what constitutes the test (although the question clearly described the procedure), while the latter is done at such long enough intervals that even people who have them could forget. With respect to age, research has suggested, that for both women and men, sigmoidoscopy or colonoscopy should be done at the age of 50 years and above. Of the 9 percent who reported having had either a sigmoidoscopy or colonoscopy, 29 percent of those were 50 years and older. More men, 50 years and older, are at greater risk of not having a FOBT/HBS (86

percent), while women are at a higher risk of not having a sigmoidoscopy or colonoscopy (74 percent) (Table 38). Risk of not having a FOBT/HBS of a sigmoidoscopy or colonoscopy decreases with age; respondents 65 years and older tend to have a FOBT/HBS or a sigmoidoscopy or colonoscopy more than any other age groups.

Table 24. Length of Time Since Last Preventive Cancer Screening, percent, 2004

	Less than 12 months ago	1 year to less than 2 years	2 years to less than 3 years	3 years to less than 5 years	More than 5 years ago	No Response	Total N
Mammogram	58.7	19.3	10.8	4.7	6.1	0.5	213
Clinical breast exam	70.5	15.6	8.6	1.9	3.0	0.5	373
Pap smear	73.5	14.5	7.1	1.4	3.0	0.5	434
Fecal occult blood test FOBT/HBS	60.3	25.3	3.6	2.4	4.8	3.6	82
Sigmoidoscopy or colonoscopy	45.5	14.3	14.3	14.3	6.5	5.2	77
PSA test	44.6	30.4	10.7	5.4	8.9	0.0	56
Digital rectal exam	48.4	27.4	9.7	8.1	6.5	0.0	62

D.C. Department of Health, State Center for Health Statistics Administration

2. Injuries and Acute Illnesses

Only 4.2 percent of respondents reported that they or someone in their family had been injured or poisoned seriously and that they did not obtain medical advice or treatment in the preceding three months. Of those who were injured, 37.5 percent obtained medical advise or treatment just once, 21.9 percent did between two and five times, and 21.9 percent did more than five times in the previous three months, including more than six percent who obtained treatment more than 30 times (an average of once per day). In these instance, an amazing 45.5 percent of cases required hospitalization.

Reasons for seeking emergency treatment varied among respondents. Just over one-quarter (25.8 percent) of respondents reported seeking medical advice or treatment for an injury due to transportation, including motor vehicle/bicycle/motorcycle, pedestrian/train/boat/airplane. Other reasons were: overexertion or strenuous movements (12.9 percent); struck, stabbed or physically assaulted by another person (12.9 percent); accidentally struck by object or person

(12.9 percent); machinery (9.7 percent); fire, burn, or scald related (6.5 percent); falls, poisoning, and cut or pierced (3.2 percent each), and other (9.7 percent). Circumstances surrounding reported injuries or poisonings that required medical intervention varied; most commonly reported were driving or operating a motor vehicle and on the job (29 percent each).

3. HIV/AIDS and Other Sexually Transmitted Diseases

The issue of sexually transmitted diseases, including HIV/AIDS, is clearly extremely sensitive, particularly in the Latino community. Nevertheless, 65.4 percent of respondents reported that they had been tested for HIV, and of those, 53.9 percent had been tested within the past year and 22.3 percent between one and two years ago. Moreover, 43.4 percent of respondents were screened for HIV as part of routine checkups, 19 percent to see if they were infected, 14.7 percent because of pregnancy, 6.9 percent because of immigration requirements, and 6 percent because of employment. Only 2.1 percent reported that they had been treated for other sexually transmitted diseases, half of these in health clinics.

Knowledge about HIV/AIDS was tested in the survey by two specific questions. Of all respondents, 59.5 percent correctly stated that a pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby, and 82.3 percent stated that there are medical treatments available to help a person who is infected with HIV to live longer.

Regarding sexual behavior in general, 17.2 percent of respondents reported that within the past 12 months, they had more than one sexual partner; 80.4 percent had not. Only about one third of respondents reported using a condom the last time they had sexual intercourse, but only 2.1 percent reported having been treated for a sexually transmitted or venereal disease. Of the latter, half were treated in a health clinic. As would be assumed, reasons for using condoms varied: to prevent pregnancy (31.5 percent); to prevent diseases like syphilis, gonorrhea, and

AIDS (23.4 percent); for both of those reasons (35.4 percent); and for other reasons (2.1. percent). Faith in the effectiveness of condoms varied; 36.4 percent of respondents judged them as "very effective," 43.9 percent as "somewhat effective" and 15 percent as "not at all effective".

F. Other Findings

-Communications Channels

Finally, the survey investigated how members of the District's Latino community obtain information about health behaviors and practices. The data presented in Table 25 paint a vivid picture; more than three in four respondents report that they get health information from television. Slightly over a third do so from radio, but only around a quarter from newspapers or from family and friends. In contrast, the Internet remains a little-used medium for health information in this population.

Table 25. Media Source Turned to Most Often for Health Information, 2004

Media Source	Yes %	No %
Radio	34.1	65.9
TV	76.0	24.1
Newspaper	26.1	73.9
Magazines	6.5	93.3
Health Fair	7.2	92.8
Internet	3.7	96.3
Family/Friends	23.1	76.9

D.C. Department of Health, State Center for Health Statistics Administration

VI. Conclusion

The DC Department of Health's efforts to address health disparities separating resident minority population from the white population have been greatly enhanced by this pilot project--the Latino Health Care Collaborative (LHCC). The LHCC community health assessment model was created in an effort to fill the gap of resident minority health baseline data at DC's DOH

State Center for Health Statistics Administration (SCHSA). The SCHSA along with community and academic partners designed this unique community-based research study. The uniqueness of the model piloted in the LHCC study lies in the actual involvement of community members at the decision making as well as the data collecting level. The data gathered in this study, not only reflects an effort by the DC Department of Health SCHSA and its core partners, but also, demonstrates the willingness of residents to work towards health improvement in their community.

The principal conclusion that emerges from the survey data presented in this report is that the District's Latino community is extraordinarily diverse in terms of demographic characteristics, socioeconomic status, access to health care, and health status. This very heterogeneity represents the major challenge to the health care system. This study's major finding, the high prevalence of obesity and overweight as the leading health conditions mirrors national findings as stated in the introduction of this report. When asked about their perception of threats to their health, respondents cited a wide variety of structural impediments. Health is viewed not only as the ability to manage biomedical conditions within the individual body, but as inherently linked to their own socioeconomic circumstances. From a list provided to the interviewees, Table 26 presents the respondents' perceptions of factors that interfere with their ability to maintain good health. Lack of on-the-job insurance coverage was 83.8 percent is closely related to not having enough money to pay for treatment (91 percent). In the District of Columbia, coverage of the uninsured is provided by the Alliance insurance plan of the Department of Health; so this lack of insurance coverage for medical procedures may illustrate the need for increased outreach efforts in the resident Latino community. Furthermore, respondents' perception of their inability to negotiate the system was also high, (85.8 percent)

which may be linked to the high percentage of respondents who reported only speaking Spanish (59 percent). This added to the lack of familiarity with institutionalized systems, such as the health care system in the U.S., may represent not only a language barrier but also a high need for health care system "navigators".

Table 26. Factors Interfering with Ability to Maintain Good Health, 2004

	Yes	No
Lack of job that includes health insurance	83.8	15.1
Lack of enough money to pay for treatment	91.0	8.4
Inability to get healthcare – inability to negotiate system – not eligible	85.8	13.6
Environmental Conditions	85.4	14.1
Difficulties in obtaining legal status here in the US	81.5	17.9
Not knowing what to do to prevent diseases and promote health	85.9	13.5
Fear or have experienced violence	68.4	31.0

D.C. Department of Health, State Center for Health Statistics Administration

Respondents also reported immigration related problems as a factor that interferes with their ability to maintaining good health, having difficulties in obtaining legal status in the U.S. (81.5 percent). This finding is in sharp contrast with the duration of residence in the U.S. that many respondents reported (41.8 percent).

Along with factors related to socio-economic status are cultural factors that should be studied further, in order to enhance these findings. These cultural factors may explain the high incidence of overweight and obesity and other major conditions among Latinos of Washington, D.C. We will explore some of these cultural factors in our report of the project "Para su Salud" workshops. Meanwhile, the LHCC findings provided in this report should be seen as an introduction to the health status of resident Latinos, a rapidly growing minority population and should reflect its uniqueness which has for long been an asset to this city.

VII. Summary of Key Findings

Highlights of the survey findings include:

- The five leading health conditions encountered among Latinos surveyed in Washington, D.C. are overweight and obesity (60.8 percent), diabetes, including pregnant women diagnosed with gestational diabetes, (18.2 percent), high blood pressure (16.8 percent), blood cholesterol (13.6 percent), and arthritis (7.7 percent).
- Latinos surveyed mentioned having health insurance coverage on more than half of the cases (58.2 percent), and a little less than a half reported not having health insurance.
- The Latino community is a relatively young population. Less than 3 percent of respondents were 65 years of age or older, 15.1 percent were 20-24 years old, 36.8 percent were 25–34 years old, 25.3 percent were 35–44 years old, 14.0 percent were 45–54 years old and less than 10 percent were 55–to more than 65 years old.
- Natives of El Salvador represent more than half of the sample. Notably, a total of 12 percent of respondents came from Guatemala and Honduras. Natives of Mexico represent another 12 percent, while the two other largest groups at the national level, Cuba and Puerto Rico, are much less represented in the District.
- A very large proportion of the District's Latino community has relatively little formal education, eight percent have never attended school and just over half have only a primary school education.
- The household income of a large proportion of the District's Latino community is extremely precarious; nearly two-thirds of respondents reported total household incomes of $25,000 per year or less, while only five percent reported total household incomes of $50,000 or more.

- While a large proportion of respondents speak only or primarily Spanish (59 percent), about two-thirds have been living in the United States for five years or more and only about a fifth report living here for less than two years.
- Latinos surveyed self-reported their race as “White” 10 percent, “Black or African American” 0.7 percent, “Asian” 0.0 percent, “Native Hawaiian or other Pacific Islander” 0.1 percent, “American Indian or Alaska Native” 1.0 percent, “Mixed” or “Other” 88.5 percent (having to specify). Among the specific answers given by respondents to the “Mixed or Other” options were: Hispanic or Latino/a (87.8 percent), Mestizo (7.2 percent), Mixed (3.1 percent), mentioned their country of origin (1.4 percent) and Moreno and Indigenous (both 0.2 percent each).

VIII. TABLES

Table 27. Number and Percent of the District of Columbia, 2000 and 2004 Latino Population Residing in Each Ward			
Ward	**200 Census**		**Unweighted 2002 DC LHCC**
	Number	**Percent**	**Number**
City Total	44,953	7.9%	819
1	18,750	23.4%	425
2	7,155	8.6%	155
3	5,138	6.5%	13*
4	9,158	12.8%	226
5	1,666	2.5%	Did not sample
6	1,585	2.4%	Did not sample
7	589	0.9%	Did not sample
8	912	1.5%	Did not sample

*Sample size too small for reliable estimate

Table 28. 2004 District of Columbia Latino Demographic Data by Ward			
	District of Columbia Ward		
	1	**2**	**4**
Demographic Characteristic			
TOTAL	**425**	**155**	**226**
SEX			
Male	42.4	57.4	36.7
Female	57.7	42.6	63.3
AGE GROUP			
20-24	13.4	19.35	16.4
25-34	34.6	39.4	39.4
35-44	26.4	25.2	22.6
45-54	14.1	11.0	15.5
55-64	8.0	4.5	3.5
65+	3.5	0.7	2.7
INCOME LEVEL			
< $10,000	9.9	3.9	6.6
$10 - $14,999	23.5	17.4	18.1
$15 - $19,999	19.1	26.5	16.8
$20 - $24,999	13.2	14.2	16.4
$25 - $34,999	10.8	14.8	14.2
$35 - $49,999	7.1	3.2	9.7
$50 - $74,999	2.8	1.9	4.9
> = $75,000	1.4	3.2	0.9
EDUCATION LEVEL			
Never attended	9.4	7.1	6.6
Elementary 1st-8th grade	55.8	45.2	51.8
Some High School 9th-11th grade	15.1	23.9	17.7
High School Graduate	12.2	8.4	15.5
Some College	4.0	7.7	5.6
College Graduate	3.5	7.7	2.2

Table 28. 2004 District of Columbia Latino Demographic Data by Ward			
	District of Columbia Ward		
	1	2	4
Demographic Characteristic			
MARITAL STATUS			
Married	39.3	47.1	50.0
Divorced	5.7	5.2	4.9
Widowed	4.2	1.3	0.9
Separated	6.8	7.7	5.3
Never been married	29.7	27.1	21.2
Unmarried couple	14.1	11.0	16.8
EMPLOYMENT STATUS			
Employed	60.5	80.0	65.5
Self-employed	5.2	0.7	4.4
Out of work > 1 year	12.9	2.6	11.5
Out of work < 1 year	8.2	7.1	5.3
Homemaker	9.2	5.8	10.6
Student	0.2	3.2	0.4
Retired	2.1	0.0	1.8
Unable to work	1.7	0.7	0.4
HEALTH CARE COVERAGE			
Yes	54.8	58.1	64.6
No	44.9	41.3	35.4
LENGTH OF STAY IN USA			
Born in USA	0.7	0.0	0.8
0 - < 2 years	11.5	17.4	11.1
2 - < 5 years	20.0	22.6	21.7
5 – 10 years	23.3	31.6	21.7
> 10 years	44.5	28.4	44.3
LANGUAGE SKILLS			
Spanish only	61.2	53.6	60.2
Spanish more than English	30.8	33.6	34.1
Spanish & English equally	7.3	12.9	4.9
English more than Spanish	0.5	0.0	0.4

Table 29. Self-Perceived Health Status
District of Columbia, 2004

	Total Surveyed N=819					
Demographic Characteristic	**N**	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
TOTAL	819	11.7	21.4	30.7	32.1	3.9
SEX						
Male	357	13.7	25.8	27.7	27.7	4.5
Female	462	10.2	18.0	32.9	35.5	3.5
AGE GROUP						
20-24	124	16.9	25.0	28.2	28.2	0.8
25-34	3.1	14.3	25.6	32.2	25.3	3.7
35-44	207	7.7	21.3	30.9	35.8	3.9
45-54	115	7.0	18.3	31.3	40.0	3.5
55-64	50	14.0	8.0	30.0	40.0	8.0
65+	22	4.6	4.6	18.2	54.6	18.2
INCOME LEVEL						
< $10,000	63	6.4	11.1	34.9	38.1	9.5
$10 - $14,999	169	10.1	27.8	27.8	31.4	3.0
$15 - $19,999	164	10.4	23.2	33.5	29.3	3.7
$20 - $24,999	120	13.3	20.0	32.5	30.0	3.3
$25 - $34,999	103	14.6	10.7	34.0	36.9	3.9
$35 - $49,999	58	15.5	32.8	25.9	24.1	1.7
$50 - $74,999	26	15.4	15.4	30.8	38.5	0.0
> = $75,000	13	15.4	38.5	15.4	30.8	0.0
EDUCATION LEVEL						
Never attended	68	7.4	17.7	22.1	44.1	8.8
Elementary 1st-8th grade	425	8.7	20.5	31.1	35.3	4.0
Some High School 9th-11th grade	144	14.6	18.1	29.9	35.4	2.1
High School Graduate	105	21.0	27.6	32.4	16.2	2.9
Some College	43	18.6	25.6	41.9	11.6	2.3
College Graduate	33	9.1	30.3	24.2	30.3	6.1
MARITAL STATUS						
Married	360	10.3	24.7	31.1	29.2	4.7
Divorced	44	15.9	11.4	25.0	40.9	6.8
Widowed	22	18.2	4.6	27.3	50.0	0.0
Separated	53	15.1	17.0	32.1	30.2	3.8
Never been married	219	13.2	20.6	27.9	34.3	4.1
Unmarried couple	117	9.4	21.4	35.9	32.5	0.0
EMPLOYMENT STATUS						
Employed	539	12.1	26.0	28.6	29.9	3.3
Self-employed	35	20.0	14.3	28.6	34.3	2.9
Out of work > 1 year	86	9.3	18.6	29.1	39.5	3.5
Out of work < 1 year	58	12.1	12.1	39.7	32.8	1.7
Homemaker	72	6.9	5.6	45.8	37.5	4.2
Student	7	28.6	42.9	28.6	0.0	0.0
Retired	13	7.7	0.0	30.8	46.2	15.4
Unable to work	9	11.1	0.0	0.0	44.4	44.4

Table 29. Self-Perceived Health Status
District of Columbia, 2004

	Total Surveyed N=819					
Demographic Characteristic	**N**	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
TYPES OF PHYSICAL ACTIVITY						
Moderate (yes)	499	12.6	19.0	30.5	33.7	4.0
Vigorous (yes)	212	13.7	23.6	27.8	31.1	3.3
HEALTH CARE COVERAGE						
Yes	477	11.7	23.9	29.8	31.2	3.4
No	340	11.5	17.9	32.1	33.5	4.4
LENGTH OF STAY IN USA						
Born in USA	5	20.0	0.0	60.0	20.0	0.0
0 - < 2 years	103	8.7	19.4	35.0	32.0	3.9
2 - < 5 years	169	16.6	24.9	27.2	29.0	2.4
5 – 10 years	199	14.1	28.6	31.2	37.7	6.4
> 10 years	342	8.8	16.4	30.4	37.7	6.4
LANGUAGE SKILLS						
Spanish only	483	9.3	18.0	3.4	37.1	5.0
Spanish more than English	268	13.8	28.0	33.2	23.1	1.5
Spanish & English equally	63	22.2	17.5	22.2	31.8	6.4
English more than Spanish	3	0.0	33.3	33.3	33.3	0.0
WARD						
Ward 1	425	10.8	14.4	29.2	40.0	5.4
Ward 2	155	13.6	32.3	27.1	24.5	1.9
Ward 4	126	11.5	26.6	35.4	23.9	2.7

Table 30. Health Care Coverage (Insurance) District of Columbia, 2004

Total Surveyed N=819

Demographic Characteristic	Yes	
	N	Percent
TOTAL	477	58.2
SEX		
Male	165	46.2
Female	312	67.5
AGE GROUP		
20-24	54	43.6
25-34	171	56.8
35-44	129	62.3
45-54	73	63.5
55-64	32	64.0
65+	18	81.8
INCOME LEVEL		
< $10,000	32	50.8
$10 - $14,999	100	59.2
$15 - $19,999	88	53.7
$20 - $24,999	75	62.5
$25 - $34,999	61	59.2
$35 - $49,999	39	67.2
$50 - $74,999	16	61.5
> = $75,000	8	61.5
EDUCATION LEVEL		
Never attended	40	58.8
Elementary 1st-8th grade	244	57.4
Some High School 9th-11th grade	77	53.5
High School Graduate	64	61.0
Some College	26	60.5
College Graduate	25	75.8
MARITAL STATUS		
Married	237	65.8
Divorced	27	61.4
Widowed	16	72.7
Separated	27	50.9
Never been married	101	46.1
Unmarried couple	66	56.4
EMPLOYMENT STATUS		
Employed	308	57.1
Self-employed	18	51.4
Out of work > 1 year	56	65.1
Out of work < 1 year	21	36.2
Homemaker	48	66.7
Student	5	71.4
Retired	13	100.0
Unable to work	8	88.9

Table 30. Health Care Coverage (Insurance) District of Columbia, 2004

Total Surveyed N=819

Demographic Characteristic	Yes	
	N	Percent
LENGTH OF STAY IN USA		
Born in USA	3	60.0
0 - < 2 years	34	33.0
2 - < 5 years	89	52.7
5 – 10 years	126	63.3
> 10 years	225	65.8
LANGUAGE SKILLS		
Spanish only	269	55.7
Spanish more than English	159	59.3
Spanish & English equally	45	71.4
English more than Spanish	2	66.7
WARD		
Ward 1	233	54.8
Ward 2	90	58.1
Ward 4	146	64.6

Table 31. Overweight and Obesity by Body Mass Index (BMI)
District of Columbia, 2004

	Overweight & Obesity (BMI 25+)		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	497	60.7	818	100
SEX				
Male	220	61.8	356	100
Female	279	60.0	462	100
AGE GROUP				
20-24	46	37.1	124	100
25-34	174	57.8	301	100
35-44	151	72.9	201	100
45-54	78	67.8	115	100
55-64	35	17.5	50	100
65+	13	59.1	22	100
INCOME LEVEL				
< $10,000	36	57.1	63	100
$10 - $14,999	107	63.3	169	100
$15 - $19,999	107	65.2	164	100
$20 - $24,999	79	65.8	120	100
$25 - $34,999	70	68.0	103	100
$35 - $49,999	34	58.6	58	100
$50 - $74,999	18	69.2	26	100
> = $75,000	3	23.1	13	100
EDUCATION LEVEL				
Never attended	45	66.2	68	100
Elementary 1st-8th grade	269	63.3	425	100
Some High School 9th-11th grade	90	62.5	144	100
High School Graduate	57	54.3	105	100
Some College	20	46.5	43	100
College Graduate	17	51.5	33	100
MARITAL STATUS				
Married	241	66.9	360	100
Divorced	26	59.1	44	100
Widowed	15	68.2	22	100
Separated	35	66.0	53	100
Never been married	110	50.2	219	100
Unmarried couple	67	57.3	117	100
EMPLOYMENT STATUS				
Employed	327	60.7	539	100
Self-employed	24	68.6	35	100
Out of work > 1 year	55	64.0	86	100
Out of work < 1 year	38	65.5	58	100

Table 31. Overweight and Obesity by Body Mass Index (BMI) District of Columbia, 2004				
	Overweight & Obesity (BMI 25+)		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
Homemaker	39	54.2	72	100
Student	0	0.0	7	100
Retired	9	69.2	13	100
Unable to work	5	55.6	9	100
TYPES OF PHYSICAL ACTIVITY				
Moderate (yes = 499)	311	62.3	499	100
< 3 days per week	39	50.0	78	100
3-4 days per week	63	69.2	91	100
5-7 days per week	224	63.6	353	100
Vigorous (yes)	119	56.1	212	100
< 3 days per week	39	61.9	63	100
3-4 days per week	19	43.2	44	100
5-7 days per week	83	61.9	134	100
FRUITS & VEGETABLE CONSUMPTION (average daily)				
1-2 times	448	62.2	720	100
3-4 times	39	45.9	85	100
5 or more	11	78.6	14	100
HEALTH CARE COVERAGE				
Yes	303	63.5	477	100
No	194	57.1	340	100
LENGTH OF STAY IN USA				
Born in USA	2	40.0	5	100
0 - < 2 years	42	40.8	103	100
2 - < 5 years	99	58.6	169	100
5 – 10 years	130	65.3	199	100
> 10 years	225	65.8	342	100
LANGUAGE SKILLS				
Spanish only	309	64.0	483	100
Spanish more than English	157	58.6	268	100
Spanish & English equally	30	47.6	63	100
English more than Spanish	0	0.0	3	100
WARD				
Ward 1	270	63.5	425	100
Ward 2	94	60.6	155	100
Ward 4	125	55.3	226	100

Table 32. Diabetes
District of Columbia, 2004

	Diagnosed Diabetes		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	137	18.2	753	100
SEX				
Male	12	4.1	291	100
Female	125	27.1	462	100
AGE GROUP				
20-24	15	13.2	114	100
25-34	43	15.6	276	100
35-44	35	19.1	183	100
45-54	24	22.0	109	100
55-64	13	27.1	48	100
65+	7	33.3	21	100
INCOME LEVEL				
< $10,000	15	25.9	58	100
$10 - $14,999	41	28.5	144	100
$15 - $19,999	21	13.4	157	100
$20 - $24,999	14	12.7	110	100
$25 - $34,999	20	20.0	100	100
$35 - $49,999	9	17.6	51	100
$50 - $74,999	2	8.3	24	100
> = $75,000	1	7.7	13	100
EDUCATION LEVEL				
Never attended	13	22.0	59	100
Elementary 1st-8th grade	72	18.4	391	100
Some High School 9th-11th grade	24	17.6	136	100
High School Graduate	15	16.0	94	100
Some College	7	16.7	42	100
College Graduate	5	16.7	30	100
MARITAL STATUS				
Married	64	18.9	333	100
Divorced	13	33.3	39	100
Widowed	7	31.8	22	100
Separated	10	20.0	50	100
Never been married	26	13.5	193	100
Unmarried couple	15	13.9	108	100
EMPLOYMENT STATUS				
Employed	71	14.7	483	100
Self-employed	6	18.2	33	100
Out of work > 1 year	13	15.5	84	100
Out of work < 1 year	10	18.5	54	100
Homemaker	24	33.3	72	100
Student	1	16.7	6	100
Retired	4	33.3	12	100
Unable to work	8	88.9	9	100

Table 32. Diabetes
District of Columbia, 2004

	Diagnosed Diabetes		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TYPES OF PHYSICAL ACTIVITY				
Moderate (yes)	72	15.6	462	100
< 3 days per week	14	21.5	65	100
3-4 days per week	13	14.6	89	100
5-7 days per week	54	16.5	327	100
Vigorous (yes)	20	10.5	190	100
< 3 days per week	14	25.9	54	100
3-4 days per week	5	12.2	41	100
5-7 days per week	9	7.8	116	100
FRUITS & VEGETABLE CONSUMPTION (average daily)				
1-2 times	118	17.9	658	100
3-4 times	14	17.1	82	100
5 or more	5	38.5	13	100
HEALTH CARE COVERAGE				
Yes	100	22.1	452	100
No	37	12.4	299	100
LENGTH OF STAY IN USA				
Born in USA	3	60.0	5	100
0 - < 2 years	11	11.6	95	100
2 - < 5 years	25	16.8	249	100
5 – 10 years	37	20.7	179	100
> 10 years	61	18.8	324	100
LANGUAGE SKILLS				
Spanish only	85	19.6	434	100
Spanish more than English	40	15.7	255	100
Spanish & English equally	10	16.9	59	100
English more than Spanish	1	33.3	3	100
WARD				
Ward 1	81	20.9	387	100
Ward 2	23	16.2	142	100
Ward 4	31	14.5	214	100

Table 33. High Blood Pressure (Hypertension) District of Columbia, 2004				
	Diagnosed Hypertension		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	135	16.8	803	100
SEX				
Male	36	10.4	345	100
Female	99	21.6	458	100
AGE GROUP				
20-24	4	3.4	118	100
25-34	23	7.8	294	100
35-44	32	15.7	204	100
45-54	36	31.6	114	100
55-64	26	53.1	49	100
65+	14	63.6	22	100
INCOME LEVEL				
< $10,000	19	30.7	62	100
$10 - $14,999	31	18.6	167	100
$15 - $19,999	19	11.8	161	100
$20 - $24,999	14	12.1	116	100
$25 - $34,999	18	18.0	100	100
$35 - $49,999	10	17.5	57	100
$50 - $74,999	5	19.2	26	100
> = $75,000	2	15.4	13	100
EDUCATION LEVEL				
Never attended	17	25.4	67	100
Elementary 1st-8th grade	71	17.2	414	100
Some High School 9th-11th grade	19	13.6	140	100
High School Graduate	10	9.5	105	100
Some College	8	18.6	43	100
College Graduate	10	30.3	33	100
MARITAL STATUS				
Married	63	18.0	351	100
Divorced	15	34.9	43	100
Widowed	8	38.1	21	100
Separated	13	24.5	53	100
Never been married	25	11.7	214	100
Unmarried couple	10	8.6	117	100
EMPLOYMENT STATUS				
Employed	72	13.7	524	100
Self-employed	9	25.7	35	100
Out of work > 1 year	15	17.7	85	100
Out of work < 1 year	8	13.8	58	100
Homemaker	16	22.2	72	100
Student	0	0.0	7	100
Retired	9	69.2	13	100
Unable to work	6	66.7	9	100

Table 33. High Blood Pressure (Hypertension) District of Columbia, 2004				
	Diagnosed Hypertension		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TYPES OF PHYSICAL ACTIVITY				
Moderate (yes)	87	17.7	491	100
< 3 days per week	15	19.2	78	100
3-4 days per week	16	18.0	89	100
5-7 days per week	60	17.3	347	100
Vigorous (yes)	29	13.9	208	100
< 3 days per week	9	15.0	60	100
3-4 days per week	8	18.6	43	100
5-7 days per week	17	12.9	132	100
FRUITS & VEGETABLE CONSUMPTION (average daily)				
1-2 times	107	15.2	704	100
3-4 times	21	24.7	85	100
5 or more	7	50.0	14	100
HEALTH CARE COVERAGE				
Yes	98	20.8	471	100
No	36	10.9	330	100
LENGTH OF STAY IN USA				
Born in USA	1	20.0	5	100
0 - < 2 years	9	9.0	100	100
2 - < 5 years	17	10.2	166	100
5 – 10 years	12	6.2	194	100
> 10 years	96	28.5	337	100
LANGUAGE SKILLS				
Spanish only	77	16.2	475	100
Spanish more than English	35	13.4	261	100
Spanish & English equally	22	35.5	62	100
English more than Spanish	0	0.0	3	100
WARD				
Ward 1	70	16.5	425	100
Ward 2	18	11.6	155	100
Ward 4	44	19.5	226	100

Table 34. High Blood Cholesterol
District of Columbia, 2004

	Diagnosed Blood Cholesterol		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	107	13.6	786	100
SEX				
Male	28	8.3	338	100
Female	79	17.6	448	100
AGE GROUP				
20-24	3	2.5	119	100
25-34	22	7.6	289	100
35-44	30	15.3	196	100
45-54	28	25.7	109	100
55-64	13	26.5	49	100
65+	11	50.0	22	100
INCOME LEVEL				
< $10,000	8	14.3	56	100
$10 - $14,999	21	12.8	164	100
$15 - $19,999	21	13.1	160	100
$20 - $24,999	14	12.0	117	100
$25 - $34,999	16	16.8	95	100
$35 - $49,999	8	14.0	57	100
$50 - $74,999	7	26.9	26	100
> = $75,000	1	8.3	12	100
EDUCATION LEVEL				
Never attended	13	20.6	63	100
Elementary 1st-8th grade	57	13.9	411	100
Some High School 9th-11th grade	19	13.8	138	100
High School Graduate	7	6.9	102	100
Some College	6	15.4	39	100
College Graduate	5	15.6	32	100
MARITAL STATUS				
Married	52	15.1	345	100
Divorced	9	21.4	42	100
Widowed	7	31.8	22	100
Separated	10	20.0	50	100
Never been married	18	8.7	208	100
Unmarried couple	11	9.6	115	100
EMPLOYMENT STATUS				
Employed	64	12.3	519	100
Self-employed	9	25.7	35	100
Out of work > 1 year	9	11.1	81	100
Out of work < 1 year	8	14.8	54	100
Homemaker	10	14.7	68	100
Student	0	0.0	7	100
Retired	4	30.8	13	100
Unable to work	3	33.3	9	100

Table 34. High Blood Cholesterol District of Columbia, 2004				
	Diagnosed Blood Cholesterol		**Total Surveyed N=819**	
	Sample		**Total Response**	
Demographic Characteristic	**N**	**%**	**N**	**%**
TYPES OF PHYSICAL ACTIVITY				
Moderate (yes)	60	12.5	479	100
Vigorous (yes)	18	9.1	199	100
FRUITS & VEGETABLE CONSUMPTION (average daily)				
1-2 times	90	13.0	692	100
3-4 times	12	14.8	81	100
5 or more	5	38.5	13	100
HEALTH CARE COVERAGE				
Yes	81	17.3	467	100
No	26	8.2	317	100
LENGTH OF STAY IN USA				
Born in USA	0	0.0	5	100
0 - < 2 years	3	3.2	94	100
2 - < 5 years	15	9.4	159	100
5 – 10 years	15	7.7	194	100
> 10 years	74	22.2	333	100
LANGUAGE SKILLS				
Spanish only	58	12.5	463	100
Spanish more than English	38	14.7	258	100
Spanish & English equally	11	18.3	60	100
English more than Spanish	0	0.0	3	100
WARD				
Ward 1	61	14.4	425	100
Ward 2	15	9.7	155	100
Ward 4	27	11.9	226	100

Table 35. Arthritis
District of Columbia, 2004

	Diagnosed Arthritis		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	63	7.7	819	100
SEX				
Male	11	3.1	357	100
Female	52	11.3	462	100
AGE GROUP				
20-24	2	1.6	124	100
25-34	4	1.3	301	100
35-44	9	4.3	207	100
45-54	20	17.4	115	100
55-64	18	36.0	50	100
65+	10	45.5	22	100
INCOME LEVEL				
< $10,000	12	19.0	63	100
$10 - $14,999	17	10.1	169	100
$15 - $19,999	10	6.1	164	100
$20 - $24,999	5	4.2	120	100
$25 - $34,999	11	10.7	103	100
$35 - $49,999	1	1.7	58	100
$50 - $74,999	1	3.8	26	100
> = $75,000	0	0.0	13	100
EDUCATION LEVEL				
Never attended	16	23.5	68	100
Elementary 1st-8th grade	29	6.8	425	100
Some High School 9th-11th grade	11	7.6	144	100
High School Graduate	1	1.0	105	100
Some College	2	4.7	43	100
College Graduate	4	12.1	33	100
MARITAL STATUS				
Married	33	9.2	360	100
Divorced	5	11.4	44	100
Widowed	5	22.7	22	100
Separated	6	11.3	53	100
Never been married	10	4.6	219	100
Unmarried couple	4	3.4	117	100
EMPLOYMENT STATUS				
Employed	32	5.9	539	100
Self-employed	2	5.7	35	100
Out of work > 1 year	11	12.8	86	100
Out of work < 1 year	3	5.2	58	100
Homemaker	6	8.3	72	100
Student	0	0.0	7	100
Retired	7	53.8	13	100
Unable to work	2	22.2	9	100

Table 35. Arthritis
District of Columbia, 2004

	Diagnosed Arthritis		Total Surveyed N=819	
	Sample		Total Response	
Demographic Characteristic	**N**	**%**	**N**	**%**
TYPES OF PHYSICAL ACTIVITY				
Moderate (yes)	35	7.0	499	100
Vigorous (yes)	1	0.5	212	100
FRUITS & VEGETABLE CONSUMPTION (average daily)				
1-2 times	57	7.9	720	100
3-4 times	6	7.1	85	100
5 or more	0	0.0	14	100
HEALTH CARE COVERAGE				
Yes	52	10.9	477	100
No	43	12.6	340	100
LENGTH OF STAY IN USA				
Born in USA	1	20.0	5	100
0 - < 2 years	1	1.0	103	100
2 - < 5 years	11	6.5	169	100
5 – 10 years	7	3.5	199	100
> 10 years	43	12.6	342	100
LANGUAGE SKILLS				
Spanish only	43	8.9	483	100
Spanish more than English	15	5.6	268	100
Spanish & English equally	4	6.3	63	100
English more than Spanish	0	0.0	3	100
WARD				
Ward 1	41	9.6	425	100
Ward 2	6	3.9	155	100
Ward 4	16	7.1	226	100

Table 36. Mammogram Screenings District of Columbia, 2004				
	Females 20 years and older		Females 40 years and older	
	No mammogram		No mammogram	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	236	53.3		
AGE GROUP				
20-24	49	84.5	-	-
25-34	126	77.8	-	-
35-44 / (40-44)	49	44.6	25	37.9
45-54	8	12.1	8	12.1
55-64	2	6.7	2	6.7
65+	2	12.5	2	12.5
INCOME LEVEL				
< $10,000	22	50.0	6	27.3
$10 - $14,999	53	55.8	11	25.6
$15 - $19,999	48	48.0	4	11.1
$20 - $24,999	30	56.6	6	26.1
$25 - $34,999	26	49.1	4	19.1
$35 - $49,999	16	57.1	3	27.3
$50 - $74,999	4	57.1	0	0.0
> = $75,000	1	50.0	0	0.0
EDUCATION LEVEL				
Never attended	15	41.7	6	24.0
Elementary 1st-8th grade	131	54.6	22	22.2
Some High School 9th-11th grade	41	56.2	6	21.4
High School Graduate	32	58.2	2	15.4
Some College	13	50.0	1	11.1
College Graduate	4	33.3	0	0.0
MARITAL STATUS				
Married	113	55.4	16	20.5
Divorced	5	22.7	0	0.0
Widowed	5	27.8	3	18.8
Separated	11	34.4	5	21.7
Never been married	53	57.6	7	22.6
Unmarried couple	48	66.7	6	40.0
EMPLOYMENT STATUS				
Employed	122	50.0	22	21.6
Self-employed	9	37.5	2	12.5
Out of work > 1 year	41	65.1	7	41.2
Out of work < 1 year	18	66.7	0	0.0
Homemaker	45	64.3	6	25.0
Student	1	100	0	0.0
Retired	0	0.0	0	0.0
Unable to work	0	0.0	0	0.0
HEALTH CARE COVERAGE				
Yes	157	52.3	21	17.1
No	79	55.6	16	29.1

Table 36. Mammogram Screenings District of Columbia, 2004				
	Females 20 years and older		Females 40 years and older	
	No mammogram		No mammogram	
Demographic Characteristic	**N**	**%**	**N**	**%**
LENGTH OF STAY IN USA				
Born in USA	3	75.0	1	50.0
0 - < 2 years	40	76.9	4	50.0
2 - < 5 years	54	60.7	5	26.3
5 – 10 years	76	65.5	9	26.5
> 10 years	63	34.6	18	15.7
LANGUAGE SKILLS				
Spanish only	154	55.6	27	24.1
Spanish more than English	73	52.9	9	18.0
Spanish & English equally	7	29.2	1	6.7
English more than Spanish	1	50.0	0.0	0.0
WARD				
Ward 1	113	47.9	23	21.1
Ward 2	34	54.0	4	21.1
Ward 4	85	62.5	10	21.7

Table 37. Prostate Specific Antigen (PSA) Exam and Digital Rectal Exam (DRE) District of Columbia, 2004

	Males 40 years and older			
	No PSA		No DRE	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL				
AGE GROUP				
40-44	32	78.1	33	80.5
45-54	35	72.9	31	64.6
55-64	11	55.0	10	52.6
65+	2	28.6	2	33.3
INCOME LEVEL				
< $10,000	7	87.5	5	71.4
$10 - $14,999	15	79.0	13	72.2
$15 - $19,999	14	63.6	16	72.7
$20 - $24,999	13	56.5	11	47.8
$25 - $34,999	10	62.5	11	68.8
$35 - $49,999	6	75.0	6	75.0
$50 - $74,999	5	100.0	5	100.0
> = $75,000	1	50.0	1	50.0
EDUCATION LEVEL				
Never attended	10	71.4	12	85.7
Elementary 1st-8th grade	44	74.6	42	72.4
Some High School 9th-11th grade	11	64.7	8	50.0
High School Graduate	9	64.3	9	64.3
Some College	2	33.3	1	16.7
College Graduate	4	66.7	4	66.7
MARITAL STATUS				
Married	48	69.6	47	69.1
Divorced	5	41.7	8	66.7
Widowed	3	75.0	1	25.0
Separated	7	77.8	6	75.0
Never been married	9	81.8	8	72.7
Unmarried couple	8	72.7	6	54.6
EMPLOYMENT STATUS				
Employed	58	70.7	55	67.9
Self-employed	2	66.7	2	66.7
Out of work > 1 year	6	46.2	8	66.7
Out of work < 1 year	11	84.6	10	76.9
Homemaker	0	0.0	0	0.0
Student	0	0.0	0	0.0
Retired	3	60.0	1	20.0
Unable to work	0	0.0	0	0.0
HEALTH CARE COVERAGE				
Yes	42	61.8	38	56.7
No	38	79.2	38	80.9

Table 37. Prostate Specific Antigen (PSA) Exam and Digital Rectal Exam (DRE) District of Columbia, 2004

	Males 40 years and older			
	No PSA		No DRE	
Demographic Characteristic	**N**	**%**	**N**	**%**
LENGTH OF STAY IN USA				
Born in USA	1	100.0	1	100.0
0 - < 2 years	7	100.0	7	100.0
2 - < 5 years	13	86.7	11	78.6
5 – 10 years	15	93.8	14	87.5
> 10 years	44	57.1	43	56.6
LANGUAGE SKILLS				
Spanish only	42	67.7	44	72.1
Spanish more than English	29	74.4	24	63.2
Spanish & English equally	9	60.0	8	53.3
English more than Spanish	0	0.0	0	0.0
WARD				
Ward 1	48	73.8	48	75.0
Ward 2	15	68.2	13	59.1
Ward 4	16	59.3	14	53.9

Table 38. Home Blood Stool Test Kit (HBS) and Colonoscopy/Sigmoidoscopy (C/S) District of Columbia, 2004

	50 years and older			
	No HBS		No C/S	
Demographic Characteristic	**N**	**%**	**N**	**%**
TOTAL	108	83.7	90	70.9
SEX				
Male	43	86.0	33	66.0
Female	65	82.3	57	74.0
AGE GROUP				
50-54	52	91.2	43	76.8
55-64	41	82.0	38	77.6
65+	15	68.2	9	40.9
INCOME LEVEL				
< $10,000	14	87.5	10	62.5
$10 - $14,999	23	82.1	19	70.4
$15 - $19,999	25	89.3	21	77.8
$20 - $24,999	15	88.2	13	76.5
$25 - $34,999	13	92.9	11	78.6
$35 - $49,999	6	75.0	6	75.0
$50 - $74,999	2	100.0	1	50.0
> = $75,000	0	0.0	0	0.0
EDUCATION LEVEL				
Never attended	18	81.8	12	54.6
Elementary 1st-8th grade	54	85.7	48	77.4
Some High School 9th-11th grade	18	90.0	15	79.0
High School Graduate	8	80.0	9	90.0
Some College	3	50.0	2	33.3
College Graduate	7	87.5	4	50.0
MARITAL STATUS				
Married	56	96.6	46	79.3
Divorced	13	76.5	12	70.6
Widowed	9	64.3	6	46.2
Separated	11	84.6	11	84.6
Never been married	13	72.2	12	66.7
Unmarried couple	6	75.0	3	42.8
EMPLOYMENT STATUS				
Employed	58	92.1	45	72.6
Self-employed	7	77.8	7	77.8
Out of work > 1 year	13	86.7	12	80.0
Out of work < 1 year	7	77.8	7	77.8
Homemaker	12	85.7	10	71.4
Student	0	0.0	0	0.0
Retired	7	53.9	7	53.9
Unable to work	4	66.7	2	40.0
HEALTH CARE COVERAGE				
Yes	71	82.6	57	67.1
No	37	86.1	33	78.6

Table 38. Home Blood Stool Test Kit (HBS) and Colonoscopy/Sigmoidoscopy (C/S) District of Columbia, 2004

	50 years and older			
	No HBS		No C/S	
Demographic Characteristic	**N**	**%**	**N**	**%**
LENGTH OF STAY IN USA				
Born in USA	0	0.0	0	0.0
0 - < 2 years	4	80.0	5	100.0
2 - < 5 years	9	75.0	9	75.0
5 – 10 years	12	100.0	8	72.7
> 10 years	83	83.0	68	68.7
LANGUAGE SKILLS				
Spanish only	71	86.6	60	74.1
Spanish more than English	25	80.7	22	71.0
Spanish & English equally	12	75.0	8	53.3
English more than Spanish	0	0.0	0	0.0
WARD				
Ward 1	64	84.2	53	71.6
Ward 2	16	94.1	12	70.6
Ward 4	25	75.8	22	66.7

Appendix 1
Technical Advisory Board
DCCHAI-LHCC

Association of Health Professionals:

1. Barbara Hatcher
   American Public Health Association
   Director of Scientific Affairs
   800 "I" St., N.W.
   Washington, D.C. 20001
   (202) 777-2490, (202) 777-APHA,
   Fax (2) 777- 2534
   bhatcher@apha.org

2. Dr. Henry Williams, National Medical Association
   Howard University School of Medicine Department of Community and Family Medicine
   Acting Chair
   520 W St., NW Suite 2400 Washington, DC 20059
   @ Howard- Ruth (assistant) (202)-806-6300
   @ NMA- Yolanda Fleming (coordinator) (202) 347-1895 x 261,
   Fax (2) 371-1162
   hwwilliams@howard.edu

Community-Based Organizations:

3. Odile Attiglah, MD, MPH, Ethiopian Community Development Council, Inc
   Health Services Coordinator
   1038 S. Highland St. Arlington, VA 22204
   (703) 685-0510 X 246
   odile.attiglah@ecdcinternational.org

4. Esther Kaggwa, National Organization of Concerned Black Men
   Program Coordinator
   1816 12th St., NW Suite 204 Washington, DC 20009
   (202) 783-2488
   (202) 783-6119 (main)
   Fax (202) 783-2480
   George Garrow, Executive Director
   (202) 467-5550
   ekaggwa@cbmnational.org

Community-Based Organizations (LHCC partnering clinics):

5. Ricardo Galbis, MD, Andromeda Transcultural Health Center
   Executive Director
   1400 Decatur St., NW Washington, DC 20011

(202) 291-4707
galbisb@aol.com
Other contacts:
Raquel Guevara, PA, Deputy Director guevararpa@yahoo.com
Alejandro Duarte, MD, aleduartecuellar@yahoo.com
Andres Jacome

6. Juan Romagoza, MD, La Clínica del Pueblo
   Executive Director
   2831 15th St., NW Washington, DC 20009
   (202) 462-4788
   (202) 448-2810
   Fax (202) 667-3607
   www.lcdp.org
   jromagoza@lcdp@org
   Other contacts:
   Alicia Wilson, Director of Grants and Contracts Administration
   (202) 464-0147
   awilson@lcdp.org

7. Maria Gómez, MPH, Mary's Center for Maternal and Child Care
   President & CEO
   2333 Ontario Rd., NW Washington, DC 20009
   (202) 483-8319 X 328
   Fax (202) 234- 3678
   mgomez@maryscenter.org
   Ali Winch (assistant) X 342 info@maryscenter.org
   Other contacts: Laura Pennycuff, Grants Manager, Ext. 340, lpennycuff@maryscenter.org
   www.maryscenter.org
   Vivian Cativo

Consumer and Provider Advocacy Groups:

8. Jacquelyn A. Brown, MPH, Consumer Health Foundation
   Program Officer
   1400 16th St., NW Suite 710 Washington DC 20036
   (202) 939-3390
   Fax (2) 939- 3391
   jbrown@consumerhealthfdn.org

Government of the District of Columbia:

9. Greg Chen, Mayor's Office on Asian and Pacific Islander Affairs
   441 4th St., NW Suite 805 S. Washington DC 20001
   (202) 727-8293
   greg.chen@dc.gov

10. Mayor's Office on Latino Affairs (OLA)
    2000 14th St., NW 2nd Floor Washington DC 20009
    (202) 671-2825
    Fax (2) 673-4557
    Gustavo Velasquez, Executive Director
    gustavo.velasquez@dc.gov

11. Dr. John O. Davies-Cole, DC DOH
    Chief of the Bureau of Epidemiology and Health Risk Assessment
    825 North Capitol St., NW Third Floor Washington DC 20001
    (202)-442-9138
    jdcole@dchealth.com

Local University Study Departments:

12. Dr. Ivor Livingston, Howard University Department of Sociology and Anthropology
    Tenure Professor
    Howard University Douglas Hall
    2441 6th St., NW Room 207 Washington, DC 20059
    (202) 806-6853 (main)
    (202) 806-9355 (office)
    Fax (202) 806-4893
    ilivingston@howard.edu
    stress1@erols.com

13. Mohamed Akhter, MD, MPH, Howard University
    Senior Associate Dean for Public and International Health
    520 W St., NW Washington, DC 20059
    (202) 884-1727
    Fax (202) 884-1733
    makhter@howard.edu
    Other contacts:
    Margo Thombs, Special Projects Administrator
    (202) 884-1729
    mthombs@howard.edu

14. Dr. Bailus Walker, Howard University School of Medicine Department of Community and Family Medicine
    Professor of Environment and Occupational Medicine
    520 W St., NW Suite 2400 Washington, DC 20059
    (202) 806-4477
    bwalker@fac.howard.edu

15. Vijaya L. Melnick, Ph.D., University of the District of Columbia
    Director of Sponsored Research and Programs
    4200 Connecticut Ave., NW. Bldg. 39 Room 3014 Washington, DC 20008
    (202) 274-5599
    vmelnick@udc.edu
    vmelnick@att.net

Research Institutes:

16. Peter Tatian
    Senior Research Associate
    The Urban Institute
    2100 "M" Street, N.W.
    Washington, D.C. 20037
    (202) 261-5588
    Fax (202) 872- 9322
    ptatian@ui.urban.org
    Margery Austin Turner, Center Director

17. Mark Rubin, DC AGENDA
    Director of Research and Neighborhood Information Services
    1825 K St., NW Suite 710 Washington DC 20006
    (202) 223-2598
    Fax (202) 223-2604
    mrubin@dcagenda.org
    www.dcagenda.org

DC-CHAI-LHCC Partner Agencies:

18. Dr. Heather McClure, Council of Latino Agencies
    Director Research and Policy
    2437 15th St., NW Washington, DC 20009
    (202) 328-9451
    Fax (202) 667-6135
    hmcclure@consejo.org
    mcclu44@attglobal.net
    Dr. Kristin Jerger
    kristinjerger@yahoo.com

19. Fern Johnson-Clarke, Ph.D.; Patsy Theiss, MS; Luz Vega, MPH; Ligia Artiles, MA; Carl W. Wilson
    District of Columbia DOH State Center for Health Statistics Administration
    825 North Capitol St., NW Suite 2100 Washington, DC 20001
    (202) 442-9039
    fern.johnson-clarke@dc.gov
    ptheiss@dchealth.com
    ligia.artiles@dc.gov
    lvega@dchealth.com

20. Will Waters, Ph.D.; James Kamau, MHSA; Muhuiddin Haider, Ph.D.; George Washington University School of Public Health Center for Global Health
    (202) 416-0097
    Fax (202) 416-0400
    iphwxw@gwumc.edu

Appendix 2
Detailed Outline of Methodology for Sampling

An outline of the methodology for sampling follows:

1. Sampling Strategy
   - Desired: 750: based on Hispanic population on Sample Frame (i.e., District Wards 1- 4)
     - 95% Confidence Level
     - 3.8 Confidence Level
   - Oversampling by 10% yields the Final Sample Size of 825.
   - Recommended: At least 5 households per sampled blocks = 165 blocks for Wards 1- 4.

2. Sample Frame: Wards 1- 4
   - Wards 1- 4 have 39,370 Hispanics. This figure represents 87.6% of all Hispanics residing in the District of Columbia (DC).
   - DC Hispanic population is 44,953. DC total population is 572,059 (Census 2000).
   - Ward 1 has 18,109 Hispanics. That represents 45.9% of the sample frame population, and 40.3% of all DC Hispanics.
   - Ward 2 has 6,997 Hispanics. That represents 17.8% of the sample frame population and 15.6% of all DC Hispanics.
   - Ward 3 has 5,027 Hispanics. That represents 12.8% of the sample frame population and 11.2% of all DC Hispanics.
   - Ward 4 has 9,237 Hispanics. That represents 23.5% of the sample frame and 20.5% of all DC Hispanics.

3. Wards 1- 4 Block Inclusion Criteria
   - From the ward level, we moved directly to the block level, because it allowed for a more diverse representation of the geographic occupation patterns of Hispanics throughout the wards in the sample frame, while also allowing for a more diverse representation of the different socio-demographic characteristics of DC Hispanics. Going to the Census tract would limit the areas in which data collectors would survey.
   - $\geq$ 25 Hispanics in the Block (based on) per Census 2000 data (Rationale: At least 5 (Hispanic) households per block will be interviewed. With 5 Hispanics per household, a total of 25 potential interviewees).
   - $\geq$ 10 (Hispanic) Household units in the block per Census 2000 data (Rationale: We would at least be able to select every other Hispanic household in the block).
   - Ward 1 has 151 blocks that meet these criteria.
   - Ward 2 has 59 blocks that meet these criteria.
   - Ward 3 has 63 blocks meeting these criteria.
   - Ward 4 has 91 blocks.

4. Blocks per Ward Based on Resident Hispanic Population.
   - Example: Ward 1 with 18,109 Hispanics represents 46% of the sample frame.

- 165 total blocks to be surveyed 46% of the sample frame (proportion of interviews per ward) are to come from 75 blocks from Ward 1.

➢ Blocks per Ward:
- Ward 1 = 75
- Ward 2 = 29
- Ward 3 = 21
- Ward 4 = 39

5. Interviews per Ward were determined by multiplying the number of blocks to be sampled in each ward by 5 (the number of interviews required per block).

➢ Interviews per Ward:
- Ward 1 = 375
- Ward 2 = 145
- Ward 3 = 105
- Ward 4 = 195

6. Interviews per block were determined by calculating a probability proportionate to size (PPS) for each block:

➢ Proportion of Hispanics in block divided by Total Hispanics in pool of blocks within the ward = the proportion (or number) of interviews from the ward.

➢ Preferably, only blocks with sample size $\geq$ 5(PPS calculation) were randomly selected to complete desired sample size for each ward. In the process, we discovered that the situation differed by ward. Some adjustments to sampling strategy had to be made, in order to select blocks to be sampled. The special circumstances in each ward are indicated in a later section (9).

➢ In general, when a ward's pool of blocks with PPS < 5 was too small to complete the recommended sample quota, the recommendation was to look at block clusters that would allow the data collectors to approach groups of blocks with enough samples for selection. Given that the pool of blocks has already been chosen to include $\geq$ 25 Hispanics and $\geq$ 10 household units, we believe that a standard over sample factor of 20% could be applied to single blocks that had enough PPS from which to be sampled.

7. Random Selection of Households (Sample Units)

➢ Each team of data collectors was assigned a block or block cluster in which to work. Blocks within block clusters are to be approached as individual blocks.

➢ Each block has a required number of interviews to be completed (sample size).

➢ The data collectors were trained to conform to the following sampling scheme:
- Go to the Northwest corner of the block and start choosing every other household as a sample unit.

- From the Northwest corner, continue walking clockwise (looking at the block map).
- Continue selecting sample units using the same process until all of the required samples (interviews) have been completed.
- Do not cross the street, for the other side of the street represents another Census block delineation.

8. Random Selection of Participant within the Household to be interviewed, and Data Collection Process

➢ Inclusion Criteria for Sample Subjects (Respondents/Interviewees)
- Self identification as Hispanic or Latino (interchangeable terms).
- ≥21 years of age (21 years old or above).
- Permanent member of the household (Permanent resident of that household is defined as having been a resident of the household for at least 6 months; not a visitor).
- The selected adult will answer both Modules of the questionnaire. Module I has questions about the respondent himself/herself, including some questions about the household. Module II has questions about a household member in each of three subgroups: children 0-5 years of age, teens 12-18 years of age, and seniors ≥ 65 years of age who reside in the household.

➢ Data collectors are trained to randomly select participants for the interview based on one per sample unit.
- Data collectors are instructed to introduce themselves and the LHCC Study to an adult in the household.
- Data collectors are to use a household listing table to write down the first name, age and gender of all household members.
- Data collectors are to use the list of household members to randomly select an adult participant for Module I. They must select the adult listed as the first (#1) in the list. Keeping track of the previously selected participant (in the previous household interview), the data collector is to choose the second (#2) on the list (then the third listed in the next household for interviewing purposes, and so on). If in the third household only two household members are eligible, the second (last listed) of the two is selected as the interviewee. If two household members are eligible, then the interviewee would be randomly selected from the household list.
- Module II contains questions that will refer to a household member in a particular age group (child, teen, senior). The data collector will choose the particular section of questions in Module II according to the availability of a family member in that age group. In case there is more than one subject identified in the household for one of the sections of Module II, the data collector is to use the same process followed in the selection of the adult to be interviewed.

➢ Once the adult who will answer the questionnaire is selected, the data collector should proceed to describe the LHCC Study to the participant and have him/her read and sign the consent form.

- Data collectors are to record all responses to the questionnaire on a survey answer sheet that will be entered later into a computer program on a spreadsheet for data analysis purposes.
- At the end of each working day, data collectors are to submit their answer sheets to their team leader who will go over each answer sheet to check for accuracy and completeness.
- Team leaders are responsible for submitting the collected answer sheets to the Principal Investigator (PI) who delivers them to the project coordinator at SCHSA for quality control before the data are entered into the computer program.

9. Field experience with the four selected wards:
   - Ward 1: Sampling proceeded according to prescribed methodology.
   - Wards 2: Some difficulties occurred which required a change in methodology. Blocks were put into groups using the maps from the Office of Planning. So block groups were used, instead of individual blocks, to obtain the desired number of interviews.
   - Ward 3: Dropped due to inability to recruit a representative sample of residents for the assessment.
   - Ward 4: As in Ward 2, some difficulties occurred which required a switch from sampling at the individual block level to sampling of groups of blocks.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention

National Center for Health Statistics
3311 Toledo Road
Hyattsville, Maryland 20782

Appendix 3

Memorandum

Date December 15, 2004

To DC State Center for Health Statistics Administration

From Wilbur C. Hadden, Statistician, NCHS

Subject Weights for survey of Hispanics

The DC State Center for Health Statistics Administration (SCHSA), working with the Latino Healthcare Collaborative Community (LHCC) and George Washington University (GW), completed a survey of Hispanics in DC.

The desired sample size was 825. At first this was to come from 4 wards which have most of the Hispanics in DC. During data collection it was found that for many reasons Hispanics in Ward 3 were difficult to survey and had different characteristics than Hispanics in other wards that made less relevant to the purposes of the survey. It was decided to drop Ward 3 and increase the sample in the other wards; the increase was accomplished by increasing the number of persons to be selected from the target blocks by 20%. Each ward was treated as a separate stratum.

The sampling frame in the strata consisted of a list of blocks with at least 25 Hispanics and 10 households. The actual selection process was somewhat complicated, and precise documentation is not available, but blocks were selected for surveying from lists of blocks ordered by number of Hispanics and from maps. For purposes of calculating a weight the process may be summarized in this way: in Ward 1, all blocks with more than 125 and every other block with 98 to 124 Hispanics were included; in Ward 2, all blocks with 75 or more Hispanics were included, as were a number (approximately one-third) of other blocks selected from maps; and in Ward 4 all blocks with 45 or more Hispanics were included. This process creates substrata in 2 of the wards, giving 5 substrata in all.

Calculating weights begins with calculating the probability of selection. The first factor of the probability (see equation below) is the probability of selecting a block. This probability is 1 if the number of Hispanics in the block exceeds the threshold for the ward and otherwise ½ for Ward 1 and 1/3 for Ward 2.

Field workers were sent to selected blocks to recruit and interview the sample. They started screening every other residence at the northwest corner of the block and proceeded clockwise (on the map), going from top to bottom in multi-unit buildings. Eligible residences were those with an adult (aged 21 years or more) Hispanic.

The second factor of the probability of selection represents the probability of selecting a household in a block. The numerator of this probability is the number of households selected from the block. The denominator is the number of eligible households in the block. This number is unknown and has to be estimated. The approximate

number of Hispanic households in a block is estimated by assuming that the ratio of Hispanic households to total housing units is the same as the ratio of Hispanic persons to all persons. That is, that the number of eligible households in a block is the total number of housing units times the number of Hispanics divided by the total number of persons. This is a bit complicated, but with simple algebra it is represented in factor 2, below.

Once a household was identified as eligible, one sample person was selected. First the names and ages of all the residents of the household were recorded, then one was selected to be the respondent.

The third factor of the probability of selection is one divided by the number of eligible adults in the household.

The whole probability of selection is thus:

$$p_i = \frac{1}{m_{wg}} x \frac{T_b n_b}{P_b H_b} x \frac{1}{n_i}$$

where:

m_{wg}	=Ward and block-sub-strata specific sampling fraction
n_b	= Number of sample persons interviewed from block
T_b	= Total population of census block
P_b	= Hispanic population of census block
H_b	= Number of housing units in census block
n_i	= Number of adults in a household

The person weight is the reciprocal of this selection probability.

The final step in calculating the weights is a combined non-response and postratification adjustment. This is done by multiplying the basic weight, estimated from the formula above, by an adjustment factor. The factor is obtained by summing the basic weights within each substratum and dividing this sum into the number of Hispanic adults in the substratum.

Inspection of the weights, calculated as above, showed that in some cases the estimate of the sampling rate of households in blocks produced extreme values which led to a few very large or very small weights. To prevent these respondents from having an undue influence on analyses of the survey extreme values of this variable were trimmed; its range was restricted to .082 - .230, and the weights were recalculated.

Note on data

The data used in calculating the weights were supplied by the DC State Center for Health Statistics Administration or obtained from the US Census Bureau. The primary source of data was the data file for the survey, from which the number of respondents per sampled block was calculated. Some spreadsheets which had been used in designing the sample contained the population, the number of housing units, and the number of Hispanics in blocks in Wards 1, 2, and 4 with 10 or more households and 25 or more Hispanics. Another useful spreadsheet was one named “data status april 20”. This spreadsheet provided an alternate, although incomplete,

list of census tract, block and respondent ID numbers which made it possible to correct some keying errors in the data file. The number of adult Hispanics per block was downloaded from the Census Bureau web-site.

Variance estimation

Representing this design for estimating variances in SUDAAN requires some recoding of the data. For simplicity, this is considered a sampling with replacement design. This is considered appropriate where sampling fractions are small. In this survey, however, the sampling fractions are generally small only in selecting household from blocks; the sampling fractions for selecting blocks and persons out of households are often not small. Nevertheless, making this assumption is reasonable and conservative because it simplifies the estimation of variances and, by eliminating the finite population correction factors, produces conservative estimates of variances.

First it is necessary to redefine the strata and primary sampling units (PSUs) for the program; two variables, strata and PSU are defined. In those substrata where all the large blocks were selected, the first sampling was the selection of household. (Note that this applies to over 90% of the sample and that within block the sampling fractions are generally small). In these blocks, each block is identified as a stratum and assigned the Census tract and block number, and households, identified by the respondent ID number, are considered primary sampling units. PSU is assigned the ID number. In those substrata where blocks were sampled there is a stratum number assigned and PSU is assigned the Census tract and block number.

Second, it is necessary to recode a few individual records where there are blocks with only a single respondent. In five cases where the block is a strata, respondents were assigned to another block in the same Census tract because they were the only respondents from their block.

Three tables applying this method are attached. Table 1 estimates the distribution of the population by age and sex. Tables 2 and 3 are prevalence estimates of reported asthma and high blood pressure by age and sex. The design effects are generally between 1.2 and 1.8.

The required SUDAAN code for this is illustrated below. In the proc statement the sample design is described as wr, with replacement. The nest and weight statements are required. The nest statement lists the design variables strata and psu. The weight variable is named wt. The code below produces that attached Table 1. The variables rsex and rage are renamed variables from the data file giving the respondents' sex and age. The recode statement groups the age variable into 3 broad age groups.

```
proc crosstab data = work.Luz2 design = wr;
  nest strata psu;
  weight wt;
  recode rage=( 20, 45, 65 );
  subgroup rsex rage;
  levels     2   3;
  tables rsex * rage;
  rformat rage agegr. ;
  rformat rsex sex. ;
  rtitle Age distribution of the population by sex;
  print nsum rowper serow deffrow / style=NCHS;
run;
```

	Ward		
	1	2	4
Total Hispanic population	18,109	6,997	9,237
Number of blocks	331	827	895
Blocks with >= 25 Hispanics and >= 10 households	151	59	91
Hispanic population in blocks with >= 25 Hispanics and >= 10 households	16,991	4,995	6,422
Hispanic population in largest blocks	9949	3189	2834
Hispanic population in middle sized blocks	2009	1806	
Hispanic adults in largest blocks	6525	2119	3026
Hispanic adults in middle sized blocks	1354	1408	
Number of blocks targeted (approximate)	41	39	44
Number of blocks with respondents	37	24	37
Number of interviews targeted	475	184	242
Number of sample persons	425	155	226
Minimum weight, largest blocks	3.7	4.5	3.2
Maximum weight, largest blocks	52.1	58.8	43.7
Average weight, largest blocks	16.6	18.4	13.4
Minimum weight, middle sized blocks	14.2	9.0	
Maximum weight, middle sized blocks	87.7	75.8	
Average weight, middle sized blocks	42.3	35.2	

Number of interviewed respondents per block (i.e. There are 11 blocks with 1 person interviewed, 7 blocks with 2…)

interviewed	Frequency
1	11
2	7
3	8
4	7
5	15
6	9
7	4
8	6
9	2
10	3
11	4
12	4
13	2
14	3
15	5
16	1
17	1
19	1
20	1
22	1
23	2
25	2
32	2

Note: 819 persons in data file.

Table 1. Age distribution of the population sex

RSEX RAGE	Sample Size	Row Percent	SE Row Percent	DEFF Row Percent #4
Total				
Total	806	100.00	0.00	.
20 - 44	623	77.21	1.85	1.56
45 - 64	161	19.99	1.55	1.21
>= 65	22	2.80	0.76	1.69
Male				
Total	352	100.00	0.00	.
20 - 44	279	79.40	2.48	1.32
45 - 64	67	19.14	2.44	1.35
>= 65	6	1.45	0.57	0.79
Female				
Total	454	100.00	0.00	.
20 - 44	344	75.38	2.73	1.83
45 - 64	94	20.70	2.08	1.19
>= 65	16	3.92	1.29	2.02

Table 2: Prevalence of asthma by sex and age
for: RSEX = Total.

RAGE Q6_9ASTM	Sample Size	Row Percent	SE Row Percent	DEFF Row Percent #4
Total				
Total	799	100.00	0.00	.
Yes	54	7.53	1.17	1.57
No	745	92.47	1.17	1.57
20 - 44				
Total	617	100.00	0.00	.
Yes	34	6.10	1.29	1.80
No	583	93.90	1.29	1.80
45 - 64				
Total	160	100.00	0.00	.
Yes	18	12.39	3.09	1.40
No	142	87.61	3.09	1.40
>= 65				
Total	22	100.00	0.00	.
Yes	2	12.18	8.71	1.56
No	20	87.82	8.71	1.56
for: RSEX = 1, male				
Total				
Total	349	100.00	0.00	.
Yes	19	6.01	1.57	1.53
No	330	93.99	1.57	1.53
20 - 44				
Total	277	100.00	0.00	.
Yes	9	4.09	1.61	1.84
No	268	95.91	1.61	1.84
45 - 64				
Total	66	100.00	0.00	.

Yes	9	12.84	4.44	1.17
No	57	87.16	4.44	1.17
>= 65				
Total	6	100.00	0.00	.
Yes	1	21.85	18.46	1.20
No	5	78.15	18.46	1.20

for: RSEX = 2, female

Total				
Total	450	100.00	0.00	.
Yes	35	8.79	1.68	1.58
No	415	91.21	1.68	1.58
20 - 44				
Total	340	100.00	0.00	.
Yes	25	7.87	1.96	1.79
No	315	92.13	1.96	1.79
45 - 64				
Total	94	100.00	0.00	.
Yes	9	12.05	4.23	1.58
No	85	87.95	4.23	1.58
>= 65				
Total	16	100.00	0.00	.
Yes	1	9.19	9.39	1.69
No	15	90.81	9.39	1.69

Table 3. Prevalence of high blood pressure
for: RSEX = Total.

RAGE Q4_1BPRE	Sample Size	Row Percent	SE Row Percent	DEFF Row Percent #4
Total				
Total	787	100.00	0.00	.
Yes	132	16.59	1.85	1.94
No	655	83.41	1.85	1.94
20 - 44				
Total	607	100.00	0.00	.
Yes	57	9.21	1.44	1.50
No	550	90.79	1.44	1.50
45 - 64				
Total	158	100.00	0.00	.
Yes	61	37.03	4.47	1.36
No	97	62.97	4.47	1.36
>= 65				
Total	22	100.00	0.00	.
Yes	14	70.00	10.96	1.26
No	8	30.00	10.96	1.26

for: RSEX = 1, male

Total				
Total	338	100.00	0.00	.
Yes	34	10.47	2.00	1.45
No	304	89.53	2.00	1.45
20 - 44				
Total	266	100.00	0.00	.
Yes	13	5.28	1.56	1.30
No	253	94.72	1.56	1.30

45 - 64				
Total	66	100.00	0.00	.
Yes	18	28.00	7.01	1.61
No	48	72.00	7.01	1.61
>= 65				
Total	6	100.00	0.00	.
Yes	3	51.15	19.49	0.91
No	3	48.85	19.49	0.91

for: RSEX = 2. female

Total				
Total	449	100.00	0.00	.
Yes	98	21.56	2.75	2.01
No	351	78.44	2.75	2.01
20 - 44				
Total	341	100.00	0.00	.
Yes	44	12.55	2.31	1.65
No	297	87.45	2.31	1.65
45 - 64				
Total	92	100.00	0.00	.
Yes	43	44.08	5.88	1.29
No	49	55.92	5.88	1.29
>= 65				
Total	16	100.00	0.00	.
Yes	11	75.82	11.95	1.25
No	5	24.18	11.95	1.25

Appendix 4a

LATINO HEALTH CARE COLLABORATIVE COMMUNITY ASSESSMENT
Questionario

Introducción

Hola, mi nombre es _____ y estoy llevando a cabo un questionario relacionado a la salud familiar para la iniciativa llamada "Latino Health Care Collaborative" o Colaborativa para el Cuidado de la Salud Latina. La misma esta auspicida por el Consejo de Agencias Latinas del Distrito de Colombia.

¿Es usted o alguna persona de este hogar Latino/a o Hispano/a?, o sea, ¿de ascendencia Caribeña o Latino Americana?

(Si no hayLatinos/Hispanos, TERMINAR QUESTIONARIO. "Gracias por su tiempo")

Para propósitos de este questionario, quisieramos entrevistar a un adulto que resida en este hogar. ***(Pasar a Hoja de Contestación)***

Consentimiento Informado

Antes de administrar el questionario, necesito leer esta Forma de Consentimiento Informado con usted.Quiero asegurarle que toda la información que usted nos provea será utilizada para propósitos de este estudio únicamente y será mantenida bajo completa confidencialidad.
(Lea Consentimiento Informado con cuidado al entrevistado y obtenga su firma)

Ahora, para comenzar el questionario, necesito recordarle que usted NO está obligado a responder a cualquier pregunta que no estime necesaria, y que puede terminar este questionario en cualquier momento. Esta entrevista tomará aproximadamente 45 minutos. Muchas gracias por acceder a esta entrevista.

Sección 1: Características Demográficas

Primeramente, me gustaría preguntarle acerca de usted.

1.1. Género

(*NO Lea. Selecione respuesta apropiada*)

1 Masculino
2 Femenino ☐

1.2. ¿Qué edad tiene usted? ☐☐

___ ___ Años

0 9 No Respuesta

1.3. Estamos entrevistando Latinos de todas las razas. ¿Cuál de las siguientes diría usted es su raza? ***(Escoja uno, NO Lea si no es necesario)***

		SI 1	***NO 2***	***NR 9***
1	Blanca	☐	☐	☐
2	Negra o Afroamericana	☐	☐	☐
3	Asiática	☐	☐	☐
4	Nativo de Hawaii u otra isla del Pacífico	☐	☐	☐
5	Indio Americano o nativo de Alaska	☐	☐	☐
6	Meztizo o Mixto *Especifique* _____	☐		

1.4. ¿Cuál es su país de origen? ☐☐

(NO Lea Opciones)

01 El Salvador
02 México
03 Puerto Rico
04 República Dominicana
05 Guatemala
06 Cuba
07 Honduras
08 Columbia
09 Perú
10 Nicaragua
11 Argentina
12 Panamá
13 Otro: Por favor especifique _____

99 No Respuesta

1.5. ¿Qué lenguaje puede hablar usted? ***(Nota: Esta pregunta se refiere a la habilidad del entrevistado de hablar uno o ambos idiomas)*** ☐

1 Sólo Español, no Inglés
2 Español más que Inglés
3 Español e Inglés igualmente
4 Inglés más que Español
5 Sólo Inglés

9 No Respuesta

1.6. ¿Por cuánto tiempo ha vivido usted en los Estados Unidos? ☐

(NO Lea Opciones)

1 Nació en este país
2 0 a menos de 2 años
3 2 a menos de 5 años
4 5 a10 años
5 Más de 10 años

9 No Respuesta

1.7. Es usted: ☐

1 Casado/a
2 Divorciado/a
3 Viudo/a
4 Separado/a
5 Nunca se casó o Soltero/a
6 Miembro de una pareja que no esta casada

9 No Respuesta

1.8. ¿Cuál es el grado o año escolar más avanzado que usted ha completado? ☐

(Lea sólo si es necesario)

1 Nunca fui a la escuela o sólo al kindergarten o jardín de infantes
2 Cualquier grado de primero al octavo grado (escuela primaria)
3 Cualquier grado de noveno al undécimo grado (comencé la escuela secundaria)
4 Duodécimo grado o GED (diploma de educación general de la escuela secundaria)
5 1 a 3 años de cursos universitarios o colegio técnico
6 4 años o más de universidad (graduación con título universitario)

9 No Respuesta

1.9. ¿Cuántos menores de 18 años viven en este hogar? ☐☐

___ ___ Cantidad de niños

9 9 No Respuesta

Ahora quisiera preguntarle acerca de su empleo e ingreso familiar.

1.10. Actualmente, usted es: ☐

1 Empleado/a asalariado/a
2 Empleado independiente
3 Desempleado por más de un año
4 Desempleado por menos de un año
5 Amo/a de casa
6 Estudiante
7 Jubilado/a
8 Incapacitado/a

9 No Respuesta

1.11. De las cifras anuales en esta tarjeta, ¿cuál corresponde al ingreso anual de este hogar – esto es, considerando todas las fuentes de ingreso de este hogar? ☐
(Use tarjeta para código de ingreso correspondiente)

9 No Respuesta

Sección 2: Estado General de Salud

Ahora, le voy a hacer preguntas relacionadas a su estado general de salud y las medidas que esta tomando para mantenerla o mejorarla.

2.1. ¿Diría usted que su estado de salud es...?: ☐ ***(Lea opciones)***

1 Excelente
2 Muy bueno
3 Bueno
4 Regular
5 Deficiente

9 No Respuesta

2.2. Ahora, quiero preguntarle sobre su salud física, incluyendo lesiones o heridas físicas, ¿durante cuántos días en los últimos 30 días o el último mes no estuvo usted con buena salud física? ☐☐

___ ___ Número de días

9 9 No Respuesta

2.3. Y ahora, con respecto a su salud mental, que incluye estrés y depresión, durante cuántos días en los últimos 30 días o el último mes no estuvo usted con buena salud mental? ☐☐

__ __ Número de días

9 9 No Respuesta

2.4. En los últimos 30 días o el último mes, ¿durante más o menos cuántos días no pudo usted realizar sus actividades de cada día, tales como sus cuidados personales, el trabajo o la recreación debido a mala salud física, mental o emocional? ☐☐

__ __ Número de días

9 9 No Respuesta

Descapacidades

Las siguientes preguntas son acerca de problemas de salud o impedimentos que algunas personas pueden tener.

2.5. Actualmente, ¿tiene usted algún problema de salud que le obligue usar algún Equipo especial, tale como bastón, silla de ruedas, cama especial o teléfono especial?

☐

1 Sí
2 No

9 No Respuesta

2.6. ***(Solo si contestó que viven niños en el hogar Q. 1.9.)*** Actualmente, ¿algún niño/a menor de 18 años de edad en este hogar tiene algún problema de salud que le exige usar algún tipo de equipo especial, tales como bastón, silla de ruedas, cama especial o teléfono especial?

☐

1 Sí
2 No

9 No Respuesta

Sección 3: Acceso a Cuidado de Salud

Acceso a Servicios de Salud y Médicos

3.1. ¿Tiene usted algún tipo de cobertura para gastos relacionados con la salud, incluyendo un seguro médico, un plan de prepagos como un HMO, o cualquier plan o programa de salud del gobierno como por ejemplo Medicare?

☐ ☐

1 Sí
2 No ***(Ir a Q. 3.3.)***
3 No sé/ No estoy seguro/a

9 No Respuesta

3.2. Más o menos, ¿hace cuánto tiempo que tiene seguro médico? ☐

1 Hace menos de 6 meses
2 6 meses a 1 año
3 1 año a menos de 2 años
4 Durante los pasados 5 años (2 años a menos de 5 años)
5 5 años ó más

9 No Respuesta

(Nota: Luego de contestar 3.2. Pase a Q. 3.5.)

3.3. ¿Cual es el motivo principal por el cual usted no tiene seguro médico? Seleccione sólo una: Si tiene más de una razón, cite la más importante. ☐☐

(NO Lea/Lea sólo si es necesario)

0 1 Perdí mi trabajo o cambié de empleo
0 2 Mi cónyugue o uno de mis padres perdió su trabajo o cambió de empleo
0 3 Me divorcié o me separé
0 4 El cónyugue o uno de los padres falleció
0 5 Perdí eligibilidad a causa de mi edad o porque dejé los estudios
0 6 El empleador no ofrece seguro o dejó de ofrecer la cobertura
0 7 Reduje mis horas de trabajo a tiempo parcial o pasé a ser empleado/a temporal
0 8 Los beneficios del trabajo o del antiguo trabajo se agotaron
0 9 No pude pagar las cuotas
1 0 La agencia de seguros rehusó la cobertura
1 1 Perdí elegibilidad para Medicaid o para la asistencia médica
1 2 Otro motivo

9 9 No Respuesta

3.4. Más o menos, ¿cuándo fue la última vez que tuvo seguro médico? ☐

1 Nunca he tenido cobertura
2 Hace menos de 6 meses
3 6 meses a 1 año
4 1 año a menos de 2 años
5 Durante los pasados 5 años (2 años a menos de 5 años)
6 5 años ó más

9 No Respuesta

Utilización de Servicios Médicos

3.5. ¿Tiene usted un médico o doctor regular que le provee cuidados de salud? ☐☐

1 Sí, sólo uno
2 Sí, más de uno
3 No

9 No Respuesta

3.6. ¿Hay alguna clínica, un centro de salud o dispensario, un consultorio médico u otro lugar en especifico al que usted generalmente iría si estuviera enfermo/a o si necesitara asistencia médica? ☐

1 Sí, un lugar
2 Sí, más de un lugar
3 No ***(Ir a Q 3.9.)*** →

9 No Respuesta

3.7. ¿Qué tipo de servicio de salud es? ☐

1 Un consultorio médico o una HMO
2 Una clínica o centro de salud/dispensario
3 Un departamento de hospital de medicina ambulatoria
4 Una sala de emergencias de un hospital
5 Un centro de cuidados de urgencia
6 Otro tipo de lugar

9 No Respuesta

3.8. Para esta serie de preguntas, conteste Sí o No para cada una. ¿Utiliza usted alguno de los siguientes como métodos complementarios, o sea complementando tratamientos recetados por su médico, o como métodos alternos, o sea en sustitución de tratamientos médicos, para su cuidado de salud?

		Sí 1	***No 2***	***NR 9***
1	Doctor espiritual o curandero……	☐	☐	☐
2	Oraciones o rezos……	☐	☐	☐
3	Hierbas medicinales……	☐	☐	☐
4	Terapia Quiropráctica……	☐	☐	☐
5	Otros……	☐	☐	☐

3.9. ¿Hubo algún momento en los últimos 12 meses o en el último año cuando necesitó ver a un médico pero no pudo por alguna de las siguientes causas?:

		Sí 1	***No 2***	***NR 9***
1	Costo	☐	☐	☐
2	Transportación/distancia	☐	☐	☐
3	Falta de tiempo libre del empleo	☐	☐	☐
4	Cuidado familiar/responsabilidades familiares	☐	☐	☐

3.10. Más o menos, ¿cuánto tiempo hace desde que ha visto a un médico para un examen rutinario? ***Un examen rutinario es un examen físico general, no un examen para una lesión o enfermedad.***

☐

(NO Lea Opciones/ Lea sólo si es necesario)

1 1 año (en cualquier momento hasta hace 12 meses)
2 2 años (más de 1año, pero menos de 2 años)
3 5 años (más de 2 años pero menos de 5 años)
4 Hace 5 años ó más

9 No Respuesta

Sección 4: Conocimientos acerca de conductas preventivas

Ahora quisiera hacerle unas preguntas acerca de la toma de cuidado de su salud.

Controlando la Hipertensión

4.1. ¿Alguna vez un médico, enfermero o profesional de la salud le ha tomado la presión sanguínea?

☐

1 Sí
2 No

9 No Respuesta

4.2. ¿Alguna vez le ha dicho un médico, enfermero o profesional de la salud que tiene usted presión de sangre alta?

☐

1 Sí
2 No ***(Ir a Q. 4.4)*** →

9 No Respuesta

4.3. Actualmente, ¿está usted tomando medicamentos para su alta presión? ☐

1 Sí
2 No

9 No Respuesta

Controlando su Colesterol

4.4 El colesterol es una sustancia grasa que se encuentra en la sangre.
¿Alguna vez se ha hecho una prueba de su colesterol? ☐

1 Sí
2 No ***(Ir a Q. 4.6)*** →

9 No Respuesta

4.5. ¿Cuánto tiempo hace, más o menos, desde la última vez que se le hiciera una prueba de su colesterol?

(NO lea/Lea sólo si es necesario) ☐
1 Dentro del último año (menos de 12 meses)
2 Dentro de los últimos 2 años (hace entre1 y 2 años)
3 Dentro de los últimos 5 años (hace 2 años pero menos de 5 años)
4 Hace 5 años ó más

9 No Respuesta

4.6. ¿Alguna vez le ha dicho un médico, enfermero o profesional de la salud que tiene usted el colesterol alto? ☐

1 Sí
2 No

9 No Respuesta

Controlando su Peso

4.7. ¿Más o menos cuánto pesa usted, sin zapatos? ☐☐
Peso en kg

___ ___ ___ ***(Divida por 2.679 = ___ ___ peso en kg)***
Libras

9 9 No Respuesta

4.8. ¿Más o menos cuál es su estatura, sin zapatos? ☐☐☐

Altura en cm

___/ ___ ___ ***(Multiplique por 12= _____ Altura en pulgadas;***
pies /pulgadas

Luego Multiplique por 2.54=_____ altura en cm)

9 9 9 No Respuesta

4.9. Actualmente, ¿esta tratando usted de...***leer respuestas a continuación***? ☐

1 Mantenerse en su peso actual
2 Perder peso
3 Aumentar de peso ***(Ir a Q. 4.12.)***

9 No Respuesta

4.10. ¿Esta usted comiendo menos calorías o menos grasas para:

		Sí 1	***NO 2***	***NR 9***
1	Perder peso	☐	☐	☐
2	Evitar aumento de peso	☐	☐	☐

4.11. ¿Esta usted haciendo actividades físicas o ejercicios para:

		Sí 1	***NO 2***	***NR 9***
1	Perder peso	☐	☐	☐
2	Evitar aumento de peso	☐	☐	☐

4.12. En los últimos 12 meses, ¿un médico, enfermero/a o profesional de la salud le ha dado consejos acerca de su peso? ☐

1 Sí, para perder peso
2 Sí, para aumentar de peso
3 Sí, para mantener el peso actual
4 No

9 No Respuesta

Ahora le quisiera preguntar acerca de la cantidad de actividad física en la que usted incurre.

(Nota: Si el entrevistado/a esta empleado/a o empleado independiente, continúe con Q 4.13. Si está desempleado, vaya a Q 4.14. Para ver el estado de empleo, ver Q. 1.10 página 4)

4.13 Cuando usted está en el trabajo, ¿cuál de las siguientes opciones es la mejor descripción de lo que usted hace?

1 Generalmente, estoy sentado/a o de pie ☐
2 Generalmente, estoy caminando o haciendo movimientos
3 Generalmente, hago trabajos pesados o que requieren un gran esfuerzo físico

9 No Respuesta

Nos interesan dos tipos de actividad física: la vigorosa y la moderada. Las **actividades vigorosas** causan grandes incrementos en la respiración y en el ritmo cardiaco, mientras que las **actividades moderadas** causan pequeños aumentos en la respiración o ritmo cardiaco.

4.14. Ahora, considerando las actividades físicas ***moderadas*** que usted realiza en una semana normal, ¿realiza usted actividades ***moderadas*** por lo menos durante 10 minutos a la vez, tales como caminar rápidamente, correr bicicleta, pasar la aspiradora, trabajar en el jardín, o cualquier otra cosa que cause pequeños incrementos en la respiración y el ritmo cardiaco?

1 Sí ☐
2 No ***(Ir a Q. 4.18.)*** →

9 No Respuesta

4.15. ¿Cuántos días por semana hace usted estas actividades ***moderadas*** durante por lo menos 10 minutos por vez? ☐

___ Días por semana
0 No hace ejercicio durante ni 10 minutos por semana

9 No Respuesta

4.16. Y ahora, considerando las actividades físicas ***vigorosas*** que usted hace en una semana típica, ¿realiza usted actividades vigorosas durante por lo menos 10 minutos a la vez, así como correr, ejercicios aeróbicos, trabajo pesado en el jardín o cualquier otra cosa que cause aumentos importantes en la respiración o el ritmo cadiaco? ☐

1 Sí
2 No ***(Ir a Q. 4.18.)*** →

9 No Respuesta

4.17. ¿Cuántos días por semana realiza estas actividades ***vigorosas*** durante por lo menos 10 minutos a la vez? ☐

___ Días por semana
0 No hace ejercicio ni 10 minutos por semana

9 No Respuesta

Incluyendo Frutas y Vegetales en su Dieta

Las siguientes preguntas se tratan de los alimentos y bebidas que usted generalmente consume. Por favor, dígame con qué frecuencia come o bebe cada cosa, como por ejemplo, dos veces por semana, tres veces por mes, etcétera. Recuerde que solo me interesan los alimentos que come generalmente. Incluya todo lo que come, tanto en la casa, como afuera.

4.18. ¿Con qué frecuencia bebe jugos de fruta tales como jugo de naranjas, pomelo o toronja, o tomate? ☐☐

__ __ Por día
__ __ Por semana Veces por semana

9 9 No Respuesta

4.19. Sin contar los jugos de frutas, ¿con qué frecuencia come fruta en un día típico? ☐☐

__ __ Por día
__ __ Por semana Veces por día

9 9 No Respuesta

4.20. ¿Con qué frecuencia come usted vegetales tales como tomates, vainitas, brocoli, espinaca, aguacate o zanahorias en un día típico?

__ __ Por día
__ __ Por semana

☐☐ Veces por día

9 9 No Respuesta

4.21. ¿Con qué frecuencia come usted carne roja (steak, carne de res, puerco o cerdo), pollo, pescado, huevos, guisantes, frijoles o habichuelas, nueces y semillas?

__ __ Por día
__ __ Por semana
__ __ Por mes

☐☐ Veces por semana

99 No Respuesta

4.22. ¿Con qué frecuencia come usted alimentos hechos de granos o fibra tales como cereales, pan de trigo, avena, etcétera?

__ __ Por día
__ __ Por semana
__ __ Por mes

☐☐ Veces por semana

9 9 No Respuesta

Tomando Suplementos Vitamínicos

4.23. Actualmente, ¿está tomando vitaminas o suplementos alimenticios?

1 Sí
2 No ***(Ir a Q. 4.25.)***

☐

9 No Respuesta

4.24. ¿Algunas de ellas son multivitaminas?

1 Sí
2 No

☐

9 No Respuesta

Vacunas para Inmunidad

4.25. En los últimos 12 meses, ¿ha recibido usted una vacuna contra la gripe o influenza?

☐

1 Sí
2 No

9 No Respuesta

4.26. ¿Ha recibido una vacuna contra la neumonía alguna vez? Generalmente esta vacuna sólo se le da a una persona una o dos veces en toda su vida y es distinta de la vacuna contra la gripe. También se le llama vacuna contra los neumococos.

☐

1 Sí
2 No

9 No Respuesta

4.27. Actualmente, ¿han recibido todos los niños de este hogar todas las vacunas recomendadas para infantes y niños de edad escolar?

☐

1 Sí
2 No
3 No hay niños en el hogar
9 No Respuesta

Conocimiento acerca de la Tuberculosis

4.28. ¿Alguna vez un médico, enfermero/a o profesional de la salud le ha administrado la prueba de la piel o rayos X para detectar Tuberculosis? ***(Explicar prueba de piel si es necesario: la prueba en que la enfermera o doctor te pincha la piel y verifica la reacción varios días después)***

☐

1 Sí
2 No

9 No Respuesta

4.29. ¿Alguna vez un un médico, enfermero o profesional de la salud le ha dicho que tiene usted Tuberculosis?

1 Sí
2 No

9 No Respuesta

Cuidado de sus Dientes

4.30. ¿Cuánto tiempo hace desde la última vez que fue al dentista o a una clínica dental por cualquier motivo?

(NO lea/ Lea sólo si es necesario)

1 Dentro del último año (en cualquier momento hasta hace 12 meses)
2 Dentro de los últimos 2 años (hace 1 año pero menos de 2 años)
3 Dentro de los últimos 5 años (hace 2 años pero menos de 5 años)
4 Hace 5 años o más

9 No Respuesta

4.31. ¿Cuántos de sus dientes permanentes han sido extraídos por caries o enfermedad de las encías? No incluya los dientes que haya perdido por otros motivos, tales como lesiones u ortodoncia.

0 Ninguno
1 1 a 5
2 6 ó más, pero no todos
3 Todos

9 No Respuesta

Sección 5: Conductas que Alteran el Estado de Salud

Ahora, le voy a hacer unas preguntas acerca de conductas o costumbres que pueden influenciar su salud.

Consumo de Alcohol

5.1. Durante los últimos 30 días o último mes, ¿cuántos días ha tomado por lo menos una copa de cualquier bebida alcohólica? Una copa de alcohol es 1 lata o botella de cerveza, 1 vaso de vino, 1 lata o botella de "winecooler", 1 cóctel, ó 1 medida de licor o aguardiente.

☐☐

__ __ Días por semana — Días en el último mes
__ __ Días en los últimos 30 días
0 0 No bebidas en los últimos 30 días ***(Go to Q. 5.4.)*** →

9 9 No Respuesta

5.2. En los días en que bebió, más o menos cuántas copas tomó, en promedio?

☐☐

__ __ Cantidad de copas

9 9 No Respuesta

5.3. Considerando todos los tipos de bebidas alcohólicas, ¿cuántas veces durante los últimos 30 días tomó 5 copas ó más en una sola ocasión?

☐☐

__ __ Cantidad de veces
0 0 Ninguna

9 9 No Respuesta

Uso de Tabaco

5.4. ¿Ha fumado en total por lo menos 100 cigarrillos o más en toda su vida? ***(100 cigarrillos= 5 paquetes)***

☐

1 Sí
2 No ***(Ir a Q. 6.1.)*** →

9 No Respuesta

5.5. Actualmente, ¿fuma usted cigarrillos todos los días, algunos días, o no fuma?

☐

1 Todos los días
2 Algunos días
3 No fumo ***(Ir a Q. 5.7.)*** →

9 No Respuesta

5.6. Si usted fuma cigarrillos todos los días, cuántos se fuma por día?

1 Menos de 5
2 Menos de 12 (menos de un paquete)
3 Un paquete
4 Más de un paquete al día

9 No Respuesta

5.7. En los últimos 12 meses, ¿ha dejado de fumar durante un día entero o más porque estaba tratando de dejar de fumar?

1 Sí, y dejé de fumar ***(únicos que responderán a Q. 5.8.)*** →
2 Sí, pero volví a fumar
3 No

9 No Respuesta

5.8. ***(Para aquellos que contestaron Sí en la pregunta anterior)*** Más o menos, ¿cuánto tiempo hace desde que usted fumó cigarrillos en forma regular?

1 Hace menos de 1 mes
2 Hace 1 mes pero menos de 3 meses
3 Hace 3 meses pero menos de 6 meses
4 Hace menos de 1 año
5 Hace más de 1 año, pero menos de 5 años
6 De 6 a 10 años
7 Más de 10 años

9 No Respuesta

5.9. ¿Qué edad tenía usted cuando comenzó a fumar de manera habitual?

___ ___ Edad en años

9 9 No Respuesta

5.10 En los últimos 12 meses, ¿le ha aconsejado un médico, enfermero/a o profesional de la salud que deje de fumar?

1 Sí
2 No

9 No Respuesta

5.11 ¿Usted se limita de fumar por alguna de las siguientes razones?

	Sí 1	*NO 2*	*NR 9*
a. Para evitar contaminar el aire dentro del hogar	☐	☐	☐
b. Para proteger a los niños del humo del cigarrillo	☐	☐	☐
c. Para respetar las leyes de no fumar del lugar de trabajo	☐	☐	☐

Sección 6. Enfermedades Crónicas- Conocimiento y Práctica

Enfermedades Cardiovasculares

6.1. Ahora le voy a preguntar si usted está **actualmente** tratando de reducir su riesgo de desarrollar una enfermedad cardiaca o de sufrir un derrame cerebral:

	Sí 1	*NO 2*	*NR 9*
a. comiendo menos alimentos con alto contenido de grasas o colesterol	☐	☐	☐
b. comiendo más frutas y vegetales	☐	☐	☐
c. aumentando su actividad física	☐	☐	☐

6.2. En los últimos 12 meses, ¿le ha dicho un médico, enfermero u otro profesional de la salud que debe hacer alguna de las siguientes:?

	Sí 1	*NO 2*	*NR 9*
a. coma menos alimentos con alto contenido de grasas o colesterol	☐	☐	☐
b. coma más frutas y vegetales	☐	☐	☐
c. aumente su actividad física	☐	☐	☐

6.3. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted había tenido un ataque del corazón?

1 Sí ☐
2 No ***(Ir a Q. 6.5.)*** →
9 No Respuesta

6.4. ¿A que edad tuvo su primer ataque del corazón? ☐☐

___ ___ Edad en Años

9 9 No Respuesta

6.5 ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted había tenido angina o enfermedad del corazón? ☐

1 Sí
2 No

9 No Respuesta

6.6 ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted había tenido un derrame cerebral?

1 Sí ☐
2 No **(Ir a *Q. 6.8.)***

9 No Respuesta

6.7. ¿A que edad tuvo su primer derrame cerebral? ☐☐

___ ___ Edad en años

9 9 No Respuesta

Verificar la edad en Q. 1.2. Si el entrevistado tiene 35 años o más, continúe con Q. 6.8. De lo contrario, vaya a Q. 6.9.

6.8. ¿Toma usted aspirinas en bajas dosis diariamente o cada dos días para evitar problemas cardiacos? ☐

1 Sí
2 No

9 No Respuesta

Asma

6.9. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted tiene asma? ☐

1 Sí
2 No ***(Ir a Q. 6.11.)***

9 No Respuesta

6.10. Todavía tiene usted asma?

1 Sí
2 No

9 No Respuesta

Artritis

6.11. En los últimos 12 meses, ¿ha tenido dolores, rigidez o hinchazón en o alrededor de una articulación o coyuntura?

1 Sí
2 No ***(Ir a Q. 6.17.)***

9 No Respuesta

6.12. ¿Tuvo estos síntomas la mayoría de los días por lo menos durante un mes?

1 Sí
2 No

9 No Respuesta

6.13. ¿Está usted actualmente limitado/a en alguna de sus actividades debido a los síntomas relacionados con sus articulaciones o coyunturas?

1 Sí
2 No

9 No Respuesta

6.14. ¿Ha consultado alguna vez a un médico, enfermero u otro profesional de la salud en cuanto a estos síntomas con sus articulaciones o coyunturas?

1 Sí
2 No

9 No Respuesta

6.15. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted había tenido artritis?

1 Sí
2 No

9 No Respuesta

6.16. ¿Está usted actualmente recibiendo tratamiento médico para su artritis?

1 Sí
2 No

9 No Respuesta

Cáncer
(Si es Hombre Ir a Q. 6.27.)
Cáncer de Seno o Mamas

6.17. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que usted tiene cancer del seno o pecho?

1 Sí
2 No

9 No Respuesta

6.18. Una mamografía es una radiografía de los senos para investigar la posible presencia de cáncer de seno. ¿Alguna vez se ha hecho una mamografía?

1 Sí
2 No ***(Ir a Q. 6.21.)***

9 No Respuesta

6.19. ¿Cuánto tiempo hace desde la última vez que se hizo una mamografía?

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.20. ¿Cuál fue el motivo principal para realizarse su última mamografía? ☐

1 Examen rutinario
2 Por medida diagnóstica por problema mamario pero no cáncer
3 Monitoreo porque tuve cáncer de mama
4 Porque mi familia tiene historial de cáncer de seno
5 Otra

9 No Respuesta

6.21. Un examen clínico de los senos es cuando un médico, enfermero u otro profesional de la salud **palpa el seno para encontrar nódulos**. ¿Alguna vez se le ha hecho un examen clínico de los senos como este? ☐

1 Sí
2 No ***(Ir a Q. 6.23.)***

9 No Respuesta

6.22. ¿Cuánto tiempo hace desde su último examen de los senos? ☐

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.23. ¿Ha sido su abuela, madre, hermana o hija diagnosticada con cáncer de seno o mama? ☐

1 Sí
2 No
3 No sé

9 No Respuesta

Cáncer Cervical o de Cuello Uterino

6.24. Una prueba Papanicolao es una prueba del cáncer del cuello uterino. ¿Alguna vez se le ha hecho un frotis o prueba Papanicolao?

1 Sí ☐
2 No ***(Ir a Q. 6.27.)***

9 No Respuesta

6.25. ¿Cuánto tiempo hace desde su última prueba de Papanicolao? ☐

1 Hace menos de 12 meses o un año
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.26. Su última prueba de Papanicolao, ¿fue parte de un examen rutinario, o para investigar un problema que tiene o tenía en ese entonces? ☐

1 Examen rutinario
2 Investigación de un problema que tengo o tenía
3 Otro motivo

9 No Respuesta

Cáncer Colorectal

6.27. Una prueba de sangre en las heces o excremento es una prueba que se puede efectuar en casa por medio de un instrumento especial para determinar si las heces contienen sangre. ¿Se ha hecho usted alguna vez esta prueba utilizando un instrumento especial para efectuarlo en casa?

1 Sí ☐
2 No ***(Ir a Q. 6.29)***

9 No Respuesta

6.28. Cuánto tiempo hace desde que se hizo su última prueba de sangre en las heces o excremento utilizando un instrumento para hacerlo en casa?

☐

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.29 La sigmoidoscopía y la colonoscopía son examenes en los cuales se inserta un tubo en el recto para poder examinar el intestino por dentro y determinar señales de cáncer u otros problemas de salud. ¿Se ha hecho alguno de estos dos examenes alguna vez?

☐

1 Sí
2 No ***(Mujer: Ir a Q 6.37.; Hombre: Ir a Q. 6.31.)*** →

9 No Respuesta

6.30. ¿Cuánto tiempo hace desde se hizo su última sigmoidoscopía o colonoscopía?

☐

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

Cáncer de Próstata ***(Preguntas para hombres solamente. Si es mujer Ir a Q. 6.37.)***

6.31. La prueba del Antígeno Específico a la Próstata, en inglés “Prostate Specific Antigen test”, también llamada una prueba de PSA, es una prueba de la sangre usada para averiguar si los hombres tienen cáncer de próstata. ¿Le han hecho una prueba PSA alguna vez?

☐

1 Sí
2 No ***(Ir a Q. 6.33.)*** →

9 No Respuesta

6.32. ¿Cuánto tiempo hace desde que se hizo su última prueba PSA?

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.33. Una palpitación rectal es un examen en el cual un médico, enfermero u otro profesional de la salud, usando guantes, coloca un dedo en el recto del paciente para sentir el tamaño, la forma y la dureza de la glándula prostática. ¿Alguna vez se hizo hacer una palpitación rectal?

1 Sí
2 No ***(Ir a Q. 6.35.)***

9 No Respuesta

6.34. ¿Cuánto tiempo hace desde su última palpitación rectal?

1 En cualquier momento hasta hace 12 meses
2 Hace 1 año pero menos de 2 años
3 Hace 2 años pero menos de 3 años
4 Hace 3 años pero menos de 5 años
5 Hace 5 años ó más

9 No Respuesta

6.35. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud que tiene usted cáncer de la próstata?

1 Sí
2 No

9 No Respuesta

6.36. ¿Alguna vez le ha dicho un médico, enfermero u otro profesional de la salud a su padre, hermano, hijo o abuelo que esa persona tenía cáncer de la próstata?

1 Sí
2 No
3 No sé

9 No Respuesta

Diabetes

6.37. ¿Alguna vez le ha dicho un médico que usted tiene diabetes?

1 Sí
2 Sí, pero sólo durante mi embarazo ***(Ir a Q. 7.1.)***
3 No ***(Ir a Q. 7.1.)***

9 No Respuesta

6.38. ¿Qué edad tenía usted cuando se le dijo que tiene diabetes?

___ ___ Edad en años

9 9 No Respuesta

6.39. ¿Está usted actualmente usando insulina?

1 Sí
2 No

9 No Respuesta

6.40. ¿Está usted actualmente tomando píldoras para la diabetes?

1 Sí
2 No

9 No Respuesta

6.41. Más o menos, ¿con qué frecuencia examina usted la glucosa o azúcar en su sangre? Incluya las veces que se lo haya hecho un miembro de su familia o un amigo, **pero no las veces que se lo haya hecho un profesional de la salud**.

1 __ __ Veces al día
2 __ __ Veces a la semana
3 __ __ Veces al mes
4 __ __ Veces por año

99 No Respuesta

Veces por mes

6.42. Más o menos, ¿con qué frecuencia examina usted sus pies por llagas o irritaciones? Incluya las veces cuando se lo haya hecho un miembro de su familia o un amigo, **pero no las veces que se lo haya hecho un profesional de la salud**.

1 __ __ Veces por día
2 __ __ Veces por semana
3__ __ Veces por mes
4__ __ Veces por año

☐☐ Veces por mes

99 No Respuesta

6.43. Más o menos, ¿cuántas veces en los últimos 12 meses le ha examinado los pies un profesional de la salud por llagas o irritaciones?

☐☐

___ ___ Cantidad de veces

9 9 No Respuesta

6.44. ¿Ha tenido alguna vez llagas o irritaciones en los pies que se hayan tardado más de cuatro semanas en sanar?

☐

1 Sí
2 No

9 No Respuesta

6.45. Más o menos, ¿cuántas veces en los últimos 12 meses ha visto a un médico, enfermero u otro profesional de la salud en relación a su diabetes?

☐☐

___ ___ Cantidad de veces

9 9 No Respuesta

6.46. La prueba de la hemoglobina "A uno C" mide el nivel promedio del azúcar sanguíneo en los últimos tres meses. Más o menos, ¿cuántas veces en los últimos 12 meses le ha hecho un médico, enfremero o profesional de la salud una prueba de hemoglobina "A uno C"?

___ ___ Cantidad de veces ☐☐

9 9 No Respuesta

6.47. ¿Alguna vez un médico le ha dicho que su diabetes le ha afectado su visión o que tiene usted retinopatía? ☐

1 Sí
2 No

9 No Respuesta

6.48. ¿Alguna vez ha tomado un curso o una clase en una feria de salud, entrenamiento u oficina del proveedor salud sobre cómo controlar o manejar usted mismo/a la diabetes? ☐

1 Sí
2 No
9 No Respuesta

Sección 7: Condiciones Severas

Heridas/ Accidentes

Ahora le preguntaré acerca de heridas y accidentes, incluyendo envenenamientos, que hayan ocurrido en los últimos 3 meses, y que requirieron consultoría o tratamiento médico- incluyendo llamadas al centro del control de envenenamientos.

7.1. Durante los pasados tres meses (o sea los últimos 90 días), sufrió usted o algún miembro de este hogar un accidente o herida suficientemente seria como para pedir consultoría o tratamiento médico? ☐

1 Sí
2 No ***(Ir a Q. 8.1.)*** →

9 No Respuesta

7.2. ¿Por cuántas ocaciones los miembros de este hogar buscaron consultoría o atención médica debido a un accidente o herida? ☐☐

___ ___ Cantidad de veces

9 9 No Respuesta

En estos momentos quisiera preguntarle acerca de las heridas/accidentes/ envenenamientos más recientes.

7.3. ¿Fue necesaria la hospitalización del miembro de este hogar por alguna herida/acidente o envenenamiento?

☐

1 Sí
2 No

9 No Respuesta

7.4. ¿A qué se debió la herida o accidente?

☐☐

(NO lea/ Lea sólo si es necesario)

01 Transportación, incluyendo vehículos de motor/ bicicleta/motora, peatón/tren/bote/avión
02 Fuego/quemaduras/heridas
03 Caídas
04 Envenenamiento
05 Sobre esfuerzo/movimientos bruscos
06 Golpeado accidentalmente por un objeto o persona
07 Golpeado, apuñalado, o atacado físicamente por otra persona
08 Mordida de insecto o animal
09 Cortadura/perforación
10 Herido por maquinaria
11 Otra

99 No Respuesta

7.5. ¿Fue alguna de las heridas relacionada a alguno de los siguientes eventos?:

☐☐

(NO lea/ Lea sólo si es necesario)

01 Manejando o viajando en vehículo de motor
02 Trabajando en empleo
03 Trabajando en el hogar o patio
04 Durante la escuela
05 No en empleo (incluyendo trabajos voluntarios, mientras estuvo de compras, etc)
06 Deportes (equipos formales o practicando deporte individualmente o con amigos tales como correr, esquiar, bicicleta)
07 Actividades de esparcimiento (no incluyendo deportes)
08 Durmiendo, descansando, comiendo, bebiendo
09 Cocinando
10 Violencia en el hogar
11 Violencia fuera del hogar
12 Mientras otra persona lo cuidaba a usted
13 Otro

99 No Respuesta

Sección 8: Medios de Comunicación

Debido a que estamos casi terminando esta entrevista, tengo una pocas preguntas más acerca de los medios de donde obtiene usted la información acerca de la salud, conductas y otras practicas relacionadas a la salud.

8.1. ¿Cuál de los siguientes medios de comunicación utiliza usted para obtener información acerca de la salud? Puede escoger más de una opción.

			Sí 1	***No 2***	***NR 9***
1	Radio	Cuál _____	☐	☐	☐
2	Televisión	Cuál _____	☐	☐	☐
3	Periódico	Cuál_____	☐	☐	☐
4	Revista	Cuál _____	☐	☐	☐
5	Feria de Salud	Cuál _____	☐	☐	☐
6	Internet	Cuál _____	☐	☐	☐
7	Familia/Amigos		☐	☐	☐

En estos momentos, me gustaría preguntarle acerca de algun problema que amenaza su salud por vivir en esta comunidad.

8.2. ¿Considera usted que alguna de las siguientes razones presenta una barrera para mantener una buena salud en esta comunidad?

		Sí 1	*NO 2*	*NR 9*
1	Falta de empleo que provea seguro médico	☐	☐	☐
2	Falta de suficiente dinero para pagar los tratamientos	☐	☐	☐
3	No puedo obtener seguro médico/ no soy elegible	☐	☐	☐
4	Condiciones ambientales tales como contaminación del aire, humo de cigarrillo o plomo en la estructura del hogar	☐	☐	☐
5	Dificultad en obtener estatus legal aquí en los Estados Unidos	☐	☐	☐
6	Falta de conocimiento acerca de qué hacer para prevenir las enfermedades y promover la salud propia y de los miembros del hogar	☐	☐	☐
7	Me ha pasado o temo violencia	☐	☐	☐

Sección 9: Enfermedades Transmisibles Sexualmente, incluyendo VIH/SIDA

VIH/SIDA

Las próximas preguntas son acerca del SIDA y del virus que lo causa, el VIH, pero no necesariamente de su condicion personal. Recuerde que sus respuestas son estrictamente confidenciales y que no tiene que contestar todas las preguntas si no desea.

Le voy a leer dos declaraciones acerca del VIH, el virus que causa el SIDA. Después de que yo le haya leído cada una, por favor dígame si usted piensa que es cierta o falsa.

9.1. Una mujer encinta que tenga VIH puede obtener tratamientos para ayudar a reducir las posibilidades de que le transmita el virus a su bebé.

☐

1 Cierto
2 Falso
3 No sé

9 No Respuesta

9.2. Hay tratamientos médicos disponibles para ayudar a las personas infectadas con el VIH a prolongar su vida.

☐

1 Cierto
2 Falso
3 No sé

9 No Respuesta

9.3. ¿Alguna vez se ha hecho la prueba del VIH? No cuente las pruebas que pueden habérsele hecho como parte de una donación de sangre.

☐

1 Sí
2 No ***(Ir a Q. 9.6.)*** →

9 No Respuesta

9.4. Sin incluir las donaciones de sangre, ¿cuánto tiempo hace desde su última prueba de VIH?

☐

1 En cualquier momento hasta hace 12 meses (1 año)
2 Hace 1 año pero menos de 2 años (2 años)
3 Hace 3 años pero menos de 5 años

9 No Respuesta

9.5. ¿Cuál fue el motivo principal por el que le hicieron la prueba de VIH hace_____?
(refiérase a la fecha provista en Q. 9.4.)

(NO lea/ Lea sólo si es necesario)

01	Para una hospitalización u operación	☐☐
02	Para solicitar seguro médico	
03	Para solicitar seguro de vida	
04	Para un empleo	
05	Para solicitar licencia de matrimonio	
06	Para admisión en las fuerzas armadas o servicio militar	
07	Para inmigración	
08	Sólo para averiguar si estaba infectado	
09	Por recomendación o pedido del médico	
10	A causa del embarazo	
11	Por recomendación o pedido de su pareja	
12	Para un examen de rutina	
13	Fue expuesto en el lugar de trabajo	
14	A causa de una enfermedad	
15	Porque tengo el riesgo de contraer el VIH	
16	Otro motivo	
99	No Respuesta	

Conducta Sexual Responsable

9.6. En los últimos 12 meses, ¿ha tenido relaciones sexuales con más de una persona?

1	Sí	☐
2	No	
9	No Respuesta	

9.7. ¿Usó un condón la última vez que tuvo relaciones sexuales?

1	Sí	☐
2	No ***(Ir a Q. 9.9.)*** →	
9	No Respuesta	

9.8. En esa ocación, el motivo por el cual usó condón fue:

1	Para evitar embarazo	☐
2	Para evitar enfermedades como sífilis, gonorrea o SIDA	
3	Ambos motivos	
4	Por otro motivo	
9	No Respuesta	

9.9. Alguna gente usa condones para evitar la infección por el VIH a través de la actividad sexual. ¿Cuán efectivo piensa usted que sea un condón usado correctamente para este propósito?
Diría usted que es:

☐

1 Muy efectivo
2 Algo efectivo
3 No es efectivo

9 No Respuesta

Enfermedades de Transmisión Sexual

Estas últimas preguntas son acerca de las enfermedades de transmisión sexual, aparte del VIH/SIDA.

9.10. En los últimos 5 años, ¿ha recibido tratamiento para una enfermedad venérea o transmitida por actividad sexual?

☐

1 Sí
2 No ***(Termina la entrevista)***

9 No Respuesta

9.11. ¿Recibió tratamiento en una clínica de enfermedades venéreas o de transmisión sexual?

1 Sí ☐
2 No

4 No Respuesta

Muchas gracias por responder a nuestras preguntas.
Ahora quisiera pasar a el Módulo 2, la parte final de este estudio.

Appendix 4b

LATINO HEALTH CARE COLLABORATIVE COMMUNITY ASSESSMENT
English Survey

Introduction

Hello, my name is _____ and I am conducting a family health survey for the Latino Health Care Collaborative. This study is lead by the Council of Latino Agencies in the District of Columbia.

Are you or any person in this household Latino or Hispanic, meaning of Caribbean or Latin American ancestry?

(If there are no Latinos/Hispanics END SURVEY. "Thank you for your time")

For the purpose of this survey we want to interview adult members of Latino households. ***(Use Answering Sheet)***

Informed Consent

Before administering the survey, I will need to go over this Consent Form with you. I want to assure you that all of the information that we gather from you will be used for research purposes only and will be kept confidential.
(Carefully review Consent Form with subject and have him/her sign it)

Now to begin the survey, I will need to remind you that you do not have to answer any question that you don't want to, and you can end the interview at any time. This interview will take about 45 minutes. Thanks for consenting to this interview.

Section 1: Demographics

First I would like to ask you about yourself.

1.1. Gender

(*Do NOT Read. Select appropriate answer*)

1 Male
2 Female ☐

1.2. What is your age? ☐☐

___ ___ Years

0 9 No Response

1.3. We are interviewing Latinos of all races. Which one of the following would you say is your race?

		YES 1	***NO 2***	***NR 9***
1	White	☐	☐	☐
2	Black or African American	☐	☐	☐
3	Asian	☐	☐	☐
4	Native Hawaiian or Other Pacific Islander	☐	☐	☐
5	American Indian, Alaska Native	☐	☐	☐
6	Mixed Which _____	☐		

1.4. What is your country of origin? ☐☐

(Do NOT read options)

01 El Salvador
02 Mexico
03 Puerto Rico
04 Dominican Republic
05 Guatemala
06 Cuba
07 Honduras
08 Columbia
09 Peru
10 Nicaragua
11 Argentina
12 Panama
13 Other: Please specify _____

99 No Response

1.5. What language can you speak? ***(Note: This questions refers to the interviewee's ability to speak one or both languages***) ☐

1 Only Spanish, no English
2 Spanish more than English
3 Spanish and English equally
4 English more than Spanish
5 Only English

9 No Response

1.6. How long have you lived in the United States? ☐

(Do NOT read options)

1 Born here in United States
2 0 to less than 2 years
3 2 to less than 5 years
4 5 to10 years
5 More than 10 years

9 No Response

1.7. Are you: ☐

1 Married
2 Divorced
3 Widowed
4 Separated
5 Never married or single
6 A member of an unmarried couple

9 No Response

1.8. What is the highest grade or year of school you completed? ☐

(Read only if necessary)

1 Never attended school or only attended kindergarten
2 Any grade from 1st through 8th (elementary)
3 Any grade from 9th through 11th (some high school)
4 Grade 12 or GED (high school graduate)
5 One to up to three years of university courses or technical college
6 College 4 years or more (college graduate)

9 No Response

1.9. How many children less than 18 years of age live in this household? ☐☐

___ ___ Number of children

9 9 No Response

I would like to ask you about your job and family income.

1.10. Are you currently: ☐

1 Employed for wages
2 Self-employed
3 Out of work for more than 1 year
4 Out of work for less than 1 year
5 A Homemaker
6 A Student
7 Retired
8 Unable to work

9 No Response

1.11. Out of the figures on this card, which corresponds to your total annual household income – that is from all sources for this household:
(Use card for range of household income) ☐

9 No Response

Section 2: General Health Status

Now I am going to ask about your general health and what you are doing to maintain or improve it.

2.1. Would you say that in general your health is: ***(Read options)*** ☐

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

9 No Response

2.2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days or the last month was your physical health not good?

___ ___ Number of days ☐☐

9 9 No Response

2.3. Now thinking about your mental health, which includes stress and depression, for how many days during the past 30 days or the last month was your mental health not good?

__ __ Number of days ☐☐

9 9 No Response

2.4. During the past 30 days or the last month, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?

__ __ Number of days ☐☐

9 9 No Response

Disabilities

The following questions are about health problems or impairments you may have.

2.5. Do you now have any health problem that requires you to use special equipment, such as a cane, wheelchair, special bed or special telephone?

1 Yes
2 No

9 No Response

2.6. **(Answer only if he/she has said that there are children living in the household Q. 1.9.)** Are there any children under 18 years of age in this household who has any health problem that may require the use of special equipment such as a cane, wheelchair, special bed or special telephone?

1 Yes
2 No

9 No Response

Section 3: Health Care Access

Health Care Coverage

3.1. Do you have any kind of health care coverage, including health insurance, prepaid plans, such as HMOs, or government plans, such as Medicare?

1 Yes ***(Go to Q. 3.3.)***
2 No
3 Don't know/ Not sure

9 No Response

3.2. About how long have you had health care coverage?

1 Less than 6 months ago
2 6 months to less than 1 year ago
3 1 year to less than 2 years ago
4 Within the past 5 years (2 years but less than 5 years ago)
5 5 or more years ago

9 No Response

(Note: After completing Q. 3.2. Go to Q. 3.5.)

3.3. What is the main reason you are without health coverage? Select only one. If you have more than one reason, give me the most important.

☐☐

(Do NOT read/ Read only if necessary)

0 1 Lost job or changed employers
0 2 Spouse or parent lost job or changes employers
0 3 Became divorced or separated
0 4 Spouse or parent died
0 5 Became ineligible because of age or because left school
0 6 Employer doesn't offer or stopped offering coverage
0 7 Cut back to part-time or became temporary employee
0 8 Benefits from employer or former employer ran out
0 9 Could not afford to pay the premiums
1 0 Insurance company refused coverage
1 1 Lost Medicaid or Medical Assistance eligibility
1 2 Other

9 9 No Response

3.4. About how long has it been since you had health care coverage?

☐

1 Never had health coverage
2 Less than 6 months ago
3 6 months to less than 1 year ago
4 1 year to less than 2 years ago
5 Within the past 5 years (2 years but less than 5 years ago)
6 5 or more years ago

9 No Response

Health Care Utilization

3.5. Do you have one person you think of as your personal doctor or health care provider?

☐☐

1 Yes, only one
2 Yes, more than one
3 No

9 No Response

3.6. Is there one particular clinic, health center, doctor's office or other place that you usually go to if you are sick or need advice about your health?

☐

1 Yes
2 Yes, more than one place
3 No ***(Go to Q. 3.9.)*** →
9 No Response

3.7. What kind of place is it? ☐

1 A doctor's office or HMO
2 A clinic or health center
3 A hospital outpatient department
4 A hospital emergency room
5 An urgent care center
6 Other

9 No Response

3.8. For these next series of questions, answer Yes or No for each one. Do you use any of the following as complementary methods, that is to **complement** treatments prescribed by your doctor, or use any as alternative methods, that is in **substitution** of any treatment prescribed by your doctor?

		Yes 1	***No 2***	***NR 9***
1	Spiritual doctor, curandero…….	☐	☐	☐
2	Prayer…….	☐	☐	☐
3	Herbal medicine……..	☐	☐	☐
4	Chiropractic therapy……	☐	☐	☐
5	Other……	☐	☐	☐

3.9. Was there a time during the past 12 months or the last year when you needed to see a doctor, nurse or health provider but could not because of any of the following reasons?:

		Yes 1	***No 2***	***NR 9***
1	Cost	☐	☐	☐
2	Transportation/distance	☐	☐	☐
3	Lack of time off work	☐	☐	☐
4	Family care/family responsibility	☐	☐	☐

3.10. About how long has it been since you last visited a doctor for a routine checkup? ***(A routine checkup is a general physical exam, not a visit for a specific lesion or illness)***

(Do NOT read options) ☐

1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (more than 1 year but less than 2 years ago)
3 Within the past 5 years (more than 2 years but less than 5 years ago)
4 5 or more years ago

9 No Response

Section 4: Awareness of Preventive Behaviors

Now I am going to ask you about taking care of your health.

Monitoring Blood Pressure

4.1. Have you ever had your blood pressure checked by a doctor, nurse or health provider? ☐

1 Yes
2 No

9 No Response

4.2. Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure? ☐

1 Yes
2 No ***(Go to Q. 4.4)***

9 No Response

4.3. Are you currently taking medicine for your high blood pressure? ☐

1 Yes
2 No

9 No Response

Monitoring Blood Cholesterol Levels

4.4 Have you ever had your blood cholesterol checked? Blood cholesterol is a fatty substance found in the blood. ☐

1 Yes
2 No ***(Go to Q. 4.6)***
9 No Response

4.5. How long has it been since you last had your blood cholesterol checked?

(Do NOT read/Read only if necessary) ☐

1 Within the past year (less than 12 months ago)
2 Within the past 2 years (1 year to less than 2)
3 Within the past 5 years (2 years to less than 5)
4 5 or more years ago

9 No Response

4.6. Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high? ☐

1 Yes
2 No

9 No Response

Monitoring and Controlling Your Weight

4.7. How much do you weigh without shoes? ☐☐

Weight in kg

___ ___ ___ ***(Divide by 2.679 = ___ ___ weight in kg)***
Pounds

9 9 9 No Response

4.8. How tall are you without shoes? ☐☐☐

Height in cm

___/ ___ ___ ***(Multiply by 12= _____ Height in inches;***
ft / inches
Then Multiply by 2.54=_____ height in centimeters)

9 9 9 No Response

4.9. Are you currently trying to: ***(Read options below)*** ☐

1 Stay the same weight
2 Lose weight
3 Gain weight ***(Go to Q. 4.12.)*** →

9 No Response

4.10. Are you currently eating either fewer calories or less fat to:

		YES 1	*NO 2*	*NR 9*
1	Lose weight	☐	☐	☐
2	Keep from gaining weight?	☐	☐	☐

4.11. Are you using physical activity or exercise to:

		YES 1	*NO 2*	*NR 9*
1	Lose weight	☐	☐	☐
2	Keep from gaining weight	☐	☐	☐

4.12. In the past 12 months, has a doctor, nurse or health provider given you advice about your weight? ☐

1 Yes, to loose weight
2 Yes, to gain weight
3 Yes, to keep my current weight
4 No

9 No Response

Now I am going to ask you how much physical activity you get.

(If interviewee is employed or self-employed, continue with Q 4.13. If unemployed, go to Q 4.13. For employment status, see Q. 1.10.)

4.13. When you are at work, which of the following best describes what you do? ☐

1 Mostly sitting or standing
2 Mostly walking or moving
3 Mostly heavy labor or physically demanding work

9 No Response

We are interested in two types of physical activity: vigorous and moderate. **Vigorous** activities cause large increases in breathing or heart rate, while **moderate** activities cause small increases in heart rate.

4.14. Now, thinking about the ***moderate physical activities*** you do when you are not working or in your free time in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening or anything else that causes small increases in breathing or heart rate?

1 Yes ☐
2 No ***(Go to Q. 4.18.)*** →

9 No Response

4.15. How many days per week do you do these **moderate activities** for at least 10 minutes at a time? ☐

___ Days per week
0 Do not exercise at least 10 minutes weekly

9 No Response

4.16. Now thinking about the ***vigorous physical activities*** you do when you are not working in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy year work or anything else that causes large increases in breathing or heart rate? ☐

1 Yes
2 No ***(Go to Q. 4.18.)*** →

9 No Response

4.17. How many days per week do you do these **vigorous activities** for at least 10 minutes at a time? ☐

___ Days per week
0 Do not exercise at least 10 minutes weekly

9 No Response

Incorporating Fruits and Vegetables in Your Diet

These next questions are about the foods and drinks you usually consume. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I am only interested in the foods you usually eat. Include all food you eat both at home and away from home.

4.18. How often do you drink 100% fruit juices such as orange, grapefruit, or tomato?

__ __ Per day
__ __ Per week

Times per week

9 9 No Response

4.19. Not counting juice, how often do you usually eat fruits a day?

__ __ Per day
__ __ Per week

Response per day

9 9 No Response

4.20. How often do you usually eat vegetables a day, such as tomatoes, broccoli, spinach, avocado or carrots?

__ __ Per day
__ __ Per week

Response per day

9 9 No Response

4.21. How often do you eat red meat (such as steak, lamb, pork), chicken, fish, eggs, peas, beans, nuts or seeds?

__ __ Per day
__ __ Per week
__ __ Per month

Response per week

99 No Response

4.22. How often do you eat foods that contain grain or fiber such as whole grain cereals, bran muffins, wheat bread, brown rice, oats, or barley?

__ __ Per day
__ __ Per week
__ __ Per month

Response per week

9 9 No Response

Taking Vitamin Supplements

4.23. Do you currently take any vitamin pills or supplements?

1 Yes
2 No ***(Go to Q. 4.25.)***

9 No Response

4.24. Are any of these a multivitamin? ☐☐

1 Yes
2 No

9 No Response

Taking Immunization Shots

4.25. During the past 12 months, have you had a flu shot? ☐☐

1 Yes
2 No

9 No Response

4.26. Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine. ☐☐

1 Yes
2 No

9 No Response

4.27. Are all the children in your household fully immunized with the recommended vaccines for infants and school age children? ☐☐

1 Yes
2 No

9 No Response

Tuberculosis Awareness

4.28. Have you ever received a skin or X-ray test by a doctor, nurse or health provider for Tuberculosis? ***(Explain test if necessary: The skin test is done by injecting the test in your skin and the doctor or nurse would verify the reaction to it a few days later)*** ☐☐

1 Yes
2 No

9 No Response

4.29. Have you ever been told by a doctor, nurse or health provider that you have Tuberculosis?

☐☐

1 Yes
2 No

9 No Response

Taking Good Care of Your Teeth

4.30. How long has it been since you last visited a dentist or a dental clinic for any reason?

☐

(Do NOT read/ Read only if necessary)

1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 years but less than 2 years ago)
3 Within the past 5 years (2 years or more but less than 5 years ago)
4 5 or more years ago

9 No Response

4.31. How many of your permanent teeth have been removed because of tooth decay or gum disease? Do not include teeth lost for other reasons, such as injury.

☐

0 None
1 1 to 5
2 6 or more but not all
3 All

9 No Response

Section 5: Health-influencing Behaviors

Now I am going to ask you about any habits that may influence your health.

Alcohol Consumption

5.1. During that past 30 days or the last month, how many days per week or per month did you have at least one drink or any alcoholic beverage? A drink of alcohol is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail or 1 shot of liquor.

☐☐

__ __ Days per week
__ __ Days in past 30 days
0 0 No drinks in past 30 days → ***(Go to Q. 5.4.)***

Days in last month

9 9 No Response

5.2. On the days when you did have an alcoholic drink, about how many drinks did you have on the average? ☐☐

__ __ Number of drinks

9 9 No Response

5.3. Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on an occasion? ☐☐

__ __ Number of times
0 0 None

9 9 No Response

Tobacco Use

5.4. Have you smoked in total at least 100 cigarettes in your entire life? ***(100 cigarettes equals 5 packages)*** ☐

1 Yes
2 No ***(Go to Q. 6.1.)*** →

9 No Response

5.5. Do you now smoke cigarettes every day, some days or not at all? ☐

1 Everyday
2 Some days
3 Not at all ***(Go to Q. 5.7.)*** →

9 No Response

5.6. If you now smoke cigarettes every day, how many do you smoke per day? ☐

1 Less than five
2 Less than 12 (a pack)
3 A pack
4 More than a pack a day

9 No Response

5.7. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? ☐

1 Yes, and I no longer smoke ***(Only ones to answer Q. 5.8.)***
2 Yes, but resumed smoking
3 No

9 No Response

5.8. ***(Only for those who answered Yes to the last Question 5.7.)*** About how long has it been since you last smoked cigarettes regularly? ☐

1 Less than 1 month
2 1 month to less than 3 months
3 3 months to less than 6 months
4 Less than 1 year
5 1 year to 5 years ago
6 6 to 10 years ago
7 More than 10 years ago

9 No Response

5.9. How old were you when you first started smoking cigarettes regularly?

___ ___ Years of age ☐☐

9 9 No Response

5.10. In the past 12 months, has a doctor, nurse or health provider advised you to quit smoking? ☐☐

1 Yes
2 No

9 No Response

5.11. Do you refrain from smoking for any of the following reasons:

	YES 1	***NO 2***	***NR 9***
a. To avoid indoor air pollution when inside the home	☐	☐	☐
b. To protect children from second-hand smoke	☐	☐	☐
c. To obey the no smoking policy at work	☐	☐	☐

Section 6. Chronic Illnesses - Knowledge and Practice

Cardiovascular Disease

6.1. I would like to ask if you are doing any of the following to lower your risk of developing heart disease or stroke:

	YES 1	***NO 2***	***NR 9***
a. Eating fewer high fat or high cholesterol foods	☐	☐	☐
b. Eating more fruits and vegetables than before	☐	☐	☐
c. Being more physically active than before	☐	☐	☐

6.2. Within the past 12 months, has a doctor, nurse or other health professional told you to do any of the following:

	YES 1	***NO 2***	***NR 9***
a. Eat fewer high fat or high cholesterol foods	☐	☐	☐
b. Eat more fruits and vegetables	☐	☐	☐
c. Be more physically active	☐	☐	☐

6.3. Has a doctor, nurse or other health professional ever told you that you had a heart attack? ☐

1 Yes
2 No ***(Go to Q. 6.5.)***

9 No Response

6.4. At what age did you have your first heart attack? ☐☐

___ ___ Years of Age

9 9 No Response

6.5 Have you ever been told by a doctor, nurse or health care provider that you have heart problems such as angina or coronary heart disease? ☐

1 Yes
2 No

9 No Response

6.6. Have you ever been told that you have had a stroke?

1 Yes
2 No ***(Go to Q. 6.8.)***

9 No Response

6.7. At what age did you have your first stroke?

___ ___ Years of age

0 9 No Response

Check Q. 1.2. for age. If respondent is 35 years of age or older continue with Q 6.8. Otherwise go to 6.9.

6.8. Do you take low strength aspirin daily or every other day to protect against heart problems?

1 Yes
2 No

9 No Response

Asthma

6.9. Have you ever been told by a doctor, nurse or other health professional that you had asthma?

1 Yes
2 No ***(Go to Q. 6.11.)***

9 No Response

6.10. Do you still have asthma?

1 Yes
2 No

9 No Response

Arthritis

6.11. During the past 12 months, have you had pain, aching, stillness or swelling in or around a joint?

1 Yes ☐
2 No ***(Go to Q. 6.17.)*** →

9 No Response

6.12. Were these symptoms present on most days for at least one month? ☐

1 Yes
2 No

9 No Response

6.13. Are you now limited in any way in any activities because of joint symptoms?

1 Yes
2 No ☐

9 No Response

6.14. Have you seen a doctor, nurse or other health professional for these joint symptoms? ☐

1 Yes
2 No

9 No Response

6.15. Have you ever been told by a doctor, nurse or health provider that you have arthritis? ☐

1 Yes
2 No

9 No Response

6.16. Are you currently being treated by a doctor, nurse or health provider for arthritis? ☐

1 Yes
2 No

9 No Response

Cancer
(If respondent is Male, Go to Q. 6.27.)
Breast Cancer

6.17. Has a doctor, nurse or other health professional ever told you that you have breast cancer?

1 Yes
2 No

9 No Response

6.18. Have you ever had a mammogram? A mammogram is an x-ray of each breast to look for breast cancer.

1 Yes
2 No ***(Go to Q. 6.21.)***

9 No Response

6.19. How long has it been since you had your last mammogram?

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.20. What was the main reason for your last mammogram?

1 Screening as part of a routine checkup
2 Diagnostic measure for a breast problem other than cancer
3 Monitoring of existing breast cancer
4 I have family history of breast cancer
5 Other

9 No Response

6.21. A clinical breast exam is when a doctor, nurse or other health professional **feels the breast for lumps**. Have you ever had a clinical breast exam?

1 Yes
2 No ***(Go to Q. 6.23.)***

9 No Response

6.22. How long has it been since your last breast exam? ☐

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.23. Has your mother, sister, daughter or grandmother ever been diagnosed with breast cancer? ☐

1 Yes
2 No
3 Don't know

9 No Response

Cervical Cancer

6.24. A Pap smear is a test for cancer of the cervix. Have you ever had a Pap smear? ☐

1 Yes
2 No ***(Go to Q. 6.27.)*** →

9 No Response

6.25. How long has it been since you had your last Pap smear? ☐

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.26. Was your last Pap smear done as part of a routine exam or to check a current or previous problem? ☐

1 Routine exam
2 Check current or previous problem
3 Other

9 No Response

Colorectal Cancer

6.27. A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?

1 Yes
2 No ***(Go to Q. 6.29.)***

9 No Response

6.28. How long has it been since you had your last blood stool test using a home kit?

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.29. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems. Have you ever had either of these exams?

1 Yes
2 No ***(FEMALE: Go to Q 6.37.; MALE: Go to Q. 6.31.)***

9 No Response

6.30. How long has it been since you had your last sigmoidoscopy or colonoscopy?

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

Prostate Cancer ***(Questions for male respondents only. If Female Go to Q. 6.37.)***

6.31. A Prostate Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?

1 Yes
2 No ***(Go to Q. 6.33.)***

9 No Response

6.32. How long has it been since you had your last PSA test?

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.33. A digital rectal exam is an exam in which a doctor or nurse or other health professional places a gloved finger into the rectum to feel the size, shape and hardness of the prostate gland. Have you ever had a digital rectal exam?

1 Yes
2 No ***(Go to Q. 6.35.)***

9 No Response

6.34. How long has it been since your last digital rectal exam?

1 Less than 12 months ago
2 1 year to less than 2 years
3 2 years to less than 3 years
4 3 years to less than 5 years
5 More than 5 years ago

9 No Response

6.35. Have you ever been told by a doctor, nurse or other health professional that you had prostate cancer?

1 Yes
2 No

9 No Response

6.36. Has your father, brother, son or grandfather ever been diagnosed by a doctor, nurse or other health professional that he had prostate cancer?

1 Yes
2 No
3 Don't know

9 No Response

Diabetes

6.37. Have you ever been diagnosed or told by a doctor that you have diabetes?

1 Yes
2 Yes, but that was during my pregnancy ***(Go to Q. 7.1.)***
3 No ***(Go to Q. 7.1.)***

9 No Response

6.38. How old were you when you were told you have diabetes?

___ ___ Years of age

9 9 No Response

6.39. Are you now taking insulin?

1 Yes
2 No

9 No Response

6.40. Are you now taking diabetes pills?

1 Yes
2 No

9 No Response

6.41. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but **do not include times when checked by a health professional**.

1 __ __ Times per day
2 __ __ Times per week
3 __ __ Times per month

Times per month

9 No Response

6.42. About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, **but do not include times when checked by a health professional.**

1 __ __ Times per day
2 __ __ Times per week
3__ __ Times per month
4__ __ Times per year

Times per month

9 No Response

6.43. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?

___ ___ Number of times

9 9 No Response

6.44. Have you ever had any sores or irritations on your feet that took more than four weeks to heal?

1 Yes
2 No

9 No Response

6.45. About how many times in the past 12 months have you seen a doctor, nurse or other health professional for your diabetes?

___ ___ Number of times

9 9 No Response

6.46. A test for hemoglobin, A1c, measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse or other health professional checked you for hemoglobin A1c?

___ ___ Number of times

9 9 No Response

6.47. Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?

1 Yes
2 No

9 No Response

6.48. Have you ever been taught how to manage your diabetes yourself in a setting such as a class or course, health fair, workshop, or providers office?

☐

1 Yes
2 No

9 No Response

Section 7: Acute Illnesses

Injury/accidents

In this next set of questions, I will ask about injuries, including poisonings, that happened in the past three months and that required medical advice or treatment, including calls to a poison control center.

7.1. During the past three months, that is 91 days before today's date, were you or anyone in the family injured or poisoned seriously enough that you (or the injured person) got medical advice or treatment?

☐

1 Yes
2 No ***(Go to Q. 8.1.)*** →

9 No Response

7.2. How many times did the people in the household seek medical advice or were treated because of injury?

☐☐

___ ___ Number of times

9 9 No Response

Now I am going to ask a few questions about the **most recent** injury/poisoning.

7.3. Did any of the injuries or poisoning require hospitalization of a member of this household?

☐

1 Yes
2 No

9 No Response

7.4. What was the injury due to?

☐☐

(Do NOT read: Read only if necessary)

01 Transportation, including motor vehicle/ bicycle/motorcycle, pedestrian/train/boat/airplane
02 Fire/burn/scald related
03 Fall
04 Poisoning
05 Overexertion/strenuous movements
06 Accidentally struck by object or person
07 Struck, stabbed or physically assaulted by another person
08 Animal or insect bite
09 Cut/pierced
10 Machinery
11 Other

99 No Response

7.5. Were any of the injuries related to any ONE of the following events:

☐☐

(Do NOT read/ Read only if necessary)

01 Driving or riding a motor vehicle
02 Working at a paid job
03 Working around the house or year
04 Attending school
05 Unpaid work (including housework, shopping, volunteer work)
06 Sports (organized team or individual sport such as running, biking, skating
07 Leisure activity (excluding sports)
08 Sleeping, resting, eating, drinking
09 Cooking
10 Violence in the home
11 Violence outside of the home
12 Being cared for (hands-on care from another person)
13 Other

99 No Response

Section 8: Communication Channels

As we near the end of this interview, I have just a few questions about how you get your information about health behaviors and practices.

8.1. Which one do you most often turn to for information about health? You can choose more than one option.

			Yes 1	***No 2***	***NR 9***
1	Radio	Which _____	☐	☐	☐
2	TV	Which _____	☐	☐	☐
3	Newspaper	Which _____	☐	☐	☐
4	Magazine	Which _____	☐	☐	☐
5	Health Fair	Which _____	☐	☐	☐
6	Internet	Which _____	☐	☐	☐
7	Family/friends		☐	☐	☐

I am now going to ask you about any threats to your health that come from life in this community.

8.2. Do you consider any of the following to interfere with your ability to maintain good health in this community?

		YES 1	***NO 2***	***NR 9***
1	Lack of job that includes health insurance	☐	☐	☐
2	Lack of enough money to pay for treatment	☐	☐	☐
3	Inability to get healthcare – inability to negotiate the system- not eligible	☐	☐	☐
4	Environmental conditions like outdoor air pollution or indoor smoking or lead paint applied to the walls or woodwork in your home	☐	☐	☐
5	Difficulties in obtaining legal status here in the United States	☐	☐	☐
6	Not knowing what to do to prevent diseases and promote your own health and that of your family	☐	☐	☐
7	Fear or have experience violence	☐	☐	☐

Section 9: Sexually Transmitted Diseases, including HIV/AIDS

HIV/AIDS

The next few questions are about HIV, the virus that causes AIDS. Please remember that your answers are strictly confidential and that you don't have to answer every question if you don't want to.

I 'm going to read two statements about HIV, the virus that causes AIDS. After I read each one, please tell me whether you think it is true or false.

9.1. A pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby. ☐

1 True
2 False
3 Don't know

9 No Response

9.2. There are medical treatments available that are intended to help a person who is infected with HIV to live longer. ☐

1 True
2 False
3 Don't know

9 No Response

9.3. As far as you know, have you ever been tested for HIV? Do not count tests you may have had as part of a screening process for blood donation.

1 Yes
2 No ***(Go to Q. 9.6.)*** →

9 No Response

9.4. Not including blood donations, how long ago was your last HIV test? ☐

1 Within the last year
2 Within the past 2 years.
3 Within the past 3 to 5 years.

9 No Response

9.5. What was the main reason you had your test for HIV in ***(date from Q. 9.4.)***?

(Do NOT read/ Read only if necessary) ☐☐

01 For hospitalization or surgical procedure
02 To apply for health insurance
03 To apply for life insurance
04 For employment
05 To apply for a marriage license
06 For military induction or military service
07 For immigration
08 Just to find out if you were infected
09 Because of referral by a doctor
10 Because of pregnancy
11 Referred by your sex partner
12 For routine checkup
13 Because of occupational exposure
14 Because of illness
15 Because I am at risk for HIV
16 Other

99 No Response

Responsible Sexual Behavior

9.6. During the past 12 months, have you had sexual intercourse with more than one person?

1 Yes ☐
2 No

9 No Response

9.7. Was a condom used the last time you had sexual intercourse?

1 Yes ☐
2 No ***(Go to Q. 9.9.)*** →

9 No Response

9.8. On that occasion when you had sexual intercourse, was the condom used to: ☐

1 To prevent pregnancy
2 To prevent diseases like syphilis, gonorrhea, and AIDS
3 For both of these reasons or
4 For some other reason

9 No Response

9.9. Some people use condoms to keep from getting infected with HIV through sexual activity. How effective do you think a properly used condom is for this purpose? Would you say:

☐

1 Very effective
2 Somewhat
3 Not at all

9 No Response

Sexually Transmitted Diseases

These last questions are about sexually transmitted diseases other than HIV/AIDS.

9.10. In the past five years, have you been treated for a sexually transmitted or venereal disease?

☐

1 Yes
2 No ***(END OF INTERVIEW)***

9 No Response

9.11. Were you treated at a health clinic?

1 Yes ☐
2 No

9 No Response

Thank you very much for answering my questions. Next, we will finish with the last part of this interview, Module 2.

Appendix 4c

LATINO HEALTH CARE COLLABORATIVE

Answering Sheet/Hoja de Contestación

☐ English ☐ Español

Household Listing/ Lista miembros del hogar

#	First Name/ Nombre de Pila	Sex/ Sexo	Age/ Edad
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Note: Place asterisk * next to the number of selected person to be interviewed./ Ponga un asterisco* al lado del número de la persona seleccionada para ser entrvistada.

Sec. 1: Demographic Characteristics/ Características Demográficas

1.1. ☐ 1 M
2 F

1.2. ☐☐ Age/ Edad

1.3.

	Yes/Sí 1	NO 2	NR 9
1	☐	☐	☐
2	☐	☐	☐
3	☐	☐	☐
4	☐	☐	☐
5	☐	☐	☐
6	☐	☐	☐ _____

1.4. ☐☐

1.5. ☐

1.6. ☐

1.7. ☐

1.8. ☐

1.9. ☐☐

1.10. ☐

1.11. ☐

Sec. 2: General Health Status/ Estado General de Salud

2.1. ☐

2.2. ☐☐

2.3. ☐☐

2.4. ☐☐

Incapacities/Descapacidades

2.5. ☐

2.6. ☐

Sec. 3: Health Care Access/ Acceso a Cuidado de Salud

3.1. ☐☐

3.2. ☐

3.3. ☐☐

3.4. ☐

Health Care Utilization/
Utilización de Servicios Médicos

3.5. ☐

3.6. ☐

3.7. ☐

3.8.

	Yes/Sí 1	No 2	NR 9
1	☐	☐	☐
2	☐	☐	☐
3	☐	☐	☐
4	☐	☐	☐
5	☐	☐	☐

3.9.

	Yes/Sí 1	No 2	NR 9
1	☐	☐	☐
2	☐	☐	☐
3	☐	☐	☐
4	☐	☐	☐

3.10. ☐

Sec. 4: Preventive Behaviors/
Conductas Preventivas

Hipertension /Hipertensión

4.1. ☐

4.2. ☐

4.3. ☐

Cholesterol/Colesterol

4.4 ☐

4.5. ☐

4.6. ☐

Controling your Weight/Controlando su Peso

4.7. ☐☐ Weight/ Peso **kg**

4.8. ☐☐☐ Height/Altura **cm**

4.9. ☐

4.10.

	Yes/Sí 1	NO 2	NR 9
1	☐	☐	☐
2	☐	☐	☐

4.11.

	Yes/Sí 1	NO 2	NR 9
1	☐	☐	☐
2	☐	☐	☐

4.12. ☐

4.13 ☐

4.14. ☐

☐

4.15.

4.16. ☐

4.17. ☐

Fruits and Vegetables/Frutas y Vegetales

4.18. ☐☐ Times per week/ Veces por semana

4.19. ☐☐ Times per day/ Veces por día

4.20. ☐☐ Times per day/ Veces por día

4.21. ☐☐ Times pe week/ Veces por semana

4.22. ☐☐ Times per week/ Veces por semana

Vitamin Supplements/Suplementos Vitamínicos

4.23. ☐

4.24. ☐

Immunizations/Vacunas para Inmunidad

4.25. ☐

4.26. ☐

4.27. ☐

TB

4.28. ☐

4.29. ☐

Dental Health/Cuidado de sus Dientes

4.30. ☐

4.31. ☐

Sec. 5: Behaviors/Conductas

Alcohol

5.1. ☐☐ Days per week/ Días por semana

5.2. ☐☐

5.3. ☐☐

Tobacco/Tabaco

5.4. ☐

5.5. ☐

5.6. ☐

5.7. ☐

5.8. ☐

5.9. ☐☐ Age/Edad

5.10 ☐☐

5.11.

	Yes/Sí 1	NO 2	NR 9
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Sec.6. Chronic Diseases/Enfermedades Crónicas

Cardiovascular Health/Enfermedades Cardiovasculares

6.1.

	Yes/Sí 1	NO 2	NR 9
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

6.2.

	Yes/Sí 1	NO 2	NR 9
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

6.3. ☐

6.4. ☐☐ Age/ Edad

6.5 ☐

6.6 ☐

6.7. ☐☐ Age/Edad

6.8. ☐

Asthma/Asma

6.9. ☐

6.10. ☐

Arthritis/Artritis

6.11. ☐

6.12. ☐

6.13. ☐

6.14. ☐

6.15. ☐

6.16. ☐

Cancer
Breast Cancer/Cáncer de Seno

6.17. ☐

6.18. ☐

6.19. ☐

6.20. ☐

6.21. ☐

6.22. ☐

6.23. ☐

Cervical Cancer/Cáncer Cervical

6.24. ☐

6.25. ☐

6.26. ☐

Colorectal Cancer/Cáncer Colorectal

6.27. ☐

6.28. ☐

6.29 ☐

6.30. ☐

Prostate Cancer/Cáncer de Próstata

6.31. ☐

6.32. ☐

6.33. ☐

6.34. ☐

6.35. ☐

6.36. ☐

Diabetes

6.37. ☐

6.38. ☐☐ Age/Edad

6.39. ☐

6.40. ☐

6.41. ☐☐ Times per month/ Veces por mes

6.42. ☐☐ Times per month/ Veces por mes

6.43. ☐☐ Times/Cantidad de veces

6.44. ☐

6.45. ☐☐ Times/Cantidad de veces

6.46. ☐☐ Times/Cantidad deveces

6.47. ☐

6.48. ☐

Sec. 7: Acute Illnesses/Condiciones Severas

Injury/Accidents/ Heridas/ Accidentes

7.1. ☐

7.2. ☐☐ Times/Cantidad de veces

7.3. ☐

7.4. ☐☐

7.5. ☐☐

Sec. 8: Communication Channels/ Medios de Comunicación

8.1.

	Yes/Sí 1	No 2	NR 9
1	☐	☐	☐

Which/Cuál _____

2 ☐ ☐ ☐

Which/Cuál _____

3 ☐ ☐ ☐

Which/Cuál_____

4 ☐ ☐ ☐

Which/Cuál _____

5 ☐ ☐ ☐

Which/Cuál _____

6 ☐ ☐ ☐

Which/Cuál _____

7 ☐ ☐ ☐

End of Module I/
Termina Módulo I

8.2.

	Yes/Sí 1	NO 2	NR 9
1	☐	☐	☐
2	☐	☐	☐
3	☐	☐	☐
4	☐	☐	☐
5	☐	☐	☐
6	☐	☐	☐
7	☐	☐	☐

Sec. 9: STD/ HIV/AIDS-
EST/VIH/SIDA

9.1. ☐

9.2. ☐

9.3. ☐

9.4. ☐

9.5. ☐ ☐

9.6. ☐

9.7. ☐

9.8. ☐

9.9. ☐

9.10. ☐

9.11. ☐

Appendix 4d

Forma de Consentimiento Informado para Participantes del Estudio
Latino Health Care Collaborative
(Colaborativa para el Estudio de la Salud Latina)
Prueba Piloto

La Colaborativa para el Estudio de la Salud Latina es un estudio dirigido por el Consejo de Agencias Latinas o Council of Latino Agencies en el Distrito de Columbia para adquirir datos relacionados al estado de salud de los Hispanos/Latinos que viven en el Distrito. Hoy estamos llevando a cabo la prueba piloto para este estudio. La información recopilada en este estudio ayudará a las organizaciones comunitarias, clínicas de la comunidad y al Departamento de Salud a desarrollar intervenciones de salud en la forma de mensajes educativos preventivos que ayudarán a la comunidad Hispana/Latina a mejorar su salud aumentando sus conocimientos relacionados a la salud y mejorando sus practicas saludables. Los resultados de este estudio también se usarán para escribir artículos de política pública y ser presentados ante el Congreso en defensa de la salud de los residentes Hispanos/Latinos de el Distrito.

Le estamos pidiendo que participe en esta prueba piloto porque usted es parte de la comunidad Hiapana/Latina en el area metropolitana de DC. Su participación es totalmente voluntaria. Usted puede decidir terminar su participación en cualquier momento, sin ninguna penalidad. Esta entrevista tomará alrededor de 45 minutos. Las preguntas en este cuestionario incluen información socio-demográfica, información sobre su estado de salud, e información relacionada a su habilidad de obtener servicios de salud. Toda la información que usted provea sera mantenida en estricta confidencialidad. Información personal suya sera utilizada SOLAMENTE para propósitos de control de calidad. Usted recibirá una compensación de un valor de $20 dólares en agradecimiento por su participación.

Esta forma de Consentimiento Informado ha sido leída y explicada al participante mencionado abajo.

Esta forma de Consentimiento Informado ha sido leída y explicada al participante mencionado abajo.

_____ _____
Nombre del participante Nombre del entrevistador

_____ _____
Firma Firma
Fecha_____

Participant Code ☐ ☐ ☐ ☐ ☐ ☐ ☐

Appendix 5

Bibliography

Aragon R, Lillie-Blanton M. 2004. "Uninsured and Underserved: The Health Care Experience of Latinos in the Nation's Capital." Washington, DC: The Henry J. Kaiser Family Foundation.

Berk ML, Schur CL, Chavez LR, Frankel M. 2000. "Health care among undocumented Latino immigrants. *Health Affairs* 19(4):51-64.

Collins JW Jr, Shay DK. 1994. Prevalence of low birth weight among Hispanic infants with United States-born and foreign-born mothers: the effect of urban poverty. *American Journal of Epidemiology* 139:184-92.

Council on Scientific Affairs. 1991. Hispanic health in the United States. *Journal of the American Medical Association* 265:248-52.

DHHS (U.S. Department of Health and Human Services. 2000. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. Washington, DC: DHHS.

Delgado JL, Johnson Cl, Rey I, Trevino FM. 1990. Hispanic health and nutrition survey: methodological considerations. *American Journal of Public Health* 80 (suppl.):27-36.

Goel MS, McCarthy EP, Phillips RS. 2004. "Obesity among U.S. immigrant subgroups by duration of residence." *JAMA* 292, 23:2860-67

The Kaiser Family Family Foundation 2003. D.C. Health Care Access Survey 2003. Highlights and Chartpack.

Kaplan MS, Huguet N, Newsorn JT. 2004. "The association bet ween length of residence and obesity among Hispanic immigrants." *Am J Prev Med* 27, 4: 323-26.

Jimenez MA, Jimenez DR. 1992. Hispanics and HIV disease: issues, practice, and policy implications. *Social Work Health Care* 17:41-51.

Lillie-Blanton M, Rushing OE, Ruiz S. "Key facts: race, ethnicity & medical care." Washington, DC: The Henry J. Kaiser Family Foundation.

Morales LS, Reise SP, Hayes RD. 2000. Evaluating the equivalence of health care ratings by whites and Hispanics. *Medical Care* 38(5):517-27.

Nickens HW. 1991. The health status of minority populations in the United States. *Western Journal of Medicine* 155:27-32.

O'Brien , Cokkindes V, Jemal A, Cardinez CJ, Murray T, Samuels A, Ward E, Thun MJ. 2003. "Cancer statististics for Hispanics, 2003. *Cancer J Clin* 53:208-226.

Olshansky, SJ, Passaro DJ, Hershow RC, Layden J, Carnes BA, Brody J, Hayflick L, Butler RN, Allison DB, Ludwig DS 2005. "A potential secline in life expectancy in the United States in the 21st century." *N Engl J Med* 352, 11: 1138-45

Popkin, BM. 2001. "The nutrition transition and obesity in the developing world." *J Nutrition* 131, 3: 871S-873S.

SCHSA (District of Columbia State Center for Health Statistics Administration). 2000 Healthy People 2010 Plan: A Strategy for Better Health. Washington, DC: Government of the District of Columbia.

SCHSA (District of Columbia State Center for Health Statistics Administration). 2002 DC Healthy People 2010: Annual Implementation Plan Year 2002. Washington, DC: Government of the District of Columbia.

SCHSA 2004. DC Healthy People & Biennial Implementation Plan 2003-2004.

SCHSA (District of Columbia State Center for Health Statistics Administration). 2004 DC Healthy People 2010 Plan: Revised Version 2005. Washington, DC: Government of the District of Columbia.

Scribner R, Dwyer JH. 1989. Acculturation and low birthweight among Latinos in the Hispanic HANES. *Am J Pub Health* 79: 629-30.

Uauy, R., C. Albala, and J. Kain. 2001. "Obesity trends in Latin America: transitioning from under- to overweight." *J Nutrition* 131,3: 893S – 899S.

U.S. Census Bureau. 2005. "Annual estimates of the population by sex, race, and Hispanic or Latino origin for the United States: April 1, 2004 (NC-EST2004-03). http://www.census.gov. Accessed 6/13/05.

Wannamethee SG, Shaper AG, Walker M. 2005. "Overweight and obesity and weight change in middle aged men: impact on cardiovascular disease and diabetes." *J Epidemiol Community H* 59 *134*-39.

Appendix 6

LHCC Training
By William Waters, GWU

A four-day training session was planned and completed as scheduled. The training was conducted entirely in Spanish, and consisted of the following elements:

- The project's purpose and goals. This component allowed team members to understand and appreciate the project's importance and their role in contributing to its overall success.

- Project logistics and field work, including sampling methodology, identification of selected households and individuals within households, rules for call backs, and informed consent. This component provided the necessary skills for applying the questionnaires in the field in the most accurate and efficient manner possible.

- Interviewing techniques, including optimizing the interviewer-interviewee dynamic, obtaining informed consent, registering responses, handling skip patterns, and closing the interview. This component was designed to provide the skills that were essential for successful interviewing and accurate recording of information provided by the respondent.

- Introduction to the questionnaire, with a focus on each section and question. This component familiarized the interviewers with the specific elements of the questionnaire: design and layout, correct formulation of each question, skip patterns, and rules for addressing respondents' questions.

- Classroom-based practice. This component provided interviewers with the opportunity to formulate the questions in the questionnaire and to record responses to each question. In general, it provided interviewers with greater familiarity with the questions, the management of skip patterns, and other features. It also gave the GW team trainers the opportunity to observe and evaluate the interviewers.

- Field-based training at the Nueva Esperanza Lutheran Church in Silver, Spring, MD. It should be noted that the instruments had previously been pilot tested at the Community Ministries of Rockville, in Rockville, MD.

The training emphasized the following points: correct selection of households and eligible adults within households, correct techniques for completing questionnaires, skip patterns, presentation at the door, protecting confidentiality, how to ask questions, avoiding bias, repeat calls (morning, afternoon, evenings, weekends) and appointments, supervision and reporting, handling of completed questionnaires, transportation, cell phones, and other logistical matters. In addition, techniques for selecting households for the additional modules were reviewed.

During the training, the teams were formed on the basis of balancing skills, experience, and gender. Team leaders were also selected using similar criteria and were given additional information on selection of blocks and households, assigning team members to households, quality assurance, and submission of completed questionnaires to the project (at CLA).

The basic technique for the training was interactive discussion. Handouts consisted of blank questionnaires and reporting forms. Flip charts were used and placed on walls to record comments and further the discussion. Following the training, supervisors were interviewed and all interviewers completed an evaluation, the results of which follow.

Evaluation of training

The methodology adapted for training the interviewers was based on prior experience both in the U.S. and abroad (Latin America and East Africa). Nearly all of the training (95%) was conducted in Spanish. Basic to this training is a full understanding of the purpose of the project. A second key area involved techniques for interviewing in general and more broadly, management of the interview environment. This portion included techniques for identifying qualified households and respondents and the principles of obtaining informed consent. The importance of the team approach to interviewing was stressed. Next, the training included a thorough review of the questions including wording, possible responses, and skip patterns. During this phase, techniques for handling non-response were discussed. Finally, management of questionnaires and quality assurance were discussed. The practical phase of the training included group practice of all modules of the interview; here, interviewers engaged in role play as both interviewer and respondent. The last part of this phase consisted of a field practice, in which the instrument was applied to Latinos in Montgomery County, Maryland.

Following the three-day training session, attendees were asked to complete a short questionnaire, in which the different elements of the session were assessed.

Question 1 consisted of five parts, each using a Likert scale of 1 to 5 using the following criteria to answer the prompt: “for the following statements, indicate your level of satisfaction from 1 to 5.”

1=very poor
2=poor
3=neither good nor poor
4=good
5=very good

Mean scores of responses were as follows:

Question 1a: physical space: 4.29
Question 1b: training content: 4.35

Question 1c: trainers/facilitators: 4.76
Question 1d: methodology: 4.18
Question 1e: group participation: 4.53

There were very few responses of "3" (Six in total: three from one individual, two from a second, and one from a third; 14 of the 17 respondents answered this section at the "good" or "very good" levels only. There were no responses of "1" or "2". This suggests a high level of satisfaction with all aspects of the training.

Question 2 asked the participants to agree (yes) or disagree (no). Frequencies of responses were as follows:

Question 2a: The objectives of the training were established at the beginning.
Yes: 17 (100%)
No: 0 (0%)

Question 2b: The objectives of the training were fulfilled.
Yes: 14 (87.5% of valid responses)
No: 2 (12.5%)
(1 missing value)

Questions 2 and 3 asked for short answers.

Question 3 asked: "What elements of the training seemed most useful to you?" Responses were as follows, and suggest that the technique of reviewing questions and answers was well regarded, as was the opportunity to practice asking and answering questions through role playing.

- The explanation of the questionnaire for Module 1
- The discussion on the format of the interviews.
- The methodology in general constituted a useful element for our learning during the training. There was good material and an excellent handling of the topic. Good attention to a comfortable ambiance.
- Explanation of the reason for the interviews.
- For me, all the elements have been useful; it is been an interesting experience.
- Techniques discussed, rhythm of work; the group [itself]
- Everything was perfect: thanks!
- Food for fueling the work; reviewing the questions; practice; knowing [everybody]
- Teams to work on possible problems; practicing the questionnaire
- Flipcharts; review of the questions; the explanation of everything was extraordinary; the conformation of work teams and the discussion.
- The questionnaire and the answers were a little confusing, so that we arrived at an agreement on changing the answer sheet.
- Most were basic tools for the interview.

- Reviewing the questionnaire.
- In general, all of the content was useful because we have acquired new knowledge.
- I think that everything was very well carried out; tactics for the training were very clear.
- The questionnaire and its content.
- Reviewing the questionnaire as a group. The "interview situation" sheet that was presented. Role playing.

Question 4 asked "what elements of the training would you change?" Note that of 17 respondents, five either left this blank or said that nothing should have been changed. One conclusion is that there should have been more time for practice using different group formats.

- The explanation of Module II. I would leave more time to practice and [ask] questions on experiences.
- More time explaining how to do the interviews and more practice.
- No response
- "Nothing"
- No response
- The form of evaluating the questions could be more dynamic, using small groups.
- The training should be longer and should include talks about Latin American culture: fashions and habits.
- [The training]should move faster. Should have corrected the questionnaires before the training.
- I think: more didactic material [like] blackboard and flipchart.
- There is nothing to change; the training was very enriching.
- The answer sheet.
- More dynamic methodology. (NB: this person rated methodology 5 (excellent0]
- Nothing
- I think that the observations we made should be changed a little. [?]
- I think the schedule: that we could be more punctual [and begin] at the scheduled time.
- The space (that is, the place); the vocabulary.
- A day of practice with colleagues; more practice with formal groups.

Question 5 asked: "After the training, do you feel capable of doing the work of interviewer?" The possible responses were as follows, suggesting that the respondents felt that the training had prepared them for the job they were to do.

1. Not capable
2. Somewhat capable

3. Very capable

Frequencies of response were:

1. Not capable: 0 (0%)
2. Somewhat capable: 2 (11.8%)
3. Very capable: 15 (88.2%)

Appendix 7

Preliminary Data Analyses

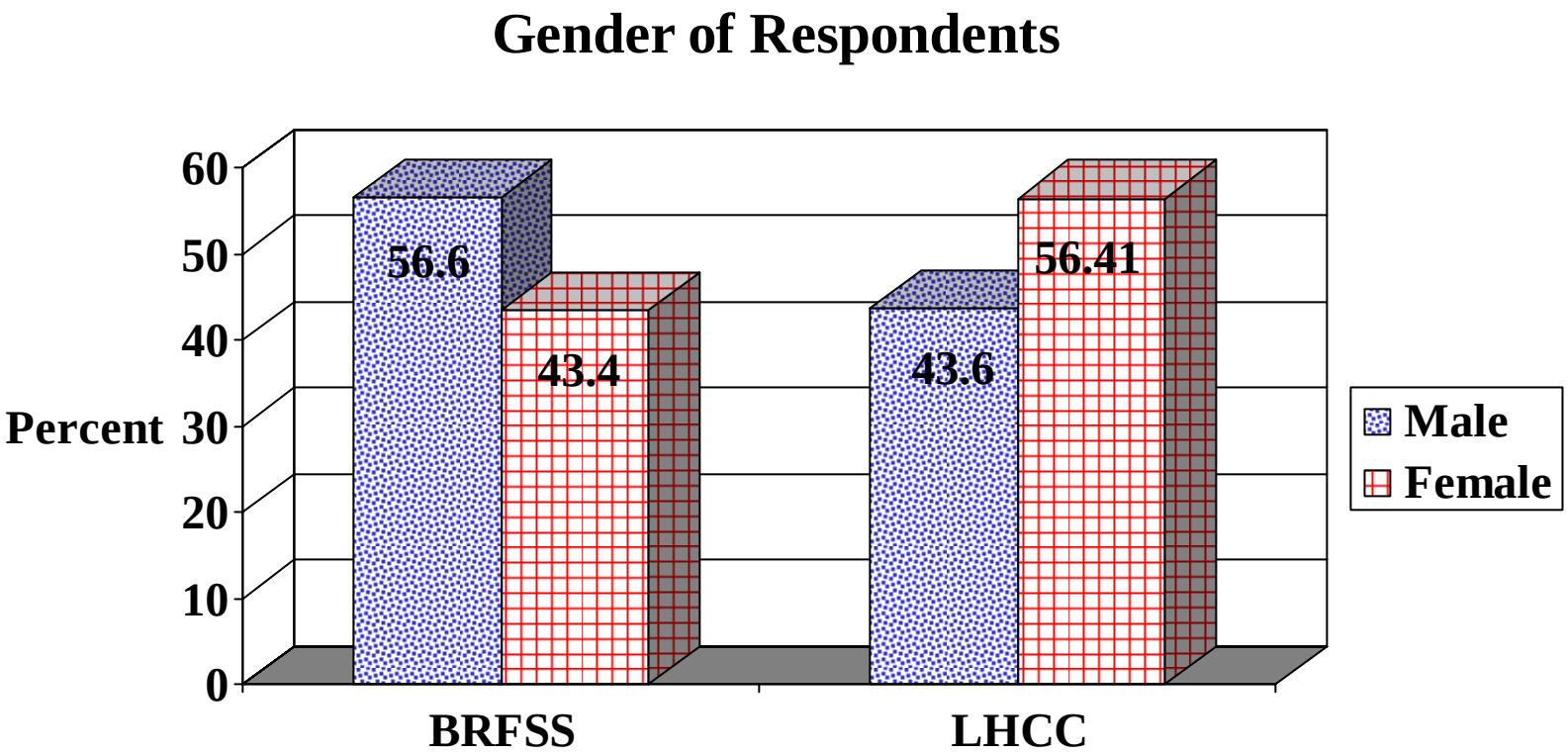
DC BRFSS 2003 vs. LHCC data

Note:

- LHCC data has not yet been weighted
- DC BRFSS 2003 data for Hispanics may number less than 50 samples
- LHCC total n=819
- DC BRFSS Hispanics total n=87
- Access to care data is BRFSS 2002

Chart 1

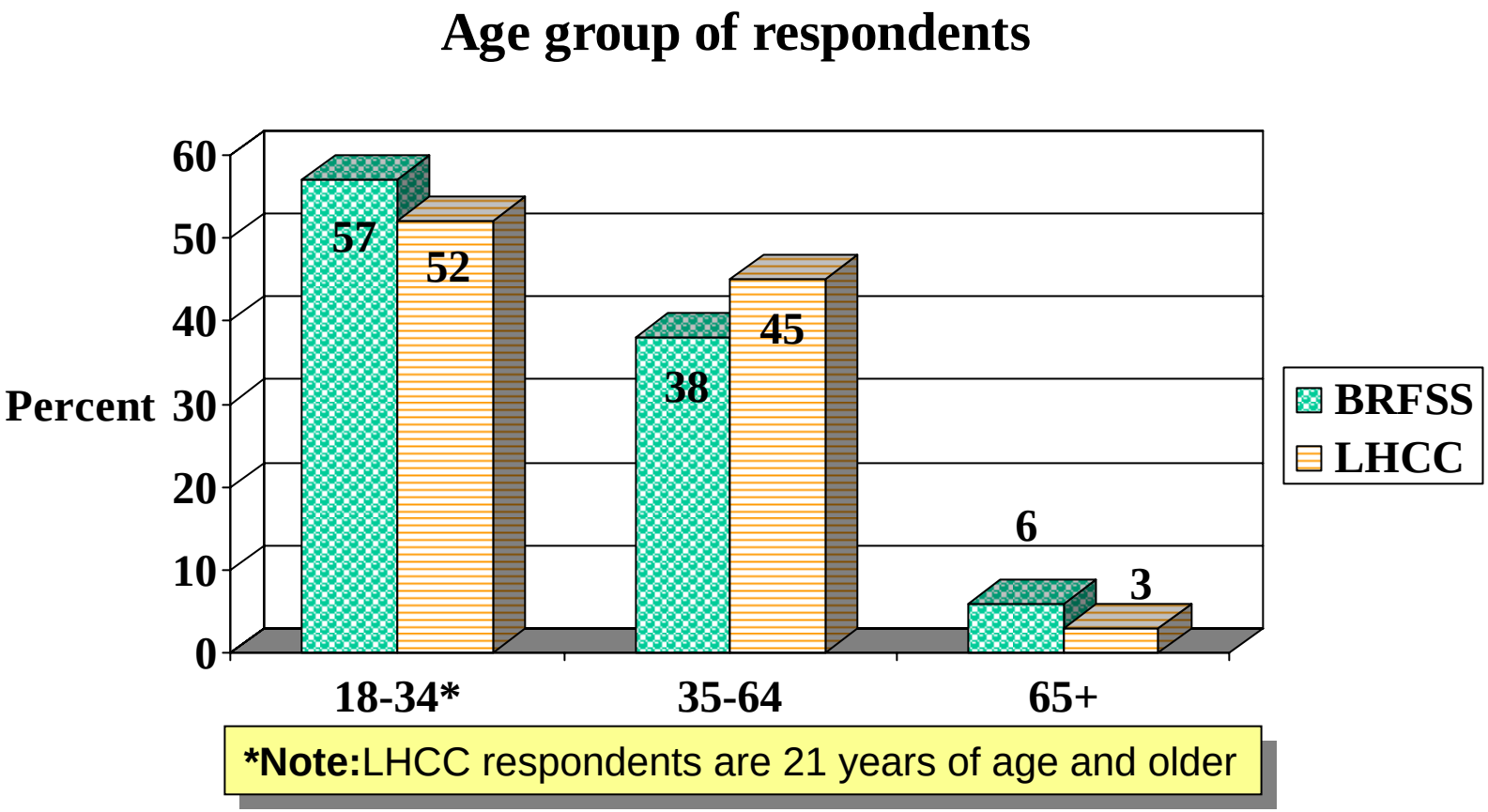
Gender



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 2

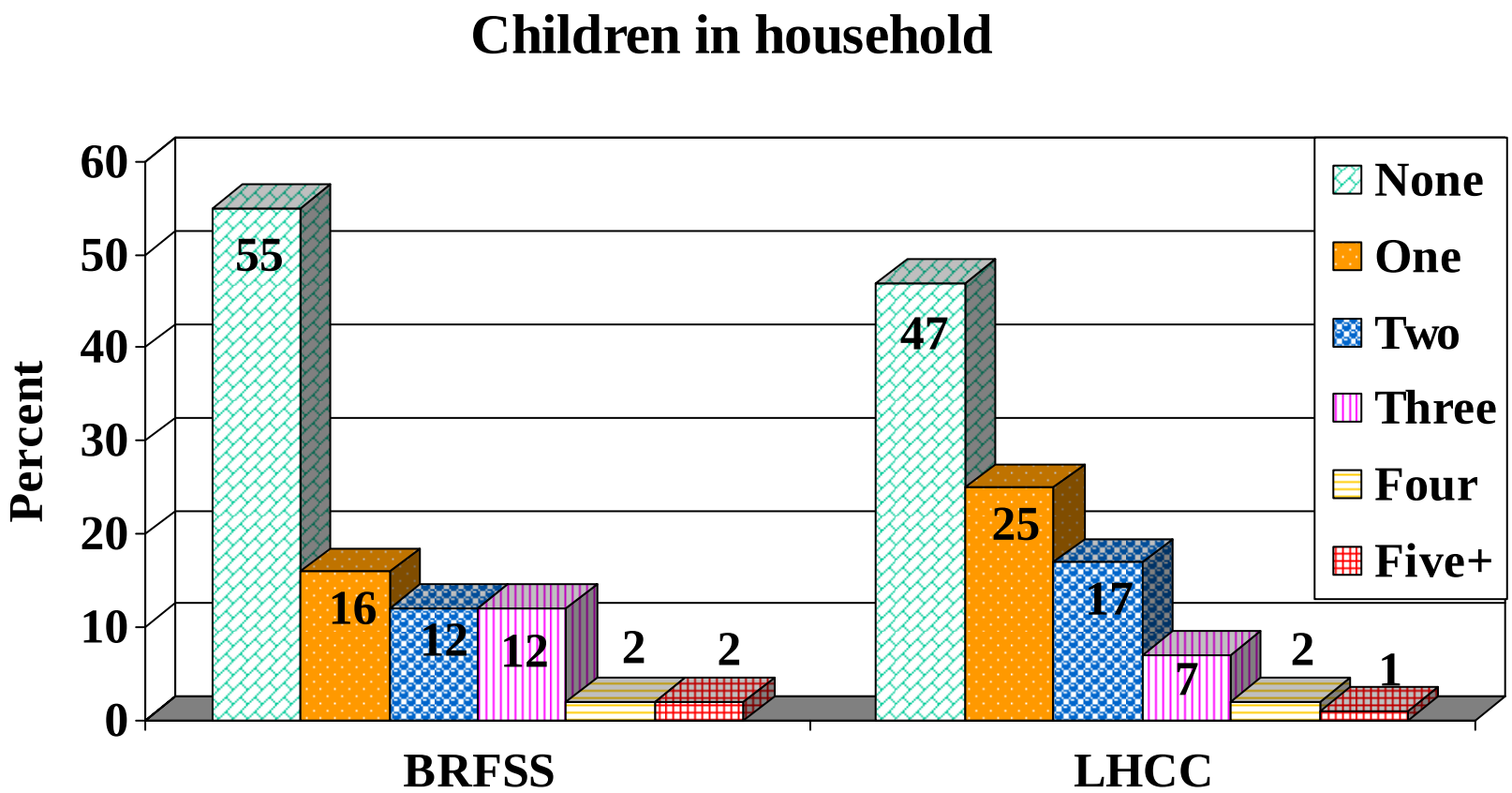
Age



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 3

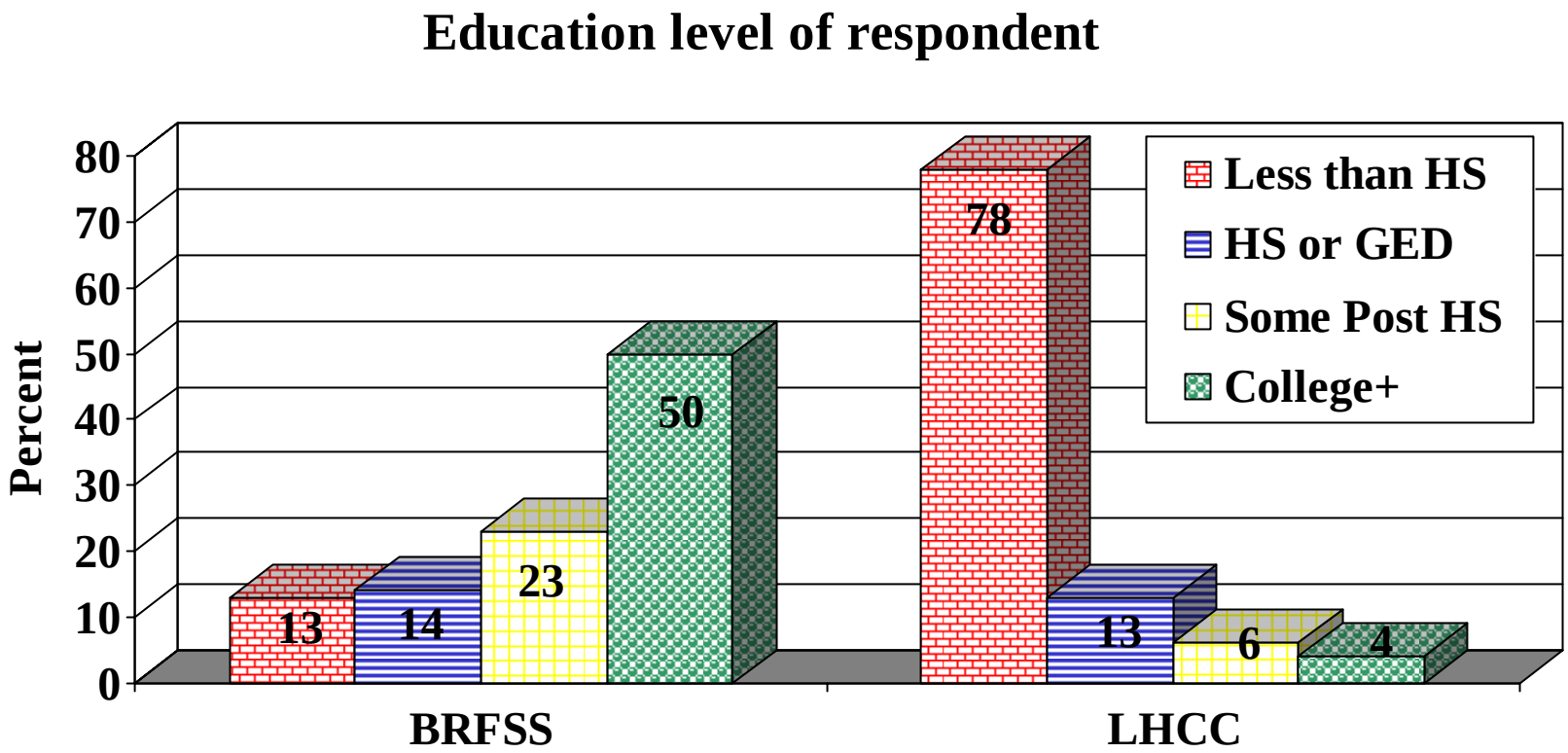
Children Under 18 y/o



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 4

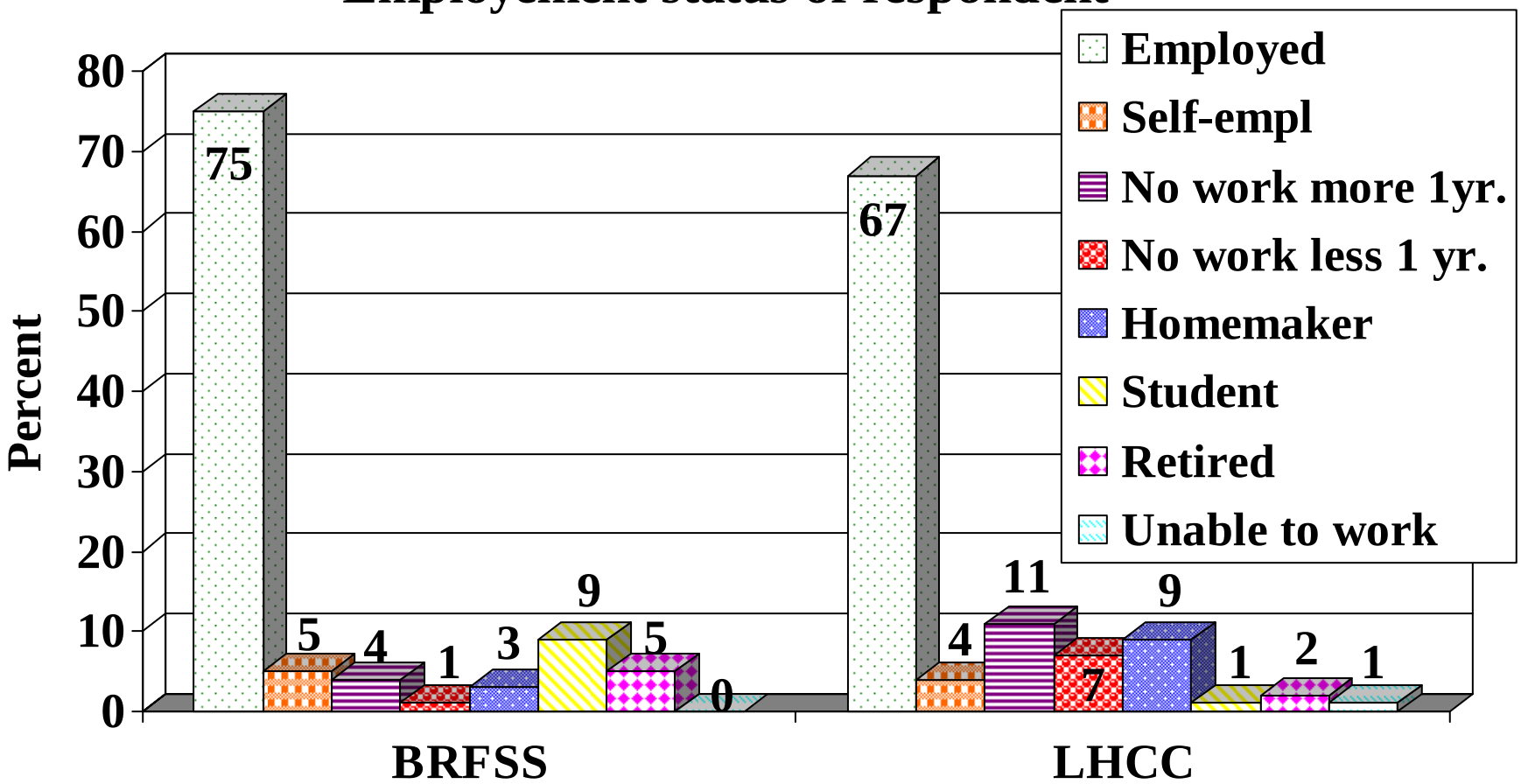
Education



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 5

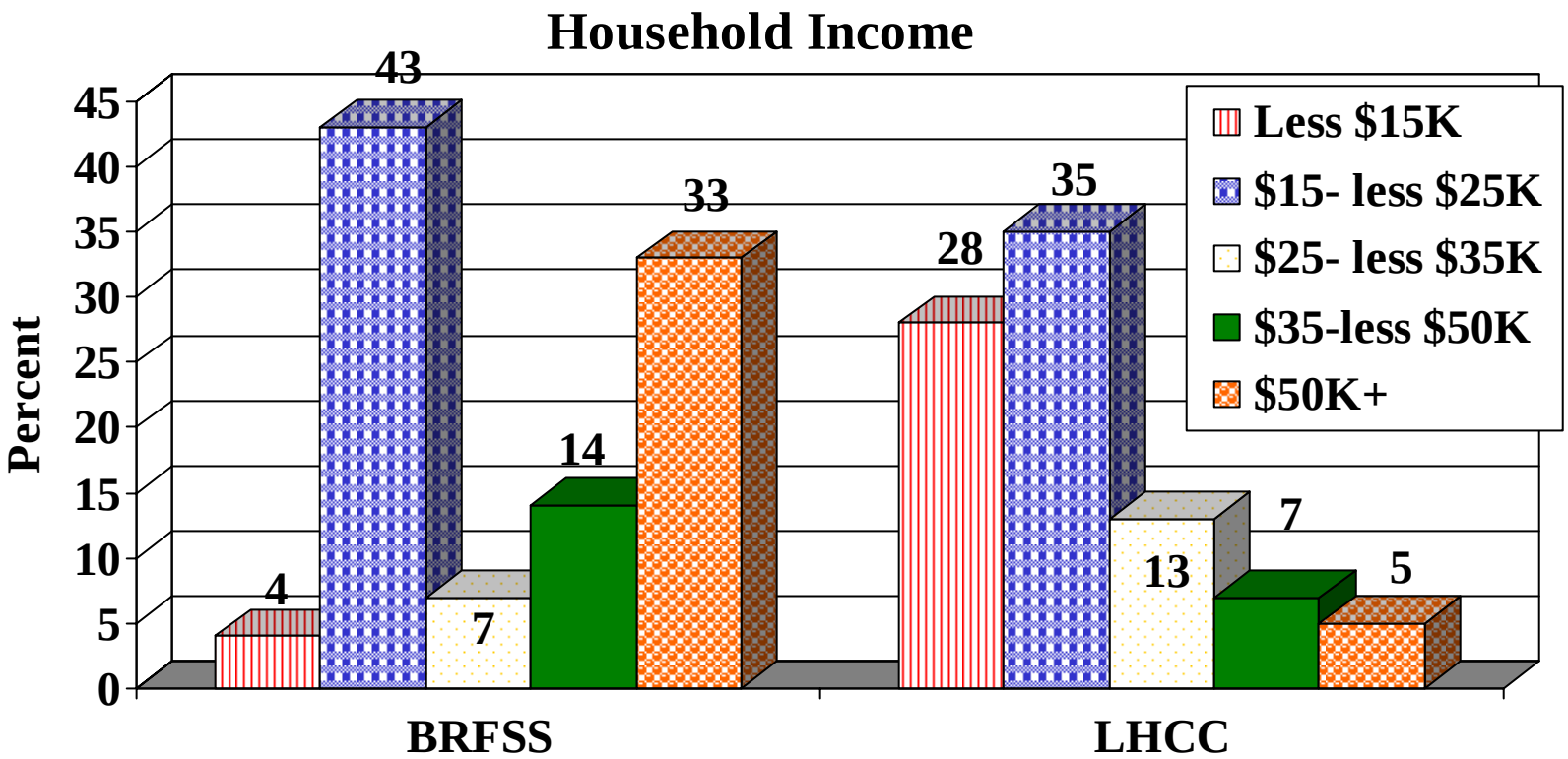
Employment



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 6

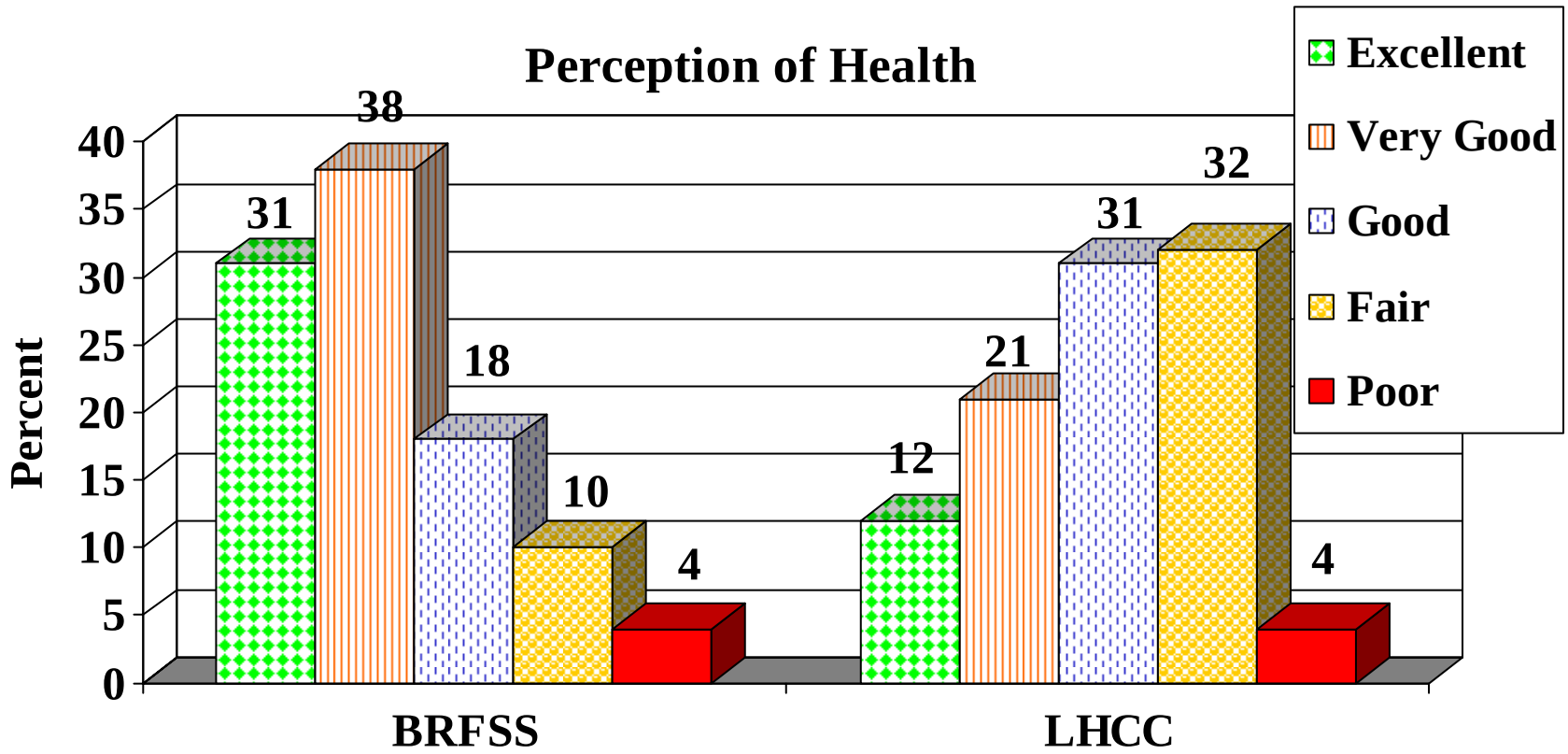
Income



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 7

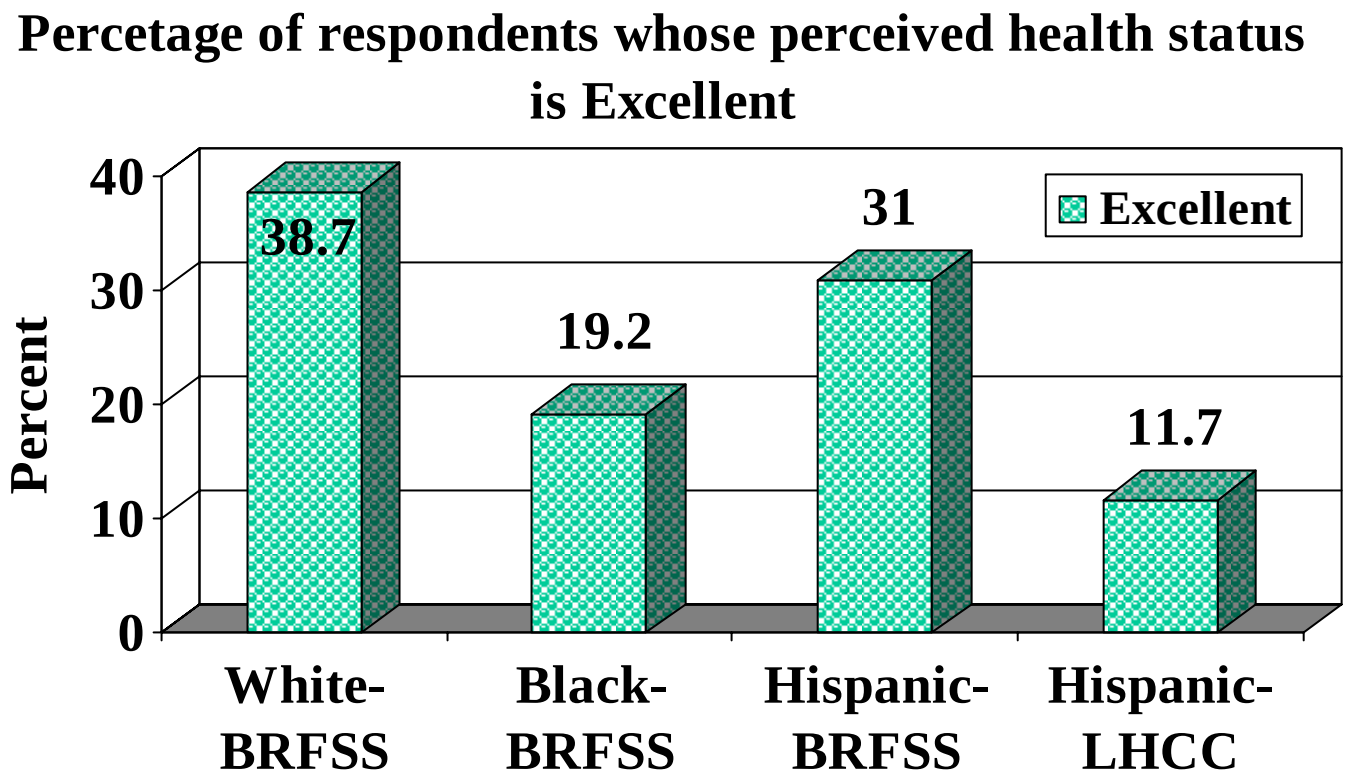
Health Status



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 8

Health Status

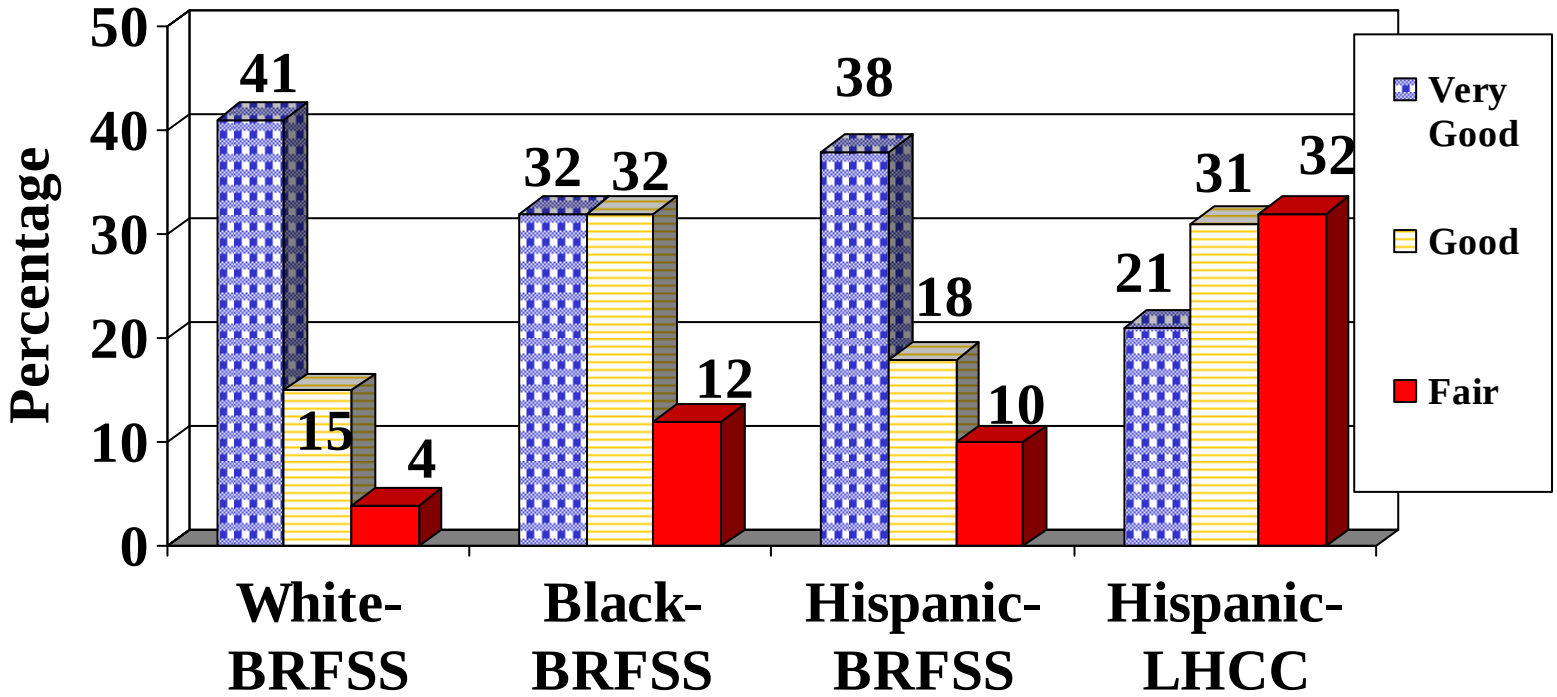


Preliminary Data, TAB presentation,
July 22, 2004.

Chart 9

Health Status

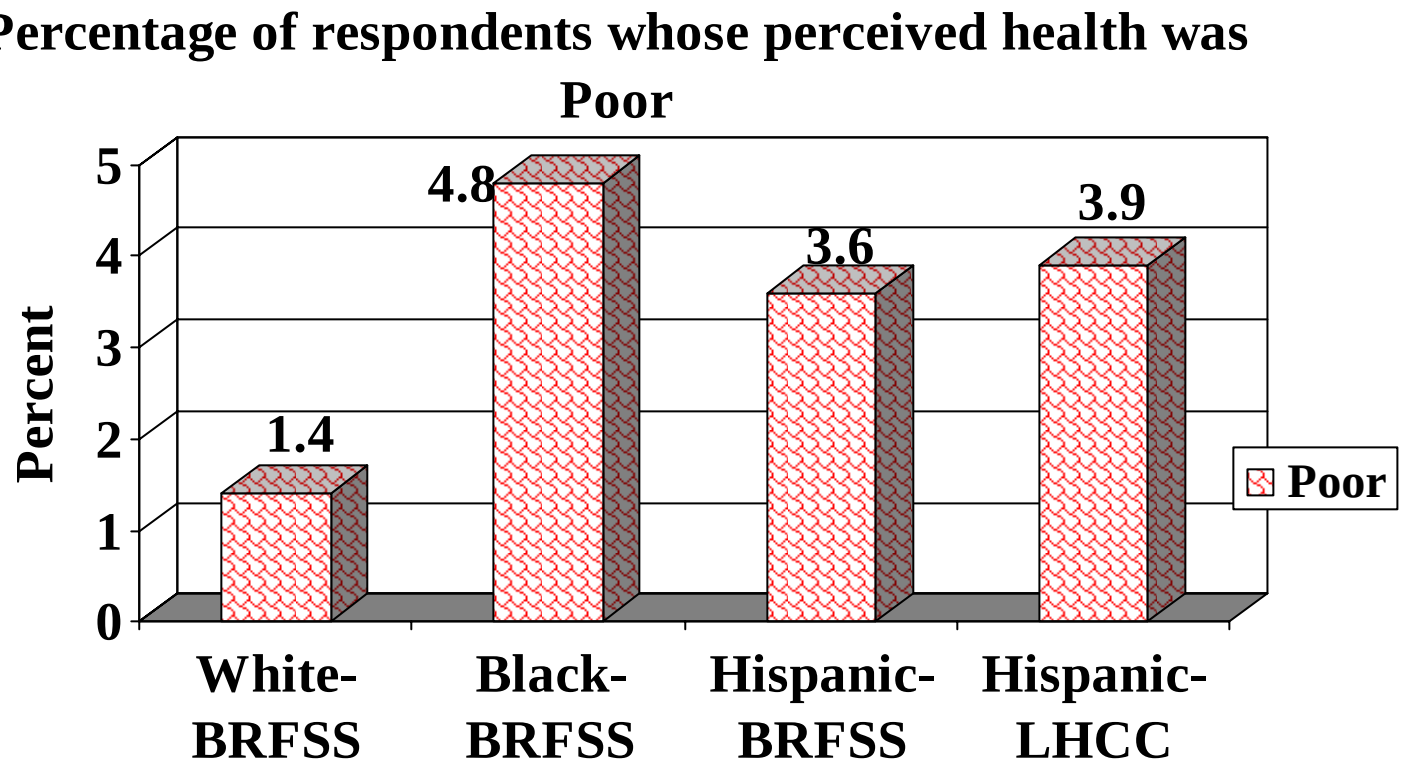
Percentage of repondents whose perceived health was Very Good, Good or Fair



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 10

Health Status

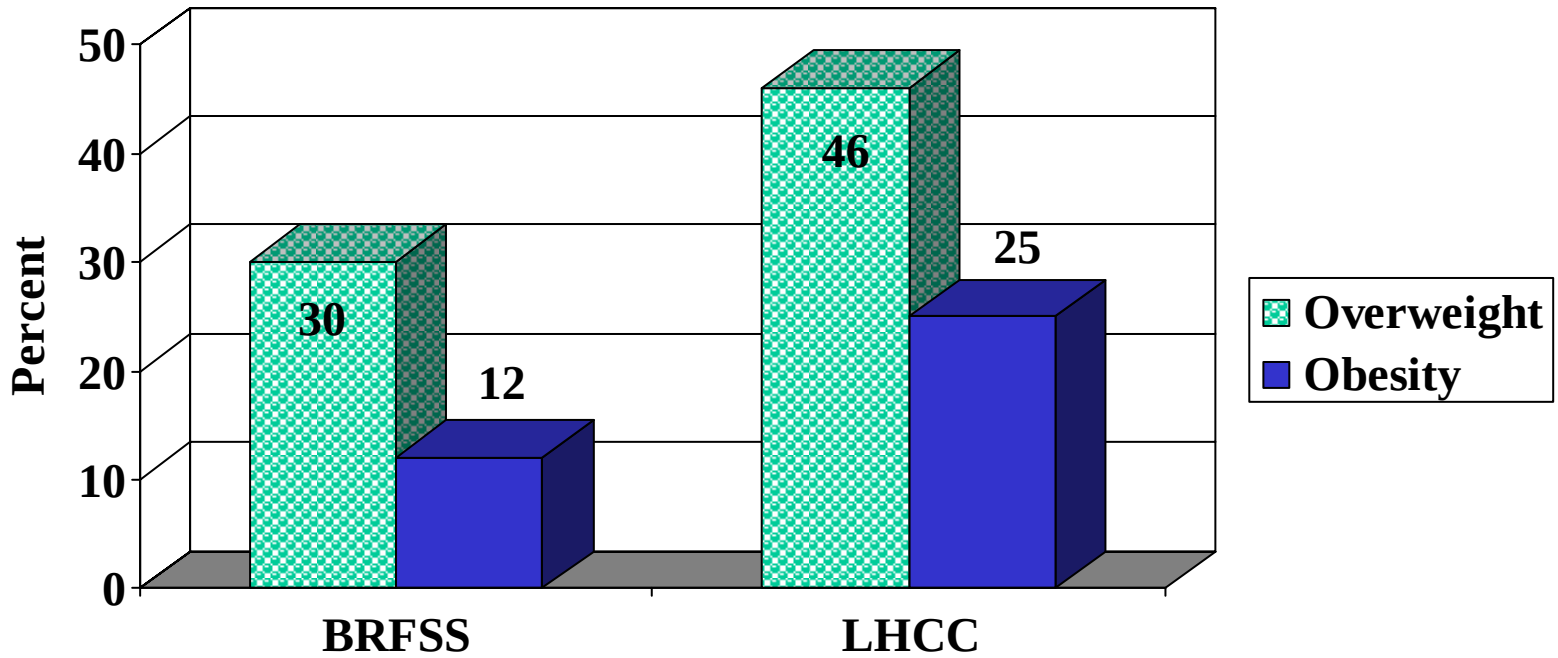


Preliminary Data, TAB presentation,
July 22, 2004.

Chart 11

Overweight and Obesity

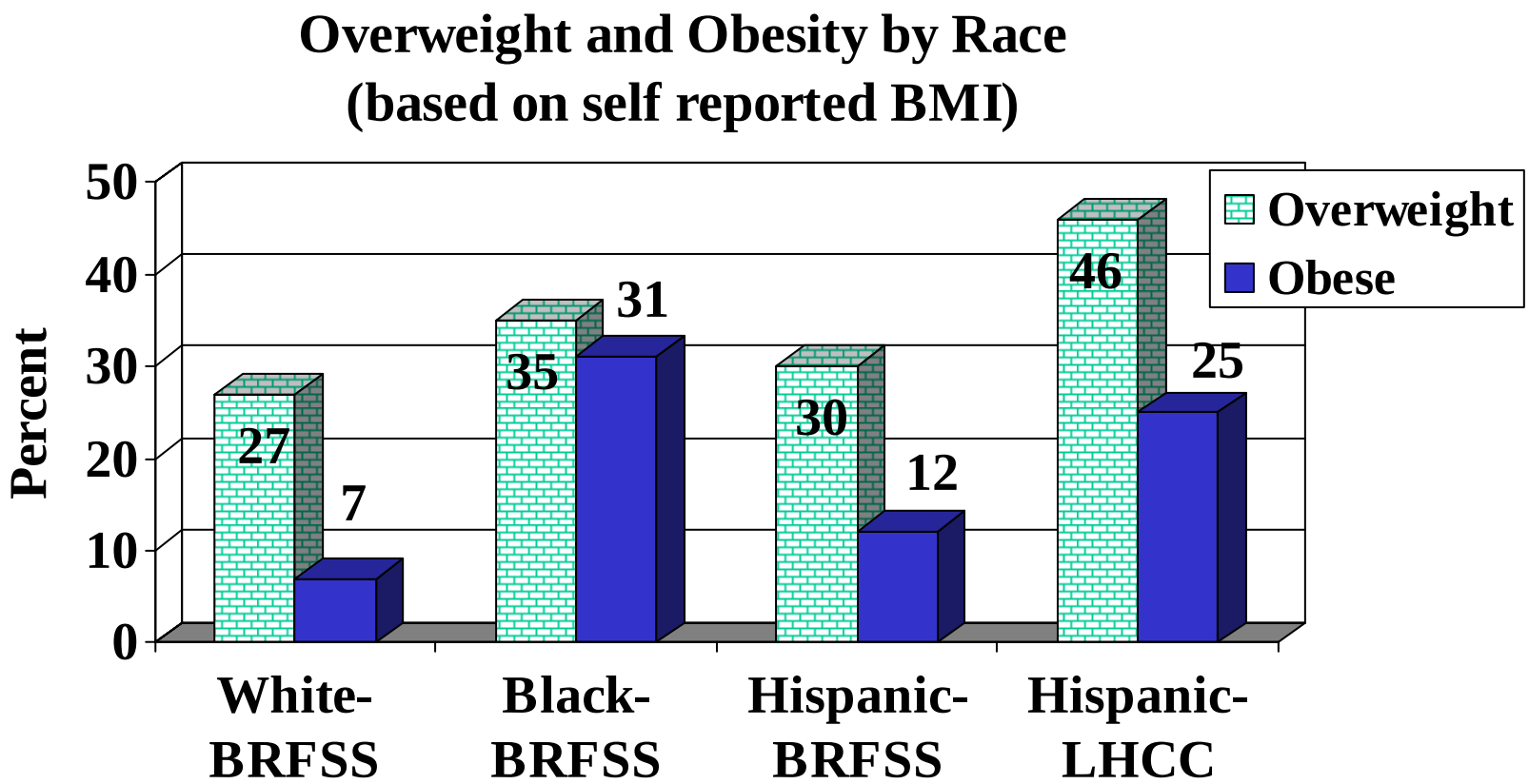
Overweight and Obesity based on BMI
(self reported weight and height)



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 12

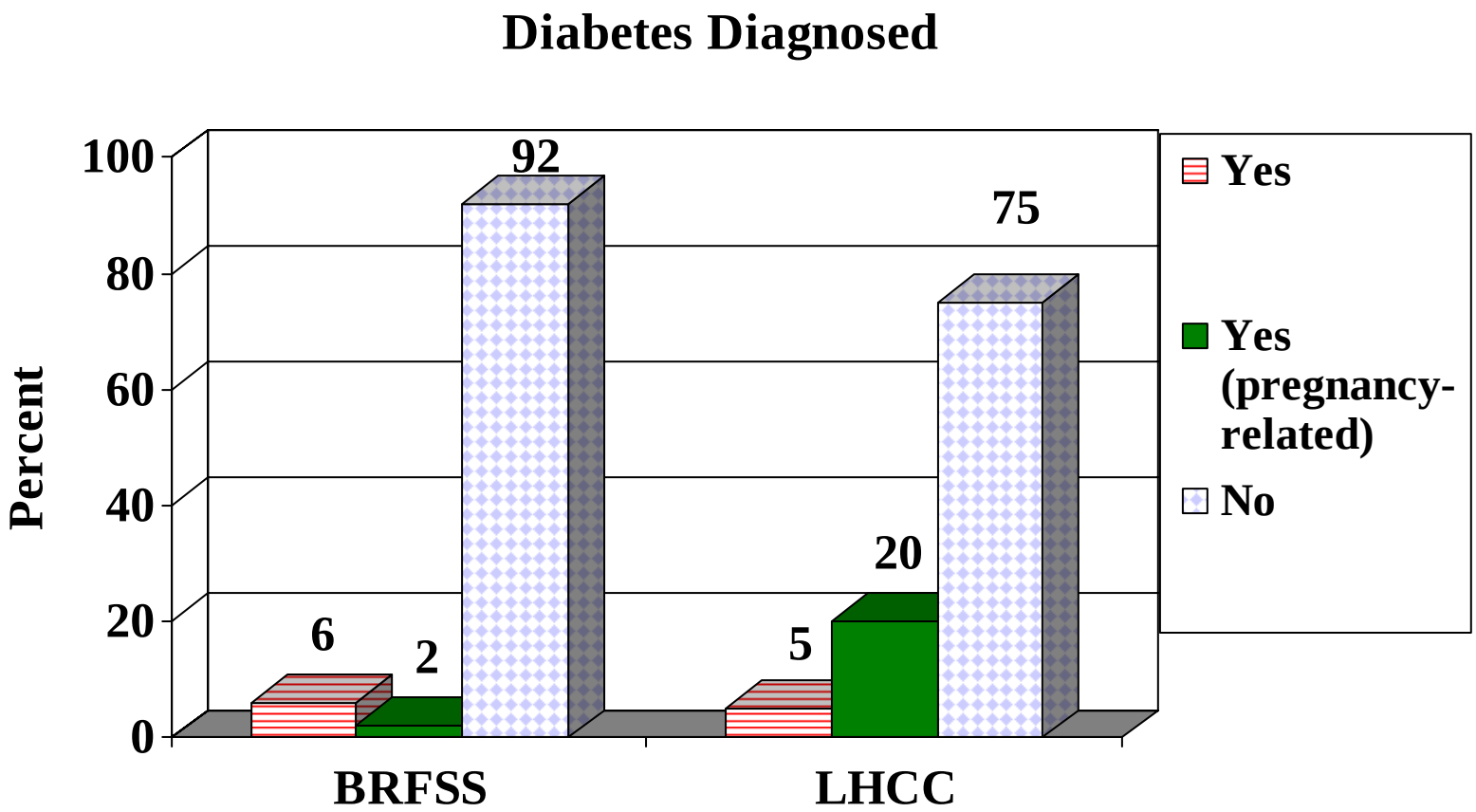
Overweight and Obesity



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 13

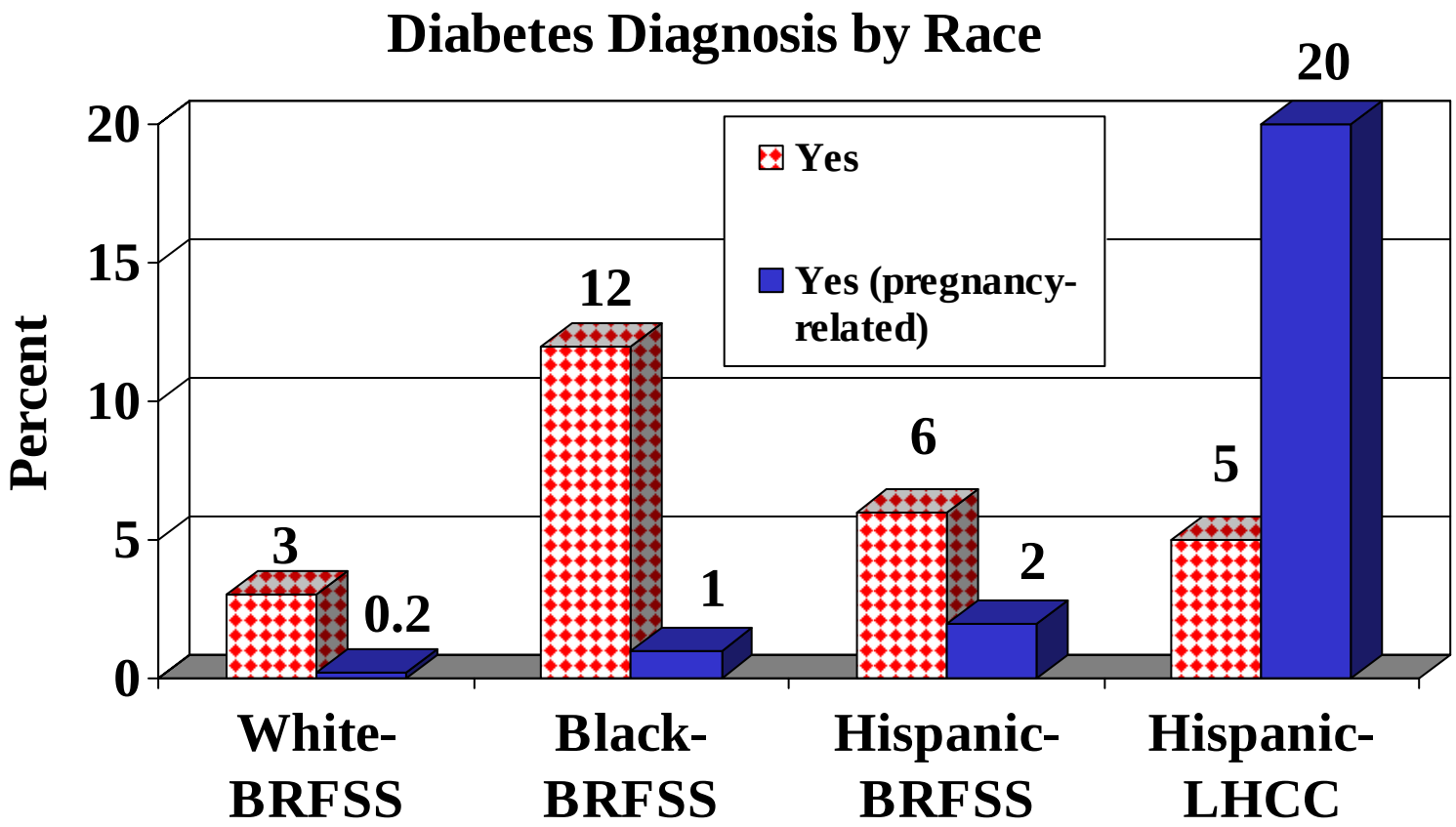
Diabetes



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 14

Diabetes



Preliminary Data, TAB presentation,
July 22, 2004.

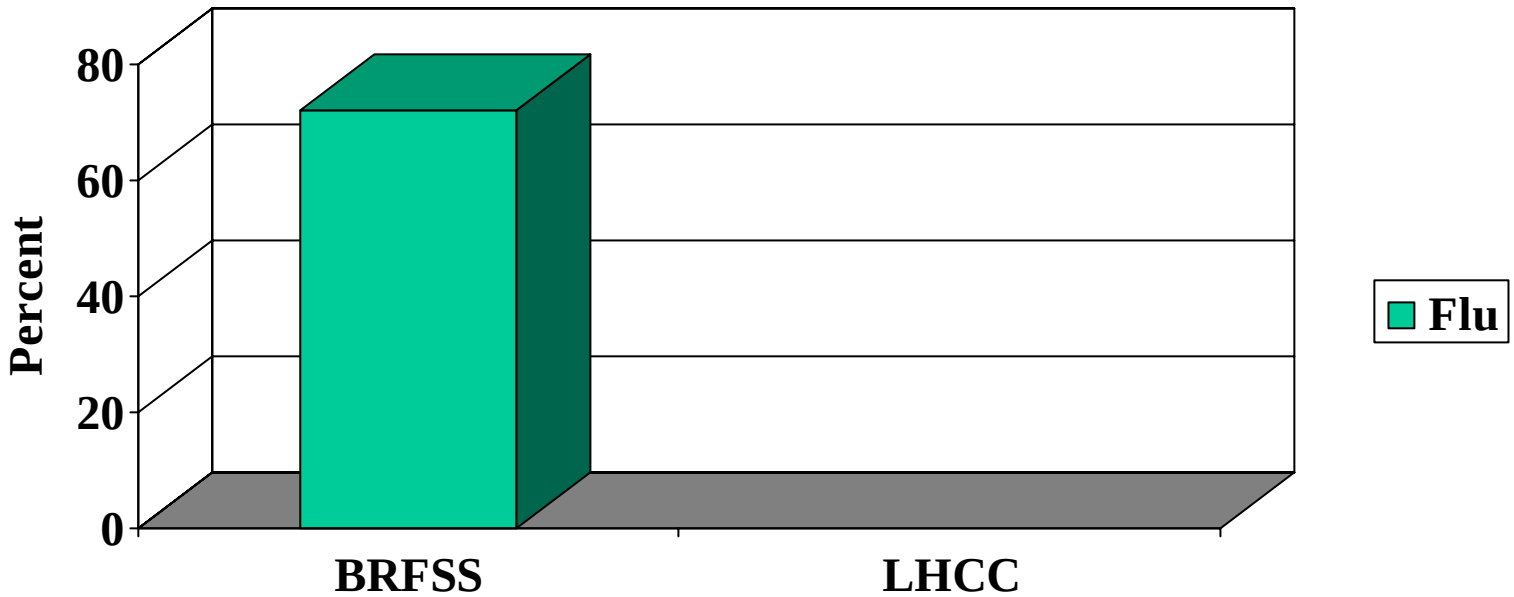
vegal:

Calculate for LHCC 65+. BRFSS question is for 65+

Chart 15

Immunizations

Respondents 65+ years old who had the Flu vaccine in the past year



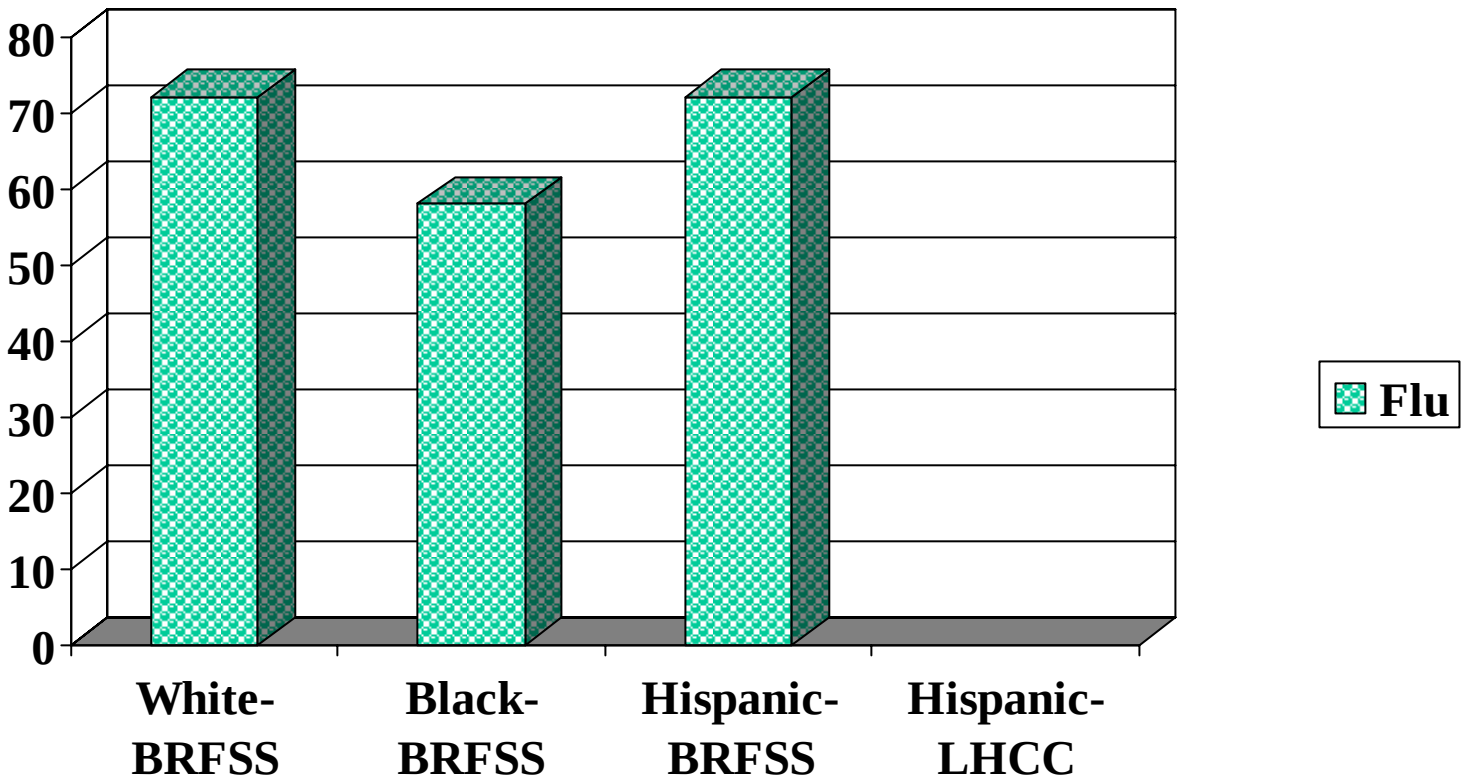
Preliminary Data, TAB presentation,
July 22, 2004.

vegal:

Calculate LHCC for 65+ y/o

Chart 16

Immunizations



Preliminary Data, TAB presentation,
July 22, 2004.

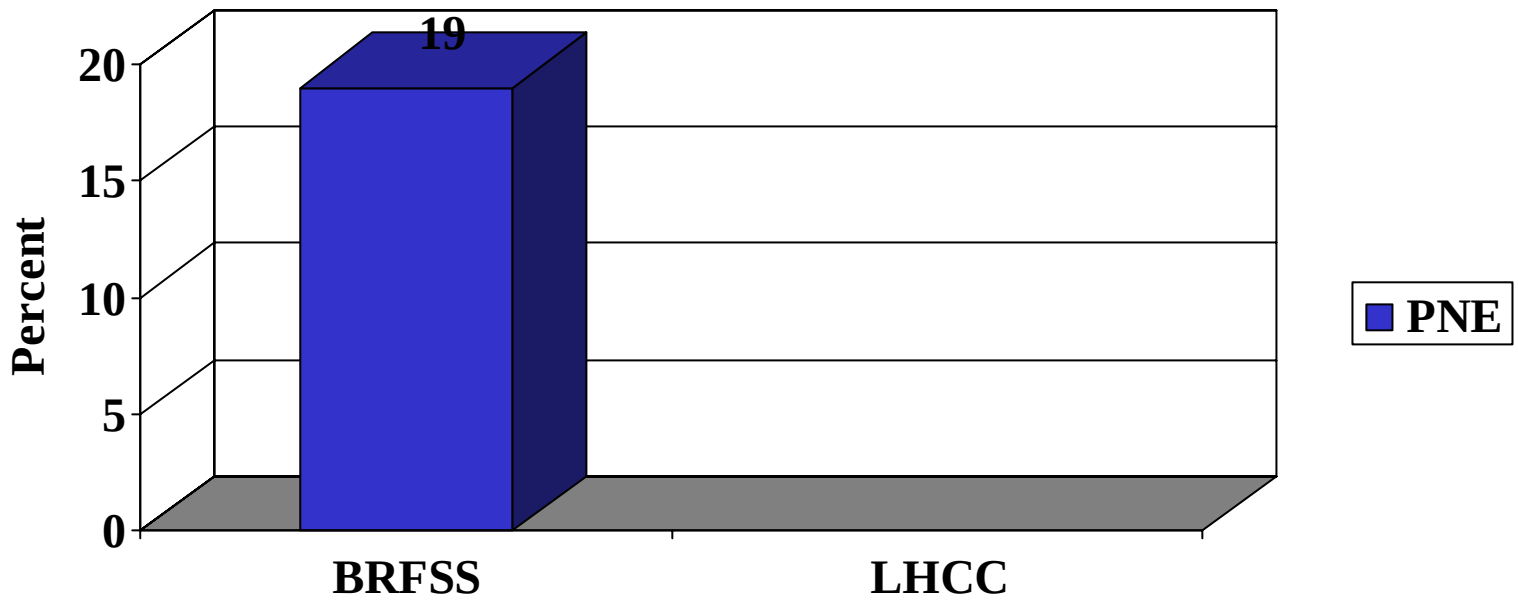
vegal:

Calculate LHCC for 65+ y/o

Chart 17

Immunizations

Respondents 65+ years old who have had the Pneumonia vaccine ever



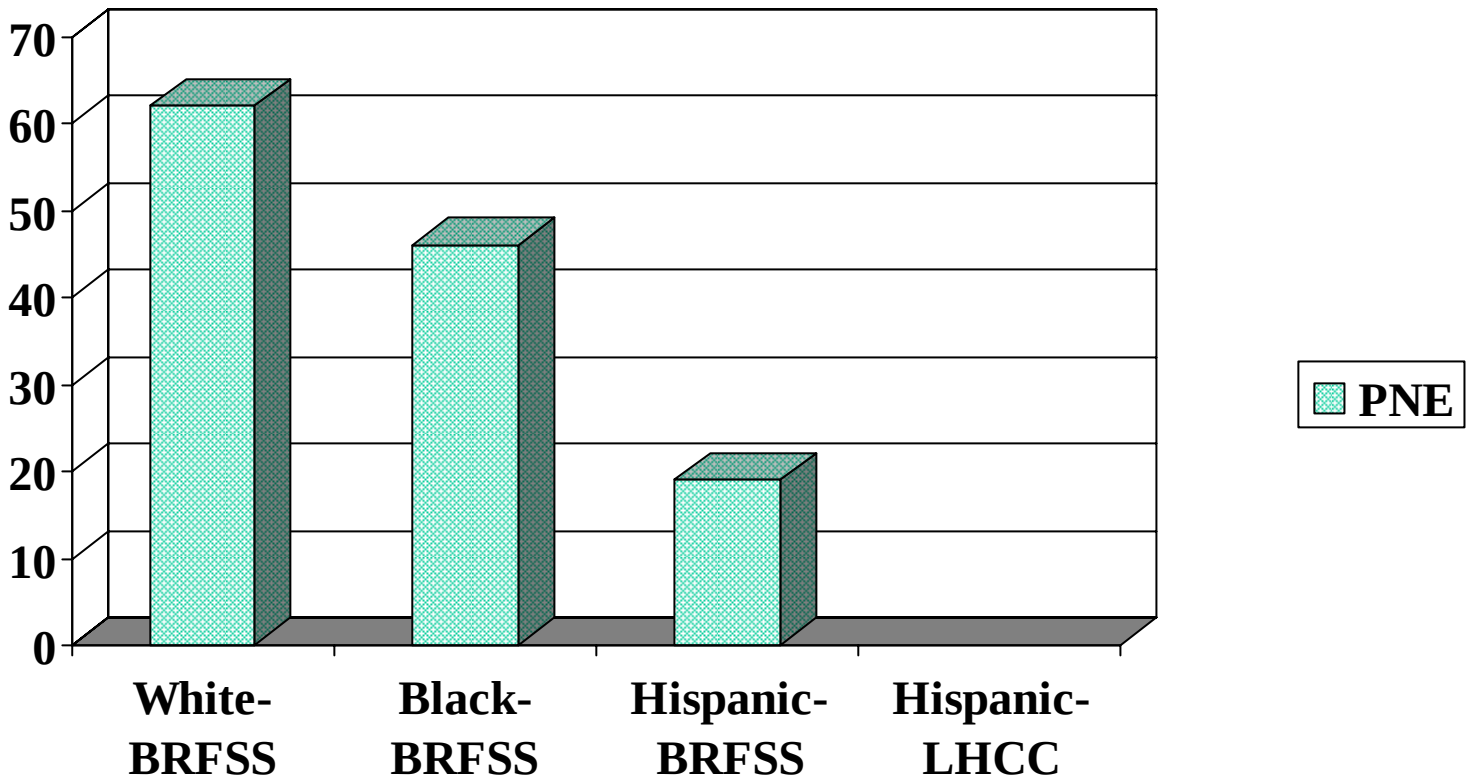
Preliminary Data, TAB presentation,
July 22, 2004.

vegal:

Calculate LHCC for 65+ y/o

Chart 18

Immunizations

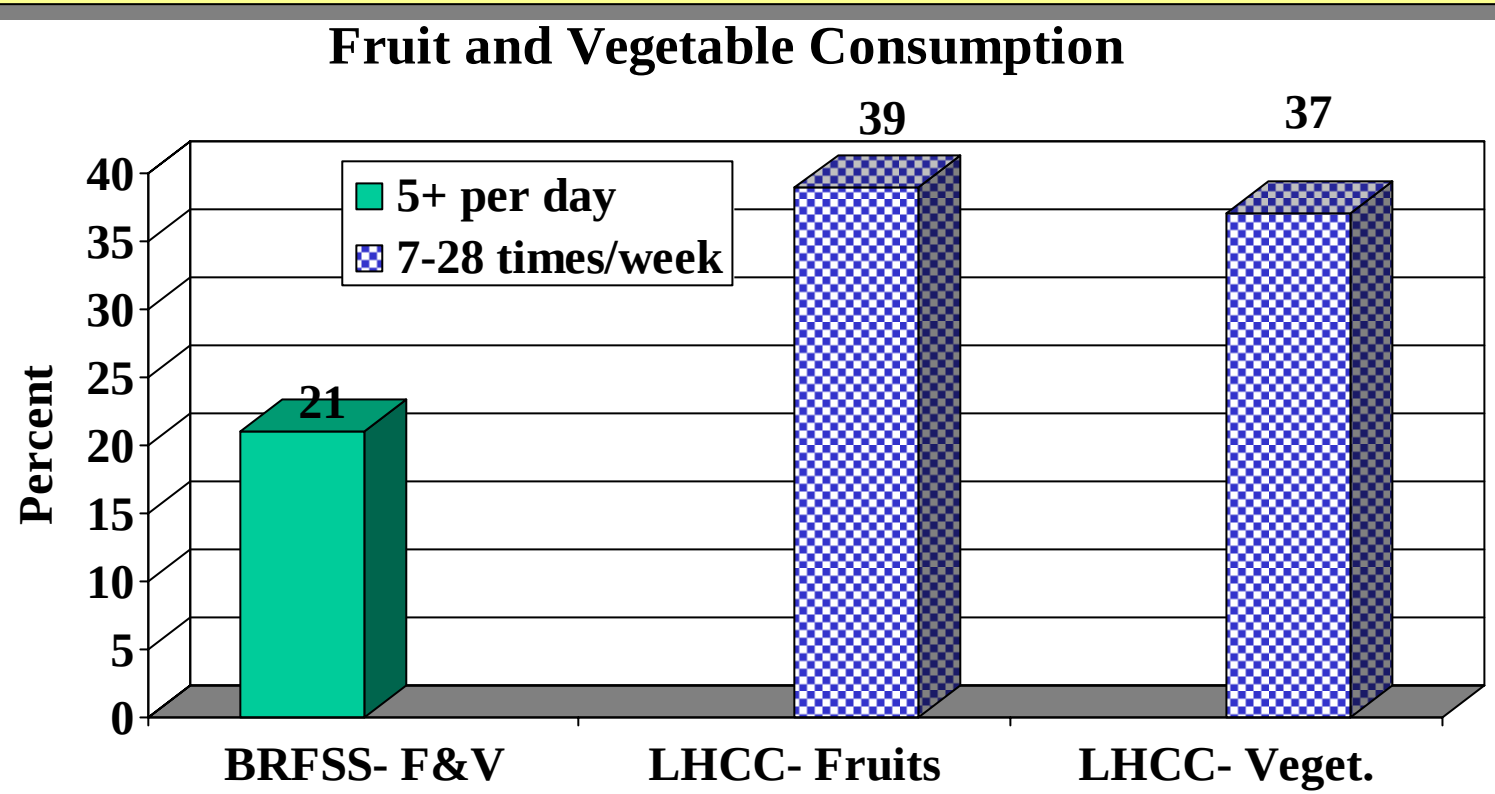


Preliminary Data, TAB presentation,
July 22, 2004.

Chart 19

Fruits and Vegetables

Note: BRFSS data expressed as Fruit and Vegetable consumption per day. LHCC data refers to consumption of Fruit and Vegetable in Times per Week

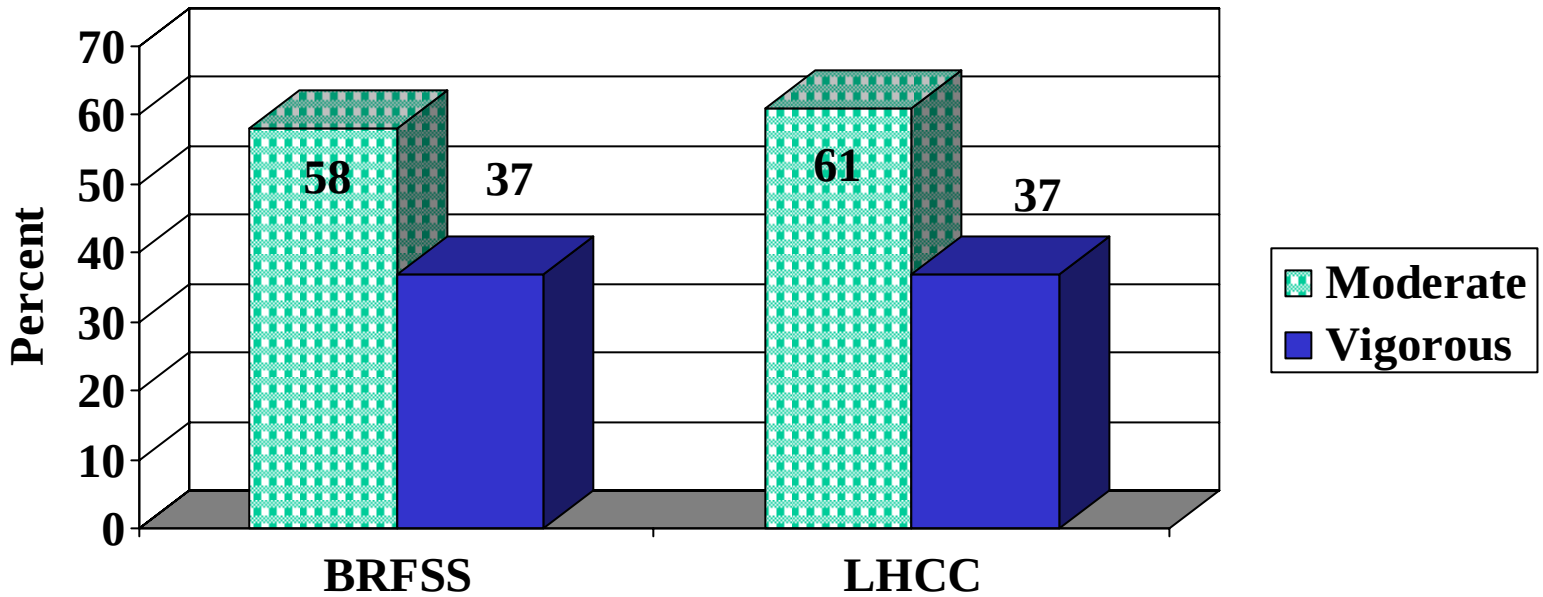


Preliminary Data, TAB presentation,
July 22, 2004.

Chart 20

Physical Activity

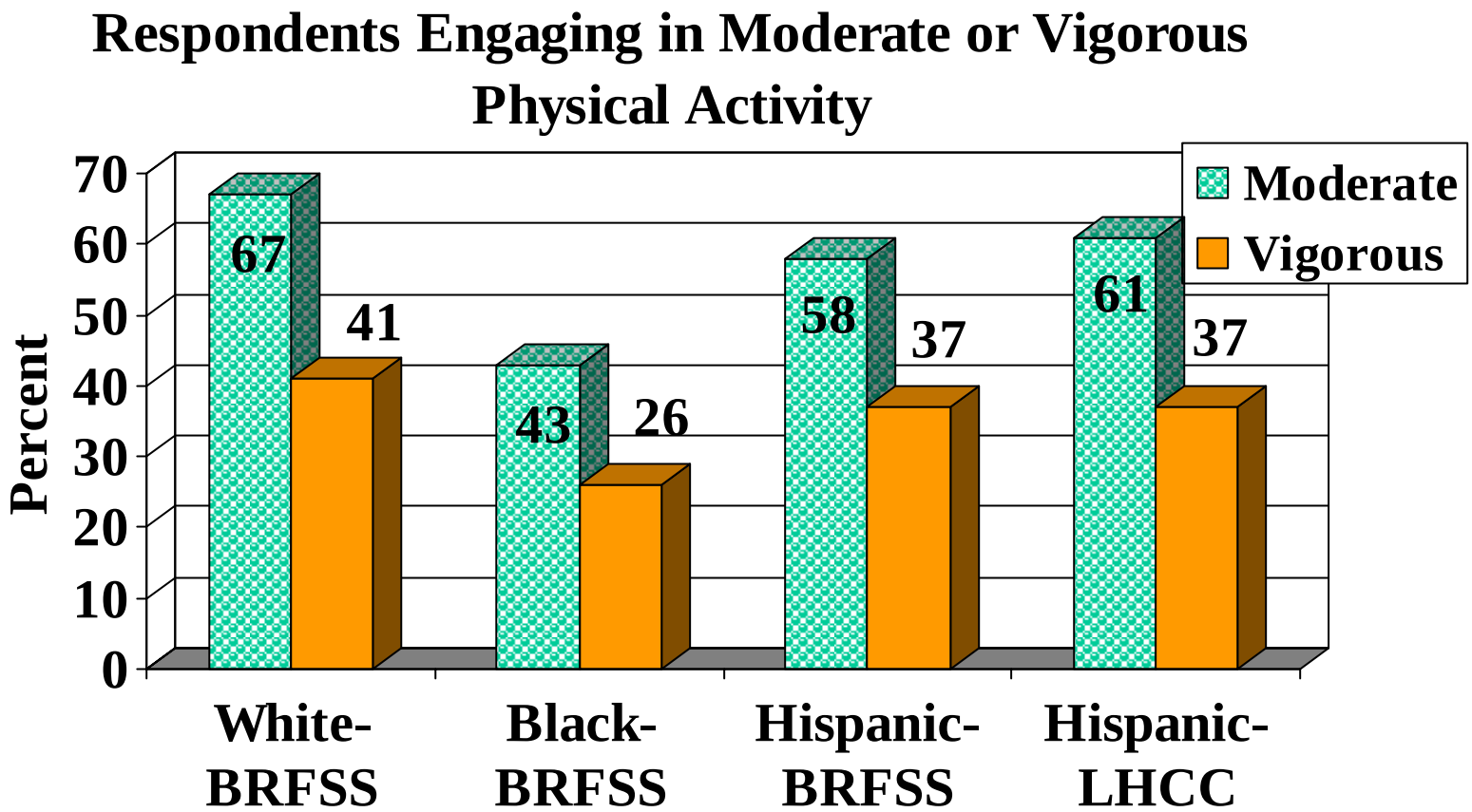
Respondents engaging in Moderate and Vigorous Physical Activity each week



Preliminary Data, TAB presentation,
July 22, 2004.

Chart 21

Physical Activity

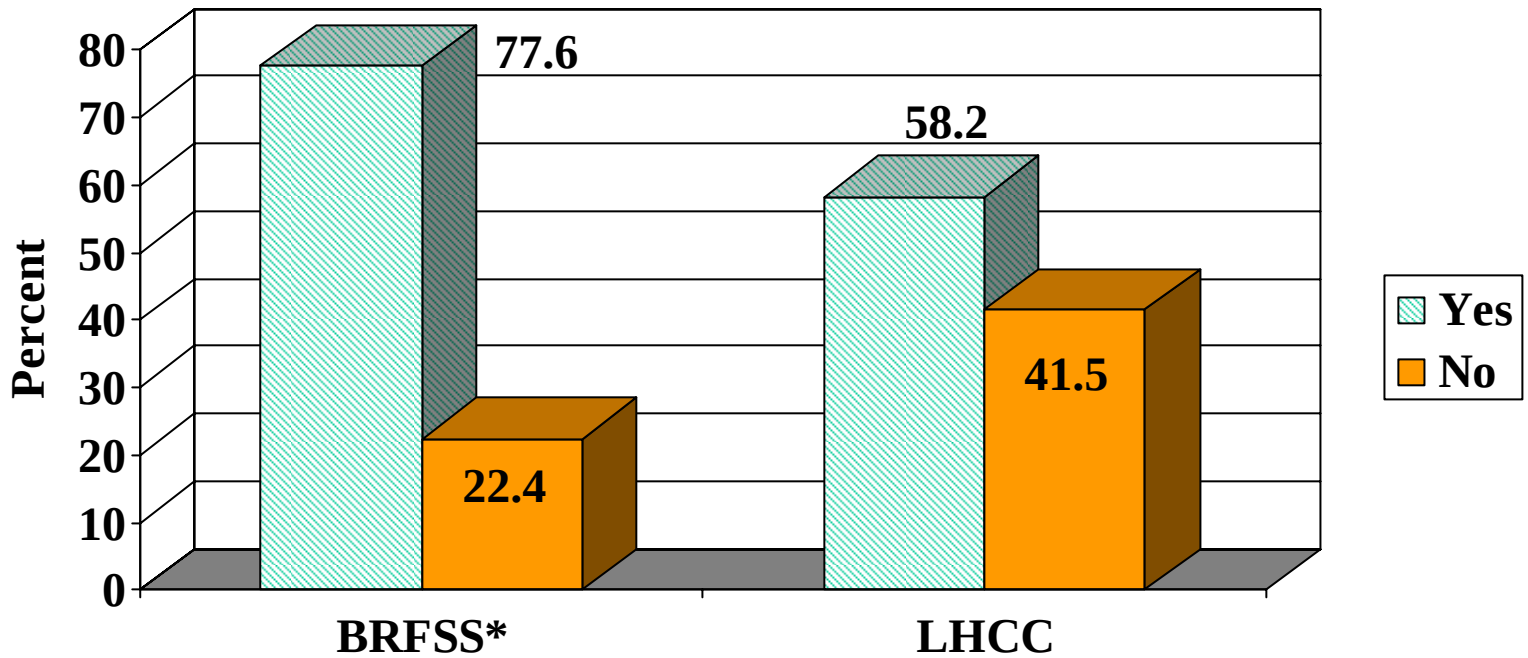


Preliminary Data, TAB presentation,
July 22, 2004.

Chart 22

Access to Care

Respondents having any type of health care coverage



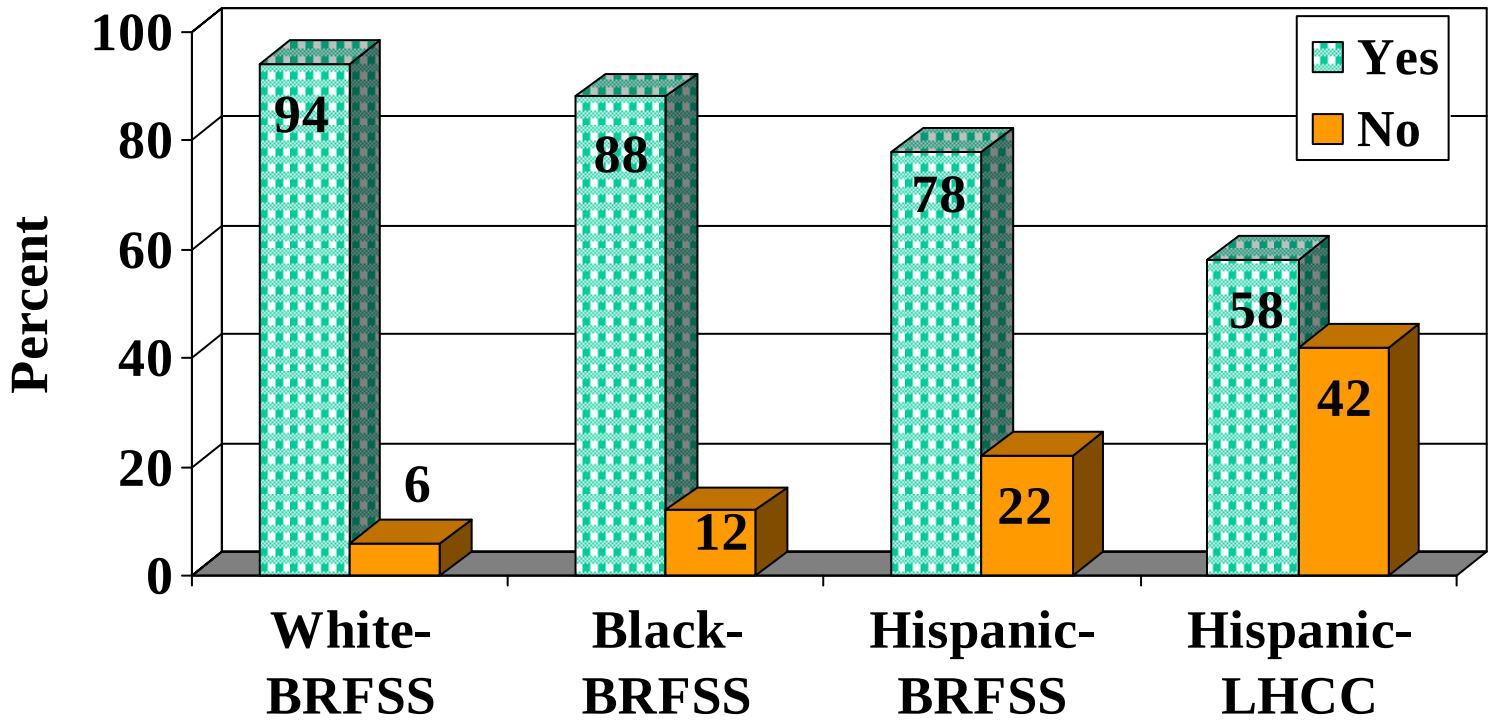
Note: This is 2002 BRFSS data

Preliminary Data, TAB presentation, July 22, 2004.

Chart 23

Access to Care

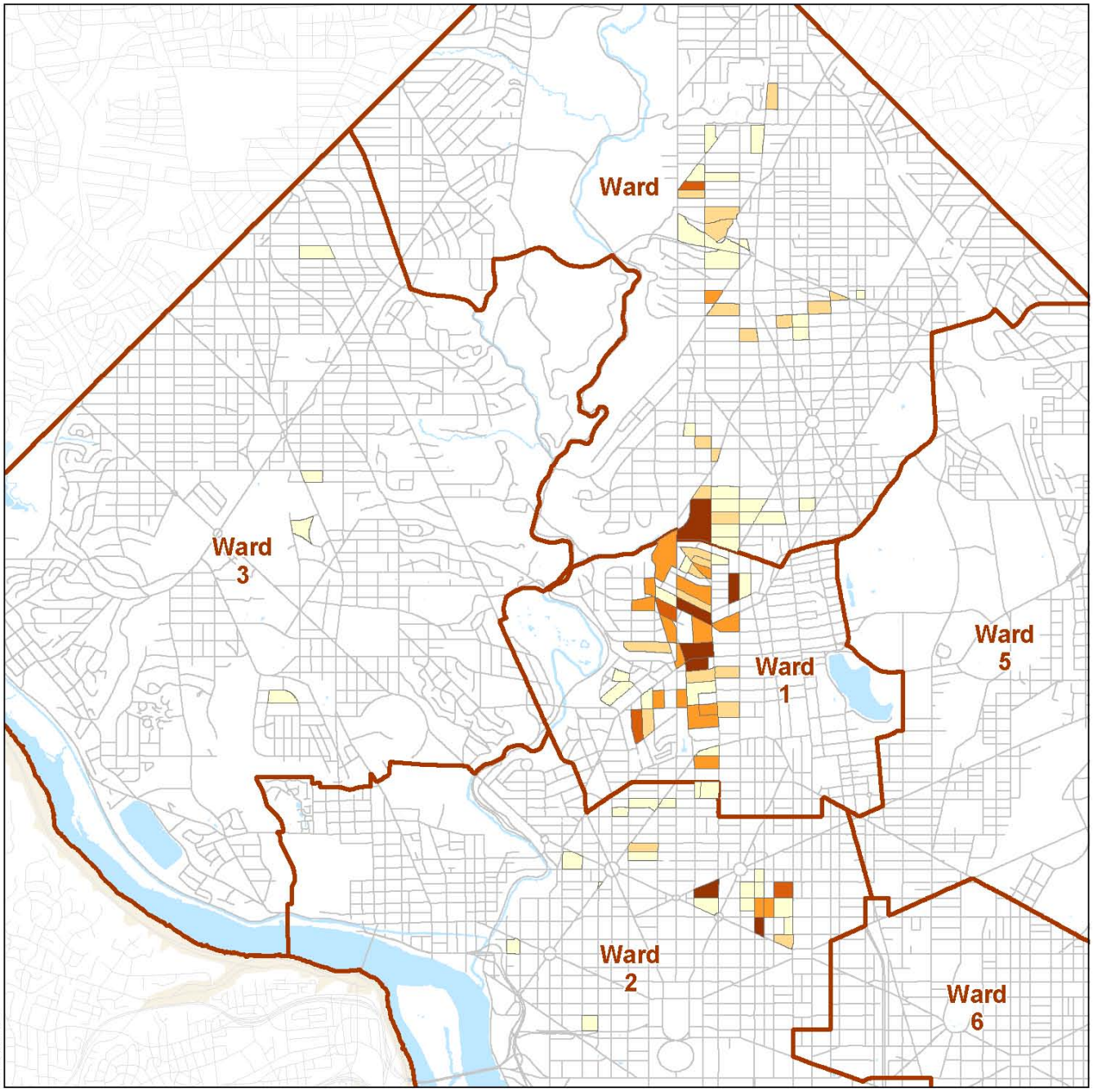
Respondents having any type of health care coverage



Note: This is 2002 BRFSS data

Preliminary Data, TAB presentation, July 22, 2004.

Appendix 8



Number of Latinos Completing Health Assessment by Census Block

Miles

N

0 0.5 1

Government of the District of Columbia
Anthony A. Williams, Mayor

Office of Planning ~ October 12, 2005

This map was created for planning purposes from a variety of sources. It is neither a survey nor a legal document. Information provided by other agencies should be verified with them where appropriate.

Survey Respondents

- 5 or fewer Respondents
- 6 -10 Respondents
- 11 - 15 Respondents
- 16 - 20 Respondents
- More than 20 Respondents