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Health Start School-Based Clinic Staff and Hmong Adolescents: Does the Servant Leadership Theory Apply?

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CERTIFICATE OF APPROVAL

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Table of Contents

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Abstract

This pilot study investigated whether the staff at Health Start's school-based clinics and the Hmong adolescents they serve are in agreement as to what health services Hmong adolescents want from the clinic and staff. In investigating this issue, servant leadership theory also was applied to answer the question: Does using servant leadership theory assist the staff in delivering culturally congruent healthcare to Hmong adolescents?

According to Servant Leadership Theory, leaders first want to serve for the purpose of developing a healthier, wiser, freer, more autonomous follower. This theory, manifested by Robert K. Greenleaf through his work experiences and thinking about leadership issues, was applied to the staff and analyzed in order to understand how this theory will benefit them and their service delivery.

This pilot study asked the following questions to answer how the services were perceived by Hmong adolescents and if the staff exhibited any traits of servant leadership:

What kinds of comprehensive health services do the Hmong adolescents in the St. Paul schools want from the school-based clinic staff?

What comprehensive health services does the staff think the Hmong adolescents want from the clinic and staff?

Introduction

Hmong means "free man." This definition is important to the cultural context of the Hmong people. Because of their history the Hmong have fled from countries or regions where they have suffered persecution, or have been pressured by the government to assimilate into the culture of the majority in that country.
(Troska, 1993, p. 37)

The Hmong are the most recent arrivals to the U.S., with over 100,000 refugees concentrated primarily in California, Wisconsin, Minnesota, Texas, and Rhode Island [Office of Refugee Resettlement 1990]. (McInnis, 1991, p. 103) Hmong refugees pose a special concern to us because they did not move to the United States willingly; instead they were forced to move because of war. What makes their transition difficult is the fact that their cultural beliefs are foreign to those in the Western world. Both the older and younger generation face certain challenges that are unique to their community.

Minnesota has seen a gradual increase in its Hmong population since the 1980's. According to the Council on Asian Pacific Minnesotans, from the 100, 000 refugees, there are approximately 60,000 Hmong refugees in Minnesota. Of these 60,000 refugees, 35,000 are in St. Paul alone.

The St. Paul School district estimate that 30% of their students enrolled in their schools (K - 12) are of Asian descent; 90% of the Asian student population are Hmong.

Although the adolescent population (about 2,000-2,500) is the smallest group in the Hmong community, they are literally the pioneers for their communities and families. Many of them are interpreters for their parents and became westernized sooner than the parents. The children age 10 and under seem to be the largest age group within the Hmong population throughout the United States and Minnesota. (Yang, 1993, p.15) In the Twin Cities alone, this age bracket keeps increasing in size.

Although secondary migration, moving to a different place other than your original destination, within the United States has allowed the Hmong to regroup into clans, it has caused considerable disruption in the education of the Hmong children. It has been very difficult for Hmong children to be placed in grade levels at school based on chronological age, particularly when the family has made more than the initial move from refugee camps in Thailand. (Moore-Howard, 1982, p. 41) Only recently have some of the Hmong kept track of their birthdays.

Hmong children and teens have experienced many problems adapting to life in their new country. Because Hmong culture was unknown to most United States residents, Hmong adolescents have had trouble establishing their identity in this country. (Moore-Howard, 1982, p. 42)

Because of the growing number of Hmong school-age children (K – 8 grades), high schools (educators, healthcare providers,

and mental health providers) must become better equipped in serving these Hmong adolescents in a manner that will encourage the adolescents' development and functioning in their own community and the larger community.

Caring professionals, community leaders, parents, and young people are overwhelmed by the threat of the four big adolescent problems: sex, violence, drugs, and depression. In the past these problems have been addressed within different professional domains, such as, the healthcare community, educators, and social workers. Because of this, each profession had its own experts, interventions, and sources of funds. Not only are drugs, sex, depression and violence a concern among professionals in the larger community; but also in the Hmong community. Only recently has there been acknowledgement of the inverse correlation between unhealthy behaviors and school performance and a willingness of these professionals to work together to find a solution. This understanding led to the conceptualization of school-based clinics, such as the ones that Health Start, a non-profit organization, oversees. School-based clinics are health clinics located on school ground. (Lyons, 1987, p.303)

The Health Start school-based clinic staff believes that they are providing adequate healthcare for the Hmong students; however, the staff want to know what they could be doing to improve their service delivery, communication styles, and understanding of the Hmong culture

and its healthcare beliefs.

For example, would a Hmong interpreter make a difference? Would learning about how Hmong culture defines communication assist in delivering adequate healthcare? What barriers do the staff need to be made aware of?

One barrier that the staff have had to work around is the language barriers; this is especially difficult when the parents do not speak the English language and parental consent is needed for treatment.

Another barrier is that Hmong children are taught to be polite and to listen to authority figures, which makes it hard for the staff to know if Hmong adolescents actually understand their instructions. Not disagreeing is one way that Hmong children and adolescents alike show their politeness and respect.

A literature search revealed no articles specific to what Hmong adolescents want in healthcare services, except pregnancies. The available literature primarily focused on the historical journey of the Hmong to America and on the group as a whole. Several articles were written on the topic of the cultural conflict between Hmong children and their parents, not specifically on the healthcare needs. Finding out what health services Hmong adolescents want is vital to the Health Start staff in order to deliver quality service and to learn how to improve the existing services.

The assumption of the study: 1) prenatal care will be very important to the young girls and boys, but for different reason; 2) the Health Start staff have their own ideas of what the students want; 3) the Health Start staff exemplifies the concept that serving comes before leading by putting the needs of the Hmong adolescent first.

History of Adolescent Healthcare

> *The young people of today are our leaders of tomorrow. Their optimal health and functioning in tomorrow's roles depend on intervention and manifested concern about their health today. Does this group not merit concern and action and support?* (Mercer, 1979, p. 56)

Although providing quality healthcare has been a primary concern in this country, the literature and readings indicate that the focus has been on young children below the age of 12 and adults. Only recently has there been an interest in adolescent healthcare; especially, the type and quality of delivery of care.

Over the past 30 years, adolescents and the kind of healthcare they require have drastically changed. Today's adolescents face problems and concerns that are complex and that have the potential to be dangerous to their health. Many live in families that are abusive, attend classes where teachers are non-caring, and frequently are manipulated for the economic advantage of others. These conditions can create a climate that exacerbates adolescent health problems (Calbrese,

1987, p.36). The Society for Adolescent Medicine urges that improving healthcare for adolescents can be evaluated by: availability, visibility, quality, confidentiality, affordability, flexibility and coordination (Klien et al, 1992, p. 45).

Adolescents have many barriers to receiving the adequate healthcare that they deserve. One of the many barriers is that adolescents are neither 'big people' nor 'small adults': medically speaking. They have their own unique physiology and their own indigenous diseases (Strasberger, 1984, p.78). Also, adolescents are often stereotyped as the healthiest individuals in our society, persons with few healthcare needs. However, adolescents are members of the only population group in America in which the rates of death and illnesses are increasing (Johnson, 1988, p. 133). Healthcare providers of adolescence realize this is the stage of physiologic and psychological transition from childhood to adulthood. It is also a period of transition from pediatric to adult healthcare.

"The visiting patterns and diagnosis of the early adolescent group (13-15) resembles the pediatric age range, and those of the late adolescent group (19-20) resemble adults. The middle adolescent group (16-18) appears to be in greatest transition, but the transition appears to be uneven. For some areas, the diagnosis seems to be in the pediatric range; in other areas, their diagnosis resembles adult patterns (Poole and Morrison 1983, p.105)." The challenges mentioned earlier hold true for all

adolescents despite cultural differences.

Because, "children are frequently the most highly traumatized person during conflict…The overwhelming differences in school, language, culture, and family values flood the refugee child. Some of the most able can stay afloat, but many sink into hopelessness, helplessness, and the belief that their attempts will be futile…" (Home/Away…, 1993, p.78) Many adolescents are either uninformed about or are reluctant to seek appropriate healthcare. Unfortunately, adolescents who are either immigrants or refugees to the United States are unfamiliar with our healthcare system. This is the case with some Hmong adolescents.

Early marriages and pregnancies in the Hmong community help define their adolescent age group (13-18) in the opposite manner of the United States. In the United States, we see it as a progressive stage of life where self-discovery is permitted and being rebellious is expected. In the Hmong community 13 or 14- year-olds are seen as adults, with adult responsibilities. Hmong adolescents get married, raise families, and are employed, not idle. By the age of 16, unmarried girls are viewed as old maids. All are expected to contribute to their community and families. (Southeast Asian Refugee, 1987, p. 11)

In terms of healthcare, early pregnancies may be alarming to American society, but they are a way of life in the Hmong community.

Birth control is very rare in the Hmong community and families tend to be large. Many of the Hmong girls want to finish school but find it difficult for them to do so with a child.

Thus, Hmong adolescents have some of the same issues as other adolescents, however, their culture dictates how they proceed in getting their healthcare needs met; such as, reproductive care and using Eastern vs Western medicine.

Hmong Healthcare Practices

> *The flexibility and gracefulness of (the) bamboo are primary characteristics of the Southeast Asians. Americans belong to an 'Either-Or Society,' and Southeast Asians belong to an 'Accommodating Society.'* (Olness, 1986, p.43)

The way the Hmong people view illness and the treatments used is different from the Western worldview: Hmong utilize shamans, herbalist, massager, acupuncturist, and other various wisemen.

The Hmong culture also incorporates "scratching the wind" which is a harmless method of treating simple illnesses and pain. This treatment involves scratching the area to let all the 'bad wind' out of the body to restore health. Some form of medicated ointment is used to scratch the area and a coin or spoon is gently rubbed over the area until dark spots that look like bruises appear. The dark spots may alarm teachers or healthcare workers, but the patient does not feel pain.

Shamans are important in Hmong society, and it is to them

that families go in times of trouble, as they have ways of settling the spirits. The herbalist is skilled in the use of fresh and dried herbs and has remedies for many sorts of complaints. The massager usually treats people who complain of muscular or stomach pains. The acupuncturist is asked to treat patients with fever or pressure problems. Finally, Hmong wisemen are able to read omens, consult Chinese charts and come up with a diagnosis for a variety of maladies (Moore-Howard, 1982, p. 89)

These families are unlikely to seek treatment in the American healthcare system until they have exhausted medical resources within their own culture. For example, surgery has become an issue with healthcare providers. Traditional Hmong culture forbids surgery because of the belief that cutting open the body allows good spirits to leave and bad spirits to enter. Despite a family's personal feeling about surgery, clan leaders may forbid the procedure (McInnis, 1991, p. 578)

The Hmong are at extremely high risk for mental illness due to multiple losses in their lives and the stress of cultural adjustment. The Hmong attribute mental illness to organic and /or supernatural causes and expect treatment from both shamans and herbalists. The American mental health system uses an interactional approach to emotional problems. Talk therapy and medication constitutes the mainstay of psychiatric treatment. This can be both alien and offensive to the Hmong patient. (Moore-Howard, 1982, p.89)

Because of these differences, healthcare providers need to

be sensitive to the needs and differences of the Hmong population and the Hmong's own healthcare beliefs.

Healthcare Provider's Challenges

> *By learning more about Asian, and specifically Hmong attitudes toward health and illness, Western healthcare workers can do much to improve the quality and appropriateness of care for this special group…Until this gap is bridged, both sides will continue to be blinded and burdened in the provision of healthcare.*
> (Thao, 1984, p.76)

Healthcare providers face a number of barriers when caring for the Hmong population, including adolescents. One of the challenges that healthcare providers' face is the language barrier. If parents of these adolescents cannot speak the language, how can they give verbal or written consent for their children? In some cases interpreters have been provided, however, these services may not be adequate. The providers usually have limited understanding of the Hmong culture and health needs. And, their limited access to the elders prevents the providers from gaining the necessary knowledge to help the Hmong community.

Another challenge is the fact that out of politeness Hmong adolescents have a tendency to pretend to understand the healthcare providers. They will do more nodding and smiling in order to please the provider, instead of asking questions and clarifying. The provider has to be willing to take the lead and ask questions in order to have a full understanding of the adolescent's comprehension. One of the challenges

is knowing which questions to ask and how to ask them.

As stated previously, the Hmong population marries young and is expected to have many children. Today's youth may not necessarily want this and seek guidance on contraceptive issues and how to deal with their community. These adolescents desire confidentiality when getting advice from authority figures on matters such as reproductive health. The staff will need to handle this issue in a sensitive manner. Another issue is that some adolescents may have conflict between receiving Western medicine and utilizing their traditional ways of treating illnesses. Could this prevent many of the Hmong students from using the school-based clinic's services?

Also, if they are using both, the treatments might contradict one another. The adolescents might not tell the provider that they are using both kinds of healing methods. Despite the many barriers and challenges the healthcare provider faces in serving this population, they are trying to be sensitive to the needs of the Hmong adolescents.

History of Health Start

> *Health Start, Inc., a non-profit organization developed a mission to improve maternal, child, and adolescent health in Ramsey County by providing primary and preventive health and education services to high risk populations, such as low income women*
> (Mission Statement of Health Start)

Health Start, Inc. is a health-oriented, non-profit organization that oversees seven school-based clinics in a large mid-west city. The organization also has non-school based clinics that help low income women with prenatal care and exams for women, adolescents, and children. However, they are not as well known as the school-based clinics.

Today, Health Start manages school-based clinics within seven high schools. Each of the clinics has a full-time staff of a medical assistant, a licensed clinical social worker, and a nurse practitioner/nurse clinician. A nutritionist and a health educator provide education and counseling in the clinics one day a week. A pediatric/adolescent nurse, family physician and/or certified nurse midwives provide additional medical services.

The organization's mission is to improve the healthcare status of low income women, adolescents, and children. In doing so, the organization hopes to educate as well as treat the many health concerns of their clients.

School-based clinics are located on the premises of a school that provides comprehensive healthcare to the high school students. The services are adolescent-focused and provided by an interdisciplinary team. The primary goal of the school-based clinic staff is to provide the students with the quality healthcare that they need.

The goals of the program are to:

> -provide comprehensive healthcare services to students who would not otherwise have access to them
> -address health problems and psychosocial issues that present obstacles to optimal student learning
> -serve as a resource to families by identifying and diagnosing student health problems that need further intervention
> -teach students to become well-informed healthcare consumers
> -help students integrate health wellness and responsible decision-making into their lives
> (Harold & Young, 1990, p. 1)

The concept of school-based clinics began in 1971 when high school staff members reported a dramatic rise in the number of teen pregnancies and of school dropouts because of these pregnancies. The staff turned to the cities' local medical center for assistance to help start a daycare center to keep these teens in school.

At the same time, Maternal Infant Care (MIC) program staff at this local medical center were also struggling with the issues around teen pregnancies. A partnership between the public schools and MIC offered an innovative response to the needs of pregnant teens. Two physicians and a senior MIC social worker initiated the first school-based clinic in this large mid-west city. In 1973, due to the efforts of parents, students, the local board, teachers, and staff of the high school, the first school-based clinic was established as a three-year demonstration project. (At the same time, a daycare center for babies of student parents was established in a neighboring church).

As the staff worked in the school with the first population of

pregnant teens, the staff soon realized that the adolescents' needs expanded to address the broad range of problems presented by adolescents. This table shows the wide range of services that the students can utilize within the context of the school-based clinic.

Table 1: School-Based Clinic Services

- assessment, diagnosis and treatment of minor illness (ranging from colds and flu to acne)
- identification of and referral for treatment of medical conditions such as high blood pressure, diabetes, and asthma
- immunizations
- athletic, employment, and school physicals
- laboratory tests
- counseling regarding interpersonal, family, or relationship problems
- counseling about depression and suicide
- assessment, counseling, and referral for eating disorders, chemical dependency, and issues of abuse
- individual and group education
- sexuality decision-making counseling that acknowledges the benefits of abstinence
- family planning education, counseling and prescriptions (contraceptives are not dispensed on site)
- diagnosis and treatment of sexually transmitted diseases (STD)
- STD prevention and education
- pregnancy testing and prenatal care
- counseling and support for student parents
- nutrition counseling
- counseling and education about weight loss or weight gain
- AIDS risk assessment and prevention education (AIDS testing is not done in the SBC)
- Support and counseling for parents of adolescents

(Harold & Young, 1990, p. 7)

When this high school closed in 1976, the school administration requested that similar clinics be established in the two schools to which the students were transferred (Harold & Young, 1990, p. 10). In 1984, only ten school-based clinics could be identified around the

country, but the most publicized model was in this large mid-west city. Between 1985 and 1991, school-based clinics were organized in high schools and middle schools in America, primarily in urban areas (Dryfoos, 1993, p.25).

The future for these clinics is uncertain, despite initial studies that support their success. Several factors will dictate their continued impact in the healthcare community. Four areas of concern that could limit the success of teen health centers are: 1) inadequate financial support, 2) insufficient health and social welfare organization, 3) negative public and political attitudes toward the lower income and adolescents populations, and 4) an unproven intervention technology (Joiner, 1988, p. 23)

Organizational Structure of Health Start

> *The comprehensive school healthcare model assumes major gaps in community healthcare services which, because of issues of availability, accessibility or acceptability, if not provided within the school setting would not exist for the population served.*
> (Blum et al, 1982, p. 67)

Health Start has approximately forty-five employees; the majority is Caucasian, middle class women. And, the clientele are mostly low income, minority women, adolescents, and children. Conversely, serving this population has been a challenge. Because of the low attrition rate, it has not been easy to hire minorities and men. This organization sees that it needs to change and is doing just that. Recently, Health Start

hired a male executive director and is in the process of searching for a new associate director. Although men are still hired in positions of power, some of the male staff who are employed in the clinic report to female team leaders. Because the team leaders have grown accustomed to male authority since the former associate director was male, the executive director's gender will not affect his leading this organization. However, these female team leaders will not hesitate to voice their opinions and band together to forge positive changes.

The structure of the organization is decentralized and teams based. This means the staff that is in the clinic work as a team and not as individual disciplines like before. The executive director reports to the Board of Directors and is responsible for the overall management and administration of the organization, including policy development, strategic planning, fiscal management, resource development, contract negotiations, and staff management. As with most boards, the members rely on the executive director to be their eyes and ears.

The new executive director will be supervising the new associate director, medical directors, support services (administrative secretary, accountant, and receptionist), obstetric & pediatric team members, Cares, Partnership, ALC, Befrienders, and non-clinic school team members. The new associate director will have his or her own team members to supervise. (See Appendix A p. 49) The new associate

director will be overseeing all the school clinics/services in the junior high, senior high, and alternative schools. The team leaders report to the new associate director and have monthly meetings with this new person as well. In the interim, the executive director has the opportunity to work closely with the team leaders.

The teams consist of a member from different disciplines: nurse, medical assistant, health educator, nutritionist, social services, interpreter, and an outreach person. Because of this team-based concept, they are able to give the clients quality comprehensive healthcare.

Each of the clinics has a full-time staff of a medical assistant, a licensed clinical social worker, and a nurse practitioner/nurse clinician. A nutritionist and health educator provide education and counseling in the clinics one day a week. Additional medical services are provided three half-days per week by a pediatric/adolescent nurse associates, family medicine physicians and/or certified nurse midwives.

The structure of Health Start and its school-based clinics has changed throughout the years, from being the traditional pyramid structure to the current team-based structure. The administration and the staff also need to identify their leadership skills to be able to provide appropriate services to their client base, both in the school-based and non-school-based clinics.

Leadership: The Integration of Two Diverse Groups

> *Will the leader stand up? Not the president, or the person with the most distinguished title, but the role model. Not the highest paid person in the group., but the risk taker. Not the person with the largest car or the biggest home, but the servant. Not the person who promotes himself/herself, but the promoter of others. Not the administrator, but the initiator. Not the taker, but the giver. Not the talker, but the listener.* (Hesselbein et. al, 1996, p. 241)

As in any health-oriented organization, "...without sufficient leadership you risk failure. Sound leadership will give you a solid foundation to meet change, adversity, and competition head on." (Capko, 1996, p. 34). Yet healthcare administrative leadership is undergoing historic change because the "healthcare industry is rapidly changing its focus from illness and hospitalization to community healthcare and illness prevention, and these changes require a change in leadership concepts for nurses." (Kerfoot, 1996, p. 200)

The need for minority representation is increasing in such fields as medicine, education, and leadership. The fact that minorities are underrepresented in the upper reaches of healthcare management means more than missed career opportunities for whole groups of people. It also means the healthcare field is equipped poorly to serve a diverse community. (Blankenau, 1994, p.45) The need for recruitment is huge and the need for recruiting for healthcare providers are even greater in the

Hmong communities.

Today's changes require the development and maturation of leadership: leadership that has very little to do with giving orders. According to Brent Filson (1994, p. 77), leaders should create heartfelt and emotionally stimulating work environments, thus encouraging people to improve their productivity and quality themselves.

A leader in the healthcare field has these three challenges ahead: (1) learn to be a change leader; (2) settle for no less than world class standards of excellence at all times; (3) accept as a moral imperative and a sacred trust that one's work must contribute to the meaning of people's lives and that the organization should be in service to humanity's greater needs. (Kerfoot, 1996, p. 200) The way people in the Western world define their world is diametrically opposed to the way Hmong people define theirs. This is why assimilation has been very difficult for the Hmong. The two worlds clash not only culturally but also in their styles of leadership.

Table 2: Leadership Styles

Hmong	**Dominant American Culture**
Clan emphasis	Individual emphasis
Present oriented	Future oriented
Time is relevant	Time is scheduled
Cooperation	Competition
Mystical	Skeptical
Extended family	Immediate family
Respect for others' differences	Contempt for other's differences

Peaceful	Aggressive
Harmony with nature	Conquest of nature
Pragmatic	Theoretical
Compact living	Space
Interdependent	Independent
Socialistic	Private
Mores	Laws
Non-materialistic	Materialistic
Modest	Overly confident
Silence	Noise

- Lyfoung, pg.6

Although leadership is very important to both worlds, leadership in the Hmong community has suffered its own tragedies.

The family is very important in the Hmong community and means more than the nuclear unit - it includes all relatives who belong to the extended family unit known as a clan, which is the basic unit of both social and political organization in Hmong culture. Families belong to one of 18 clans, hence there are only 18 Hmong surnames. (McInnis, 1991, p.573)

The clan leaders, usually male, are looked upon as the traditional leaders within the refugee communities. Clan leaders are not chosen, but the leaders emerge from within the Hmong society. These leaders gain respect from their contributions to the Hmong community here in America. The clan leaders have two roles in American Hmong life: as liaisons between the non-Hmong and Hmong communities and as arbitrators in resolving intraclan and interclan conflict. As arbitrators, they often resolve disputes between spouses or between child and parent. As liaisons, clan leaders function as the gatekeepers to the Hmong

community regarding: housing, healthcare, etc.. If the clan leaders disapprove, the Hmong people will not participate in American societies mores. Although the clan leaders serve a vital purpose in their community, Western culture has created a new set of issues to address for both the Western and Hmong communities. (McInnis, 1991, p. 573)

Hmong community leaders have had to address shifts of leadership in their community. One of the reasons for this shift is that Hmong children are growing up in a Westernized society, which has created tension between the young, and their elders. Hmong children and adolescents often lose respect for their elders whom they see as helpless and dependent in coping with life in the United States and, therefore, view them as incapable of being their teachers and mentors. This not only disrupts the parent-child relationship, but also restricts or cuts off the passing of cultural values, history, and traditions from one generation to the next. Passing on the history of the Hmong people is a vital process that provides identity, self and community esteem to the Hmong adolescents. (Moore-Howard, 1982, p. 15)

The clan leaders have felt the loss of power and prestige among their own people, especially with the young. These perceived losses have brought about a feeling of sadness among the clan leaders.

Another reasons for the feeling of loss is the language barrier. Because of the language barriers, the men have had to use their

children as interpreters. This loss of power has caused many of the males to become depressed and has left them with a sense of helplessness. Not only has this loss of power affected the leaders, the changing leadership in the Hmong community can and will influence their healthcare choices by not turning to their elders as often and become more influenced by the Western standards of healthcare.

As the older generation feels this loss, the younger generation has to decide whom to turn to for leadership. Do they adhere to their clan leaders or will they become influenced by their more Westernized peers? This is a question that needs to be researched and answered because the future of the Hmong community is still in transition and the clearer the vision for this community the better the services for them.

Ironically, Hmong women have adjusted to the Western culture more rapidly than the men have. Because the Hmong culture is very patriarchal in nature, the women have either had to develop their talents quietly or not at all. The primary reason for this is that the Hmong women are becoming more educated and are not willing to tolerate the old way of thinking about the genders. The Hmong women have also been able to own property and make their own money which translates into the ability to make their own decisions and gives them the sense of accomplishment that they did not have in their homeland. Because of this new found independence with the women, Hmong girls and adolescents

will be able to look at leadership differently. These Hmong girls and adolescent will have choices that their mothers and grandmothers did not have, such as schooling, reproduction, and career.

Presently, there are fourteen Hmong organizations operating in the Twin Cities; two are women's organizations. Leadership within the Hmong community is not unusual. However, because they come from a every simple, agrarian, and isolated life in the highlands of Laos, the Hmong people have had to learn the Westernized version of leadership. Both Hmong men and women have had to learn the politics of running an agency and how to develop resources outside their communities. All this has not been easy for them.

The longer Hmong people reside in the United States, community leaders from both worlds will need to learn how to effectively work with each other. The Hmong community leaders will have a dual role. They will need to know how to manage effectively with their divided community members, as well as, deal with leaders outside their community. These leaders will have to be attuned to which community members respond to the old way of leading or which community members adheres to the Westernized way of leading. Like Robert Greenleaf's Servant Leadership Theory, (Greenleaf, 1970) the Hmong leaders will have to look at their followers' needs first before leading them. Another reason to be aware of leadership styles is that by utilizing the resources of

the Western world, the Hmong leaders will be able to bring valuable knowledge to their community and share resources with leaders outside their community.

On the other hand, non-Hmong community leaders who learn what the Hmong community values and respects will be able to communicate more effectively with this population. Because the Hmong community uses the social services and other services being provided to them outside their community, the assumption is that learning these values will assist non-Hmong leaders in providing the quality services that the Hmong deserve. One of the benefits is that leaders will be able to bring this perspective to their work environment and family unit. Both community leaders will benefit greatly and so will their respective communities.

Servant Leadership Theory

> *"What are you trying to do?" is one of the easiest to ask and most difficult to answer of questions. A mark of leaders, an attribute that puts them in a position to show the way for others, is that they are better than most at pointing the direction.* (Greenleaf, 1970, p. 15)

The servant as leader idea comes about through Robert Greenleaf's numerous experiences in thinking and working on leadership and service issues. It crystallized when he read Herman Hesse's short novel, *Journey to the East*. Greenleaf concluded that great leaders see themselves as servants to others.

The central concept of servant-leadership is the natural feeling that one wants to serve, to serve first before leading. Then conscious choice brings one to aspire to lead. The difference between a person who wants to serve first and a person who wants to lead first manifests itself in the care taken by the servant-first to make sure that other people's highest priority needs are being served. While the person who leads first and serves second only because out of prompting of conscience or in conformity with normal expectations. The final decision for which the person becomes a servant or leader first comes down to their own personal choices.

Greenleaf had two concerns when he developed this theory. First was the concern for the individual in society who deals with problems wholly in terms of systems, ideologies and movements. He felt that this type of individual does have its place, but this type does not have the ability to serve and lead – the prime movers. When Greenleaf mentioned prime movers – he meant the people that will affect the larger society and who were not afraid to affect society in this manner. Second, Greenleaf did not want to see the serving person who may have the tendency to deny creative fulfillment fail to lead when there is an opportunity. (Greenleaf, 1970, p. 5)

Putting the follower's needs first assist the leader in determining what the needs are and to find the most effective way to lead

the individual or group.

The best, and difficult test to administer, is: do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society; will they benefit or, at least, not be further deprived? (Spears, 1991, p. 5)

An example of servant leadership is in the book, The Leader of the Future (1996). William Bridges writes about leading a de-jobbed organization where there is a constantly shifting group of people, some of whom work for your organization in the traditional sense and some who don't. The "job title" of a person is almost forgotten in a de-jobbed organization. The main focus is getting the work done. This means that the organization might outsource, use temps for no more time than necessary. Bridges believes that "Robert's Greenleaf's powerful metaphor of the leader-as -servant fits the de-jobbed organization well." (Hesselbein, 1996, p.17) this is because the leaders will need more sophisticated skills, not the opposite. The leader will need to be more in tune to the followers that is because task now is to forget about jobs and move toward the work that needs doing.

In the book, The Leader of the Future (1996), Peter Drucker mentions that servant leaders listen and learn from those they lead. They work at making themselves available. They become frantic learners and avoid the trap that so many so-called successful leaders experience - the

arrogance of ignorance.

In Robert Terry's book, Authentic Leadership: Courage in Action(1993), as he writes about ethical leadership, Terry quotes Robert Greenleaf – "The failure(or refusal) of a leader to foresee may be viewed as an ethical failure because a serious ethical compromise today is sometimes the result of a failure to make the effort at an earlier date to foresee today's events and take the right action when there was freedom for initiative to act.", (Terry, 1993, p. 43) For Greenleaf, foreseeing the unforeseeable and having the courage to act on that knowledge appropriately are the keys to leadership.

While servant leadership is not a religious belief, it nevertheless is a very powerful idea, and one that can potentially be corrupted by similar attempts to define it as a fixed or complicated set of requirements. This is according to Larry Spears, CEO of the Robert K. Greenleaf Center for Servant-Leadership and editor of The *Servant Leader,* its quarterly newsletter. Spears also developed a list of characteristics that define a servant leader, through his readings on servant leaders.

Table 3: Servant Leadership Characteristics

Listening receptively to what others have to say

Acceptance of others and having empathy for them

Foresight and intuition

Awareness and perception

Having highly developed powers of persuasion

An ability to conceptualize and communicate concepts

An ability to exert a healing influence upon individuals and institutions

Building community in the workplace

Practicing the art of contemplation

An ability to exert a healing influence upon individuals and institutions

Building community in the workplace

Practicing the art of contemplation

Recognition that servant-leadership begins with the desire to change oneself. Once that process has begun, it then becomes possible to practice servant leadership at an institutional level. (Spear, 1995, p. 6)

In Janet Hagberg's book, Real Power: Stages of Personal Power in Organizations (1984), she believes that one must "take a leap of faith" toward the emerging model of what it means to truly lead and away from the need to be successful, famous, rich, in control, or powerful. Her belief can be transferred to servant leadership. In Greenleaf's theory, one does not think of what one can gain from being in a leadership position but how to help others in the process of leading.

Today, Robert Greenleaf's dreams and passions live on in his center. The staff at the Robert K. Greenleaf Center hold workshops and train all over the world on servant-leadership in hopes to encourage others to think differently about leadership.

Research Questions

The purpose of this pilot study is to identify and describe the healthcare services desired from the school-based clinics of Health Start by the growing Hmong adolescent population and the kind of staffing it would take to fulfill their medical and psychosocial needs. Also, the data gathered will be used as a program evaluation for the Health Start school-based clinic.

The research questions are as follows:

What kinds of comprehensive health services do the Hmong adolescents in the St. Paul schools want from the school-based clinic staff?

What does the staff think the Hmong adolescents want from the clinic and staff for their comprehensive health services?

During the course of gathering the data, many other important and vital questions were of interest to me. However, because of limited time and resources, I will focus on the medical and psychosocial services to the Hmong high school students. This study will give both the staff and board a perspective of the utilization of the clinics and the efficiency with which the staff is providing these services to the Hmong high school students.

Methodology

Because of the growing Hmong population, Health Start, Inc. wanted to know their success or failure rate of the services to the Hmong

adolescents.

After much deliberation from the clinical management team, Health Start chose questionnaires instead of face-to-face interviews for the following reasons:

The possibility of gathering valid, reliable, information from the staff and adolescents by face-to-face interviews would be questionable

Health Start would be dealing with minors that may have reservations being honest to a total stranger. Plus, getting the adolescents to give the consent forms to their parents/legal guardian would be a challenge.

Due to the limitation of money and time, they believed that questionnaires would be the most effective and efficient method of gathering data.

Last, but not least, this method keeps the participants anonymous, which will increase their chances of getting valid, reliable data. Also, this method respects their privacy.

With my assistance, the clinical management team constructed a two page questionnaire to be given to the Hmong high school students that utilized the St. Paul school-based clinic and a one-page questionnaire given to the Health Start school-based clinic team leaders. The questionnaires consisted of both open and close-ended questions whose purposes were to compare the perception of the team leaders versus Hmong adolescents on what they wanted in their healthcare needs. Also, the questionnaires was designed to reveal any other services desired by these students. (See Appendix B & C, pgs. 51-53)

Sampling:

The high schools - Harding, Como, Johnson, AGAPE, and Highland –

were chosen because of their high ratio of Southeast Asian students. The actual participants consisted of 12(92%) team leaders and 44(1%) Hmong adolescents.

Procedure:

After the questionnaire was constructed and approved by Augsburg's Institutional Review Board and Health Start's Clinical Management Team, the former executive director distributed it to the team leaders. For each questionnaire a letter was attached stating that this was only voluntary and their participation or non-participation would not affect their relationship with Health Start, Augsburg College or the St. Paul public school. (See Appendix D, p. 54)

Both groups were asked to complete a standard consent form that Health Start has devised in situations such as this.

The team leaders handed out the questionnaires to Hmong patients after their clinic appointment.

Results

The student survey revealed that:

The data showed that the Hmong adolescents wanted the lab tests, physical exams, and nutritional services as their top services.

The results of the closed ended questions can be seen on Appendix E on pages 46-47.

The staff survey revealed that:

The data showed that 99% believed that they were giving the best possible services and 1% said no. The 1% wrote that the forms were not in Hmong and the staff had limited access to interpreters. The staff believed that the Hmong adolescents wanted all the comprehensive services provided by the school-based clinic. The data showed that the words respect, understanding, use interpreters, learning, recognizing differences, listening, aware, and non-judgmental were common in how the staff handle cultural differences.

The results of the closed-ended questions can be seen at Appendix F on page 57 and 0% put any additional comments on the bottom of the questionnaire.

Data Analysis

As the data has revealed, the staff and the students are not in agreement when it comes to the healthcare needs of Hmong adolescents.

Hmong adolescents would consider using lab tests, physical exams, a nutritional services as their top three services. However, when broken down by gender, the data revealed that females are more apt to use lab tests, nutritional services and physical exams while the males would use physical exams, immunizations and minor illness as the clinic's services.

The boys' answers are indicative of the fact that they get

sports physicals and get minor illness taken care of at the clinic. However, the girls are the ones that use the clinics for pregnancy tests and nutritional services. Surprisingly enough, prenatal care was one of the least sought after services. This was surprising because of the traditional early pregnancy in this community. However, it may because the girls are not willing to get married and raise a family as early as their traditional counterparts.

The staff on the other hand showed that they felt that Hmong adolescents would put equal weight on all the services. This proved not to be true. (Look at Table 1: Services of the School-Based Clinic, p. 19)

The percentage of Hmong adolescents that adhere to Western medicine is hard to determine due to the types of questions on the questionnaire. A good majority of the participants have been in this country a number of years, but this does not mean that the ones that utilize the clinic's services are more Westernized than the non-users. The questionnaire does not specifically ask the students which kind of treatments they prefer.

In terms of leadership in delivering these services to Hmong adolescents, I see the team leaders as the primary leaders in effectively serving these students. The teams that the team leaders have direct contact with are considered the secondary leaders. The team leaders are the ones that help carry out Health Start's mission and vision by instilling

the mission and vision in the people they supervise.

The basic premise of Greenleaf's servant leadership theory is to serve first and then lead. Looking over the comments that the students and staff made on their questionnaires and comparing the comments to Hmong leadership style, I have concluded that the staff does exhibit some of the basic characteristics of servant leadership. The most prominent is the ability to truly listen to the Hmong adolescents during their visits. In the Hmong community, leaders are expected to use cooperation and silence as a way to lead.

Comments such as these: understanding, caring, & helpful, makes me realize that the students do feel comfortable with the staff. While the staff wrote comments like: we show sensitivities to their cultural differences, try to be aware of cultural practices and consider what they are in making recommendations and respect for their cultural traditions, practices and willingness to work with their frame of reference. Looking over Spear's list, I realized that the staff exemplifies listening, acceptance, awareness and perception. Although I have based these assumptions on the comments written in the questionnaire, these comments does not indicate that the staff are servant leaders in the true sense of the word. What it does tell me is that their desire to serve first is inherent in their working with the Hmong adolescents.

The questionnaires do not measure foresight and

perception, powers of persuasion, ability to conceptualize and communicate concepts, practicing the art of contemplation or the concept of servant leadership.

As with any study, the limitations were considered. Because this study is focused only on the School-Based Clinics, generalizing the findings to the other clinics throughout the country is questionable. Also, concentrating on Hmong students limits generalizations to any other ethnic group from the Southeast Asian community or any other ethnic group.

Furthermore, only the school-based clinic team leader views were represented in this study; the school nurses or other staff were not represented. The reason is that the leaders saw the whole picture of the team and the school nurse had a different view from the school-based clinic staff.

Although a questionnaire preserves the participant's confidentiality, the information gathered does not measure the adolescent's understanding of the questions and the staff's willingness to be honest.

Overall, both parties seem to be satisfied with the services being delivered by the clinic and staff. The study does show that there is much to be learned when it comes to servicing this population of adolescents.

Conclusions

The first responsibility of a leader is to define reality. The last is to say 'thank you.' In between the two the leader must become a servant and debtor."
(DePree, 1989, p. 11)

This pilot study has tried to answer these questions:

What kinds of comprehensive health services do the Hmong adolescents in the St. Paul schools want from the school-based clinic staff?

What does the staff think the Hmong adolescents want from the clinic and staff for their comprehensive health services?

The Hmong adolescents seem to want lab tests and physical exams and seem less interested in prenatal care and other services. The staff was not correct in thinking that the students put stock in all the services at the clinic.

The staff does exhibit parts of what Robert Greenleaf would consider servant leadership. Their desire to serve first is very important to both Greenleaf's theory and as a way of leading in the Hmong community. The staff's willingness to respect the Hmong culture and learn from the Hmong is another sign of servant leadership.

Looking at my assumptions, it was determined by the study that two of the three were right. Prenatal care were not as important to the students as other services. The staff did have their own ideas but still exemplified some characteristics of the servant leader.

Overall, the Hmong adolescents are appreciative of the staff

and the services. They are grateful that the clinic exist in their school and will continue to utilize the services.

Recommendations

True leadership begins with the willingness to be someone other than who the world wants you to be.
(Hagberg, 1984, p. 174)

Many recommendations come to mind as the data was being analyzed. Being culturally sensitive is one recommendation. The meaning of being culturally sensitive means different things to different people within the organization and the clientele they are serving. The administration and staff need to be willing to look at the organization, themselves, and the clientele to see where they stand on being culturally sensitive. To be able to have a unified definition of cultural sensitivity would be a start.

One of the ways to look at the issue of cultural sensitivity is to maintain the diversity committee with both staff and board members. This committee has worked on this issue; but the members realize how much more needs to be done within the organization. Eventually, inviting former clients to sit on this committee might be helpful and the organization move forward towards a more culturally sensitive place.

Another activity that the staff and board members should be doing is finding better ways to access interpreters and how to bridge gaps

between themselves and the elders in the Hmong community. Hiring more Hmong staff would assist in this learning process.

Another suggestion would be to put together a student forum, not just involving Hmong students. To be able to give these students a voice in their own healthcare would be a tremendous self-esteem booster and learning tool for the staff, administration, and Board.

The team leaders should take the initiative to inform the administration and Board of any additional service or services that are not working for these students. I see the team leaders as the true leaders because of their close contact with the students and schools.

A workshop to learn about the healthcare needs of the Hmong community and what it would take to deliver quality services is another way to gain access to the Hmong community and add to the staff and boards' knowledge. In reviewing Table 2 and 3, I noticed that Servant Leadership and the Hmong leadership style have similarities. My suggestion would be to have the organization, both administration and staff, learn about Servant Leadership and how the Hmong community leaders lead their community.

As mentioned before, this study is limited only to the Hmong adolescents and their healthcare needs. Other studies/research would benefit the community and other caregivers.

Although the staff has the desire to serve these students, I feel that the staff need to be made aware of Greenleaf's theory and how

they can fully apply it to their work in the school-based clinics.

As in all studies, many other questions need to be researched and answered. Because of the minimal knowledge of the Hmong culture itself, specific research could be done on these areas:

- How does the school-based clinic staff attract more Hmong students?
- How can they attract more males to the clinic?
- What are some of the gender differences in delivering these services
- What is the long term effects on Hmong adolescents because they are in the United States?
- What kind of leadership do these Hmong adolescents see in the future? Do they see themselves as leaders in their community and others?

Appendix A

GLOSSARY

ALC: Alternative Learning Centers
Health Start provides a variety of services to alternative school students in both Minneapolis and St. Paul. In Minneapolis, they provide nutrition counseling and health education under a contract that uses United Way funding.

In St. Paul, health education is provided at several school sites, including Fresh Start, Community of Peace (a charter school), and at the ALC located in the Uni-Dale mall.

Their most complete services to alternative school students are offered at Guadalupe Alternative Programs school on St. Paul's west side. GAP has extensive health education services including an HIV peer education program and classroom teaching, in addition to clinical services that include health care provided by a nurse practitioner, individual health education, and nutrition counseling.

Parenting Programs:

Partnership
Health Start began providing parent education and support programs in 1988, when they received a federal SPRANS grant (Special Projects of Regional and National Significance) from the Bureau of Maternal and Child Health.
The intervention consisted of home visits, education/support groups, pediatric care, and reproductive healthcare for mothers.

Cares Project
It is open not only to Health Start clients but to any family affected by the mother's drug use prenatally (and often post-partum.) The project includes home visits, support/education groups, regular assessment of child development and early referral for intervention when needed.

Befrienders
Is a collaborative effort between Health Start, Children's Home Society of Minnesota, and the Jeremiah project. The program trains women volunteers from the community, pairs them with young mothers, supervises and supports volunteers. Volunteers and mothers agree to face-to-face weekly contact for a year. A number of the relationships last beyond that time. The program has been successful in improving women's self-image and increasing hope for the future.

Appendix B

Student Survey

(Please note, if you do not want to finish this survey or any part of it, you may stop at anytime. Thank you)

General Information

How long have you lived in the United States? _____ years _____months

Are you male or female? (circle one)

How old are you? _____

What grade are you presently in? _____

Which school do you presently attend? _____

Can you speak English fluently? _____yes _____no (please check one)

How did you hear about the Health Start clinic in your school? _____
_____

How often do you use the health Start clinic? _____weekly _____monthly _____once a year _____twice a year _____other

How **satisfied** are you with the clinic in meeting your healthcare needs? _____ very _____satisfied _____somewhat ____not ____not at all _____ uncertain

How **important** would it be for a Hmong staff person to work at the school-based clinic? _____ very _____important _____somewhat _____not at all

Does the current Health Start school-based clinic staff meet your needs? _____ yes _____ no

If not, how could they better meet your needs?
_____
_____
_____

If yes, can you tell me how they have met your needs?
_____
_____

Student survey cont., pg. 2

Please check only the Health Start clinic services listed below that you might use.	
1.Minor Illness (flu, sore throat, earache)	
2. Laboratory Tests (Pregnancy, STDs, HIV, throat culture, Pap Smears etc.)	
3. Physical Examination (for sports, employment, other)	
4. Immunizations (shots)	
5. Medications	
6. Health Education (information on stop smoking, parenting classes, family planning, STDs, AIDS, decision-making, etc.)	
7. Social Services (counseling for issues of dating, family problems, depression, suicide, abuse, etc.)	
8. Nutrition Services (weight loss or gain, eating problems, cholesterol checks, etc.)	
9. Prenatal Care for pregnancy	
10. Other known services	

Any comments you wish to make:

Appendix C

Staff Survey

(Please note, if you do not want to finish this survey or any part of it, you may stop at anytime. Thank you)

General Information

How long have you worked at Health Start? _____

Are you male or female? (circle one)

What is your ethnic background? _____

Which school-based clinic site(s) do you provide services at?

_____

What is your job title at Health Start? _____

In your opinion, does the school-based clinic(s) you help staff provide the best possible services to Hmong adolescents? Yes No (please circle one) If not, why?

_____

_____

How does the school-based clinic staff handle cultural differences and still deliver quality services to the Hmong adolescent?

_____

_____

Please check only the Health Start clinic services listed below that in your opinion Hmong students might use.	
1. Minor Illnesses (flu, sore throat, earache)	
2. Laboratory Tests (pregnancy, STDs, HIV, throat culture, Pap Smears, etc)	
3. Physical Examinations (for sports, employment, other)	
4. Immunizations (shots)	
5. Medications	
6. Health Education (Information on stop smoking, parenting classes, family planning, STDs, AIDS, decision – making, etc)	
7. Social Services (counseling for issues of dating, family problems, depression, suicide, abuse etc.)	
8. Nutrition Services (weight loss or gain, eating problems, cholesterol checks, etc.)	
9. Prenatal care for Pregnancy	
10. Other known services	

Any comments you wish to make:

Appendix D

Date

To the Staff and Students at Health Start:

I am a graduate student in the Masters of Arts in Leadership program at Augsburg College. I am presently working on my paper titled: Health Start Staff and Hmong Adolescents.

As the Hmong population grows in St. Paul, I feel that it is vital to Health Start's future and the future of the Hmong children that the organization understands the healthcare needs of the Hmong adolescent.

I am in the process of gathering my data for my paper. Both Augsburg's Internal Review Board and Health Start's Internal Review Board have approved the questionnaire.

Your participation and non-participation will not affect your relationship with the St Paul School district, Health Start or Augsburg College. Your confidentiality will be preserved.

If you have any questions, please do not hesitate to give me a call (651) 699-2128. Thank you for your time a effort on this project.

Sincerely,

Tie H. Oei

Appendix E

Results of Student Surveys

Table 4 – Services Used at School-Based Clinics

Services Used and by Whom	A	M	F
1. Minor Illnesses	19	2	17
2. Laboratory Tests	25	1	24
3. Physical Examinations	25	3	22
4. Immunizations	21	2	19
5. Medications	13	1	12
6. Health Education	19	1	18
7. Social Services	22	1	21
8. Nutrition Services	24	1	23
9. Prenatal care for Pregnancy	10	0	10
10. Other known services	8	0	8

Table 5: Usage of the Clinic

Weekly	9
Monthly	11
Once/year	5
Twice/year	4
Other	17
N/A	1

Table 6: How Satisfied Are You?

Very	21
Satisfied	18
Somewhat	3
Not	0
Not at all	0
Uncertain	2

Table 7: How Important Is It To Have A Hmong Staff Person?

Very	13
Important	11
Somewhat	18
Not at all	2

Table 8: How Did You Hear About Health Start

Nurse	7
Asked	2
Friends	16
Yes *	1
Walk-ins	1
Pretty Nervous*	1
Teacher	3
School	2
Ramsey Hospital	1
Health Start Director/Coordinator	1
Health Educator	2
Clinic	1
School Placement Center	2
I don't know*	1
Announcements	3
Sports Instructor	1
Coach	1
Older sister	2
Sister	1

- 100% of the students said that the school-based clinic staff met their needs.

Appendix F

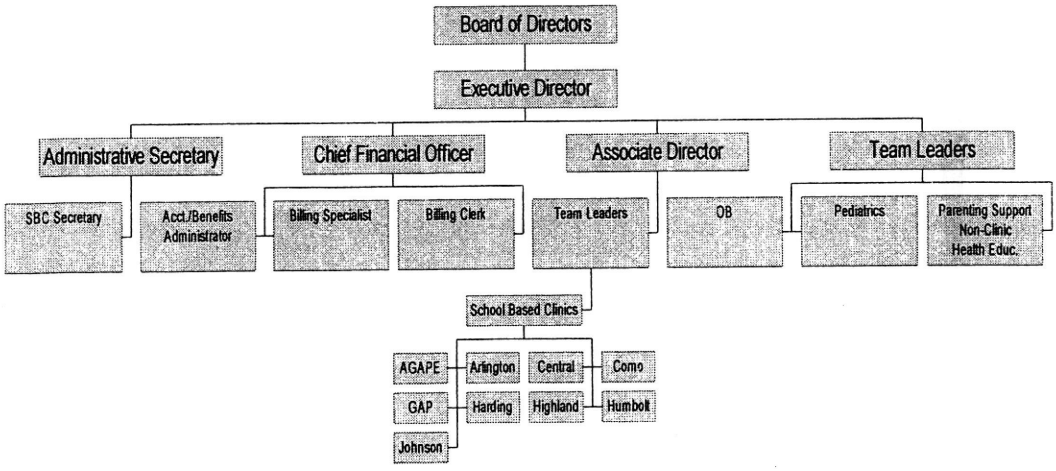
Results of Staff Surveys

Table 9: Services Used at School-Based Clinics

1. Minor Illnesses	10
2. Laboratory Tests	10
3. Physical Examinations	10
4. Immunizations	10
5. Medications	10
6. Health Education	10
7. Social Services	10
8. Nutrition Services	10
9. Prenatal care for Pregnancy	10
10. Other known services	10

Appendix G

Health Start Organizational Chart



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