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HEALTH, HEALTH PERCEPTIONS, HEALTHCARE PRACTICES, AND INFLUENCING  
FACTORS AMONG KOREAN IMMIGRANTS LIVING IN RURAL TEXAS

by

MARY BETH WINTON

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
Department of Nursing

Beth Mastel-Smith, Ph.D., Committee Chair

College of Nursing and Health Sciences

The University of Texas at Tyler  
April 2014

The University of Texas at Tyler  
Tyler, Texas

This is to certify that the Doctoral Dissertation of

MARY BETH WINTON

has been approved for the dissertation requirement on  
April 2014  
for the degree of Doctor of Philosophy in Nursing

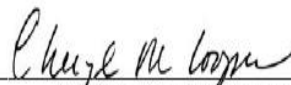
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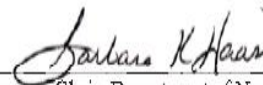
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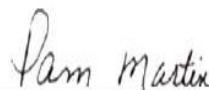
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## Abstract

### HEALTH, HEALTH PERCEPTIONS, HEALTHCARE PRACTICES, AND INFLUENCING FACTORS AMONG KOREAN IMMIGRANTS LIVING IN RURAL TEXAS

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April 2014

The population of Asian immigrants in the United States increased 43.3% from 2000 to 2010. During the same period, Texas experienced an increase of Korean immigrants of over 47%. Despite the increase of Korean immigrants, only a minimal number of studies explored health and healthcare needs specific to this population. Furthermore, none of the studies addressed Korean immigrants living in rural Texas. Hence, an ethnographic study was conducted to examine the health and healthcare among Korean immigrants living in rural Texas. Face-to-face interviews were conducted and transcribed. Five major themes emerged which included acculturation, health and health perceptions, healthcare, relaxation and extracurricular activities, and social connectedness. Rural Korean immigrants had arduous work schedules, financial constraints, and lacked English competency causing stress and fatigue. Furthermore, chronic health problems such as hypertension and hypercholesterolemia existed. However, a majority of the immigrants felt their health was “good” and engaged in some form of health promotion activities, such as walking or exercising. Despite the health problems, Korean immigrants did not perceive the need for routine healthcare. In addition to receiving no routine healthcare, immigrants did not socialize with other Korean immigrants for a variety of reasons. Furthermore, organizations to assist Korean immigrants did not exist in their community.

## **Chapter 1: Overview of the Research Study**

### **Overall Purpose of the Study**

Federal initiatives continue to focus on decreasing health disparities among all ethnicities, including Asian Americans and Pacific Islanders (AAPI) (Texas Health and Human Services [THHS], 2010; Healthy People 2020 [HP 2020], 2010). Health promotion activities among individuals and families (THHS, 2010) are aimed to improve overall health ([HP 2020], 2010). However, health and healthcare needs among Korean immigrants (KI) are lacking (Han, Kan, Kim, Ryu, & Kim, 2007; Park & Grindel, 2007; Weir, Tseng, Yen, & Caballero, 2009), as are social and psychological support (Lee, Hann, Yang, & Fawcett, 2011; Lee, Lee, & Im, 2011; Yang & Yang, 2011), potentially exacerbating chronic health problems (Frisbie, Cho, & Hummer, 2001; Jang, Kim, & Chiriboga, 2005; Ko et al., 2011). Improving health and increasing health awareness among KIs might be achievable by identifying areas for improvement through qualitative research.

### **Introduction to Articles**

This portfolio consists of two manuscripts, Health and Healthcare among Korean Immigrants in the United States, and Health and Healthcare among Korean Immigrants Living in Rural Texas. The first article provides a systematic review of the literature (SROL), and the impetus for research is reported in the second manuscript. Topics searched for the SROL were Korean immigrants, Texas, rural, and health care. Findings indicated research on KIs' health and healthcare were set in large US metropolitan areas, and health and healthcare resources as well as organizations that provided socialization were readily available. Generally, KIs continued to experience health and healthcare disparities despite the availability of resources.

The second manuscript, *Health and Healthcare among Korean Immigrants Living in Rural Texas*, reports the findings of an ethnographic study on the health, health perceptions, healthcare practices, and influencing factors among KIs living in rural Texas. This study used Fetterman's (2010) approach to obtain meaningful data. Fourteen participants responded to demographic questions and semi-structured interviews. Five major themes emerged: acculturation, health and health perceptions, healthcare, relaxation and extracurricular activities, and social connectedness. Major factors that influenced KIs' health and healthcare in addition to recommendations that could improve this population's health and healthcare are presented. Promoting health among specific Asian immigrants, such as Koreans, is necessary to achieve the goals and objectives for HP 2020 and THHS.

**Chapter 2: Health and Healthcare among Korean Immigrants: A Systematic Review of Literature**

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## Abstract

**Background:** The number of Asian immigrants in the United States increased 43.3% from 2000 to 2010. From 1990 to 2009, Texas experienced an increase in Korean immigrants of over 47%, representing the greatest percent increase of any state and more than a 22-fold increase since 1970. The majority of Korean immigrants in Texas reside in Bexar, Dallas, Harris, Hidalgo, and Tarrant Counties.

**Objective:** A working knowledge of Korean immigrants' health and healthcare is necessary to decrease health disparity in this population. A systematic review of literature was conducted to determine Korean Immigrants' health and healthcare practices.

**Method:** A systematic review of relevant studies was conducted using CINAHL Complete and Science Direct within the EBSCOhost Discovery Service and the Cochran Library. The search process as outlined by the Preferred Reporting items for Systematic Reviews and Meta-Analyses was utilized.

**Results:** No articles were found using all the key terms during the initial search. Using various combinations of the key terms, the search produced 243 potential relevant records with only 25 being eligible for review. No studies represented rural regions. Furthermore, only one study was conducted in Texas.

**Conclusion:** Barriers to health and healthcare for Asians, including Korean immigrants, continue to prevent optimum health for this population.

*Keywords:* Korean immigrants, rural, Texas, healthcare

The United States is a multicultural nation with Asians being one of the fastest growing minority groups (Shive et al., 2007; Weir, Tseng, Yen, & Caballero, 2009). According to the 2010 U.S. Census Bureau (2012), over 14 million residents in the United States (US) are Asians, nearly 1.5 million of which are Koreans. Furthermore, with the continuing immigration of Asians, varying locales in the US are experiencing a population boom, especially among younger generations (Kandel, 2011). Rhoads (2012) reported that of the 50 states, Texas had the greatest increase of immigrant Koreans. In addition, Texas experienced a 22-fold increase in the number of Korean immigrants (KIs) from 1970 to 2009, most of whom reside in Dallas and Harris Counties. Many others reside in Bexar County, and on military bases (Rhoads, 2012). The population growth of KIs necessitates a better understanding of KIs' health and healthcare.

### **Background and Significance**

Federal initiatives continue to focus on decreasing health disparities among all ethnicities, including Asian Americans and Pacific Islanders (AAPI). Healthy People 2020 (HP 2020, 2011) included 1,200 objectives in 42 topic areas. These areas of focus suggested that improving access to comprehensive, quality healthcare services, enabling patients to locate healthcare providers whom they trust, and promoting and providing health equity will diminish many of the existing health disparities (HP 2020, 2011). Furthermore, the goal of the Texas Health and Human Services (HHS, 2010) is to “promote the health, responsibility, and self-sufficiency of individuals and families” (p. 3). To achieve federal and state initiatives, a better knowledge of health awareness, health improvement, and health and healthcare among KIs is warranted.

Despite these initiatives, quality health and health care among specific subgroups of AAPIs such as KIs are lacking (Han, Kang, Kim, Ryu, & Kim, 2007; Park & Grindel, 2007; Weir et al., 2009). Furthermore, KIs tend to seek social and psychological support as well as healthcare advice from other Koreans (Lee, Hann, Yang, & Fawcett, 2011; Lee, Lee, & Im, 2011; Yang & Yang, 2011) rather than from professional healthcare providers of Western medicine, potentially contributing to the existing health disparity (Sin, Fitzpatrick, & Lee, 2010).

Additionally, KIs have traditionally defined their health based on quality of life (QOL) rather than on quantity of life. A life worth living was a direct function of being in harmony with one's immediate surroundings (Choe, Padilla, Chae, & Kim, 2001) whether at work, school, or home. Choe et al. (2001) also reported that factors such as helplessness and powerlessness affected QOL and KIs' willingness to seek healthcare. KIs viewed their health as "good" when symptom free and consequently did not seek screening and preventive healthcare (Han et al., 2007; Ihara, 2009; Yoo & Kim 2008). The general lack of health screening, preventive medicine, and health maintenance among KIs potentially increases the incidences of chronic illnesses (Frisbie, Cho, & Hummer, 2001; Jang, Kim, & Chiriboga, 2005; Ko et al., 2011). Therefore, the purpose of this analysis was to systematically review the evidence on the health and healthcare perceptions, behaviors, and practices among KIs.

### **Korean Immigrants in Rural Texas**

According to the Migration Policy Institute (MPI, 2012) the majority of American KIs lived in California (31%). Three other states had five to 10 percent of KIs (Texas, New York, and Virginia). Furthermore, the population of KIs in Texas had increased dramatically since the liberalization of the US immigration law in 1965 (Rhoads, 2012). Consequently, Koreans constituted over one percent of the total population of foreign-born residents in Texas. According to ZipAtlas (2012), the majority of immigrants lived in urban areas; yet five of the top ten Texas towns (Cresson, Coppell, Harker Heights, Campbellton, and Copperas Cove) with the highest percentage of KIs were located in rural Texas (Figure 1). The percentage of KIs in these locales ranged from 1.11 to 2.17 percentage of the total population per town.

### **Rurality and Health Disparity**

According to the Rural Policy Research Institute (RPRI, 2007) health panel, no universal definition for *rurality* exists. Furthermore, the definition for rurality varied based on the intended outcomes. Consequently, multiple definitions for rurality produced some degree of vagueness and ambiguity in relevant research (Vanderboom & Madigan, 2007). For the purpose of this

paper, *rurality* is defined as, “all population, housing, and territory [that is] not included within an urban area” (U.S. Census Bureau, 2010, para. 3) and has a population of fewer than 50,000 people (U.S. Census Bureau: American FactFinder2, 2010).

Optimal healthcare for people living in rural areas can be difficult to obtain because of significant barriers (Brems, Johnson, Warner, & Roberts, 2006) such as sociocultural and structural factors (Graves, 2008). Specific examples included cultural beliefs, language difficulties, financial constraints, and minimal availability of healthcare resources (Graves, 2008). Additionally, rural healthcare providers faced challenges in delivering appropriate healthcare. Such challenges included residents’ unwillingness to participate in health prevention or screening programs (Brems et al., 2006; Brown, Ojeda, Wyn, & Levan, 2000). Without appropriate healthcare, health disparities increased, resulting in a higher morbidity and mortality (Andrulis, 2003; Brown et al., 2000; Jones, 2010). The National Institute of Health (NIH, *n.d.*) reported that despite the improvement of overall health in America, disproportionate levels of health disparity continue to exist for various ethnic minorities and rural dwellers. For the purpose of this paper, *health disparity* is defined as “. . . differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups. . . .” (NIH, *n.d.*, p. 12).

## **Methods**

This literature review was conducted as outlined by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) developed to provide a clear path for conducting and reporting literature review (Liberati et al., 2009) and guides the process for systematic literature searches. The goal is to assist authors in transparent reporting of systematic reviews and meta-analyses. The process includes a 27-item checklist, and depending on the review objectives, these items may be modified.

The CINAHL Complete, ERIC, Health/Psychosocial Instrument, Health Source: Nursing/Academic Edition, SocINDEX with Full-text, Science Direct, and Texas Reference

Center databases within the EBSCOhost Discovery Service (EBSCOhost), and the Cochran Library were searched for articles published between 2005 and 2013 using the terms *Korean immigrants, Texas, rural, and health care*. Additionally, the subject terms *Koreans, research, and United States* were added during the search. The search included three rounds. Articles were deemed appropriate when appraised for the relevance and quality of the study. During round one, articles were searched based on the key terms, excluding those that were not original research. During round two, abstracts were screened for eligibility. In round three, full-text articles were obtained for further review. Both qualitative and quantitative studies were included. During the collection of articles, duplicate records were removed. Most of the records were extracted during the perusal of titles and abstracts. The remaining records were obtained by reading the article to ascertain eligibility.

## **Results**

### **Study Selection**

The selection of records to be reviewed was accomplished during the search process (Figure 2). When all the key terms (*Korean immigrants, Texas, rural, health care*) were included in the search, no eligible records were found. Therefore, various combinations of the key and subject terms were utilized. Two-hundred forty-three articles were identified. After removing duplicate articles, 216 records were eligible for screening; however, all but 25 articles were excluded due to irrelevance. No articles were discovered with the key terms *Korean immigrants, rural, and Texas*. Furthermore, no research articles were found on KIs' health and healthcare in rural US. Overall, the majority of the records failed to satisfy the basic requirements of relevancy to the key terms and were excluded. More specifically, the excluded records either failed to be exclusive to Koreans, did not qualify as original research (editorials, personal commentaries, or newspaper clippings) conducted in the US, were not established within the required time frame, or some combination of the above.

## **Study Characteristics/Synthesis of Results**

All studies were conducted in the US. Unfortunately, no studies among KIs living in rural Texas or rural US were located. Consequently, this paper will investigate the broader issue of health and healthcare among KIs living in the US. All key and subject terms (subtopic) as discussed earlier were utilized throughout the selection process to maintain continuity.

Of the 25 studies reviewed (Table 1), 19 were quantitative (Bernstein, Park, Shin, Cho, & Park, 2011; Choi, Wilbur, & Kim, 2011; Donnelly & Kim, 2008; Eun, Lee, Kim, & Fogg, 2009; Han et al., 2010; Hofstetter et al., 2010; Hwang & Zerwic, 2006; Jang et al., 2005; Jang, Park, Cho, Roh, & Chiriboga, 2012; Jo, Maxwell, Wong, & Bastani, 2008; Kim, 2011; Kim & Menon, 2009; Kim et al., 2011; Kim, Kim, & Gulick, 2009; Lee, Eun, Lee, Nandy, 2011; Lee, Kim, & Han, 2009; Lee & Yoon, 2011; Maxwell, Jo, Crespi, Sudan, & Bastani, 2010; Shin, 2011; Yang, 2007), four were qualitative (Jo, Maxwell, Yang, Bastani, 2010; Sin et al., 2010; Sin, Jordan, & Park, 2011; Yoo & Zippay, 2012), one was a retrospective analysis (Han et al., 2007), and one used mixed-method (Yoo & Kim 2008). Various topics of these 25 articles included hypertension/stroke (Han et al., 2010; Hwang & Zerwic, 2006; Kim et al., 2011), tobacco smoking among KIs (Hofstetter et al., 2010; Kim et al., 2009), the perspectives of church leaders in assisting KIs with resources for health and healthcare (Jo et al., 2010; Yoo & Zippay, 2012), cancer behaviors and health beliefs among KIs (Eun et al., 2009; Jo et al., 2008; Kim & Menon, 2009; Lee, Eun et al., 2011; Lee, Kim et al., 2009; Maxwell et al., 2010), depressive disorders (Bernstein et al., 2011; Donnelly & Kim, 2008; Jang et al., 2012; Kim, 2011; Sin et al., 2011), enabling factors affecting health perceptions (Lee & Yoon, 2011), and physical activities for promotion of general well-being (Choi et al., 2011; Shin, 2011; Yang, 2007). Multi-generational cardiovascular health perceptions (Sin et al., 2010) and healthcare utilization (Jang et al., 2005; Yoo & Kim, 2008) among KIs were also reported. One retrospective study on the recruitment barriers of KIs for health promotion studies was located (Han et al., 2007). All studies were conducted in geographic areas where large populations of KIs were located and Asian grocery

stores, faith, and non-faith based organizations were available. Only one study was located in Central Texas (Yang, 2007) with a large population of KIs. During the analysis, nine major categories emerged that could affect health and healthcare of KIs. These categories include (a) health, health perceptions, and healthcare, (b) knowledge of diseases, (c) culturally sensitive educational programs, (d) physical activities, (e) cancer screenings, (f) depression, (g) financial constraints, (h) English language competency, and (i) Korean organizations.

***Health, health perceptions, and healthcare.*** According to the Kaiser Family Foundation (KFF, 2008), Koreans tended to be healthier than other Asian immigrants. Conversely, KIs generally considered their own health to be fair to poor (Eun et al., 2009; Yang, 2007). Furthermore, KIs who were older, female, and less educated were more likely to view their health as poor (Jang et al., 2005). A variety of factors influenced KIs' health perceptions. For example, factors negatively influencing KIs' health perceptions included lower financial status, increased physical disability (Jang et al., 2012), lack of English competency, mistrust in the Western healthcare system (Jang et al., 2005), and length of US residency (Lee & Yoon, 2011; Yang, 2007). Conflicting results regarding the length of US residency as it related to KIs' health perceptions were discovered; longer residency both positively (Yang, 2007) and negatively (Lee & Yoon) correlated with poorer health (Yang, 2007), and might be related to the amount of acculturation. Poor psychological and physical health negatively impacted KIs' health perceptions; depression, loneliness, and decreased vitality resulted in lower perceived health (Lee & Yoon, 2011). Healthcare satisfaction and subjective perception of health affected healthcare utilization (Jang et al., 2005). Not surprisingly, KIs with more negative health perceptions and higher healthcare satisfaction were more likely to seek healthcare (Jang et al., 2005).

Since migrating to the US, KIs experienced increased illnesses such as cancer (Jo et al., 2008; McCracken et al., 2009), heart disease (Boo & Froelicher, 2012; Fitzpatrick et al., 2012; Jang & Kim, 2010), diabetes (Jang et al., 2012; So, Chin, & Lee, 2011), and depression (Bernstein et al., 2011; Donnelly & Kim, 2008; Jang et al., 2012; Yoo & Zippay, 2012).

Furthermore, diabetes was significantly correlated to negative health perceptions (Jang et al., 2012).

***Knowledge of diseases.*** KIs' knowledge of risk factors and health promotion activities were varied and some knowledge was inaccurate. Additionally, knowledge of cardiovascular health (CVH; Sin et al., 2010) and strokes (Hwang & Zerwic, 2006) were different among the younger and older generations. KIs considered healthy diet, physical activity, less stress, and clean environment as important in promoting CVH; the younger generation considered walking and being spiritual as beneficial and nonfat food items such as jelly beans as harmful (Sin et al., 2010). On the other hand older people perceived relaxation and laughter beneficial and loneliness and stress harmful (Sin et al., 2010). Additionally, young people were more knowledgeable than the older generation on the risk factors for strokes; however, neither younger nor older generations identified stroke risk factors such as diabetes, hypertension, and cardiovascular disease and non-stroke risk factors such as extreme weather and physical activities (Hwang & Zerwic, 2006). Furthermore, stress, which is not a risk factor for stroke, was incorrectly identified among both generations (Hwang & Zerwic, 2006). The younger generation was also more knowledgeable of stroke symptoms; however, vision changes and severe headache were least identified while chest pain, dyspnea, and hand tremors were incorrectly construed as stroke symptoms (Hwang & Zeric, 2006).

***Culturally sensitive educational programs.*** Many KIs lacked health screenings such as mammograms (Kim & Menon, 2009; Maxwell et al., 2010) and few with chronic medical conditions made lifestyle modifications (Han et al., 2010; Kim et al., 2011). However, culturally tailored educational interventions increased KIs' participation in health screenings and improved health and healthcare practices. Appointment reminders, explanations for mammogram follow-up tests, provisions of health information, and referrals for mammography increased health screenings (Maxwell et al., 2010), and bi-monthly telephone counseling for medication adherence with hypertension (Han et al., 2010; Kim et al., 2011). Furthermore, telephone counseling



decreased alcohol consumption and increased physical activity (Han et al., 2010; Kim et al., 2011). A stage-based, semi-structured, interactive program was not significant for increasing KIs' readiness for mammography; however, it was effective in increasing knowledge of breast cancer (Kim & Menon, 2009).

***Physical activities.*** Another category of literature findings was physical activity. KIs did not participate in leisure time physical activity; instead, KIs participated in transportation-related physical activity (walking and cycling) and household physical activity (Choi et al., 2011). Furthermore, physical activity influenced physical and mental health (Shin, 2011; Yang, 2007); exercise was a significant predictor for improved health (Yang, 2007), and with more vigorous activity, greater health improvement was noted (Shin, 2011).

***Cancer screenings.*** The low incidences of cancer screenings among KIs was affected by a variety of factors. Mammograms (Eun et al., 2009; Kim & Menon, 2009; Lee et al., 2009; Maxwell et al., 2010), cervical exams (Lee, Eun et al., 2011), and colorectal exams (Jo et al., 2008) were sporadic among KIs. Several facilitators and barriers for cancer screenings were noted. Factors such as having symptoms, financial means, transportation, and a trustworthy physician significantly increased the likelihood of obtaining cancer screenings (Jo et al., 2008). Barriers to cancer screenings included being unfamiliar with the process of obtaining mammograms (Kim & Menon, 2009), English language difficulties (Lee et al., 2009; Maxwell et al., 2010), and financial constraints (Jo et al., 2008; Lee et al., 2009; Maxwell et al., 2010). Additionally, KIs' perceptions for the seriousness and benefits of cancer screenings also influenced screening rates; furthermore, age influenced these perceptions (Eun et al., 2009; Lee et al., 2009; Lee, Eun et al., 2011). Older women perceived significantly more seriousness to having cancer (Eun et al., 2009; Lee, Eun et al., 2011) and potentially more benefits to screenings (Lee et al., 2009; Lee et al., 2011) compared to younger women; however, older women had lower screening rates than younger women (Eun et al., 2009). Furthermore, perceived benefits

were greater among those who had mammograms in the past (Eun et al., 2009; Lee et al., 2009). Finally, perceived susceptibility to cancer also influenced screening rates (Lee et al., 2009).

***Stress and depression.*** Stress and depression are common among KIs. In fact, many KIs often used the words “depression” and “stress” interchangeably. Symptoms were related to feelings of introversion, loneliness, isolation (Sin et al., 2011), fatigue, appetite changes, and sleep disturbances (Donnelly & Kim, 2008). Depressive symptoms increased among KIs in poor physical health (Donnelly & Kim, 2008); depression was positively correlated with chronic diseases such as diabetes (Jang et al., 2012) and negative health behaviors, such as smoking (Kim et al., 2009). Depressive symptoms increased hostility and neglect and decreased signs of affection among parents of teenagers; fathers were affected to a greater degree than were mothers (Kim, 2011). Acculturative stress might affect depressive status (Bernstein et al., 2011; Sin et al., 2011), and KIs were almost twice as likely to experience stress as the general US population (Bernstein et al., 2011). In fact, lack of English proficiency and longer length of US residency significantly caused higher anxiety and depression in addition to decreased self-control and vitality (Lee & Yoon, 2011). Additionally, depression and discrimination had significant positive correlation (Bernstein et al., 2011). One-third of participants in one study (Bernstein et al., 2011) and one-fourth in another study (Jang et al., 2005) experienced some form of discrimination, such as disrespect, due to race or ethnicity. On the other hand, social support and spirituality significantly improved psychological health and general well-being among KIs (Lee & Yoon, 2012).

***Financial constraints.*** Another factor influencing health and healthcare was financial constraints. Yoo and Kim (2008) explored barriers and challenges to health services among insured and uninsured KIs. Even though most participants had insurance, older KI women’s insurance covered the cost of the mammograms while younger KI’s insurance did not (Yoo & Kim, 2008). Furthermore, no significant differences were found in overall healthcare utilization among the insured and uninsured. High deductibles prevented accessing health services for those

with insurance. Jo et al. (2008) reported a lack of insurance or inability to afford healthcare were major factors discouraging cancer screenings.

***English language competency.*** Another factor that influenced health and healthcare among KIs was lack of English competency. The inability to speak English significantly increased negative health perceptions which negatively influenced healthcare utilization (Jang et al., 2005; Lee et al., 2009). Furthermore, poor English speaking abilities was significantly associated with increased depression (Bernstein et al, 2011; Lee & Yoon, 2011).

***Korean organizations.*** Korean American churches assisted KIs in the promotion of health and healthcare utilization and provided socialization with other KIs. Churches provided not only spiritual guidance but also a sense of community belonging (Jo et al., 2010; Yoo & Zippay, 2012). Additionally, churches tried to meet KIs' physical and mental health needs through health promotion clinics, anger management seminars, and smoking cessation programs in addition to preserving Korean culture (Jo et al., 2010). Church attendance was found to be a significant predictor in increasing smoking cessation, in addition to decreased exposure to second hand smoke and smoking in homes (Hofstetter et al., 2010). However, Korean churches were largely not equipped to provide healthcare advice, did not have the clinical knowledge, and were not aware of available community resources to support KIs' health and healthcare needs (Jo et al., 2010).

## **Discussion**

A systematic review of literature on the health and healthcare of KIs living in the US revealed twenty-five records, none of which addressed health and healthcare for rural KIs. Twenty of the results were self-reports, four were interviews and one study used retrospective data analysis. Nine major categories emerged during the analysis that included health, health perceptions, and healthcare; knowledge of diseases; culturally sensitive educational programs; physical activities; cancer screenings; depression; financial constraints; English language competency' and Korean organizations. Factors identified that affected or had the potential to

impact KIs' health included health perceptions, disease knowledge, financial constraints, English competency, and physical activity. In addition, perceptions, beliefs, age, perceived susceptibility for cancer, knowledge about healthcare system, and benefits of screening impacted cancer screening behaviors. Depression was associated with stress, poor health, and feelings potentially exacerbated by immigrant status, namely loneliness, isolation, and discrimination. Culturally sensitive health promotion programs demonstrated improved health behaviors including cancer screening, medication adherence, decreased alcohol consumption, and increased exercise. Additionally, Korean churches provided spiritual guidance and promoted health, healthcare, and socialization.

### **Limitations**

A literature search for health and healthcare on Asians produced many results. However, records on individual subgroups of Asians such as KIs were few. Consequently, studies that were identified usually represented the Asian community as a whole rather than regional subgroups. When KIs were identified as participants, they were commonly classified together as “others.” Furthermore, no studies were available on healthcare disparities among Asians in rural areas. Most studies conducted on Asians were done in a locale where a large population of KIs resided, such as California, Illinois, New York, Maryland, and Washington States. Furthermore, studies utilized self-reports and small sample sizes, which prevented generalizing the conclusions to the overall KI population.

### **Conclusions**

The status and perceptions of health vary among different ethnicities. Variables such as race/ethnicity, socio-economic status, level of education, and gender are associated with health outcomes (Department of State Health Services, 2010). Among the studies on health and healthcare disparities in minority groups, the dominant perception is that disparities continue to exist and no clear solution to the problem has been determined (Fowler-Brown, Ashkin, Corbie-Smith, Thaker, & Pathman, 2006). A better understanding of KIs' culture, including health and

healthcare needs, is required to decrease health disparities in this vulnerable population. Exacerbations of current chronic health conditions, including mental disorders such as depression, can be reduced or even prevented with appropriate health education and readily available healthcare (Jang et al., 2012). Further exacerbating health and healthcare disparities is the fact that people living in rural regions tend to be poorer, older, and have poorer overall health than those residing in metropolitan areas (Agency for Healthcare Research and Quality, 2011). To decrease health disparities among KIs, studies are needed to better understand their health and healthcare needs, especially those living in rural areas. Additionally, health resources in rural communities specifically for Asian immigrants are desperately needed in order to promote health and healthcare knowledge among KIs. The lack of evidence on KIs living in rural America should be a primary focus for future research.

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Figure 1



Figure 1. Partial Map of Texas Counties (Texas County Selection Map, *n.d.*). The arrows depict the rural counties with the largest Korean immigrant population (Atascosa County, Bell County, Coryell County, Dallas County, and Hood County) (ZipAtlas, 2012).

Figure 2

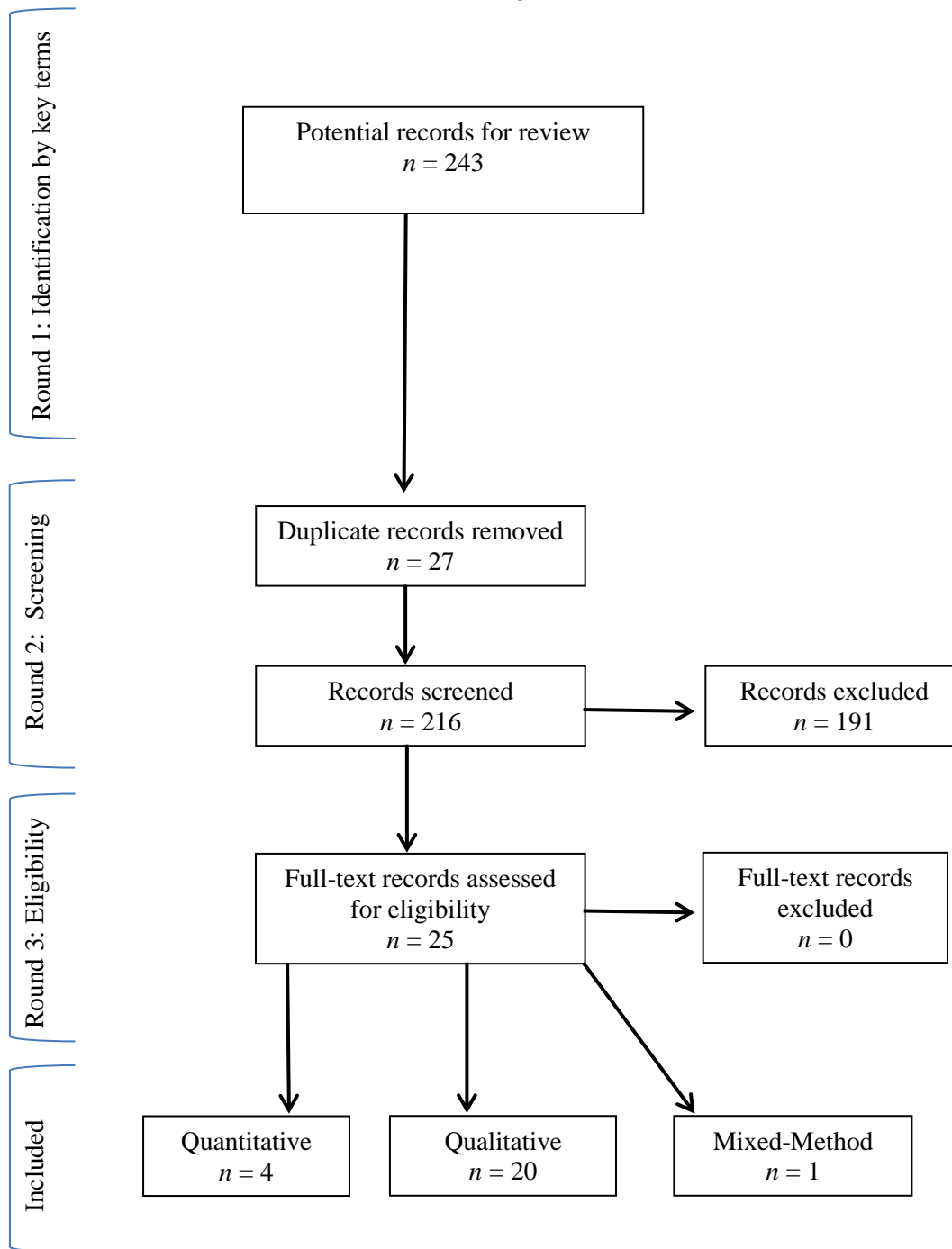


Figure 2: Flow Diagram of the Systematic Review Process as Described by PRISMA. This diagram shows the flow of information through the different phases of the review process (Liberati et al., 2009).

Table 1

Records Included in the Systematic Review of Literature

Author, Study Design, & Population	Purpose	Results	Limitations
<p>Bernstein, K.S., Park, S.Y., Shin, J., Cho, S., &amp; Park, Y. (2011).</p> <p>Cross-sectional</p> <p><i>n</i> = 304 KIs living in New York City</p>	<p>Examine the prevalence of depressive symptoms among KIs in New York City and its relation to self-reported discrimination and acculturation</p>	<p>13.2% of KIs demonstrated some depressive symptoms. Variables of living alone, marital status, education, years in the US, and income impacted depression scores. Multiple regression analysis revealed proficiency in the English language (<math>p &lt; .05</math>) and discrimination (<math>p &lt; .001</math>) were significant predictors for depression after controlling for socio-demographic factors, years in the US, and acculturative stress.</p>	<ol style="list-style-type: none"> <li>1. Causal inferences are not possible with cross-sectional studies.</li> <li>2. Self-reports could bias results.</li> <li>3. Convenience sampling minimizes the generalizability of the findings.</li> <li>4. Majority of the participants had high level of education, which could bias the results; therefore, could not be generalizable.</li> <li>5. The Acculturative Stress Scale used was not specific to KIs, but rather to Latinos and Asian Americans; this could bias the results.</li> </ol>
<p>Choi, J.W., Wilbur, J.E., &amp; Kim, M.J. (2011).</p> <p>Cross-sectional</p> <p><i>n</i> = 197 KI women living in a large metropolitan area and midsized towns in the Midwest</p>	<p>Identify patterns for job, transportation, household, and leisure time physical activity; examine the differences in patterns for KIs' non-leisure and leisure time physical activity to the demographic characteristics.</p>	<p>Patterns of inactivity were more prevalent in all domains except for household physical activity.</p> <p>Job related: inactive pattern 49%</p> <p>Transportation related: inactive pattern 78.7%.</p> <p>Household related: inactive pattern 26.4%.</p> <p>Leisure time related: inactive pattern 46.7%.</p> <p>Demographic related: Age related to inactive job pattern was younger (<math>p = .008</math>).</p> <p>Marital and age statuses related to inactive transportation pattern were unmarried (36%) and older (<math>p &lt; .001</math>) respectively.</p>	<ol style="list-style-type: none"> <li>1. Self-reported studies could bias results.</li> <li>2. Results might not be generalizable to other KI women living in other US regions.</li> <li>3. Causal inferences are not possible with cross-sectional studies.</li> </ol>

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Table 1 (Continued)

<p>Donnelly, P.L. &amp; Kim, K.S. (2008).</p> <p>Cross-sectional</p> <p><i>n</i> = 79 older-aged KIs in NE metropolitan area</p>	<p>Examine the prevalence of depressive disorders using translated Korean version of the PHQ-9 K instrument.</p>	<p>Depression scores among five of the nine items were high with little interest or pleasure in doing things being the dominant factor (60.54%). 51% (<i>n</i> = 40) experienced some difficulty at home or interpersonal relationships due to depression.</p>	<ol style="list-style-type: none"> <li>1. Results might not be generalizable to all KI elderlies.</li> <li>2. Causal inferences are not possible with cross-sectional studies.</li> <li>3. Self-reports could bias results.</li> <li>4. Findings might not be generalizable to KIs living in rural area.</li> </ol>
<p>Eun, Y., Lee, E.E., Kim, M.J., &amp; Fogg, L. (2009).</p> <p>Cross-sectional</p> <p><i>N</i> = 187 KI women in metropolitan area of Illinois <i>n</i> = 73 older <i>n</i> = 114 younger</p>	<p>Identify the differences of health beliefs between older and younger KI women using HBMS-K instrument); Determine how health beliefs affect breast cancer screening rates between the two groups.</p>	<p>Health beliefs differed on all four HBMS-K subscales between older (&gt;= 65 years old) and younger (40 and 64 years old).</p> <p>Older KA women reported a significantly higher level of seriousness than the younger generation for breast cancer screening (<i>p</i> = .003).</p>	<ol style="list-style-type: none"> <li>1. The results might not be generalizable among KIs living in rural area.</li> <li>2. Telephone surveys could bias the results since not all Korean women have phones or have Korean surnames, therefore missing potential participants.</li> <li>3. Self-reports could bias results.</li> <li>4. Causal inferences are not possible with cross-sectional studies.</li> </ol>
<p>Han, H.R., Kang, J., Kim, K.B., Ryu, J.P., &amp; Kim, M.T., (2007).</p> <p>Retrospective analysis</p> <p><i>n</i> = 14 studies conducted in the Baltimore-Washington metropolitan area</p>	<p>Describe barriers to recruitment of KI for health promotion research; identify community facilitators who could potentially increase recruitment efforts.</p>	<p>Barriers and recruitment strategies at the individual (4 barriers, 4 strategies) and community (5 barriers, 6 strategies) levels were identified.</p>	<ol style="list-style-type: none"> <li>1. Interviewing team members years after the studies could bias the recollection of events.</li> </ol>

Continued on next page

Table 1 (Continued)

<p>Han, H.R., Kim, J., Kim, K.B., Jeong, S., Levine, D., Li, C., Song, H., &amp; Kim, M.T. (2010).</p> <p>Longitudinal (12 month duration)</p> <p><i>N</i> = 360 middle-aged KIs  <i>n</i> = 182- More intensive  <i>n</i> = 178 - Less intensive</p>	<p>Examine the effect of bilingual nurse-delivered telephone counseling in controlling hypertension and compare the key behavioral outcomes by the amount of counseling.</p>	<p>Both groups showed improvement to the intervention (telephone counseling) on hypertension management. Overall success rate for the intervention was 80.3%.</p> <p>The behavioral outcomes (being on medication, alcohol consumption, exercise) were significant during the counseling period (<math>p &lt; .05</math> for within-group). Smoking behavior did not improve significantly (<math>p &gt; .05</math> for within-group). Behavioral outcomes, except being on medication (<math>p &lt; .05</math>), did not differ significantly between the more intensive and the less intensive group.</p>	<ol style="list-style-type: none"> <li>1. Self-reports could bias results.</li> <li>2. No true control group was utilized; therefore, it might not be possible to determine if telephone counseling is better than usual care. Findings might not be generalizable to other population of KIs, especially among less-educated and those living in rural area.</li> </ol>
<p>Hofstetter, C.R., Ayers, J.W., Irvin, V.L., Sim, D.E.K., Hughes, S.C., Reighard, F., &amp; Hovell, M.F. (2010).</p> <p>Cross-sectional</p> <p><i>n</i> = 2,085 adult KIs</p>	<p>Correlate church attendance with smoking prevalence, cessation, exposure to environmental tobacco smoke and household smoking bans among Korean immigrants</p>	<p>13% of the sample was currently smoking and 50% reported daily exposure to environmental tobacco smoke.</p> <p>Church attendance was a significant predictor to all four variables (<math>p &lt; .05</math>).</p> <p>Church attenders were less likely to smoke (5.37%), be exposed to tobacco smoke (6.57%), resume smoking (11.63%), and allow smoking in the homes (7.24%) than non-attenders.</p>	<ol style="list-style-type: none"> <li>1. Self-reports could bias results.</li> <li>2. Findings might not be generalizable to KIs who do not have access to Korean organizations and/or churches.</li> <li>3. Amount of church attendance was not measured; therefore, correlation to the “dose effect” of church attendance and tobacco use might not be possible.</li> <li>4. Causal inferences are not possible with cross-sectional studies.</li> </ol>

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Table 1 (Continued)

<p>Hwang, S.Y. &amp; Zerwic, J.J. (2006).</p> <p>Descriptive</p> <p><i>n</i> = 119 KIs in a Midwestern metropolitan area</p>	<p>Assess knowledge of stroke symptoms and risk factors among Korean immigrants</p>	<p>Cluster analysis revealed two distinct groups:                  Women in cluster one (<i>n</i> = 83) were more knowledgeable in stroke symptoms, were younger, married, and less likely to have hypertension.</p> <p>Women in cluster two (<i>n</i> = 36) were less knowledgeable in stroke symptoms but more knowledgeable in non-stroke symptoms, were older, less likely to be married, and have had hypertension.                  Women in cluster one (<i>n</i> = 63) were more knowledgeable in the stroke risk factors but women in cluster two (<i>n</i> = 56) were more knowledgeable in the identifying non-stroke risk factor except for one factor (varicose veins).</p> <p>Same participants (94%) were in cluster one for both stroke symptoms and stroke risk factors.</p>	<ol style="list-style-type: none"> <li>1. Self-reports could bias results.</li> <li>2. Results might not be generalizable to KIs who do not have access to community centers. Small sample size might not allow generalization.</li> </ol>
<p>Jang, Y., Kim, G., &amp; Chiriboga, D.A. (2005).</p> <p>Cross-sectional</p> <p><i>n</i> = 230 older KIs in two cities in Florida</p>	<p>Assess predictive models of subjective perception of health, healthcare utilization, and satisfaction with healthcare service.</p>	<p>Participants who were older, female, and less educated were significant predictors (<math>p &lt; .05</math>) for negative health perceptions.</p> <p>Participants with chronic conditions and functional disability were significant predictors (<math>p &lt; .001</math>) for negative health perceptions.</p> <p>Participants who were female, had poor health perceptions, have chronic conditions, and have health insurance were significant (<math>p &lt; .05</math>) for healthcare utilization.</p> <p>Enabling factors of lack of insurance, racial discrimination, poorer English speaking, and distrust of Western medical care were significant (<math>p &lt; .05</math>) in decreasing healthcare satisfaction.</p> <p>Being treated with disrespect due to ethnicity was not a significant factor on health perception; however, 25% did experience disrespect or other ethnic discrimination in healthcare settings.</p>	<ol style="list-style-type: none"> <li>1. Causal inferences are not possible with cross-sectional studies.</li> <li>2. Small sample size could prevent generalizability.</li> <li>3. Findings might not be generalizable to KIs living in rural area.</li> <li>4. Self-reports could bias results.</li> </ol>

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Table 1 (Continued)

<p>Jang, Y., Park, N.S., Cho, S., Roh, S., &amp; Chiriboga, D.A. (2012).</p> <p>Cross-sectional</p> <p><i>n</i> = 672 older KIs adults in two metropolitan cities in Florida</p> <p><i>n</i> = 539 without diabetes</p>	<p>Examine subjective perceptions of health as a potential mediator in association between diabetes and depressive symptoms.</p>	<p>Diabetics (<i>n</i> = 133, 20%) were significant for more medical comorbidity and functional disability, depressive symptoms, and poorer health perceptions (<i>p</i> &lt; .01). Having diabetes significantly impacted health perceptions and symptoms of depression.</p> <p>Final model in hierarchical regression model, poorer health perceptions were significant (<i>p</i> &lt; .001) to having diabetes, poorer financial status, longer US residency, more medical comorbidity and functional disability.</p> <p>Higher depressive symptoms were significant (<i>p</i> &lt; .05) with young unmarried KI, greater functional disability, and poorer health perceptions.</p>	<ol style="list-style-type: none"> <li>1. Causal inferences are not possible with cross-sectional studies.</li> <li>2. Generalization of the results might not be possible among KIs in other geographically located region.</li> <li>3. Self-reports could bias results.</li> <li>4. Limited confounding variables were limited (did not consider alcohol consumption, body mass index, and smoking).</li> </ol>
<p>Jo, A.M., Maxwell, A.E., Wong, W.K., &amp; Bastani, R. (2008).</p> <p>Cross-sectional</p> <p><i>n</i> = 151 KI adults in Los Angeles</p>	<p>Gain knowledge on predictors, facilitators, barriers, and intervention preferences with respect to colorectal cancer screening.</p>	<p>13/22 participants' characteristics were significant predictors (<i>p</i> &lt; .05) for screenings rates.</p> <p>The strongest barriers toward cancer screenings included lack of insurance (41%), cost prohibitive (11%), language barriers (25%), lack of knowledge (30%), and fear of being a burden to families (21%).</p> <p>Interventional preferences included educational seminars (42%) with group seminars being overwhelmingly popular (94%), Korean media (30%), and printed materials (20%).</p>	<ol style="list-style-type: none"> <li>1. Small sample size might not allow generalizability of the findings to other KIs.</li> <li>2. Findings might not be generalizable to other KIs since the characteristics of the sample population were mostly uninsured.</li> <li>3. Causal inferences are not possible with cross-sectional studies.</li> <li>4. Self-reports could bias results.</li> </ol>
<p>Jo, A.M., Maxwell, A.E., Yang, B., &amp; Bastani, R., (2010).</p> <p>Qualitative Exploratory</p> <p><i>n</i> = 58 leaders from 23 faith and 3 non-faith based organizations in Los Angeles</p>	<p>Gain an in-depth understanding of Korean American churches with respect to conducting future health intervention research.</p>	<p>Six major themes emerged: congregational health: Beyond spiritual; looking after the flock: meeting health and social needs; health needs of the Korean church memberships; barriers to adequate health care among Korean American church-goers; how can Korean American churches participate in health research; and suggestions for health interventions and research strategies.</p> <p>Korean churches and leaders seek to meet a variety of social and health needs of their congregation and the surrounding community. However, many leaders felt overwhelmed and frustrated stating they were not equipped with clinical knowledge or aware of available resources to help KIs health and healthcare needs.</p>	<ol style="list-style-type: none"> <li>1. Small sample size prevents generalizability of the results.</li> <li>2. Community leaders were known by the author or were referred by leaders who had already completed the interview, which could bias participating numbers.</li> <li>3. Primary author conducted all the interviews, which could prevent the community</li> <li>4. Leaders from fully expressing themselves during the interview.</li> </ol>

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Table 1 (Continued)

<p>Kim, E. (2011).</p> <p>Cross-sectional</p> <p><i>n</i> = 64 mothers and <i>n</i> = 35 fathers living in Pacific Northwest</p>	<p>Explore the relationships between Korean American parental depressive symptoms and parenting; explore how the influence of parental depressive symptoms differ between mothers and fathers</p>	<p>No significant differences for depressive symptoms between mothers and fathers (<math>p &gt; .05</math>).</p> <p>Multiple regressions showed that maternal depressive symptoms had a significant positive correlation to neglect, explaining 14% of variance (<math>p &lt; .05</math>).</p> <p>Paternal depressive symptoms had a significant negative influence toward affection, explaining 35% of variance (<math>p &lt; .001</math>) but had a positive influence toward hostility, neglect and undifferentiated rejection, explaining 31-35% of variance (<math>p &lt; .001</math>).</p>	<ol style="list-style-type: none"> <li>1. Self-reports could bias results.</li> <li>2. Study used two self-reports which might result in false correlations.</li> <li>3. Results might not be generalizable among KIs who do not have access to Korean organizations.</li> <li>4. Reliabilities for the three control measures were low, which could influence how parents interact with their adolescent children.</li> </ol>
<p>Kim, J.H. &amp; Menon, U. (2009).</p> <p>Prospective, repeated-measures, quasi-experimental</p> <p><i>N</i> = 300 KI women &gt; 40 years old in Chicago, IL</p> <p>Group I: Precontemplation (<i>n</i> = 21)</p> <p>Group II: Contemplation (<i>n</i> = 38)</p> <p>Group III: Relapse (<i>n</i> = 241)</p>	<p>Assess differences in acculturation, knowledge, beliefs, and stages of readiness for mammograms using pre- and post-interventions (GO EARLY educational session)</p>	<p>Group I women were younger, worked outside of the home, lacked health insurance, and did not have regular physician. Group III have resided in the US longer than the other groups.</p> <p>No significant differences were seen with interventions related to the stages of readiness for mammograms.</p> <p>In acculturation, knowledge, and beliefs, Group II had significantly lower knowledge scores than Group III (<math>F = 2.996, p &lt; .05</math>); but Group I significantly perceived mammograms as not necessary as Group II or III (<math>F = 15.263, p &lt; .01</math>).</p> <p>Post-intervention: significant positive changes were noted in Group III for acculturation (<math>p &lt; .05</math>), knowledge, obstacles, self-efficacy, fear, modesty, and fatalism (<math>p &lt; .001</math>) while Group I and Group II significant positive changes include knowledge, obstacles, and fatalism (<math>p &lt; .001</math>). Additionally, Group II also had significant positive score on self-efficacy (<math>p &lt; .001</math>).</p>	<ol style="list-style-type: none"> <li>1. Findings might not be generalizable among KI women who have been diagnosed with breast cancer.</li> <li>2. Findings might not be generalizable to KIs living in rural areas nor those who can afford mammography screenings.</li> <li>3. Self-reports could bias results.</li> </ol>

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Table 1 (Continued)

<p>Kim, M.T., Han, H., Hedlin, H., Kim, J., Song, H.J., Kim, K.B., &amp; Hill, M.N. (2011).</p> <p>Longitudinal (15 months)</p> <p><i>N</i> = 359 middle-age KI</p> <p>More intensive (<i>n</i> = 182)</p> <p>Less intensive (<i>n</i> = 177)</p>	<p>Determine the sustainability in lowering blood pressure with short-term education via home tele-monitoring and regular counseling by bilingual nurses.</p>	<p>More intensive group received biweekly telephone counseling while less intensive group received monthly telephone counseling.</p> <p>No significant improvements in more intensive and less intensive groups at 3, 6, 12, and 15 months (<math>p &gt; .05</math>); however, both groups were able to sustain the lower blood pressure at 15 months with the more intensive group showing greater control (68.86%) than the less intensive group.</p> <p>Scores for depression, self-efficacy, and blood pressure knowledge improved in the two groups but were not significantly different.</p>	<ol style="list-style-type: none"> <li>1. No true control group could bias results.</li> <li>2. Interventions were multi-faceted preventing precise conclusions for the two interventions (counseling versus home blood pressure monitoring).</li> <li>3. All participants not reporting same number of required blood pressure reports could skew the findings.</li> <li>4. The variety of participants' demographics (56.8% worked full-time, 94.4% married, &lt;40% lacked insurance, among other demographics) could skew the findings.</li> </ol>
<p>Kim, S.S., Kim, S., &amp; Gulick, E.E. (2009).</p> <p>Cross-sectional</p> <p><i>n</i> = 118 KI adult male smokers</p> <p><i>n</i> = 93 at one-month follow-up</p>	<p>Examine the psychometric properties of a Smoking Abstinence Self-Efficacy Scale with Korean American men (SASES).</p>	<p>Cronbach's <math>\alpha</math> for all instruments were <math>&gt; .70</math>. The item-to-item and item-to-total correlations of the SASES were significant except for "when you feel happy and celebrate" (<math>p &gt; .05</math>).</p>	<ol style="list-style-type: none"> <li>1. Results might not be generalizable to KIs living in other geographical locale.</li> <li>2. Self-reported measurements could bias results.</li> <li>3. Large attrition rate (<i>n</i> = 25) could bias results.</li> <li>4. Test-retest validity might not be valid with long interval (1 month).</li> </ol>
<p>Lee, E.E., Eun, Y., Lee, S., &amp; Nandy, K. (2011).</p> <p>Quantitative using telephone survey</p> <p><i>N</i> = 189 KI women in Midwestern US</p> <p>40-64 years old (<i>n</i> = 117)</p> <p><math>\geq 65</math> years old (<i>n</i> = 72)</p>	<p>Compare the socio-demographic and healthcare related characteristics, knowledge, and health beliefs with receiving cervical cancer screening based on the Health Belief Model (HBM).</p>	<p>There were significant differences in health beliefs between the older and younger groups of women. Older women had significantly higher perceptions of the seriousness, benefits, and barriers than younger women. Furthermore, Older women were more likely to obtain Pap test with decreased perceived barriers (<math>p &lt; .0001</math>) and increased perceived benefits (<math>p = .005</math>); whereas, younger women were more likely to obtain Pap test when perceived barriers were decreased (<math>p &lt; .0001</math>).</p> <p>Cervical cancer screenings were significant between the older (66.7%) and younger groups (95.7%); Younger KI have had a pap test (<math>p &lt; .001</math>).</p> <p>Younger KIs received pap test in the preceding three years (78.6%, <math>p &lt; .0001</math>) compared to older KI (44.4%).</p>	<ol style="list-style-type: none"> <li>1. Results might not be generalizable to KIs living in rural locale.</li> <li>2. Self-report could bias results.</li> <li>3. Significance level for the predictors was 0.10 which can skew the findings report.</li> <li>4. Telephone recruitment could introduce sample selection bias.</li> <li>5. Results might not be generalizable to the general population of KIs.</li> <li>6. Potential participants could have been overlooked in telephone recruitment (KIs who do not have Korean surname).</li> </ol>

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Table 1 (Continued)

<p>Lee, H., Kim, J., &amp; Han, H., (2009).</p> <p>Cross-sectional</p> <p><i>N</i> = 100 adult KI women history of mammogram (<i>n</i> = 51) no history of mammogram (<i>n</i> = 49)</p>	<p>Examine the correlations of mammogram use among Korean American women</p>	<p>Women who had mammogram in the past were significantly older (<math>p &lt; .001</math>) with mean age 58.5 years old and perceived benefits were significantly higher (<math>p &lt; .05</math>) than those who never had a mammogram. Cultural factors with significant association include perceived susceptibility (<math>p &lt; .05</math>) and perceived benefits (<math>p &lt; .05</math>). <i>Post hoc</i> analysis revealed English competency (little or no skills) were significant barriers in obtaining mammograms (<math>r = .42, p = .001</math>).</p>	<ol style="list-style-type: none"> <li>1. Self-reports could bias results.</li> <li>2. Causal inferences are not possible with cross-sectional studies.</li> <li>3. Convenience sampling could prevent generalizability of the results.</li> </ol>
<p>Lee, K.H. &amp; Yoon, D.P. (2011)</p> <p>Cross-sectional</p> <p><i>n</i> = 206 KI elders living in Los Angeles County and Orange County</p>	<p>Explore factors that influence the general well-being of low-income KI elders using the General Well-Being Schedule (GWBS).</p>	<p>Lack of English proficiency was a significant predictors for all six subscales of GWBS (<math>p &lt; .001 - p &lt; .05</math>). Length of residence in the US was significant predictor for all subscales except for positive well-being (<math>p &gt; .05</math>).</p> <p>Social Support was a significant predictor for all subscales except for general health (<math>p &gt; .05</math>). Depression was the only significant subscale that correlated with age (<math>p &lt; .01</math>). Religious/spiritual coping was significant predictor for anxiety, depression, positive well-being, and self-control (<math>p &lt; .05</math> for all subscales).</p>	<ol style="list-style-type: none"> <li>1. Purposive sampling could prevent generalization of the results.</li> <li>2. GWBS instrument was not tailored specifically for KIs which could be misconstrued by the KIs, thereby skewing the results.</li> <li>3. Causal inferences are not possible with cross-sectional studies.</li> <li>4. Findings might not be generalizable to KIs living in rural area.</li> </ol>
<p>Maxwell, A.E., Jo, A.M., Crespi, C.M., Sudan, M., &amp; Bastani, R. (2010).</p> <p>Post-randomization consent</p> <p><i>N</i> = 116 adult KI women in Los Angeles Koreatown Intervention (<i>n</i> = 58) Usual care (<i>n</i> = 58)</p>	<p>Test an intervention (appointment reminders, education, face-to-face meeting, form completion, and emotional support) to assist KI women with breast cancer screening.</p>	<p>No significant differences were noted in the demographics (<math>p &gt; .1</math>) and health-related characteristics (<math>p &gt; .1</math>) between the two groups.</p> <p>Self-reported completion was significant between intervention (97%) and usual care (67%) (<math>p &lt; .001</math>).</p>	<ol style="list-style-type: none"> <li>1. Small sample size could prevent generalizability of the findings.</li> <li>2. Large attrition (176/116) rate could bias results.</li> <li>3. Self-reports could bias results.</li> <li>4. Interviewers were not blinded which could bias results.</li> <li>5. Single peer navigator for the intervention group could limit the generalizability of the findings.</li> <li>6. Findings might not be generalizable to KIs living in rural area.</li> <li>7. <i>p</i> value set <math>&gt; .05</math> might bias results.</li> </ol>

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Table 1 (Continued)

<p>Shin (2011). Cross-sectional <i>n</i> = 517 adult Korean Americans in Midwestern city</p>	<p>Examine the health and physical activity of Korean American adults</p>	<p>Korean Americans who were younger (&lt; 41 years old), male, unmarried, and physical/mentally fit were significant for vigorous activity (<math>p &lt; .05</math>). Acculturation was positively correlated with more vigorous activity (<math>p &lt; .05</math>). No significant differences were seen with education, income, and employment status.</p>	<ol style="list-style-type: none"> <li>1. Findings in Table 3 were not congruent with the narrative.</li> <li>2. Findings might not be generalizable to other KIs.</li> <li>3. Causal inferences are not possible with cross-sectional studies.</li> </ol>
<p>Sin, M., Fitzpatrick, A.L., &amp; Lee., K. (2010). Qualitative using photovoice <i>N</i> = 20 <i>n</i> = 7 adults <i>n</i> = 6 teenagers <i>n</i> = 7 children 9-12 years old</p>	<p>Describe cardiovascular health perceptions among multi-generational Korean immigrants using photovoice</p>	<p>Similar perceptions among all participants were noted. Common theme promoting cardiovascular health was exercise. Common theme promoting poor cardiovascular health was diet.</p>	<ol style="list-style-type: none"> <li>1. Small sample size could bias results</li> <li>2. Convenience sampling could bias results.</li> <li>3. Gender distributions were unequal which could bias results (<i>n</i> = 13 males; <i>n</i> = 7 females).</li> <li>4. Level of education was unequal between the groups which could bias results.</li> </ol>
<p>Sin, M., Jordan, P., &amp; Park, J. (2011). Qualitative <i>n</i> = 28 adult KI in Washington State 2 groups of 7 women and 2 groups of 7 men</p>	<p>Understand perceptions of depression in KIs.</p>	<p>Causes of depression included language barrier, lifestyle changes, different culture/food, poor economic and social status, isolation, and loneliness. Ways KIs prevented or coped with depression included being socially interactive, attending churches, and staying busy (diligent). KIs interchanged acculturation stress with depression.</p>	<ol style="list-style-type: none"> <li>1. Results might not be generalizable to other KI population.</li> <li>2. Level of education was unequal which could skew results.</li> <li>3. Participants' ages (40 – 81 years old) varied widely within each group which could bias results.</li> <li>4. Length of US residency was unequal which could bias results.</li> </ol>
<p>Yang, K. (2007). Cross-sectional <i>n</i> = 137 adult KI women in Central Texas</p>	<p>Determine how KI women perceived health and to identify associations between social indicators and the health of KIs.</p>	<p>Among all variables, length of residency and participation in exercise were significant predictors to the perception of health status (<math>r = .226, p &lt; .001; F = .445, p = .022</math>, respectively). 48.9% of participants rated their health as fair or poor.</p>	<ol style="list-style-type: none"> <li>1. KIs with health problems affecting mobility were excluded, which could bias the findings.</li> <li>2. Nonprobability sampling might not be representative of the total population of KI, thereby results might not be generalizable to other KIs.</li> <li>3. Length of US residency and level of education could bias results.</li> </ol>

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Table 1 (Continued)

<p>Yoo, G.J. &amp; Kim, B.W. (2008).</p> <p>Mixed-method</p> <p><i>n</i> = 14 interviews  <i>n</i> = 268 surveys  adult Korean Americans in large metropolitan areas in California</p>	<p>Determine barriers and challenges to health service use among insured and uninsured KIs.</p>	<p>There were no significant differences in using health services between the two groups except for the use of traditional Korean health services such as herbalist/acupuncturist (<math>p = .014</math>), furthermore, high deductibles and premiums prevented insured participants from using available health services.</p>	<ol style="list-style-type: none"> <li>1. Findings might not be generalizable to KIs living in rural areas.</li> <li>2. Mismatched number of interview respondents compared to the survey respondents could bias results.</li> </ol>
<p>Yoo, J.A. &amp; Zippay, A. (2012).</p> <p>Qualitative Cross-sectional</p> <p><i>N</i> = 15 elder KIs in central New Jersey  <i>n</i> = 13 females and  <i>n</i> = 2 males</p>	<p>Examine the composition and cultural context of the social networks, resources, and supports among low-income elder KIs.</p>	<p>Non-kin KIs and Korean organizations were the primary sources of social contacts. Most cited socialization barriers were related to Language and transportation difficulties.</p>	<ol style="list-style-type: none"> <li>1. Findings might not be generalizable to the general population of KI population, especially those living in rural area.</li> <li>2. Low number of respondents could bias results.</li> <li>3. Gender inequality could bias results.</li> </ol>

**Chapter 3: Health and Healthcare among Korean Immigrants Living in Rural Texas**

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## Abstract

**Background:** Little is known about rural Texas Korean immigrants' health, health perceptions, healthcare practices, and influencing factors.

**Purpose:** The purpose of this study was to explore health, health perceptions, healthcare practices, and influencing factors among Korean immigrants living in rural Texas through a cultural lens.

**Method:** This study used an ethnographic approach for a qualitative study.

**Findings:** Five major themes related to health and healthcare among Korean immigrants living in rural Texas included (a) acculturation, (b) health and health perceptions, (c) healthcare, (d) relaxation and extracurricular activities, and (e) social connectedness. Health and healthcare among Korean immigrants living in rural Texas were similar to those living in metropolitan areas. Health issues included hypertension, hypercholesterolemia, viral hepatitis, and allergies. Barriers common to health and healthcare were lack of time, lack of English competency, and financial constraints. Rural immigrants tended to utilize home remedies rather than professional healthcare. When professional healthcare was sought, Korean immigrants preferred to utilize Korean healthcare providers.

**Conclusion:** Korean immigrants living in rural Texas reported their health to be "good" despite having chronic health problems. Furthermore, Korean immigrants did not perceive the need for improving their health or healthcare. However, lack of financial means was a common thread deterring them from professional healthcare. Future studies are warranted to determine how best to serve this vulnerable population.

*Keywords:* Korea immigrants, rural, Texas, healthcare

Rhoads (2012) reported that Texas experienced a significant population growth of Korean immigrants (KIs) since the liberalization of the immigration law in 1965. According to ZipAtlas (2012), five of the top ten towns with the highest percentage of KIs were located in rural Texas. Vulnerable populations living in rural areas have disproportionate levels of health disparity (National Institute of Health [NIH], *n.d.*). The healthy initiatives are aimed to decrease health disparity. Furthermore, the objectives of Healthy People 2020 (HP 2020, 2013) assist in decreasing health disparity by focusing on improving access to comprehensive, quality healthcare services; enabling patients to locate healthcare providers whom they trust; and promoting and providing health equity. Additionally, the goals for Texas Health and Human Services (HHS, 2010) are to “promote the health, responsibility, and self-sufficiency of individuals and families” (p. 3). The fostering of these initiatives requires knowledge of rural KIs health and healthcare.

Knowledge of health and healthcare among KIs is lacking (Han, Kang, Kim, Ryu, & Kim, 2007; Park & Grindel, 2007; Weir, Tseng, Yen, & Caballero, 2009). Health disparities continue to be prevalent among KIs with preventable or controllable diseases (Choe et al., 2005). Furthermore, rural living exacerbates these health conditions since rural residents tend to be poorer, older, and have poorer overall health (Agency for Healthcare Research and Quality [AHRQ], 2011). A better understanding of health and healthcare among KIs living in rural Texas might lead to service and resource development to meet identified needs.

### **Human Subjects Protection**

Institutional review board approval was obtained from the university at which the primary investigator (PI) was enrolled and the university at which she was employed. Participants signed an informed consent and a separate consent for photography and observation. Participation was voluntary and participants were informed they could withdraw anytime without repercussion. Strict confidentiality and anonymity was ensured by (a) the use of pseudonyms in all written work, (b) all data was maintained in a secured area, and (c) electronic data was stored on a password protected computer.

## **Methods**

### **Research Questions, Design, and Purpose**

The purpose of this study was to explore health, health perceptions, healthcare practices, and influencing factors among Korean immigrants living in rural Texas through a cultural lens. Research questions that guided this study included (a) what are rural KIs' health and health perceptions, (b) what are rural KIs' healthcare practices, and (c) what factors affect rural KIs' health and healthcare?

### **Philosophical Underpinnings**

An ethnographic design as discussed by Fetterman (2010) was utilized for this qualitative study to examine health and healthcare among KIs living in rural Texas. Fetterman (2010) stated that ethnography portrays an authentic story from the emic perspective (KIs) while understanding what is observed by keeping an open mind. Furthermore, maintaining an etic (researcher) perspective provides a comprehensive picture during data collection and allows the researcher to use previous knowledge to “make sense of what [was] . . . collected in terms of both the native’s view and their own scientific analysis” (Fetterman, 2010, p. 22). Furthermore, ethnography allows the researcher to develop “cultural inferences . . . (a) from what people say; (b) from the way people act; and (c) from the artifacts people use” (Spradley, 1979, p. 8).

### **Setting and Sample**

The sample was recruited from rural regions of North Central Texas in close proximity of the researcher. The search area was increased to recruit participants until the data were saturated. Participants were recruited through snowball and convenience sampling. Recruitment flyers in both English and Korean were translated and back-translated by a Korean born local resident and posted on bulletin boards at Korean owned businesses. The researcher conducted all face-to-face interviews at the participant’s place of business. All but one interview were conducted after business hours. Twenty-dollar gift-cards were provided as an incentive to participate in the study.

Inclusion criteria were (a) Korean-born Koreans, (b) the ability to speak and comprehend English, (c) 18 years of age and older, and (d) reside in rural Texas. *Rurality* was defined as “all population, housing, and territory [that is] not included within an urban area” (U.S. Census Bureau, 2010, para. 3) and has a population of fewer than 50,000 people (U.S. Census Bureau: American FActFinder2, 2010). Participants were selected based on their ability to provide substantial data for the direct purpose of the research (Fetterman, 2010). Those who were not Korean-born Koreans were excluded. The sample population included 14 participants with 57% ( $n = 8$ ) males and 43% ( $n = 6$ ) females. The age range was 18 – 65 with the majority being less than 50 years old ( $n = 11$ ). Participants’ ages was delineated into two groups, those 18 – 34 years old who preferred to speak English (younger generation,  $n = 4$ ) and those 35 – 65 years old who preferred to speak Korean (older generation,  $n = 10$ ). Fifty percent of the participants lived in the US for over 10 years; the average number of years lived in the US was 14 years. All participants graduated from high school and 86% ( $n = 12$ ,  $SD = 1.57$ ) acquired education beyond high school. Nine of the 14 participants owned small businesses and five were employed by Koreans who owned donut shops. Four of the five employees were attending college and worked part-time at their parents’ businesses. The annual household income ranged from \$5,000 ( $n = 2$ ) to more than \$50,000 ( $n = 1$ ).

### **Data Collection**

Data were collected and recorded through fieldwork that included interviews, observations, and artifact retrieval. Data collection occurred between December 2012 and July 2013. Once consent was obtained, face-to-face interviews were arranged at a time and place convenient for the participants.

The Korea Immigrant Health Survey (KIHS), adapted from the *Community Health Needs Survey – Asian American Health Initiative* (CHNSAAHI, Hsu et al., 2005) with permission, was completed prior to the interviews. All surveys were scrutinized for completeness and any ambiguous statements were clarified during the interview. Interviews were conducted in English

using a semi-structured interview protocol. Nine participants were interviewed individually, each lasting approximately one hour. A group of three and another group of two participants were interviewed separately, each lasting approximately two hours. Additional meetings with two of the 14 participants were conducted to clarify or expand on previous statements. During the meeting, body language, voice tones, and other nuances were documented in the field notes. Detailed notes were taken during the interview. After each interview, a complete description of the interview and reflective journaling was documented. All but two interviews were audio-recorded; two participants refused to be taped.

In order to ascertain congruence in what participants say and how they act (Spradley, 1979), all were observed at their place of employment; interactions with and the ability to communicate with customers and other employees were the focus of these observations. The language spoken and body language were also noted. Photographs of the participants and their interactions with customers were not obtained since all subjects refused to have their pictures taken. Additionally, descriptions of the buildings and furniture arrangements of each business were noted. Artifacts were obtained including Korean newspapers and Internet websites that provided health and healthcare information for Koreans. Health related brochures written in Korean were also sought throughout rural communities.

### **Data Analysis**

Demographic data from the Korean Immigrant Health Survey were entered into the Statistical Package for Social Sciences<sup>18</sup> to obtain a description of the sample population. Qualitative data analysis was conducted using Fetterman's (2010) approach to ethnography, which maintained an iterative process throughout by configuring and reconfiguring data from interviews, field notes, and artifacts, among other methods to gain an overall picture. Analysis began with comparing what was said and observed. To facilitate the analysis, qualitative data were uploaded into the qualitative software NVivo 10 and line-by-line coding commenced. Once all texts were reviewed and coded, the coded texts were triangulated with notes from artifacts and

observations, which were then compared, contrasted, and combined into appropriate categories. The categories were then analyzed for major themes. During data analysis, a codebook (Table 1) was developed and relevant and meaningful texts were assigned to its appropriate codes and categories (Table 1).

A matrix was constructed consisting of domains by columns and the appropriate codes by rows. Themes were entered at the intersection of the appropriate row and column. A matrix analysis was conducted to complement the thematic analysis (Averill, 2002). Such a matrix analysis aided in summarizing the findings by highlighting differences and similarities across all the participants, thereby allowing the researcher to discover the meaning (Averill, 2002) of the health and healthcare among KIs in rural Texas.

Credibility was demonstrated through triangulation, member checking, observation, field notes, reflexivity, and maintaining a clear audit trail. An experienced qualitative researcher coded the data, further enhancing trustworthiness. Inconsistencies in the resulting codes were discussed and revised. Triangulation of data by both matrix analysis and thematic analysis significantly strengthened the study (Averill, 2002). Further reliability of the data was obtained through member checking; two participants reviewed interview transcripts, discussed the major themes, and addressed any discrepancies. A clear audit trail of recordings, transcriptions, artifacts, and field notes containing reflective journaling of the interview process and observations of the participants and businesses were maintained in a password protected computer. Reflective journaling allowed the researcher to identify and address biases throughout the study.

## **Results**

Five overarching themes emerged from this ethnographic study: (a) acculturation, (b) health and health perceptions, (c) healthcare, (d) relaxation and extracurricular activities, and (e) social connectedness. Figure 1 depicts a model developed by the researcher illustrating the five themes. Table 2 illustrates the five themes with its appropriate sub-themes.

## **Theme 1: Acculturation**

Acculturation is the “process of cultural and psychological change that results following [a] meeting between cultures” (p. 472) and involves assimilating and adapting to a new culture (Berry, 2010). Five categories emerged from the data related to acculturation: (a) language, (b) lifestyle, (c) Korean community, (d) diet, and (e) family. Differences were noted between the older and younger KIs on their primary language. However, diet, lifestyle, and family were similar between the two groups.

***Language.*** Language preference differed by generation. Even though the younger KIs ( $n = 4$ ) were fluent in both Korean and English, they preferred to use English. Many of the younger KIs’ friends were non-Koreans who did not speak Korean. In contrast, older KIs preferred to speak in their native language. However, older KIs were observed speaking English in short simple phrases with customers and non-Korean employees. The older KIs instilled the Korean language in their children while emphasizing the importance of English as one participant verbalized:

You never use English at home . . . I pester them culture, scripture, bible. . . Language is very important. Never don’t forget Korea. So every time, read book, Korean Bible, book so they understand Korean. . . . I’m already handicapped [in speaking] English. Two boys never handicapped English. . . . I very stress English, even in Korea.

***Lifestyle.*** Korean immigrants’ lifestyle was similar to that in Korea; both were fast-paced. One participant reported “Korea, people more fast. . . . Everything fast; people, personality is fast. . . . Everybody is competition, little kids, older people . . . so I work hard.” A busy lifestyle left minimal time for relaxation and extracurricular activities. All the participants either owned and managed small businesses such as donut shops and dry cleaners or were employed in such businesses. A common thread among small business owners was that they had “no more relaxing time” and according to one owner “donut shops, we work very . . . hard. . . . This job is very very sad you know, because of working . . . you don’t have space, time to rest.” On the rare occasions when not working, participants traveled more than 60 miles to attend church or shop at a Korean

market. Additionally, older KIs generally listened to Korean music and watched Korean shows from the Internet while the younger KIs, according to one participant, listened to “hip hop”, “rock”, and “eclectic” music whenever they “have time in between classes [and] when I exercise.” Listening to Korean music was relatively unusual among younger KIs.

***Korean community.*** Surprisingly, all the participants reported that they did not “know other Koreans [living in the same community] except for . . . family” even though they were aware that most donut shops were owned by Koreans. Socialization among KIs did not occur. Furthermore, no Korean organizations existed in the rural communities where the study took place. Instead, a few of the participants attended Korean church services in distant communities located over 100 miles away; however, such attendance was minimal because of work demands.

***Diet.*** Both the younger and older KIs’ diet consisted primarily of traditional Korean foods such as Kimchi and other pickled products, rice, fish, and eggs. A majority of the participants did not consume meat products. All participants agreed that traditional Korean foods were “spicy. . . . [and] quite balanced . . . [consisting of] carbs with fibers.” Younger KIs consumed a minimal amount of non-Korean foods, primarily from fast-food restaurants. One young KI stated that he “eat just about anything. Usually I eat my own food from my family.”

***Family.*** Family was important to both younger and older KIs. Four of the younger participants who attended college and lived away from home frequently visited family members. While at home and out of respect for their parents, younger KIs spoke Korean. Furthermore, college students living away from their parents frequently returned to their parents’ homes to assist with shopping and with the operation of the parents’ businesses. Many of the KIs had family members who immigrated to the US; however, they still traveled to Korea to visit other family members. Maintaining Korean names was more important to the older generation. When the younger generation immigrated, their names were changed to better reflect the American culture.



## **Theme 2: Health and Health Perceptions**

Data immersion on the health and health perceptions revealed five categories: (a) general health knowledge, (b) health perceptions, (c) holistic health, (d) health behaviors, and (e) barriers to health.

**General health knowledge.** Health knowledge among KIs was evident. Many participants were aware that a diet high in sodium and sugar was unhealthy. One participant stated “Salt not good. Too much, cause blood pressure problem.” Only one participant who owned a donut shop reported eating “a lot of donuts and sausage rolls” but realized that “it’s not good.” Some participants were aware that stress “can affect one’s train of thought” and “can affect [a person] negatively if it’s long term.” Most participants knew the importance of physical activity such as walking after a meal helped digestion and circulation. Many participants reported home remedies improved their health. One participant who used an inversion table stated “The table helps . . . [been using it] five times a week . . . [for] almost a year.” Another reported “Acorns have a lot of fiber . . . [and] are really good for your body,” “for everything, for cholesterol, diabetes . . . make your body function.”

**Health perceptions.** The presence of physical symptoms influenced KIs’ health perceptions. Many KIs reported themselves as “good” or “healthy” even in the presence of chronic health problems such as hypertension, hypercholesterolemia, and liver disease. Furthermore, health problems were not a concern when symptom free. This outlook was expressed by one participant with “tennis elbow” and upper respiratory symptoms: “Everything healthy . . . I never sick.” Another participant with hypertension and hypercholesterolemia stated “I’m healthy, survive.” One younger KI stated “I think I feel healthy . . . I know my blood pressure, I know my glucose level.”

**Holistic health.** Holistic health encompassed bio-physical, psychological, and spiritual aspects. Various physical health conditions were reported. One young participant complained of ankle, knee, and back pain from misuse. Older KIs reported several health problems. One older

KI complained of tennis elbow caused by repetitive motion. Several reported back and knee pains due to frequent bending while at work. Fatigue and stress from arduous work schedules were also common. Another expressed concerns about recent allergy problems from regular exposure to second-hand smoke while helping customers at the drive-through-window at work. “Spots” on the lungs, hypothyroidism, and “low blood” were also reported by another participant. Other KIs’ medical problems included sinus problems, hypercholesterolemia, and chronic weakness. One male participant reported hemorrhoids and colonic polyps that were surgically removed. Viral liver disease that was “not transferrable” was reported by another KI. Finally, older participants expressed concerns about dental health, such as cavities; one reported issues with the temporal-mandibular joints.

Participants’ knowledge of other KIs’ health focused on dental problems rather than general health; dental health was considered a higher priority. Many participants reported that they had no knowledge of other KIs’ general health condition. In cases where the participants did have some knowledge about the health of other KIs, they voiced that other KIs’ lifestyles and health knowledge were similar to theirs.

Relatively few KIs were concerned about their mental and emotional wellbeing, despite experiencing stress and fatigue from long work hours. Several KIs reported they were always happy and smiled frequently; they were never depressed. One even stated “What reason to be sad? I never have chance [reason] to be down.” However, emotional responses were related to the inability to communicate in English and isolation from families who lived in Korea. A general lack of time also caused poor sleep patterns and a disorganized home life, resulting in anger with oneself, an “acid problem” related to stress, and the inability to properly care for one’s spouse. Psychological and spiritual health was also attributed to financial constraints and a busy lifestyle resulting from owning and operating small businesses. One participant expressed concern by stating that “a lot of people don’t have insurance. . . . They run donut shop, they don’t have enough money to do that [maintain health]. . . . They [are] really stressed.”

***Health behaviors.*** Many participants engaged in healthy behaviors. Four subcategories emerged related to health behaviors: (a) addictive behaviors, (b) dietary habits, (c) health promotion activities, and (d) health information.

*Addictive behaviors.* A few participants regularly consumed alcohol. Those that did were aware of alcohol's effects; one participant stated "You drink too much your liver will be gone." Despite this knowledge, an evident lack of concern was exhibited among the younger KIs who considered the consumption of alcohol and liver problems to be "nothing really serious." The participants who utilized alcohol were usually younger and met friends at bars for socialization. Tobacco products were considered unhealthy by the participants and none smoked.

*Dietary habits.* Dietary habits were deemed important in maintaining health. One KI stated "We don't eat too much salt, or too much oil. We eat Korean food [more] than American food." Another with liver disease expressed having "throat allergy" after consuming foods containing monosodium glutamate; eating Korean food at restaurants was not possible.

*Health promotion activities.* A few subjects reported that they did not engage in any health promotion activities. Others engaged in health promotion activities such as riding bicycles, performing yoga, walking, utilizing exercise equipment, and stretching while at work. One considered staying busy at work to be a form of physical activity. A few participants performed dental hygiene practices such as gargling or flossing. One participant monitored blood pressure with automatic machines located in stores. Rarely did any of the KIs interviewed receive routine healthcare including cancer screenings. Only one participant received routine mammograms and another reported receiving annual influenza vaccine.

Physical exercise, meditation, reading, or speaking with family members were perceived to promote mental and emotional health. Additionally, spiritual health was facilitated by praying, listening to pre-recorded sermons, or listening to gospel music. Some participants believed that older KIs attended church more often than the younger generation to "handle psychological

stress.” One young participant met “friends [to] have a drink, talk, try to relieve the stress like that.”

Participants discussed the need for preventive services for KIs living in rural communities. Blood pressure and cancer screenings, mental health services, and routine dental health examinations were identified as needed services. Even among younger KIs, lack of health screening was a serious concern. One participant stated:

What if I have cancer right now and I don't know it. You hear about these articles all the time where it might be too late. . . . I would like to get a full check-up to see how I am right now and see what I need.

*Health information.* Korean immigrants sought health information from a variety of sources. Some participants searched for health information from Korean Internet sites such as [www.newskorea.com](http://www.newskorea.com). Several websites containing health related information were located. One website provided nutritional brochures and another had information about medical conditions, such as bronchitis and substance abuse. Both sites provided information in both English and Korean. Another site included a search feature so visitors could locate diseases and diagnostic information provided in Korean; however, visitors to the site would need to know the English medical terminologies. Other participants obtained health information from Korean newspapers printed at a large urban center located over 100 miles away, while others watched television shows broadcasted from Korea; health topics included colon and dental health, diabetes, hypertension, and healthcare advertisements for dental and alternative medicine. No health information written in Korean was found in the rural community. KIs sought information about teeth grinding, colon health, such as causes and preventions for hemorrhoids, and back pain. Younger KIs received health information from their parents. Only one participant reported acquiring health related advice from another KI who was a non-family member. One KI related the sharing of health information as follows:

[KIs] put [health information] on the refrigerator or tell the family member. I think that goes for . . . most Korean families as well. Like the mother would read certain article regarding child health or family health, and they would tell the family about it like, ‘Hey

don't eat this, don't eat that'. They would inform the whole family about it. . . . In Korean culture . . . they have high conscious about health so they would, you know if they find an article that is kind of shocking to them or intriguing them, they would really take it in.

***Barriers to health.*** A few KIs reported that nothing prevented them from maintaining good health. However, the majority of participants identified various barriers to health. Five subcategories for barriers to health included (a) daily schedule, (b) financial constraints, (c) English competency, (d) age, and (e) health constraints.

***Daily schedule.*** A busy daily schedule was the most frequently reported barrier to health. The majority owned donut shops working 14 or more hours each day. One participant stated “sometimes, you have to get up sometimes 1:30, sometimes 2:30 [in the morning].” Another reported “spending time here [work], going home, taking some food, go to park, come back [to work]” to prepare for next day. Nearly half of the participants explained that a “lack of time” because of long work hours prevented them from maintaining a healthy lifestyle. Because of the busy daily schedule, the inability to eat on a regular schedule prevented one KI from maintaining health. Another stated “Running donut shops, we cannot think about health or anything like that. Really sometimes, you don't have time. It take a long time . . . and taking care of our body [is not possible].” Furthermore, the amount of time available was usually insufficient to participate in healthy eating patterns and exercise routines.

***Financial constraints.*** Participants reported financial constraints as a barrier to health. Lack of insurance prevented KIs from obtaining health services. One KI stated that insurance “cost a lot of money . . . too expensive to buy insurance.” Additionally, the same lack of funds that prevented KIs from purchasing health insurance also made it difficult to maintain a healthy lifestyle or to pay for routine dental and preventive care. Small business owners had difficulty in “exercis[ing] like I want to because of work too long.” One participant with tennis elbow exacerbated the condition by required job activities and must work because of financial need. Consequently, taking time off from working to recuperate was not possible.

*English competency.* English competency was another factor that affected health and presented a barrier to maintaining good health. While younger KIs were competent in reading the English language, many of the older KIs reported that although they knew basic words and simple phrases required to operate their small businesses, the general lack of English proficiency negatively affected their overall health. One participant stated that “the language barrier” affects the ability to appropriately communicate with health professionals. Another stated the inability to effectively communicate caused stress and nervousness, or became “scared inside my heart.” Miscommunication was also illustrated as being harmful to health as one KI expressed: “I understand about donuts, about buying donuts but other things I can’t understand. . . . Sometime not understand [doctor]. Miscommunicates. Wrong take medicine. Sometime take wrong thing. So, that’s [communication] big problem still.”

*Age.* KI considered age a barrier to health. The majority reported that “getting older” negatively affected their health and prevented the ability to bend and lift properly while at work. Poor dental health was also identified as a problem due to aging. One participant reported that her age caused her to be “lazy” but was unable to “take a break” from working.

*Health constraints.* Various medical problems prevented some KIs from participating in a healthy lifestyle. One KI woman expressed the inability to take medicine due to the taste and difficulty swallowing, resulting in “make me throwing (*sic*) up.” Intermittent joint and back pain prevented “using [exercise] machines” stated one young participant. Poor mental and emotional health was a barrier to eating healthy; one participant stated: “Stress prevent eating, from eating, no tasty.” Additionally stress was implicated in promoting “insomnia.”

### **Theme 3: Healthcare**

Several factors influenced KIs’ healthcare, healthcare practices and experiences, and healthcare knowledge. Three major categories emerged: (a) barriers to healthcare, (b) perceptions regarding the need for healthcare, and (c) healthcare practices.

***Barriers to healthcare.*** Barriers to healthcare included financial considerations, English competency, and work schedule.

*Financial constraints.* One barrier to healthcare was financial constraints. Many KIs reported they did not have health and dental insurance because of the cost. Even among participants who had health insurance, high co-payment or deductibles prevented them from obtaining adequate healthcare. One KI stated, “. . . the financial, like before we go in there [clinic], we’re worried about how much this going to cost even just getting check-up or something.” Because of the financial constraints, many sought medical and dental care in Korea town over 100 miles away or traveled to Korea where healthcare cost was often negotiated. One participant stated “If one goes to a Korean doctor [in the US], you might be able to get better deal . . . even with Korean dentist.” Another stated “You work out financial options that are more viable than with [non-Korean providers].” One participant verbalized that finances were not an issue in obtaining healthcare; healthcare benefits were provided by the spouse, but dental care was paid out-of-pocket. The cost of dental care among small business owners was often negotiated: “I don’t have [dental] benefit . . . one time . . . charged me \$4,000 . . . I pay \$2,500, half price.”

*English competency.* Lack of English competency prevented KIs from obtaining healthcare, especially among older participants. Older KIs knew basic words and phrases to effectively own and manage their small businesses but not to adequately interact with the healthcare system and providers. Many felt that if they were able to speak better English, then they “can visit clinic, community but is not comfortable, not good [speaking English]” as one older KI stated. Furthermore, older participants were more comfortable with a provider of the same cultural background and one who spoke Korean: “It’s very easy to explain our symptom to Korean doctor. America, not so, we cannot explain ourselves. . . . We don’t know English words to explain” and another stated “I don’t know terminology of medicine [in English].” On the other hand, younger KIs preferred to see a doctor who spoke English since “medical words in Korean is

a big factor in going to a Korean doctor because one is not able to describe their symptoms.” Another younger participant stated “They [Korean doctor] mostly speak Korean . . . take care other Koreans and I rather speak English.” “English is what I’m most comfortable with” was reported by another participant. However, no Korean providers were located in rural communities where this study took place. Consequently, KIs tended to travel over 100 miles to see a Korean healthcare provider as one participant stated: “No Korean doctor here so naturally I go to [metropolitan city].”

*Work schedule.* Another major barrier in seeking healthcare was the participants’ work schedule. Since most Koreans owned and operated small businesses, they worked long hours every day of the week, and consequently did not have time to take off work for healthcare. One participant stated “Most Koreans are working all the time, so it’s hard to take a break and make an appointment to take care of things like [health issues].” Even with health benefits, one subject stated “I never have the time for check-up or anything like that.”

*Perceptions regarding the need for healthcare.* The perceived seriousness of health concerns prevented some participants from seeking healthcare. Many participants waited to obtain healthcare because, “You don’t really feel the need for [healthcare] unless you’re really, really sick or something is really wrong with you.” Even though medical conditions such as anemia and “spots in the lungs” were reported, healthcare was not sought because of the lack of symptoms. One participant stated:

[Physicians] recommended . . . to check [the spots in the lung] and if they get to be bigger it’s a big problem. They told me but I never check it. I don’t have any symptom about that and then so I think I health[y].

Many participants would seek healthcare if their health was in jeopardy. Even among other KIs, it was common that “[they] wait until it actually affects them . . . you know time wise, financially wise.”

*Healthcare practices.* Healthcare practices among KIs while in the US were different from when they were in Korea. When in Korea, participants routinely sought professional



healthcare since “[Korea is a] free country, good to see doctor.” Since immigrating to the US, many participants did not seek routine healthcare except when pregnant. A few older participants were uncomfortable when healthcare was sought in the US. One older KI stated that “He’s a doctor, so, I kind of scared . . . I can’t complain anything about that.” Further data immersion revealed three subcategories related to healthcare practices: (a) knowledge of the US healthcare, (b) healthcare practices in the US and Korea, and (c) quality of healthcare in the US and Korea.

*Knowledge of the US healthcare.* Many participants did not understand the American healthcare system and did not know “how . . . [to] changed (*sic*) the doctor. It’s kind of complicate for me.” Older participants stated that they did not learn the American healthcare system upon arriving in the US. What knowledge KIs did have about the American healthcare was mostly related to the quality and cost of healthcare as illustrated by one participant:

Comparing America’s healthcare system to other countries, you see it’s inferior, like it doesn’t work too well. . . . It can be better. . . . Basically, it . . . is pretty expensive, especially if there is trouble. . . . If there was a national healthcare system, like people obviously don’t have to worry too much about getting sick. And it seems like in America if you get sick once, you’re screwed [financially] especially if you don’t have insurance.

Another KI described the American healthcare system as follows:

[American healthcare system is] fairly accessible. Even in small community, there are plenty of clinics or hospitals you can go to. But, I think the main issues, you know the financial, like before we go in there [doctor], we’re worried about how much this is going to cost even just getting check-up or something. . . . People [KIs] here especially have the notion that medical is expensive and they tend to be. . . . I think it is accessible but not accessible in financial terms.

Younger KIs learned enough about the healthcare system to “know what doctor I need for certain things.” The perceived quality of healthcare also influenced when and where healthcare was sought.

*Healthcare practices in the US and Korea.* Prior to moving to rural Texas, some participants lived in a large Korea town in Orange County, California. Korea town had healthcare facilities owned and operated by Koreans; therefore, knowledge of English and the American healthcare system were unnecessary. Since moving to rural Texas, all the participants

reported seeking professional healthcare when they perceived a “serious problem” as reported by one participant: “Only like whenever I’m sick. If I’m sick enough. . . . Other than that I try to rest when I know it’s nothing serious.” In addition to resting, most KIs with medical problems routinely used home treatments rather than professional healthcare. Self-treatments included using an inversion table for back and knee pains, taking “Nyquil” for cold symptoms and to promote sleep, cupping to “help with circulation”, and blood-letting for joint pains. All the participants reported using over-the-counter medications such as acetaminophen and sleep aides. In addition to cupping and blood-letting, acupuncture was utilized among a few of the participants. Other alternative therapies included the consumption of pear juice, acorns, garlic, and ginger. All the participants stated that they rather not take medications, but chose instead to “endure it” except in the case of dental health. Dental care was seen as “more essential” and overcoming the problem was “considerably quicker” compared to physical health issues.

When professional healthcare was needed, many participants did not know where to obtain the appropriate services. Healthcare referrals were often obtained by “word of mouth” from family members, friends, or pastors. KIs preferred to travel to a Korea town, a Korean cultural district, located in large metropolitan areas over 100 miles away for healthcare when necessary. One participant used vacation time to travel to California for healthcare. Reasons for obtaining healthcare in Korea town included the ability to “work out financial option that is more viable” and the ability to communicate in Korean.

However, many KIs waited until they traveled to Korea to obtain health and dental care, but because of immigration travel limitations, travel was limited to every five years (U.S. Department of Homeland Security, 2007). Even with the travel cost to Korea, it was cheaper to obtain healthcare in Korea than in the US. One participant described the Korean healthcare system as “Everywhere is hospital, small hospital . . . easy go to see a doctor . . . free medication, is cheap . . . so I want to always get to see a doctor.” Additionally, a special healthcare program was available for KIs living abroad. One KI stated that a “[person] under 60 years old, [cost of

healthcare was] reimburse[d] [and they receive] free medication, is cheap, is paid.” Another stated the following:

[In Korea] all the specialists [are] in one place. . . . There are so many [Koreans] coming back [to Korea] getting treatment. They have this special program for foreigner Koreans coming in. . . . [They have healthcare] package and they get all this [healthcare] service. [KIs] just buy it and it’s easier.

Being treated with equality was another reason for seeking healthcare in Korea; one KI stated “Same race or same ethnicity. I think you would be treated with more equal.”

*Quality of healthcare in the US and Korea.* The care received in Korea was deemed better than that provided in the US. One KI expressed that Korean healthcare providers were “smart . . . Korean is good in precising (*sic*) small tiny job. . . . Is good at small thing, like industry, semi-conductor.” Another participant stated that the American healthcare system was “not very good [and that] Korea [was] very good. So, I want to go to Korea.”

When professional healthcare was sought in the US, many participants had unfavorable experiences. One who had no health insurance explained the frustration of seeking childhood immunizations at the local community clinic:

[The staff at the clinic] gave me some information and then [she told me that] we need to bring in tax information. . . . But at that time my son didn’t have time, and then they don’t give exact information at the time. My son and husband went to some [other] place.

Participants were frustrated because of fragmented services such as having to wait to see a specialist and receiving inappropriate treatment, as one participant reported:

If I go family doctor, it takes more than two months, right? Go [to the family doctor], and [ask if I] can go to specialist. Family doctor keep giving [me] medicine. Family doctor say I got a virus. Specialist say no, your ear is just dryness, that why itching, put some olive oil. Family doctor . . . give me very strong medicine. That why I hate going to family doctor. That why I don’t use my insurance.

Another participant voiced concern when her child received the same treatments as herself for similar symptoms:

Same medicine he give me. But it is not good for my son. Maybe in Korea . . . a doctor changes things, change method to help patient. . . . Maybe take an x-ray in lung or something another area to help patient, maybe blood test.

One KI described her experience with the emergency room in the US as “slow” but was aware that there were “many patient problem . . . they delay . . . other patients go first . . . because, you know people has heart attack and a lot of really, really severe [health problems].”

#### **Theme 4: Relaxation and Extracurricular Activities**

A variety of extracurricular activities provided relaxation. The majority of KIs listened to Korean music or watched Korean drama broadcasted from Korea. Many read Korean newspapers published from a large metropolitan area. The younger KIs exercised or played video games. The majority of the participants stated that they slept for relaxation. Some mentioned the desire to travel but were unable to do so because of their business. Only one participant stated that the business was closed for one to two weeks during the summer for vacation; others “close one day a year.”

#### **Theme 5: Social Connectedness**

Social connectedness provides a sense of belonging and social identity by developing relationships with others (Soleimani, Negarandeh, Bastani, & Greysen, 2014). Social connectedness was rare among the participants; participants did not socialize with non-kin KIs. Additionally, social networks of Koreans within their community were lacking and no faith or non-faith based Korean organizations were available. Participants acknowledged that other KIs lived in their community but did not personally know them. According to some participants, Koreans tended to keep to themselves and not socialize outside the family, choosing to maintain privacy instead. One stated that “sleep-overs would be quite common among [American] friends but Korean, not much people stay over. . . . It’s like the whole family . . . [keeps] to their own.” Even among KIs married to a non-Korean, socialization did not occur. One such participant tried to meet other KIs who were married to non-Koreans, but was told “[I] never associate with the Koreans . . . [and that] she [was] not interested.” Some KIs interviewed reported that they traveled outside their community to be with other Koreans; however, such travel was infrequent due to work schedules. Older KIs went to Asian markets and Korean churches located over 100

miles away to be with other KIs. One of the younger KIs met Korean friends at restaurants or bars.

Another reason for not socializing with other KIs was that others were viewed as business competitors, for example, donut shop owners. One participant stated “All donut guys, competitor.” Another reported “We have competition here, talks bad about each other.” Furthermore, older KIs did not socialize with non-Koreans due to “everything difficult because of language problem. Conversation and in community, every information . . . to store, to market it’s okay.” Another participant expressed frustration in not being able to converse with other people in Korean. Instead, the participant would “look in mirror [and] talk in Korean . . . speak Korean to self in mirror.” In contrast, the younger KIs tended to socialize more with non-Koreans.

### **Discussion**

Research on rurality and health suggested health resources were more limited in rural regions (Kim, 2006), and rural dwellers generally had poorer overall health (AHRQ, 2011). Additionally, knowledge of KIs’ health and healthcare is limited (Choe et al., 2005). The purpose of this ethnographic research was to explore the health and healthcare among Korean immigrants living in rural Texas. Data collection was done through interviews, observations, and artifact retrievals. Artifacts included Korean newspapers containing health information on diabetes, high blood pressure, dental care, and colon health. Internet sites provided information on multiple medical conditions in English and Korean; however, no artifacts in Korean were found where participants resided.

Korean organizations are sources for acculturation, healthcare information, and socialization for KIs living in the US (Jo, Maxwell, Yang, & Bastani, 2010). Community groups such as churches provided assistance via human and community development programs, for example, translation, health insurance, and food co-op (Boddie, Hong, Im, & Chung, 2011). This study revealed no Korean organizations in the rural communities represented in this study.

Consequently, participants lacked venues to learn about the American healthcare system, gain language proficiency, or socialize with others.

Kaiser Family Foundation (KFF, 2008) reported that KIs tended to be healthier than other Asian immigrants; however, in prior research KIs consider their health as fair to poor (Eun, Lee, Kim & Fogg, 2009; Sohn, 2004). KIs in this study reported their health as “good” and “healthy.” However, health concerns existed. Previously, stress was linked to depression (Bernstein, Park, Shin, Cho, & Park, 2011). However, KIs in this study did not report symptoms of depression even though their work schedule caused fatigue and stress. Furthermore, some KIs in this study participated in health promoting behaviors such as maintaining a healthy diet, exercising, and abstaining from alcohol and tobacco. However, participants lacked health screenings and preventative medicine which reflects previous research (Lee, Eun, Lee, & Nandy, 2011; Kim, Menon, Wang, & Szalacha, 2010).

KIs used over-the-counter and alternative therapies for most health complaints rather than Western healthcare. These findings are consistent with research conducted in large cities (Choi & Kim, 2010; Hsiao, Wong, Goldstein, Becerra et al., 2006; Hsiao, Wong, Goldstein, Yu et al., 2006; Kim, 2009; Mehta, Phillips, Davis, & McCarthy; 2007; Zhang et al., 2008). Experiencing disrespect or discrimination due to ethnicity was similar to a previous study (Jang, Kim, & Chiriboga, 2005). Additionally, KIs in rural communities felt the American healthcare system was fragmented and many had unfavorable experiences. KIs in large cities were reluctant to seek Western healthcare for many reasons, including financial constraints, the inability to speak English, and the lack of Korean providers (Jo, Maxwell, Rick, Cha, Bastani, 2009; Kwok et al., 2011; Weir et al., 2009). Results of this study indicated KIs living in rural Texas were reluctant to access the US healthcare system for the same reasons. In the case of rural KIs, owning small businesses and consequent work schedule also prevented them from obtaining healthcare.

According to previous research, KIs do not generally participate in leisure activities (Choi, Wilbur, & Kim, 2011; Shin, 2011). However, this study indicated that some KIs living in

rural Texas routinely engaged in some form of physical activity, such as exercising and walking in parks and neighborhoods. Other activities included listening to music and watching Korean shows. However, the amount of leisure activities was minimal due to their daily schedule, even among the younger generation.

As a Korean born Korean who immigrated to the United States at the age of seven years old, I share many of the experiences of the participants in this study. Speaking only Korean when I came to the United States, I naturally struggled with language issues which made it difficult to communicate at home, at school, in the community, and with medical providers. I also experienced a lack of socialization outside my family since my adopted American parents were not social people and did not allow me the opportunity to socialize with others. Most children who immigrate to the United States at a young age do not have an understanding of the American healthcare system, and I was no exception. However, growing up in an American family exposed me to the US healthcare system. Furthermore, my education and professional career as a registered nurse and nurse practitioner allowed me to gain more knowledge about the healthcare system. My American family worked hard with decent jobs to provide the financial resources necessary so that I received adequate healthcare. Therefore I was never burdened by the financial constraints experienced by many Korean immigrants. Finally, my access to healthcare was not limited by long work hours like many adult Korean immigrants. In conclusion, I have acquired a rich mixture of both Korean and American cultural aspects which provided me a rare insight into both the American healthcare system as well as the reasons behind the barriers discussed by KIs in this study.

### **Recommendations**

Promoting health and improving healthcare access are essential if health disparity is to be decreased (AHRQ, 2011). Findings from this study indicated barriers to health and healthcare for KI participants included the inability to obtain linguistically accessible and affordable care. In fact, many KIs traveled to Korea for healthcare, which is restricted to every five years due to

travel limitations (U.S. Department of Homeland Security, 2007). Future studies are warranted to determine how best to serve rural KIs' health and healthcare needs in addition to provision of socialization opportunities. Community based participatory research (CBPR) offers stakeholders (KIs, community leaders, and healthcare providers) an opportunity to "address complex health and social problems" (p. 5) particularly when targeting diverse populations (Minkler & Wallerstein, 2008). Core principles of CBPR include participation, cooperation, co-learning, capacity building, empowerment, and balance between research and action (Minkler & Wallerstein, 2008). Furthermore, CBPR promotes cultural sensitivity enhancing both research and population outcomes (Viswanathan et al., 2004). A CBPR approach involving rural KIs would likely improve quality and outcomes. In addition, research should investigate the impact of the Patient Protection and Affordable Care Act (PPACA) on KIs' health and healthcare. With the health reform mandate, the rate at which KIs acquired coverage, usage, and satisfaction with care should be explored.

### **Study Limitations**

Several limitations were identified including a small sample, which prevents generalizing the findings to other KIs. Another limitation was the use of convenience and snow-ball sampling methods. The researcher is a KI which might have biased the etic perspective, having shared many of the participants' experiences as a Korean-born Korean. However, the researcher has resided in the US for over 40 years, was educated in the US and as a provider, is familiar with the American healthcare system. This combination of American and Korean cultural backgrounds might have influenced how the researcher interpreted participants' perceptions and actions related to their health and healthcare. Finally, some of the participants lived in the same community as the researcher; this might have impeded the participants from being honest with their responses.



## **Conclusions**

Insights into rural KIs' health, health perceptions, and healthcare in addition to leisure and socialization activities were uncovered. Most KIs described their health as "good" but had chronic health conditions and did not perceive health and healthcare needs. In addition, participants did not utilize professional healthcare nor did they socialize in the community in which they resided. A variety of influencing factors on health and healthcare included lack of English competency, perceived need for healthcare and understanding of the healthcare system, financial and health constraints, and daily work schedule. Recreational activities included walking or exercising, listening to music, watching Korean drama, playing video games, sleeping, and meeting friends. KIs did not socialize with other KIs because of daily work schedules and seeing other KI business owners as competitors, yet participants missed their heritage. No Korean organizations or organizations that assisted KIs were located in the community where the participants lived. Health information was obtained from a Korean newspaper published in an urban area over 100 miles away, family members, or online. Future studies that involve key stakeholders including KIs should determine how best to provide health and healthcare services to rural KIs.

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Table 1  
Codebook

Codes	Definition	Inclusion/Exclusion Criteria	Example from Text
<b>ACCULTURATION</b>	Any statements by the participants on how and what of the American culture was assimilated with the Korean culture	<p>Inclusion: statements that include the ability to learn and integrate American culture with the Korean culture, whether it was a positive or negative experience(s) (i.e. diet, family, Korean community, language, and lifestyle)</p> <p>Exclusion: any statements related to health or healthcare (i.e. “pastor helped me find doctor”).</p>	They [music] are American and Korean. But, I mostly listen to Korean. Internet, you know, you can listen to Korean songs. But my kids, they listen to American so I listen too, sometimes.
<b>Language</b>	Any statements by the participants related to language(s)	<p>Inclusion: any statements pertaining to the language used and the comfort of speaking English or Korean with families, friends, and in the community</p> <p>Exclusion: any statement showing a relationship between language difficulty and health/healthcare</p>	I’m already handicapped [in speaking] English. Two boys never handicapped English. ... I very stress English, even in Korea.
<b>Lifestyle</b>	Any statements by the participants on lifestyle	<p>Inclusion: any statements that pertain to KIs’ daily lifestyle with work, play, family obligations, etc</p> <p>Exclusion: any lifestyle statement related to health or healthcare.</p>	Donut shops, we work very very ... hard. ... My situation is very very sad. This job is very very uh sad you know, because of working ... you don’t have space, time to rest. A lot of customers do not understand ... donut shop people situation. We work very very hard operation. You cannot make a lot of money to hire a lot people.

Continued on next page

Table 1 (Continued)

<b>Korean Community</b>	Any statements about the knowledge of other Koreans, Korean communities, and/or whether KIs sought assistance with assimilation and adaptation to the American culture	Inclusion: any statements by the participants related to the knowledge of other Koreans living in the same community as that of the participants; statements related to the knowledge of any Korean community; statements related to seeking assistance from Koreans or a Korean community that assists KIs in assimilating and adapting to the American culture.  Exclusion: any statement related to health or healthcare (i.e. “pastor helped me find doctor”.)	Really I don’t get to know anyone [other Koreans]. We don’t visit each other you know.
<b>Diet</b>	Any statements by the participants on the types of food consumed	Inclusion: statements related to KIs’ dietary habits (i.e. Kimchi, pizza, rice, etc.)  Exclusion: any dietary statements consumed as related to health or healthcare (i.e. “I eat healthy”.)	I eat just about anything. Usually, I eat my own separate food from my family. I eat like chicken breast, brown rice, veggies, beans, cheese. Basically, I eat anything that’s good for me.
<b>Family</b>	Any statements by the participants related to family	Inclusion: statements related on the significance of the family, where other family members live, and what the family values are  Exclusion: any statements on family related to health or healthcare (i.e. “my dad went to Korea for dental care”.)	When [they] come to America, they change name.
<b>HEALTH AND HEALTH PERCEPTIONS</b>	Any statements by the participants on health, whether positive or negative	Inclusion: any statements about general health knowledge, health perceptions, barriers to health, health behaviors, and health concerns/problems holistically  Exclusion: any statements related to healthcare not directly linked with health	My health? I don’t know. You know, I have no problems. I guess, I healthy. I don’t believe there is anything wrong with me.

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Table 1 (Continued)

<b>General Health Knowledge</b>	Any statements by the participants on the general health knowledge	Inclusion: any statements on health related knowledge, such as sodium causing hypertension.  Exclusion: any statements about healthcare not directly linked to general health knowledge	Salt not good. Too much cause blood pressure problem.
<b>Health Perceptions</b>	Any statements by the participants on health perceptions	Inclusion: any statements on health perceptions, including bio-physical, mental/emotional, spiritual, and dental health and how previous health history affected health  Exclusion: any statements about perceptions of the healthcare system in the US or Korea	I mean I am healthy, but I guess I would still rate it fair because of my injuries.
<b>Holistic Health</b>	Any statements by the participants on health concerns and problems holistically	Inclusion: any statements alluding to KIs' medical (i.e.: HTN, DM, cancer, stress, depression, etc.), dental, and mental problems  Exclusion: any statements related to healthcare not directly linked to holistic health	My legs [hurt] during sleep; I felt it. I have problems with blood circulation [and] at night [my] legs hurt.
<b>Health Behaviors</b>	Any statements by the participants on the activities engaged affects health and whether the activities are perceived as beneficial	Inclusion: any statements on what KIs do that affect health, such as activities that promote mental, emotional, and spiritual health; activities that are addictive, such as smoking; dietary habits related to health; health promotion activities such as health screenings and seeking health information and what is done with the health information  Exclusion: any statements related to healthcare not directly linked to health	The best of medicine is exercise. Here doctor say you need to [exercise] 2-3 times a week, [so] I take recommendation.

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Table 1 (Continued)

<i>Addictive behaviors</i>	Any statements by the participants on the types of addictive behaviors engaged in and how the addictive behaviors affects health	Inclusion: any addictive behavioral statements  Exclusion: any statements related to healthcare not directly linked to addictive behavioral health	I drink a lot cuz ( <i>sic</i> ) when you get together with friends... especially younger, younger people they drink a lot.
<i>Dietary habits</i>	Any statements by the participants on dietary habits and how they affect health and whether dietary habits are perceived to maintain or improve health	Inclusion: any statements on dietary habits related to health  Exclusion: any statements related to diet that is not related to health behaviors.	I eat seaweed. Has iron. I use it a lot with the garlic.
<i>Health promotion activities</i>	Any statements by the participants on the types of health promotion activities and how the activities help to maintain or improve health	Inclusion: any statements on health promotion activities, such as health screenings; activities promoting physical, mental, emotional and spiritual well-being; routine healthcare; seeking health information and what is done with the health information  Exclusion: any statements on activities that do not allude to health behaviors	I walking every day, take our dog, in park across street. Here at work walk a lot and usually after I eat, I walk. I think when I really get stressed, I let it out before it gets long term problem. I exercise, walk. Sometime I talk to my dad when I'm stressed.
<i>Health information</i>	Any statements by the participants on their sources of health information and what they do with the information	Inclusion: any statements on sources for health information (i.e. church, Korean organization, friends, and family) and what they do with the information (i.e. share the information with family members)  Exclusion: any statements on sources of information not related to health	They [healthcare providers] don't usually tell me much information. So [I] look at the internet. I like get information from there wanting to learn about health, to take care myself. So, I search. I learn and tell family what to do. I very interested in health.

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Table 1 (Continued)

<b>Barriers to Health</b>	Any statements by the participants on the barriers or perceived barriers to maintain or improve health	Inclusion: any statements related to barriers or perceived barriers to health such as work schedule, financial considerations, language fluency, age, physical constraints, and the inability to take medications  Exclusion: any statements related to healthcare not directly linked to health	You know run donut shop, right, and work seven days a week. So, uh I can't exercise like I want to because of work too long.
<i>Daily schedule</i>	Any statements by the participants on whether work schedule influences health and whether work schedule is perceived as a barrier in maintaining or improving health	Inclusion: any statements related to work schedule, including lack of time  Exclusion: any statements related to healthcare not directly linked to health	Running donut shops, we cannot think about health or anything like that. Really sometimes you don't have time. It take a long time. Really, you know, really we're poor and uh taking care of our body.
<i>Financial constraints</i>	Any statements by the participants on how financial status influences health and whether financial status is perceived as a barrier in maintaining or improving health	Inclusion: any statements alluding to how financial status affects health (positive or negative comments), including health insurance  Exclusion: any statements related to healthcare not directly linked to health	Insurance cost lot of money. You know, it's too expensive to buy insurance. So, I don't have insurance. I don't go to doctor too much. If too sick then I go.
<i>English competency</i>	Any statements by the participants on how language influences health and whether English fluency is perceived as a barrier to maintaining or improving health	Inclusion: any statements on how language affects health  Exclusion: any statement related to healthcare not directly linked to health	Sometime not understand each other. Miscommunicates. Wrong take medicine. Sometime take wrong thing. So, that's still big problem still.
<i>Age</i>	Any statements by the participants on how age influences health and whether age is perceived as a barrier to maintaining or improving health	Inclusion: any statement on how age relates to health  Exclusion: any statements related to healthcare not directly linked to health	I'm just getting lazy because I think of my age. I say, oh, I want to take a break you know, yeah, I want to take a break.

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Table 1 (Continued)

<i>Health constraints</i>	Any statements by the participants on how health conditions influence overall well-being and whether these problems are perceived as barriers to maintaining or improving health	Inclusion: any statements on how health is affected by health conditions (i.e. joint pains prevent exercising)  Exclusion: any statements on healthcare not directly linked to health	People got stress. First they don't want to eat. Sometime they can't sleep. Too much stress is main source of disease.
<b>HEALTHCARE</b>	Any statements by the participants on the factors that affect healthcare; what, where, and who provides care/treatments	Inclusion: any statements on what affects healthcare (i.e. healthcare barriers, healthcare knowledge, past healthcare experiences, and usual healthcare practices)  Exclusion: any statements related to health not directly linked to healthcare	I don't know. I know nothing about health in America. That time, I wasn't sick. So, you know I didn't need doctor. I went to doctor only when I delivered.
<b>Barriers to Healthcare</b>	Any statements by the participants on the actual or perceived barriers to effective healthcare	Inclusion: any statements alluding to healthcare barriers, including time constraint, perceptions for the need of healthcare, financial considerations, lack of Korean healthcare providers, language fluency, knowledge of the US healthcare system, and previous healthcare experiences in the US  Exclusion: any statements related to health not directly linked to healthcare	Language barrier that definitely has to do with it too, I think financially... lots of Koreans... they don't have healthcare. ... It is so expensive. So they wait until they... go to Korea because it is cheaper over there.
<i>Financial constraints</i>	Any statements by the participants on how healthcare is affected by financial status	Inclusion: any financial statements as related to healthcare, such as the ability to haggle the cost of healthcare with Korean healthcare providers, healthcare cost being cheaper in Korea or in the US Korea towns, lack of financial resources, and lack of health insurance.  Exclusion: any statements related to health not directly linked to healthcare and finances	I uh don't see one on a regular basis because of I don't have the funds for it. My parents, they uh you know own donut shop and they don't have any insurance.

Continued on next page

Table 1 (Continued)

<p><i>English competency</i></p>	<p>Any statements by the participants indicating that not being able to speak English is a barrier to effective healthcare, including the availability of Korean healthcare providers</p>	<p>Inclusion: any statements related to language fluency, Korean healthcare providers, and healthcare</p> <p>Exclusion: any statements related to health not directly linked to healthcare or to Korean healthcare providers</p>	<p>It's very easy to explain our symptom to Korean doctor. America, not so, we cannot explain ourselves, that's why. We don't know English words to explain. No Korean doctor here so naturally uh I go to Dallas. You know, when I lived in California, also went to Korean doctor.</p>
<p><i>Work schedule</i></p>	<p>Any statements by the participants on how work schedule impacts healthcare</p>	<p>Inclusion: any statements alluding that work schedule, such as lack of time, is perceived as actual or perceived barrier to healthcare impacts healthcare</p> <p>Exclusion: any statements related to health not directly linked to healthcare</p>	<p>Why don't you go see a doctor and things like that, but that's the thing. You're always working, you're always tired and like, I will go some other time.</p>
<p><b>Perceptions Regarding the Need for Healthcare</b></p>	<p>Any statements by the participants on health perceptions and how those perceptions impact healthcare</p>	<p>Inclusion: any statements on the need for healthcare (dental, medical, etc) based on health perception</p> <p>Exclusion: any statements related to health not directly linked to healthcare</p>	<p>Well, it's more like, you don't really feel the need for it, unless you're really, really sick or something is really wrong with you. That is about the same for a lot of Koreans</p>

Continued on next page

Table 1 (Continued)

<p><b>Healthcare Practices</b></p>	<p>Any statements by the participants on healthcare practices, including where healthcare was received</p>	<p>Inclusion: any statements alluding to where healthcare is sought and the types of healthcare practices such as acupuncture, home remedies, etc</p> <p>Exclusion: any statements related to health not directly linked to healthcare practices</p>	<p>I've noticed my dad have dental issues. But, uh he doesn't go to a dentist on a regular basis. Not here in America. Last time we went to Korea, my dad, uh, I think he went to a dentist there cuz (<i>sic</i>), you know dental, dental care is expensive here; In Korea it is much cheaper. A lot of Koreans wait to have healthcare until they uh go to Korea.</p>
<p><i>Knowledge of the US healthcare</i></p>	<p>Any statements by the participants on their knowledge of US healthcare system</p>	<p>Inclusion: any statements related to the US healthcare system</p> <p>Exclusion: any healthcare statements not related to the US system</p>	<p>Comparing America's healthcare system to other countries, you see it's inferior, like it doesn't work too well. . . . It can be better.</p>
<p><i>Healthcare practices in the US and Korea</i></p>	<p>Any statements by the participants on the healthcare practices when in Korea and US</p>	<p>Inclusion: any statements related to usual healthcare practices when in Korea and US including when they travel to Korea</p> <p>Exclusion: any healthcare practices not related to Korea or US.</p>	<p><u>Practices in the US</u>            Vitamins I take. You know ginkgo and... ginseng. You know once a month, sometimes when I go to [big city] sometimes acupuncture. But usually use Korean needles. It's not really like acupuncture, but not at clinic. I'm using the . . . treatment, sometimes at home.</p> <p><u>Practices in Korea</u>            I go doctor and I get medicine. You know, I live in country in Korea. I go doctor.</p>

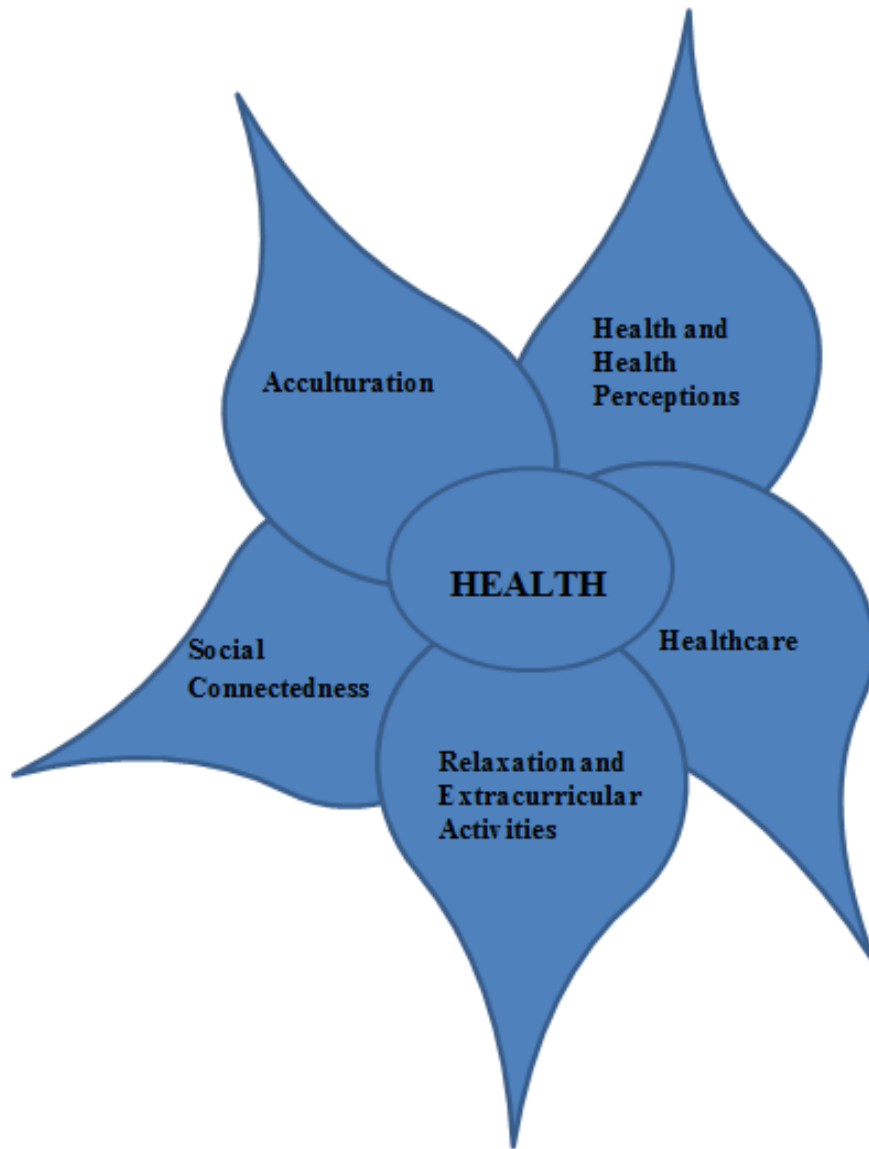
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Table 1 (Continued)

<i>Quality of healthcare in the US and Korea</i>	Any statements by the participants on the quality of healthcare	Inclusion: any statements that allude to the quality of healthcare received when in Korea and the US Exclusion: any statements related to health not directly linked to healthcare	The quality of treatment [Koreans] think it [healthcare from Korea] is better [than US healthcare], not to mention it is cheaper
<b>RELAXATION AND EXTRACURRICULAR ACTIVITIES</b>	Any statements by the participants on activities engaged in when not at work or school	Inclusion: any statements that allude to relaxation or other activities when not at work or school, such as listening to music, going on vacation, reading, etc Exclusion: any statements related to activities engaged in for health or healthcare	I like to listen to some what do you call it, the uh, modern music, like eclectic and some rock. But, I don't listen too much of it... I don't have time.
<b>SOCIAL CONNECTEDNESS</b>	Any statements by the participants on socialization	Inclusion: any statements that allude to socialization among Koreans or non-Koreans, including barriers to socialization and other considerations for socialization Exclusion: any statements related to health not directly linked to socialization	[Barriers to socialization include] time constraint, driving back and forth, that's work. They, they'll be really tired if they have the opportunity to get out, not to mention distance. If they were living in [big city], that would be different story; but, since they live in [small town], it's an hour or something drive. So it's not as much as they want to and they don't have time to drive back and forth.

*Note:* Data-Driven Codes, Definitions, Inclusion/Exclusion Criteria, and Examples: level I **HEADINGS** appear in bold capitalized font; level II **Subheadings** appear in bold upper and lower font; level III *Subheadings* appear in upper and lower italicized font.

Figure 1



*Figure 1: Overarching Themes:* This researcher-developed model shows the five overarching themes influencing health among KIs living in rural Texas.

Table 2  
Themes with Subthemes

<b>Acculturation</b>	<b>Health and Health Perceptions</b>	<b>Healthcare</b>	<b>Relaxation and Extracurricular Activities</b>	<b>Social Connectedness</b>
Language	General Health Knowledge	Barriers to Healthcare 1) Financial constraints 2) English competency 3) Work schedule		
Lifestyle	Health Perceptions	Perceptions regarding the need for Healthcare		
Korean Community	Holistic Health	Healthcare Practices 1) Knowledge of the US healthcare 2) Healthcare practices in the US and Korea 3) Quality of healthcare in the US and Korea		
Diet	Health Behaviors 1) Addictive behaviors 2) Dietary habits 3) Health promotion activities 4) Health information			
Family	Barriers to Health 1) Daily schedule 2) Financial constraints 3) English competency 4) Age 5) Health constraints			

*Note:* This table lists the five over-arching themes with its appropriate subthemes in order of discussion.



## **Chapter 4: Summary and Conclusion**

Decreasing health disparity is an overarching goal for Healthy People 2020 (HP 2020, 2011) and Texas Health and Human Services (THHS, 2010) healthy initiatives. The purpose of this ethnographic study was to determine the health, health perceptions, healthcare practices, and influencing factors among Korean immigrants (KIs) living in rural Texas. Five major themes emerged from the interviews, observations, and artifacts: (a) acculturation, (b) health and health perceptions, (c) healthcare, (d) relaxation and extracurricular activities, and (e) social connectedness. The findings from this study aided in providing a broader picture on the overall health and healthcare among KIs. Improved healthcare for vulnerable populations is fundamental to the healthy initiatives.

Chapter two is a systematic review of literature (SROL) on health and healthcare among KIs. The 25 articles reviewed included studies that were conducted in large US metropolitan cities. No studies among KIs living in rural US regions were identified. The SROL revealed nine categories of factors affecting KIs' health and healthcare: (a) health, health perceptions, and healthcare, (b) knowledge of diseases, (c) culturally sensitive educational programs, (d) physical activities, (e) cancer screenings, (f) stress and depression, (g) financial constraints, (h) English competency, and (i) Korean American churches, health, healthcare, and socialization.

Chapter three describes an ethnographic study conducted in rural Texas that explored the health, health perceptions, healthcare practices, as well as influencing factors of 14 KIs. Five themes (a) acculturation, (b) health and health perceptions, (c) healthcare, (d) relaxation and extracurricular activities, and (e) social connectedness emerged from the data.

Further investigation is needed to reduce health disparities for KIs. KIs living in rural Texas have several disadvantages related to healthcare access such as geographical distance from

Korean speaking healthcare providers. A lack of community resources are in contrast to KIs residing in large metropolitan areas where organizations that provide assistance to KIs are readily available. This lack of resources potentially impacts KIs' acculturation, further affecting their ability to obtain adequate healthcare. A community-based participatory approach to resource development might positively impact rural KIs' health and healthcare.

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<http://dx.doi.org/10.1177/104973231-379238>

Appendix A: Institutional Review Board The University of Texas at Tyler

The University of Texas at Tyler

Institutional Review Board

December 10, 2012

Dear Ms. Winton,

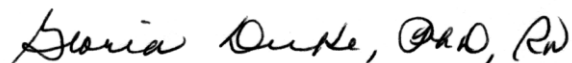
Your request to conduct the study entitled: *Health and Healthcare Perceptions among Korean Immigrants in Rural Texas*, IRB #F2012-36 is approved under expedited review by The University of Texas at Tyler Institutional Review Board. This approval includes use of the written informed consent for each participant that is attached to this approval letter. In addition, ensure that any research assistants or co-investigators have completed human protection training, and have forwarded their certificates to the IRB office (G. Duke).

**Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:**

- This approval is for one year, as of the date of the approval letter
- Request for Continuing Review must be completed for projects extending past one year
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- **Any adverse event or unanticipated event MUST be reported promptly to academic administration (chair/dean), and to the IRB.**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,



Gloria Duke, PhD, RN

Chair, UT Tyler IRB

Appendix B: Institutional Review Board Tarleton State University

Tarleton State University

IRB Approval Notification

December 18, 2012

RE: IRB Notification

Eichenberg, Dr. George

You forwarded this message on 12/18/2012 10:47 AM.

Sent: Tuesday, December 18, 2012 9:57 AM

To: Evans, Dr. Elaine; Haynes, Dr. R. Michael; Lewis, Dr. Sally; Snider, Dr. Larry Dwayne;  
Little, Dr. Bertis; Minix, Dr. Dean; Newby, Dr. Robert; kstyron@tarleton.edu

Cc: Williamson, Ms. Nona; WINTON, MS. MARY B.

Dear Colleagues:

Pursuant to federal regulations, this is to notify you that the following applications were approved under the 'expedited' classification as having minimal risks to human subjects:

Ms. Mary Winton, Nursing.

Health and Health Care Perceptions among Korean Immigrants in Rural Texas

Face-to-face interviews and anonymous survey. Low risk, possibly high benefits. Sufficient protections in place.

If you have any questions or would like to review the applications please contact me.

Thank you,

George

M. George Eichenberg, Ph.D.  
Professor of Criminal Justice  
IRB-Human Subjects Chair  
T-0665 Tarleton State University  
Stephenville, Texas 76402

"Quae Sursum Volo Videre" (Quinn family motto).

"Optimism is cowardice" (Spengler, 1931).

**THE UNIVERSITY OF TEXAS AT TYLER  
INSTITUTIONAL REVIEW BOARD**

**PROGRESS REPORT FOR CONTINUING REVIEW**

**\*\*IMPORTANT: PLEASE ATTACH THE FOLLOWING DOCUMENTS WITH YOUR COMPLETED STATUS REPORT:**

- **Current sample informed consent document(s);**
- **Any proposed or requested modifications to the informed consent document or protocol;**
- **Any other significant information related to subject risk, such as the most recent report from any Data Safety Monitoring Board (DSMB) monitoring the research, if available.**

IRB: **F2012-36**

Approved by: **G Duke**

Date: **October 16, 2013**

**Please Answer All Questions. If a Question Does Not Apply to Your Study Answer "N/A."**

Original Date of Approval: 12/10/2012

1. IRB# F2012-36
2. Title of Project: **Health and healthcare perceptions among Korean immigrants in rural Texas**
3. Principal Investigator: **Mary Beth Winton**  
**If PI is a student, please identify your UT Tyler faculty sponsor: Beth Mastel-Smith**
4. Email: [mwinton2@patriots.uttyler.edu](mailto:mwinton2@patriots.uttyler.edu)  
[bethms@swbell.net](mailto:bethms@swbell.net)
5. For this protocol, approval is

Appendix C (Continued)

requested for:

**(For This And All Other Boxes, Highlight Box And Type “X”)**

- Continuance (If Continuance, skip to #6 and submit to IRB from your UT Tyler email box.)
- Discontinuance

**Reason for Request for Discontinuance:**

- Enrollment closed and project is limited to data analysis of de-identified data, and no further interaction is planned for human subjects.

**NOTE:** A study may not be discontinued as long as the investigators continue to work with identifiable data.

- Study is completed, including all data analysis activities.
- PI has no desire or is unable to pursue the study.

**Reason for Request for Continuance**

6. Check the one(s) which most accurately describes the current status of the above protocol:

- Study has not yet begun since the original date of approval (please explain):
- Study is currently active
- Study is on “hold” (please explain):
- Other (please explain):

7. Has the project protocol, procedures and/or the Informed Consent form changed in this last reporting period? (Consider changes in title, sample size, subject reimbursement, clinical procedures, drugs, etc.).

Yes  No

(If yes, answer a-c):



Appendix C (Continued)

a. Were changes in the project protocol, procedures and/or Informed Consent Form reported in writing (using IRB Modification Form and/or via email) to, and approved by, the IRB?

Yes  No

b. Briefly describe the changes:

c. Has your assessment of the risks the benefits or risks changed during this reporting period (since initial, last modification or last continuing review)?

Yes  No

If yes, please explain:

***SUBJECT RECRUITMENT/PARTICIPATION***

8. Total number of subjects enrolled to date: **14**

If none, state "0" and explain:

9. Have any subjects withdrawn? No

- a. If yes, explain reasons (if unknown, write "unknown")
- b. If yes, how many?

10. If your investigation required written subject consent:

a. Was this consent obtained from each subject?  YES  NO

b. Did subjects receive a copy of the Informed Consent

Form?  YES

NO

11. If your investigation was approved for non-written consent:

a. Was this consent obtained from each subject?  YES  NO

b. Where is evidence recorded that consent was obtained?

PI's private laptop, password protected

c. Briefly describe any problems encountered in obtaining subject consent:

**Lack of Korean immigrants living in rural Texas having the time to participate.**

Be sure consent forms are readily available for periodic IRB compliance reviews

12. Expected timeframe for completion of study, including data analysis **April 2014**

**UNANTICIPATED PROBLEMS/ADVERSE EVENTS:**

13. Did any unusual and/or unanticipated problems, adverse effects, complaints from subjects, or other serious problems arise during this reporting period (includes medication errors)?  YES  NO

Appendix C (Continued)

If yes, please answer 11a. and 11b.

- a. Were these problems reported in writing (IRB Unanticipated Problem or Adverse Event/Death form) to, and acknowledged by, the IRB?

YES    NO

- b. Please describe these problems briefly with number of occurrences and/or number of subjects involved:

14. Has there been any new and relevant information, published or unpublished, since the last IRB review, especially information about risks associated with the research?

No

If Yes, please explain:

**INSTRUCTIONS:** Please ensure all relevant spaces are completed, and electronically return this form to the IRB Chair.

My signature indicates that I am taking every precaution to minimize risks to subjects:

**PI Name:** *Mary Beth Winton*      **Date**   *10/15/2013*

Note: Electronic submission of this form by PI indicates signature

Appendix D: Informed Consent

THE UNIVERSITY OF TEXAS AT TYLER

Informed Consent to Participate in Research

**Institutional Review Board #F2012-36**

**Approval Date: December 10, 2012**

**1. Project Title:** Health and Healthcare Perceptions and Influencing Factors among Korean Immigrants in Rural Texas

**2. Principal Investigator:** Mary Beth Winton, MSN, RN, ACNP-BC

**3. Participant's Name:**

**To the Participant:**

You are being asked to take part in this study. The following are basic information if you agree to be in the study.

- This consent form describes the reason for this research study.
- This consent form describes what you will be doing the study.
- This consent form describes any risks you may have.
- This consent form describes any benefits you have.

You should know what the study is about after talking with the researcher. You know that you can take part in this study. You know what will happen in this study.

**4. Description of Project**

The reason for this study is to learn what Korean immigrants think about their health and healthcare.

**5. Research Procedures**

If you agree to be in this study, you will be asked some questions about yourself. In addition, you might

- \_\_\_ meet and talk to the researcher about your health and healthcare. You might be asked to meet more than one time. Meetings with the researcher will take about one hour.
- \_\_\_ be observed at church
- \_\_\_ be observed at work
- \_\_\_ be observed at a doctor's visit
- \_\_\_ be observed at another location \_\_\_\_\_
- \_\_\_ be photographed. You might be asked to talk about the pictures.

The reason for observations and photographs is to learn about how you are with other people. Please check any of the activities above that you agree to. You can refuse any of them without penalty.

## Appendix D (Continued)

### **Potential Side Effects/Risks**

There are low risks to this study. You might be unhappy when talking about your health. If you become too sad, you may stop the meeting at any time. You can leave the study at any time without penalty.

### **7. Potential Benefits**

The information you give may help improve the knowledge of your health and healthcare. The information you give may help other Koreans.

### **Understanding of Participants**

8. The consent has been read to me.
  - I was able to tell the researcher about the study in my own words.
  - I know how the research can affect me.
9. If I sign this consent form I know it means that:
  - I have been told about this study. I am taking part in this study because I want to. I choose to be in this study. I know how the study can affect me.
  - I know that I do not have to be in this study. Nothing will happen to me if I am not in the study.
  - I will be told about any new information that can affect me if I remain in this study.
  - The researcher will get my written permission for any changes that can affect me.
  - I know the researcher can change or stop the study at any time. I know The UT Tyler can change or stop the study at any time.
  - I know I can stop being a part of the study whenever I want to. If I do stop, I know nothing will happen to me.
10. I know my name will not be in any written reports in this study unless I give my consent.
11. I know that non-identifying information may be shared. I know my name, address, and other identifying information will not be shared unless I give permission. I know the shared information can include health information. Information may be shared with the following.
  - Information may be shared with organization giving money to be able to do this study.
  - Information may be shared with other researchers to be used with other studies.
  - Information may be shared in presentations or publication.
12. The Institutional Review Board (IRB) makes sure that research is done right. The IRB makes sure that procedures are in place to protect my safety. I know The UT Tyler's IRB may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also know that my personal information will not be shared with anyone.
13. I have been told about possible risks that can happen if I am in the study.

Appendix D (Continued)

14. I know I will not be charged for any costs involved in this study. I know I will receive a \$20 Wal-Mart gift card for being in the study. I know I will not be given money for any patents or discoveries that may result from being in this study.
15. If I have any questions about being in this study, I will contact the researcher: Mary Winton at 254-592-2369 or email at mwinton@tarleton.edu
16. I know I can contact Dr. Gloria Duke, Chair of the IRB at (903) 566-7023 or gduke@uttyler.edu if I have any questions concerning my rights as a participant. I know I can contact Dr. Duke for any injuries related to this study. I can also contact the University's Office of Sponsored Research:

The University of Texas at Tyler  
c/o Office of Sponsored Research  
3900 University Blvd  
Tyler, TX 75799

17. **CONSENT/PERMISSION FOR PARTICIPATION IN THIS RESEARCH STUDY**  
The consent has been read or I have read the consent. I know what has been explained to me. I give my consent to be in this study as it is explained to me. I give the study researcher permission to register me in this study. I have received a signed copy of this form.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Signature

18. I have discussed this project with the participant, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks. I believe the participant understood this explanation.

\_\_\_\_\_  
Researcher/Principal Investigator

\_\_\_\_\_  
Date

Appendix D (Continued)

Consent to Photography

1. **Project Title:** Health and Healthcare Perceptions and Influencing Factors among Korean Immigrants in Rural Texas
2. **Principal Investigator:** Mary Beth Winton, MSN, RN, ACNP-BC
3. **Participant's Name:**

**Description of Project:** The reason for this study is to learn what Korean immigrants think about their health and healthcare.

**To the Participant**

I know my name will not be used. I know these pictures might be used for educational and publication purposes.

I know I can cancel this consent at any time by notifying Mary Winton at 254-592-2369 or email mwinton@tarleton.edu. I know that nothing will happen to me if I cancel this consent. I know all images will be stored in a safe location. Only the researcher will have access to the pictures. I have been told about the purpose of the pictures. I understand the reason for the pictures.

I agree to have my pictures taken by Mary Winton.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix E: Korean Immigrant Health Survey

### Korean Immigrant Health Survey<sup>1</sup>

**Directions:** The reason for this study is to learn what Korean immigrants think about their health and healthcare. Please answer the questions as honestly as possible. Your participation in this survey is voluntary. Your answers will be grouped together with the answers of other participants. Your name is not asked in the survey and will not be used in any report. You are free to ask questions, not answer any question, or stop at any time without penalty. **Please, do not write your name down anywhere on the survey.**

Which county do you live in Texas? \_\_\_\_\_

#### **HEALTH STATUS:**

**1. How would you describe your health?**

- 1. Good
- 2. Fair
- 3. Poor
- 4. Do not know

**2. When was your last visit to a doctor?**

- 1. Less than 6 months ago
- 2. 6 months to 1 year ago
- 3. 2 to 5 years ago
- 4. Over 5 years ago
- 5. I have never seen a doctor

**3. When was your last visit to a dentist?**

- 1. Less than 6 months ago
- 2. 6 months to 1 year ago
- 3. 2 to 5 years ago
- 4. Over 5 years age
- 5. I have never seen a doctor

---

<sup>1</sup> Modified from Hsu, E., Atkinson, N., Gold, R., Billing, A., Li, J., Richardson, L., . . . Tian, J., 2005. Asian American health initiative - Community health needs assessment. Montgomery County, MD: Department of Health and Human Services.

Appendix E (Continued)

- 4. Which of the following screenings have you received in the last year?**
- 1. Blood pressure check
  - 2. Blood sugar check
  - 3. Cholesterol screening
  - 4. Blood stool/urine test
  - 5. Infectious diseases (e.g. Hepatitis B)
  - 6. Cancer screening (e.g. Pap smear)
- 5. Do you prefer to go to a Korean doctor?**
- 1. Yes
  - 2. No
- 6. Do you prefer to go to a doctor who speaks Korean?**
- 1. Yes
  - 2. No
- 7. Do you regularly go outside your county for health services?**
- 1. Yes
  - 2. No
- 8. What factors keep you away from seeing doctors when in need?**
- 1. Cannot afford co-pay and/or deductible
  - 2. Do not have health insurance
  - 3. Language barrier
  - 4. Concerns about immigration status
  - 5. Do not have transportation
  - 6. Do not have time
  - 7. Do not understand the American medical system
  - 8. Lack of resource for referrals
  - 9. Long wait for services
  - 10. Other \_\_\_\_\_
- 9. For which of the following health conditions do you receive ongoing treatment?**
- 1. High blood pressure
  - 2. Hepatitis (type \_\_\_\_\_)
  - 3. Diabetes
  - 4. Cancer
  - 5. Mental health
  - 6. Other \_\_\_\_\_



Appendix E (Continued)

**10. Which of the following resource services do you use?**

- 1. Senior center
- 2. Special transportation to access healthcare services
- 3. Nursing home
- 4. Home health aide
- 5. Meals-on-wheels
- 6. Community healthcare clinic

**11. If there are seniors/elderly living in your household which of the following services do they use?**

- 1. Senior center
- 2. Special transportation to access healthcare services
- 3. Nursing home
- 4. Home health aide
- 5. Meals-on-wheels
- 6. Community healthcare clinic

**12. How would you describe your child/children's health?**

- 1. Good
- 2. Fair
- 3. Poor
- 4. I do not know

**13. Is there any vaccination program at school for your child/children?**

- 1. Yes
- 2. No
- 3. I do not know

**14. In the last month, how often did you feel tired for no good reasons?**

- 1. Usually
- 2. Sometimes
- 3. Rarely
- 4. Never
- 5. Do not know

Appendix E (Continued)

**15. In the last month, how often did you feel so nervous that nothing could calm you down?**

- 1. Usually
- 2. Sometimes
- 3. Rarely
- 4. Never
- 5. Do not know

**16. In the last month, how often did you feel depressed?**

- 1. Usually
- 2. Sometimes
- 3. Rarely
- 4. Never
- 5. Do not know

**17. In the last month, how often did you feel so sad that nothing could cheer you up?**

- 1. Usually
- 2. Sometimes
- 3. Rarely
- 4. Never
- 5. Do not know

**INSURANCE STATUS:**

**18. What kind of health insurance do you have?**

- 1. Managed Care (e.g. HMO, PPO, etc.)
- 2. Private Insurance (e.g. BCBS, Aetna, etc)
- 3. Medicaid
- 4. Medicare
- 5. Other Government (e.g. CHIP, CHAMPUS, etc.)
- 6. I do not have health insurance

Reason for no

insurance \_\_\_\_\_

Appendix E (Continued)

**19. If there are seniors living in your household, what type of health insurance do they have?**

- 1. Managed Care (e.g. HMO, PPO, etc.)
- 2. Private Insurance (e.g. BCBS, Aetna, etc)
- 3. Medicaid
- 4. Medicare
- 5. Other Government (e.g. CHIP, CHAMPUS, etc.)
- 6. I do not have health insurance  
Reason for no insurance \_\_\_\_\_

**20. How do you pay for your health insurance?**

- 1. Employer
- 2. I pay for all costs
- 3. I do not buy health insurance

**21. If you do not have health insurance, where do you seek healthcare?**

- 1. Hospital/ER
- 2. Community health clinic
- 3. Government-provided healthcare
- 4. Faith-based clinics
- 5. Pay cash for the care at the doctor's office
- 6. Use Korean or alternative/herbal medicine
- 7. Others \_\_\_\_\_

**LANGUAGE SKILLS:**

**22. What is your ability in speaking and understanding English?**

- 1. I do not speak and understand English
- 2. Basic words and simple phrases
- 3. Short conversation
- 4. I speak and understand English without any problem

**23. When using health services provided by English-speakers, do you usually...**

- 1. Go by yourself
- 2. Bring a friend or relative to translate
- 3. Bring a social worker to translate
- 4. Use an interpreter
- 5. Other \_\_\_\_\_

Appendix E (Continued)

**COMMUNITY RESOURCES:**

**24. Do you feel the following healthcare issues are a problem for Koreans in the community you live in?**

- 1. Serious problem
- 2. Moderate problem
- 3. Not a problem
- 4. I do not know

\_\_\_\_\_healthcare facilities

\_\_\_\_\_social services

\_\_\_\_\_mental health services

\_\_\_\_\_dental services

\_\_\_\_\_public transportation

\_\_\_\_\_language services

\_\_\_\_\_alcohol/drug use

\_\_\_\_\_smoking

\_\_\_\_\_domestic violence

\_\_\_\_\_health information availability

\_\_\_\_\_disease prevention

\_\_\_\_\_health insurance

**25. Who are your primary sources of health information?**

- 1. Health clinic
- 2. Family/friends
- 3. Mass media
- 4. Community organizations
- 5. Other\_\_\_\_\_

**DEMOGRAPHIC INFORMATION:**

**26. Gender**

- 1. Male
- 2. Female

**27. Age group**

- 1. 18-34
- 2. 35-49
- 3. 50-64
- 4. 65 and over

Appendix E (Continued)

**28. How would identify yourself of your race?**

- 1. Korean
- 2. Korean-American
- 3. American
- 4. Other \_\_\_\_\_

**29. How long have you lived in America?**

- 1. More than 10 years
- 2. 5 – 10 years
- 3. 1-5 years
- 4. Less than 1 year

**30. How many people are living in your household?**

- 1. Adults \_\_\_\_\_
- 2. Children \_\_\_\_\_
- 3. Seniors 65 and older \_\_\_\_\_

**31. How long have you been living in the United States?**

- 1. Less than 1 year
- 2. 1 to 4 years
- 3. 5 to 7 years
- 4. 8 to 10 years
- 5. More than 10 years

**32. What is your highest level of education?**

- 1. Did not complete high school
- 2. High school
- 3. Vocational training program
- 4. Some college
- 5. College degree
- 6. Graduate school

**33. What is your average annual household income?**

- 1. Less than \$5,000
- 2. \$5,000 to \$9,999
- 3. \$10,000 to \$19,999
- 4. \$20,000 to \$29,999
- 5. \$30,000 to \$39,999
- 6. \$40,000 or \$49,999
- 7. \$50,000 or more

Appendix E (Continued)

**34. What is your employment status?**

- 1. Full-time
- 2. Part-time
- 3. Self-employed
- 4. Unemployed
- 5. Retired
- 6. Student
- 7. Other\_\_\_\_\_

This is the end of the survey. Thank you for taking the time to answer the survey. If you have any questions or concerns about this survey, please feel free to contact me.

## Appendix F: Interview Protocol

### Interview Protocol

#### 1. Introduction

Hello, my name is Mary Winton. I am a doctoral student at The University of Texas at Tyler. This study is part of the requirement for The University of Texas at Tyler. Thank you for taking the time to meet with me.

#### 2. Obtain Informed Consent – see the Informed Consent Form

- a. Provide a synopsis of the study
- b. Read the informed consent out loud (if necessary)
- c. Ask each participant “Just to be sure we have the same understanding about what the study is about, please tell me what you think the study is about”.
- d. If the person agrees to participate, ask them to check the activities listed on the consent that they agree to.

#### 3. Obtain the Korean Immigrant Health Survey

- a. Read the survey aloud (if necessary).
- b. Note areas not answered and why (if possible)

#### 4. Semi-structured Interview

Thank you for answering the survey questions. Now I want to ask you some questions about your health and healthcare. There are no right or wrong answers. You are free to say what you think.

- a. Tell me about yourself.
  - a. What kinds of food do you eat?
  - b. What kind of music do you listen to?
  - c. What language do you speak at home or with your family?
  - d. What are your childrens’ names?
- b. Tell me about your health.
- c. Do you have any health concerns? If yes, tell me about that.
- d. What do you do to be healthy?
- e. Is there anything that keeps you from being healthy? Tell me about that.
- f. How long have you lived in the US?
- g. Did you learn about healthcare when you first moved to the US? Tell me about that.
- h. What do you do if you get sick?
- i. When you lived in Korea, what did you do when you got sick?
- j. Since moving to the US, have you visited a doctor? Tell me about that visit.
- k. Tell me about the Korean community here in \_\_\_\_\_.
- l. Where do you go to be with other KIs?
- m. What health concerns do you have for other KIs?
- n. Who else should I talk to about KIs’ health?
- o. Is there anything else I should know about you and your health? Tell me about them.
- p. What other questions should I ask about KIs and their health?

## Appendix F (Continued)

### 5. Non-participating/Non-obtrusive Observations

- a. **If doing non-participatory observation/pictures:** I would like to take pictures of you interacting with other people in \_\_\_\_\_.
- b. **Physician's office:** Hello. My name is Mary Winton. I am doing a study on Korean's health. \_\_\_\_\_ gave me permission to observe his/her interactions with you. No health information will be obtained. May I observe this visit, please?
- c. **Church members:** Hello. My name is Mary Winton. \_\_\_\_\_ agreed to allow me to observe his/her interactions with other church members. No information about you will be recorded. Would it be okay if I took pictures of you with Mr/Mrs for educational and publication purposes? Obtain consent for photography if necessary.

### 6. Closing Statement

Thank you for speaking with me. I will think about what you shared with me. I might need to contact you for another meeting. Is that OK? Again, thank you for meeting with me.



## Research Opportunity for Koreans

The purpose of this study is to learn about Korean's health. Another purpose is to learn what affects their health.

If interested, you will be asked some questions about your health. The meeting will take about one hour. You might be asked to be observed such as at your work. You might be asked to have your pictures taken. All information will be kept private.

### INVITATION

If you are:

1. Korean immigrant
2. 18 years old or older
3. Live in rural Texas
4. Speak English

If you are interested to be in the study, please contact Mary Winton at 254-968-9137 or email [mwinton@utdleton.edu](mailto:mwinton@utdleton.edu)

The researcher is currently a doctoral student at The University of Texas at Tyler



# 한국인들에 대한 연구 기회

## 참가하는 안내장

당신은 당신의 인생에서 연구의 기회를 놓치지 마세요.

1. 한국 이민자
2. 18 세 이상
3. 휴스턴 텍사스에 살
4. 유선 열의를 이해

관심 있거나 더 많은 정보를 원하든 모든 것은 무료입니다. 문의를 부탁드립니다.

Mary B. Winton, PhD(c), MSN, RN, ACNP  
The University of Texas at Tyler  
234-592-2369

[mwinton2@patriots.uttyler.edu](mailto:mwinton2@patriots.uttyler.edu)

당신은 당신의 인생에서 연구의 기회를 놓치지 마세요. 연구는 당신의 인생에서 시간을 절약하는 것입니다. 당신의 인생에서 시간을 절약하는 것은 당신의 인생에서 시간을 절약하는 것입니다.

당신은 당신의 인생에서 연구의 기회를 놓치지 마세요. 연구는 당신의 인생에서 시간을 절약하는 것입니다. 당신의 인생에서 시간을 절약하는 것은 당신의 인생에서 시간을 절약하는 것입니다.

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English (U.S.)

## Appendix I: Permission Letter from Dr. Hsu

### Permission to Use and Modify *Community Health Needs Survey – Asian American Health Initiative*

#### **WINTON, MS. MARY B.**

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**From:** Ed Hsu <edhsu@umd.edu>  
**Sent:** Friday, August 03, 2012 2:14 PM  
**o:** WINTON, MS. MARY B.  
**Subject:** Re: Permission request

Mary, you are welcome and have my permission to use the instruments. Please just cite the literature reference as saying it was modified from our work in MD. I think your revised questionnaire works better for your research. Good luck with the dissertation work!

Ed

-----  
C. Ed Hsu, PhD, MPH  
Associate Professor  
Public Health Informatics  
UTHealth

On Aug 3, 2012, at 14:07, "WINTON, MS. MARY B." <MWINTON@tarleton.edu> wrote:

> Dr. Hsu,  
> My name is Mary Winton. I am a PhD nursing student at the University of Texas at Tyler. I will be working on my dissertation this Fall. I came across your questionnaire that was used in Montgomery County, Maryland and was interested in using it for my dissertation and future research. Additionally, if I have your permission to use the questionnaire, I would like your permission to change few of the questions since my research focuses on Koreans. The following questions include:

> Delete:  
> #4 - ethnic background - my population will only be Koreans # 10 and  
> 11 - children (my inclusion criteria are 18 and over)  
>  
> Alter the question for "Community Resources" #19. Rather than asking for community resources, I would like to state it as such: Which of following issues do you think have problems that need to be addressed in rural medically underserved area?  
>  
> I am looking forward to your response.  
>  
> Thank you and sincerely,  
>  
>  
> Mary B. Winton, MSN, RN, ACNP-BC  
> Assistant Professor  
> Tarleton State University  
> Department Of Nursing  
> Box T-0500  
> Stephenville, TX 76402  
> 254-968-9137 (office)  
> 254-968-9716 (fax)  
> [mwinton@tarleton.edu](mailto:mwinton@tarleton.edu)

Biosketch

BIOGRAPHICAL SKETCH			
NAME Mary Beth Winton		POSITION TITLE Assistant Professor	
CREDENTIALS PhD, APRN, RN, ACNP-BC		Tarleton State University Department of Nursing Stephenville, TX	
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)</i>			
INSTITUTION AND LOCATION	DEGREE	MM/YY	FIELD OF STUDY
Tarleton State University, Stephenville, TX	ADN	May 1994	Nursing
The University of Texas at Arlington, Arlington, TX	BSN	Dec 2000	Nursing
The University of Texas at Arlington, Arlington, TX	MSN	Dec 2003	Nursing – ACNP
The University of Texas at Tyler Tyler, TX	PhD	May 2014	Nursing

**A. Personal Statement**

The goal of the research is to gain insights on the health, health perceptions, healthcare practices, and influencing factors among Korean immigrants. More specifically, I want to determine if Korean immigrants living in geographically isolated areas perceive more problems with their health and healthcare than Korean immigrants who live in metropolitan areas where health and healthcare resources for immigrants are readily available. Being a professional nurse since 1994, nine years with hospital medicine as an acute care nurse practitioner, and ten years on faculty at Tarleton State University in the Department of Nursing provide qualified background to conduct research on the health and healthcare of any population.

**B. Positions and Honors**

**Employment**

2004	Adjunct Instructor, Tarleton State University, Department of Nursing, Stephenville, TX
2004 – 2009	Instructor, Tarleton State University, Department of Nursing, Stephenville, TX
2004 – 2013	Acute Care Nurse Practitioner, Hospital Medicine, Weatherford Inpatient Physicians Associate, Weatherford, TX

### Biosketch (Continued)

- 2009 – 2010 Adjunct Instructor, Tarleton State University, Department of Nursing, Stephenville, TX
- 2011 – Present Assistant Professor, Tarleton State University, Department of Nursing, Stephenville, TX

### **Honors**

- 2009 – 2011 Health Information Technology Scholar, University of Kansas School of Nursing in collaboration with Schools of Nursing at University of Colorado, Denver, and Indiana University, in partnership with the National League of Nursing
- 2013 Teaching Excellence Award – Tarleton State University