

Asian American Health Assessment

Prepared by AARC, Inc.

July 2014

Vince Cobalis, Lesley Varghese, Peteria Chan



Table of Contents

INTRODUCTION	3
PARTICIPANT RECOMMENDATIONS.....	4
TAIWANESE AMERICAN COMMUNITY REPORT.....	5
CHINESE AMERICAN COMMUNITY REPORT	9
VIETNAMESE AMERICAN COMMUNITY REPORT.....	13
KOREAN AMERICAN COMMUNITY REPORT.....	17
SOUTH ASIAN AMERICAN COMMUNITY REPORT	18
ASIAN AMERICAN SENIOR COMMUNITY REPORT	19
ASIAN REFUGEE COMMUNITY REPORT.....	20

INTRODUCTION

Asian American Resource Center, Inc. (AARC, Inc.) is a community-based nonprofit organization formed in 2006 to support the construction and operation of the City of Austin Asian American Resource Center facility (Facility) located at 8401 Cameron Road, in Austin, Texas. The Asian American Health Assessment study was performed by AARC, Inc. as part of its broader cultural competency endeavors and community needs assessment for the Facility. It is hoped that the community needs described herein can be addressed in part through effective community partnerships and a cohesive, culturally competent vision for wellness programming, health education and community outreach at the Facility.

The Asian American population of Austin/Travis County is extraordinarily diverse: socioeconomically, linguistically and geographically within Austin. This study seeks, first and foremost, to disaggregate Asian American health care experiences in order to identify vulnerable populations.¹ The study gathers qualitative data concerning participants' perceptions of their community's general health and healthcare access, including both health care utilization and health care barriers. Each subpopulation report concludes with participant-driven recommendations to address community concerns.

Asian American subpopulations experience some of the same prevalent chronic illnesses – most notably diabetes and cardiovascular disease. In addition, a scarcity of health resources and information in Asian languages appears common to all Asian American subpopulations. However, the reports also reflect disparities, particularly in health literacy, perceived rates of hepatitis, and perceived access to care and transportation. This report, generously funded by the City of Austin/Travis County Health and Human Services Department, is intended to raise awareness of the health concerns and disparities within the diverse and understudied Asian American community in Austin/Travis County, and to propel the participant recommendations herein into actionable solutions.

¹ This report studies only the largest of Austin/Travis County's Asian American subpopulations. The study does not cover the Pacific Islander community or smaller Asian American subpopulations such as Filipino Americans, Japanese Americans, Malaysian Americans, Cambodian Americans or Thai Americans. All of the foregoing include vulnerable populations. As members of Austin/Travis County's fastest growing ethnicity, they should be noted for further study.

PARTICIPANT RECOMMENDATIONS

Detailed participant recommendations can be found at the conclusion of each Asian American subpopulation report. Categories of participant recommendations include:

- 1) Provide culturally competent health education, accessible health care resources (including low cost clinics and free health screening), and appropriate Asian language outreach at the AARC Facility and elsewhere.
- 2) Publicize existing affordable, culturally sensitive health care resources, in Asian languages and in appropriate community media and venues.
- 3) Develop accessible transportation solutions for Asian elders and refugees.
- 4) Promote and support social activities for subpopulations at the AARC Facility where culturally friendly wellness programs and education can be introduced (publicized in Asian languages and in appropriate community media and venues).
- 5) Connect the uninsured to accessible care by improving insurance enrollment and providing low cost health care options.
- 6) Improve quality of care with culturally competent medical consultants and patient navigators.
- 7) Support patient-provider communication through cultural education for providers and by increasing availability of culturally competent and Asian American providers for specific subpopulations.
- 8) Develop culturally sensitive health care support systems for the elderly and disabled with household assistance, home health workers, and long term care facilities sensitive to Asian cultures.

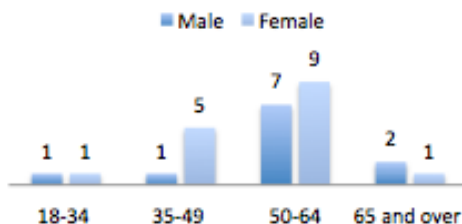
I. TAIWANESE AMERICAN COMMUNITY REPORT

Focus Group Overview

The Asian American Resource Center non-profit organization (AARC, Inc.) conducted a Taiwanese American focus group on August 4, 2013, at Xiang Yun Buddhist temple in northwest Austin. This is a location for many community events and community members are at the facility on Sundays for other purposes. The meeting was organized by two community leaders, one of whom was an AARC, Inc. Board member.

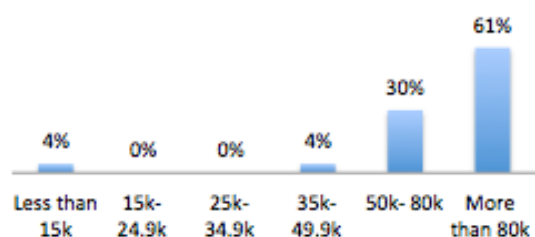
- There were 27 participants.
- Only two participants were born in the US; the rest were born in Taiwan or China.
- Only two participants were uninsured.

Gender and Age



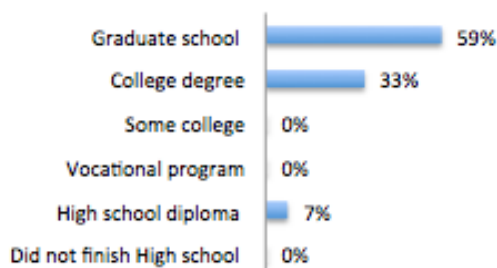
Total Responses: 27

Annual Household Income



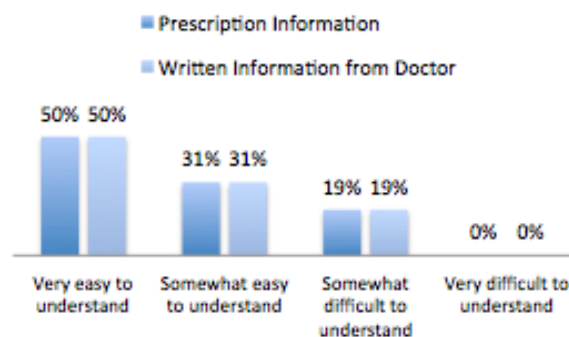
Total Responses: 23

Education



Total Responses: 27

Health Literacy



Total Responses: 52

Perceptions of Community Health

a. General Health Issues

The Taiwanese American focus group participants defined good health as being happy “with peace between the mind, body, and soul”, “being active and sleeping and eating well”, and “absence of a chronic disease or mental problems, such as depression”.

Vulnerable populations include those who are either underinsured or uninsured (restaurant workers, small business contractors), the elderly, and those experiencing social and academic pressure.

Focus Group Highlights:

- ***Perceived Community Health Issues:*** Perceived key community health issues of the Taiwanese American community include diabetes, cardiovascular problems, hypertension, arthritis, cancer and allergies. Participants perceive that Taiwanese American youth suffer high stress related to educational and parental expectations and do not communicate stress-related concerns to their parents.
- ***Sources of Health Information:*** Internet, friends, family physician, temple, community health articles, ethnic media, and Taiwanese cultural associations.
- ***Diabetes:*** Diabetes is perceived to be common in the community.
- ***Obesity/Fitness:*** Obesity is not perceived to be common in the community. Participants felt that activities such as dancing, tai chi and walks are enjoyed by some community members, but that the community as a whole should be more physically active. No discussion of youth in relation to obesity and activity levels. Participants agreed that healthy and active lifestyles should be perpetuated and encouraged to prevent many of the diseases and conditions that are prevalent in the population.
- ***Immunizations:*** Most participants felt immunizations were important but perceived that immunizations were only taking place in the community where required by schools for youth. Some participants disagreed about the importance of immunizations for adults, with one participant stating that better self-care, decreasing stress, and vitamins and minerals may be used to increase immunity (“immunizations aren’t always needed”).
- ***Hepatitis:*** Participants perceived hepatitis to be a problem in Taiwan and for older immigrants, but not for younger immigrants or Taiwanese Americans born in Austin. Appeared there was a need for education around this topic.

b. Mental Health Issues

Good mental health was defined as having good family relationships, sleep patterns, and “the ability to forgive”. Participants felt that they were not privy to mental health issues in the community such as suicidal ideation, which was described as too private of an issue to be aware of the frequency. However, it was felt that suicidality may be of concern among young Asian women, who are high achievers but are locked within cultural and parental expectations. As with other Asian American focus groups, participants observed that mental illnesses are a big taboo within the community.

Participants perceive that seeking help for mental health does not occur much in the community because of fear of embarrassment.

c. Complementary and Alternative Medicine (CAM)

Participants advised that the Taiwanese American community's health is maintained with the usage of both Western and Eastern medicines, such as massages, acupuncture, and herbal medicines. Participants perceived that the community seeks alternative medicines for holistic and natural solution to chronic conditions, rather than acute care concerns. There is the belief that Eastern medicines "last longer".

Among participants 14 people had utilized the services of an acupuncturist, herbalist or other alternative health practitioner for massages, acupuncture or herbs, and 17 people had taken non-prescription Oriental herbal preparations or nutrition supplements. Participants largely did not share their use of Eastern or alternative medicine with their physicians because of the language and cultural barrier and/or perceived distrust of Eastern medicine by Western doctors.

Perceptions of Health Services Access

a. Health Services Utilization

Participants report that preventative care and check ups are among the reasons that Taiwanese Americans will visit a physician, in addition to acute concerns. Immunizations and vaccinations were perceived to be common for school-aged youth, but there was not a complete consensus as to importance and utilization by adults.

b. Barriers to Health Care

Participants stated that language and cultural barriers were the biggest obstacles in health care for the Taiwanese American community. Participants also noted that there are community members without insurance and that co-payments are high even with insurance. One participant noted that community members may fail to seek care because of pride – assuming they know better than a medical profession – potentially related to perceptions of Western versus Eastern medicine.

Participant Recommendations

This is the first time participants had been asked about their community's health. To their knowledge, the health of Austin's Taiwanese American population has never been studied, so participants felt that the **studies should continue and more detailed surveys should be conducted across the community**. While the community appears well educated and affluent in the aggregate relative to the general population (including some of the other Asian American populations), **lower income Taiwanese Americans are a vulnerable population that should also be studied** so they do not fall through the cracks. In addition, language and culturally barriers appear to impact Taiwanese Americans, a predominantly immigrant community, across socioeconomic lines.

Disseminating health-related information in culturally appropriate venues and in Asian languages was agreed to be a very important aspect of improving health access for this community.

Participants made numerous comments and recommendations to improve outreach and dissemination of health information to this community:

- **“Need more information and health seminars in native language”.**
- “People don’t go to doctors unless there is a problem, make it known what services are available so they know where to go (for preventative treatment).…”
- “People look for resources if they know they have cancer, but they don’t know where to go for help”; “do not have enough information from government”.
- Participants perceive there is “less outreach” to this community about public health.
- **Public health information should be disseminated by telling community leaders and have them pass out Chinese language flyers, pamphlets, etc. With that information, people will spread the information to their friends through phone.**
- **Health information may be disseminated through newspaper advertisements in ethnic news (Capital News) or local news, and also in schools so that children may bring information home to their parents.**

Participants also noted that registering to vote to have an impact on local policies, allowing for voices to be heard, and being more involved in the public health policy making process are all important for the community. **Participants also recommended increasing access to more culturally friendly low cost clinics.**

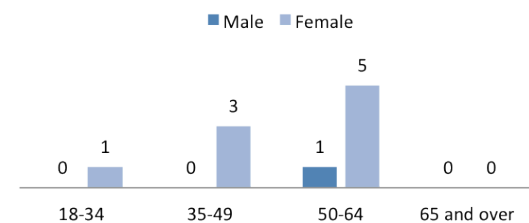
II. CHINESE AMERICAN COMMUNITY REPORT

Focus Group Overview

The Asian American Resource Center non-profit organization (AARC, Inc.) conducted a Chinese American focus group on August 11, 2013, at Xiang Yun Temple, a Buddhist Temple in northwest Austin. This is a location for many community events and community members are at the facility on Sundays for other purposes. The meeting was organized by two community leaders, including an AARC, Inc. Board member.

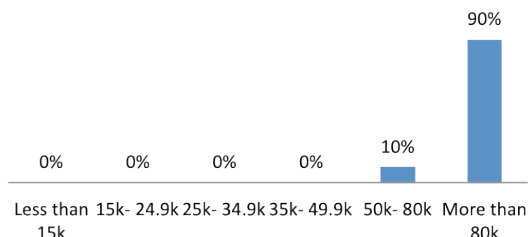
- Although there were 11 participants, only 10 submitted surveys.
- Only one male completed the survey, the rest were female.
- All but one were born in Mainland China.
- All had health insurance.

Gender and Age Range



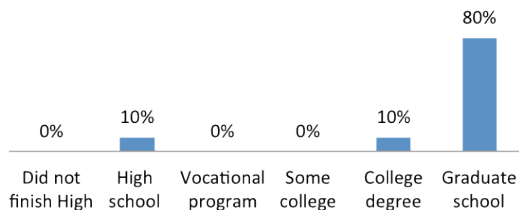
Total Responses: 10

Annual Household Income



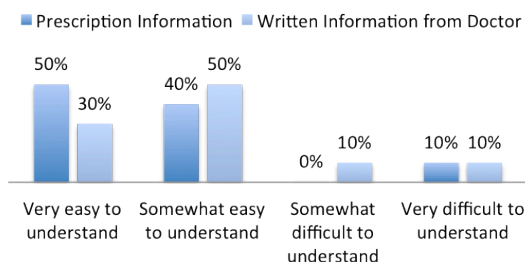
Total Responses: 10

Education



Total Responses: 10

Health Literacy



Total Responses: 20

Perceptions of Community Health

a. General Health Issues

Chinese American focus group participants defined good health as an absence of pain, and the freedom to do what you want, including eating, walking and drinking without difficulty. Participants agreed that good health means both mental and physical well-

being. Participants identified several reasons for seeking health care including prevention, routine medical check-ups, and dental problems. Certain participants who were immigrants stated that more comprehensive health care services were available in China.

Focus Group Highlights:

- ***Perceived Community Health Issues:*** Participants perceive hypertension/"blood pressure", allergies, Hepatitis B and dental health to be key community health issues. Participants perceive the top overall health issue in the community to be poor diet and lack of exercise.
- ***Sources of Health Information:*** Participants used friends, relatives and colleagues, information from family doctors, "city lists" and the Internet to obtain health/health care provider information.
- ***Smoking/Tobacco Use:*** Participants perceive that tobacco use is a much bigger problem in China, than it is in the Chinese American population.
- ***Obesity/Fitness:*** Most participants felt they were of normal weight. About 40% of the group felt they get enough physical activity, but some also pointed out that there is more incentive to walk in China than the US due to accessibility of services and availability of cars. Participants felt that community members might eat healthier if there were more discussion and encouragement in social situations such as parties.
- ***Cancer:*** Participants were cognizant of the need for an annual breast exam for women and the importance of early detection. Participants perceived that cancer rates are lower in China "due to more exercise". Participants noted that prostate cancer is a concern.
- ***Hypertension/Heart Disease:*** Participants perceive that high blood pressure due to work stress is an issue in the community. Participants were unfamiliar with medications used to prevent heart disease but take the medications they are provided.
- ***Diabetes:*** Participants largely agreed that diabetes is an issue in the community and defined diabetes as "high blood sugar". Participants perceived the following to be contributing factors to diabetes: "being overweight", excess consumption of "rice, sugar and salt" and too much processed food. Participants felt that watching what you eat, or substituting white rice with brown rice or "mixed rice", sharing healthy recipes through the Asian American Resource Center, and eating smaller meals would help address the community diabetes problem.

b. Mental Health Issues

Participants defined good mental health as "positive energy" or *chi* (harmonized inner being), and getting along well with others. Participants observed that Chinese Americans may seek mental health support for family arguments and depression. Participants felt that "individuals have the ability to help themselves", but also noted that some people seek help from church. Some participants suggested that experiencing some degree of mental health concerns is commonplace. One participant noted that if you "if you think you have a problem, then you're normal".

Participants felt that Austin does not provide enough mental health services for Chinese American immigrants; one reported that a friend returned to China for mental health resources.

Participants noted that community members did not appreciate that eating disorders are a mental health issue.

Participants did not perceive local Chinese Americans to be at particular risk of suicide; in relation, they observed that gun violence/owning firearms is not a cultural norm in the community. However, they observed that elderly Chinese Americans without much family can experience loneliness and related mental health issues. In addition, participants observed that those struggling with suicidal ideation need more support from the community, as they have lost the social support structure they had in Asia.

Participants, largely first generation Chinese Americans, felt that alcoholism was not as prevalent in the Chinese American community as it is in the general American population, but perceived that second generation (American born) Chinese Americans who are more assimilated may drink more.

c. Complementary and Alternative Medicine (CAM)

Participants noted that community members may need to travel to Houston to consult a Chinese doctor. Notably, several participants expressed a lack of confidence in Western medicine. Participants observed that Western physicians look at “symptoms, not the whole person” and that they “follow protocol” instead of thinking for themselves. Some members of the community believe that Western medicine is overly dependent on prescription medication, which they perceive doctors to be proscripting in large doses irrespective of one’s body type. This was of concern to participants who perceive that Asian Americans may have smaller body types, on average, than other Americans. Some participants felt that it was prudent to seek out a Chinese doctor for a natural remedy before seeing a Western doctor, noting that Western medicine is “too strong”.

At least half of the participants had utilized the services of an acupuncturist, herbalist or other alternative health practitioner within the preceding twelve months. As well, half of the participants had taken non-prescription Oriental herbal preparations or nutritional supplements within the preceding twelve months. Examples given were “ginseng for digestion” and “Chinese medicine for colds”. Some participants felt it was unwise to inform their Western doctors about one’s use of Chinese medicine due to the perception that Western doctors are sceptical of Chinese medicine. Other participants felt a cooperative dual approach was possible and provided anecdotes about their own health care providers who were open to patients using a combination of Western and Chinese medicine.

III. Perceptions of Health Services Access

a. Health Services Utilization

Participants agreed that immunizations were essential to good health and felt they should be freely available. Participants perceive check ups, preventative care and dental care as reasons for seeking medical care.

b. Barriers to Health Care

Factors that discouraged Chinese American participants from seeking health care included concerns regarding the high costs. Individuals felt that insurance was expensive but essential, especially for emergencies as well as for labor and delivery. There was concern that insurance would not cover tests, and when it did that there might be a large deductible/co-pay. Some participants explained that they prefer to seek medical attention such as check-ups and flu shots abroad because it is less expensive and the testing is more comprehensive. In addition, Chinese American participants are discouraged by the long waits for services or to make appointments with health care providers. Participants reported that Chinese Americans also being rejected for health and life insurance due to hepatitis.

Participant Recommendations

- **Participants felt the community should better educate itself, research medicines prescribed to them, and also look to alternative medicine.**
- **Participants agreed that local doctors should learn more about treating Asian Americans.**
- **Participants felt that more health information should be made available in Chinese and disseminated through ethnic media (“Capital News”) and other newspapers, grocery store bulletin boards, faith-based institutions, and the AARC newsletter.**
- **Participants requested that actual “Patient Navigators” and a referral directory for culturally competent health care providers be housed at the AARC Facility.**
- **Participants expressed an interest in health care hotlines and felt the 2-1-1 number could be better publicized and utilized by the community.**

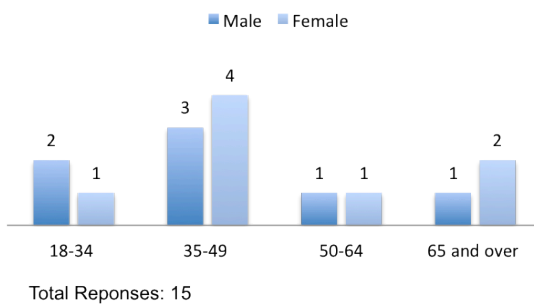
IV. VIETNAMESE AMERICAN COMMUNITY REPORT

Focus Group Overview

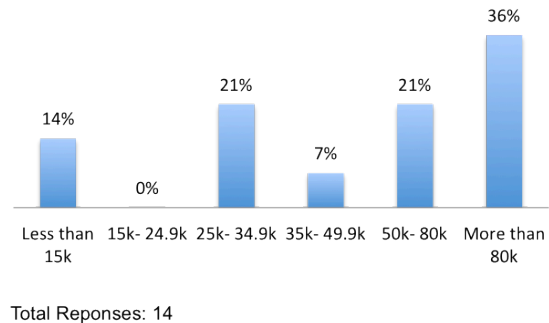
The Asian American Resource Center non-profit organization (AARC, Inc.) conducted a Vietnamese American focus group on April 15, 2014, at Summit Elementary School, a public school with a large number of Vietnamese American students. The meeting was scheduled and organized by a teacher and a retired pharmacist, both of whom have strong connections with the community. At the meeting, both assisted with translation for participants.

- There were 15 participants.
- A broad range of age groups was represented, including three elderly individuals.
- Two participants were born in the U.S.; they were in the 18-34 age group.
- Only one was uninsured, but he identified many of the barriers to accessing health care.

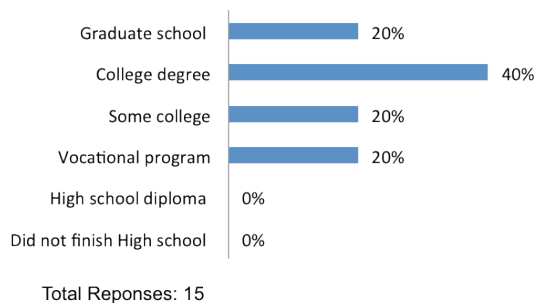
Gender and Age



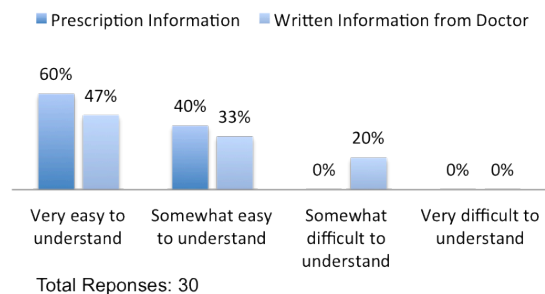
Annual Household Income



Education



Health Literacy



Perceptions of Community Health

a. General Health Issues

Vietnamese American focus group participants defined good health as absence of interactions with health care providers (e.g., not needing to see a doctor, or only going once a year for a check-up) rather than other more positive indicators. Participants perceive that Vietnamese American community members seek medical care for “blood pressure”, “preventive services” and “sick visits”.

Vulnerable populations include uninsured, underinsured, elderly, undocumented individuals, victims of domestic violence and families with limited English proficiency.

Focus Group Highlights:

- ***Perceived Community Health Issues:*** Participants perceive high cholesterol, diabetes, smoking, strokes, and cancer as key health concerns facing the Vietnamese American community.
- ***Sources of Health Information:*** Vietnamese American participants identified themselves as belonging to a ‘tight’ community and generally identified discussions with family and friends – especially the elderly – as being the most useful resource in order to learn about health issues. Other health information sources included: grocery stores, religious groups (churches/temples), schools, magazine (Báo Trẻ), VACAT (Vietnamese American Community of Austin, Texas).

b. Mental Health Issues

Discussion of mental health issues among the group was largely limited to generalized depression. It was acknowledged that there is a lack of relevant resources, especially ones that are sensitive to culture, language, and age.

Participants felt that some Vietnamese American General Practice doctors do not want to discuss mental/behavioral health issues, even stating that the physicians themselves may not have a good understanding of these issues.

Another isolating factor discussed in the mental health context was age, both in terms of interactions with health care providers and with other community members. Participants stated that many older adults are less likely to trust younger Vietnamese American doctors, even though they may share the Vietnamese language as well as culture. Furthermore, participants stressed the difficulty of having mental health discussions between children and parents due to the generational and culture gap.

c. Complementary and Alternative Medicine (CAM)

There was much discussion regarding complementary and alternative medicine (CAM). The group reported that many people who use alternative medicine do not communicate that information with their western doctor, and likewise they do not tell their alternative medicine practitioner about their western medications. This notwithstanding, the group did state that patients ought to talk to both.

It was reported that people often rely on Thuoc Bac (northern Vietnamese medicine) because they feel comfortable talking to that provider; essentially they become a counselor.

Of the participants, approximately 30% admitted to using acupuncture, and 30% to using herbal remedies. They stated that the prevalence in the wider community is likely higher.

Despite the prevalent use of CAM, participants were concerned that certain treatments have not been tested or may actually be dangerous. Furthermore, there were concerns about the degree of aggressive advertisement, both through radio and TV as well as direct marketing through websites or friends.

Perceptions of Health Services Access

a. Health Services Utilization

There was general agreement about the importance of immunizations for children, as required for school. However, most adults felt that immunizations were less important for them, although participants identified shingles, hepatitis, and flu vaccinations as being necessary. The best way to obtain information regarding immunizations was reported to be through family as well as doctors.

b. Barriers to Health Care

Participants observed that Vietnamese Americans are discouraged from seeking medical care due to a variety of reasons, including lack of insurance, lack of convenience, health not being a priority, and symptoms not being recognized until too late. However, the main barrier to health care identified by participants was related to language barriers. Participants stressed that a budget for translation was necessary, and they mentioned some successful examples from California. Lack of awareness of both health issues as well as difficulty navigating the public health system (e.g. accessing the City Health Van) were cited as additional barriers.

Regarding health insurance, participants advised that there was no clear understanding about how to qualify for Obamacare. Participants cited the complexity of the system as cause for procrastination. Other concerns included the cost of premiums.

Expense of health care was universally acknowledged to be a problem. The group reported difficulty in obtaining free flu shots for children. There was some discussion about vulnerable populations who fall through the cracks; those not qualifying for subsidized insurance but for whom self-pay is too high. Participants were not aware and/or did not have a good understanding of MAP.

Participant Recommendations

- **Participants were keen on community programs that support good eating, exercise, and healthy lifestyles.** They emphasized the importance of **support systems within families**, sharing economic resources to meet family needs.
- Participants expressed a desire for a center where people can congregate to talk and participate in sports or games (chess, mah jong). They felt that such socialization would help avoid feelings of loneliness and depression, especially among the elders, as well as promote a safe and healthy place for younger people, thereby easing social issues. Participants do not appear not sufficiently aware of the City of Austin Asian American Resource Center facility (AARC Facility) or its offerings. Whereas Vietnamese Americans constitute a significant percentage of Austin's Asian American population, the AARC Facility should conduct culturally appropriate outreach, in Vietnamese and English, utilizing the community sources of information identified herein. In addition, it is **recommended that City of Austin parks and recreational facilities develop culturally appropriate community programming for Vietnamese Americans, including seniors and refugees, near to where they live and/or at the AARC Facility.**
- **Participants recommended greater access to free check-ups to promote proactive rather than reactive medical visits.**
- **Participants recommended that the annual Vietnamese American health fair in Austin be held quarterly instead, to improve community health.**
- **Participants perceive that the senior community would like more Vietnamese American health care providers; ideally the same age as the patients, but the main concern is good medical knowledge.**
- **In addition, a few participants recommended creating physician "consultant" positions, similar to patient navigators, who can spend more time with the patient and coordinate messaging between different doctors.**

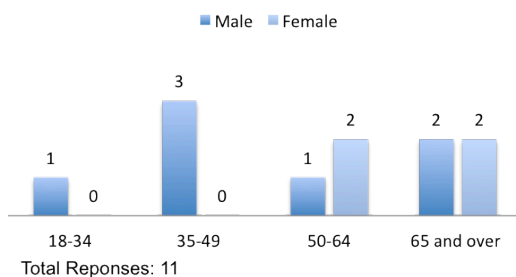
V. KOREAN AMERICAN COMMUNITY REPORT

Focus Group Overview

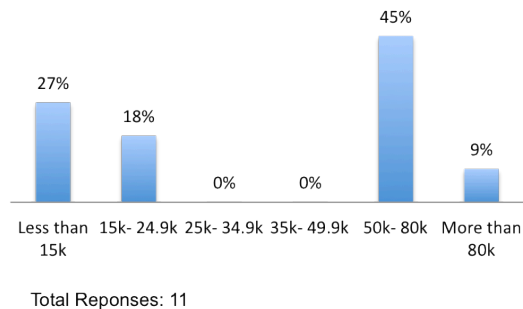
The Asian American Resource Center non-profit organization (AARC, Inc.) conducted the Korean American focus group on May 23, 2014, at the City of Austin AARC facility (AARC Facility). In order to obtain a diverse focus group, two separate individuals were asked to recruit focus group participants: a Korean American community leader and a Social Work professor at the University of Texas at Austin. The professor provided one student to translate and ask survey questions and another to take notes. The focus group was conducted entirely in Korean. Translated notes were provided the following week.

- There were 11 participants. More than half did not speak English well.
- All the participants were born in Korea and four (36%) had no medical insurance.

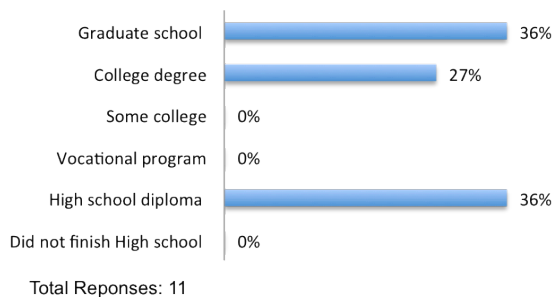
Gender and Age



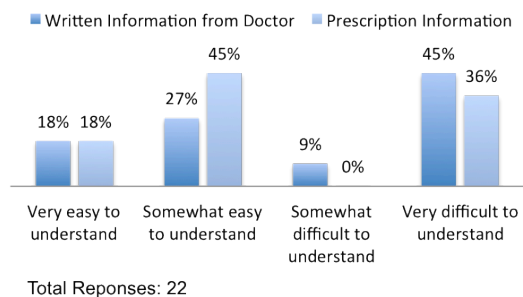
Annual Household Income

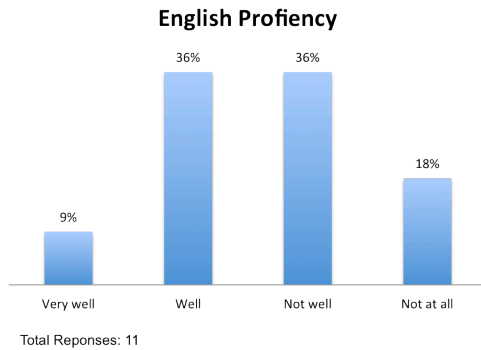


Education



Health Literacy





Perceptions of Community Health

a. General Health Issues

Korean American participants defined ‘good health’ as freedom from illness or disease. They emphasized that the definition of good health is not just about physical health; it should include all dimensions of health, such as physical, mental, emotional, and social health. They also highlighted a close relationship between health and appetite, stating that in order to be healthy, one should have a good appetite; they noted that you should eat well to be healthy, but that when you get sick, you lose your appetite.

Focus Group Highlights:

Perceptions of Community Health: Participants perceived the following as key health problems in the Korean American community:

- **Hypertension** – this was attributed to the high amount of salt in the traditional Korean diet.
- **Diabetes** – it was recognized that diabetes requires good management.
- **Cancer** – it was noted that this is becoming increasingly prevalent, though people are now living longer with cancer.

Sources of Health Information: Internet, Church, Family

It was agreed that many Korean Americans attempt to make a diagnosis themselves at home, especially with the aid of the internet. Sometimes they may undertake (over the counter) medication trials before going to see a doctor. The group agreed that churches play an important role in Korean American communities in Austin, though none in Austin provide health services (unlike Korean churches elsewhere). Another major source of information and support is one’s family. However, some elderly participants expressed reluctance in sharing symptoms with their family, since they did not wish to cause undue worry. However, communication is not always straightforward. There is an old proverb in Korea: “Words become seeds”; some people believe that if they talk about illness and death, it will happen.

b. Mental Health Issues

Participants perceive that there is low awareness of mental health issues in the Korean American community. Depression was acknowledged by the group to be a significant problem, especially in the context of aging, bereavement, and loneliness. Other substrates for depression in the Korean American community that were identified include (1) intergenerational conflicts between parents and children, as well as loneliness related to ‘empty nest syndrome’; (2) immigration and acculturation, *‘adjusting to a new life, language, and culture easily bring depression’*.

Participants were aware of a few cases of suicide in the Korean American community but explained that there was general reluctance to engage in related discussion. The group reported that although many Korean immigrants suffer from depression, there is a great stigma surrounding mental illness so they are afraid to disclose their diagnosis even to their family members. Stigma is the biggest barrier that keeps Korean Americans from seeking mental health treatment. Churches play a critical role in Korean American communities, and many Korean immigrants rely on their churches for their emotional concerns.

In terms of treatment, participants related that certain mental health conditions were readily amenable to treatment. However, the main challenge was getting Korean Americans past the stigma concerns and actually engaged in a treatment program. Even those who do get successfully treated do not talk openly their problems in case they bring shame on their family. Many individuals in this community believe that they ought to be able to overcome depression through ‘willpower and self-discipline’.

The group highlighted language and cultural barriers as a particular challenge in the context of mental health services. They felt that mental health providers should be familiar with their patients’ culture as well as the language. While it is not hard to find bilingual health providers in major cities such as New York and Los Angeles, participants agreed that there is a dearth of such in the Austin area.

c. Complementary and Alternative Medicine (CAM)

Participants discussed various CAM modalities including acupuncture, chiropractic, tai chi, yoga, herbs, and reflexology. Many agreed that acupuncture can be more effective than western medicine in some cases, especially in the treatment of pain. The group noted that sometimes western doctors recommend acupuncture, thus lending further credence to this treatment option. However, some participants were not aware that acupuncture was available in Austin, and others noted that it is more expensive than many Western treatment options. Indeed, limited insurance coverage and high cost was cited as reasons for individuals not utilizing other CAM options.

Herbal remedies are commonly used in the Korean American community. However, the route to acquire this treatment can sometimes be convoluted, involving both the Korean oriental medical clinic as well as the Chinese oriental medical clinic to obtain the medicines. Furthermore, there is some mistrust concerning the sources of herbs in China.

Perceptions of Health Services Access

a. Health Services Utilization

Reasons elicited for seeking health care included both preventative services – ‘regular medical check-ups to stay healthy’ – as well as acute visits – ‘when I feel sick’. However, it was acknowledged that Korean Americans usually do not go to see a doctor until they are seriously sick; there being a tendency to stay away from doctors and clinics. It was noted that the ability to access health care was greatly facilitated by health insurance.

The group was asked about uptake of immunizations among Korean Americans in Austin/Travis County. It was felt that most Korean Americans do not get regular check-ups or vaccinations, even for conditions such as hepatitis B that are more widespread in Asia. The group agreed that many Korean Americans have a tendency not to seek medical attention unless they have serious symptoms, and acknowledged that sometimes it can be too late. “When people don’t have health insurance, preventive care is a luxury”, observed one participant.

Some participants reported obtaining their routine medical care in Korea, since they do not qualify for Medicare or Medicaid and thus cannot afford simple tests or prescriptions in the U.S.

b. Barriers to Health Care

Participants identified several factors that discourage Korean American people from seeking health care.

- One of the chief concerns is the language barrier, rendering it difficult to communicate with health care providers. Participants were aware of interpreter services, but some had not used such services and others commented that these are expensive. The availability of Korean-language speaking health care providers was felt to be very limited in Austin.
- Participants felt that lack of health insurance is the biggest problem in accessing health care. The group stated that many Korean immigrants cannot go to see a doctor because they lack health insurance and cannot afford out-of-pocket medical bills. It was noted that many Korean Americans are self-employed or work in small businesses that do not provide health insurance benefits, leading to financial burden and sometimes bankruptcy. Even for individuals with health insurance, there were concerns that coverage can be very limited and confusion over which medical services and treatments were covered.
- The group noted that undocumented immigrants were not able to access health care, even avoiding free check-ups or community health fairs since they are afraid of using these services.
- Participants commented on the complexity of the U.S. health care system, and some cited this as a direct cause for their difficulty accessing health care. One participant noted, “[e]very time I go to a clinic, I have to fill out so many forms; it is a huge burden to me”. Some mentioned that they receive multiple bills from different hospitals and clinics, making it hard to sort out how much and whom to pay.

- The group shared concerns that language and cultural barriers could lead to misunderstandings, with potentially serious consequences. An example was provided of parents erroneously being accused of child abuse after taking their infant to the hospital after an injury, and the group recounted that such instances make others hesitant to access health care services.
- Unfamiliar (American style) food in hospitals was cited as an additional challenge. The group discussed how cold drink or food is provided to mothers after childbirth, whereas in Korean culture, everything is served warm or at room temperature. Many individuals like to make hot soup and take it to their fellow Church members when they have a baby, but many U.S. hospitals prohibit outside food. It was felt that cultural differences should be valued and respected.
- It was felt that although there are many community care clinics in Austin, Korean Americans rarely use them and many are not even aware of their existence.
- Dental care was another area of concern, and participants expressed that this is not affordable.

Participant Recommendations

It was widely acknowledged that the greatest priority ought to be given to improving communication between the Korean American community and health care providers. Participants expressed a strong desire for Korean-speaking health care professionals, including not only physicians but also mental health providers, social workers, case management, and other staff. The group felt that this is a priority that needs to be addressed by the City of Austin, not just the private sector. In addition, increased availability of Korean interpreter services was recommended.

Participants agreed on the need for health education programs as well as information on chronic disease management, again available in the Korean language. Faith based institutions, Korean language newspapers, Korean weekend language schools (targeting second generation Korean American youth) and the Korean American Association of Greater Austin are all potential sources of health information dissemination.

It was felt that health clinics like *CommUnity Care* should be more involved in culturally appropriate outreach to the Korean American community.

The group felt that the presence of a **Korean American community center** would be of great benefit, not only for the dissemination of health information but also since they saw a close link between social activities and emotional state. Although Churches are a major part of the Korean American life, some people are not affiliated with any of these and as such are even more isolated; thus **outreach efforts were deemed to be necessary.**

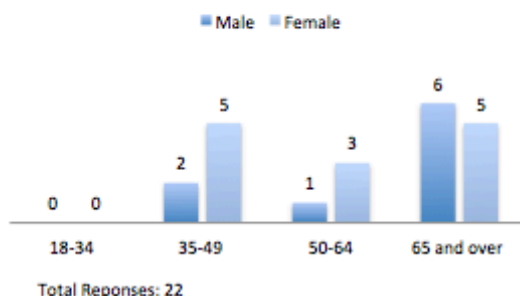
VI. SOUTH ASIAN AMERICAN COMMUNITY REPORT

Focus Group Overview

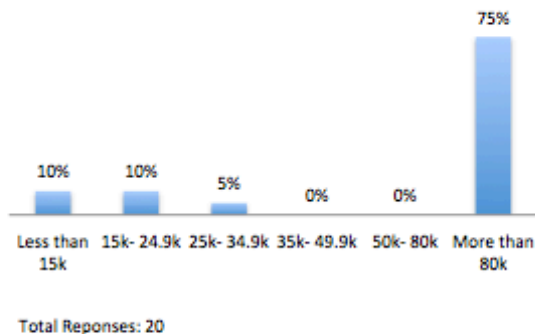
The South Asian American focus group was conducted by the Asian American Resource Center non-profit organization (AARC, Inc.) on Saturday May 24, 2014, in a classroom at the City of Austin AARC facility (AARC Facility). Saturday was most convenient to participants, particularly seniors dependent on adult children for transportation. Multiple people and South Asian American community organizations were involved in organizing this group and the room was at capacity.

- There were 22 participants: most were born in India, but 1 was born in the U.S., 2 born in Pakistan, and 1 in Uganda.
- All but two participants had health insurance.

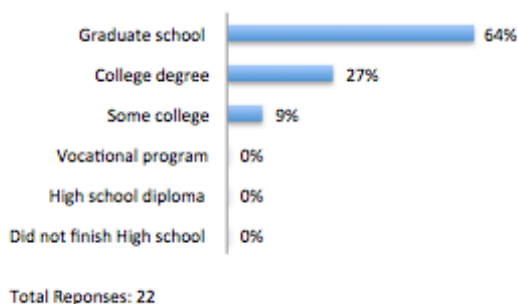
Gender and Age Range



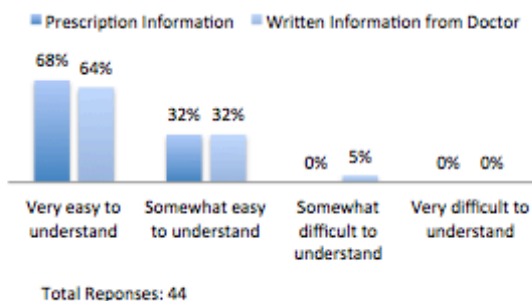
Annual Household Income



Level of Education



Health Literacy



Perceptions of Community Health

a. General Health Issues

South Asian American community focus group participants defined good health as an absence of visits to a health care provider, how one feels “both physically and mentally”, receiving a clean bill of health from a physician, and the ability to perform activities without extra aid. One participant noted that good health is defined “by insurance companies”. Participants perceived that South Asian American community’s health is maintained with the usage of Western medicine as well as homeopathic and ayurvedic herbal remedies through alternative medicine. Vulnerable populations include those who are either underinsured or uninsured (employees of small businesses or undocumented individuals) and the elderly.

Participants reported seeking health care in response to “physical restrictions”, “anxiety” about health, and for their annual physical. One participant noted “[w]hen we find things are outside our control is when we access care”. Another observed, “acute symptoms require care, chronic care is required, but we also need to ensure the healthy state is maintained...we pray to God, too.”

Focus Group Highlights:

- ***Perceived Community Health Issues:*** Participants perceive diabetes, high cholesterol, anxiety and high blood pressure; joint problems/arthritis and chronic poor life habits and lifestyles to be key community health issues.
- ***Sources of Health Information:*** Google, Friends, Neighbors, Family and television. Television includes Indian TV (Zee TV, TV Asia) for older South Asian Americans.

b. Mental Health Issues

Participants perceive that members of the South Asian American community experience mental health issues relating to depression, loneliness, marriage, financial pressure, domestic violence, PTSD (especially for refugees from violence), stress, anxiety, dementia, and Alzheimer's disease. Many in the community state that a major issue, when receiving treatment at mental and spiritual health centers, is that cultural differences between the doctor and the patient are present. Also, mental illnesses are seen as a big taboo within the community. It was also noted by a participating educator that a safe place is required for Asian American students, including LGBTQ students, suffering from issues prevalent in school such as bullying, and to simply meet and talk. The need for role models and a possible mentoring system was also mentioned for youth.

Perceptions of Health Services Access

a. Health Services Utilization

A participating physician stated that many South Asian American patients do not follow through with comprehensive care, instead taking care of what their immediate needs are. Further, rather than engaging preventative care, many community members address issues reactively as they occur.

Participants perceive that immunizations and vaccinations are obtained regularly by the community, and utilized on a frequent basis (when recommended by corresponding doctors). Participants also stated that children in the community are vaccinated and immunized as required by schools and that immunizations are available to everyone, subject to having transportation. However, only half of the participants, all of whom were adults, reported having had a flu vaccination and almost none reported having had pneumonia or hepatitis vaccinations.

b. Barriers to Health Care

Anxiety over health care costs, mismatched “philosophies” with health care providers, and transportation for the elderly emerged as perceived barriers to health care. Several participants stated that the combination of having Medicare and Medicaid came as a problem because of the ease with which they were dropped from the program when visiting their family in India for an extended period. Accessibility, doctors accepting Medicare, and philosophical match-ups were considered important when searching for a physician. One participant mentioned the absence of low cost, culturally sensitive clinics such as those said to be available to Asian Americans in Houston. Participants expressed and reported concerns about the absence of culturally appropriate long-term elder care in Austin.

Participant Recommendations

- Participants recommended **utilizing the AARC Facility for health education, dissemination of health information and socialization for the elderly**. Participants agreed that **healthy and active lifestyles should be perpetuated and encouraged** to prevent many of the diseases and conditions that are prevalent in the population. Older participants stated that regimen and socialization helps them to stay active. Participants stated that **fitness education in terms of establishing an exercise routine to fit schedules, and building fitness into the social aspects of the South Asian American community** would help its general health exponentially.
- **Recommendations for the City of Austin and the AARC Facility to share health-related information in a culturally competent manner include placing information in ethnic media (such as “Austin South Asian” and TV Asia) and in temples, grocery stores and “quarterly listserves”. Information for seniors should be translated, and available in non-electronic mediums and also provided to caregivers.**
- **Participants stressed that Austin’s lack of culturally appropriate home health workers and long term care facilities for South Asian American elderly needs further study and action.**

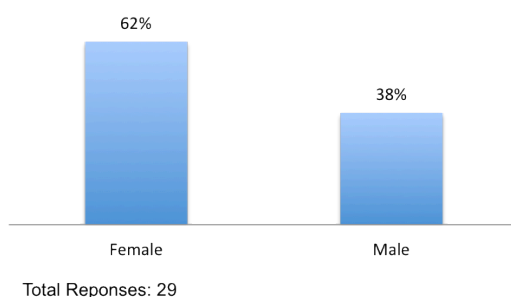
VII. ASIAN AMERICAN SENIOR COMMUNITY REPORT

Focus Group Overview

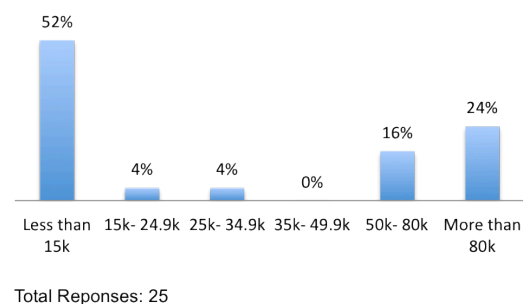
Starting in April 2014, the Asian American Resource Center non-profit organization (AARC, Inc.) posed separate questions to Asian/Asian American seniors in order to assess their unique health issues and barriers. Since many Asian/Asian American seniors rely on others for transportation, the senior questions were posed at the end of the subpopulation and refugee focus groups (five groups).

No “mixed” Asian senior focus groups were successfully conducted by AARC, Inc.; it was noted that a cross-section of Asian seniors would not likely share a common language. A separate focus group for just seniors was attempted at the City of Austin AARC facility (AARC Facility) just before senior events on May 15, 2014, but only two individuals attended. (The Asian senior meal program at the Facility had not yet started.) Both seniors were Korean, so they have been added to that group for demographic calculations. Pertinent facts regarding focus group participants are set forth below.

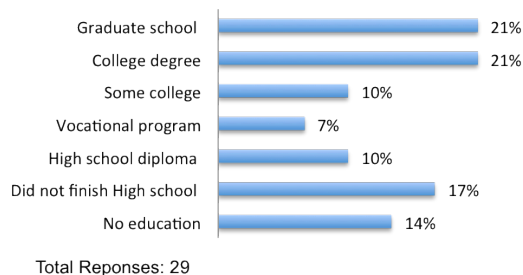
Gender



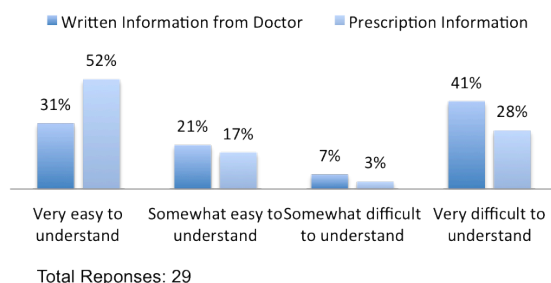
Annual Household Income



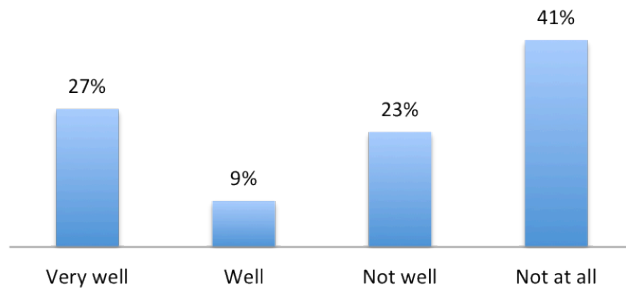
Education



Health Literacy



English Proficiency



Total Responses: 22

Additional information:

- There were 29 participants.
- All but one was 65 or older.
- None of the participants in the senior surveys were born in the U.S.
- The English proficiency question was not asked to all seniors, hence the total responses for this metric was 22.
- Of the 29 participants, 25 (86%) had insurance, 2 had no insurance, 1 did not respond, and 1 was in the process of losing his coverage.
- Of the 25 with insurance, 4 (16%) did not use it in the last year.

Perceptions of Community Health

a. General Health Issues

Participants perceived the following to be key health issues for Asian/Asian American seniors:

- **Arthritis** – It was agreed that even though one's joints may hurt, it is necessary to keep using them. Many endorsed using herbal supplements for their joints, as well as acupuncture, massage and homeopathy.
- **High blood pressure** – Many Asian/Asian American seniors reported checking their blood pressure on a regular basis. There was discussion about locations where one could get blood pressure checked for free. Some individuals noted that their blood pressure fluctuates with their mood. Those who do not monitor their blood pressure stated that they would be more likely to do so if it were easier and free. However, others were reluctant to have it done by machines in stores even if free, saying they are not reliable, and would only have their blood pressure checked by a medical professional they trusted.
- **Diabetes** was described as common.
- **Dementia**
- **Visual impairment**
- **Tiredness** – This was reported by many participants. The groups discussed various self-help strategies, including trying to wake up with a positive attitude

(meditation), focusing on healthy eating, following an exercise regimen, and socialization helps to stay active.

- ***Loss/lack of appetite.***

b. Mental Health Issues

Many seniors expressed feelings of sadness or loneliness at times, especially at night. Many participants seemed to feel that depression is an expected – almost normal – part of the ageing process. Key precipitating factors identified by the communities included conflict with family (notably intergenerational conflicts) or friends, being ignored, bereavement, and social isolation (both in terms of separation from friends and loved ones in their country of origin, as well as during weekdays when no one is at home, and separation from other seniors). Many commented that in their countries of origin, one can step outside of their home and immediately see people they know; in contrast, here in the U.S., they felt there is no community outside the house.

Certain health-related factors were also identified as causing sadness, including deteriorating health, certain medications, and ‘too much medication’.

Seniors reported that they have insufficient access to mental health care. They identified a need for doctors who understood their language as well as their culture. They wished for more time to communicate with their doctors and ensure understanding.

There is very limited access to mental health counseling for Asian/Asian American seniors that is culturally and linguistically sensitive. It was acknowledged that seniors need to spend more time with health care providers to overcome these barriers.

c. Complementary and Alternative Medicine (CAM)

All but two of the participating seniors separately discussed use of complementary and alternative medicine (CAM) in the larger focus group for their applicable Asian American sub-ethnicity. See subpopulation reports for CAM information.

Perceptions of Health Services Access

a. Health Services Utilization

Insured participants felt that they were largely able to access the mental and physical care they needed. In the context of these discussions, some seniors confided that they were afraid to retire since they were unsure as to whether health care would be as readily available.

b. Barriers to Health Care

- Participants identified language as a barrier to health care.
- Participants also reported long wait times, not only for medical visits but also for physical therapy.
- Participants identified transportation as a barrier to health care. Participants believed that a free ride might be available through Cap Metro with SSI, but did

not know how to access the free ride. They also noted that individuals are not all eligible for SSI.

- Many participants discussed the barriers to the health care that they experience as Medicare beneficiaries. They reported that it is hard to find physicians who accept Medicare. One participant suggested that people get a doctor before qualifying for Medicare, to in the hopes that one could somehow keep using that doctor.
- Participants expressed concerns about costs for those unable to pay even on a sliding scale, noting that MAP does not provide free access to dental care, only a sliding scale.
- Participants also expressed concerns about the limitations of long-term care insurance- what it covers and how much/often services can be provided. One participant observed, “I am not sure how many Asians buy long-term care insurance - my suspicion is that many do not - and therein lies the challenge. If there were support services that provide in-home support, that would go a long way to meeting many of the needs. In fact, if that was available, there would be many more cases whereby an elderly parent, particularly a widowed parent, can move in with one of their children without causing too much burden. In fact, this kind of service could benefit white Americans too”.

Relationships with Children

Participants reported helping their children in a variety of ways, both emotional (Vietnamese American seniors focused on teaching their children to be good people) as well as around the house (help with cooking, cleaning, and childcare).

Seniors reported receiving financial support from their children as well as general advice and help with reading. Most seniors are perceived to be entirely dependent upon their children for accessing health care services, for example scheduling and providing transportation to office visits. Indeed, some seniors reported feeling worried about falling sick at least in part because they did not how to get to the clinic or hospital.

South Asian American seniors discussed how their children generally want to help them, but have difficulty committing to help due to the intensity of work in the U.S. In addition to time limitations, they cited physical limitations making it difficult for children to help on their own, without the help of the extended family: “a 100-lb person can’t lift a 120-lb parent to get dressed or go to the bathroom”.

Perceived Challenges to Quality of Life

Participating seniors were asked about their greatest difficulties living in Central Texas. The following concerns were elicited:

- **Transportation** – Participants felt that public transportation is limited, while others were not familiar with how to access the existing services. Others not reliant on public transportation reported inability to drive at night, limiting their activities.

- **Senior activities** – Multiple ethnic groups discussed the potential benefits of having an elderly living center for residential and daytime activities
 - It would be good to have regular group meetings (maybe at the AARC Facility) where people can discuss a wide range of issues including health and mental health counseling. This may be more effective and less threatening.
 - One participant noted, “[i]f Korean seniors involve in active social activities (e.g., attending Korean senior association meetings), they can alleviate their depressive symptoms. In that sense, having a Korean community center is very meaningful. By having a place that Korean seniors hang out together, they can stay active and happy. I badly need that space”.
- **Domestic violence** – “Church leaders should be trained”. “Men need subtle/gentle education for it to be effective. Maybe address violence through the arts.”
- **Language barrier** – limiting an individual’s ability to go out alone.
- **Lack of insurance** – see discussion of Health Barriers above.
- **Lack of awareness of resources**– especially among those individuals without health coverage. Participants were generally unaware of resources such as the Texas Department of Aging and Disability Services.

Participant Recommendations

- **Participants collectively stressed the need for health education and dissemination of information, in Asian languages.** Participants suggested that there is very limited information made available in Asian languages, such as Korean, about chronic illnesses or community health resources. **There also appears to be a dearth of information and/or outreach to the Asian American community by low or no cost community health resource providers. Participants felt the AARC Facility should provide this information but that it should also be disseminated through temples, grocery store bulletins and ethnic media.**
- Long-term care was discussed extensively, especially by South Asian American seniors. Specifically the need for more culturally sensitive care options, including home care and a culturally sensitive long-term care facility. Korean senior participants were concerned about funeral/burial costs and felt there was a need for information.
- Social system of long-term household help and joint families allow children to support their parents in India. In the United States, in the absence of extended families acting as caretakers for the family’s children and seniors, **participants felt there needed to be a system of care where culturally appropriate hired help is available “for all cultures”.**

- **Participants requested senior transportation and recreational programming and socialization opportunities for mental and physical health.** A lunch program has since been implemented at AARC Facility, but the AARC transportation program is still being developed and culturally appropriate offerings are not yet available for all Asian senior populations. Moreover, Asian American seniors are dispersed throughout the city, and the AARC Facility is currently the only facility with any culturally appropriate meals (that include a regular vegetarian option) and programs. Additional Parks and Recreation Departments and city-sponsored senior programs should be inclusive of the Asian American community where they live. See Asian American community maps, *supra*.

VIII. ASIAN REFUGEE COMMUNITY REPORT

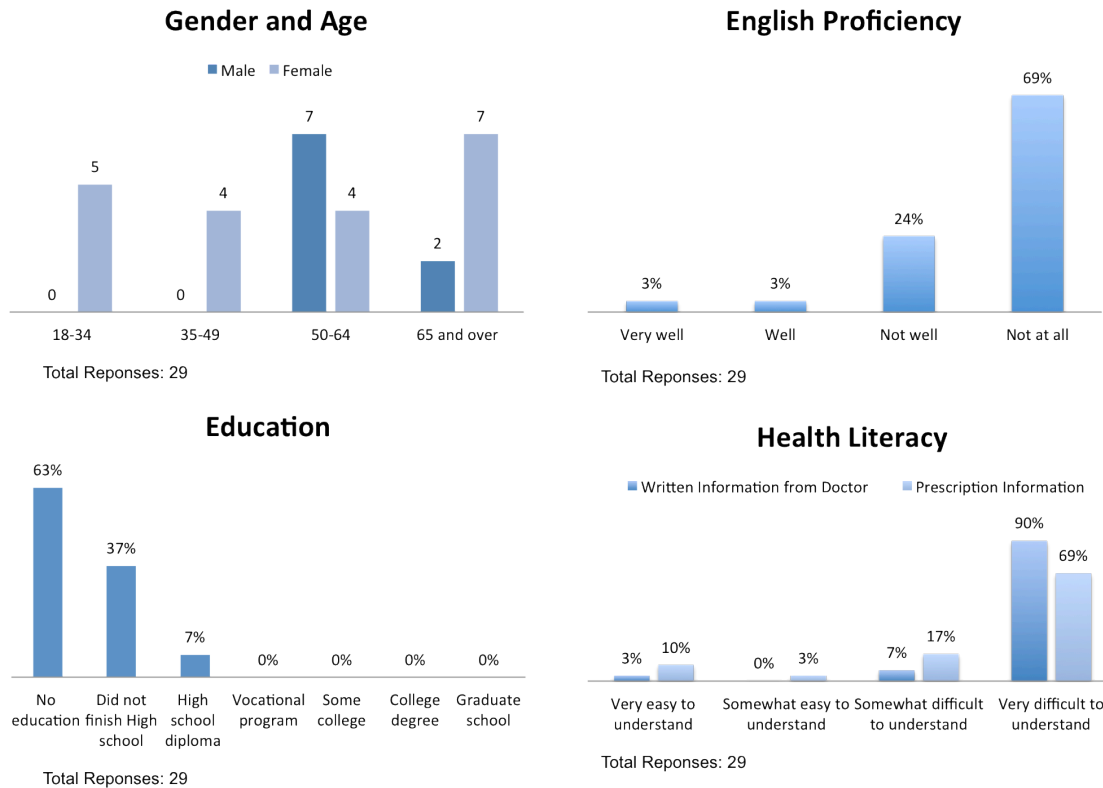
Focus Group Overview

- Refugee Focus Group 1 (6/10/14) Bhutanese-Nepali (ethnically Nepali refugees from Bhutan/Nepali language) and Vietnamese, 12 participants
- Refugee Focus Group 2 (6/21/14) Karen refugees from Burma (ethnically Karen refugees from Burma/Karen language), 17 participants

The Asian American Resource Center non-profit organization (AARC, Inc.) conducted two refugee focus groups. The first one on June 10, 2014 was organized by the Multicultural Refugee Coalition. It was conducted in the evening at an apartment complex where many refugees reside. Both a Nepalese and a Vietnamese interpreter were used, with the two language groups separated in order to reduce confusion and hear better. The interpreters provided responses to the facilitator in English. Although most of the refugees in this group had some form of insurance, one person reported a significant barrier long term refugees may face. He is a South Vietnamese veteran, who is unable to obtain Medicare or other public benefits in the US.

The second focus group with Karen refugees from Burma was conducted on June 21, 2014 at the City of Austin AARC facility (AARC Facility), which is close to where many of these refugees live. A family practice physician organized the Karen refugee group with help from an English-speaking community member who often provides assistance to these refugees in navigating the US systems. She provided interpretation for the focus group and was also a participant. No other participants in this group spoke English, except for a few words.

- There were 7 ethnically Nepali refugees from Bhutan (Bhutanese-Nepalis), 5 Vietnamese refugees, and 17 Karen refugees in the refugee focus groups.
- Of the 29 refugees surveyed, only one reported speaking English well.
- No one reported having significant income other than public benefits, although 2 did not respond to that question.
- Two participants had high school diplomas (one Vietnamese and one Bhutanese-Nepali). None of the other refugees had any formal US education.
- Most of the Bhutanese-Nepalis and Vietnamese refugees were actively engaged in the focus group discussions, but the Karen refugee group from Burma was more reserved. They acknowledged that they usually rely on their pastor as a spokesperson, and he often led the response to difficult questions during that refugee meeting.
- Both focus groups were recorded to assist in developing written notes.



Perceptions of Community Health

a. General Health Issues

Refugees defined good health using a number of frameworks: (1) functional (being able to eat, sleep, work, and be happy); (2) having no disease; and (3) having health care was part of their definition.

Focus Group Highlights:

Key health issues among the refugee community were perceived to be the following:

- Diabetes.
- High blood pressure.
- Heart disease.
- Asthma – This was perceived to be more of a problem for children.
- Hepatitis – Hepatitis B was acknowledged to be common among certain refugee groups, for example the Vietnamese, but was so prevalent in these communities that it was not seen as a ‘problem’. There was little awareness of the long-term risks of untreated chronic viral hepatitis, namely liver cancer, liver failure, and death. There was interest in more understanding of this condition.
- Back pain/body aches.

Possible causes or contributors to these conditions were largely unexplored. Many refugees participating in the focus groups admitted to knowing very little about diseases, and thus relying entirely on their health care provider(s) for information.

- **Obesity:** Many in the refugee community reported weight gain since moving to the U.S., even though their food intake was not excessive and sometimes in fact reduced; this was attributed in part to lack of time to exercise, as well as working night shifts. While nutrition was acknowledged to be important, there was limited understanding of general principles.
- **Tobacco/Smoking:** The prevalence of tobacco use varied across refugee communities. Generally smokers had limited awareness of the risks, and little knowledge of the availability of tobacco cessation programs.
- **Cardiovascular Disease/Diabetes:** There was limited awareness of the risks of high blood pressure, high cholesterol, heart disease, and diabetes. Individuals diagnosed with these conditions reported trying to comply with the recommendations of their health care providers, but were frequently limited in their ability to adhere with prescribed medications due to lack of insurance. There was little discussion of non-pharmacologic interventions such as dietary and lifestyle changes.
- **Tuberculosis:** There was little discussion of other conditions such as tuberculosis.
- **Sources of Health Information:** Family doctor, Community Health Fairs, Vietnamese Radio/TV

b. Mental Health Issues

Refugee focus group participants defined good mental health as being happy, which was included in their definition of good health in general.

When asked if refugees in Austin/Travis County have enough mental health resources to meet their needs, participants reported that no culturally and language appropriate services were available. There was little awareness of available resources, particularly online or electronic resources. They reported that refugees tend to focus on their physical needs, but when they require attention for mental health issues they usually look for spiritual guidance or, in extreme cases, present to urgent care clinics or the emergency department rather than specific mental health facilities.

Reasons for seeking mental health care among the refugee community were not volunteered readily. On probing into suicidality, there was discussion of financial worries, but participants did not endorse thoughts of suicide. One issue that was identified was memory impairment, but this was not explored in detail.

c. Complementary and Alternative Medicine (CAM)

Although use of herbal remedies was common in their countries of origin (sometimes obtained from the wild) and felt to be preferable over use of medications, their use in the U.S. was limited by lack of availability (of both the native herbs as well as the alternative medicine practitioners) and warnings from their local health care providers to avoid such

agents. Participants reported use of acupuncture, especially for joint and back pain, as well as reflexology.

Perceptions of Health Services Access

a. Health Services Utilization

For general health issues requiring a doctor's care or prescription medicine, refugee participants reported using volunteer clinics (e.g., *Hope Clinic*), private practice doctors, and the "Emergency Department".

Perceptions of health care services in the refugee community were mostly positive. Participants felt that there seems to be enough health care, but many were unsure of how to access it.

Refugees reported looking for the following attributes in a health care provider: ability to speak their language; familiarity with their personal situation; lack of discrimination; timeliness; ability to spend sufficient time with the patient; value; and location.

Members of the refugee community considered health insurance coverage to be essential.

Reasons for seeking health care among the refugee community included regular treatment for conditions such as high blood pressure and diabetes as well as acute visits for new-onset conditions or injuries, especially those limiting one's ability to work.

Immunizations were perceived to be essential for good health. However, it was reported that they are only freely available when entering the U.S., at the refugee clinic, and for children but not adults. Many individuals were unsure as to whether they were up-to-date on their immunizations as well as which diseases were preventable through immunization. They were keen on receiving regular immunizations, if these were free. Refugees reported that the best ways to inform their community about immunization would be through community conversations in their native language and health fairs, and they volunteered that the AARC Facility would be the ideal location for such events.

b. Barriers to Health Care

Refugee participants identified the following major barriers to health care in their community:

- **Insurance:** The major factor discouraging members of the refugee community from seeking health care was the lack of health insurance and consequent fear of receiving a large bill. Without insurance, refugees are unable to afford health care services. However, even individuals with insurance were cautious about seeking health care due to the co-pay, and so they did not present for 'simple things' like colds or headaches.
- **Language:** Inability to communicate was a pervasive problem in accessing health care services, from calling to schedule an appointment to participating in the consultation. Participants reported lack of providers in the area able to speak their

language. They reported that telephone interpretation services were sometimes difficult to understand.

- **Complexity of Health Care System:** Many reported difficulty understanding how to use services. Some who had heard about the clinic did not know how to get there. Further complexity was added when being referred from one facility to another (e.g. for specialist care): some individuals did not know how to get to the new location and ended up presenting to the Emergency Department.
- **Differences from Country of Origin:** Participants felt some scepticism regarding the ability of health care providers to make the correct diagnosis and treatment plan. Participants shared anecdotes:

“Even though I feel sick, doctor said nothing is wrong.”

“A friend really felt sick, but doctor said there was nothing wrong; he died.”

There was equally a feeling that doctors were overzealous in their prescription habits, recommending medications that they did not need or want. The underlying reasons for this scepticism was not explored in detail, but it is likely that communication difficulties were at least in part responsible.

Participant Recommendations

Participant recommendations mirrored the barriers listed above:

- **Insurance:** Need more services for uninsured, more affordable prescription medications. A South Vietnamese refugee mentioned he is unable to get benefits here in the US, despite his military service in the Vietnam War.
- **Language:** Need more translation services.
- **Complexity of Health Care System:** Participants requested greater assistance with navigating the health care system, e.g. applying for food stamps, Medicaid, or the Medical Access Program (MAP). It was reported that even with MAP, individuals have to pay for their medications, which are too expensive. Some reported difficulty calling 2-1-1, as the telephone operators spoke too fast. Many were unsure as to why they were denied services. Individuals requested explanation as to why they were billed for services from CommUnity Care clinics, or how to deal with large bills for care provided after they were no longer eligible for Medicaid. Participants expressed a wish to have one facility for all necessary services, including a walk-in clinic as well as vision and dental.
- **Screening and Preventative Services and Education:** There was great interest in health fairs to raise awareness and provide screening and preventative services such as free blood pressure checks and flu shots. There was a request for access to free birth control. Poor health literacy is in the context of poor literacy in general, since many members of the refugee community are not educated or able to write their own language. Refugees suggested the AARC Facility as an ideal location for these services.

The Karen refugees from Burma explained that the best way of disseminating information within their community is through their Pastor. The best timing of meetings

was weekdays for working individuals, and weekends for those retired. Church space is very limited, so it was felt that the AARC Facility is the best location.

Asian-American Health Assessment/Recommendations



Prepared by
Asian American Resource Center Nonprofit (AARC)

Lesley Varghese, Executive Director, AARC
Vincent Cobalis, Program Manager, Consultant
Peteria Chan, Graduate Intern, MPH Candidate

About the Asian American Resource Center nonprofit

Asian American Resource Center, Inc. (a/k/a AARC Nonprofit) is a community-based nonprofit organization formed in 2006 to support the construction and operation of the City of Austin Asian American Resource Center facility (Facility) located at 8401 Cameron Road, in Austin, Texas.

The Asian American Health Assessment study was performed by AARC Nonprofit as part of its broader cultural competency endeavors and community needs assessment for the Facility. It is hoped that the community needs described herein can be addressed in part through effective community partnerships and a cohesive, culturally competent vision for wellness programming, health education and community outreach.

Asian-American Health Assessment Overview

- The Asian American population of Austin/Travis County is extraordinarily diverse: socioeconomically, linguistically and geographically
- This study seeks to disaggregate, document and better understand Asian American health care experiences.
- Scarcity of Asian language health resources and information is common to all Asian American (AA) subpopulations
- They experience some similar chronic illnesses – most notably diabetes and cardiovascular disease.
- Focus group reports also reflect disparities, particularly in health literacy, perceived rates of hepatitis, and perceived access to care and transportation.

Definitions

- *Asian*
 - Origins in any of the original peoples of the Far East, Southeast Asian, or Indian subcontinent
 - Examples: Bangladesh, Cambodia, China, Indonesia, India, Japan, Korea, Malaysia, Pakistan, Philippines, Taiwan, Thailand, and Vietnam.
- *Native Hawaiian and Other Pacific Islander (NHPI)*
 - Origins in any of the original peoples of Hawaii, Guam, Samoa, or Pacific Islands.

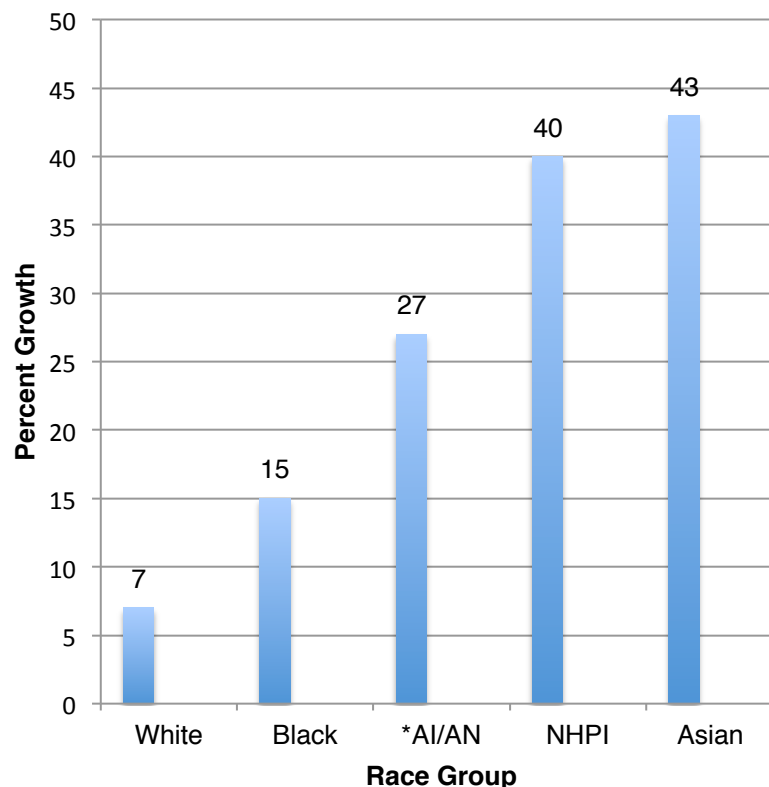


These populations are very diverse...

Population Growth

- Nationally the Asian American, Native Hawaiian and other Pacific Islander (AANHPI) populations are the two fastest growing race groups
- Texas has the 3rd largest Asian population and one of the largest NHPI populations
- Asian population in Travis County doubled since 2000 to almost 60 thousand in the 2010 census

U.S. Population Percent Growth from 2000 to 2010 by Race alone

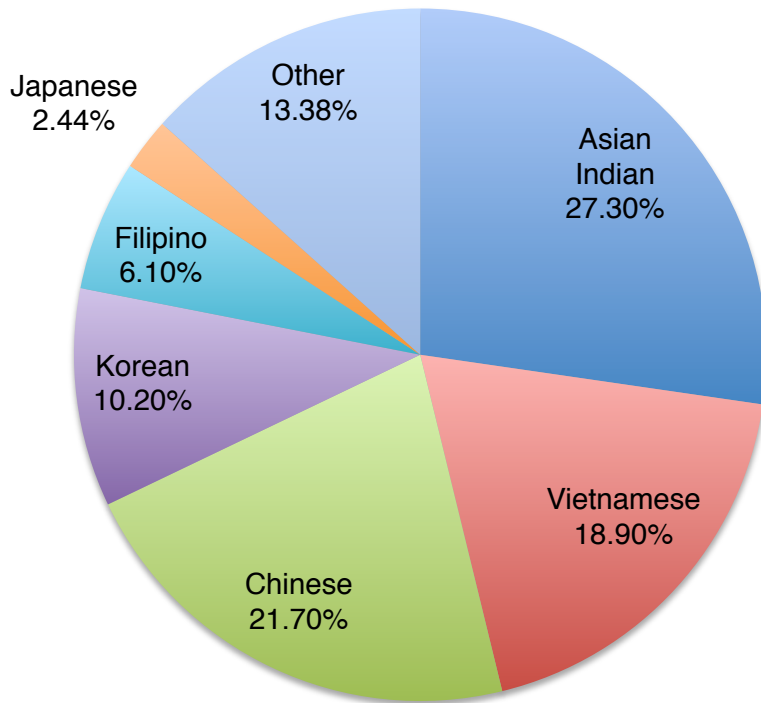


U.S. Census 2010- In the 2010 Census, "Hispanic" was no longer classified as a race.

* American Indian/Alaska Native (AI/AN)

Travis County Asian alone Population

Percent Shares of total Travis County Asian alone Population by Country of Origin



- Asian alone make up about 6% of total population (about 60,000 in 2010)

Texas Population

	Texas	Travis County	Harris County
Population, 2010	25,145,561	1, 024, 266	4,092,459
One Race	97.3%	96.7%	96.8%
<i>Asian</i>	4.4%	6.8%	6.9%
<i>Asian alone</i>	3.8%	5.8%	6.2%
White alone, Non-Hispanic	45.3%	50.5%	32.9%
Black alone, Non-Hispanic	11.4%	8.1%	18.4%
Asian alone, Non-Hispanic	3.7%	5.7%	6.1%
AI/AN alone, Non-Hispanic	0.3%	0.2%	0.2%
NHPI alone, Non-Hispanic	0.1%	0.1%	0.1%
Other alone, Non-Hispanic	0.2%	0.2%	0.2%
Hispanic or Latino	36.3%	31.9%	38.9%

Table 2. Source: U.S. Census Bureau, 2010 Census. Numbers in this figure calculated from census data from 2010 Summary File 1, Tables P5 and P7: *Race Alone or in Combination and Hispanic or Latino*. Geography: Texas, Travis County, and Harris County. Accessed October 6th, 2012.

Population Totals for Texas, Travis County, and Harris County by race, 2010

Age Groups by Gender- Asian alone

	NUMBER					
	TEXAS			TRAVIS COUNTY		
<i>Age groups by race</i>	Both sexes	Males	Females	Both sexes	Males	Females
*Total Asian alone, 2010	964,596	334,977	366,924	59,333	29,327	30,006
20-29	15.9% (n=153,790)	7.9% (n=76,646)	8.0% (n=77,144)	23.3% (n=13,829)	11.8% (n=7,018)	11.5% (n=6,811)
30-39	18.7% (n=180,149)	8.9% (n=85,527)	9.8% (n=94,622)	21.1% (n=12,524)	10.6% (n=6,273)	10.5% (n=6,251)
40-49	15.6% (n=150,751)	7.6% (n=73,600)	8.0% (n=77,151)	13.9% (n=8,265)	7.0% (n=4,176)	6.9% (n=4,089)
50-59	11.5% (n=111,348)	5.3% (n=51,434)	6.2% (n=59,914)	8.1% (n=4,807)	3.7% (n=2,187)	4.4% (n=2,620)
60 and over	11.0% (n=105,863)	5.0% (n=47,770)	6.0% (n=58,093)	7.5% (n=4,438)	3.4% (n=1,991)	4.1% (n=2,447)

Travis County Asian Population

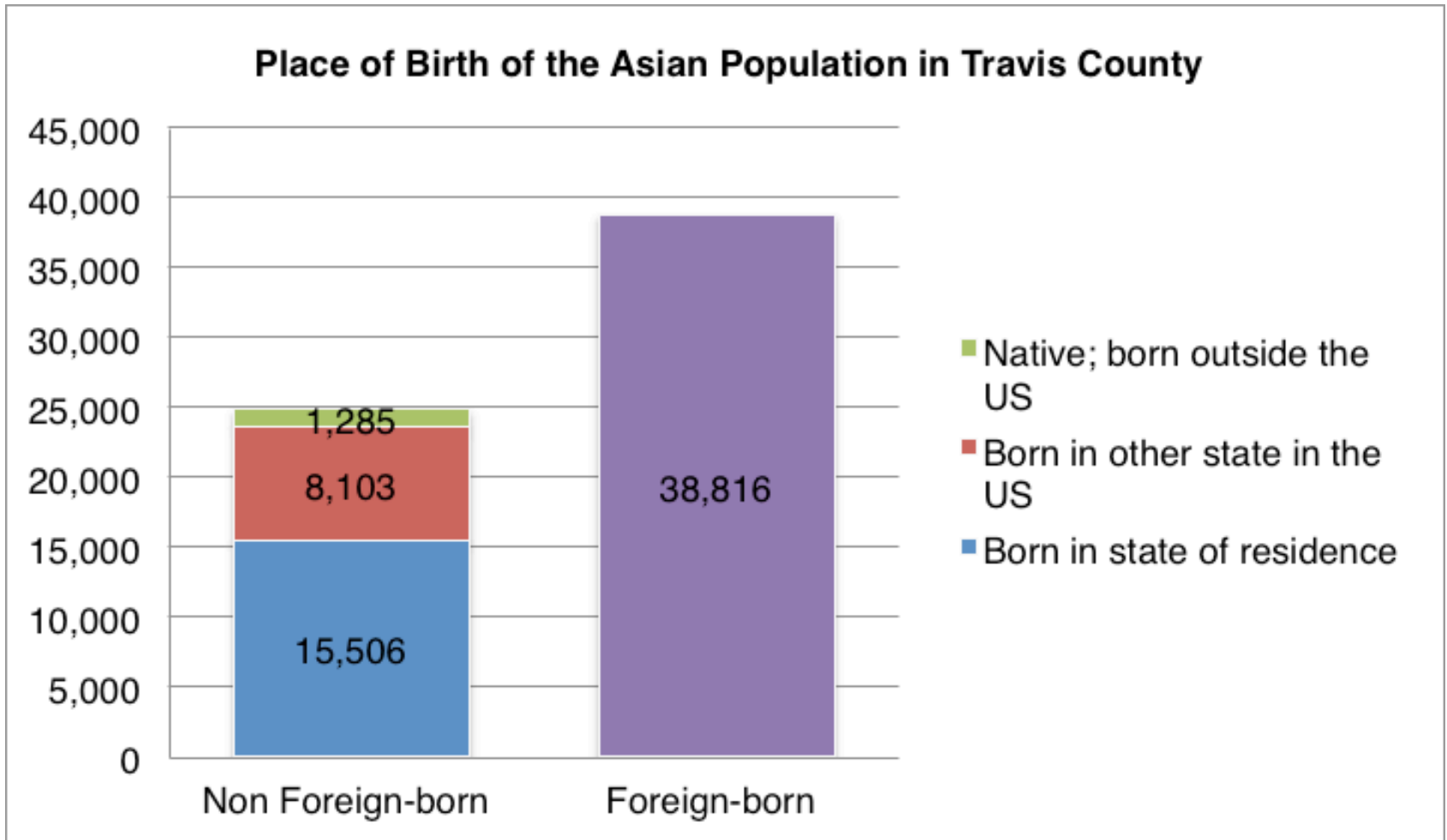


Figure 3. Source: U.S. Census Bureau, 2010 American Community Survey, 5-year estimates, 2006-2010. *Place of Birth by Sex in the United States*. Geography: Travis County. Population group: Asian alone or in combination. Accessed October 10th, 2012.

Country of Origin

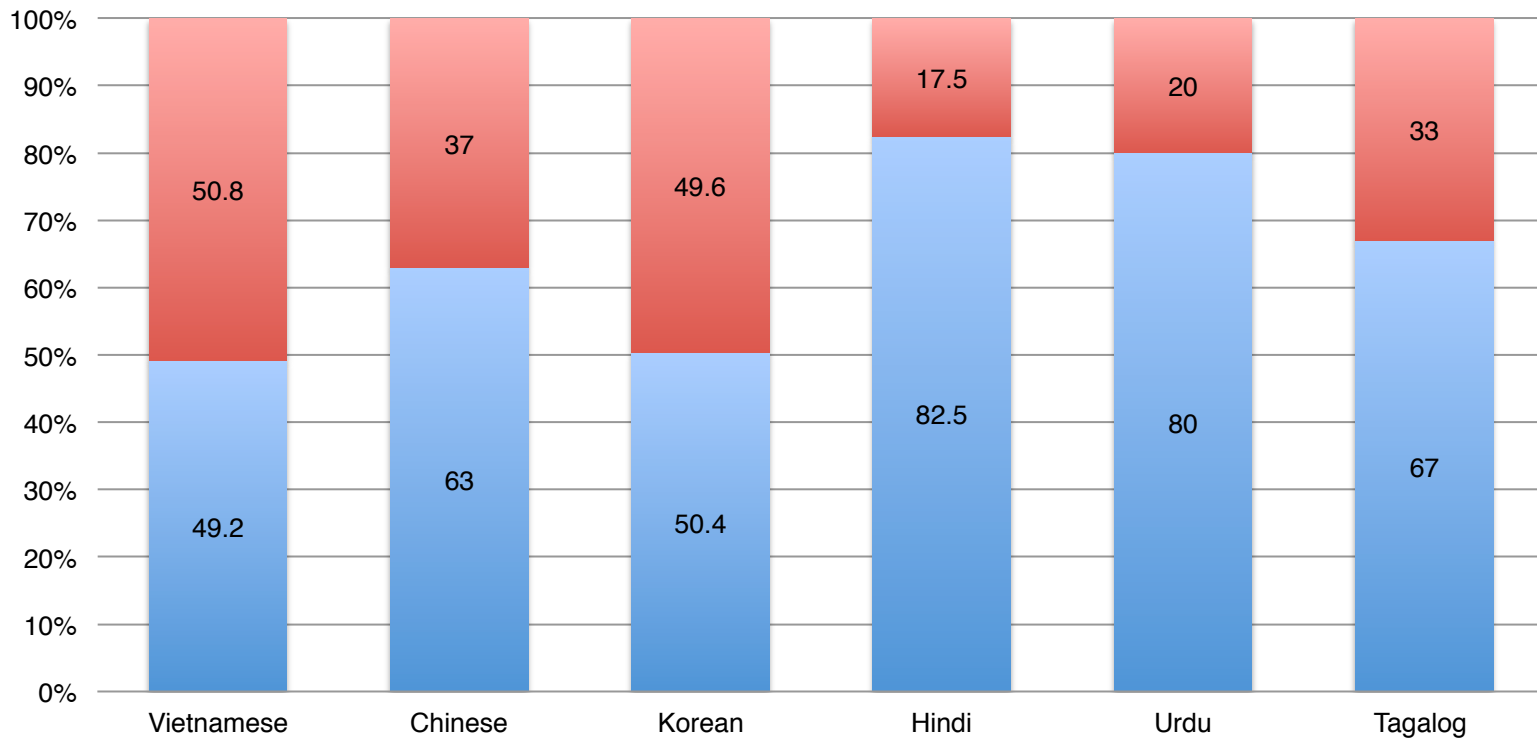
Place of Birth for the Foreign-born Population in Travis County

Total Population (excluding population born at sea) <i>Asia</i>	38,816 37,727
India	9,856
Vietnam	8,444
China Hong Kong (732)	5,060
Korea	4,036
Taiwan	2,435
Philippines	2,200
Pakistan	1,735

Table 3. Source: American Community Survey, 5-year estimates, 2006-2010.

Linguistic Isolation

Percent of total households speaking English less than "very well" and "very well" by Language



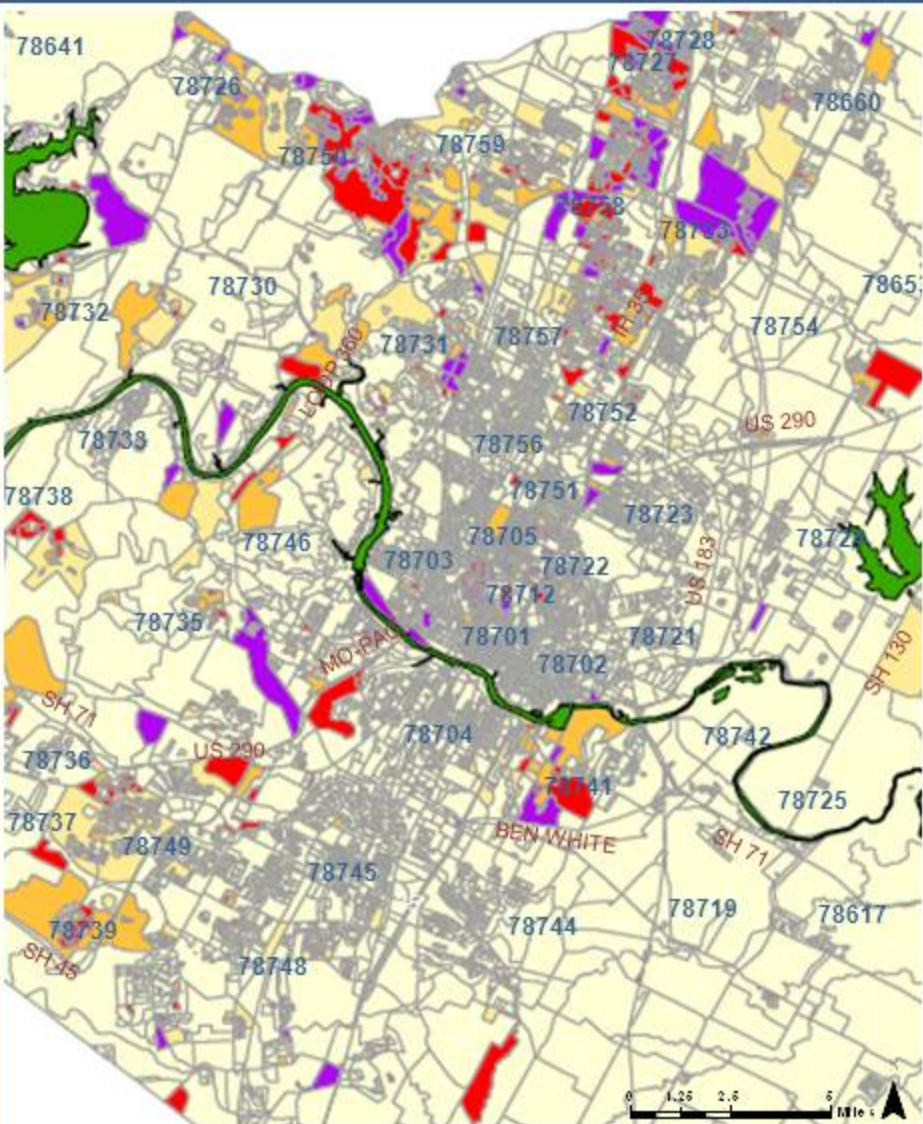
■ % of total households that speak English "very well" ■ % of total households that speak English less than "very well"

* The primary Chinese dialects are Mandarin and Cantonese

Changing Asian Landscape--Travis County

Asian Population Concentrations, 2000 and 2010

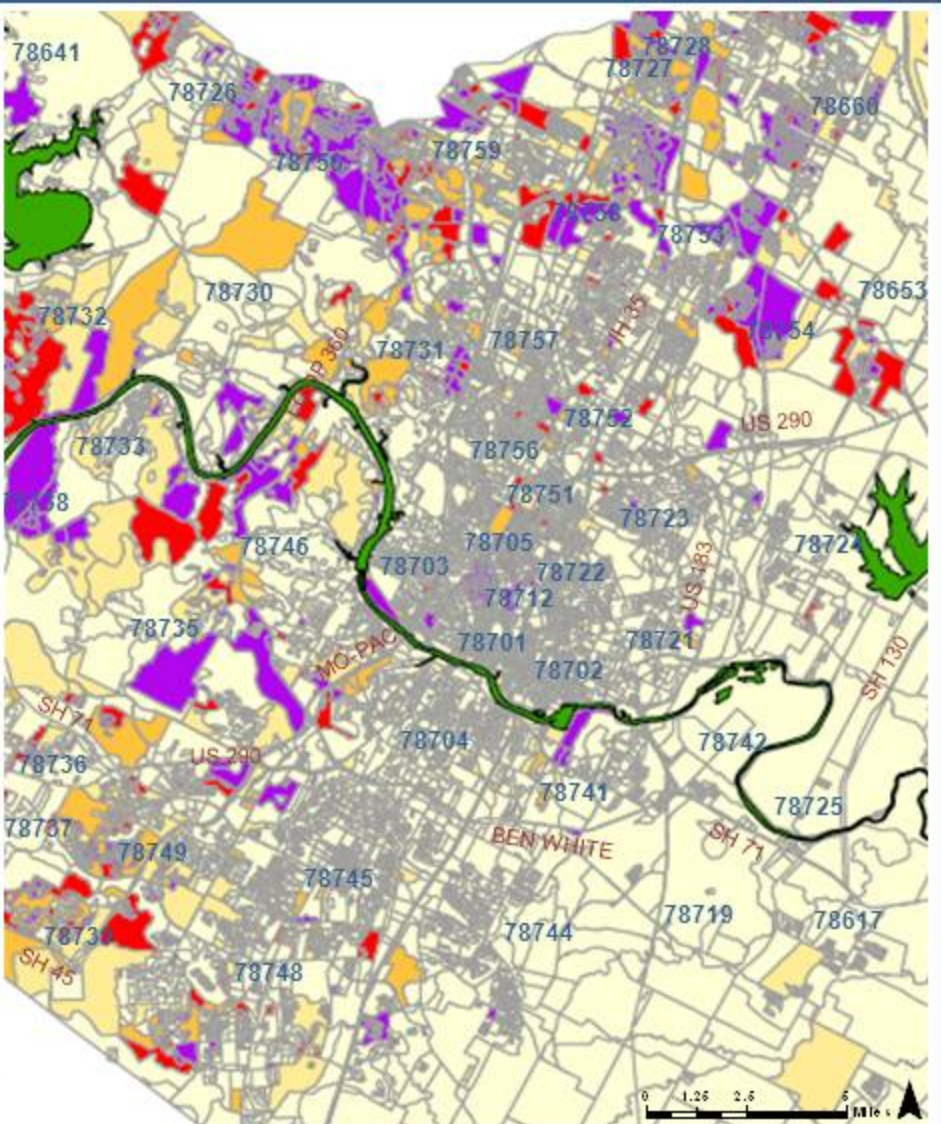
This map has been produced for:
"Instructional Use Only."
No warranty is made regarding its accuracy, completeness, or relevance.



Census 2000 Data
Census Blocks

Percentage of the Total Population that is Asian

Less than 5%
5% to 7.5%
7.5% to 10%
10% to 15%
15% Plus



Census 2010 Data
Census Blocks

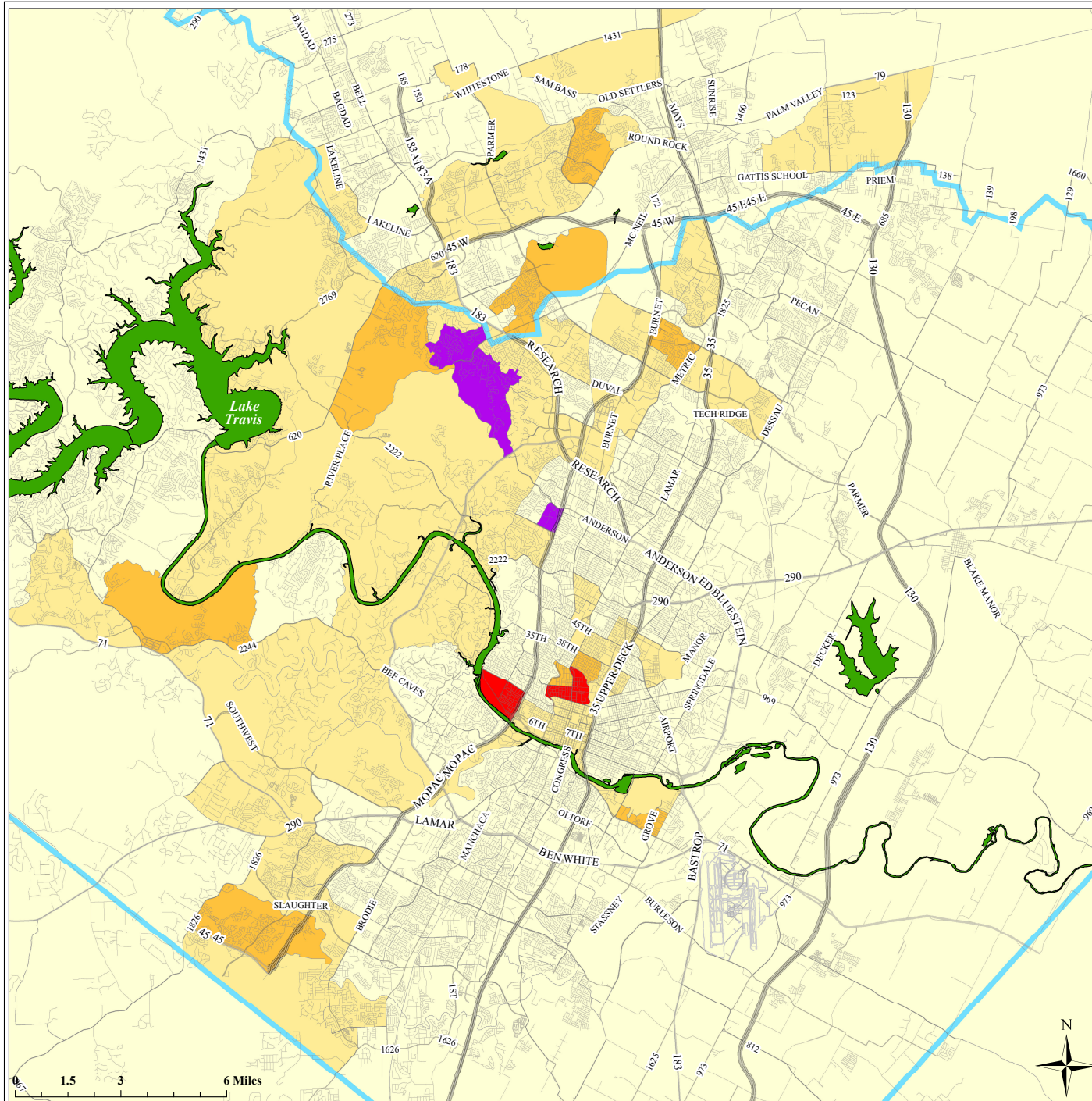
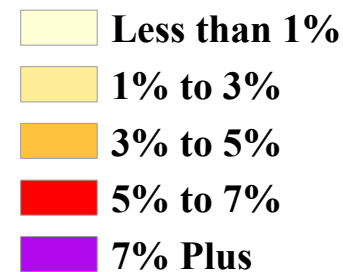
Percentage of the Total Population that is Asian

Less than 5%
5% to 7.5%
7.5% to 10%
10% to 15%
15% Plus

Chinese Share of Total Population

Austin, Texas
Census 2010 Data

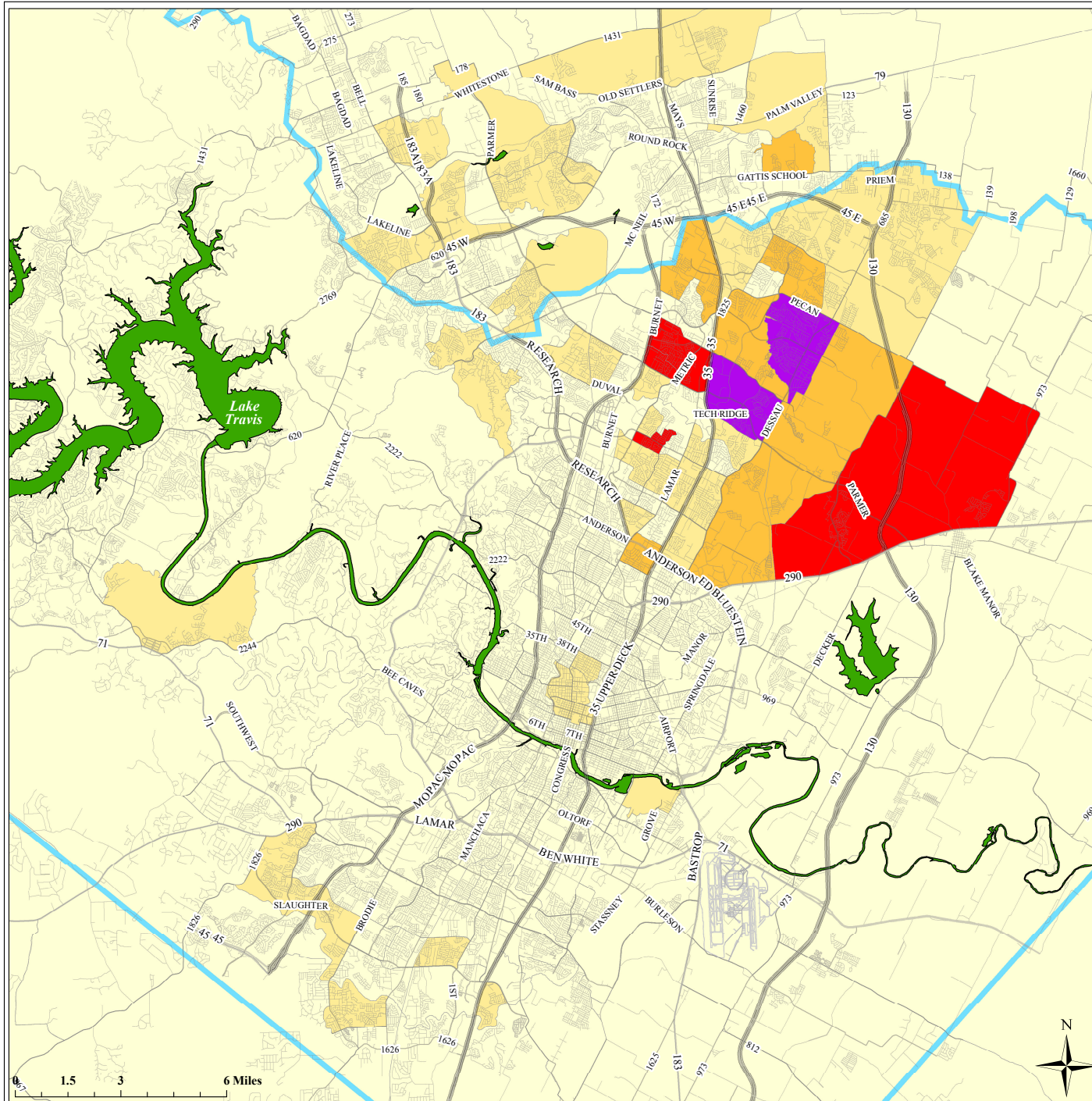
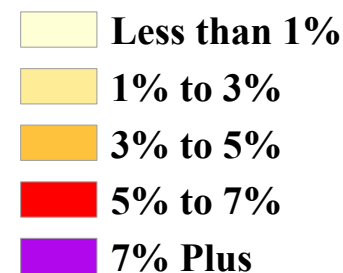
Percentage of
Total Population
that is Chinese



Vietnamese Share of Total Population

Austin, Texas
Census 2010 Data

Percentage of
Total Population
that is Vietnamese



Phase I

Health Issues Identified

(national and other community research)

- Obesity
- Diabetes
- Heart Disease
- Cancer
- Hepatitis B
- Tuberculosis
- Behavioral Health
- Healthcare Access Barriers



Health Issues

Obesity / Overweight

- Asian American population (as aggregated and defined by the U.S. Census) has lower BMI values and a lower prevalence of overweight/obesity than other groups. **Disaggregation of data amongst Asian American subpopulations however, reflects discrepancies within the Asian American community.** For example, Filipino American adults are 70% more likely to be obese as compared to the overall Asian American population.
- Studies suggest that being foreign-born is associated with a greater resiliency to obesity.
- In one study conducted exclusively with the Asian American population, it was determined that physical activity, fruit intake, consumption of meat and sweetened beverages were all positively associated with acculturation at baseline. However, acculturation to the United States was also associated with a greater BMI.

Health Issues

Diabetes

- **South Asian American immigrants are 7 times more likely to have type 2 diabetes than the general population.** In an analysis of 1.5 million New York City birth records registered between 1990 and 2001, South Asian American women experienced the highest prevalence rate of gestational diabetes (11.1%) and the highest increase in prevalence (95% increase since 1990) when compared to other groups.
- Diabetes is also highly prevalent among Pacific Islanders; Guam's death rate is 5 times higher than the U.S. mainland and diabetes is one of the leading causes of death in American Samoa.
- Surprisingly, the association of type 2 diabetes with increased obesity, as measured by BMI, is not strong in the Asian American population as it is with other ethnic groups. However, the risk of developing type 2 diabetes is high in the Asian American community. **It is likely that current BMI standards are not a valid predictor of diabetes in Asian Americans.**

Health Issues

Cancer

- Asian Americans have lower incidence and mortality rates from cancer than all other ethnic groups. However, **cancer is the leading cause of death among Asian Americans**, with heart disease being first among all other American ethnic groups.
- Asian American females are the first American population to experience cancer as the leading cause of death.
- Vietnamese American women have highest incidence and death rates from cervical cancer. Cervical cancer incidence rates are five times higher among Vietnamese American women than White women. Vietnamese American men have the highest rates of liver cancer in comparison to all other ethnic groups.
- Korean American men experience the highest rate of stomach cancer of all racial/ethnic groups, and a five-fold increased rate of stomach cancer over white men.

Health Issues

Hepatitis B

- **1 million Asian Americans are living with chronic hepatitis B -more than half of all the cases in the United States.** It constitutes the biggest health disparity between Asian Americans collectively and the U.S. population. **Asian Americans are also seven times more likely to die from hepatitis B** than whites.
- Southeast Asian Americans and Pacific Islanders are disproportionately affected by hepatitis B, a viral infection of the liver that can lead to cirrhosis, liver cancer, and liver failure.

1 in 12
ASIAN AMERICANS
is living with
chronic Hepatitis B.



Health Issues

Heart Disease

- While, according to the U.S. Department of Health and Human Services Office on Women's Health, Asian American women have much lower rates of heart disease than other women, heart disease is still the second leading cause of death for this group.
- **The rate of heart disease amongst Indian Americans is four times higher than the rate amongst whites.**
- The prevalence of smoking is higher among foreign-born Asians in comparison with U.S. born Asians, although Asian Americans have the lowest smoking rate compared to other ethnic groups. 16.9% of AA men and 7.5% of AA women smoke.
- The risk factors for high blood pressure include low levels of awareness and control; very little awareness among Cambodian, Laotian and Vietnamese immigrants and low screening rates among Asian Americans in general.

Health Issues

Behavioral Health

- Asian American college students report higher levels of depressive symptoms than white students.
- National data indicates that Asian Americans have historically been at higher risk for behavioral health problems and also have the highest rates of reported suicides compared to other races when disaggregated by age, gender, and subgroup.
- Centers for Disease Control and Prevention (CDC) reports that rates for suicide death among Asian American women were higher compared to non-Hispanic whites for age groups 15-24 years and 65 years and older.
- **Older Asian American women have the highest suicide rate of all women aged 65 and older, with elderly Chinese American women exhibiting rates 10 times higher than those of white elderly women.**
- Certain mental health conditions like depression, anxiety, and posttraumatic stress disorder are common among Southeast Asian Americans and other refugees (Nepali-Bhutanese, Sri Lankan, Burmese) who have experienced and fled political and economic turmoil at home and while being in the United States.

Health Issues

Health Care Barriers

- Asian Americans are less likely than non-Hispanic Whites to receive health insurance through their employers. Uninsured Asian American increased from 16.5% in 2004 to 17.9% in 2005. **For Texas, Asian Americans are the second largest population who are uninsured.**
- Asian Americans tend to avoid going to the doctor until they are very ill.
- Lack of access to care, language challenges and lack of culturally and linguistically responsive providers are major challenges.



Phase II

(local perspective)

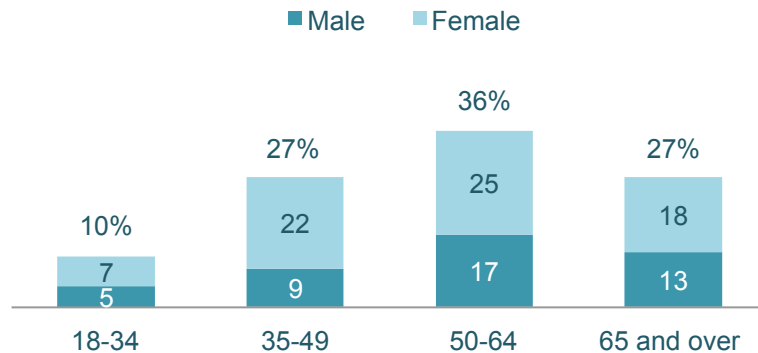
- Conduct Focus Groups to define specific needs (completed)
 - Asian Subpopulations in Austin/Travis County
 - Elderly
 - Refugee populations
- Create Physician Advisory Group (completed)
 - Assess lessons learned from their experience in working with Asian American clients
 - Review focus group results and recommendations
 - Develop culturally relevant treatment protocols
- Create a Council appointed commission to address Asian American quality of life (created October 2013)

Asian American Health Assessment *Survey and Focus Group Summary*

By Peteria Chan

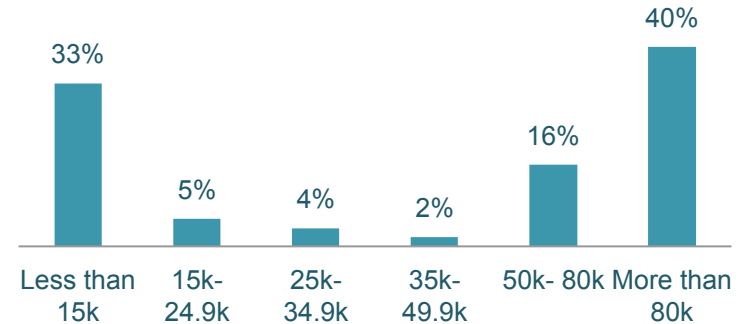
All Respondent Summary Figures

Age Range and Gender



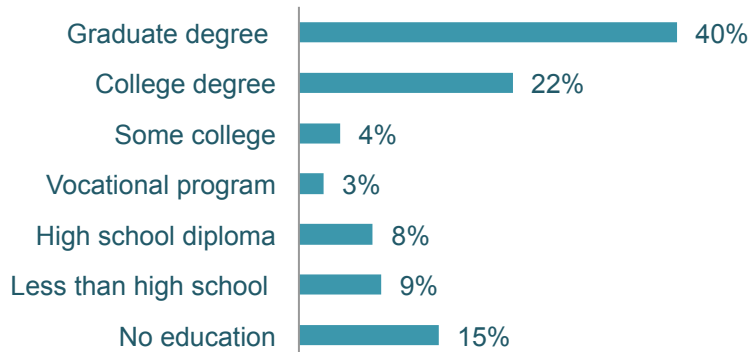
Total Responses: 116

Annual Household Income



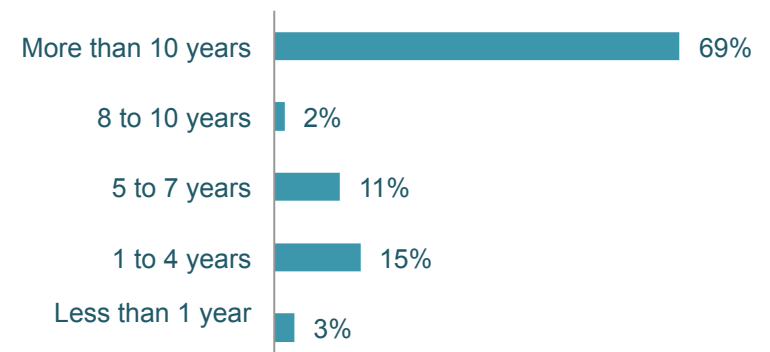
Total Responses: 110

Education Level



Total Responses: 116

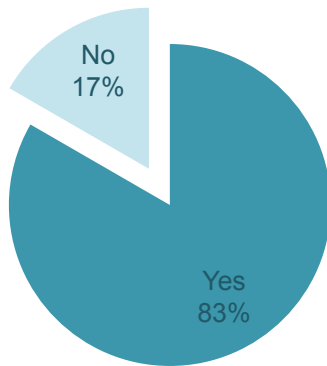
Duration in the US



Total Responses: 116

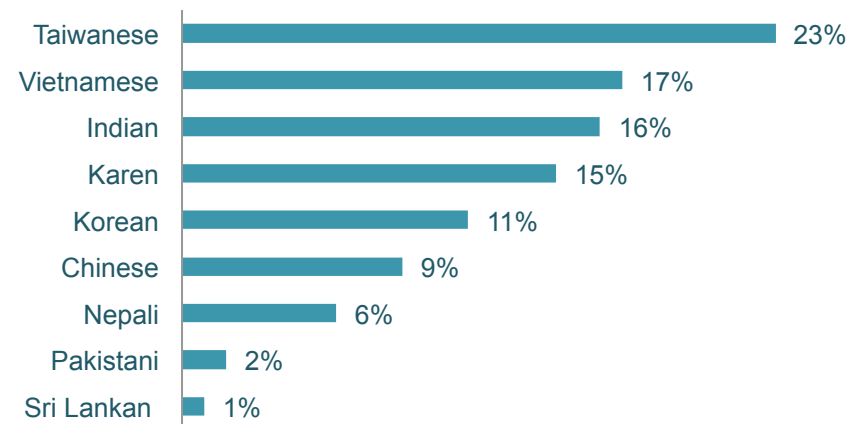
All Respondent Summary Figures

Health Insurance



Total Responses: 114

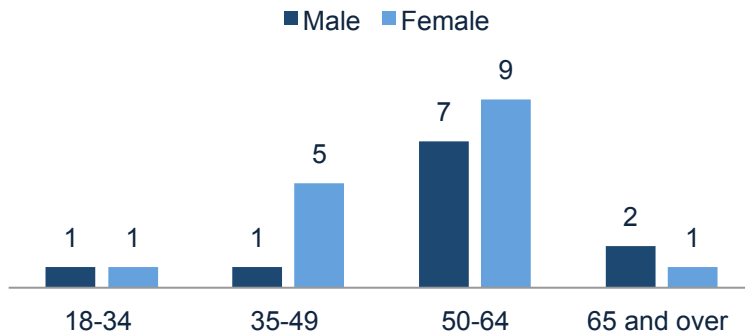
Ethnic Groups



Total Responses: 116

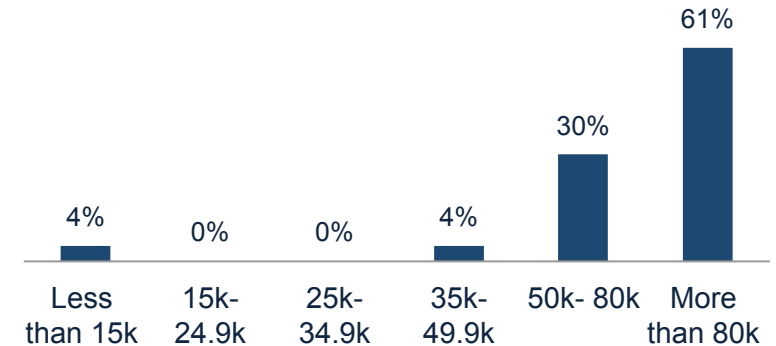
Taiwanese Summary Figures

Age Range and Gender



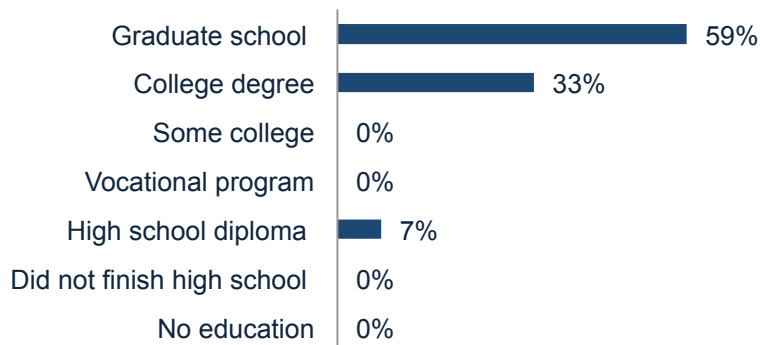
Total Responses: 27

Annual Household Income



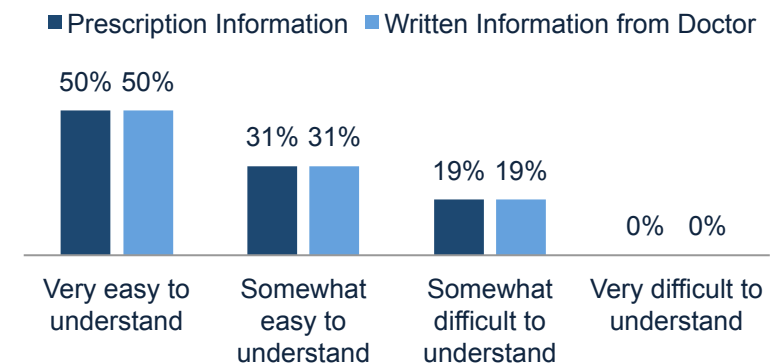
Total Responses: 23

Education Level



Total Responses: 27

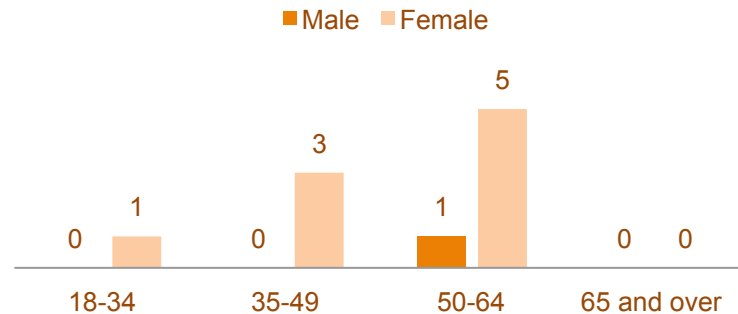
Health Literacy



Total Responses: 52

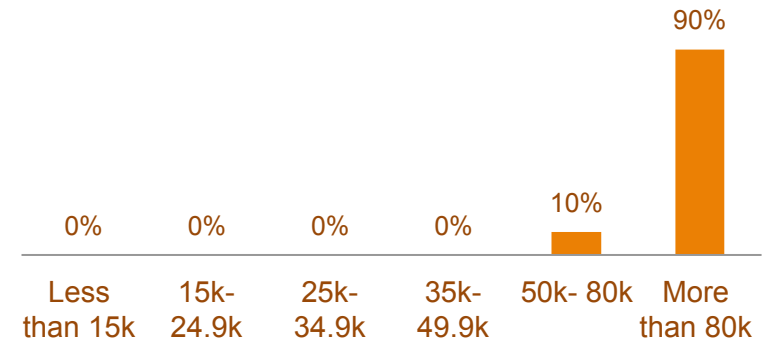
Chinese Summary Figures

Age Range and Gender



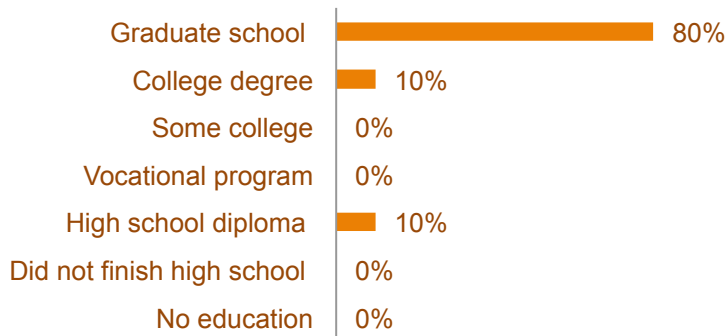
Total Responses: 10

Annual Household Income



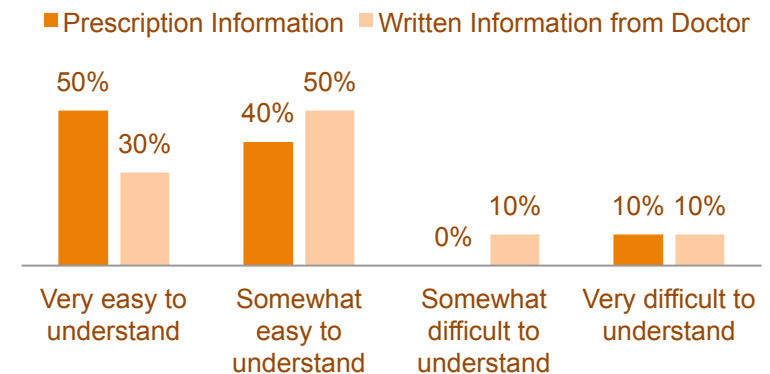
Total Responses: 10

Education Level



Total Responses: 10

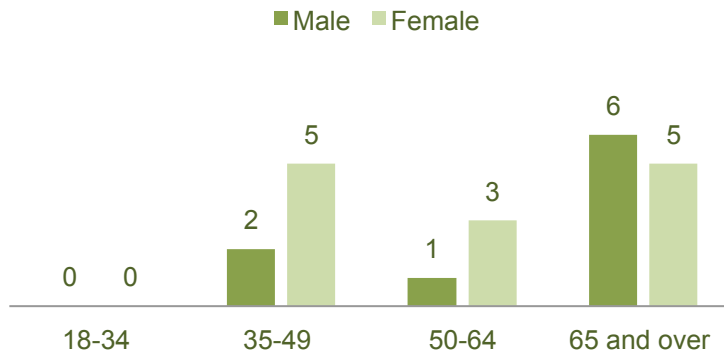
Health Literacy



Total Responses: 20

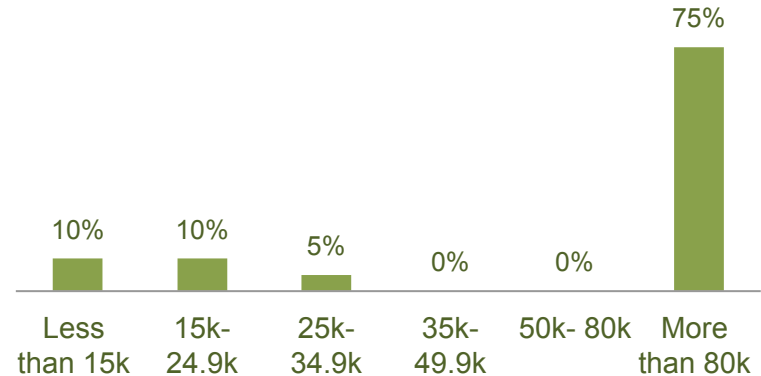
South Asian Summary Figures

Age Range and Gender



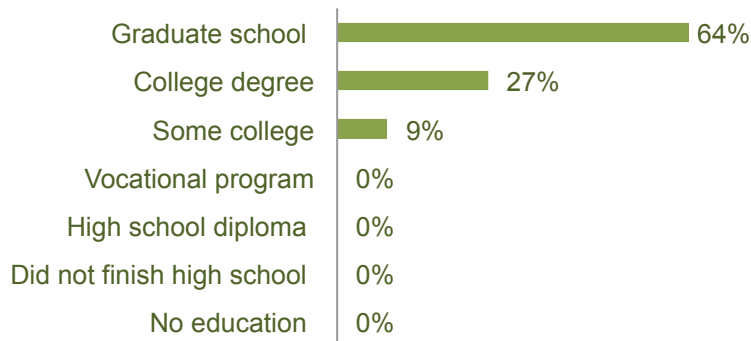
Total Reponses: 22

Annual Household Income



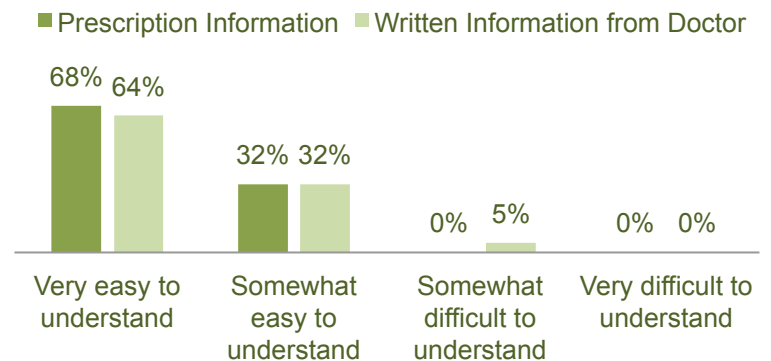
Total Reponses: 20

Education Level



Total Reponses: 22

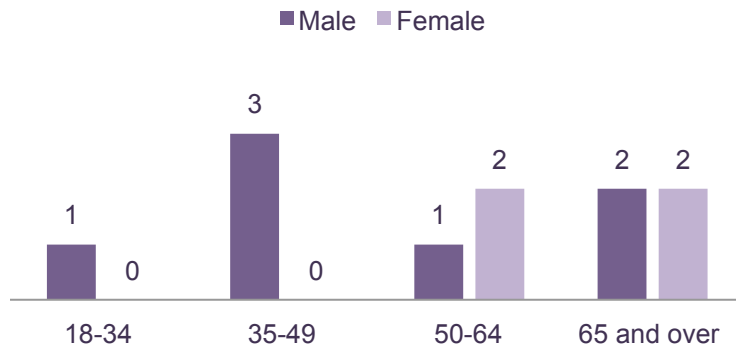
Health Literacy



Total Reponses: 44

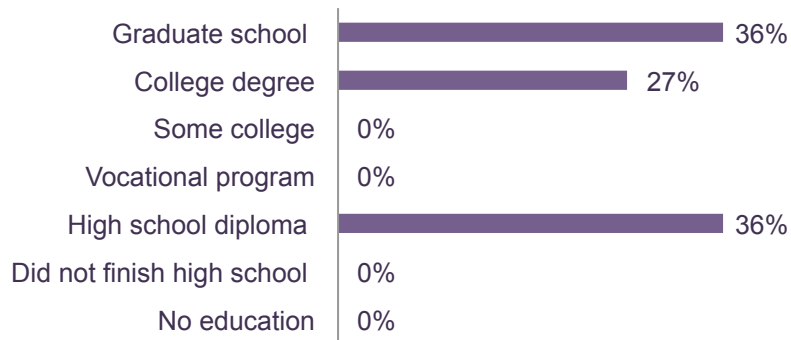
Korean Summary Figures

Age Range and Gender



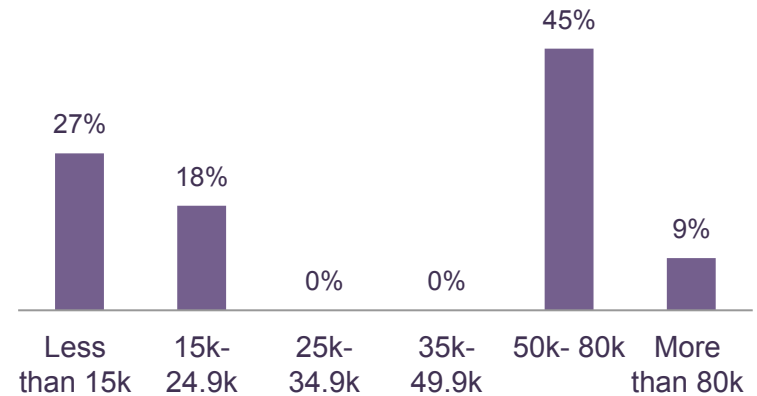
Total Responses: 11

Education Level



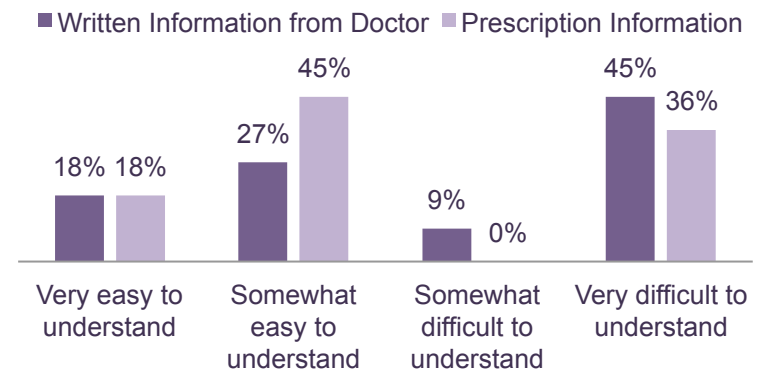
Total Responses: 11

Annual Household Income



Total Responses: 11

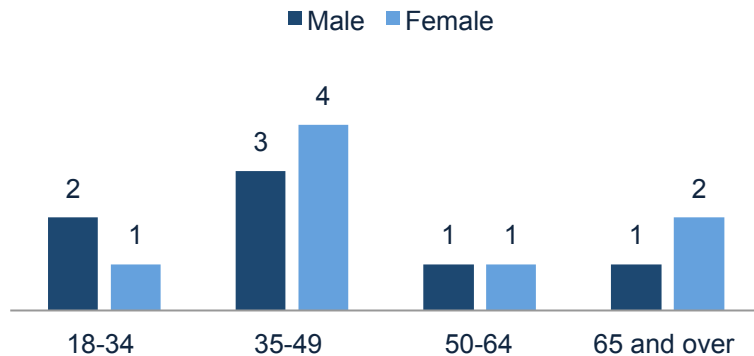
Health Literacy



Total Responses: 22

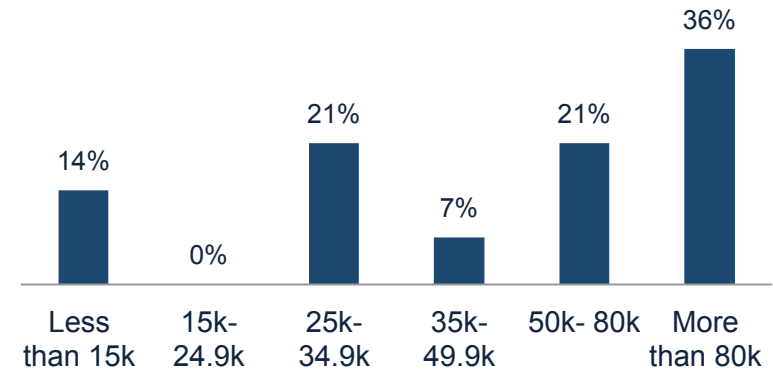
Vietnamese Summary Figures

Age Range and Gender



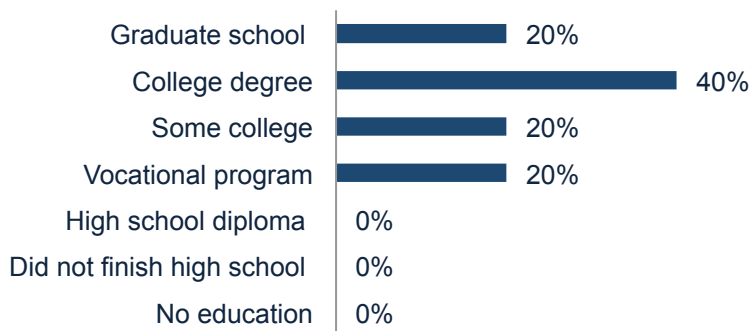
Total Responses: 15

Annual Household Income



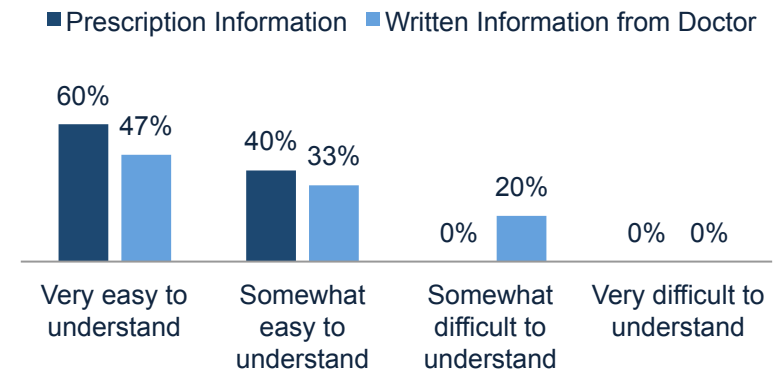
Total Responses: 14

Education Level



Total Responses: 15

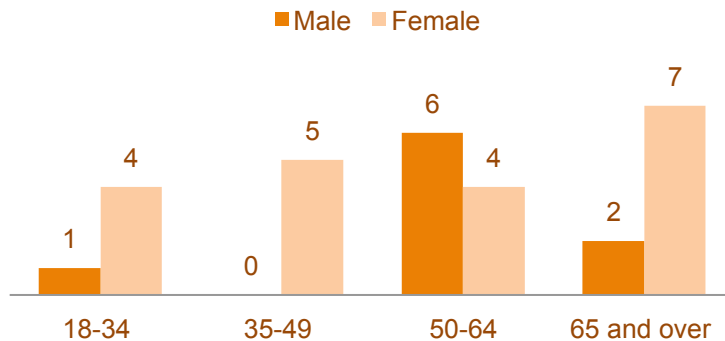
Health Literacy



Total Responses: 30

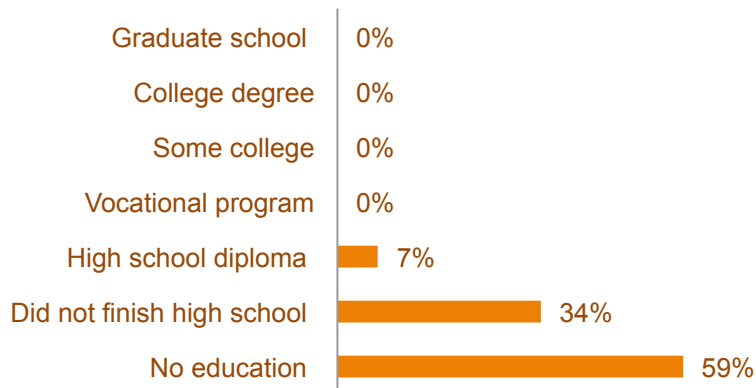
Refugee Summary Figures

Age Range and Gender



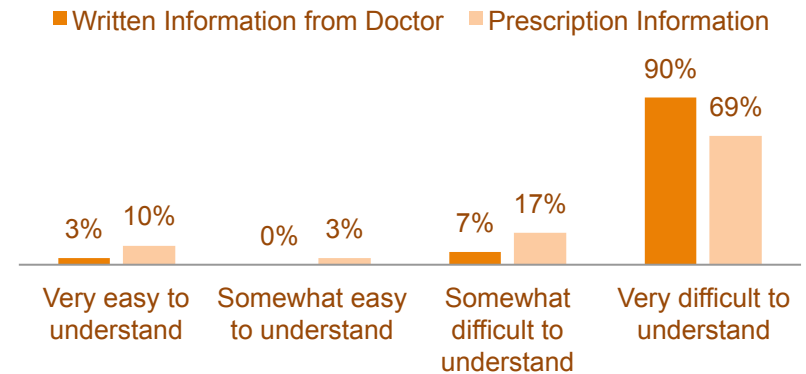
Total Responses: 29

Education Level



Total Responses: 29

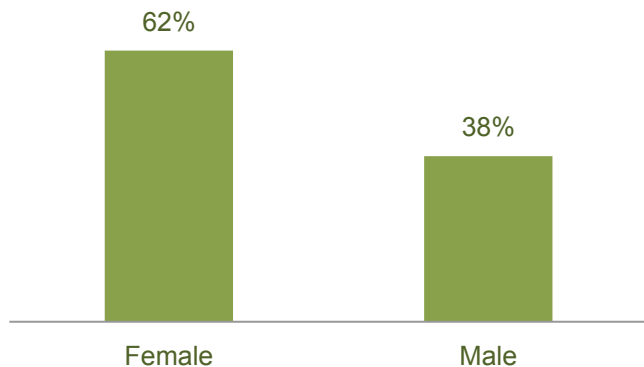
Health Literacy



Total Responses: 58

Senior Summary Figures

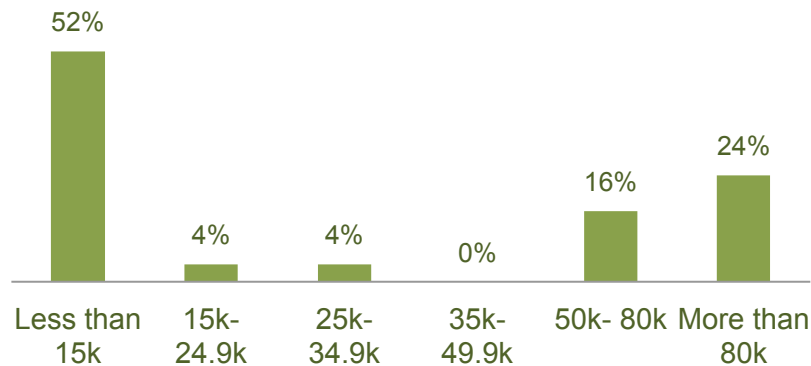
Gender



Total Responses: 29

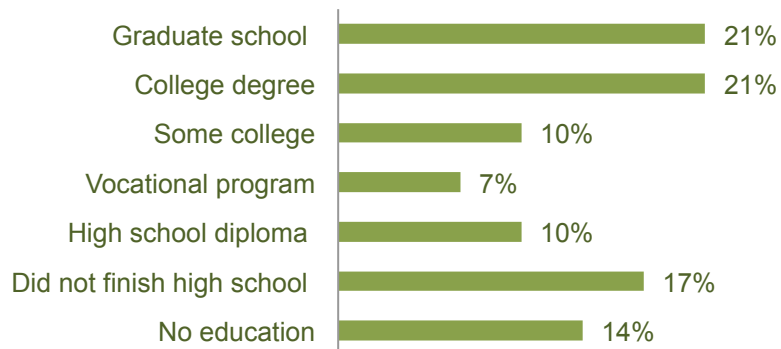
Note*- Senior age range is over 50 years

Annual Household Income



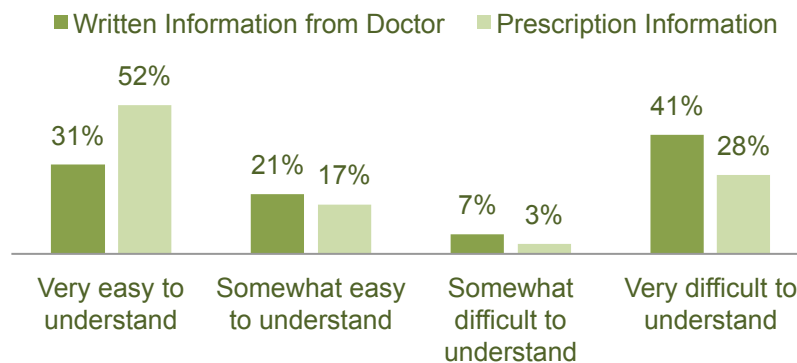
Total Responses: 25

Education Level



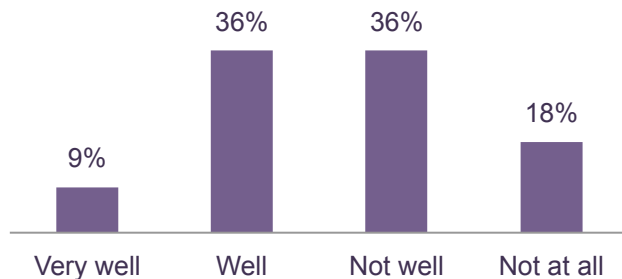
Total Responses: 29

Health Literacy



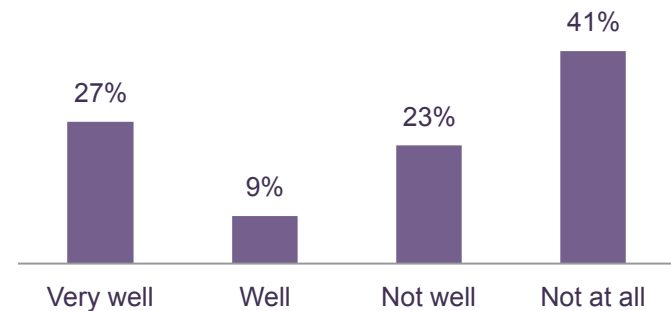
Total Responses: 58

Korean FGD Participants



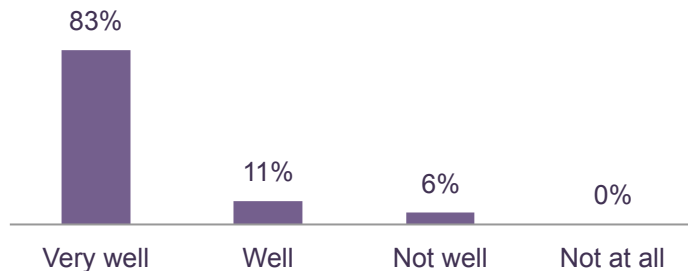
Total Responses: 11

All Senior Participants



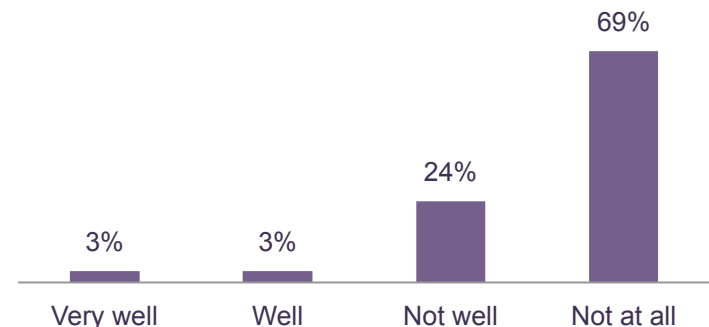
Total Responses: 22

South Asian FGD Participants



Total Responses: 18

Refugees



Total Responses: 29

*Note: The English proficiency question was added to the survey later in the project. Only participants in the Korean, South Asian, and Refugee focus groups were asked this question.

Major Health Issues

	Taiwanese	Chinese	Vietnamese	Korean	South Asian	Refugees	Seniors	Total
Diabetes	✓	✓	✓	✓	✓	✓	✓	7
Hypertension	✓	✓		✓	✓	✓	✓	6
Mental Health		✓	✓	✓	✓	✓	✓	6
Cancer	✓	✓	✓	✓				4
Arthritis	✓				✓	✓	✓	4
Heart Disease	✓					✓		2
Allergies	✓	✓						2
Hepatitis		✓				✓		2
Dental Health		✓		✓				2
Cholesterol			✓		✓			2
Smoking			✓			✓		2
Stroke			✓					1
Vision							✓	1
Obesity						✓		1
Asthma						✓		1

Asian-American Health Assessment Recommendations

- Improve **OUTREACH** to subpopulations
- Focus on **PREVENTION**
- Increase **ACCESS** to health care
- Provide **CULTURALLY SENSITIVE** health care

Improve **outreach** to Asian American subpopulations

- Utilize existing community hubs and resources (temples, churches, media) for outreach.
- Promote and support social activities for culturally/linguistically homogeneous groups that also incorporate culturally sensitive wellness education and programs.
- Publicize information and activities in Asian languages and in appropriate community media/venues.
- Support the Asian American Resource Center (AARC) as a focal point for outreach, education and services.

Focus on **prevention**

- Encourage/create more culturally appealing exercise options and activities
 - walking or gardening in social groups
 - sports like soccer that are popular within the community.
- Combine recreation and health (wellness) activities at the AARC facility
- Provide targeted screening and education to address health issues in specific subpopulations, with cultural awareness.

Increase **access** to health care.

- Reduce regulatory barriers and improve access to the MAP eligibility system
- Develop accessible transportation solutions for Asian elders and refugees
- Connect the uninsured to accessible care by improving insurance enrollment and providing low cost health care options
- Provide free health screenings at the AARC facility and other community hubs and venues.

Provide **culturally sensitive** health care

- When possible, providers should cluster medical appointments for patients from the same community
 - better utilize resources, (share interpreters and transportation)
 - provide a less stressful environment
- Develop different BMI standards for Asian ethnic subgroups to measure obesity
- Create a paradigm where mental and physical health are perceived as combined (consistent with many Asian cultures)

Provide **culturally sensitive** health care (continued)

- Improve quality of care with culturally competent medical consultants and navigators
- Increase availability of culturally competent and Asian American providers for subpopulations
- Develop culturally sensitive health care support systems for elderly and disabled
 - e.g., household assistance, home health workers, long-term care facilities

Questions?

If you have questions or would like to request a copy of the Asian American Health Assessment report, please contact:

- Vince Cobalis, Project Manager/Human Services Consultant (vcobalis@me.com)
- Lesley Varghese, AARC, Inc. Executive Director (lesleyvarghese@gmail.com)