Conference Proceedings

Working Together for Healthier Asian American and Pacific Islander Communities: Capacity-Building in the Midwest

Oak Brook, Illinois • June 4, 2004

AAPCHO • Association of Asian Pacific Community Health Organizations

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Introduction

2nd AAPCHO Midwest Conference on AAPI Health and Capacity Development

The Promoting Access to Healthcare (PATH) Program of the Association of Asian Pacific Community Health Organizations (AAPCHO), along with the Asian Health Coalition of Illinois (AHCI) and the members of the 2004 AAPCHO Midwest Conference Planning Committee, convened a conference, entitled "Working Together for Healthier Asian American and Pacific Islander Communities: Capacity-Building in the Midwest" in Oak Brook, Illinois, on June 4, 2004.

This conference, which builds on the momentum of AAPCHO's first regional conference in the Midwest two years ago, was convened to address the health issues of the fastest growing population in the Midwest, Asian American and Pacific Islanders (AAPIs).

Through this one-day conference, participants discussed issues and obstacles to improving health care services for AAPIs in the Midwest, and further developed their skills in AAPI health advocacy leadership and organizational capacity building. In addition, the conference served as a forum in which the participants networked with one another and developed stronger relationships that would help them better advocate on behalf of AAPI health in this region.

AAPCHO created this document for those individuals who missed the conference, as well as for those who attended the event, but wanted to refer back to information. The following information was compiled from meeting notes and conference speakers' presentation materials. Readers may also go online to www.aapcho.org, for more information on a session or to view a presentation. For information on a particular speaker, readers should refer to the Participant List section of this booklet.

AAPCHO believes that this conference served as a key opportunity for us to strengthen our relationships with one another in the Midwest, and to contribute to the progress we have made in improving the health of our communities. We hope this resource will be helpful to our AAPI health advocate colleagues in the Midwest who are striving to better serve their communities.

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Conference Proceedings

Working Together for Healthier AAPI Communities: Capacity-Building in the Midwest

Oak Brook, Illinois • June 4, 2004

Conference Goals:

- To share information on health issues such as mental health, diabetes and cancer that are affecting new and emerging Asian American and Pacific Islander (AAPI) communities;
- To highlight and promote strategies and models of practice that will shift the paradigm from health care that simply provides competent care to all communities, to health care that provides culturally competent care to AAPI patients; and,
- To further develop partnerships between AAPI health advocacy organizations, governments, grant-making entities and community-based organizations working with AAPI communities in the Midwest.

Opening Keynote

Rethinking Health Services for Asian Communities in the Midwest

Walter Tsou, MD, MPH

President-Elect, American Public Health Association

Walter Tsou, DJ Ida of NAPIMHA, and Joanna Su of AHCI.

Dr. Tsou talked about the issues in trying to develop culturally competent clinical services for approximately 500,000 AAPI people who live in the Midwestern states, and discussed the benefits of hiring bilingual, bicultural staff versus utilizing translation services.

Key Points of the Presentation:

AAPIs in the Midwest:

- There are approximately 500,000 AAPIs living in the Midwest. According to the US Census, the AAPI population in the Midwest is projected to grow to well over 700,000 by 2025. Illinois will continue to have the largest AAPI population in the Midwest, whereas AAPIs in Wisconsin and Minnesota are the fastest growing in the region.
- Currently the AAPI population in the Midwest accounts for 11.5% of the total AAPI population in the US. Chicago ranks No. 7 in the nation among the cities with the largest AAPI population. The AAPI population accounts for 4.3% of Chicago's total population.
- Metropolitan cities such as Chicago and Twin Cities house the largest AAPI populations, however, most AAPI communities in the Midwest are relatively small in size and scattered throughout the Midwest.

Linguistically Isolated:

- AAPIs in the Midwest who speak their native language at home grew 65% from 1990 -2000. Certain ethnic groups such as Hmong, Vietnamese, Lao and Cambodian are among the majority of ethnic groups that are linguistically isolated (no person 14 or older speaks English very well in the household), and these Southeast Asian groups are the fastest growing Asian ethnic groups in the Midwest.
- According to the 1999 US Census, the following Southeast Asian groups ranked high among AAPIs who do not speak English "well" (or at all) or are linguistically isolated: Hmong (76% and 60% respectively), Cambodian (70% and 55%), Laotian (68% and 52%) and Vietnamese (61% and 42%).

Growing Linguistically Isolated AAPI Population and Its Policy Implications:

- The growing AAPI population in the Midwest is too big to ignore. But are states able to provide culturally competent health and social services for this population?
- There are two sides of immigration: new blood for labor pool vs. taking jobs from "Americans"; diversity is treasure vs. uniformity is treasure; bilingual/bicultural vs. English only; helps grow cities and communities vs. burden on cities and communities; and, we offer help for all vs. we offer for help for the "deserving".
- Choices for states to build AAPI capacity: to make existing programs culturally competent and linguistically appropriate, or to create new services for AAPIs.

Developing Culturally Competent Care for AAPIs in the Midwest:

- Making existing health care facilities more culturally competent by providing bilingual health education materials, pictures and AAPI language signs in the facilities, and hiring bilingual/ bicultural community-based health educators.
- Interpretation services: Use trained medical interpreter, and create certification in medical interpretation. There is also an option to use the remote simultaneous medical interpreter services.
- Create a clinic in your community to serve your AAPI community residents: location - where is the critical mass of AAPIs?; staffing – as diverse as those we serve and trained bilingual specialists; funding – FQHC, Medicaid and private funds, and consider who will pay for undocumented immigrants.

Dr. Whitaker (left), Director of IL Dept. of Public Health, and
Mildred Hunter, OMH Region V Officer, welcome conference participants.

Morning Plenary

AAPI Health Conditions in the Midwest

Improving Diabetes Care for Asian American and Pacific Islander

Marshall Chin, MD, MPH, FACP

Associate Professor of Medicine, University of Chicago

Diabetes affects thousands of AAPIs. Dr. Chin discussed that community, public health, and medical organizations can play major roles in preventing diabetes and its complications. State of the art diabetes care involves systems of care that incorporate chronic care models and techniques of continuous quality improvement. Community health centers have been at the forefront of designing and implementing creative interventions to improve diabetes care for at-risk populations. Effectively utilizing culturally-specific educational materials for AAPIs developed by organizations such the National Diabetes Education Program and AAPCHO is critical.

Key Points of the Presentation:

Clinical Issues and Epidemiology:

- Diabetes is a disease caused by elevated glucose and impaired insulin secretion, and causes vascular-related complications such as blindness, kidney failure, nerve damage, amputations and heart disease.
- According to CDC National Diabetes Fact Sheet 1998, more than 16 million people in the US have diabetes (type 2), which accounts for 13% of the population older than age 40 and 19% of the population older than age 65. 35% of persons with diabetes are undiagnosed.
- Prevalence in AAPIs is 2-4 times higher than non-Hispanic whites. AAPIs in the US have a higher prevalence of diabetes than Asians in Asia. Overweight and obesity are major risk factors for diabetes, and the current BMI (body mass index), used to assess diabetes risk, needs to be revised for AAPIs.

Pre-Diabetes and Diabetes:

- Risk factors for type 2 diabetes include age, obesity, body fat distribution, physical inactivity, family history of diabetes, race/ethnicity, previous gestational diabetes (GDM), elevated fasting glucose levels and impaired glucose tolerance (IGT).
- According to the 2004 American Diabetes Association Guideline, pre-diabetes is defined as the condition with impaired fasting glucose and impaired glucose tolerance. 40 million people in the US are living with pre-diabetes.
- Pre-diabetes is a major factor for cardiovascular disease, however; it is also an optimal time for intervention to prevent individuals from developing diabetes complications. Diet and exercise are components of intensive lifestyle intervention.

Improving Diabetes Care in the Community:

- There are models such as Rapid Plan-Do-Study-Act cycles and Chronic Care Model for diabetes care in the community.
- "Standard" Quality Improvement (QI) packages include education, practice guidelines/ flow sheets, computerized patient tracking and reminders, audit and feedback and opinion leaders.
- Components of patient self-management include: patient empowerment approaches, patient conviction that controlling diabetes is important to them, patient confidence that they have the ability to control their diabetes, and family support systems.
- Successful diabetes care in the community requires leadership, clear direction and lots of examples, buy-ins from key stakeholders, time and resources, partnerships between health centers and community organizations, and computerized patient registry system to track improvements.

Diabetes Resources for AAPIs:

- Resources at the National Diabetes Education Program (www.ndep.nih.gov).

Policy Issues:

- AAPIs are largely unrecognized as an at-risk population for diabetes. Barriers to care for AAPIs include: lack of insurance, lack of culturally competent care, lack of services for patients with limited English speaking ability, and lack of collaboration among government agencies at all levels.

Cancer in Asian Americans: Lifting the Veil

Karen Kim, MD, MS

Associate Professor of Medicine, University of Chicago

Cancer prevalence in AAPIs is significant. Yet AAPIs have the lowest cancer screening rates of all ethnic groups, and are more likely to be diagnosed at a later stage in the cancer's progression. Certain subgroups of AAPIs suffer from increased rates of cancer incidence and decreased rates of cancer screening. However, these statistics vary by geographic location within the US, and small datasets, in part, contribute to differences in cancer reporting in the Midwest. Few studies have included an adequate assessment of specific Asian subgroups; disaggregated data of Asian subgroups may reveal unexpected trends and important risk factors. Dr. Kim argued that it is crucial to better understand the determinants of inadequate use of preventive health care and screening measures by AAPIs, in order to positively impact time to diagnosis and produce better long-term outcomes for AAPIs. Dr. Kim calls for dialogue and collaborative action for change, in order to improve cancer prevention, screening and awareness in our often difficult to reach communities.

Key Points of the Presentation:

Cancer Prevalence in AAPI Communities:

- 45% of men or 1 in 2 men as well as 37% of women or 1 in 3 women in the US develop cancer in their lifetime. Healthy People 2015 aims for a 50% reduction in cancer mortality and 25% reduction in care incidence by 2015. The problems for AAPIs are:

- Rapid increase in AAPI populations (50% or more are foreign-born) widens the gap.
- Insufficient data on AAPI subgroups maintains the gap.

- According to a National Vital Statistics Report 2002, the leading causes of death for AAPIs are cancer followed by heart disease and stroke. Asian Americans are the only racial/ethnic group with cancer as the No. 1 leading cause of death.
- Cancers in AAPIs may be different from the mainstream US population. Cervix, stomach and thyroid cancers for women and liver and stomach cancers for men are regarded as signature cancers for AAPIs. Theses cancers in AAPI communities may not be detected due to lack of resources, education, knowledge of disease prevalence and preventive services such as Hepatitis B for liver cancer, and H pylori and early detection for gastric cancer.
- AAPI women are the only US population group to experience an increase in cancer mortality between 1990-1995. US-born AAPI women have a 60% higher breast cancer risk than Asian-born AAPI women. Also, foreign-born AAPI women have increased in breast cancer rates within one generation.
- Cancer screening and early detection in AAPI communities are poor. Examples include:
  - Vietnamese, Filipino and PI women have cervical cancer rates 5-75 times higher than non-Hispanic white women, yet AAPI women have the lowest rates of taking a pap test among all racial/ethnic groups.
  - Breast cancer rates between 1990-1997 increased the most in AAPI women, however; AAPI women under the age of 40 ranked the second lowest to have had a mammogram in the last two years.
  - Japanese Americans have the highest rates of colorectal cancer. However; AAPIs over 50 ranked among the lowest in taking stool blood testing for colorectal cancer screening in 2003.
  - Filipinos have the second poorest 5 year survival rate from colorectal cancer, however in the past 5 years, AAPIs had the second lowest rates of taking sigmoidoscopy/colonoscopy for colorectal cancer screening.

Policy Implications:

- Paucity of data for AAPIs and AAPI subgroups:
  - Asian Americans in NCI-supported clinical trials from 1994-1998: 4.8% of screening/diagnosis, 1.8-2.2% of treatment trials and 0.9% of prevention trials.
  - Diverse subgroups among AAPIs mask significant differences in data.
- Marginal funding for AAPIs:
  - Comparison of total numbers of NIH-funded projects and subprojects by racial/ethnic minority populations from 1990-1994.

Dr. Karen Kim discusses issues on cancers and AAPIs.

Fiscal year	1990	1991	1992	1993	1994
Asian American	17	22	33	36	36
Native American	47	72	60	72	77
Hispanic American	54	93	113	130	145
African American	89	146	207	254	278

  - o MEDLINE database from 1966-2000 has 10 million articles. Of those, 1499 (0.01%) directly involve AAPI health.
  - o CRISP database from 1986-2000 holds records of 150,369 federal health related grants. 342 (0.2%) were grants for AAPI health.
- Model Minority Status:
  - o Although AAPIs account for only 3% of the US population, AAPIs account for 6% of US science/engineering workforce, 7% of Ph.D. workforce and 10% of MD workforce. This creates the perception of AAPIs as an overrepresented minority.

Recommendations for Closing the Gap:

- Break barriers for cancer screening by ensuring equal access, culturally competent and ethnically specific education and training.
- Emphasize the importance of community based organizations for cancer prevention.
- Establish partnerships with physicians, public health agencies, state and national health organizations to promote cancer awareness, prevention and early detection in AAPI communities.
- Lobby for increased funding for research in AAPIs.

The Role of Culture in Adjustment to Illness and Disability

Kathryn McGraw-Schuchman, MA, LP

Multicultural Center for Integrated Health

Health is influenced by a variety of psychosocial factors. While disease and disability often cannot be prevented or cured, an individual's response can have significant implications for health outcomes. Ms. Schuchman discussed that cultural beliefs, attitudes and knowledge play an important role in adjustment to chronic and acute health conditions. By understanding and addressing cultural factors related to illness and disability, health and human service providers can help increase resilience and improve health outcomes.

Key Points of the Presentation:

Perceptions of illness and disability are influenced by:

- Knowledge and understanding of bio-physiology.
- Patient's familiarity with scientific concepts of illness and disability.
- Patient's experience with western medicine.

- Patient's experience with medical and mental health treatment.
  - o In order to transform a negative experience to a positive one, it is important to go to a medical facility when a patient is healthy.
  - o Many people do not know that medical facilities can offer them services to prevent illnesses.
- Cultural and religious beliefs about life threatening conditions.
  - o Need to strike a balance between medical conditions and spiritual beliefs.
- Attitudes about chronic conditions.
  - o There is a western belief that a chronic condition can be overcome, but many AAPIs believe it is a death sentence.

Psychosocial Adjustment and Health Outcomes:

- Attribution and hope impact on adjustment.
- Minimization and exaggeration impact on coping.
- Importance of patient's prior experiences.
- Communicating problems is critical.
- Issues of compliance.
- Impact of cultural beliefs and traditional healing practices.

Recommended Approaches:

- Working within patient's belief system.
- Importance of health education and integrating mind, body and spirit.
- Including alternative and traditional healing practices.
- Role of peer support.

Leisure Time and Non-Leisure Time Physical Activity in Asian Americans

Namratha Kandula, MD, MPH

*University of Chicago**

As Asians live in the US longer, their risk for heart disease, diabetes, obesity and other chronic disease increases. Regular physical activity reduces the risk of these diseases, yet little is known about physical activity in Asian Americans and how it changes after immigration. Using the data from the 2001 California Health Interview Survey, Dr. Kandula presented her investigation of the effects of ethnicity, nativity, and years in the US on leisure time (LTPA), non-leisure time (NLTPA), and occupational physical activity for Asian Americans. These data provide evidence that Asian Americans participate in recommended LTPA at much lower rates than US-born non-Asians, and that Asian immigrants are at high risk for being physically inactive. This is contrary to the common perception that sedentary lifestyle increases after immigration and is one of the reasons for increased heart disease, diabetes, and obesity in immigrants as time since immigration increases. NLTPA does not offset these lower levels of LTPA. Increasing physical activity is key to protecting the health of this rapidly growing population.

* At time of presentation. Dr. Kandula's contact information is updated in the Participant List section of this booklet.

Key Points of the Presentation:

Physical activity is a national health priority:

- Healthy People 2010 made physical activity one of the ten leading health indicators.
- CDC reported in 2001 that 30% of Americans meet physical activity recommendations.
- Data on physical activity in Asian Americans are lacking.

Why is physical activity important?

- Regular physical activity brings substantial health benefits to people of all ages.
- Reduces the risk of heart disease, obesity, diabetes, stroke, and other chronic diseases.

What kind of physical activity has proven health benefits? (CDC Recommendations)

- 30 minutes of moderate physical activity 5 times per week such as walking briskly, tennis (doubles), bicycling 5 to 9 mph on flat ground, weight lifting, long-form Tai Chi Chuan, Hatha yoga, scrubbing floors, climbing stairs, raking lawn, pulling weeds, and planting.
- 20 minutes of vigorous physical activity 3 times per week such as jogging/running, walking briskly uphill, swimming laps, tennis (singles), bicycling more than 10 mph or on uphill terrain, moving or pushing heavy furniture, and shoveling heavy snow.
- Duration of time depends on intensity (the more intensive, the less time).

Physical Activity and Asian Americans:

- Definitions of physical activities:
  - o Leisure time physical activity: an activity performed during free time or for recreation, that is not associated with work or transportation.
  - o Non-leisure time physical activity: walking or bicycling for transportation to work, school, or for errands.
- 75% of Asian Americans in California do not meet national recommendations for regular leisure time physical activity.

Confrence participants listen to the Morning Plenary presentations.

- Recent immigrants are much less likely to meet national recommendations for regular leisure time physical activity than US-born Asians.
- Although older Asian Americans and Chinese and Vietnamese Americans are less likely to meet the national recommendations for leisure time physical activity, they may be more likely to walk or bicycle for transportation.

Further research is needed:

- There is an urgent need for data on Asian Americans living outside of California.
- Need to understand how Asian American men and women perceive physical activity: explore barriers and motivators.
- Physical activity questionnaires in this population may need to incorporate questions about traditional Asian physical activity (e.g. tai-chi or yoga).
- Examine the influence of immigration, acculturation, and ethnicity on the types of physical activity that Asian Americans are willing to incorporate into their lives.

Recommended Interventions:

- Population-level
  - o Creating neighborhoods that are more conducive to physical activity: could target Asian enclaves.
- Community-level
  - o Culturally and linguistically appropriate media campaigns to educate the Asian American community about the importance of physical activity.
  - o Community-based physical activity programs that take into account age, gender, acculturation, and cultural differences.
  - o Family-oriented programs that encourage children and adults to participate in physical activity.
- Individual-level
  - o Encourage health care providers to counsel Asian Americans about how to incorporate physical activity into their lives.

Model Practice Presentations

Building Capacity for Healthier AAPI Communities in the Midwest

Session 1: Access to Quality Health Care

Opening Doors Cultural Competency Training for Health Care Providers

Susan Kim, MPH

Project Coordinator, Asian Health Coalition of Illinois

The Asian Health Coalition of Illinois (AHCI), in response to the need for culturally competent care in the Chicago area, launched the Opening Doors Cultural Competency training program in January of 2001. The goal is to instill health care providers with the awareness, knowledge, and skills to provide quality health care service to patients of different cultural backgrounds. Ms. Kim talked about the program's evaluation findings from pretest/post test to measure the immediate impact of the training on participants and from follow-up telephone interviews to document actual change in behavior. She discussed that data collected from participants reveal that the training program resulted in participating providers gaining knowledge and skills that impacted their behavior change, and which may lead to improved health outcomes for their patients.

Key Points of the Presentation:

Why is there a need for cultural competence education in healthcare?

- AAPI Demographic Trends in the US:
  - o Foreign-born AAPIs outnumber native-born AAPIs.
  - o AAPIs are the fastest growing populations. 64% of the fifth largest AAPI population in the US resides in Chicago, and the Asian population in Chicago suburbs is rapidly increasing.
  - o Some subgroups such as Korean, Vietnamese and Pakistani have higher rates of uninsured or poverty among other AAPI groups.
- Linguistic Barriers:
  - o 1 in 5 of the AAPI population in Illinois speak English either "not well" or "not at all".
  - o Impact patient-physician interaction such as patients' confidence in doctors, their decision-making about healthcare, and their time spent with doctors.
- Cultural Barriers:
  - o Asians and other minority groups are less satisfied with care received; least likely to feel that their doctors understood their background and values; have greater problem

communicating with their doctors; and, do not feel very confident about receiving quality care when needed.

Opening Doors Program:

- Objective: to provide health care providers with the necessary knowledge and skills to deliver culturally competent care and services to multicultural clients.
- It provided 60 trainings, reached over 700 health care providers, and worked with 37 health care provider organizations in Chicago and its surrounding suburbs.
- Curriculum utilizes diverse teaching methods including didactic presentation, interactive exercises, role playing, and case study analysis.
- Evaluation Process:
  - o Pretest and post test to measure immediate outcomes in increase in awareness and knowledge, and intentions to change behavior.
  - o Follow-up telephone interview 1-3 months after the training to measure behavior change, change in organizational policy and organizational culture.
- Evaluation Outcomes:
  - o Awareness and knowledge gain: the majority of training participants became more aware of how their assumptions and stereotypes toward others may impact the quality of care; learned how to resolve cross-cultural communication barriers; and, believed that providing culturally competent care requires policy changes on an organizational level.
  - o Behavior change: communication tools enabled participating providers to better listen to their patients and understand where they are coming from. The training improved perceived benefits to the provider by the providers feeling that they have a better understanding of patients' perspectives and background; that they are able to more effectively help patients; and, their jobs became easier.
  - o Perceived benefits to patients were improved by patients feeling better understood; more included in decision-making; more comfortable with doctors; and, better health outcomes.

Participants attend a breakout session.

Benefits of the Medical Home Model: Access to Quality Health Care

Charles Onufer, MD

Director, Division of Specialized Care for Children, University of Illinois at Chicago

Dr. Onufer introduced and discussed the Medical Home Model. "Medical Home" refers to a way of improving access to quality health care in a cost-effective manner in a primary health care setting. The Illinois Medical Home Model defines and illustrates this concept by dividing it into three components: 1) the "Foundation" represents the family-professional partnership; 2) "Critical Supporting Elements" provide the basis for the broad definition of a Medical Home, as care provided by a primary care physician that is accessible, compassionate, coordinated, comprehensive, continuous, culturally competent, and family-centered; and, 3) "State-Specific Enhancing Elements" describe the activities used in Illinois to promote the Medical Home Model. The way in which cultural competency is integrated into the Medical Home Model should be considered as a model for other primary health care settings.

Key Points of the Presentation:

What is medical home?

- Medical Home refers to access to quality health care in a primary health care setting for all children including those with special health care needs.
- The concept of "Medical Home" has a long history in pediatric practice since 1967, when it referred to providing care for children with special needs.
- It is a proactive approach to provide care in a cost-effective manner, and emphasizes a family-physician relationship.

Illinois 3 Components:

- Foundation: Family-Professional Partnerships
  - o The primary care physician and other health care providers know the child's health history; listen to the parents' and child's concerns and involves them in decision-making; share a trusting, collaborative relationship with the family; and, treat the child with compassion and understanding.
  - o Parents and child are comfortable sharing concerns and questions with the child's primary care physician and other health providers; routinely communicate their child's needs and family priorities to the primary care physician, who facilitates communication between the family and other health care providers when necessary.
- Critical Supporting Elements: Standards of pediatric care that include policies and guidelines for screening, treatments and health supervision of infants, children and adolescents to ensure care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally competent.
  - o Cultural competency:
    - The child's and family's cultural background such as beliefs, rituals and customs are valued and incorporated into the care plan.
    - All efforts are made to ensure that the child and family understand the results of the medical encounter and the care plan including the provision of trained interpreters or translators as needed.
    - Written materials are provided in the family's primary language.
    - Physicians should strive to provide these high quality services and incorporate these values into the way they deliver care to all children.

- Illinois State Specific Enhancing Elements:
  - o Improve the quality of care through regularly scheduled meetings of parents and physicians, and by establishing a baseline Medical Home Index, developing plans and implement change for quality improvement, and by conducting self assessment on cultural competency that includes materials and resources, communication styles, and values and attitudes.

Benefits of Medical Home Model:

- Physicians see a family (the child patient and parents) as a unit.
- Focus is on the family's agenda, and better understanding of family challenges, frustrations and the need for respite care.

Additional Resources:

- The National Center of Medical Home Initiatives for Children with Special Needs at www.medicalhomeinfo.org.
- Center for Medical Home Improvement at www.medicalhomeimprovement.org.
- Bright Futures at http://brightfutures.aap.org.
- National Center for Cultural Competence at http://gucchd.georgetown.edu/nccc/index.html.

Session 2: Health Data and Policy

Coalition-Building to Improve Asian American Health Data and Policy: A Chicago Model

Laurent Tao, MD

Assistant Professor, Department of Internal Medicine, Rush Medical College
Attending Physician, Division of General Internal Medicine, John Stroger Hospital, Cook County

Jini Han, MD, MSc

Clinician-investigator, Department of General Medicine, John Stroger Hospital, Cook County and Rush University Medical Center

Co-presenters, Dr.Tao and Dr. Han, shared a Chicago-based model for bringing local researchers and community-based organizations together to share information on AAPI health data and to mobilize toward improved AAPI data collection at the local levels. They discussed the current state of local AAPI health data and the coalition they have created together with key stakeholders. They also shared information on current research efforts as well as their advocacy efforts with local and state health departments for change.

Key Points of the Presentation:

Current State of AAPI Health Data:

- Although Healthy People 2010 lists 28 focus areas of improvement, little data for AAPI ethnic

groups are available on these areas. This lack of data makes it difficult to identify baseline data, to measure progress, and to make a case for further research.

- 0.2% of federal health research grants support research projects on AAPIs. Many reports use aggregated AAPI data.
- In 2004, Chicago Department of Public Health examined AAPI health indicators. They found limitations on AAPI data included small sample size of some AAPI subgroups that resulted in difficulty calculating rates.
- Illinois Department of Public Health Report on AAPI Cancer Patterns in IL: Evaluation was limited by data issues such as a lack of reliable population data for subgroups, and undercounting on cancer registry.

Asian Health Research Interest Group of Chicago:

- Formed in May 2003 with local health researchers and community health advocates including the South Asian Public Health Association, public health officials and physicians who share common interests in AAPI health promotion through research, networking and advocacy.
- The group meets to discuss AAPI health and data needs in Chicago and Illinois, as well as brainstorm, network, share local resources, collaborate on projects, advocacy, policy paper and data review.

Asian Communities' Capacities in Tobacco Control: Issues and Policy Implications

Surendra Bir Adhikari gives his presentation on AAPI tobacco control and community capacity development.

Surendra Bir Adhikari, Ph.D.

Ohio Tobacco Use Prevention and Control Foundation

Dr. Adhikari focused his presentation on enhancing participants' understanding of the social context of tobacco use behavior among Asian Americans, and suggesting development areas for culturally sensitive programming and action plans in concert with Asian communities' capacities in tobacco control. He discussed the findings of the Asian Tobacco Use Survey of adults (2001-02) in Northeast Ohio which revealed a considerable stratification in tobacco use behavior in terms of demographic and ethnic orientation. The glaring disparities in Asian communities point to the need for culturally enabling and community-specific program interventions and action plans.

Key Points of the Presentation:

Current State of Affairs:

- Lack of baseline data on AAPI tobacco use.
- Lack of culturally and linguistically tailored programs and limited impact of mainstream tobacco control programs for these communities.

- High social acceptance of and disparities in tobacco use in Asians. Low health care utilization to quit smoking among Asians.
- Targeted marketing to AAPIs by the tobacco industry.

Challenges and Solutions:

- Challenges:
  - o Outreach to diverse communities.
  - o Social acceptance, low capacity to respond to tobacco use and targeting.
  - o Cultural and linguistic barriers.
- Solutions:
  - o Conduct community-based need assessment and prevalence studies in multiple languages.
  - o Capacity-building: resource networking with mainstream agencies and engaging community leaders.
  - o Increase broader cross-sectional involvement among ethnic communities and resource providers.
  - o Support community events.
  - o Develop multi-language materials and culturally competent programs.

Summary:

- Integrate health into community events.
- Culturally sensitive programming to change social norms.
- Culturally competent programming.

Session 3: AAPI Involvement in Health Research

Grassroots Participatory Research on Social Indicators of Health

Mona Bormet, BS

Minnesota Asian/American Health Coalition

Ms. Bormet talked about Minnesota Asian/American Health Coalition's (MA/AHC) community-based participatory research project on social indicators of health to identify intermediate outcomes that affect the health status of Minnesota AAPI communities. This study was funded through the Eliminating Health Disparities Initiative of the Minnesota Department of Health. In this session, attendees learned about the community-based participatory research methodology and how it is applied in an effort to eliminate health disparities among Minnesota's AAPIs.

Mona Bormet talks about community participatory research for AAPI health.

Key Points of the Presentation:

- The problem: Aggregated data on Minnesota's AAPI populations led to a belief that AAPIs are the "model minority".
- The MA/AHC was interested in finding out the needs in the AAPI community. Using a Participatory Research Partnership (PRP) approach, MA/AHC went into the community, attending meetings to discuss health indicators, and to educate the community about PRP methodologies. MA/AHC developed and administered a community questionnaire, and conducted one-on-one interviews.
- Researchers spent a lot of time explaining research to potential subjects. They found that they had to pare down the inventory from more than 100 questions, to an amount that was more manageable.
- Essential engagement elements included: trust, flexibility, community ownership, developing relationships, sharing and valuing. For instance, researchers found it important to develop trust among individuals in the community. It was important to be flexible in approach (e.g., scheduling of time, what works well in one community may differ in the next). They also found that community ownership was important. That is, finding key community people who were interested in research. Other elements in engagement, such as taking the time to talk to people, rather than simply rushing through conversations, were important. Sharing information and findings, valuing the people from whom you are gathering information and the data that you are collecting, were also important.
- Indicators were identified and organized according to four types of factors: system factors, risk and protective factors, community assets, and social and environmental factors.

HIV/AIDS Needs Assessment for Non-English Speaking AAPI Population

David Amarathithada, MPH

*Asian Human Services**

Mr. Amarathithada presented on the needs assessment project which Asian Human Services in Chicago conducted to assess HIV/AIDS prevention, care, access and service needs of the non-English speaking and limited English proficiency Asian immigrant and refugee population of Chicago. The project was supported in part by the Chicago Department of Public Health. Focus groups, in-depth interview, and surveys were conducted as a part of this assessment.

Key Points of the Presentation:

Assessment Findings:

- There were 112 respondents. The majority lived on the Northside and Chinatown. For perceived vulnerability, 81.1% responded with "not at all" and another 14.4% stated "a little". Other sample findings include: for those that used protection, 34% had gotten it from a drug store, 5.7% from peers (the balance did not use protection); 62.5% of respondents had received HIV/AIDS educational materials. When asked if they had ever gotten an HIV test, 10.8% of the respondents said yes, and 89.2% no.
- Other findings include: 60.4% did not use protection (condoms, clean needles, etc), 60% lived in the US for less than two years, 73% had no health insurance. There is a need to educate medical providers about culturally specific issues and risk factors of AAPIs. Furthermore, HIV-related needs of the AAPI community will continue to increase. Advocacy in funding and research policy for the AAPI community is needed to increase services for the population.

* At time of presentation. Mr. Amarathithada's contact information is updated in the Participant List section of this booklet.

Recommendations include:

- Educate medical providers about culturally-specific issues and risk factors for AAPIs.
- There should be capacity-building for community organizations and leaders by building trust within the community.
- A public health educational campaign should be developed and maintained.
- Support groups should be provided.
- Healthcare data needs to be collected to document needs.
- Educate community on immigration laws and discrimination laws based on health status.
- Develop linguistically and culturally sensitive materials.
- Funds need to be allocated to examine the impact of HIV in the AAPI community. Advocate or change funding and research policies.

Session 4: Community Health Organizations and Program Development for AAPIs

Coalition Building for Health Literacy

Lynn Buhmann, RN, MSN

MeLee Thao, RN

Wausau Family Practice Center

Ms. Buhmann and Ms. Thao presented on the collaborative project in Wausau, Wisconsin to create the first Hmong language educational video/CD in the country. Using this project as an example, they shared with the participants how they worked together with other local organizations to develop and bridge the language and cultural gaps necessary to create a Hmong language educational tool on the very sensitive topic of sexually transmitted disease.

Key Points of the Presentation:

Four Community-Based Organizations in Wausau, Wisconsin: the Wausau Family Practice Center, the Wausau Area Hmong Mutual Association, the Marathon County Health Department and Northern Wisconsin Area Health Education Center got together to develop culturally sensitive patient education materials in Hmong.

At the beginning of the project, they faced problems such as:

- Unable to recruit students.
- Had unrealistic expectations about expertise required to write a script.
- Had unrealistic idea of the money necessary to get a quality video educational materials.

Translation issues they faced included:

- Hmong language doesn't have words to explain "Western" medical terms. They had difficulty conveying "germ theory" in Hmong language. Or the original Hmong narrator was using the same word for all the different diseases.

Questions you should ask yourself as you develop cross-cultural materials are:

- Who is your audience?
- What do you want them to do with the information?
- What is the best way to communicate with your audience?
- What are your target population's beliefs?
- How does your target population view this disease?

Questions you should ask yourself when working in a collaborative are:

- Who do we represent?
- What does each partner organization have to offer?
- What each organization will get out of working on this project?

A Community Health Needs Assessment Survey of Asian Communities in Chicago

Jing Zhang discusses the community health needs assessment survey her organization conducted in Chicago.

Jing Zhang, Ph.D.

Director of Community Health Programs, Asian Human Services

In the summer of 2000, with funding from AAPCHO and Illinois Primary Health Care Association, Asian Human Services (AHS) in Chicago began its journey to apply for a grant to establish a Federally Qualified Health Center (FQHC), a community clinic that provides comprehensive primary health care services for AAPIs in the Metropolitan Chicago Area. In this presentation, Dr. Zhang talked about the Community Health Needs Assessment Survey which she conducted in part for AHS' FQHC application. This needs assessment was necessary due to a lack of health data for local Asian American communities. The efforts led to the opening of the Asian Human Services Family Health Center in the summer of 2003. Dr. Zhang also discussed some roles this needs assessment project played in community development to improve health care access for the community.

Key Points of the Presentation:

Data from Community Health Needs Assessment:

- The assessment survey interviewed 525 residents who live on the north and northwest side of Chicago.
- The needs assessment identified the following critical health needs and other issues that will impact the health care of this growing community:

- o Of the 525 survey participants, 47% reported not having any health insurance.
- o 39% of the respondents were more likely to pay for medical care by cash, 23 % use Cook County Hospital, and 13% use a physician who did not charge for services.
- o Nearly 40% reported that in the past year there were times they felt that they needed to seek medical care but did not, while 47% delayed or postponed medical care that was needed because of cost, waiting time for appointments, transportation difficulties, and/or language barriers.
- o The same respondents reported receiving very limited health care services throughout their lives. Nearly 60% have not received any vision screening and nearly 70% have never received any form of hearing screening. More than half of the population did not receive any dental care in the past year.
- o Among the 312 women respondents, slightly over one-third had taken a Pap smear examination and more than 70% had not had mammograms.
- o Of the 207 male respondents, nearly 85% have never received a prostate screening.
- o Other finding include: 83% of respondents were foreign born and have lived in the U.S. for less than five years; more than 50% of the respondents did not speak English, or did not feel comfortable using English, and 40% needed interpreter services when seeking a doctor.

What did this needs assessment mean to community development?

- This health needs assessment was critical not only for a FQHC grant application, but also helped identify other health needs in the community, and strengthened the capacity of community-based research and advocacy:
  - o Asian Women's Health programs development, including an on-site OB/GYN clinic prior to the establishment of the FQHC clinic.
  - o A better tool for data advocacy resulted in two other funded health needs assessments on HIV among non-English speaking Asian American populations and on tobacco control among AAPI youth.
  - o Stronger partnerships among key stakeholders to bring AAPI health issues to the forefront.

Participants network during lunch.

Voices from the Midwest

Policy Recommendations

Background

After the model practice presentations, participants discussed policy recommendations on each of the following topics: access to quality health care, health data and policy, AAPI involvement in health research, and health organizations and program development. The goals of the discussion session were to: 1) assess the current state of the issue; 2) voice our concerns and provide ideas on how to improve the situation; and, 3) provide AAPCHO and other AAPI health advocacy organizations with recommendations for change.

Due to the time constraints, only the AAPI Health Data and Policy and AAPIs Involvement in Health Research groups were able to hold discussions. The "Voices from the Midwest: Policy Recommendations" is summarized by group discussions, and by the challenges facing AAPI health advocates in the Midwest. The challenges were identified by participants throughout the conference.

Summary of Group Discussions: As mentioned above, discussions for policy recommendations were conducted on AAPI health data and policy issues as well as AAPI involvement in health research. Because these topics are similar in nature, the following issues regarding the quality of data, research methods and opportunities and policies that create a supportive environment to address these issues are identified. First, there are a lack of disaggregated data for subgroups and a gap in research efforts between metropolitan areas such as Chicago and Twin Cities and suburban and rural communities. Also, there is a tendency for researchers to target American-born AAPIs, even though the majority of the underserved AAPI population is foreign-born. Only highly educated AAPIs may participate in research projects, while other subgroups may be reluctant to become involved in community surveys or research and continue to be left out. The communities want a research project to be conducted in a way that benefits the communities. Movement toward participatory research and action research should be encouraged in AAPI communities, so communities have ownership of the research process and outcomes. And, through such research projects, there should be tangible outcomes other than data for community capacity development, such as survey tools and manuals and health educational materials. Developing culturally competent research methods for AAPIs is also critical to better serve the community needs.

The groups also discussed how to address these issues. In order to improve the quality of AAPI health data, it is important to advocate for over-sampling as well as more use of qualitative data. Culturally competent research methods for AAPIs should also be developed. In order for these efforts to be successful, it is also critical to improve the environment in which we work by increasing representation on advisory boards at all levels of government, as well as educating our funders and grant reviewers on AAPI community-based research issues. We also need our AAPI researchers to conduct research for our AAPI communities, and pay attention to suburban and rural issues. We also need to be more creative, and ask for affluent AAPI groups to support research efforts that benefit AAPIs as a whole. We need to continue our dialogue through AAPCHO or other AAPI health advocacy listservs.

Policy Recommendations

Challenges for Midwestern AAPIs in Addressing Health Care Needs:

- Rapid increase in AAPI populations, particularly higher % of foreign-born widens the gap of health disparities. (i.e. language barriers, cultural barriers to health care, first-generation immigrants less likely to seek preventive care and more likely to seek services only after symptoms become severe).
- Although AAPI population growth is big, AAPIs are still relatively small in numbers in the Midwest.
- Geographically dispersed AAPI communities without ethnic community centers or social service agencies to assist them.
- Insufficient data on AAPI subgroups maintains the gap.
- Polarized views on AAPIs: Model minority who doesn't need help or immigrants/refugees who are burden for the community.
- Marginal funding for AAPIs, due in part to lack of data.
- Challenges for foreign-trained health care professionals to become licensed in the US (i.e. need affordable prep courses, and elimination of unnecessary or duplicative tests).
- Lack of bilingual, bicultural health care providers, particularly for Southeast Asians.

Closing the Gap: Recommendations

- Continue to outreach to the Midwest and invite Midwestern AAPI leaders to participate in the national health dialogue such as developing the AAPI National Healthcare Platforms.
- Include the concerns of Southeast Asian communities, which have sizable populations in several Midwest metropolitan areas but are sometimes overlooked by national groups.
- Assist in establishing partnerships with AAPI community-based organizations, physicians, public health agencies, state and local health organizations to promote prevention in AAPI communities in the Midwest.
- Emphasize the importance of community-based organizations for prevention/health education.
- Lobby for increased AAPI research funding, not only for university-based researchers but also for community-based needs assessment projects by AAPI health advocates in the Midwest.
- Recognize that some Asian American groups are indeed underrepresented in the health professions and develop scholarship programs to encourage students from these populations to enter health professions.

AAPCHO will be working with other national and local AAPI health advocacy organizations to develop action plans that improve health services for underserved AAPIs in the Midwest. For more information, contact Junko Honma, PATH Program Coordinator, at jhonma@aapcho.org, and join the PATH listserv. To subscribe, visit http://groups.yahoo.com/group/aapcho-path/.

Participants network during lunch.

Technical Assistance

Workshops

Effective Grantwriting and Fundraising

Inhe Choi

Program Director, The Crossroads Fund

Kulsum Ameji

Development and Communications Director, Coalition for African, Asian, European, and Latino Immigrants of Illinois

Facilitators discussed helpful tips that community-based organizations can use to develop successful grant proposals. The information provided was tailored to meet participants' expectations for this session such as: the process of developing a successful proposal; making a case specific to AAPIs, identifying appropriate funders, and developing relationships with funders, particularly with private foundations.

Key Points of the Presentation:

Problems with Grant Writing:

- Lousy odds.
- Restrictions such as no indirect costs, or a cap on those costs.
- Most funds are short-term focused and have specific interests. Because organizations try to make a proposal fit, it distorts the work of organizations that chase funds.

Positives of Grant Writing:

- Provides chances to articulate needs, organization's mission and future plans.
- Provides on-the-job training of grant writing, and if all staff is included in the process, it can create buy-in among staff.
- Foundation grants give organizations credibility.
- Foundations talk, share information with one another, and they can leverage funds.

What foundations look for?

- Budget to assess the level of support from community.
- If proposal meets issue areas they fund.
- Legitimacy of the group.
- Referrals.
- Enthusiasm and passion toward the proposed project, and if the work of the organization is moving a community forward.
- The history of the organization, particularly its successes, its funding source and diversity.

Tips for Approaching Foundations:

- 3 steps: 1. Provide a quick introduction of organization, 2. Set up time to meet, and 3. Provide a letter of intent.
- Do your homework before approaching a foundation about their interests and RFP deadlines.
- Ask current funders to identify and refer to other potential funders.

Health Advocacy: What We Do at the National Level and What You Can Do at Your Local Community

Gem Daus, MA

Director of Policy, Asian Pacific Islander American Health Forum

Jeff Caballero, MPH

Executive Director, Association of Asian Pacific Community Health Organizations

This workshop features activities of two national AAPI health advocacy organizations. Facilitators provided an update of the issues under the current political environment, as well as strategies and partnerships for improving access, language and cultural appropriate services, data collection, and health disparities, and discussed what roles community-based organizations can play at the local level to advance AAPI health issues together.

Key Points of the Presentation:

Lobbying:

- Direct lobbying specifically refers to someone asking a legislator to support a particular bill/ legislation. (There is also grassroots lobbying, which calls on the general public to support specific legislation).
- There is a limit on the amount of time 501(c) b organizations can spend on lobbying, but the organizations are allowed to participate in lobbying unless you are restricted by funding sources.
- Federally funded projects or staff cannot use funds to lobby or to attend hearings unless you are asked to give testimony.
- Health care lobbying does not contribute to campaigns or a vote for a particular politician, rather influencing politicians to have a conscience about their constituents' needs.
- Lobbying Example – Minority Health Bill: Office of Minority Health (OMH) is up for re-authorization and is at risk of being taken off the current budget of 50 million. The Democrats' Minority Health Bill, which asks for the OMH to be re-authorized with a $100 million budget, will fund HIV, diabetes, access to health care, and language access, etc. A large group of AAPI health lobbyists visited Senator Frisk's office to counter his bill, and asked him to hold hearings and work with Democrats.

Advocacy:

- Advocacy is about raising awareness to issues, educating legislators and the general public by telling our stories.
- Advocates organize and amplify the voices of community members and constituents, and make it possible for others to speak or bring attention to people who cannot speak for themselves.

Main Take-Home Messages:

- It is important to show Congressional legislators that you care about how they vote on legislations/bills.
- Call or visit local offices often to ask for the health legislative assistant or to talk about your community agenda. When there is a critical mass, DC will finally open its ears to your issue.
- Educate specific legislators you think may help you, and thank them for their support.
- Register AAPIs to vote.

Coalition Building: From Basics to Multicultural Coalition

Virginia Martinez, JD

Director, University of Illinois at Chicago International Center for Health Leadership Development

Ms. Martinez talked about various levels of "working together," and presented on stages of coalition development, as well as success factors and common barriers to multicultural coalitions. The presentation also discussed the characteristics of collaborative leadership. Through group discussions, participants were given the opportunity to share challenges with the group, and brainstorm potential strategies to address those challenges. The workshop enabled participants by the end of the session, to recognize various levels of working together, describe the stages of development of a coalition, and understand the factors that increase the success of multicultural coalitions.

Key Points of the Presentation:

Levels of Working Together:

- Networking (high degree of autonomy)
- Coordinating
- Cooperating
- Collaborating (high degree of commitment and shared resources)

Stages of Development of a Coalition:

- Coalition defined: A coalition is formed when two or more organizations are in pursuit of at least one mutual objective for a particular cause.
- Stage I: Getting to know you includes: identify key players; share information about issues and resources to address them; and, confirm initial "buy-ins."
- Stage II: Getting Ready for Action includes: define the mission, assign roles, outline work plans; and, identify decision making process.
- Stage III: Taking Action includes: implement work plans; allocate resources; and, develop leadership.
    - o During the life of the coalition, members play different roles at different stages, and they take on leadership roles when they are: committed to the process, willing to accept responsibility for coalition goals and outcomes, and willing to take risks.
    - o To sustain a coalition, it requires members who have the following leadership skills: patience, listening, ability to take charge, ability to delegate, ability to compromise, having a big vision, and keeping others reminded of the vision.
- Stage IV: Death or Disfigurement:
    - o Is there still a common vision/mission for the group?

- Is our work done?
- Is it time to have a retreat and find out where we are and where we are going?

Overcoming Common Barriers for Successful Multicultural Coalitions:

- Barrier #1: Lack of Common Meeting Culture – Meetings are inaccessible due to language and cultural differences, or the use of acronyms and jargon that is not understood even with a common language. How to address this barrier: Make communication ground rules and develop a common meeting culture that respects all participants.
- Barrier #2: Dominance by Professionals – Key professionals dominate the coalition process and decision making. They view "others" from a deficit point of view. How to address this barrier: Go out into the community to actively recruit "others" in coalition, and ask their feedback.
- Barrier #3: Failure to Create Inclusive Leadership and Mentor New Leaders – A coalition is stuck with a single dominant leader or a lack of leadership. How to address this barrier: Conduct regular evaluations on leadership, and seek out new individuals to take leadership roles so that a coalition can foster the development of leaders from its membership.
- Barrier #4: Lack of Shared Vision – Unstated assumptions lead to misunderstanding of what goals are shared, and members to compete over funding and other resources. How to address this barrier: Examine assumptions and allow time to state and clarify each member's vision, and find a common goal for the group.
- Barrier #5: Failure to Act – A coalition suffers from endless, long term planning meetings, and no one seems to be committed to take actions. How to address this barrier: Plan carefully and make a group commitment to produce actions and results with scheduled timelines.
- Barrier #6: Bad History – Coalition members particularly from communities do not trust a coalition because they have been discriminated by health care providers; are suspicious of researchers and institutional health providers because of the history of lack of respect and consultation with communities of color. How to address this barrier: Learn a community's history particularly the history of conflict and cooperation, and create open dialogues with a community where everyone can participate.
- Barrier #7: Turf and Competition within Multicultural Coalitions – Territoriality and competitions for client, media attention, and funding. How to address this barrier: Understand each other's self-interest, and work together to create a vision for a larger good.

Organizational Capacity Building and Technical Assistance around HIV Programming: A Tool Kit for Success!

Karl Villanueva-Kimpo, MPH

Project Coordinator, Asian Health Coalition of Illinois

This session addressed some of the issues that an AAPI community-based organization should consider when implementing HIV prevention and case management programs. The issues discussed included: the importance of assessing the preparedness of the an agency's staff to provide non-judgmental, client-centered HIV prevention and case management, being involved with a local HIV community planning group, and other capacity building and technical assistance issues. Mr. Kimpo also provided participants with information on how to request HIV technical assistance. Although this presentation revolved around capacity and technical assistance issues in existing HIV programs,

the information shared was relevant to any agency that is diversifying its scope of service including HIV prevention and case management.

Key Points of the Presentation:

AAPI HIV Data Facts:

- According to estimates by CDC, 1% of all AIDS cases in the US are among AAPIs. However, from 1998 to 2002, AAPIs had the highest % increase of people living with AIDS (35%).
- Underreporting and race or ethnicity misclassification in medical records and self-reports also mask the reality of HIV infection in the AAPI community.
- About 2/3 of AAPI AIDS cases are among AAPI men who have sex with men (MSM).
- 22% of AAPI women who have HIV did not identify their risk behavior to contract HIV.
- Aggregated AAPI HIV data make this population invisible on the HIV epidemiological radar.

Cultural Competency for Health Service Providers – Steps to Minimize Bias:

- Acknowledge that the client's culture is different from his/her own culture, make efforts to learn client's cultural norms, and never impose one's own culture onto the client.
- Establish an alliance in which the client can educate the provider and be empowered to solve problems.
- Use resources in the community – community leaders or colleagues who share the client's culture
  - to verify client's cultural norms.
- Be aware of a common pitfall, which is to switch old biases and stereotypes for new ones. This can be avoided if the provider remembers that the goal of cultural competency is to deliver client-centered services.

Issues to consider when working with AAPI clients:

- Clients might think that their HIV risk is low.
- Assessing a client's sexual history may be a challenge because discussing sex may be a taboo to the client.
- Different levels of acculturation and English language competency.
- Women may need more support in protective sex education.
- Homosexuality as well as HIV is stigmatized.

Afternoon Plenary

Effective Partnership Building

Moderator: **Grace Hou**
Assistant Secretary, Illinois Department of Human Services

Panelists: **Cora Munoz, Ph.D.**
Ohio Commission on Minority Health

Mae Hong
Program Director, Field Foundation

Valerie Lee, MA
Program Officer, Minneapolis Foundation

Although AAPI communities in the Midwest are considered to be relatively new and small, many of them, in fact, have made their home in the Midwest for more than a few decades. AAPI community-based organizations today face the unique challenges of serving the Midwest's fastest growing population who needs affordable, culturally competent and linguistically accessible care. Building effective partnerships with government agencies and local private foundations is essential more than ever before to better serve our community needs.

The goal of this panel presentation was to give an assessment of the current state of partnerships between funding organizations and AAPI communities in the Midwest. It sought to identify important issues for communities to consider when they wish to strengthen partnerships with their funding organizations, and what recommendations funding organizations can propose for collective efforts by the AAPI community in the region to address health disparities in partnerships with them.

Recommendations for Effective Partnership Building for AAPI community organizations

With Government Agencies:

- Increase AAPI representation in all levels of government, so that AAPI issues and perspectives will be reflected within government agencies' priorities and programs.
- Need more AAPIs in government that can act as a change agent in the status quo environment of the government bureaucracy.
- Build more reviewer and advisory board capacity in our community so we can have stronger voices in the government systems.

With Private Foundations:

- In order to increase chances to get funded, take time to research who funds what. In order to

strengthen your proposals, examine the issues from different perspectives such as class, urban vs. rural, and think of them in a wider context such as environmental justice, so that you make your case stronger than a conventional needs statement.

- Approach funders with a solution in mind. Present some evidence about what works and how innovative your approach is.
- Educate funders about AAPI health needs. Many foundations do not have a specific approach to AAPIs, nor do many foundations have program officers who are AAPI health specialists.
- Invite funders to work together with you and your group to develop shared goals and priorities.
- Keep in mind that whatever his/her background your foundation officer may have, the more tools and information you can provide to the officer, the easier it is for you to make your case.
- Regarding disaggregated data collection, most foundations do not fund it. But organizations are encouraged to be obsessed with data collection. Be creative and build a data collection piece into your programs.

Essential Groundwork in the Era of Scarce Resources:

- Organize people at grassroots and political levels, and build bridges with black and Latino groups because we all have similar needs. Instead of competing to get your needs noticed, ask the funders how they will address the group's collective needs.
- Framework and perspective are important for building cross cultural bridges. For example, Minnesota Foundation conducted an arts program on immigration at the American Indian Center. The theme was how our minority populations have been labeled as "Enemies of the People." In our history, Japanese Americans were interned in Native American reservations, and recent terrorist attacks have led to rumors that history could repeat itself with our Arab American communities. Addressing the common issues of cross cultural communities is a very effective means of building bridges.

Participants listen to the afternoon plenary discussion.

Evaluation Summary

Conference Evaluation Results

N=30 **Ratings (1 = poor, 5 = excellent)**

	1	2	3	4	5
Overall program content (agenda)				9	21
Quality of information presented			1	10	19
Opportunities to participate in discussion and ask questions			4	10	16
Opportunities for exchange of ideas and experiences		1	6	11	12
Structure and length of meeting		1	5	14	10

Summary

Overall, this one-day conference program was well received by the conference participants. Many participants appreciated the well organized conference agenda, diversity and selection of workshops and topics, and breadth and quality of information presented. They were also impressed by the quality and credentials of the speakers/panelists and presentations. This in itself was a testament to the wealth of AAPI health researchers and practitioners, AAPI leadership in government and grant-making entities and AAPI community-based health advocates in the Midwest. The majority of respondents found that the conference provided a great atmosphere for discussions on a variety of AAPI issues and provided more than ample networking opportunities. By convening speakers and panelists from various states and communities, the conference provided a forum for participants to broaden their perspectives and better understand the value of expanding their networks and cross-border collaborations.

Respondents also provided valuable feedback that will assist staff in future conference planning. With respect to administrative issues, respondents suggested the need for improved registration processes and time management throughout the conference program. Most participants recognized that the day

was packed with a very ambitious program, but many felt, simultaneously, that time constraints kept discussions to a minimum. Since many of the breakout sessions and workshops were interest areas for participants, many respondents found it difficult to select a session to attend. Respondents wished they could have attended more than one concurrent session. They also expressed the need for more hand-outs during the sessions.

Conference planning staff was encouraged to hear that the conference participants enjoyed the meeting, and want us to continue these presentations and workshops regularly.

Appendices

Conference Agenda

8:00 REGISTRATION AND BREAKFAST

8:30 WELCOME

2004 AAPCHO Midwest Conference Planning Committee
Mildred Hunter, DHHS Office of Minority Health Region V
Eric Whitaker, Illinois Department of Public Health

8:50 OPENING KEYNOTE

Walter Tsou, President-elect, American Public Health Association
Rethinking Health Services for Asian Communities in the Midwest

9:10 MORNING PLENARY: AAPI Health Conditions in the Midwest

- *Improving Diabetes Care for Asian American and Pacific Islanders*
  Marshall Chin, University of Chicago
- *Cancer in Asian Americans: Lifting the Veil*
  Karen Kim, University of Chicago
- *The Role of Culture in Adjustment to Illness and Disability*
  Kathryn McGraw-Schuchman, Multicultural Center for Integrated Health
- *Leisure Time and Non-Leisure Time Physical Activity in Asian American*
  Namratha Kandula, University of Chicago

10:30 BREAK

10:45 – 11:55 BREAKOUT SESSIONS:
Building Capacity for Healthier AAPI Communities in the Midwest

4 concurrent presentations and discussions on following topics:

- Access to Quality Health Care
- Health Data and Policy
- AAPI Involvement in Health Research
- Community Health Organization and Program Development for AAPIs

10:45 – 11:30 PART 1: MODEL PRACTICE PRESENTATIONS

SESSION 1: Access to Quality Health Care

a) *Opening Doors Cultural Competency Training for Health Care Providers*
Susan Kim, Asian Health Coalition of Illinois

b) *Benefits of the Medical Home Model: Access to Quality Health Care*
Charles Onufer, Illinois Title V Program for Children with Special Health Care Needs

SESSION 2: Health Data and Policy

a) *Coalition-Building to Improve Asian American Health Data and Policy: A Chicago Model*
Laurent S. Tao and Jini Han, Rush Medical College/John Stroger Hospital

b) *Asian Communities' Capacities in Tobacco Control: Issues and Policy Implications*
Surendra Bir Adhikari, Ohio Tobacco Use Prevention and Control Foundation

SESSION 3: AAPI Involvement in Health Research

a) *Grassroots Participatory Research on Social Indicators of Health*
Mona Bormet, Minnesota Asian/American Health Coalition

b) *HIV/AIDS Needs Assessment for Non-English Speaking AAPI Population*
David Amarathithada, Asian Human Services

SESSION 4: Community Health Orgs. and Program Development for AAPIs

a) *Coalition Building for Health Literacy*
Lynn Buhmann and MeLee Thao, Wausau Family Practice Center

b) *A Community Health Needs Assessment Survey of Asian Communities in Chicago*
Jing Zhang, Asian Human Services

11:30- 11:55 PART 2: DISCUSSIONS - VOICES FROM THE MIDWEST: Policy Recommendations and Action Plans

12:00 – 1:25 LUNCH AND NETWORKING

12:35 DISCUSSIONS REPORT BACK

1:30 – 2:30 TECHNICAL ASSISTANCE WORKSHOPS

1) *Effective Grantwriting and Fundraising*
Inhe Choi, The Crossroads Fund
Kulsum Ameji, Coalition for African, Asian, European, and Latino Immigrants of Illinois

2) *Health Advocacy: What We Do at the National Level and What You Can Do at Your Local Community*
Gem Daus, Asian Pacific Islander American Health Forum
Jeff Caballero, Association of Asian Pacific Community Health Organizations

3) *Coalition Building: From Basics to Multicultural Coalition*
Virginia Martinez, UIC International Center for Health Leadership Development

4) *Organizational Capacity Building and Technical Assistance around HIV Programming: A Tool Kit for Success!*
Karl Villanueva-Kimpo, Asian Health Coalition of Illinois

2:30 BREAK

2:45 – 4:00 AFTERNOON PLENARY: Effective Partnership Building

Moderator: Grace Hou, Illinois Department of Human Services
Panelists: Cora Munoz, Ohio Commission on Minority Health
Mae Hong, Field Foundation
Valerie Lee, Minneapolis Foundation

4:00 CLOSING

Mildred Hunter, DHHS Office of Minority Health, Region V
Jeff Caballero, Association of Asian Pacific Community Health Organizations

4:15 CONFERENCE ADJOURNS

Participant List

Speakers:

Surendra Bir Adhikari
Program Manager
Ohio Tobacco Use Prevention and Control Foundation
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Information on AAPCHO, PATH Program and Other AAPCHO Programs

Association of Asian Pacific Community Health Organizations (AAPCHO)

AAPCHO is a national, not-for-profit organization, representing the nation's leaders in providing quality, comprehensive community health care services that are financially affordable, linguistically accessible and culturally appropriate for Asian Americans, Native Hawaiians, and Pacific Islanders. Each year AAPCHO health centers serve over 200,000 clients through our 19 member centers located across the nation. AAPCHO's mission is to improve the health status of AAPIs in the U.S. and its territories, with a special emphasis on low-income, limited-English proficient and medically disenfranchised populations. For more information, please visit www.aapcho.org.

Promoting Access To Healthcare (PATH) Program

Founded in 1999 through a cooperative agreement with the Office of Minority Health, this project aims to address the health care needs of the nation's growing AAPI communities in the Midwest and mountain states by helping community-based organizations develop the capacity to provide culturally competent and linguistically accessible health care services for their communities. The past activities include:

- Convening annual Advisory Committee meetings,
- Developing and distributing fact sheets on AAPI populations in 12 Midwest and mountain states;
- Disseminating electronic AAPI health resource lists;
- Moderating a PATH listserv that provides community health advocates with a forum for sharing information and resources and discussing health access issues facing their communities;
- Providing mini-grants to 12 community-based programs to strengthen their ability to improve their community health care access and culturally competent services; and,
- Presenting program findings at the 2003 and 2004 APHA Conferences, the 2003 and 2004 Hmong National Development Conferences, and the University of Michigan Social Justice for AAPI Communities Conference to increase attention and understanding of the issues of underserved AAPIs in the Midwest and mountain states.

In order to provide a forum for local AAPI health advocates to network and develop strategies on improving AAPI health in the Midwest region, the PATH Program convened two regional conferences on AAPI health in the Midwest: "Body and Soul: Mental Health for Asian Americans, Challenges and Perspectives" in St. Paul, Minnesota in May 2002 and "Healthier AAPI Communities: Capacity Building in the Midwest" in Oak Brook, Illinois in June 2004.

To join the PATH listserv, visit http://groups.yahoo.com/group/aapcho-path/

If you have any questions about the PATH program please contact Ms. Junko Honma, PATH Program Coordinator at jhonma@aapcho.org or 510-272-9536 x116.

Other Current AAPCHO Programs

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) – APPEAL is a national network of individuals and organizations working towards a tobacco-free AAPI community. The goal of the program is to prevent tobacco use among the AAPI community through five priority

areas: network development, capacity building, education, advocacy and leadership development. In December 2004, APPEAL was incorporated and will soon become an independent not-for-profit organization.
For more information, please visit www.appealforcommunities.org

Building Awareness Locally and Nationally through Community (BALANCE) Program for Diabetes – Funded through a three-year cooperative agreement with Center for Disease Control and prevention (CDC), BALANCE is designed to work cooperatively with the National Diabetes Education Program (NDEP) to increase diabetes awareness and improve diabetes care in AAPI communities.

Building Resources In Development, Growth, and Expansion (BRIDGE) Program for CHCs – Funded by the Bureau of Primary Health Care (BPHC), this project aims to improve health care services for AAPIs and their access to services by promoting culturally and linguistically appropriate health care service models.

Capacity-Building in HIV/AIDS for Medical Providers Program (CHAMPs) – Funded through a cooperative agreement with the Office of Minority Health, Office of Public Health and Science, Department of Health and Human Services and the Pacific AIDS Education and Training Center, this project aims to build the capacity of health care providers in community health centers and local health departments to address HIV/AIDS in underserved AAPI communities.

Enabling Services Accountability Project – Funded by the California Wellness Foundation, Office of Minority Health, and the MetLife Foundation, the project involves collaboration between AAPCHO, its member clinics, and the New York Academy of Medicine. The purpose of the project is to develop a model for improving data collection on enabling services and to describe the impact of these services on access to health care.

Expanding a National Information Infrastructure for Asian and Pacific Islander Communities – Funded through a cooperative agreement with OMH, this project will be awarding mini-grants that enable organizations with emerging AAPI communities to connect to the Internet, add videoconferencing capabilities to member agencies and make improvements to www.aapcho.org.

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