Asian American Health Initiative
Community Health Needs Assessment

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Montgomery County, State of Maryland
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By the Research Team of the Public Health Informatics Research Laboratory
Department of Public and Community Health, University of Maryland
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SECTION A
Background: Demographics and Health Concerns

Demographics: Asian Americans of Montgomery County

According to Federal Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity provided by OMB statistical Directive 15,[1] *Asians* refers to persons of origin from any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

The Asian American population has become one of the fastest growing communities in Montgomery County, Maryland. According to US Census Bureau (Census 2000), the Washington DC-Baltimore Metropolitan Area was among top 5 US regions with the largest Asian population (following Los Angeles, New York, San Francisco and Honolulu). In 2000, 11.3% (n=98,379) of the Montgomery County population identified as Asian American. Among the minority groups of the County this was second to the African American, and was comparable to the size of the Hispanic community in Montgomery County (see Figure 1). The Asian community is known for its fast-growing and diverse composition of culture, race, and ethnicity. According to the Census (2000), there were seven racial/ethnic subgroups which constituted the majority (92%) of the Asian community of Montgomery County. The American Community Survey (2003) found that there were more than 120,000 Asian residents in Montgomery County, Maryland, composing about 13.5% of Montgomery County's population. They were represented by the following subgroups: Chinese/Taiwanese (41,170, 26%), Asian Indians (33,442, 21%), Korean (26,219, 17%), Filipino (16,043, 10%), Vietnamese (11,183, 7%), Japanese (4,675, 3%) and Others (26,030, 17%) (see Figure 2).[2] The diverse composition of this community has presented a unique challenge in terms of meeting their health and social services needs. Completed after many site visits and public meetings with Asian American leaders in major U.S. cities, a recent report by the President's Advisory Commission on Asian Americans and Pacific Islanders (AAPI) concluded that the priority concern of this community was health.[1] According to the literature, this health concern is characterized by a lack of preventive services, a disproportional burden of diseases presented in this community, and the quality of care this community received from certain health services.

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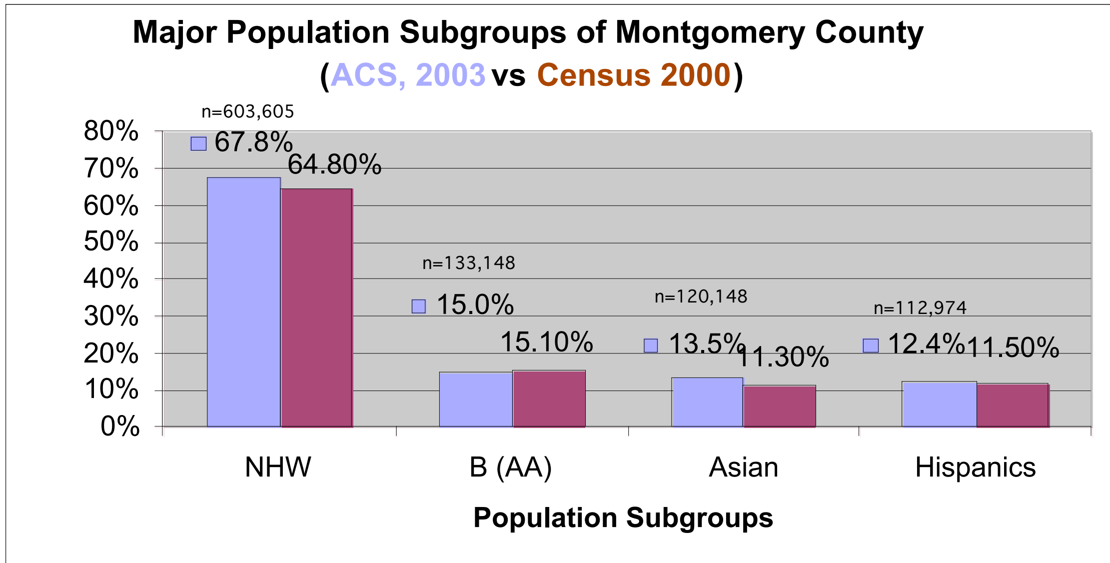
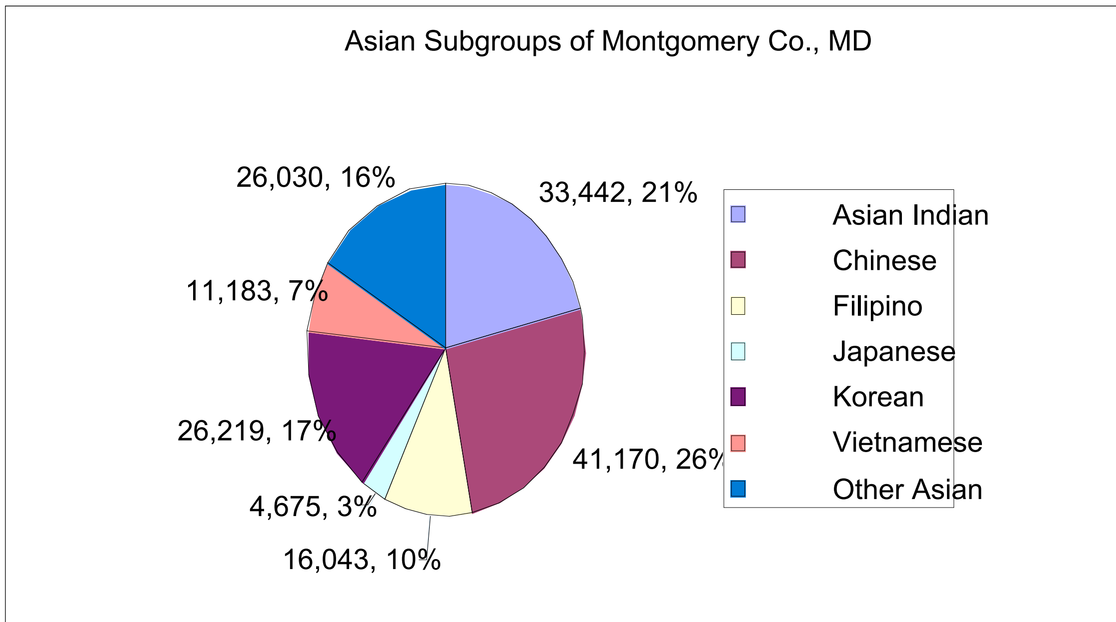
[1] *Federal Register*, October 30, 1997. http://www.doi.gov/diversity/doc/racedata.htm Accessed: Aug 28, 2005.
[2] 2003 American Community Survey Estimates for Maryland. http://www.mdp.state.md.us/msdc/dw_2003ACS.htm Accessed: August 28, 2005.

Figure 1:



NHW=non-Hispanic Whites B(AA) = blacks or African Americans

Figure 2:



Literature review

Due to a lack of State of Maryland or county-level data/analyses on Asian health, the following summarizes national data on Asian health in terms of preventive services, health outcomes, and quality of care.

A. Preventive Services

The lack of preventive care among many Asian Americans warrants closer attention. Compared to other ethnic groups, AAPI women in the United States have the lowest rates of cancer screening and are usually diagnosed at a later stage of cancer.[2] One study estimated that only 58.4 percent of adult AAPI women in the United States have had a Pap test within the past 2 years, the lowest rate of screening among all racial and ethnic groups.[2] Studies have shown that Korean, Vietnamese, and Cambodian women have low rates of cervical cancer screening as well.[3,4,5] Only 48.5 percent of AAPI women aged 50 and older in the United States reported having mammography or clinical breast exams in the past 2 years, which represented the lowest rate for breast cancer screening among all racial and ethnic groups.[6]

B. Cancers, Infectious and Chronic Diseases

The lack of preventive services may potentially contribute to the prevalence of cancers and certain infectious and chronic diseases, such as HIV infection, Hepatitis B and Tuberculosis in the Asian community. For example, cervical cancer was the most common cancer among Vietnamese women (43.0 per 100,000) in 1996, a rate that was five times higher than that of non-Hispanic White women.[7] Other form of cancers also disproportionately burden Asian Americans. For instance, the incidence rate for liver cancer among AAPIs is 13.8 per 100,000 - a rate that is substantially higher than that of Hispanics and Latinos (7.7), American Indians and Alaska Natives (6.8), African Americans (6.2), and Non-Hispanic Whites (4.2). In addition, the incidence rate of stomach cancer among AAPI populations is 18.5 per 100,000, which also is substantially higher than the rates among African Americans (13.9), Hispanics and Latinos (12.8), American Indians and Alaska Natives (10.4), and Non-Hispanic Whites (7.9).[8]

Infectious diseases that are particularly prevalent among Asian Americans have included HIV infection, Hepatitis B and Tuberculosis. Two separate studies have concluded that AAPIs were more likely to be diagnosed at an advanced stage of HIV disease,[9] and to be suffering from opportunistic infections at the time of diagnosis.[10] AAPIs account for over half of the 1.3 million chronic Hepatitis B cases and for half of the deaths resulting from chronic Hepatitis B infection in the United States. In 1999, AAPIs were 3 to 13 times more likely to die from liver cancer than Caucasians, with Chinese Americans at 6 times higher risk, Korean Americans at 8 times, and Vietnamese Americans at 13 times. AAPIs also have a higher prevalence of tuberculosis than all other racial and ethnic groups. Asian Americans accounted for 20 percent of all cases in 2003.[11]

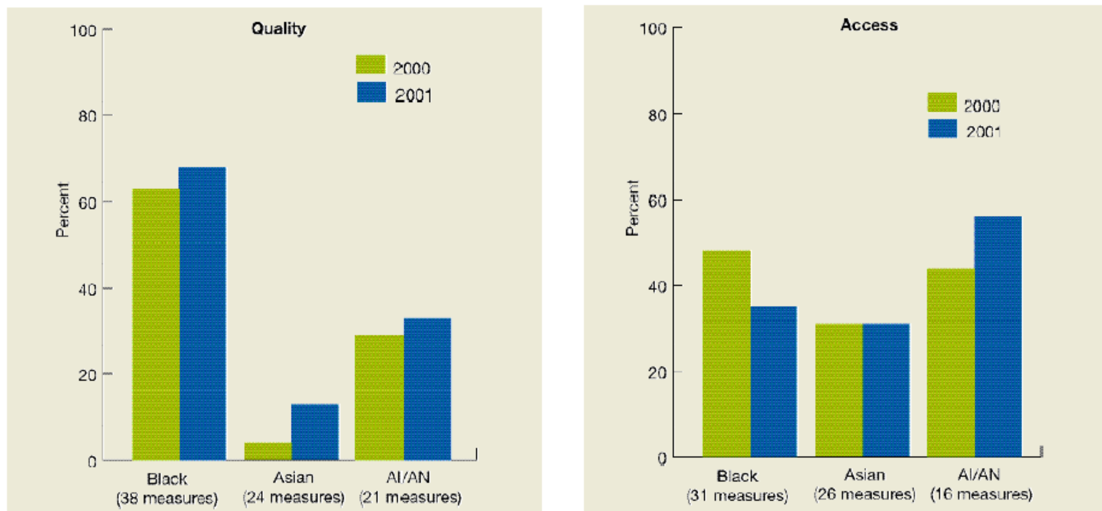
C. Mental Health and Suicide

Many Southeast Asian refugees are at risk of Post-Traumatic Stress Disorder (PTSD) associated with trauma experienced before and after immigration to the United States. One study found that 70 percent of Southeast Asian refugees receiving mental health care met the diagnostic criteria for PTSD.[12] In a study of Cambodian adolescents who survived Pol Pot's concentration camps, nearly half experienced PTSD and 41 percent suffered from depression 10 years after leaving Cambodia.[12] On the other hand, many AAPI cultures tend to stigmatize mental health problems, and very little has been done to address stigmatizing attitudes about mental illness in AAPI communities.[13] One study indicated that only 17 percent of AAPIs experiencing mental health problems sought care, and AAPIs tend to use complementary therapies at rates equal to or higher than Whites.[14] Due to the cultural practice and bias, suicide has emerged as a major health problem. A study conducted in 1997 found that suicide was the leading cause of death among Asian Indians aged 15 to 24, and Asian American women aged 15 to 24 had a higher suicide rate than did White, Black, and Hispanic women in the same age group.[15]

D. Quality of Care

One recent National Healthcare Disparities Report released by the Federal Agency for Healthcare Research and Quality released findings on quality of care by racial status based on 38 measures of effectiveness of health care and 31 measures of access to health care. According to these findings, Asians received a poorer quality of care than Whites for about 10% of the quality measures and had worse access to care than Whites for about a third of access measures.
Source: http://www.qualitytools.ahrq.gov/disparitiesreport/documents/nhdr2004.pdf

Figure H.1. Percent of measures for which members of selected racial groups experience poorer quality of care (left) or have worse access to care (right) compared with whites in 2000 and 2001



Source: SEER, USRDS, MEPS, CDC AIDS Surveillance System, NVSS-N, NIS, NHIS, NHDS, 2000-2001.

Note: Poorer quality of care and worse access to care indicate that for a particular measure, the group does not receive as high quality care or have as much access to care as whites and that the relative difference is at least 10% and statistically significant with $p<0.05$. Number of measures available for each group is indicated in parentheses.

In response to the growing Asian American population in its jurisdiction, the emerged health problems and needs associated with AAPIs, and charged with a mission of reducing health disparities between racial/ethnic minorities and the general population, the Department of Health and Human Services of Montgomery County, Maryland launched the “Asian American Health Initiative.” This program sought to develop an initial health needs assessment and database to assess the health related needs of its Asian American residents, particularly those who are low income and uninsured, and explore alternative approaches to alleviating health access barriers. This health needs assessment database will help the County to formulate and further refine a plan of action for the Asian American Initiative so that it is responsive to meeting those needs.

The following report first summarizes the findings of the focus groups and individual interviews that involved 61 local Asian American constituents and stakeholders. This is followed by meeting summaries of each of the seven Asian communities (Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, and Vietnamese), including community health issues, issues specific to subgroups (including seniors and children) and specific concerns (such as mental health care), community health resources available, and concludes with summaries and recommendations. The focus group guide and informed consent form used for focus group meetings are appended.

SECTION B: Executive Summary

Asian American Health Initiative
Community Health Needs Assessment

Background

Between October 2004 and February 2005, the research team of the Public Health Informatics Research Laboratory at the University of Maryland, College Park (hereafter, the Research Team) began to conduct needs assessment interviews among 7 Asian-American community stakeholders to assess their needs regarding access to health care in Montgomery County, Maryland. The present summary report includes preliminary findings as of February 15, 2005, consisting of the responses from 7 Asian-American communities.

By employing qualitative methods including focus group meetings and individual interviews, the Research Team used the research protocol approved by the Institutional Review Board of the University of Maryland (approved September 2004) to successfully gather information from 61 Asian community members that represented 7 Asian American (including Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, and Vietnamese) constituents of Montgomery County. See Table 1 for the methods of data collection and the numbers of enrolled subjects stratified by Asian subgroup. Participating Asian community members/groups were asked to provide their opinion on health issues such as their perceptions of the health status of their respective community, barriers to health care, concerns for special populations such as seniors and youths, and community resources that may assist in addressing the aforementioned issues. See Appendix A for the questions used in the needs assessment interviews, and Appendix B for the informed consent form.

Table 1: Participants in the Asian American Health Initiatives as of Feb 2005

Subgroup	Telephone interviews	Individual/Group interviews	Paper/pencil surveys	Total number of interviews	Total number of interviewees
Asian Indian	1	0	0	12	13
Cambodian	0	3	0	3	7
Chinese	2	3	1	6	8
Filipino	0	0	0	6	6
Japanese	0	0	0	6	6
Korean	2	1	3	5	8
Vietnamese	0	1	0	10	10
General*	3	0	0	3	3

Respondents in the “General” category were of Asian background, but they responded to the questions covering Asian community overall rather than focusing on a particular subgroup.

A wide representation of the Asian constituents of Montgomery County participated. Participants included leaders of senior centers, temples and churches, community resource centers, and youth organizations; physicians; and government employees. Many of these professionals worked in social programs or were health practitioners who have hands-on experience and first-hand knowledge of health issues confronting their respective Asian subgroups and the Asian community overall. The following report summarizes the common themes that emerged from the 7 Asian groups to date in this study.

A. Community Health Concerns

The three most common concerns across Asian American groups were lack of health insurance, language and transportation barriers, and a lack of funding to deal with health issues for Asian Americans in the County. In addition, the Research Team found that many Asian community members were not fully aware of the American health care system and as such were lacking information about health resources that were available to them, both of which might potentially prevent them from adequately accessing preventive and health care services.

In terms of disease, many diseases were common across Asian-American groups. Arthritis, cancer, diabetes, hepatitis, hypertension and stroke were common health concerns among many subgroups. Cambodian communities expressed the need for both physical and mental health care services that took into account refugee health issues, such as Tuberculosis (TB) and insomnia, particularly for senior women. Mental health care needs included treatment for Post-Traumatic Stress Disorder (PTSD) and depression as the result of former extreme political experiences in their countries of origin. Asian community members also seemed to either neglect or were less attentive to preventive care, possibly due to cultural barriers or lack of health insurance.

B. Particular Subpopulations and Health Concerns

B1. Seniors

For senior citizens, the most serious health problems were arthritis and hypertension and, particularly for senior women, insomnia. In terms of access to care, those seniors aged 65 or older have access to care through Medicare, and many working adults have access through employment-based insurance that may also cover their children through age 18. However, seniors who were less likely to have insurance included those who were: 1) retired (but not yet aged 65), 2) unemployed, 3) senior immigrants who did not have sufficient work history that would otherwise qualify them for social security, and 4) undocumented immigrants. The most significant barriers to care, in addition to the lack of

insurance, were the lack of 1) English language literacy, 2) communication competencies, 3) transportation, and 4) money for insurance and medical copays.

B2. Mental Health

For mental health, findings suggest that depression and suicidal thoughts were more common among the refugee populations compared with the other Asian subgroups. A particular emphasis should be placed on Vietnamese/Cambodian immigrants who came to the United States after 1975 who are at a higher risk of PTSD and have not received adequate screening or intervention. Many Asian seniors were at a higher risk of experiencing mental health problems possibly due to language barriers, isolation (especially among elderly people), and lower levels of acculturation. Some respondents mentioned that community members tended to be in denial of mental health conditions due to the social stigma associated with them. When asked from whom they would seek help if necessary, they stated that they would prefer to see health practitioners from their own cultural backgrounds.

B3. Child Health

For child care, the Vietnamese group mentioned that the Children's Health Insurance Program (CHIP) did not work well because of the quality of the services provided by the program, and it was difficult to find a doctor who could both provide culturally-sensitive care and accept the insurance provided by CHIP. Respondents also mentioned that different age groups of children have different needs, and at a minimum there should be a pediatrician who is knowledgeable of their native language who is available to provide services at the Pan-Asian Clinic for each Asian community.

C. Community Resources

In terms of strengths, most agreed that community strengths included the presence of volunteer doctors and nurses from the community, particularly Korean and Chinese clinicians. The community also has several active and trusted (either community or faith based) organizations. For example, the Buddhist temple holds events on three major Cambodian holidays and thematic meetings occasionally where community members can meet, seek counseling by talking to temple staff, and exchange information. In addition, senior centers, youth groups and community resource centers also hold routine events that enable their community members to exchange information. The fact that trusted community organizations may be more religious or social in nature may also indicate that they often were not equipped to provide adequate health and social services or assistance. On the other hand, existing community organizations

were interested in doing more, but lack knowledge on how to best meet health and social service needs or how to organize health-related programs effectively.

Many groups said that there were a lack of community organizations dealing with health issues among individual Asian minority groups; lack of health care providers and translators with the same cultural/religious background; lack of follow-up care after being identified as having health conditions in screening programs; and lack of long-term health programs for this group. In particular, many health-related community organizations lacked sustained funding that would allow them to continue and grow their programs to meet the increasing demand for services by the growing Asian population.

D. Use of Alternative Medicine and Health Information

In general, respondents contended that the use of alternative medicine and home remedies were common among the Asian population and preferable to the use of faith healers or Western medicine. Alternative medicine (e.g., herbal/Chinese medicine and oils) and modalities (e.g., acupuncture) were more affordable and more widely used by undocumented residents who typically pay cash for medical care. The uninsured or undocumented residents often used the emergency room as the last resort of care.

Respondents explained that health education materials were generally available only in the English language, and they requested that health education information be translated into their native language and be distributed to their members. Many groups were also in need of support and training in community program development. Some group members suggested that there was a need to conduct further research investigating the numbers of uninsured and other related burdens faced by this community.

E. Pan Asian Volunteer Clinic

The Pan Asian Volunteer Clinic was thought to be one of the best ways of dealing with health issues among Asian Americans. As they have become known and trusted, more and more patients have come seeking services. However, the clinic has not able to meet the need for health services due to limited hours, language barriers, and a lack of doctors and nurses. Many subgroups expressed an interest in obtaining information on the services provided by the clinic. To fully maximize its utility for the Asian communities, many subgroups that have expressed needs for care suggested that the County may consider expanding the services of the clinic to Cambodian, Vietnamese, Korean, and other Asian subgroups by hiring health professionals who speak in these languages. Having more clinicians and expanded office hours could also reduce the waiting list for treatment.

F. Other Issues

Within certain subpopulations (e.g., Cambodian, Vietnamese), relatively low income and education levels may prevent community members from buying health insurance. In addition, self-employed or business-owning people may not qualify for health insurance assistance and must pay out of pocket for health services. Working adults were seen to be at higher risk for health-related problems because of work and family pressures.

One temple group was concerned that they failed to obtain government funding to extend the services they are providing, possibly because of the 'separation of religion and state' statute. This group maintained that the social functions they organized not only served as regular social events but also provided a venue for counseling, information exchange and stress relief. The events may arguably serve the faith-healing purpose when health needs are not being fully met by existing social programs.

The youth organization group also expressed an interest in applying for funding to conduct research on the Cambodian community and provide services to younger Cambodian members. There appeared to be a need for the County to provide direction or resource kits with information on faith-based/minority health funding mechanisms. They could also provide technical assistance related to the grant preparation and submission process to meet this need. The Department of Public and Community Health of the University of Maryland may also collaborate with the County to prepare grant applications for this effort as needed.

SECTION C: Summary Results of Health Needs Assessment Survey

Ranking Method:

In order to quantify the health data collected to examine health needs, we developed a qualitative rating system to rate each health focus area. Each Asian subgroup is assigned a symbol to denote the standing/status of their responses in relation to other 7 groups. In specific,

- X is assigned when the specific Asian group is ranked "below average" (ranked <= 3) for that specific item (question);
- V is assigned when the specific Asian group is ranked "above average" (ranked >= 4) for that specific item (question);
- -- is assigned when the specific Asian group is ranked in the middle for that specific item (question).

Summary Results:

1. **Health status**: based on 5 indicators, *Vietnamese* group rating is the least favorable (x=5), followed by *Cambodian* and *Chinese* groups (x=4), and Korean group (x=3). AI, Filipino and Japanese groups rated very well (v=5).

2. **Health care access**: based on 7 indicators, *Korean group* rating is the least favorable (x=6), followed by *Chinese* (x=5), *Vietnamese, Cambodian and AI* groups (x=3), and *Japanese* (x=2). Filipino community rated very well (v=3).

3. **Senior care**: based on 2 indicators, *Korean and Cambodian* groups ratings are the least favorable (x=2), followed by *AI, Vietnamese, and Chinese (*x=1). Filipino and Japanese groups rated very well.

4. **Child care:** based on 2 indicators, *Korean and Chinese groups* ratings are the least favorable (x=2). This is followed by *Cambodian, Filipino and Vietnamese* groups (x=1). AI and Japanese groups rated fairly well.

5. **Health information availability**: based on one indicator, *Japanese group* rating is the least favorable. The other groups rated fairly well.

6. **Health concerns**: based on 6 indicators, *Vietnamese group* rating is the least favorable (x=6), followed by *Korean* and *Cambodian* (x=5) and *Japanese* (x=3), *Chinese* (x=2) and *Filipino* group (x=1). AI group rated fairly well.

7. **Language barrier**: based on 3 indicators, *Vietnamese, Japanese and Chinese ratings* are the least favorable (x=3), followed by *Cambodian and Korean* (x=2) groups. AI and Filipino groups rated fairly well.

Summary Table: Health Status, Health care access, language barrier, senior/child care, and health concerns

	AI (Asian Indian)	Cambodian	Chinese	Filipino	Japanese	Korean	Vietnamese
HEALTH STATUS							
Self-Rated Health	V	X	X	V	**V**	X	**X**
Self-Rated Child Health	**V**	---	**X**	V	V	X	X
Felt tired out for no good reason?	**V**	X	X	V	V	X	**X**
Felt Nervous?	**V**	X	V/X	V	V	---	**X**
Felt Depressed?	V	X	X	V	**V**	---	**X**
HEALTH CARE ACCESS							
Last visit to a doctor?	V	V	X	V	X	X	---
Latest dental visit?	--	--	X	--	**V**	X	**X**
Having received cancer screening	--	V	--	V	X	--	**X**
No health insurance is the primary barrier of access	X	--	X	--	--	**X**	---
Senior uninsured status	X	X	**X**	--	--	X	---
Senior day care a major problem to be addressed	--	X	**V**	--	--	X	**X**
General health uninsurance status	X	X	X	V	**V**	**X**	---
LANGUAGE							
	AI (Asian Indian)	Cambodian	Chinese	Filipino	Japanese	Korean	Vietnamese
Ability in speaking and understanding English	V	---	X	**V**	X	X	**X**
Language services is a problem for health access	V	**X**	X	---	X	X	X
Using English is the primary barrier of health	---	X	X	---	X	---	**X**

	AI	Cambodian	Chinese	Filipino	Japanese	Korean	Vietnamese
SENIOR CARE							
Senior uninsured status	X	X	**X**	--	--	X	---
Senior day care a major problem to be addressed	--	X	**V**	--	--	X	**X**
CHILD CARE							
Vaccine Availability	V	X	X	V	V	**X**	--

Child day care	--	--	X	X	V	X	**X**
HEALTH INFORMATION							
Health information availability is a problem	V	--	V	V	**X**	--	V
HEALTH CONCERNS							
Health Care Facilities Availability	V	**X**	V	V	--	X	X
Public transportation	--	**X**	V	V	V	X	X
Alcohol and drug use	V	X	V	--	X	**X**	X
Smoking	--	X	--	X	V	**X**	X
Domestic violence	V	X	X	V	X	X	**X**
Disease prevention	--	--	X/V	--	X	V	**X**

X = ranked the least favorable X= ranked below average V= ranked above average --- = ranked in the middle

Summary and Recommendations

Based on the expressed needs identified in this study, it appears that potential barriers for Asian Americans of Montgomery County in accessing health care and social services have included (but are not limited to): insurance status, language (lack of English literacy), culture, and community resources. Based on the preliminary findings, we recommend that the County consider taking the following steps to address these issues:

1. Provide long-term funding for existing, effective, and trusted programs so that these organizations can expand their hours and services.
2. Translate health education information into each native language on specific health conditions, use of alternative therapies, how to obtain health insurance, and how to navigate the American health care system. Provide information specific to the Asian community on Medicare eligibility and services, as well as low cost insurance options for those who are currently uninsured.
3. Develop a community resource guide for each group in their native language that includes a description of services, contact persons, directions, and hours. Provide a list of sliding scale, low-cost or free services available in the community.
4. Explore ways to improve transportation to services, such as using shuttle services, improving the routing of the MobileMed services, or enlisting volunteers to escort people to services.
5. Provide culturally appropriate mental health services where they can receive care from members of their communities. Set up targeted mental health programs and outreach for refugees to address mental health problems such as PTSD and depression.
6. Provide senior/community centers where health promotion activities can be conducted and seniors can congregate and support each other to reduce isolation and potential depressive symptoms.
7. Expand free health care services for the treatment of diseases identified in early detection programs.
8. Provide translators fluent in various languages at County-supported Clinics. Make a public schedule showing hours and services available.
9. Make health information available in trusted community organizations (churches, temples, etc.) in the native language of the populations, provide training programs for community organizations in making appropriate referrals, and capitalize on the routine events and services these organizations offer.
10. Collect data to describe the health status of the Asian community in Montgomery County on an ongoing basis and make available the results.

SECTION D. Focus Group Results

Meeting Summary for Asian Community Groups

Asian Indian Community Needs Assessment Summary Report
Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

Background

In December 2004, the research team conducted one focus group meeting and one individual interview to assess the health needs of the Indian-American Community of Montgomery County. More than thirty members joined the focus group meeting, among which twelve actively participated in the study. The interviewees (hereafter, this group) consisted of a fairly wide representation of the Asian Indian community in Montgomery County, including community leaders from a faith group (i.e., Hindu temple), health professionals, engineers, and academicians.

A. Community Health Issues

This group expressed needs similar to those expressed by other Asian communities in the County**.** In terms of disease or health related symptoms among this community, they expressed concerns about obesity, diabetes, neoplasm, heart disease, hypertension and high cholesterol. When asked to rate the most important health issues, this group rated lack of health insurance highest, followed by the lack of funding (for health related programs and activities), transportation, and language barriers respectively. In terms of access to health care, the members of the group responded differently to this issue. Those participants from the Hindu temple expressed more concerns about access to health insurance, while those members from the Indian professional group explained that they had fewer barriers to health care, perhaps due in part to their relatively higher socioeconomic status. They indicated that certain community members were at a higher risk of being uninsured, including 1) newly-arrived immigrants (e.g., those sponsored by their U.S. relatives and who had recently migrated here), 2) retired elderly people (had never worked in the United States and not yet reached 65 years old), and 3) the undocumented population. In terms of strengths, most agreed that the majority were well educated and highly literate. They also stated that this group has strong religious and professional organizations with a strong volunteer pool. Compared to other subgroups, the two groups interviewed in this study consisted of more affluent communities that do not have as many language barriers to health care. Many members of this group expressed the need for having an Asian Indian community center.

B. Particular Groups or Concerns

For senior citizens, this community believed that the uninsured and the ineligibles for Medicare faced the most serious problems. Particularly vulnerable members have included 1) the unemployed, 2) newly arrived immigrants who have no working history in America, and 3) retired senior citizens who were younger than age 65. They believed that depression and isolation were the most common problems among the Asian-Indian elderly.

Participants were also asked about specific needs for children in the community. They requested an affordable, reliable, and community-based (small business like) daycare program provided by the County government.

Mental health needs were not expressed as a serious problem for this community, which may be due in part to a cultural bias toward mental illness. The most common mental health issues included isolation and depression (due in part to cultural barriers, lack of transportation, etc.). However, compared with other racial/ethnic communities (e.g., African American), the Indian American community appeared to have the tendency to either neglect or be unwilling to acknowledge mental health issues. This finding was similar to other Asian subgroups and warrants attention.

This group expressed a preference for the use of alternative medicine to Western medicine. Alternative medicine (such as herbal medicine and oil) was more affordable and widely used by undocumented and uninsured residents where they paid cash to get care. Community members with insurance generally used Western medicine and visited their physicians on a regular basis. They recommended that insurance provides coverage for alternative medicine costs. Contrary to many other Asian subgroups, this community did not express the need for health education materials to be translated into their native Indian language.

C. Community Health Resources

Religious organizations (temples and mosques) are an important part of the community. Participants recommended that the County provide information on faith-based and minority health funding mechanisms. In addition, they suggested that the County ensure that service providers and researchers are culturally sensitive in dealing with the issues within this community.

D. Summary and Recommendations

Based on the results of the interviews, this group had fewer language or cultural barriers compared to those expressed by other Asian American communities in the County. They expressed a need for the County to enhance existing health promotion and communication activities, and preventive health services for this

community. Both groups suggested that the County provide outreach and social programs to guide the Indian community on issues such as where to get insurance and whom to talk to when they are facing health problems. They suggested that additional health education programs be offered to this community. Programs to be considered may include those that guide them on how to organize the community and those that provide nutritional consultation. Additionally, the group expressed a need for free services and available hours for public facilities (such as community centers from Montgomery County). They also articulated a need for resource support to provide health promotion activities such as Yoga classes to the community and to the general public. To address the issues of communication in health care, participants suggested that the County Government provide health information in paper or electronic newsletters to be distributed to the community on a regular basis. These newsletters may include announcements of health fairs and information about health insurance and health services that are available. The community also requested that the Pan-Asian Volunteer Clinic, a very well known and trusted organization among the Chinese community, extend their services to the Asian Indian community. This community expressed a willingness to share its health professionals (such as physician and nurse resources) to assist with other communities. In addition, this community expressed a need for a community center for its members. Lastly, the fact that the Indian American community appeared to have the tendency to either neglect or be unwilling to acknowledge mental health problems and thus warrants special notice. This may suggest the need for more culturally-sensitive, accessible screening programs for mental health problems for this and other Asian subgroups.

Cambodian Community Needs Assessment Summary Report
Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

In November 2004, the research team conducted a focus group meeting and 2 individual interviews to assess the health needs of the Cambodian-American Community in Montgomery County. Twelve community members participated in the interviews. The interviewees (hereafter, the group) consisted of wide representation of this community, including 3 leaders of a Cambodian Senior Center, 1 leader of a faith group (Buddhist temple), 1 coordinator of a community resource center (United Cambodian American Resources for Enrichment), and 2 leaders of Cambodian youth organizations.

A. Community Health Issues

The group expressed the need for both physical and mental health care that take into account refugee health issues. Physical health care needs include infectious/chronic disease control, such as Tuberculosis (TB) screening, diabetes and high blood pressure screening and treatment, and nutrition education and counseling. Mental health care needs include Post-Traumatic Stress Disorder (PTSD) and depression as the result of former extreme political experiences in Cambodia, including the loss of family members. The group suggested that there was no specific community-based preventive care addressing the needs of this group, and their needs might not be completely met by the services currently provided by the Pan Asian Clinic. In terms of access to care, those seniors aged 65 or older have access to care through Medicare, and many working adults have access through employment-based insurance that may also cover their children through age 18. However, those who are 1) retired (but not yet reaching 65), 2) unemployed, and 3) undocumented immigrants were at a higher risk of being uninsured. The number of uninsured persons within this community was unknown, however, one interviewee estimated it to be approximately 1/3 of the community. Most significant barriers to care, in addition to the lack of insurance, are the lack of 1) language and communication competencies, 2) transportation, 3) money for insurance and medical co-pays, and 4) a long waiting list for the Pan Asian Clinic, with some waiting for 1 _ to 2 months to see a doctor. In terms of strengths, most agreed that the Buddhist temple is one of the strengths of the Cambodian community. The Buddhist temple has a large number of volunteers. In addition, senior centers, youth groups and community resource centers also hold routine events that enable the community members to exchange information. The community also has a Washington based radio station broadcasting information specific to the Cambodian-American community in the US.

B. Particular Groups or Concerns

For senior citizens, the group believed that the most serious health problems for this population were arthritis, high blood pressure/cholesterol, and particularly for senior women, insomnia. For mental health, a particular emphasis should be placed on those who came after 1975 who are at a higher risk of PTSD and have not received adequate screening or intervention. Some respondents mentioned that a few community members tend to be in denial (of mental conditions) due to social stigma associated with mental problems, even though they are potentially at a higher risk. There was at least one Cambodian speaking psychiatrist who provides psychiatric counseling to this community. For child care, the group mentioned that different age groups of children have different needs, and at a minimum there should be a pediatrician who is knowledgeable of the Cambodian language available to provide services at the Pan-Asian Health Clinic.

C. Community Health Resources

The group contended that the use of alternative medicine and home remedies is more common than the use of faith healers within the Cambodian community. Alternative medicine (such as herbal/Chinese medicine and oils) was more affordable and is widely used by undocumented residents that typically pay cash for medical care. The uninsured or undocumented residents often use the emergency room as the last resort of care. For health education materials generally available in the English language, the group requested that health education information be translated in the Cambodian language, and be distributed to its members. The group was also in need of support and training in community program development. Some group members suggested that there is a need to conduct further research investigating the numbers of uninsured and other related burdens faced by this community. In terms of community resources, the Buddhist temple holds events on three major Cambodian holidays and thematic meetings occasionally where community members can meet, seek counseling by talking to temple staff, and exchange information. The Senior Center Group meets once a month and works actively with other groups (such as youth groups) on issues related to health promotion.

D. Other Issues

The temple group expressed concerns that they failed to obtain government funding to extend the services they are providing, possibly regulated by the 'separation of religion and state' clause. The Buddhist group maintained that the social functions organized by the group not only serve as regular social events, but also provide a venue for counseling, information exchange and stress relief. The events may arguably serve as a faith-healing purpose, especially when health needs are not being fully addressed by existing social programs. The

youth organization group also expressed an interest in applying for funding to conduct research on this community, and provide services to younger Cambodian members. There appeared to be a need for the County to provide direction or resource kits including information on faith-based/minority health funding mechanisms, or provide assistance related to the grant preparation and submission process. The Department of Public and Community Health of the University of Maryland may also provide technical assistance on grant application for this group when needed.

E. Summary and Recommendations

To address the issues of transportation and communication related to health care, it was suggested that health care clinics (such as the Pan-Asian Clinic) should extend their services to this community. It was mentioned that at least one staff member at the Pan-Asian Clinic can speak the Cambodian language. Additional resources may be considered to 1) hire translators/interpreters, 2) hire physicians and/or health professionals who are native speakers of the Cambodian language, 3) train community helpers, and 4) cover travel costs such as mileage reimbursement or travel vouchers to facilitate the provision of care to community members. In addition, there is an expressed need for the translation of existing County health resources into the Cambodian language for this group.

In terms of implementation, one interviewee suggested that *"the County (clinic) should have translators at least two days a week for set hours each day, and put out flyers to let them know and then more people will go because they will know that someone there understands them…. It may provide more information to the Cambodian community at the Temple and grocery store about health care services. The County should also provide some free (preventive) services".*

Several Cambodian community assets in Montgomery County, including the Buddhist temple, Senior Center, resource center and youth organizations may be capitalized upon as resources or act as liaisons between the County and the community. These community-based organizations seem to establish sufficient rapport, including trust and confidence, with the community members that they serve. It should be noted that the group indicated an expressed need for PTSD/depression prevention and treatment. Compared with other Asian subgroups, the need was seemingly higher and more pressing for this group, although it remains unclear as to how many people were at a higher risk than the others. Lastly, public health services provided by the Pan Asian Clinic to other Asian subgroups may be expanded to include this community more effectively.

Quotes of other interviewees who attended the focus group meetings[ASB1]:

"I believe that there should be more studies done on the Cambodian community. We have very little concrete resources to turn to in terms of research and such. We lack even something as basic as Cambodian population and demographics in the county, state and nation"

"Every time I read health surveys and such Cambodians are almost never included in the studies. I would like to see the county provide programs (or at least include our community in future studies) to do such research so that we can better assess the community and built programs to fit the needs"

"The Pan Asian Clinic at the moment while it is open to all, however, it only reached the Chinese community and only now reaching the Korean community both groups already overfilling appointments. Although there is a proposal to extend availability, this is still only a proposal and not a reality. Even with the additional one day a month, as you can imagine still will not be enough availability. So there is an urgent need to provide more programs and resources for the community"

"We need leadership and community development training as well as training in accessing government resources or even knowing what is available to us"

"I am extremely grateful for [the] research of the Cambodian Community. It is something that we desperately need in order to better our community. Thank you very much"

Chinese Community Needs Assessment Summary Report
Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

Between October and November 2004 the research team conducted 10 individual interviews to assess the health needs of the Chinese-American community in Montgomery County. The interviewees (hereafter, the group) consisted of a wide representation of this community, including physicians, a retired professor who previously worked in health field, leaders of faith groups, cultural and community service center workers, and government officials specializing in Asian health. The following report summarizes the findings based on these interviews.

A. Community Health Issues

According to the group, the diseases common to the Chinese American community have included diabetes, high blood pressure, indigestion, stroke, and liver dysfunction (e.g., hepatic carcinoma). Perceived health needs identified among Chinese Americans have included the lack of insurance and/or under insurance among low-income people. One interviewee contended that 42% of Asian Americans lacked health insurance. Among them, those who were most likely to be uninsured included those 1) working in restaurants or 2) the newly arrived elderly without enough work credits to qualify for Medicare and social security benefits. These uninsured residents often have to travel back to their home countries for care when the needs arise. Language, cultural and transportation barriers also make it difficult for them to access health care. In terms of language barriers, the group acknowledged that the County government has noticed the health problems within the Asian community, with 20 clinics for low-income populations in place. However, most physicians working in the clinics were either English speakers or Spanish speakers, which present a barrier for Asian American patients. It should also be noted that there is a lack of health data collection among Asian Americans, particularly in studies of diseases that confront Asian Americans most, such as cancer, heart disease and high cholesterol. In addition, care for the senior citizens has become an increased concern as the population of this community grows older. Some participants were concerned that the need for preventive services were not fully met by either the community itself or the health services provided by the County.

B. Particular Groups or Concerns

For the health care of senior citizens, many of the group members mentioned that the most common chronic diseases included high blood pressure, diabetes,

heart disease, and rheumatoid conditions. Common health care barriers of seniors included the lack of 1) health insurance, 2) language capabilities, and 3) transportation. The latter two together often lead to a sense of isolation and depression, which were known mental health issues common to many elderly immigrants. Chinese American people with mental health problems often avoided seeking help for fear of being stigmatized, which is a particularly sensitive issue in the Asian culture. In a related vein, there are few Chinese psychiatrists or mental health providers available to deal with the mental health issues. The Chinese community has voluntarily provided health education to address this issue, such as providing seminars with a health focus.

Most of the group members acknowledged that the Asian American Clinic supported by the County has provided health services for many seniors who may otherwise be denied health care. The group also provided suggestions for improving current services provided by the Clinic, such as the provision of Chinese translation services in the clinic and additional staffing of Chinese-speaking psychiatrists. Traditionally, Chinese people perceive taking care of the elderly at home as their responsibility. However, this attitude tends to change following acculturation. With the cultural shift, there does not appear to be an adequate number of nursing homes and culturally sensitive programs to meet the demand.

For child care, the group mentioned that members of the community are at increased risk of childhood depression and second-hand or passive smoking. The County government could improve the health of children by providing information to the community about how to insure their children and where they may seek help. For example, it may be useful to provide information about the Maryland Children Health Insurance Program (MCHIP). Health education opportunities through schools were suggested. Preventive health care for young children is also needed.

The respondents also discussed a particular dilemma confronting both the legal system and public health, namely the health of newly-arrived and undocumented immigrants. Among these populations, many are working in labor-intensive industries, and thus are usually subject to a higher risk of adverse health outcomes. In terms of serving the health needs of these populations, some practitioners contended that the government should focus not on an individual's immigration status but rather on their health status, and others have suggested that patients should be educated regarding which (health) programs require a legal immigration status. This information may be important for undocumented immigrants when attempting to access health care when necessary.

C. Community Health Resources

The group explained that valuable assets of this community have included the Pan Asian Volunteer Clinic, with many volunteer health practitioners, and faith-based groups (churches and Buddhist group, such as Tzu-Chi, the Buddhist Compassion Group) in the region. The community has a few local Chinese newspapers (e.g., the World Journal, the Epoch Times (DaJiYuan) News) and several weekend Chinese language classes (e.g., Hope Chinese Program) that may be used as venues of health information dissemination. In addition, several organizations for the elderly (e.g., Chang Qing She) provide health services to more than 500 senior members of this community. The Chinese Community Center also provides health education to its community members, such as free health seminars. The group suggested that the County provide free venues for community activities aimed at health promotion and additional funding to support volunteers and their health promotion activities. The community expressed genuine interest in working closely with the County to provide health services to Chinese and other Asian Americans.

D. Alternative Medicine

Several respondents provided interesting remarks on the use of Complementary and Alternative Medicine (CAM). One practitioner commented that, while Chinese medicine was more popular among Chinese Americans, acupuncture was more popular among persons of other races and ethnicities. One practitioner found that less than 20 percent of patients seeking alternative medicine in his practice were Chinese. This practitioner suggested that this was because most of the CAM modalities are not considered “medical” but “dietary” or “nutrient” therapies by the FDA. As a result, they are often not covered by insurance and patients have to pay out-of-pocket. The use of the CAM was also more popular among and trusted by the older generation. Users preferred it because of its low costs, and as such it was often used by undocumented immigrants.

E. Summary and Recommendations

In light of the aforementioned barriers to health care access, participants recommended that the County consider: 1) providing compensation for volunteer efforts, and providing training to community leaders in terms of health education; 2) recruiting bilingual social workers or health practitioners in the Pan Asian Health Clinic; 3) providing health education information to the younger generation, who might in turn influence behavior changes of the older generation; and 4) collecting and reporting health data among Chinese/Asian Americans, particularly of those diseases prevalent in the Chinese American community, such as cancers, Hepatitis and diabetes. They also suggested that the County set up a hotline and provide bilingual health services to this community. In terms of improving the services provided by the Pan Asian Clinic, it was suggested that the Pan Asian Clinic is very popular among Chinese community, and about 70%-

80% of its patients are the elderly and low-income, with the majority of patients being either underinsured or working in restaurants. However, so far the Pan Asian Clinic only has 8 Chinese physicians, thus the clinic cannot satisfy the needs of patients waiting to receive care. Additional health professionals should be recruited to meet the increased demands for the needed services. In addition, several Chinese organizations requested more resources to implement cancer screening programs, evaluations of existing health programs, and support transportation for all people in need. Finally, the County could include information about how immigration status affects access to health and social services within educational materials about those services. Lastly, interviewees provided helpful comments in implementing the AAHI project. For example, they suggested that AAHI staff work with community leaders (such as community center and/or faith-based groups) to coordinate efforts with the community, and if funding permitting, provide incentives (in the form of money or food) to recruit subjects.

Filipino Community Needs Assessment Summary Report
Research Team, Department of Public and Community Health
University of Maryland College Park

Background

In January and February 2004, the research team conducted one focus group meeting and two individual interviews to assess the health needs of the Filipino Community of Montgomery County. Six community members shared their insights into the health care access issues facing this population. Among them, four were physicians from the Filipino community. The interviewees (hereafter, the group) consisted of a fairly diverse representation of professionals within the Filipino community in Montgomery County, including two officials from County government agencies responsible for health and social affairs, three practicing physicians (specializing in pediatrics, OB/GYN and psychiatry), and one private sector press officer.

A. Community Health Issues

This group expressed needs mostly similar to those expressed by other Asian communities in the County**.** In terms of disease or health related symptoms of this community, they expressed concerns about diabetes, hypertension, high cholesterol, hepatitis, heart disease, arthritis (i.e., gout) and liver cancer. With reference to preventive health, the perceived needs of this group included hepatitis, pap smears, mammography, and mental health screening. This group discussed the lack of health insurance among the highest potential health access barriers, followed by the lack of transportation, health promotion/education related programs and activities, and the lack of knowledge of the health information and resources available to them. Health insurance status was reported as being associated with immigration status. In terms of access to health care, they indicated that certain community members were at a higher risk of being uninsured, including 1) newly-arrived immigrants (e.g., those sponsored by their U.S. relatives as new migrants here), 2) retired senior citizens (had never worked in the United States and not yet reached age 65), and 3) the undocumented population.

B. Particular Groups or Concerns

For senior citizens, this community believed that the uninsured and the ineligibles for Medicare faced the most serious access barriers. Senior citizens were confronting health problems such as high cholesterol, high blood pressure and osteoporosis, and were adversely affected by the lack of transportation. For women’s health, preventive services were lacking in terms of mammography, pap smears and prenatal care.

Participants were also asked about specific needs for children in the community. They believed that depression and emotional difficulties were among the most common problems in Filipino young children and teenagers, particularly among those from new immigrant families. Compared with other health priorities and conditions, mental health needs were identified as among the most important health problems in this community. Particularly at higher risk were those who had never received any screening and/or treatment. In terms of potential contributing factors, the group contended that a lower level of acculturation (for new immigrants) and cultural stigmatization towards mental illness may restrict mental health care access. Similar to other Asian subgroups, the Filipino American community appeared to have a tendency to either neglect or be in denial of mental health issues. This observation warrants attention for this group.

Similar to the utilization of Western medicine, alternative medicine was reported as commonly used in this group.

C. Community Health Resources

In terms of community strengths, most agreed that the majority were very family-centered and religiously-oriented. This community also appeared relatively independent, with strong values and expectations for educational attainment. This group has strong network of religious (such as Holy Cross Clinic) and professional organizations of 80+ organizations in the DC area, with a strong volunteer pool. This group has 2 local newspapers (Manila Mail and FilAm Image) and Filipino Cable TV that provide potential channels for health communication. In addition, compared with other subgroups, the Filipino community was much more fluent in the English language and had less language barriers to health care compared with other groups. In terms of the lack of community health resources, many members of this group expressed the need for a Filipino community center to provide preventive care, health education and follow through the continuum of care.

Religious organizations (primarily churches and mosques) are an important part of this community. Participants recommended that the County work with the faith-based organizations to provide health information. In addition, they suggested that the County ensure that service providers and researchers are culturally sensitive in dealing with the issues among this community.

D. Summary and Recommendations

Based on the results of the interviewees, this group seemed more independent, and had less perceived language barriers compared with other Asian American communities in the County. Expressed needs seem to center around health promotion, preventive services, and mental health screening and treatment. They felt that screening children was important, and bringing the families in and getting them involved would be a great help to the family and the community. One

potential challenge is to reach the most vulnerable population of the community, including undocumented community members. The group suggested that the County consider the "Linkage to Learning" model popular among the Hispanic community. This would include working with community organizations and social programs to provide outreach to the community regarding health care insurance access and medical providers. They suggested that additional health education programs be offered in schools and churches to this community, and to provide health information in paper or electronic newsletters to be distributed to the community on a regular basis. In the short term, the community requested that the Pan-Asian Volunteer Clinic, a very well known and trusted organization among the Chinese/Korean community, extend their services to the Filipino community. Several physicians expressed a strong interest in learning more information about participating in the Clinic activities. In the long term, this community expressed a need for a community center for its members. Lastly, the Filipino American community appeared to have the tendency to either neglect or be unwilling to acknowledge mental health problems. This was common across many Asian subgroups, and thus warrants special notice. This may suggest the need for more culturally-appropriate, accessible screening programs for mental health problems particularly within Asian subgroups.

Japanese Community Needs Assessment Summary Report

Research Team, Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

In February 2005, the research team conducted one focus group meeting and one individual interview to assess the health needs of the Japanese American Community in Montgomery County. The 6 interviewees included two community leaders of faith based organizations, and four new residents of the Montgomery County – among them many of their family members work for either federal health agencies or international organizations in DC.

A. Community Health Issues

In preventive services, health needs identified among Japanese Americans in Montgomery County have included screening services for breast cancer (i.e., mammography), prenatal care, diabetes and osteoporosis. Physical conditions identified particularly among seniors included hypertension and depression. One community member mentioned that the copays of dental treatment were prohibitedly high, suggesting a potential lack of access to routine dental screening in this community.

In terms of access to care, it was suggested that members of this subgroup have access primarily through employment-based plans. One particular challenge that prevented the Japanese community from accessing health care was a language barrier. Because of the language barrier, many members of the community had no idea of what types of health services were available to them, and as such, seldom took advantage of either preventive services or health care services. There are very limited health education materials in the Japanese language.

In terms of utilization of health services, oriental medicine utilization was less common in this community compared with other Asian communities in the County.

B. Particular Groups or Concerns

Common diseases reported among seniors were high blood pressure and depression, with the latter possibly attributable to isolation due to lack of acculturation. In terms of women's health, this community recognized that exams and screenings on a regular basis were very important to them, particularly in terms of prenatal care, mammography, dental care, and bone density exams.

C. Community Health Resources

According to American Community Survey conducted by the Census Bureau, it was estimated that approximately 3,000 Japanese Americans resided in Montgomery County in 2003. One community leader suggested that more than 80% of Japanese community members in Montgomery County are short-term residents who usually stay 2 to 3 years and then return to Japan. Many work for international companies or organizations headquartered in DC. It was estimated that 1/4 to 1/5 of Japanese community members work for federal health agencies, with most of them in their 30's or 40's with children at home.

There is a newly-established, faith-based Japanese community center in the Talbot Mall in Rockville, with several Japanese restaurants, grocery stores and a bookstore. Additionally, there are several dozen Japanese restaurants situated along Rockville Pike in Rockville. However, there is neither a local newspaper, radio station or cable TV program in Maryland, and no specific Japanese community-based organization taking a leadership role in dealing with the health issues of the community. A social service group "Japanese American Care Fund" and "Sakura Kyokai" were mentioned as the care providers available to provide culturally and linguistically appropriate assistance to this Community. Two pastors in this community are specialized in marriage counseling which has seen an increased need in this community due to the increased number of married couples with the husbands working in Japan and wives raising families in Maryland. However, there is no organization which provides an annual health fair to promote health among this community.

D. Summary and Recommendations

Based on the expressed needs identified in the Japanese community, it appeared that potential barriers of Japanese Americans of Montgomery County in accessing health care included: language barriers due to a lack of English fluency and literacy, culture, and community resources. Many of the community members (particularly new immigrants) were much less acculturated compared to other groups. There is an expressed need for screening and preventive services, as well as marriage and legal counseling. Based on the aforementioned findings, the County may consider allocating resources to translate health education information, including instructions for navigating health care services, into the Japanese language, and providing low cost insurance options for those that are currently uninsured.

This community has access to a new faith-based community center and a few business installations owned by community members. In addition, the group recognized that the community's strength or asset lies in the Japanese faith-based organizations. The church and community center serve the community members by providing English language training, and as a venue of retrieving and exchanging information. The church seems to serve as a point of contact,

both geographically and (to an extent) culturally, for reaching out to this community.

This group acknowledged the importance of the services provided by the Pan Asian Volunteer Clinic but was unaware of its service provision. Given that there is no annual health fair for this community, it may benefit the Asian community as a whole, and the Japanese community in particular to sponsor an Asian American Health Fair in the County. In addition, there seems an expressed need for the County to assist in recruiting Japanese-speaking physicians to serve at the Pan Asian Volunteer Clinic.

Korean Community Needs Assessment Summary Report
Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

In November 2004, the research team conducted one focus group meeting and five individual interviews to assess the health needs of the Korean-American community in Montgomery County. The 8 interviewees included four community leaders from the Korean Community Service Center, Korean American Senior Association, and Korean Resource Center respectively; two Korean physicians; one Korean pediatrician; and one Korean Oriental medicine practitioner. Three interviewees completed the questions at a health fair of Korean community in a church in Silver Spring, MD.

A. Community Health Issues

Physical health care needs identified among Korean Americans included infectious and chronic disease control, such as Tuberculosis (TB), Hepatitis B, diabetes, stomach cancer, hypertension, and hypercholesterolemia. Special health issues associated with this community included the identification of true TB cases and potential infection due to cultural practices. For TB screening, a unique challenge has presented in the identification of TB patients. Many Koreans were administered the Bacille calmette-guerin (BCG) vaccine in their home country. Individuals receiving the BCG vaccination tend to have a clinical manifestation of false positives, which makes the identification of true positives a challenging task. For Hepatitis B infections, one interviewee suggested that a potential route of transmission might be the sharing of razors used for shaving in Korean barbershops. Another potential source of infection might be the use of blood letting, which was an alternative therapy commonly performed by complementary care providers.

In terms of access to care, the lack of health insurance was suggested as the principal barrier. One interviewee estimated that although most of the elderly have Medicare, about 20 percent of seniors have no health insurance before they become eligible for Medicare. Many Korean-American small business owners do not want to buy private health insurance. It was suggested that the lack of insurance is not due entirely to monetary constraints, because some Koreans avoid buying medical insurance while betting on the chance of not needing to use it. However, when they do get sick, they tend to seek help from the community. Some Koreans, especially new immigrants, are unfamiliar with the American health care system. Some are hesitant to use health services because of the misunderstanding that frequent use of health care and poor health records could affect their immigration and citizenship applications. Some employers may take advantage of this widely-held misconception and do not provide health

insurance. Illegal immigrants especially are not likely to use health services due to their fear of deportation.

Another barrier that prevented Koreans from accessing health care was the presence of a language barrier. Because of the language barrier, many members of the community did not know what types of health services were available for use and as such, seldom took advantage of the health care services. There were very limited health education materials in the Korean language. Health information provided from the government did not meet specific needs of Korean Americans and did not address their practical problems. Possibly due to the language barrier and lack of information, many Koreans lacked awareness of disease prevention and screening services. Several community leaders argued that they paid the same amount of tax as other ethnic groups but got less health benefits from the government. They expressed a need for state-sponsored, ongoing health projects to help the Korean community.

The group recognized that the Korean community's strength lies in the Korean church. Many members of the Korean community are very church-centered. Many of them would like to use churches as a venue to retrieve and exchange health information. If churches could get involved in health education, it would be an important partner in dealing with health issues for this community. The County should be aware of the church's potential role in health interventions. Some community leaders mentioned that the health services provided by the Pan-Asian Clinic were very good. However, a lot of Korean patients were unaware of the clinic and its service provisions.

Another characteristic of this group is that the Korean community maintains health by using both alternative medicine and Western medicine. Seniors are interested in staying healthy and care about healthy eating and nutrition. Oriental medicine (e.g., herbal medicine and acupuncture) is popular. Most alternative care practitioners are certified. There was an understanding that both Western and Oriental healthcare have a place in medicine. However, some Korean doctors were concerned about the possible interaction between Western medication and complementary medicine modalities.

B. Particular Groups or Concerns

Common diseases reported for seniors were cancers, diabetes, high blood pressure, and stroke. Senior Korean Americans contended that they would prefer an integrated health service model that combined alternative medicine and Western modern medicine using different medical approaches. Seniors usually require a higher level of physician-patient communication and more attention from doctors. Young Korean doctors should be trained to care for Korean patients' needs. Because of transportation barriers, the elderly sometimes had to ask for rides from the Korean Community Center. Due to language barriers, seniors needed family or friends to translate during their physician visits even

when the latter were often not medically trained. They had no systematic information providers, such as a local newspaper in the Korean language. However they did listen to a radio program from which they would hear public service announcements and health information. The Korean Senior Center seemed to be a good place for the elderly people to deal with their health issues. The Center provided some college-level classes and English instruction, and invited guest speakers, such as doctors, to talk about nutrition and health issues. Courtesy meals were provided in the Senior Center.

In terms of childcare, this community recognized that exams and screenings on a regular basis were very important to children's health. It has been difficult to track children and ensure that they come regularly for check-ups. Many parents only took their children to clinic when they were sick or when immunizations were required. A good proportion of daycare for Korean children was provided by their grandparents since other daycare options were limited. This situation may result in speech and developmental delays because of lack of developmental stimulation when children in homecare tend to spend too much time watching television. Developmental issues may affect newborns and those less than 2 years old. There was stigma associated with developmental delays among children in the Korean community. Those parents with children affected by developmental disabilities tend to avoid seeking help even when special programs are available.

In terms of mental health, many Koreans were experiencing depression, and some seniors suffered from dementia. Family members might attempt to hide these cases or feel ashamed to tell others. They thought mental problems were untreatable and resisted seeking or receiving treatments. Sometimes patients only used prayer to cope with mental problems. In addition, limited mental health services were offered in the Korean language, which may have also prevented patients from seeking help.

C. Community Health Resources

It was estimated that there were approximately 200,000 Koreans in the DC area and about 15,000 in Montgomery County. However, no specific Korean organization has taken a lead role in dealing with health issues in this community. Health research programs available in the community were far from meeting the health needs of this group. The Korean community took limited action in dealing with this situation, partially due to financial constraints. Doctors and churches provided an annual health fair for the uninsured. The respondents stated that getting help and funding from the County to coordinate the events would improve the health status of this community. The community leaders also thought that it would be helpful if the County provided training to community organizers in terms of health care services.

D. Other Issues

Other health issues for the Korean community included: 1) drug use, including adolescent drug use; 2) domestic violence; 3) drunk driving; 4) smoking among both males and females; and 5) suicide.

E. Summary and Recommendations

Based on the expressed needs identified in Korean group, it appeared that potential barriers of Korean Americans in Montgomery County in accessing health care included (but were not limited to): insurance status, language barriers, (lack of English fluency and literacy), culture, and community resources. Based on the aforementioned findings, we recommend that the County consider providing long-term funding for the Pan Asian Clinic and Korean community organizations, translate health education information into the Korean language, provide low cost insurance options for those that are currently uninsured, and plan for targeted mental health programs.

Vietnamese Community Needs Assessment Summary Report
Public Health Informatics Research Laboratory
Department of Public and Community Health
University of Maryland College Park

On December 7, 2004, the research team conducted a focus group meeting to assess the health needs of the Vietnamese-American community in Montgomery County. Ten community members participated in the focus group interviews. The interviewees (hereafter, the group) consisted of the president and board members of the Maryland Vietnamese Mutual Association (MVMA), two officers working in Montgomery County government, and one health researcher from a company specialized in health business (Solutions Linx).

A. Community Health Issues

Common health problems among the Vietnamese community that were mentioned by the group included diabetes, domestic violence, hypertension, hepatitis B, a high prevalence of cervical cancer in women, and a lack of disease prevention. The group expressed concern about the lack of health insurance among the elderly, undocumented immigrants, and those who were unemployed. In addition, the group mentioned that those who were self-employed may not be eligible to receive Medicaid, and could not afford to pay health care costs. The Regional Service Center assists people in becoming eligible for Medicaid. Even though Medicaid provides coverage for the poor, some health care providers do not accept Medicaid. The group also mentioned that people do not opt for Part B because it requires an additional deduction of Social Security Income and reduces their take-home salaries. As a result, people end up going to the emergency room when a problem arises. It was noted that on November 30, 2004, the Department of Social Services cut back on some insurance programs and services.

The existing health services provided by the County (i.e., the Pan-Asian Clinic and Mobile Clinic) still cannot fully meet the health needs of low income Vietnamese and those without insurance. MobileMed (available on Wednesdays) costs between $5-8 per visit, but patients must be assisted by their own translators because there was no translation available. Furthermore, people have a very long wait for these services. A very small fraction of Vietnamese received health screenings and follow-up treatment. However, for those who did receive screenings, many did not seek follow-up treatment or prescriptions for identified diseases because they could not afford treatment costs. Language and transportation were also barriers that prevented Vietnamese from seeking follow-up treatment.

In terms of access to care, those seniors aged 65 or older have access to health care through Medicare, and many working adults have access through employment-based insurance; however, some insurance policies do not cover their spouses, and they end up paying out-of-pocket to pick up the costs. The most significant barriers to accessing health care were: 1) a lack of health insurance, 2) language and communication difficulties, 3) lack of transportation, 4) little money for insurance and medical co-pays, and 5) long waiting lists for the Pan-Asian Clinic and Mobile Clinic (e.g., some waited for more than a month for physician visits).

B. Particular Groups or Concerns

For senior care, a particular problem was a need for health insurance. Some have Medicaid or Medicare while the others do not have any health coverage. When they did not have health insurance, they used whatever resources they could. Dental care was an important health issue among the elderly population because it was not covered by Medicare. Dental care costs are very expensive when paying out-of-pocket, so many do not go to the dentist for this reason. The elderly population also needs health education, because they are unaware of the medicine and resources that are available. Many elderly Vietnamese cannot speak English, so there was a language barrier. The group suggested hiring multilingual individuals in the Pan Asian Clinic who can speak the Vietnamese language who could translate, which would help alleviate the language barrier.

The elderly population also experienced isolation problems. Many elderly people stayed home by themselves, so it was difficult for them to interact with people. Isolation could cause mental health problems because the elderly may feel trapped in their own homes. The group suggested starting a community center for seniors. For mental health concerns, a particular emphasis should be placed on Vietnam-War-Era soldiers. The Multicultural Project has Vietnamese psychiatrists and therapists on its staff, but there was a long waiting list for appointments. In addition, many people were reluctant to admit that they have mental health problems and would not seek treatment.

For child care, the group mentioned that the Project CHIP did not work well because of the quality of the services provided by the program, and it was difficult to find a doctor who could both provide culturally-sensitive care and accept the insurance provided by CHIP. Furthermore, children were running away from home because of the lack of communication between the two generations (e.g., children become acculturated). Common to the culture of many Asian immigrants, many Vietnamese parents also had high expectations of their children to do well in school, which could be stressful for the children.

C. Community Health Resources

The group contended that the use of alternative medicine and herbal remedies was more common than the use of faith healers. Interviewees stated that Vietnamese physicians in Montgomery County used mostly herbal medicines compared to Western medicine. For most health education materials generally available in the English language, the group requested that health information be translated into the Vietnamese language. In terms of community resources, there was an annual Health Fair in the Vietnamese community. Many people were unaware of the Health Fair and did not have transportation to it. The group stated that funding was needed to provide more services through the Health Fair and to advertise this event to the community.

D. Other Issues

The group further acknowledged the need for the study to go more in-depth and to be conducted on an ongoing basis. They suggested that more community representatives (such as professionals in the medical field) should be involved in the interviews. In addition, more money and time was needed to find more participants to identify other health needs in the Vietnamese community. Flyers could be useful in promoting the project as well as local Vietnamese media (e.g., radio, TV, and websites). In terms of the implementation of the AAHI projects, the group contended that in order to assess health needs continually, conducting several sessions with each Asian-American subgroup in the community may be a better way of approaching the AAHI project. They cautioned that by completing the focus group interview with only a small group of Vietnamese, the responses were limited in scope and should not be overgeneralized as the complete depiction of the health needs of the Vietnamese community in Montgomery County.

E. Summary and Recommendations

The main health concerns expressed by the group were a lack of health insurance among 1) the elderly, 2) undocumented immigrants, 3) the unemployed, and 4) self-employed individuals ineligible for Medicaid who could not afford health insurance. The group also mentioned several barriers to accessing health care in addition to a lack of health insurance, including language and communication competencies, transportation, and money for out-of-pocket health care costs. The group expressed concerns regarding the Pan Asian Volunteer Clinic because they were not fully meeting the needs of low-income and uninsured Vietnamese, primarily due to the lack of language translation and the waiting times were long for these services. Other concerns have included those who have received screenings, many did not seek follow-up treatment for identified diseases because they could not afford treatment and prescription costs.

The group suggested that the County capitalize upon Vietnamese community organizations in Montgomery County as resources or as liaisons between the County and the community. In addition, they recommended that the County fund long-term projects in order to provide health care assessments and services on a continuous basis. They saw the AAHI project as an important point of departure for understanding the health needs of the Vietnamese community in Montgomery County. Focus group participants suggested that (the establishment of) a community center for this group could serve as a central point of contact for the provision of health information. In addition, a senior center is needed for the elderly, who could otherwise be isolated. Finally, the health care services provided by the Pan-Asian Clinic should be expanded to other Asian subgroups by including multilingual health professionals in the clinics in order to serve each group more effectively. Furthermore, the annual Health Fair needs additional funding to provide more services and to advertise the event to the community.

Appendix A

Asian American Health Initiative:
Focus Group Guide for Community Stakeholders

1. Introduction

Hello, my name is _______. Thank you for taking time to talk with us. Today we are holding <a focus group or an interview>. I will be leading this <focus group or interview>, and ____(name of recorder) will be taking notes. This focus group (or interview) is part of a research study being done at the University of Maryland, College Park.

The Public Health Informatics Research Laboratory of University of Maryland, College Park is assisting Montgomery County Health and Human Services to study health needs among Asian American communities in Montgomery County. The purpose of this interview is to gather information on a broad range of priority health issues, barriers to health services, health and social service needs, and community assets among Asian populations in Montgomery County. Your participation is very important to the success of this project. Your feedback in the meeting will be combined with other information to help us identify key issues and concerns to be included in a health survey questionnaire. The questionnaire will be later administered in the Asian community of the County. The results of the survey will inform County health officials of key issues related to health needs that will then be communicated to policy makers of the County. The results will also be used to compile a community health database for Asian Americans in the County. The database will be used to assess the health needs of this group and, based on the needs identified, may be used to allocate resources to this community.

Your name or any other identifying information will not be included in the report. All information will be kept confidential. Your participation is voluntary, and you may decide to stop at any time. If you decide to stop you will not be penalized in any way. If you have questions or don't understand what I am asking at any time, please let me know and I will explain further.

The most important thing is to be straightforward and honest. We are interested in your opinions, and different opinions are welcomed. There are no right or wrong answers. Please feel free to say whatever you are thinking.

<FOR FOCUS GROUPS> I would like to ask that you speak one at a time and that everyone participate. I'd like everyone just to say their first name or a nickname they'd like to use during this session. We'd also like you to complete this statement:

"One thing that members of <asian subpopulation> do well in protecting their health is ____________(fill in the blanks)."

For example, "One thing that members of <asian subpopulation> do well in protecting their health is eat many vegetables daily."

The interview may take less than 2 hours. In order to take notes in the most efficient manner while truly representing your comments, we would like to tape record the interview. Is that right with you?

2. Responding to Community Health Issues

- What do you think that the Asian community (specify) thinks of their health needs?
- What are the most important health issues of the (specify) community in Montgomery County? Are these issues being addressed adequately? How?
- What is the level and type of access the Asian community (specify) has to health care services? How does this access compare to the access of other communities?
- What do you think are the most important/significant barriers (social, economic, cultural, etc.) that prevent Asians, such as yours (specify) from
  - knowing about the health care services available to them?
  - using the health care services?
  - meeting their health needs with the health care services?

3. Responding to Elderly Care and Mental Health

- In terms of elderly care, what are the most important health issues of the (specify) community? Are these issues being addressed adequately? How can we make improvements?
- In terms of mental health, what are the most important health issues of the (specify) community? Are these issues being addressed adequately? How can we make improvements?

4. Responding to Community Health Resource

- What roles do Asian Americans such as yourself (specify) play in dealing with health issues? What role do you think that Asian community (specify) should play?
- What are your community's strengths? What strengths do they have in terms of health and health care?
- If your community (specify) had health issues to deal with, where would they want to seek help? Who would they like to talk with? And why?
- What groups need to have input into a study of health issues of Asian Americans (specify) in Montgomery County?
- Are there any specific individuals you know of that we need to contact as part of this process? Or do you know specific contacts at organizations or within the Asian community (specify) who can help us identify the health needs and solutions?

- In addition to existing programs/partnership the county has with the Asian community such as yours (specify), do you know any programs that promote health issues among the Asian community?
- Are there any other assets that could be leveraged or applied to address your community's health concerns?

5. General Questions

- What advice would you give to the Asian American Health Initiative about how to identify the health needs of Asian Americans (specify) in Montgomery County?
- What is your advice about the best way to survey members of your community (specify)? Where can we reach them?
- What areas may the existing programs/partnerships of Montgomery County Health and Human Services be improved to better serve the Asian Community such as yours (specify)? How might the health department help your community address its priority health issues (specify from question 2)?

6. Thank you and Close

Thank you very much for helping use today. We are going to analyze the information we get from the interviews. With your permission, we would like to contact you in the future to consult with you on the direction of the needs assessment questionnaires. Thanks again for your assistance.

Appendix B

Informed Consent Form For Asian American Health Initiative

Project Name	Asian American Health Initiative - Developing a Community Health Surveillance Database for Asian Americans of Montgomery County, Maryland
Participant Age	I am at least 18 years old, and wish to be part of a study being done by Chiehwen Ed Hsu, PhD, Nancy Atkinson, PhD and Robert S. Gold, PhD, DrPH, who are part of the Public Health Informatics Research Laboratory, Department of Public and Community Health at the University of Maryland, College Park.
Study Purpose	The purpose of this focus group meeting is to collect information associated the needs of health care access involving Asian community in Montgomery County. I will provide feedback to the researchers about my perceptions and experience of the issues.
Study Activities	The discussion will last about 2 hours. I understand that I will be asked to provide my opinion about health care access issues involving Asian communities. The researchers will take notes and audio-tape the session so they can accurately report my opinions.
Confidentiality	All information collected in this study is confidential. Any personal information about me (like my name) will not be shared with anyone who is not a member of the research team. I understand that the opinions I provide will be combined with other's opinions and my name will not be used. My name will not be written in the notes or in any documents with information that I have shared. Information will be kept in a locked file drawer and only used by University of Maryland research staff. Audio-tapes will be kept in a locked office and only University of Maryland research staff will be allowed to use them.
Risks	I understand that participating in this project involves a level of risk similar to ordinary daily experiences.
Benefits, Freedom to Withdraw, & Ability to Ask Questions	I understand that this study is to help people living in my community, not me personally. I am free to ask questions, to not answer a particular question, or stop my participation at any time without penalty. If I decide not to participate or do not want to answer some questions, it will not affect my interests and wellbeing.
Contact Information of Researchers **Contact Information of Institutional Review Board**	University of Maryland, College Park, MD, 20742 Nancy L. Atkinson, Project Investigator Telephone: 301-405-2522 Email: atkinson@umd.edu Robert Gold, Project Investigator Telephone: 301-405-2441 Email: rsgold@umd.edu Chiehwen Ed Hsu, Project Director Telephone: 301-405-8161 Email: edhsu@umd.edu If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: **Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) irb@deans.umd.edu; (telephone) 301-405-4212**

Printed Name ______________________________

Signature _________________________________ Date______________________

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