

Barriers to Healthcare Access for Cognitively Impaired Older Hispanics

*Freddy Ortiz and *†L. Jaime Fitten

**Greater Los Angeles Veterans Affairs Healthcare System, Sepulveda Campus, North Hills, California, U.S.A.; and Alzheimer's Disease Research Center and †Department of Psychiatry and Biobehavioral Sciences, UCLA School of Medicine, Los Angeles, California, U.S.A.*

Summary: This study describes the development of the Barriers to Healthcare Access Survey (BHAS) used to evaluate seven barrier factors believed to influence healthcare access for elderly Hispanics with memory or cognitive problems. This study further reports the results of the BHAS applied to a community sample of cognitively impaired older Hispanics and their caregivers. The study includes (1) The BHAS's development and procedures to establish instrument validity and reliability; (2) Interviews with the BHAS on 65 cognitively impaired Hispanics who were undergoing full diagnostic assessment for dementia and their caregivers. The most frequently perceived healthcare barriers reported in our study were related to (1) personal beliefs (38%), (2) language proficiency (33%), and (3) economic status (13%). The BHAS possesses the requisite psychometric properties to be an effective instrument for an initial survey of perceived barriers to access health care for low-education, cognitively impaired, elderly Hispanic patients. The findings suggest that perceptions regarding illness, health consequences of aging, and beliefs about the utility of medicine do, in fact, influence healthcare use by older Hispanic patients with dementia. Language proficiency and economic status remain common barriers among elderly Hispanic subgroups, but when these barriers are experienced by the cognitively impaired, serious healthcare implications ensue, especially delay in early diagnosis and treatment. **Key Words:** Access barrier—Aged—Cognitively impaired—Dementia—Elderly—Healthcare access—Hispanics.

Alzheimer disease (AD) and other age-related dementias produce increased healthcare costs, disability, and lost productivity of both patients and family caregivers (Winblad and Wimo, 1999). In 1997, cross-sectional studies estimating the prevalence of AD in non-Hispanic whites in the United States suggested that there are approximately 2.32 million cases (range: 1.09 to 4.58 million). It is projected that the prevalence will nearly quadruple in the next 50 years, by which time approximately

1 in 45 Americans will be afflicted by the disease (Brookmeyer et al., 1998). However, little is known about the prevalence rate of dementing disorders among elderly Hispanic subgroups. It is well documented that the Hispanic elderly are among the most rapidly growing aging minorities in the United States and are in need of quality health care (Council on Scientific Affairs, 1991; Ginzberg, 1991; Hahn, 1992; Valdez et al., 1993). Several studies (Ginzberg, 1991; Parra and Espino, 1992; Noel, 1994; Gordon, 1995; Preciado and Herny, 1997) indicated poor health and diminished access to health care among cognitively unimpaired Hispanic people. However, the impact of dementing disorders on the elderly Hispanic populations has not been investigated in detail (Hu et al., 1991; Pousada, 1995; Markides and Miranda, 1997).

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Address correspondence and reprint requests to Freddy Ortiz, M.A., Greater Los Angeles Veteran Affairs Healthcare System, Sepulveda Campus, 16111 Plummer Street (116A-9), North Hills, CA 91343, U.S.A.

Clinical research on dementing illness among Hispanic persons requires designs that are culturally sensitive to the unique characteristics of the diverse elderly Hispanic subgroups. Elderly Hispanic persons are a racially and ethnically heterogeneous group with widely differing origins, levels of acculturation to the dominant culture, language proficiency, educational level, economic and psychosocial status, migration history, and cultural traditions and beliefs. For the Hispanic aged, several of these factors may develop into barriers to healthcare access and participation in research (Burnam et al., 1987; Kemp et al., 1987; Roberts, 1988; Collins et al., 1992; Trankina, 1992; Zamanian et al., 1992; Rodger, 1993; Valdez et al., 1993; Brink, 1994; Cooper, 1994; Markides and Miranda, 1997). The shortage of well-trained bilingual-bicultural clinical researchers as well as of normed and standardized language—proficient assessment instruments have negatively influenced diagnosis, management, and service utilization patterns of this population. An example of this is evidenced in the work of Stricks et al. (1998), who found that Spanish-speaking patients have been excluded from many treatment trials because of the lack of Spanish language assessment tools. McCracken et al. (1997) studied prevalence rates of dementia and depression among different ethnic minority groups and found higher levels of dementia among non-English-speaking groups. However, the sensitivity and accuracy of the diagnosed dementias were shown misleadingly high for those who did not speak English. Similar findings were reported by Escobar et al. (1987) when he noted that elderly Hispanic patients were misdiagnosed as demented when they failed to understand questions posed by their physicians. Misdiagnoses were also likely when the patient failed to articulate symptomatic complaints in the manner expected by investigators of the host culture and when patient's level of education was not properly considered (Hough et al., 1987; Mungas et al., 1996; Preciado and Herny, 1997).

Another barrier to healthcare access for the elderly Hispanic is posed by certain healthcare delivery policies and services that do not take into sufficient account cultural variability. The literature on use of healthcare services by nondemented Hispanic persons shows that they are likely to receive too little care and to receive services too late for optimal management (Lopez-Aqueres et al., 1984; Treviño et al., 1991; Gordon, 1995). Russell and Maxwell (1997) studied the perception of Medicaid recipients regarding managed care services in relation to their racial/ethnic status. They found that non-English-speaking Hispanic patients were unable to contact their primary care providers, particularly after usual service

hours, because many 24-hour services did not have bilingual capacity. The nondemented participants in this study stated that they had difficulty understanding written materials mailed to them by their providers and that they did not have a clear understanding of the managed care system and how to access its services.

Given the current fragmented nature of available information, it remains unclear how these various factors interact to influence elderly Hispanic patients with dementing disorders in their efforts to access the multifaceted American healthcare system. Cognitively impaired older Hispanic persons are largely overlooked in the dementia and clinical geriatric research literature. In view of the paucity of measurement instruments, the Barriers to Healthcare Access Survey (BHAS) was developed to explore and describe these barriers. This article presents the results of a study with the BHAS that was used to explore perceived barriers to healthcare access in cognitively impaired older Hispanic patients.

METHODS

BHAS Content and Administration

Overview

The BHAS is a 7-minute assessment questionnaire that provides information on possible barriers that affect the patient's access to health care, treatment compliance, and continuity of care (see Appendix). The BHAS is based on a structured interview with a caregiver familiar with the patient. The caregiver must have been in at least daily contact with the patient over a prolonged period and be capable of making reasonably good observations of the patient.

Content

The BHAS evaluates seven barrier categories believed to influence healthcare access for the elderly Hispanic patients with memory or cognitive problems. These categories are groups of statements that describe the different barriers. These barrier categories are (see Appendix):

1. Economic barriers (B) refer to limited or no financial resources and no health insurance.
2. Family support barriers (C) refer to limited or no emotional or physical support from blood relatives or social support systems.
3. Geographic barriers (D) were defined as accessibility barriers, distance from clinic, or the need to travel through unsafe areas. Cultural barriers involved two subtypes: language and immigration barriers.
4. Language barriers (E2) refer to limited or no English proficiency or isolation caused by language barriers.

5. Immigration barriers (E) refer to limited or no qualifications for medical assistance because of illegal status or fear of deportation.
6. Personal belief barriers (F) refer to perception of illness, health needs, attitudes, and values or beliefs about medicine, healthcare workers, treatment, or consequences of aging.
7. Transportation and time barriers (G) refer to the need for or fear of transportation, need of assistance, and time constraints on going to doctors. Statements marked with the different capital letters indicate the barrier category that they represent.

Administration

Caregivers are asked to describe the first symptom or symptoms of the disease, to estimate the date of onset, and to characterize the manifestation of the symptom (e.g., sudden or gradual). Then, they are asked what reasons may have delayed or were barriers to accessing healthcare services since the onset of the first symptom. Barriers that match the survey list are marked off. Barriers not on the list are written down. Then, the entire list of barriers is read to the caregiver, and barriers not identified before are marked. Caregivers were chosen as the source of information for the survey because cognitively impaired patients often are not a reliable source of information.

Scoring

Barrier subscale score is calculated by adding the marked barriers according to their respective category, and a total score is calculated by adding all marked items.

BHAS Psychometric Properties

Validity

Concurrent validity. An extensive search of the literature could not find a "gold standard" instrument designed to explore healthcare barriers in low-education, cognitively impaired Hispanic patients. Therefore, topics and survey items were developed after a comprehensive review of the literature pertaining to elderly Hispanic and healthcare access barriers (Lopez-Aqueres et al., 1984; Hough et al., 1987; Ailinger, 1989; Council on Scientific Affairs, 1991; Ginzberg, 1991; Hu et al., 1991; Marín and Marín, 1991; Treviño et al., 1991; Angel and Angel, 1992; Collins et al., 1992; Hahn, 1992; Krause and Goldenhar, 1992; Parra and Espino, 1992; Trankina, 1992; Zamanian et al., 1992; Rodger, 1993; Valdez et al., 1993; Cooper, 1994; Tran, 1994; Frey, 1995; Gordon 1995; Gwyther, 1995; Pousada, 1995; Cummings, 1996; Yeo et

al., 1996; Markides and Miranda, 1997; Preciado and Herny, 1997; Russell and Maxwell, 1997; Tran and Dhooper, 1997; Tran, Dhooper, and McInnis-Dittrich, 1997). Professionals from mental health clinics and local senior centers and social workers later evaluated these items.

Content validity. Experts' judgment from Los Angeles Chapter of the Alzheimer Association, the UCLA Alzheimer Disease Research Center, and the Veteran Administration Geriatric Centers in Los Angeles were consulted on the items selected by professionals. Selection of the survey items was made by consensus between professional and experts' recommendations. This supported content validity.

Face validity. A focus group of ten healthy, aged, community-dwelling, cognitively assessed, nondemented Hispanic people were recruited from different senior centers and churches in the San Fernando Valley to discuss barriers to healthcare access. Two group meetings, each lasting 1½ hours, were conducted in Spanish by a bilingual, bicultural facilitator. Participants were screened for information regarding demographics, social, family, medical, and medications history. Table 1 compares demographic characteristics of the focus group and study sample. Participants had no relatives afflicted with a cognitive disease. The focus group specifically discussed issues about healthcare access by using a hypothetical patient scenario. A comparison of healthcare access barriers generated from the consensus by the professional group and, independently, by the community elderly Hispanic group were similar, with the exception of three barriers described by the professional group, which included discrimination and religious beliefs. Because the community group did not include these, they were dropped from the final survey. Table 2 shows the barrier categories identified by the consensus of professionals and the community elderly Hispanic focus group. This approach provided additional support for the instrument's face validity. The overall close consensus on barriers between professional and lay group supports the high content validity of the instrument.

Construct validity. Ten subjects' caregivers and seven individuals, with family members with no cognitive or memory complaints, and whom experts determined did not exhibit any of the characteristics associated with the construct, participated in the construct validity study. Participants were asked to identify barriers to healthcare access associated with their relatives' current medical condition. A Pearson chi-square statistical analysis found significant difference between the two groups' total responses scores ($df = 14, p \leq 0.0001$), indicating support for the instrument's construct validity.

TABLE 1. Comparison of demographic characteristics

Characteristics	Focus group (N = 10)			Study sample (N = 65)		
	Mean	SD	N (%)	Mean	SD	N (%)
Age	66	5	—	68	9	—
Gender						
Male			4 (40)			27 (41)
Female			6 (60)			38 (59)
Education (y)	8	3	—	7	5	—
English proficiency						
None/Very limited			6 (60)			54 (83)
Good English			3 (30)			6 (9)
Completely fluent			1 (10)			5 (8)
Marital status						
Married			6 (60)			33 (51)
Unmarried			4 (40)			32 (49)
Annual income below \$15,000			7 (70)			54 (83)
Health insurance status						
Insured or ATP			5 (50)			37 (57)
Uninsured			5 (50)			28 (43)

ATP, able to pay.

Reliability

Test–retest reliability. Test–retest reliability was determined by conducting a second BHAS interview over the telephone within 3 weeks of the first visit. Twenty

caregivers participated in the test–retest reliability assessment of the BHAS. Test–retest total scores were significantly correlated. The overall correlation was 0.97 at the $p \leq 0.01$ level (two-tailed).

TABLE 2. Comparison of barriers identified by the professional consensus group and elderly Hispanic focus group

Category	Professional consensus group	Hispanic focus group
Economic	I cannot afford it. I have no health insurance.	I cannot pay for the services. I have no health insurance.
Family support	My family thinks my problems are due to old age. My family thinks I am getting crazy. My family is opposed to treatment because they think I do not need it.	My family did not want me to go to the doctor. I did not go because my family thinks that I am getting crazy. My family did not think I needed medical attention because they thought my symptoms were part of old age.
Geographic	The clinic was too far.	I was afraid of getting lost. I did not know how to get there.
Transportation/Time	I did not know where to go. I have no transportation. I do not like to be out too late.	I did not know where to go. I had no car or no one to take me to the doctor. Appointments were too late.
Language	I do not speak English.	I do not speak English.
Immigration	I am afraid immigration will get me.	I was afraid of being deported or losing my green card. I prefer to get help at the other side of the border.
Personal beliefs	I do not need help.	I think I can manage without medical attention. I was afraid the doctor would think that I was crazy. I was afraid doctors would find something worse. I believed there was nothing doctors could do for me because I was too old.
	I am too old to get any help. Memory problems are normal in old age.	I thought this was normal—part of old age. I was treating myself with herbs, tea, etc.—“natural stuff.”
	No medicine can help me; only God can help me. I was afraid of being discriminated against. I was afraid of what the medication would do to me. I do not think I am sick.	I was afraid of what doctors would do to me. I forget things, but I did not think it was a problem. I believe there is nothing wrong with me.

Application of the BHAS

After survey development, 65 subjects with memory or cognitive problems and their respective caregivers or informants were recruited at the Olive View Neuropsychiatry/Hispanic Research Memory Clinic for this study. The Olive View/UCLA Medical Center in Sylmar, California, is a county inpatient and outpatient hospital and clinic and is one of three principal clinical sites for the UCLA Alzheimer's Disease Center. The main site is located in Westwood, and the third clinical site is at Martin Luther King–Drew Medical Center in Los Angeles. The Olive View Medical Center serves primarily the East San Fernando Valley, which has an estimated population of nearly one million, with a demographic composition of 38% Hispanic, 30% white non-Hispanic, 4% African American, and 28% others (U.S. Census Bureau, 1990). With some communities reaching a population over 89% Hispanic, this area has one of the highest concentrations of Hispanic persons in Los Angeles County. Elderly Hispanic persons here are mostly of Mexican descent (60%). Overall, the Northeast San Fernando Valley is comparable demographically and socioeconomically to other high Hispanic density communities in Los Angeles County such as Monterey Park, Alhambra, Montebello, El Mone, and Whittier (Table 3).

Cognitively impaired subjects were recruited from the community by a fully bilingual, bicultural staff, through presentations at local churches, senior centers, and social service agencies such as a Meals on Wheels program, daycare workers, and so forth. Other outreach strategies included a bilingual, Spanish-speaking, 24-hour answering service, with on-call staff, community flyer distributions, as well as presentations to primary healthcare professionals and the use of articles published in local newspapers. Recruitment included two-way transportation services, arranged by staff for door-to-door pick-up and reimbursed costs for other transportation. The sample used, although not randomly selected, was considered appropriate for this descriptive study, because prediction was not a goal of this study.

Informed consent in Spanish was obtained from patients and their significant others. All consenting subjects were required to have a designated caregiver or informant who had at least near-daily contact with the patient. Subjects with cognitive and memory complaints received a full mental status evaluation, which included the Spanish version of the Mini-Mental State Examination adjusted for age and education (MMSAdj) collection of demographic, social, family, medical, and medication information. The MMSAdj Spanish version (0–30 points) was used as the screening test for cognitive and memory

TABLE 3. Demographic characteristics in two highly Latino-populated areas in Los Angeles*

Demographic characteristics	Eastern Los Angeles area	Northeastern San Fernando Valley
Ethnic composition	<i>N</i> = 429,620	<i>N</i> = 509,403
Hispanic (%)	39	38
White (%)	37	30
Other (%)	23	28
African American (%)	1	4
Educational attainment		
below 9th grade	<i>N</i> = 39,735†	<i>N</i> = 52,347†
Hispanic (%)	58	70
White (%)	41	28
African American (%)	0.3	2
People 65 and older		
Hispanic (%)	5	3
White (%)	14	12
African American (%)	2	6
People 65 and older below poverty level (poverty threshold in 1997: \$7,698)		
Hispanic (%)	8	15
White (%)	6	7
African American (%)	0.3	20
Level of English proficiency in Hispanic persons 65 and older	<i>N</i> = 8,950	<i>N</i> = 5,187
None (%)	24	39
Good (%)	18	20
Very good (%)	48	35

*U.S. Census Bureau, 1990, estimates 1999 San Fernando Valley Almanac 2000 (Van Nuys).

†Calculated only on reported cases.

impairment because study results have shown greater stability of sensitivity and specificity across education levels and different ethnic groups for the MMSAdj than for the traditional Mini-Mental State Examination (Mungas et al., 1996). Medical comorbidity was assessed by using the Cumulative Illness Rating Scale for Geropsychiatric patients, which has proven satisfactory interrater reliability and discriminant and face validity in quantifying medical comorbidity in geropsychiatric and geriatric institutional populations (Miller et al., 1992; Parmelee et al., 1995). The score from the Cumulative Illness Rating Scale for Geropsychiatric patients provided a rating of chronic illness, ranging from no significant medical problems to extremely important or chronic medical problems, based on the caregiver's accounts about the patient's past and present medical history. Medical records, when available, also were reviewed for illness verification.

Presence of dementia was established according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, criteria for dementia (DSM-IV: 290.00 or 290.10: American Psychiatric As-

sociation, 1994). Patients diagnosed as demented received a thorough assessment that included a neuropsychologic assessment, normed and standardized for Hispanic patients in Southern California (Pontón et al., 1992; Pontón et al., 1996), a complete neurologic examination, laboratory tests and brain imaging (i.e., computed tomography or magnetic resonance imaging). Diagnosis for probable or possible AD was established by matching the diagnostic findings with the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association criteria for probable AD (McKhann et al., 1984). Diagnosis for vascular dementia was established by using the National Institute of Neurological Disorders and Stroke, and the Association Internationale pour la Recherche et l'Enseignement en Neurosciences research criteria for probable vascular dementia (Roman et al., 1993).

Individuals serving as the patient's caregiver or informant were interviewed by using the BHAS. Using scripted questions, caregivers were asked to estimate the date of onset of the patient's first symptoms. They were asked also for additional comments that would explain any delay in receiving healthcare services and to check which of the items listed in the BHAS were barriers to access to their health care.

RESULTS

The most common presenting symptoms reported by the caregivers of the study patients were memory loss (80%), confusion and disorientation (13.5%), behavioral disturbance (3%), delusions and hallucinations (1.5%), and language problems (1.5%). Of the 65 patients presenting with cognitive complaints, 44 (68%) were found

to meet DSM-IV criteria for the dementia syndrome (MMSAdj mean score, 18.66; SD = 8.05), whereas 21 (32%) were found to have either a mood disorder, adjustment disorder, or mild memory impairment (MMS-Adj mean score, 27.57; SD = 3.37). The raw MMS score (mean = 15.66, SD = 8.01) correlated with diagnosis ($r = 0.670$, $p \leq 0.0001$). However, when the raw MMS score was controlled for age and education, a more reliable and significant correlation was obtained ($r = 0.589$, $p \leq 0.0001$).

Both demented and nondemented patients had scores on the Cumulative Illness Rating Scale for Geropsychiatric patients that indicated only mild current medical problems or past uncontrolled significant ones. No significant differences in comorbidity levels were found between the demented (mean = 2.48, SD = 0.51) and nondemented group (mean = 2.05, SD = 0.22). However, based on normal approximation, a Pearson chi-square analysis found that medical comorbidity rates strongly correlated with presence of dementia ($r = 11.720$, $df = 1$, $p < 0.001$), subject's age ($r = 52.841$, $df = 30$, $p < 0.006$), and insured status ($r = 5.616$, $df = 1$, $p < 0.018$).

Figure 1 shows the patients' duration of symptoms before presenting for assessment reported by patients' caregivers. Over half the patients had symptoms for more than 1.5 years and reported for evaluation only when sought through our efforts. A full one fourth of patients had those symptoms for 5 years or more without seeking medical help for diagnosis.

Barriers to Health Care

The most frequently reported barriers to healthcare access by the study sample were personal beliefs (mean,

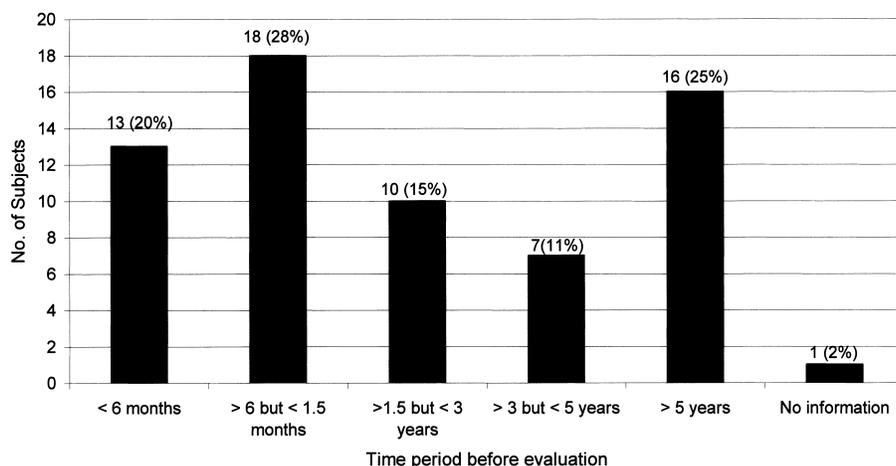


FIG. 1. Duration of symptoms before first cognitive evaluation.

1.75; SD = 2.35) and language (0.94; SD = 0.24). The barriers least reported were family support (0.31; SD = 0.47) and immigration (0.40, SD = 0.63). However, economic barriers was the only category to correlate with delayed diagnosis for at least 6 months or less, in the nondemented group ($r = -0.589$; $p < 0.005$). There was no patient without identified barriers.

An initial analysis examined the relationship between barriers and demographic variables. A nonparametric (two-tailed) correlation analysis, including barriers as the dependent variables and demographics and socioeconomic status as independent variables, found that the low level of English proficiency ($r = -0.367$; $p < 0.000$), acculturation ($r = -0.318$, $p < 0.010$), and income ($r = -0.213$; $p < 0.018$) correlated with reported immigration-related barriers to healthcare access. Economic barriers appear to be more significant for younger subjects (range, 50–64) than for older ones ($r = -0.397$, $p < 0.001$). Further correlation analysis found that lack of insurance strongly correlated with the economic barrier ($r = .28$, $df = 5$; $p < 0.000$). In addition, subjects' caregivers with low levels of income were more likely to report poor family support as a barrier to healthcare access compared with those with moderate or higher income ($r = -0.304$; $p < 0.014$). Linear by linear association analysis found that subjects who had an extended family member or friend as a caregiver or informant were more likely to report lack of family support as a barrier ($r = 0.658$; $df = 1$; $p < 0.003$).

CONCLUSIONS

This study found that for the cognitively impaired elderly Hispanic patients, barriers to healthcare access and utilization appeared multifactorial and affected early diagnosis and treatment. For example, since the first onset of symptoms, we found that, regardless of severity, 50% of our sample delayed or withheld diagnosis or treatment for a period of 18 months to 5 years. Of the remaining population, 48% delayed or withheld treatment for 18 months or less, respectively. Although no comparable specific dementia data are available for the non-Hispanic white population, evidence from other diseases suggest that non-Hispanic whites are more likely to seek diagnosis and treatment during the earlier stages of illness than are Hispanics (Caserta et al., 1987; Bastida and Gonzalez, 1995; Gordon, 1995; Gilliland et al., 1996; Sennott-Miller et al., 1998).

The most significant barriers to healthcare access and utilization were personal beliefs, language proficiency, and economic status, as detailed in Figure 2. Thirty-eight percent of the sample reported personal beliefs as the most significant barrier for healthcare access and use. Our findings suggest that perceptions regarding illness, life attitudes, values, and beliefs about health and the utility of medicine influenced healthcare use even when a physical or financial barrier did not impede healthcare access. For example, even when controlling for education, age, acculturation, and ethnicity, the perception that

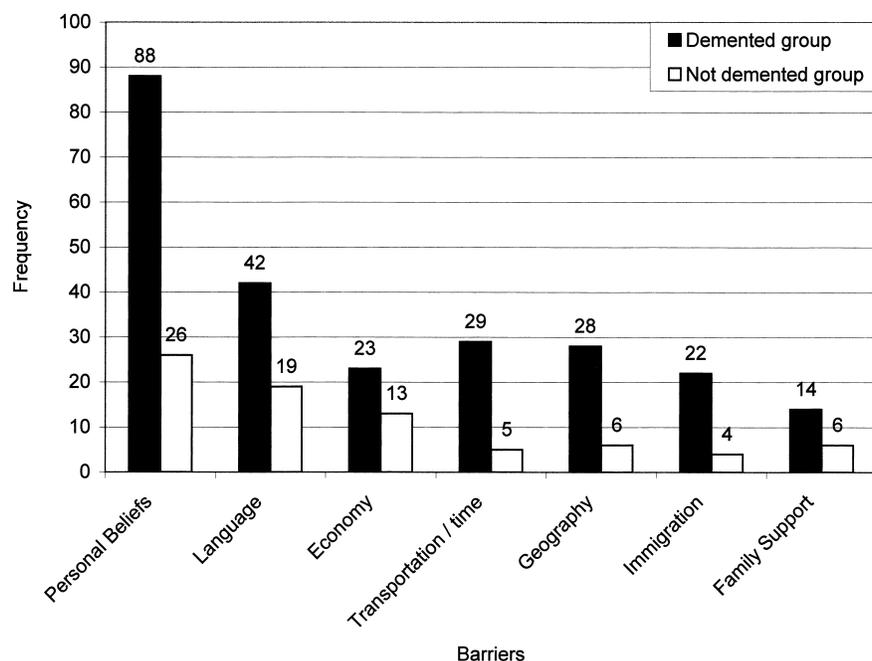


FIG. 2. Barriers to healthcare access for cognitively impaired Hispanics.

memory loss and forgetfulness were normal consequences of old age and not symptoms of an illness was prevalent among members of our sample.

Following personal beliefs, language was reported as another significant barrier to healthcare access and utilization. Eighty-three percent of our sample had limited or no English proficiency, and 33% reported language as a barrier. Language proficiency in our sample strongly correlated with low acculturation level and education level, regardless of the number of years living in the United States (mean = 26.6 years).

Economic status was the third and most significant barrier reported. In addition to limited economic resources (see Table 2), 43% of our sample had no health insurance. Types of health insurance coverage included MediCal (23%), Medicare (22%), health management organization (9.2%), and other types of health insurance (3.1%), for example, disability with medical coverage, veteran benefits, etc. Additional but less frequently reported barriers were lack of transportation and time, immigration issues, poor family support, and distance from the clinic. Comparing the effect of demographic and socioeconomic variables in Hispanic persons and non-Hispanic whites, results from other studies on healthcare access have indicated that Hispanic persons (and other minority groups) have lower access and exceptionally low economic status and health insurance coverage (Council on Scientific Affairs, 1991; Ginzberg, 1991; Bassford, 1995; Gordon, 1995). However, there is a paucity of information in the literature regarding how personal beliefs may affect healthcare use in cognitively impaired elderly Hispanic patients and their caregivers.

Our study has several limitations. We must temper our conclusions by the recognition that our sample was small and is not entirely representative of all Mexican and Central Americans. Our findings apply most directly to Southern California urban Mexican and Central Americans. Another limitation is that other potential barriers were not studied. This could have a bearing on our findings as well. The structural barriers, which are defined as features in our society and medical care system that occur mostly independently of the minority group, were not studied here in detail. For example, Valle (1994) observed that ethnically diverse groups were not included as an integral part of the major research conducted in the noncognitive behavioral symptom arena. These "external barriers" are well documented in the literature (Advisory Panel on Alzheimer's Disease, 1992; Damron-Rodriguez, Wallace, and Kington, 1994).

To our knowledge, this is the first attempt to investigate "perceived" yet potentially powerful barriers to healthcare access and use in the aged and cognitively

impaired sector of the Hispanic population, which, by its vulnerability to illness because of aging and socioeconomic status, clearly needs healthcare access. Regardless of whether these perceived barriers actually existed as described, they remained "real" to the subjects in this study. These barriers were causal attributions, which explained the subject's reasons for following a particular course of action or inaction. Thus, these beliefs are important shapers of subject choice and activity. Healthcare agencies, professionals, and researchers will need to increase their understanding of the barriers to health care faced by growing numbers of cognitively impaired elderly Hispanic patients to devise outreach strategies and interventions that can effectively reduce the barriers.

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APPENDIX

UCLA / Olive View Medical Center, The Neuropsychiatry / Research Memory Clinic BARRIERS TO HEALTHCARE ACCESS SURVEY (BHAS)[©] Freddy Ortiz, M.A. & L. Jaime Fitten, M.D.		
Patient's name: _____ Date: _____ Examiner Initials _____		
Caregiver's name: _____		
Chief Complaint: _____ By: _____		
Ask the patient: What is the problem that brings you here today? _____		
Ask the patient's caregiver: Why have you brought (Name of pt.) here for evaluation: _____		
What were the first symptoms of ...? _____		
When did the first symptoms start?: _____ Was the onset: <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Don't know		
Please tell me what reasons or factors were barriers for the patient to receive these services earlier. The list below contains possible reasons that may have delayed the patient to receive these services at an earlier time. Please tell me which of these may have been true to the patient since the initial symptom(s) of the patient's disease. Check (✓) only those that apply.		
<i>The patient did not come for evaluation before because....</i>		
	(✓)	Barriers to healthcare access
F		At the time, the patient was not interested in these services.
D		The clinic was too far.
F		The patient disliked the place.
F		The patient distrusted the medical treatment.
F		The patient distrusted the doctor.
F		The patient did not believe he/she had memory problems in spite of what the doctor told him/her.
F		The patient did not believe he/she had memory problems in spite of what family members told him/her.
C		The family members opposed the patient see a doctor.
F		The patient did not believe he/she was ill.
G		The patient did not have transportation.
D		The patient did not know how to get there.
G		The patient presented the excuse that the appointment was too late.
G		The patient presented the excuse that the appointment was too early.
E		He/she thought it might affect his/her U.S. residency status.
F		He/she was concerned about the medical treatment.
F		He/she was afraid of being told by others that he/she was crazy.
E ₂		He/she did not speak English.
F		He/she did not like how doctors have treated him/her before.
F		He/she felt doctor did not understand him/her.
F		He/she did not understand what the treatment consisted of.
F		He/she did not understand what the illness consisted of.
F		He/she did not think that treatment was of any help to him/her.
E ₂		He/she did not understand what the doctors were telling him/her.
B		He/she could not afford the medical evaluation/treatment.
F		He/she felt afraid of doctors finding something worse.
D		He/she was afraid of getting lost.
G		He/she was afraid of going by him/herself.
F		He/she was afraid the doctors would tell him/her that he/she was crazy.
E		He/she was afraid of being reported to immigration authority.
F		He/she thought he/she was too old for getting any help.
F		He/she thought that since memory problems were part of old age there was no need to go and see a doctor.
E		He/she distrusted people of authority
F		He/she thought he/she could get by without any medical attention.
F		He/she believes "medicine does not help anybody."
F		He/she believes that at home he/she has all the help he/she needs.
F		He/she thought that God was the only one that could help me.
F		He/she wanted to try other medical alternatives, first.
G		At that time, he/she had no time to go to the doctor.
F		His/her (religious beliefs, church) prohibits him/her of receiving these services.
E		He/she preferred to cross the border to receive these services.
Besides these barriers, are there any other reasons for the delay of services?		