Maternal and Child Health Journal (2019) 23:1482–1488
https://doi.org/10.1007/s10995-019-02798-1

Group Well-Child Care and Health Services Utilization: A Bilingual Qualitative Analysis of Parents' Perspectives

Benjamin J. Oldfield[1,2,3,4] · Patricia F. Nogelo[5,6] · Marietta Vázquez[1] · Kimberly Ona Ayala[1] · Ada M. Fenick[1] · Marjorie S. Rosenthal[1,3]

Published online: 20 June 2019

Abstract

Objective Alternative primary care structures such as group well-child care (GWCC) may enhance care for families, particularly those subject to structural vulnerabilities such as poverty or restrictive immigration policies. The purpose of this study was to characterize how group dynamics in GWCC impact the perceptions of low-income, immigrant, and/or Spanish-speaking parents of health services. *Methods* Using Spanish and English interview guides that were conceptually identical, we conducted semi-structured interviews with parents who elected to participate in GWCC at an urban academic center. We drew from directed content analysis, grounded theoretically in the Andersen model of health services utilization. Modeling a bilingual, multicultural analytic strategy, we preserved the narrative of participants in the source language through all stages of analysis. *Results* From March through August 2017, we interviewed 22 caregivers in their preferred language. Most (82%) were mothers and half spoke Spanish only. Three themes emerged: participants perceived that (1) GWCC facilitates their and their peers' discovery of inherent expertise, which moderates parents' use of health services, (2) GWCC encourages rearrangements of hierarchies of knowledge, professional roles and genders; and (3) in the context of structural vulnerabilities, relationships formed in GWCC facilitate collective efficacy. *Conclusions for Practice* By considering the self and peer as sources of health-related expertise, GWCC may extend current theoretical models of health services utilization. GWCC provides opportunities to impact health services utilization among families subject to structural vulnerabilities.

Keywords Primary health care · Vulnerable populations · Qualitative research · Cultural diversity · Multilingualism

Significance

Group well-child care (GWCC) is a pediatric primary-care redesign that has demonstrated favorable child health outcomes. This is the first bilingual qualitative analysis of parents' experiences in group well-child care in an urban academic practice that serves primarily low-income families. Participants perceived that GWCC facilitates the discovery of parents' inherent expertise and the rearrangements of social hierarchies which may impact health services utilization among vulnerable families.

Introduction

Well-child care is an important opportunity to address biological, social, and structural issues affecting families (Hagan et al. 2017). Many families experience unmet needs during well-child care (Norlin et al. 2011), particularly

✉ Benjamin J. Oldfield
benjamin.oldfield@yale.edu

1 Department of Pediatrics, Yale School of Medicine, New Haven, CT, USA

2 Department of Medicine, Yale School of Medicine, New Haven, CT, USA

3 National Clinician Scholars Program, Yale School of Medicine, P.O. Box 208088, New Haven, CT 06520, USA

4 Fair Haven Community Health Care, New Haven, CT, USA

5 Department of Social Work, Yale-New Haven Hospital, New Haven, CT, USA

6 Department of Social Work, School of Public Health and Human Services, Southern Connecticut State University, New Haven, CT, USA

families subject to structural vulnerabilities as defined by Bourgois et al. 2017 such as poverty or racial/ethnic discrimination (Bethell et al. 2011; Coker et al. 2009). For example, limited English proficiency among family members is associated with decreased access to and quality of care (Yu et al. 2006). Approaches to primary care redesign that are responsive to the needs of vulnerable families are therefore needed (Coker et al. 2009).

Group visits are a primary care redesign in which multiple patients meet with an interprofessional team to address self-management informed by the goals and experiences of patients and families. Group well-child care (GWCC) offers pediatric care in an environment where families support each other and model parent–child interactions (Connor et al. 2018; Page et al. 2010). These features may promote resilience in families for whom structural vulnerabilities impede engagement with traditional well-child care (Coker et al. 2009) and influence their utilization of health services (Holland et al. 2012). Additionally, when conducted in the primary language of parents, these visits are satisfying to Spanish-speaking parents (Coker et al. 2009) who may be less likely to report satisfaction in pediatric care (Flower et al. 2017).

GWCC is associated with positive behavior change around preventive care (Thomas et al. 1984) and implementation of obesity prevention efforts (Machuca et al. 2016) in a visit structure that is cost-neutral or cost-saving (Yoshida et al. 2014). One qualitative study of 11 mothers participating in GWCC found support between mothers to be a positive feature of their experience (Page et al. 2010). Another qualitative study involving 33 low-income parents participating in GWCC identified peer support and peer education as positive features of the GWCC experience (DeLago et al. 2018). However, neither qualitative study focused on recent immigrants or non-English speakers. Given the vulnerabilities of these populations, their perspectives may inform best practices of group and individual care for socially isolated groups. Accordingly, the purpose of this study was to characterize how the group dynamics of GWCC impact low-income, immigrant, and/or Spanish-speaking parents' perceptions of health services.

Methods

Guided by the Consolidated Criteria for Reporting Qualitative Research (Tong et al. 2007), we used an inductive approach and qualitative methods to characterize perspectives on social interactions and decision-making, which are difficult to measure quantitatively (Pope and Mays 1995). Our theoretical approach was informed by the Andersen model of health services utilization, which considers environmental, population, and behavioral characteristics that modulate how individuals interact with health services (Andersen and Newman 1973). All members of our research team were bilingual (English and Spanish), in aggregate were multinational (of Argentinian, Ecuadorian, Eastern United States, Puerto Rican, and Venezuelan descent), and included pediatricians and a pediatric social worker with experience in qualitative methods (Oldfield et al. 2019) and group well-child care (Rosenthal et al. 2014, 2016). Our methods were underpinned by directed content analysis, a qualitative research strategy whose goal is to extend an existing theoretical framework (in our case, the Andersen model) (Hsieh and Shannon 2005). The Yale School of Medicine Human Investigation Committee approved all study procedures.

Setting

GWCC is offered in the Yale Primary Care Center, an urban hospital-based clinic that is the medical home for approximately 7,500 children, serves primarily families who receive public health insurance (97%), about 45% of whom identify as African American and about 45% as Hispanic or Latino/a. GWCC is offered to all families electing for infant care at the Primary Care Center for which the mother has the infant in her care and if she reports that she is able to participate in visits in English or Spanish.

Our model of GWCC includes 90-min health maintenance appointments in either English or Spanish (participants choose), in place of traditional well-child care, throughout the first year of life. For the first 30 min, four to eight families cycle through: anthropometric measurements by the nurse, physical exam by the resident and pre-visit questionnaires with the child-life specialist or social worker. During the next 45 min, the resident, supported by a nurse, attending pediatrician, and child-life specialist or clinical social worker, facilitates a discussion about anticipatory guidance and parenting strategies. The last 15 min are for vaccine administration and follow-up on families' individual needs.

Participants

We sampled purposefully from parents electing for GWCC at the Yale Primary Care Center from 2016 through 2017, seeking to be inclusive of heterogeneity in age, language spoken (English or Spanish), number of children, and parental role (mother, father, grandparent). We included parents who had completed at least three GWCC visits to ensure a lower limit of information-richness among participants, 40 of whom existed during the study timeframe. We continued recruiting until we achieved thematic saturation: when no new themes emerged with subsequent interviews (Glaser 1992).

Measures

The authors developed conceptually identical interview guides in English and Spanish that were agreed upon by all research team members to be culturally and structurally competent (Metzl and Hansen 2014). Open-ended questions encouraged participants to address predisposing factors, enabling factors, and needs for health services utilization according to the Andersen model (see Box 1) (Andersen and Newman 1973).

Grand Tour Questions from Interview Guide

Tell me about your experiences with group well child care.

Can you describe one thing you've taught others in group well-child care? And one thing you've learned from others in group well-child care?

What is it like to share in a group with other parents who are different from you (according to age, first child or not, having a partner or not)?

Are there experts in the group? Who "runs" the group?

What is your relationship like with the facilitators of the group? What is your relationship like with the other parents?

What do you think you offer the group?

Procedures

We chose an interview strategy to optimize privacy and welcome participants to discuss their care experiences (Strauss and Corbin 1998). Depending on the participant's preference, the interview occurred in either English or Spanish, in either a private office in the clinic (not connected to a GWCC visit) or in the patient's home by the first author, who did not provide GWCC. With verbal informed consent, we digitally recorded all interviews, and a professional transcriptionist transcribed the recordings. Those who agreed to participate received a $10 gift card.

Bilingual Analyses

Although standards of rigor exist for the conduct of qualitative research (Tong et al. 2007), to our knowledge, no standards exist for the transformation of source to target language or the integration of multiple source languages. After consulting the literature (Santos et al. 2015; Tong et al. 2007) and qualitative research experts, we decided to retain data in the source language to preserve participants' narratives through all steps of analysis. Translation was performed only upon dissemination of findings with the agreement of at least two analysis team members.

In the first stage of analysis, the research team created conceptually identical codes in English and Spanish in consensus as concepts emerged from the data (Strauss and Corbin 1998); codes were not limited to concepts in the Andersen model and analyses were not conducted separately by language. We compared coded text to identify novel themes and to expand upon existing themes until no new concepts emerged in subsequent transcripts (Glaser and Strauss 1980). In the second stage of analysis, a non-coding member of our research team read all transcripts and discussed the major concepts with the coders, for refinement of the code structure and to query its dependability. The first author then used the final code structure to recode all transcripts. We used qualitative analysis software (ATLAS.ti 7.0, Scientific Development, Berlin, Germany) to facilitate data organization.

In the final stage of analysis, the coding team invited all participants to a series of two luncheons to verbally discuss a summary of the results to determine if emerging themes accurately reflected participants' experiences (validity). This occurred after all participants had completed 1 year of GWCC visits.

Results

Participant Characteristics

From March through August 2017, we approached 23 parental caregivers and interviewed 22; one caregiver declined to participate. Half of the interviews occurred in the home of the family and half in an office in the Primary Care Center. Half were conducted in English and half in Spanish. The mean duration of the interviews was 33 min. Most (81%) participants were mothers but we also interviewed fathers and grandparents who were active participants in GWCC. The age of the mother at the child's birth ranged from 18 to 44. The sample was racially and ethnically diverse and most children (94%) were insured by Medicaid (Table 1).

Of all participants invited ($n = 22$) to the two luncheons, 14 (64%) attended.

Emerging Themes

Three themes emerged: participants perceived that (1) GWCC facilitates their and their peers' discovery of inherent expertise, which influences parents' use of health services, (2) GWCC encourages rearrangements of hierarchies of knowledge, professional roles, and genders; and (3) in the context of structural vulnerabilities, relationships formed in GWCC facilitate collective efficacy, defined as social cohesion among participants combined with their willingness to intervene on behalf of the common good (Sampson et al.

Table 1 Interview participant characteristics ($n = 22$)

Characteristic	*n* (%) or mean [range]
Interviewee relationship to child	
Mother	18 (81)
Father	2 (9)
Maternal grandmother	1 (5)
Paternal grandmother	1 (5)
Mother's age at child's birth (years)	31 [18–44]
Child's age at interview (months)	6 [3–12]
First liveborn child	7 (39)
Race/ethnicity of child	
Black/African American	6 (33)
Hispanic/Latino/a	10 (56)
White	2 (11)
Insurance of child	
Medicaid	17 (94)
Commercial	1 (6)
Participant's preferred language	
Spanish	11 (50)
English	11 (50)

1997). We provide verbatim quotations (translated into English when necessary) from participants to illustrate each theme.

Theme 1: Discovery of Inherent Expertise Influences Health Services Utilization

Caregivers were surprised at the discovery that they held knowledge others did not, and that they could be educators. One mother described this surprise:

> I still sometimes feel like, "Wow, I also know things that even I didn't realize I knew, and I've shared them with the others"—things like what I've learned from my mother or my grandmother. It's beautiful.

The sharing of knowledge among participants represented an informal triage system that may inform decision-making regarding health care utilization. One mother offered an anecdote:

> I know one of the moms, she texted me. She was like "Oh, my God, I think the baby colic [*sic*]. I was like, "On no, he ain't colic, he probably just gassy." She was like "All right." So she ended up taking the baby to the emergency room and he was—he had gas—so she texted me back and she was like "Oh, it was gas." I was like, "See, I told you." They'll text me, like "What do you think I should do?"

The expertise that caregivers demonstrated in GWCC had a bi-directional interaction with the advice of the clinical staff. On the one hand, clinical staff validated the expertise put forth by a participant, as one father described:

> The doctor asks you: "What do you all think?" And each one gives his or her opinion and then at the end the doctor says what it is, something like "Yes, you're right in this way, but let me tell you what we as doctors recommend."

In other circumstances, the participants' expertise validated the recommendations of the clinical staff. One mother said:

> Maybe the doctor will tell you to do something that you don't really want to do, but the moms would have, like, experience that if you would do it, it works out. And then you try it, or let's say the doctor tells you, "Okay, you have to do this for your baby." And you're like, "What?" And the other moms have done it already, so they're like, "No, it works, trust me."

The experiences of other families stand as moderators between parents and their utilization of health services, by either endorsing the recommendations already made by clinicians or being sources of new recommendations.

Theme 2: Rearrangements of Hierarchies

Participants reported that social arrangements cast by profession, culture, or gender were reorganized in GWCC. This was perceived positively and negatively. One grandmother said staff spoke differently to the group than she had experienced with other doctors:

> Some doctors, if you ask a question, they'll be like, "Well, studies say this and that and that and this." The doctors in the group, they ask questions back and talk in ways you understand. They put it simple, right to the point, rather than other doctors.

By facilitating a discussion ("asking questions back," as GWCC facilitators are trained to do), the leaders in this grandmother's group made preventive care principles more accessible. In addition to professional discordance, cultural discordance was also engaged and sometimes celebrated by participants. One mother said:

> Mexicans give their children chilis. Cubans, Venezuelans—we don't give them chilis. So this is what happens, and it's a beautiful thing among us—we see the experiences of others.

Gender roles are another arrangement that GWCC caused participants to reappraise. One father described how he felt comfortable participating in GWCC:

> Latin men have a *machista* mentality. They don't go to these things. But since this is my first daughter, well, I've loved it. It lets me learn from the experiences of the moms, and then at the same time I'm able to speak with the other men about work.

Not all comments were positive. Some caregivers reported that they desired traditional hierarchies in interacting with staff. One mother desired more prescriptive advice:

> I'm waiting for the pediatrician to tell me: "Look, he should eat chicken or beef, at such and such an hour, and he can eat these fruits, and do it in this way." But here they don't do it this way. I end up going to my mother.

This parent sought advice outside the group because of a perceived lack of directive information.

Theme 3: Relationships Formed in GWCC Facilitated Social Cohesion

Participants contextualized the experience of being a caregiver in the isolation shaped by immigration. One mother attributed changing patterns in family structure as a driver of this isolation:

> There's a lot of first-time moms. They probably don't have their mom to show them or talk to them about what to do with the child. So I think that's where [GWCC] comes in, because maybe they just don't have that guidance to help them.

Cultural discordance also informed this isolation. A father described the difference between American culture and that from his home country:

> Here, I don't even know my next-door neighbor, nor the one across the street. They close their doors. Not like in my country where I know the whole neighborhood; the whole world says hi to me. So in the group it's a fresh experience because you get to know other people, there's contact, you make connections.

GWCC allowed participants to raise and discuss fears regarding current political issues surrounding immigration:

> We talk about the President, about the new rules about immigration and all that. We're all living in fear, in one way or another. I hadn't known it, but when you get to the group you realize that other people, too, feel like "I am in fear of leaving to go to the store" and I'm like "Wow! This is affecting everyone."

The relationships formed therein extended beyond GWCC appointments and into social spaces, as one mother offered in an anecdote:

> And there was this white lady. I know her from the shelter. She's in there, so it's like, a lot of people in there, like, you see on a day-to-day basis. And then we see each other in store and they be like, "Oh, she in that group." So, it's like, those are relationships inside of a group, but, even though we go outside or whatever, I still see them and you can conversate. "How's the baby doing?" I wouldn't have done that otherwise.

The resulting relationships formed a network of knowledge and support that helped caregivers make decisions about caring for their babies. One mother explained:

> By going to a group with a whole bunch of mothers, like, nine or ten, all the mothers in there know a little something. So we get all our ideas together and then we know enough about the baby.

More than the sharing of knowledge alone, it was togetherness that helped mothers meet the daily exigencies of life as a parent, as another mother said:

> Mothers gotta stick together especially when they got little kids. It's so important to have somebody to actually go be in a group with.

Discussion

We have characterized how GWCC influences participants' perception of medical expertise and their choices to utilize health services; their relationships across professions, cultures, and genders; and their ability to meet the daily exigencies of parenthood despite isolating, structural vulnerabilities. This is the first analysis of group well-child care to employ a bilingual and multicultural analysis strategy, which facilitated our understanding of the contributions of and challenges of GWCC for families living in poverty, those who may have recently immigrated, and those who may be experiencing various forms of discrimination.

While previous qualitative studies identified the importance of peer relationships in GWCC (DeLago et al. 2018; Page et al. 2010), our study identified possible mechanisms by which peer relationships fostered by GWCC influence health services utilization. Peer-to-peer triage may be an important contribution of GWCC to other strategies for self-triage that have been limited by diagnostic uncertainty (Semigran et al. 2015). We also identify pathways by which GWCC rearranges social hierarchies, which may enhance adherence to treatment plans and child health outcomes (Litchfield et al. 2018). On the other hand, some participants perceived a lack of directive advice in GWCC and this drove them to seek such advice elsewhere.

The Andersen model of health care utilization identifies factors that enable utilization at individual and contextual

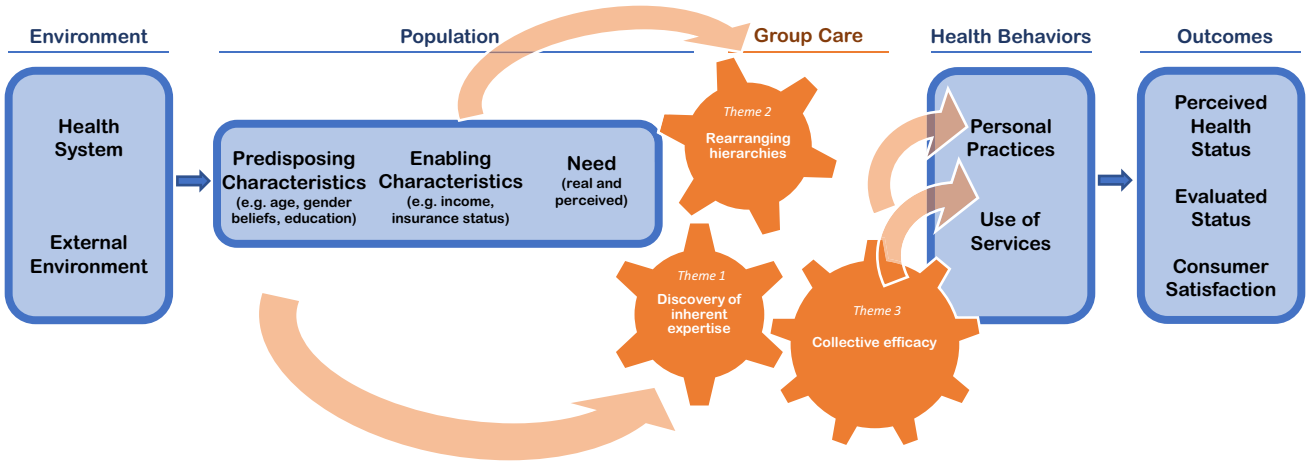

Fig. 1 Andersen model of health care utilization (blue) with emerging themes overlaid (orange). Predisposing characteristics comprise inherent expertise (Theme 1) and enabling characteristics drive the rearrangements of hierarchies (Theme 2), both of which may lead to relationships that facilitate collective efficacy (Theme 3), which, in turn, alters personal practices and the use of services

levels (Andersen and Newman 1973; Andersen 1995). These factors include social support, defined as the emotional, informational, and affectionate support generated through a social network (Seeman and Berkman 1988), but they have not previously included one's own expertise or the expertise of peers undergoing a similar medical or life condition. Our findings build on the Anderson model to suggest that inherent strengths of oneself and one's peers may be an important vehicle by which presdisposing and enabling characteristics influence personal health practices and the use of health services (Fig. 1).

Our study has notable limitations. First, caregivers have chosen to participate in our GWCC model, so they may be more interested in fostering togetherness and being open to others' ideas than other parents. Second, our sample included urban, low-income parents and so the hypotheses generated may not apply to other populations. However, if these individuals are positive outliers, identifying their strengths may identify best practices to improve the quality and experience of care (Luft 2010). Finally, our study was conducted at a period of increased political and media focus on immigrant populations in the United States, potentially emphasizing the importance of safe spaces for peer support that may not be applicable to other periods.

GWCC is a primary care delivery model that provides unique opportunities to enhance care experiences known to impact health care utilization and social cohesion. These include opportunities to discover one's own expertise as a care giver, to reappraise social hierarchies that may impede health services utilization or experiences of care, and to form bonds across social barriers that are durable beyond the clinic walls. Our findings may generate hypotheses for future work that investigates the nature of peer-to-peer triage in pediatric and other settings, and the interplay between social hierarchies and health services utilization.

References

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10.

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society, 51*(1), 95–124.

Bethell, C., Reuland, C., Schor, E., Abrahms, M., & Halfon, N. (2011). Rates of parent-centered developmental screening: Disparities and links to services access. *Pediatrics, 128*(1), 146–155. https://doi.org/10.1542/peds.2010-0424.

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine, 92*(3), 299–307. https://doi.org/10.1097/ACM.0000000000001294.

Coker, T. R., Chung, P. J., Cowgill, B. O., Chen, L., & Rodriguez, M. A. (2009). Low-income parents' views on the redesign of well-child care. *Pediatrics, 124*(1), 194–204. https://doi.org/10.1542/peds.2008-2608.

Connor, K. A., Duran, G., Faiz-Nassar, M., Mmari, K., & Minkovitz, C. S. (2018). Feasibility of implementing group well baby/well woman dyad care at federally qualified health centers. *Academic Pediatric, 18*(5), 510–515. https://doi.org/10.1016/j.acap.2017.09.011.

DeLago, C., Dickens, B., Phipps, E., Paoletti, A., Kazmierczak, M., & Irigoyen, M. (2018). Qualitative evaluation of individual and group well-child care. *Academic Pediatric, 18*(5), 516–524. https://doi.org/10.1016/j.acap.2018.01.005.

Flower, K. B., Skinner, A. C., Yin, H. S., Rothman, R. L., Sanders, L. M., Delamater, A., et al. (2017). Satisfaction with communication in primary care for Spanish-speaking and English-speaking parents. *Academic Pediatric, 17*(4), 416–423. https://doi.org/10.1016/j.acap.2017.01.005.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Mill Valley: Sociology.

Glaser, B. G., & Strauss, A. L. (1980). *The discovery of grounded theory: strategies for qualitative research*. Hawthorne: Aldine Publishing Co.

Hagan, J. F., Shaw, J. S., & Duncan, P. M. (2017). *Bright futures: Guidelines for health supervision of infants, children, and adolescents* (4th ed.). Elk Grove Village: American Academy of Pediatrics.

Holland, M. L., Yoo, B. K., Kitzman, H., Chaudron, L., Szilagyi, P. G., & Temkin-Greener, H. (2012). Mother-child interactions and the associations with child healthcare utilization in low-income urban families. *Maternal and Child Health Journal, 16*(1), 83–91. https://doi.org/10.1007/s10995-010-0719-z.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687.

Litchfield, I., Bentham, L., Hill, A., McManus, R. J., Lilford, R., & Greenfield, S. (2018). The impact of status and social context on health service co-design: An example from a collaborative improvement initiative in UK primary care. *BMC Medical Research Methodology, 18*(1), 136. https://doi.org/10.1186/s12874-018-0608-5.

Luft, H. S. (2010). Data and methods to facilitate delivery system reform: Harnessing collective intelligence to learn from positive deviance. *Health Services Research, 45*(5 Pt 2), 1570–1580. https://doi.org/10.1111/j.1475-6773.2010.01148.x.

Machuca, H., Arevalo, S., Hackley, B., Applebaum, J., Mishkin, A., Heo, M., et al. (2016). Well baby group care: Evaluation of a promising intervention for primary obesity prevention in toddlers. *Child Obes, 12*(3), 171–178. https://doi.org/10.1089/chi.2015.0212.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine, 103,* 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032.

Norlin, C., Crawford, M. A., Bell, C. T., Sheng, X., & Stein, M. T. (2011). Delivery of well-child care: A look inside the door. *Academic Pediatric, 11*(1), 18–26. https://doi.org/10.1016/j.acap.2010.12.008.

Oldfield, B. J., Munoz, N., Boshnack, N., Leavitt, R., McGovern, M. P., Villanueva, M., et al. (2019). "No more falling through the cracks": A qualitative study to inform measurement of integration of care of HIV and opioid use disorder. *Journal of Substance Abuse Treatment, 97,* 28–40. https://doi.org/10.1016/j.jsat.2018.11.007.

Page, C., Reid, A., Hoagland, E., & Leonard, S. B. (2010). WellBabies: Mothers' perspectives on an innovative model of group well-child care. *Family Medicine, 42*(3), 202–207.

Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *BMJ, 311*(6996), 42–45.

Rosenthal, M. S., Connor, K. A., & Fenick, A. M. (2014). Pediatric residents' perspectives on relationships with other professionals during well child care. *Journal of Interprofessional Care, 28*(5), 481–484. https://doi.org/10.3109/13561820.2014.909796.

Rosenthal, M. S., Connor, K. A., & Fenick, A. M. (2016). Pediatric residents' perspective on family-clinician discordance in primary care: A qualitative study. *Journal of Health Care for the Poor and Underserved, 27*(3), 1033–1045. https://doi.org/10.1353/hpu.2016.0114.

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*(5328), 918–924.

Santos, H. P., Jr., Black, A. M., & Sandelowski, M. (2015). Timing of translation in cross-language qualitative research. *Qualitative Health Research, 25*(1), 134–144. https://doi.org/10.1177/1049732314549603.

Seeman, T. E., & Berkman, L. F. (1988). Structural characteristics of social networks and their relationship with social support in the elderly: Who provides support. *Social Science and Medicine, 26*(7), 737–749.

Semigran, H. L., Linder, J. A., Gidengil, C., & Mehrotra, A. (2015). Evaluation of symptom checkers for self diagnosis and triage: Audit study. *BMJ, 351,* h3480. https://doi.org/10.1136/bmj.h3480.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks: Sage Publications.

Thomas, K. A., Hassanein, R. S., & Christophersen, E. R. (1984). Evaluation of group well-child care for improving burn prevention practices in the home. *Pediatrics, 74*(5), 879–882.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042.

Yoshida, H., Fenick, A. M., & Rosenthal, M. S. (2014). Group well-child care: An analysis of cost. *Clinical Pediatrics (Philadelphia), 53*(4), 387–394. https://doi.org/10.1177/0009922813512418.

Yu, S. M., Huang, Z. J., Schwalberg, R. H., & Nyman, R. M. (2006). Parental English proficiency and children's health services access. *American Journal of Public Health, 96*(8), 1449–1455. https://doi.org/10.2105/AJPH.2005.069500.