GREATER CINCINNATI ASIAN AMERICAN NEEDS ASSESSMENT

2010

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AN ASSESSMENT OF HEALTH CARE AND OTHER NEEDS OF THE ASIAN AMERICAN POPULATION IN GREATER CINCINNATI.

Asian Community Alliance

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For a copy of **The Questionnaire (in English, Chinese, Korean, and Vietnamese)**, please visit **http://www.acacinci.org**/

Executive Summary

1. Purpose and Background. This is a preliminary assessment of health care and other needs of the general Asian American population in Greater Cincinnati. The purpose is to identify possible areas neglected in order to advocate for more and better services.

The inadequate and conflicting reports about Asian Americans' health and socioeconomic conditions, as well as their generally underutilization of services, have been linked to the delay of systematic planning of health and human services. Meanwhile, existing public policies and community advocates alike, tend to focus on the needs of the most recent immigrants, the frailest, and/or the poorest of the population. As more Asian Americans are born and age in this country, a broader perspective of a wider spectrum of needs is in order.

2. Methodology. This report integrates recent demographic estimates, literature reviews from particularly two recently published collections on Asian American health issues, and results of a non-representative sample survey.

A highly structured questionnaire, in four languages, was distributed through various Asian American groups in Greater Cincinnati from winter 2009 to spring 2010. The anonymous response of **472** individuals were collected at site or mailed back with a stamped envelop.

3. Socio-demographics. Based on Census and American Community Survey data, the Greater Cincinnati Asian American population is estimated to **continue growing faster than that of the total population** in the area. A much larger proportion of the Asians are in the economically productive age. Their family income is higher, so is their family size and education attainment. The proportion of low-income Asian families is as large as that of all families in Cincinnati but much smaller as that in Hamilton County. There are more female than male, particularly in the 18-64 age range in the City (1.42 women to 1 man).

Respondents to this survey also have higher education attainment: 95.7% have at least a family member graduated from high school, 68.5% with a BA/MA, and 23.0% a doctorate degree. High education, however, does not guarantee high income, as 10% of the families with at least a doctorate degree holder are in poverty, and fewer than 40% have a family income over $100K.

4. Three subgroups instead of dozens. Asian Americans are very diverse. Respondents in this survey speak 25 languages at home. Having too many small categories presents difficulty in statistical analysis, policy development and program planning. The most efficient and practical way to classify Asian Americans is by three subcategories in accordance with their **eco-**

nomic condition. Economic condition, as shown in hundreds of tables analyzed for this survey, is also the most consistent and often the strongest independent variable in differentiating conditions, attitudes, behaviors, and needs of the respondents. The three groups are:

- **a)** **The low-income group** (26.0% of the respondents) is a group whose economic condition is below federal poverty level, are more likely to be below 25 years old, men, living in the U.S. for shorter than 5 years, and have no college graduate in the family.
- **b)** **The high-income group** (18.4% of the respondents) is a group whose family income exceeded $100,000 last year. Their characteristics tend to be the reverse of that of the low-income group.
- **c)** **The middle-income group** (55.5% of the respondents) is a group whose characteristics tend to be between the high- and low-income groups.

5. **The Analysis Scheme.** In addition to economic condition, four more **independent variables** (**age, sex, education, and years of living in the U.S.**) are systematically studied in terms of their relationship with **seven sets of dependent variables**:

- **a)** **Health knowledge and attitude** toward Type 2 Diabetes, heart/vascular problems, and Hepatitis B;
- **b)** **Health and risk behaviors** (exercise, smoking, drinks, and drugs);
- **c)** **Health conditions** (blood pressure, blood sugar, cholesterol, 10 physical and mental health conditions);
- **d)** **Medical treatment behaviors** (number of doctor visits, non-compliance issues like not taking full dosage and using Oriental Medicine simultaneously);
- **e)** **Prioritization of needs** (in 21 areas); as well as
- **f)** **Support system** (health insurance and contacts for help).

6. Health Knowledge and Attitude. All subgroups have a correct notion about cholesterol and **heart/vascular problems**. The low-income group members are more likely to have a wrong belief and/or have no knowledge about **Type 2 Diabetes** and **Hepatitis B**. Families with middle-income, with a college degree or higher, including some with a doctoral degree holder, are not immune to misconception or ignorance about T2D and Hepatitis-B.

7. Health and Risk Behavior. Men, the poor, and the lower educated groups **drink** and **smoke** more. Mid-age, middle-income groups are most likely to do no exercise at all, and are also slightly more likely to use **drugs** not for medical purposes.

8. Health Conditions. A much larger proportion of respondents in poverty do not know about their **blood pressure, sugar, and cholesterol levels**. The proportion of high cholesterol level among middle-income respondents is the highest (33.8%). Moreover, many of them do not know about their

blood sugar (6.5%), cholesterol level (6.9%), and blood pressure level (2.7%). Cholesterol is also high in the high-income groups (32.4%).

The low-income group is more likely to have suffered from **stress, anxiety, depression, Hepatitis B, heart conditions, and allergy/asthma**. The higher income groups are more susceptible to **T2D**. A substantial proportion of them are suffering from **mental conditions and allergy/asthma**.

9. Number of Medical Visits. Over 1/5 of the poor made no medical visit in a year. About 1/10 in the high-income group also did not, although no one in this group is uninsured. The most frequent medical visitors are in the middle-income group.

10. Non-compliance. The effectiveness of medicine is at least occasionally questioned by over 1/2 of the respondents in the low-income, 1/3 in the middle-income, and 1/4 in the high-income groups. Over 1/2 of the low- and mid-income groups are at least occasionally afraid of the adverse side effects of prescribed medicine.

Over 1/10 of the low- and middle-income groups do not always buy all of the prescribed medicine, 1/4 of the middle-income group do not finish taking all of the medicine purchased, 1/5 of the middle-income group do not take the full dosage. About 3/10 of the middle-income and 1/5 of the high-income group use Oriental Medicine alongside with prescribed medicine, at the same time.

11. Self-assessed Needs. Twenty-one areas where Asian Americans may need help are ranked in terms of the combined proportion of respondents who say their family "urgently need help" and "need help" in each area. Between 7.0% to 46.1% of the respondents say their family is in need of help in at least one area. The 21 areas are classified into **six clusters**:

Health/medical care is by far the area most Asian families need help, as nearly half of them need it, including 1/6 who need it urgently. The needs to cope with mental health, disability, drug/substance abuse are substantial even though they are likely to be under-reported.

The identification of **social needs** indicate the desire to come out from social isolation. Over 1/3 of the respondents want more socialization and volunteer opportunities, nearly 3/10 want to improve neighborhood relationship, and 1/5 want to increase access to politician.

New immigrant needs are still important, as close to 2/5 of the families have at least one member who wants to attend an English class, while 3/10 of the families need help in interpretation/translation. About 1/5 – 2/5 need help in legal/immigration issues.

Among **environmental issues**, safety is the most serious one as over 1/3 of the respondents are concerned, while public facilities (like gar-

bage removal) bother 1/5 of them. Close to 1/4 of the respondents need help regarding housing affordability and housing quality.

Regarding **employment**, nearly 1/3 of the respondents have a family member who need help in job training or/and finding a job.

About 1/4 of the families need help in **elder care**, and 1/6 needs help in **child-care**. Possible explanations for the relatively lower need for help in family care include the traditional Asian value of family responsibility and the larger Asian family unit.

In almost all 21 areas, economic condition is the most consistent and often the strongest predictor. Respondents in poverty generally need help the most. The proportion of middle-income group member who need help in most areas is still substantial, particularly in mental health. The high-income group is not immune to difficulties, e.g., 1/5 need help in health/medical care and socialization. Prioritization is different between and within income groups. Education and length of living in the U.S. also have substantial ties with needs, which are often stronger than the ties between age and sex with needs.

Even under financial difficulty, child-care is the area least likely for respondents to skip; followed by mortgage, rent, and utilities; then medical and medication. Vacation, dental service, and housing repairs are most likely skipped.

12. Health Insurance. Among all respondents, **1/6 are uninsured**, **nearly 1/2 are insured through employment**, about 1/7 pay premiums from their own pocket, **1/8 have Medicare**, and **1/18 receive Medicaid.**

The uninsured-rate is 42.6% in the low-income group, 11.2% in the mid-income, and zero in the high-income group. Only 1/12 in the middle-income group has public insurance, who are mostly elderly through Medicare.

College graduates are more likely to be insured through employment. However, there are a few with a doctorate degree uninsured or receiving Medicaid. The shorter the length living in the US, the more likely one is uninsured. The mid-aged are more likely to have employment insurance, compared to only 1/4 of those under 25 years. The elderly are least likely to be uninsured. Meanwhile, 1/3 of the elderly are not Medicare recipients.

13. Contact for Support. Among all of the respondents: **42.0% say they do not need help at all,** and **14.2% contacted no one for help**.

Among respondents who looked for help, about 2/3 contacted only one source. Of all the contacts: 81.9% are relatives, friends, or neighbors; 29.6% church/temple; 11.2% government; 14.0% service agencies; 4.0% business; and 2.9% others such as an employee co-op.

The primary source of contact for all sub-groups is their informal relationship. **Very few have sought help from the government, service agencies, a church or temple**. About 1/5 of the respondents in poverty say they have no need at all and 1/6 has contacted no one for help. Over half of the middle-income and over 2/3 of the high-income group have not sought help at all over the past year.

The mid-education group is the less likely to say they need help. The shorter one has been living in the U.S., the more likely one needs help, and the more likely to have contacted someone for help. The older one is, the more likely one needs help, and the more likely to have contacted someone for help.

14. Conclusion. As supported by the findings, the most efficient way to desegregate the diverse Asian American population is to classify them into three subgroups based on their economic condition. **Economic condition is the most consistent and often the strongest independent variable related to the respondents' physical and mental health conditions, health knowledge and attitude, health and risk behaviors, as well as their needs**. The economic classification framework is therefore not only conceptually and policy-/program-wise clear-cut and practical, but also evidence-based. While the low-income group tends to need help most, higher-income groups are not immune from difficulties.

Education, length of living in the U.S., age, and sex may also have an impact with individual dependent variables, which sometimes is stronger than that of economic condition. The bivariate relationships between many of these variables, however, are generally not very strong. To further explore and confirm how these and other independent variables affect the conditions, attitudes, behaviors and needs, multi-variate analyses of large scale random sample data are required.

Though not systematically studied here, **culture** may also profoundly influence the respondents' knowledge, attitude, behavior, and needs. The most prominent evidences include the widespread non-compliance in taking prescribed medication reported by the respondents, their health beliefs and risk behaviors. Less obvious examples include the **small fraction of mental health needs acknowledged among those experiencing stress, anxiety, and depression**; and the **generally larger proportion needing help among those who have lived in the U.S. for less than five years**.

Due to their diverse backgrounds, being Asian American alone is an inadequate criterion to judge an individual's eligibility for public assistance. **Once eligible** for assistance, however, **because of the additional barriers, Asian Americans do need more help**, such as in interpretation and culturally sensitive/competent service.

Acknowledgments

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Asian Community Alliance, Inc., Cincinnati
Association of Indian Physicians of Cincinnati
Association for India's Development
Cambodian Association of Greater Cincinnati & Kentucky
Catholic Charities of Southwestern Ohio Refugee Resettlement Program
Chinese American Association of Cincinnati
Chinese Senior Lunch Program
Cincinnati Asian Culture Festival
Cincinnati Chinese Church at Mason
Cincinnati Chinese Church at Mt. Healthy
Cincinnati Chinese Culture Learning Association (CCCLA)
Cincinnati Korean American Association
Cincinnati Music & Wellness Coalition
Cincinnati Museum Center
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Ms. Arlene desilva
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Greater Cincinnati Tamil Sangam
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Korean Presbyterian Church of Cincinnati
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Ms. Kim Tien Nguyen
Northern Kentucky University International Student association
Ohio Department of Job & Family Services
Our Lady of Lavang Vietnamese Catholic Church
Ms. Angie Tee Pang
Ms. Chandra Prasad
Proctor & Gamble International Transferees, Inc. (the India and Subcontinent group, Southeast Asian Group, and Chinese Group)
Queen's Nails Salon
Scarlet Oaks Adult Education
St. Andrew Kim Korean Catholic Church
Tarangini Association
Vietnamese Buddhist Temple
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Dr. Stanley Wang
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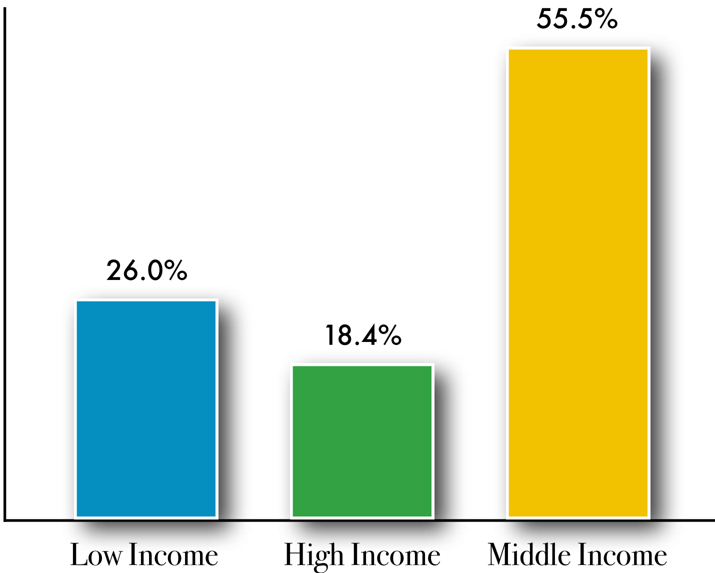
Disclaimer: The opinions expressed in this report pertain only to the investigator, and may not necessarily represent those of Asian Community Alliance, Inc.



1. **The Low Income Group** is a group whose economic conditions is below the federal poverty level, are more likely to be below 25 years old men, living in the US for shorter than 5 years, and have no college graduate in the family.

2. **The High Income Group** is a group whose family income exceeded $100,000 last year. Their characteristics tend to be the reverse of that of the low-income group.

3. **The Middle Income Group** is a group whose characteristics tend to be between the high- and the low-income groups.

Table 6.2a Health and Mental Conditions (in %)

	Never	*Maybe*	*Yes before, but not now*	*Yes, I have it now*	*Don't Know*	*n =*
Stress	26.0	31.1	8.9	31.1	3.0	438
Anxiety	39.7	26.8	8.6	20.8	4.2	433
Depression	54.2	13.4	9.8	15.3	7.4	419
Hepatitis B	86.6	1.9	3.1	1.4	6.9	419
Tuberculosis	88.3	1.4	5.0	0.7	4.6	418
Diabetes	84.0	4.5	2.1	5.2	4.3	424
Heart conditions	83.0	5.7	3.1	4.5	3.8	423
AIDS/HIV	95.7	0.2	1.4	0	2.6	420
Cancer	91.2	0.2	3.8	1.4	3.4	418
Allergy/ Asthma	57.5	11.7	7.9	20.3	2.6	428
Others	32.0	8.0	4.0	56.0	0	25

7. Medical Care Behaviors

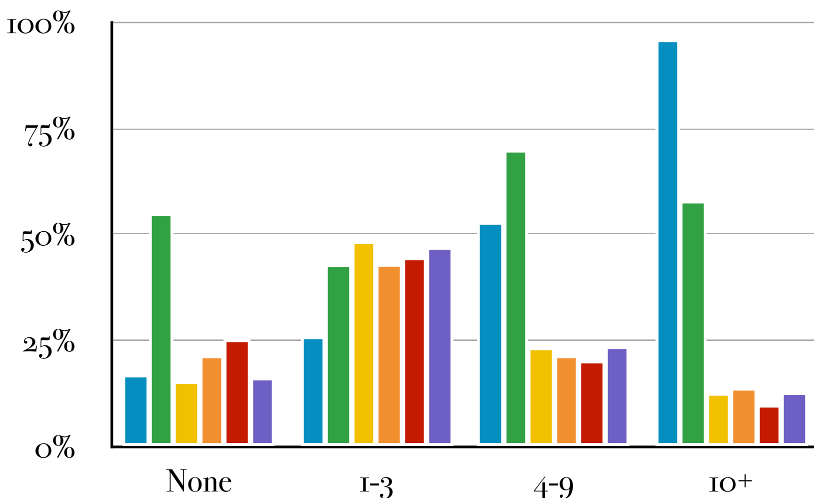
7.1 Frequency of Medical Visits

In 2006, the national average number of visits to office-based physicians was 3.1. Asians had the second highest rate (22.0%, Table 7.1a) of making no visit at all, much higher than the national average (16.3%). Asians were also least likely to make ten or more visits (9.2%, vs. 12.9% nationwide) (Cherry, et al.).

Table 7.1a Number of Visits To Doctor Offices by Race (in %)

	None	*1-3*	*4-9*	*10+*
Asian only	22.0	48.9	19.9	9.2
White only	16.2	46.8	24.0	13.0
Black only	15.5	48.4	23.4	12.7
Am. Indian/Alas.	21.5	43.1	21.5	13.9
Hispanics	25.3	44.6	20.3	9.9
Total	16.3	47.1	23.7	12.9

Source: National Center for Health Statistics, 2010, Table 80.



8. Self-assessed Needs

Twenty-one areas where Asian Americans may need help are ranked in terms of the combined proportion of respondents who "urgently need help" and "need help" in each area. For better coordination of services, these 21 areas are grouped into six clusters. We will also look into some areas where their needs were not fulfilled last year due to money concerns.

8.1 Comparison of Needs

About 90% of the respondents responded to the question, "Does your family need help in these areas?" If some non-respondents skipped these questions because they have no need, the proportion of those who have needs would be smaller, but variation is no more than 10%.

The percentages of families reported needing help presented in Table 7.1 are calculated using the total number of respondents as the denominator, without distinguishing whether an area is relevant to them or not. The proportion of families having needs in child-care, for instance, would be much larger if the denominator consists of only families with children. Meanwhile, using the total number of respondents as the denominator offers a comparative perspective, though in cruder terms.

Between 7.0% to 46.1% of the respondents say their family is in need of help in at least one area. Given the heterogeneity of the Asian American population, the diversity of their needs is not a surprise at all. The 21 areas are classified into six clusters: health, socialization, newer immigrant, environment, employment, and family care, which will be discussed separately below. Sources of service or support to meet the need in areas within the same cluster are more likely to be coming from the same agencies/system. Except for family care, each of these clusters has at least one area in which over 30% of the families need help (see the top 8 areas). Possible explanations for the relatively lower need for help in family care include the larger Asian family unit and the traditional Asian value of family responsibility.

9. Support System

9.1 Health Insurance Coverage

The uninsured rate in the Asian American population in 2007 was 16.8% (Tsou, 766), reversing the downward trend since 1992. Although the overall uninsured rate among Asian Americans is lower than other minority groups, subgroup rates can be higher than that in African Americans (Ponce, 346-9).

One in every six of the respondents (16.2%, n=451) is uninsured. Nearly half (47.3%) of the respondents are insured through employment, including 44.4% who are insured only through employment. About 1/7 (14.1%) of the respondents pay health insurance premiums from their own pocket, including 11.5% who have no other source of payment. About 1/8 (13.0%) of the respondents are Medicare recipients, including 7.5% who have Medicare only. Medicare recipients comprised only 65.2% of the respondents aged 65 or older, meaning 1/3 of the older respondents are either ineligible, do not know, or do not apply for Medicare. About 1/18 (5.6%) of the respondents are Medicaid recipients, including 2.2% who have Medicaid only. Almost 3/4 of the Medicaid recipients aged 65 or older. About 1/8 (12.3%) of the respondents have other insurance, such as Veteran's and railroad employee insurance.

Over 40% of the respondents in poverty are uninsured (n=101, Table 9.1), while only 6.9% of them rely on Medicaid and 3.0% rely on Medicare only. About 1/4 of the respondents have insurance through employment, and only 3% have multiple coverage.

One in nine respondents in the middle-income group are uninsured (n=214), about half of the rest are at least partially covered through employment, and 1/10 have multiple coverage. Only 1/12 of them have public insurance, predominantly through Medicare.

No one in the high-income group are uninsured or on Medicaid. Over 3/4 of them have coverage at least through employment.

Table 9.1 Health Insurance by Economic Condition (in %)

	No Ins	*Emp Ins*	*Self*	*Medi-care*	*Medi-caid*	*Other*	*Multi -*	*n =*
Poverty	42.6	24.8	12	3.0	6.9	7.9	3.0	101
Middle	11.2	43.0	16	7.9	0.5	11.2	10.3	214
>$100K	0	76.7	4.1	4.1	0	8.2	6.9	73

OUR ACCOMPLISHMENTS

ACA website (May 2007) www.acacinci.org: Developed in May 2007 - allowing for the sharing of information among various Asian populations in the Cincinnati area. This website includes a Calendar and Forum for the sharing of vital data among Asian communities within the Greater Cincinnati community.

Community Resource Guide (Sept 2007): Created, developed, and began distribution in 2007, the Community Resource Guide outlines all human services so Asian populations know where to turn for family needs such as health, schools, legal, social service providers, housing, and more. For more information on the Resource Guide, please contact us at info@acacinci.org

Cultural Competency Training Seminar/Workshops (2007) included an Asian overview of Japan, China, Vietnam, India, Bangladesh, and Pakistan. The workshops helped train social service providers (including law enforcement, legal aid, healthcare and county agencies) increasing their cultural sensitivity.

Free Hepatitis B Screenings (April 2008 and August 2009): ACA initiated work with health providers to pursue a Hepatitis B screening and vaccination process. Free screenings were made possible with funding received from Gilead. More than 75 Asians have been tested under the grants. Further, ACA partners with local health experts from Ohio Gastroenterology and Liver Institute enabling free reviewing of lab results including providing follow-up treatment, where necessary. Participants were also given information on Health Clinics of several counties in Greater Cincinnati. In addition, ACA in partnership with the Ohio Asian American Health Coalition and Gilead continue to hold talks by physicians at the various Asian communities to raise awareness and educate the Asian community on Hepatitis B.

The 4th Ohio Asian American Health Conference (May 2009): With over 200 participating in the conference from across the state, the event was funded by Ohio Commission of Minority Health, and Ohio Asian American Health Coalition. Besides keynote topics that included Hepatic & GI cancers and Metabolic Syndrome, several concurrent workshops were also held on aging, diabetes, oral health, complementary and alternative medicine, tobacco and substance abuse, HIV/AIDS, domestic violence, cardiovascular disease, and mental health. Free Health Screenings and cardiovascular consultations sponsored by Cincinnati Korean American Doctors Association were also available during the day. Ohio's Director of Health, Dr. Alvin Jackson, gave an eloquent talk on Minority Health: Challenges & Issues with Health Care. Further, ACA received from Ted Strickland, Governor of Ohio, a proclamation emphasizing the importance of educating and raising awareness of the diseases that uniquely affect the Asian American population.

The Asian Health Symposia (April 2008 and April 2010): The two-day event focused on the critical health concerns of the community: Cardiovascular Disease, Hepatitis B, and Teen-smoking. The Ohio Commission on Minority Health, Cincinnati Korean American Doctors Association, Christ Hospital, and Cincinnati Museum Center sponsored the Symposia during Minority Health Month. Free Health Screenings and health brochures on both cardiovascular and hepatitis B diseases, developed by ACA and translated into Japanese, Chinese, Korean, and Vietnamese were provided to the attendees.

Ohio Asian American Needs Assessment (Sept 2009 - March 2010): ACA has developed a survey with the intent to identify general barriers to health prevention and treatment among Asian populations in the Greater Cincinnati area. It is an attempt to provide socio-culturally unique background information for service agencies directly working with Asian American populations. The data collected and final report of findings (published in Nov 2010) can serve as a pilot study for larger research projects by other Asian agencies across the state. Please visit our website www.acacinci.org to learn more details on how you can obtain a copy.

Asian Forum on Caregivers & Emergency Preparedness (April 2009): The objective of Caregivers workshop was to hear from the community their experiences as caregivers of parents and older adults, and their challenges. The objective of the Emergency Preparedness workshop was to share with the participants the importance of being prepared and emergency kit information. Further, 2 focus group (Korean & Vietnamese) sessions in June 2009 were held to gather information such as needs, barriers, and concerns in the communities as well as to assess their current knowledge on preparedness.

Health & Wellness Program (Nov 2009 - Nov 2010): ACA collaborates with Cincinnati Music & Wellness Coalition to provide Health Rhythm Drum Circle sessions to Asian seniors. This music therapy program in a manner similar to exercise, laughter, meditation, and other interventions that are practiced or enjoyed has the potential to help seniors to reduce stress and eliminate loneliness that comes from lack of social networking and limited English proficiency. So far we have held 5 sessions and reached out to more than 80 seniors.

Census Awareness Project (Jan 2010 - July 2010): As a regional member of the Cincinnati Census Complete Count Committee, ACA partnered with local Asian communities and held 16+ focus meetings to educate and engage Cincinnati's Asians to fully participate in events related to the Census 2010. ACA also developed an article explaining the Census survey form and the importance of filling out the forms. It was translated into 4 languages: Vietnamese, Korean, Japanese and Chinese and distributed to the communities as well as posted on our website.

Asian Advocacy Forum (June 2010): ACA hosted the Advocacy Forum (prior to Legislative Day) bringing leaders of Asian communities together to discuss in particular 4 areas of concern: civil rights, health, economic development, and cultural arts and education. This forum provided an opportunity for our community leaders to understand how to advocate on issues of concern as well as be a unifying voice in the political process. Subsequently, 400 Asians from 5 cities in Ohio gathered in the State House in Columbus for the first ever Ohio Asian American Pacific Islander Legislative Day.

Asian Summit (Oct 2007, Oct 2008 & Oct 2010): ACA hosted the hosted 3 Asian Summits partnering with Northern Kentucky University. The Summits provide a unique opportunity for local Asian communities to come together to identify specific needs and concerns for further action. The concurrent breakout sessions have included workshops on racism, immigration, domestic violence, health and mental health, small business, aging and retirement, and intergenerational dialogue: understanding our youth.