Working with Asian American, Native Hawaiian, and Pacific Islander communities:
Cultural Competency In Practice

Presented by
NICOS Chinese Health Coalition
San Francisco, CA
February 1, 2013

NICOS Chinese Health Coalition

Mission: To Enhance the Health and Well-Being of San Francisco's Chinese Community.

- Founded in 1985
- Located in SF Chinatown
- Public-private-community partnership of 30+ groups
Community Alliance for Culturally and Linguistically Appropriate Services (CLAS)

- Funded by the State Dept. of Health Care Services
- Provides free consultation, training, and resources
- All health and human service organizations eligible (public, private, or non-profit)

Workshop Objectives

- Demonstrate knowledge of the diversity and complexity inherent in the AANHPI community.
- Conceptualize designing services to accommodate culture as fluid and evolving.
- Understand the application of the CLAS standards for the AANHPI community
- Self-assess organizational strengths and weaknesses toward the CLAS standards.
Asian American, Native Hawaiian and Pacific Islander (AANHPI) Communities

“ASIAN AMERICAN”

**What is Race?**
Race is a social category based on similar physical appearance.

**What is Ethnicity?**
Ethnicity is a social category based on shared culture or cultural heritage.

Racial Group ≠ Ethnic Group
Ethnic Group ≠ Racial Group
AANHPIs in 2010 Census

• ASIAN AMERICANS:
  • 14M single-race (4.8% of US pop.)
  • 17M single-race & multi-race (5.6%)

• NATIVE HAWAIIANs & PACIFIC ISLANDERS:
  • 500K single-race (0.2%)
  • 1.2M single-race & multi-race (0.4%)
  • More likely than other racial groups to report multiple races (55.9%)

Asian American Population Growing

![Percentage Change in American Population from 2000 to 2010](image)
Where do AANHPI communities live?
Over half (51%) of our communities live in just three states—California, New York, & Hawaii.

Where are AANHPI communities originally from?
Originate from over 50 countries.
AANHPIs speak over 100 different languages and major dialects.

Largest AANHPI ethnic groups:

- Asian Indian
- Bangladeshi
- Burmese
- Cambodian
- Chinese
- Fijian
- Filipino
- Guamanian/Chamorro
- Hmong
- Indonesian
- Japanese
- Korean
- Laotian
- Malaysian
- Mien
- Mongolian
- Native Hawaiian
- Nepali
- Pakistani
- Samoan
- Sri Lankan
- Taiwanese
- Thai
- Tongan
- Vietnamese
Immigration

- Asians make up 36% of new immigrants (compared to 31% Latino)
- Family sponsorship is most common pathway
- Asians make up est. 11 percent of total unauthorized immigrants
- Top countries of origin: China, Philippines, India, Korea, Vietnam

Limited English Proficient AANHPI communities

Among those who spoke languages other than English at home, 32.4% of AA spoke English less than “very well” verses 8.6% of the total population.

Data Source #1

Percent of Racial/Ethnic Group that is Limited English Proficient

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Limited English Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>37.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>32.4%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>8.4%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>6.2%</td>
</tr>
<tr>
<td>White</td>
<td>5.8%</td>
</tr>
<tr>
<td>Black</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total Population</td>
<td>8.6%</td>
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</tbody>
</table>
Consequences of Model Minority Stereotype

• Used to justify the exclusion of needy communities in distribution of public and private assistance.

• Less funding for crime and mental health prevention work.

• Pressures to succeed can lead to suicide, depression, and other mental health illnesses.

• Delegitimizes the experiences of the many AANHPI in poverty and low educational attainment.

Acculturation & Identity

- Level of acculturation: High to Low
- Ethnic identity: High to Low

Community Alliance for Culturally & Linguistically Appropriate Services (CLAS)
NICOS Chinese Health Coalition
### Families in Transition

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Traditional** | • Whole family Asian-born and raised  
                    • Subscribe to traditional Eastern values                                   |
| **“Cultural Conflict”** | • Varying levels of acculturation  
                                • Intergenerational conflicts                                               |
| **Bicultural**  | • Been in US for many years  
                    • Familiar with Eastern & Western values                                      |
| **“Americanized”** | • Parents and children born/raised in US  
                            • Fully adopt Western values; English only                             |
| **Interracial** | • Integrating additional cultural values  
                    • Biracial/multiracial identity                                              |

### Mental Health & Addiction in AANHPI Communities

[Source: Community Alliance for Culturally & Linguistically Appropriate Services (CLAS)
NICOS Chinese Health Coalition]
AANHPI communities: Mental Health

• Prevalent issues in AANHPI communities: problem gambling, domestic violence, PTSD, depression

• High risk populations: immigrants, refugees, limited English proficient

• Less likely to seek mental health services; may prefer to ask for help from family

• Barriers: Stigma, language, economic issues, lack of culturally competent services

AANHPI communities: Substance Use

• Overall drug and alcohol use lower in Asian Americans than general population, but varies widely by subgroup and drug type

• Ex: AANHPI have higher than average rates of stimulant use; Pacific Islander illicit drug use higher than any other race/ethnic group; Korean binge-drinking rate 3x Chinese

• Among Asian adults, those born in US have nearly 3X higher rates of drug use than foreign born
**AANHPI Communities: Problem Gambling**

- Most studies point to higher rates of problem and pathological gambling among AANHPI populations in comparison to other ethnic groups

- Ex: Groups such as Southeast Asian refugees and asylees have been shown to have significantly greater rates of PG, possibly due to trauma and other environmental factors

- Among Asians, those who are immigrants appear to have higher rates of PG.

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**Common beliefs about the root of Mental Illnesses**

- Imbalance of yin and yang
- Supernatural intervention
- Karma
- Genetic vulnerability or defect
- Physical or emotional strain
- Manifestation of physical illness
- Character weakness
Somatization:
the expression of mental distress as symptoms of physical illness when no organic cause for illness can be found.

Example: Depression described as “feeling tired and fatigued,” “pains and aches,” and gastrointestinal or cardiovascular symptoms, rather than sadness, loneliness, or hopelessness.
Why are some groups less likely to seek outside help?

“I made the mistake of telling my best friend. He said, ‘you’re crazy? Oh my God, I can’t believe it. Get away from me. You’re dangerous.’

- **Stigma**
  “All the counselor wants to talk about is feelings! Why can’t they just focus on helping me with my real problems?!”
  “I just tell my children to not to think about the problems that bother them! You don’t need to see a psychiatrist, that’s for crazy people.”

- **Emotional Expression**
  “Everyone’s got problems, just tough it out!”

- **Self Reliance**
  “This is a family matter. If anyone finds out about it, I will lose face!”

- **Airing dirty laundry**

Comparison of Asian Ethnic Groups:
Needed help but did not seek or receive treatment

Source: CHIS 2007, 2009
Why are some groups less likely to seek outside help?

“In OUR culture, we don’t talk about suicide.”
- **Cultural Taboos**
  “They don’t have anyone who speaks my language, and the last time I had to wait more than 1 hour for an interpreter…”
  “For small problems I prefer to see my Chinese herbalist because he understands about ‘Yeet Hay’”
- **Lack of Bilingual/Culturally Competent Services**
  “I don’t know if I sign up for this service, will they share what I tell them with MediCAL? I don’t want to lose my benefits…”
- **Distrust of Systems**
  “I don’t feel comfortable going there because I hear other clients verbally bash gay people and the staff don’t say or do anything about it.”
- **Perceived or Actual Racism/Discrimination**
National Standards for Culturally and Linguistically Appropriate Services (CLAS)

- Originally developed by Office of Minority Health in 1999
- Recent revision (April 2013):
  - Culture as more than race/ethnicity
  - More inclusive definition of “health”
  - Added standard on leadership

Stay up to date: www.thinkculturalhealth.hhs.gov
Guiding Principle

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Example: Integrating Traditional Chinese Medicine

Chinese Community Health Study:

- 54% report that they take soup with Chinese herbal medicine in it at least once a week
- 43% believe that home remedies are as good as western medicine for minor health problems.

For Latest Research:
National Center for Complementary and Alternative Medicine (www.nccam.nih.gov)
Governance, Leadership, & Workforce

Standard 2: Leadership Support for CLAS

Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
Standard 3: Diverse Staff & Leadership

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

- Partner with local schools to bring in bilingual and bicultural interns
- Advertise positions in local, ethnic media outlets
- Offer financial incentives for bilingual staff/new hires
- Develop a leadership or mentoring program for staff from underrepresented populations
Standard 4: Ongoing Education

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Communication & Language Access Services

Standard 5: Free Language Assistance

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
“Threshold Language”

A language that has been identified as the primary language for 3,000 people or five percent of the population, whichever is lower, in an identified geographic area.

Example Tool:
Deciding on Face-to-Face vs. Telephonic Interpretation
From California Academy of Family Physicians

Face-to-Face:
- New patient/initial visit
- Delivering bad news
- Clients from very traditional cultures

Telephonic:
- Determining what language client speaks
- Simple content
- Unacceptably long wait for in-person interpretation
Multi-Lingual Access Model (MLAM) program

“MLAMs”:

• Paid advocates
• Bilingual, bicultural women from un-served and underserved communities
• Serve as communication bridges
• Provide emotional support by accompanying residents to meetings

Language Access Success Story:

Established in 1994
Language services and trainings specifically for health care
Services include:
  o Interpretation
  o Translation and Multilingual Health Education Materials Development
  o Multilingual Focus Group and Field Testing Services
  o Simultaneous Interpreting Equipment Rental

Language Access Success Story:

Language & Cultural Access Program (LCAP)
Standard 6: Information about Language Assistance

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Example Tool:
Standard 7: Competent Language Assistance

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

A Few Tips for Working with an Interpreter

- Introduce yourself and make sure client knows the interpreters name
- Look and talk to the client, not the interpreter
- Be aware of cultural differences and dynamics between the client and interpreter (e.g. class, gender, from different regions)
- Speak at a moderate pace, a few sentences at a time
- As the health professional, it is your job to ensure the client understands your message. Have the client repeat back what they have heard for verification.

FOR MORE TIPS: UC Davis Health System
http://www.ucdmc.ucdavis.edu/cne/resources/multicultural/guidelines.html
Standard 7: Materials and Signage

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Gold Standard for Translation
“Cross-Cultural Adaptation of Health-Related Quality of Life Measures: Literature Review and Proposed Guidelines” (Guillemin, Bombardier & Beaton, 1993)

1. **Translation**: produce several, using qualified translators
2. **Back-translation**: have qualified translators translate back into original language
3. **Committee review**: multidisciplinary group to compare source and final versions
4. **Pre-testing**: test with lay people

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Engagement, Continuous Improvement, and Accountability
Standard 9: Goals & Policies

Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.

Standard 10: Ongoing Assessment

Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
Example Tool:
Community Alliance for CLAS Assessment

9. Culturally Competent Strategies

38. Please rate how well your organization performs on the following measures.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not well at all</th>
<th>Not very well</th>
<th>Somewhat well</th>
<th>Very well</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well does your organization understand and respond to the cultural needs of its clients? (i.e., responding to the different needs of diverse-cultural groups such as, older adults with mobility problems, youth who communicate via text message, homeless people without address, women with children, people in same sex relationships, transgender people, cross generational conflict)</td>
<td></td>
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<tr>
<td>How well does your organization respond to the linguistic needs of its clients?</td>
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<tr>
<td>How well do the FORMAL policies of your organization facilitate cultural understanding between staff and clients?</td>
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<tr>
<td>How well do the INFORMAL policies of your organization facilitate cultural understanding between staff and clients?</td>
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<tr>
<td>How well does staff advocate for diverse populations?</td>
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</tbody>
</table>

Standard 11: Demographic Data
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
Standard 12: Community Health Needs
Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

• NICOS/ Four Winds, 1997
• Survey of 1,800 Chinese American adults in SF
• Purpose: Health profile
• Key Findings:
  • 70% identified gambling as a problem
  • Barriers to access health care
  • High rates of uninsured

Chinese Community Health Study
Standard 13: Community Partnership

Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Engaging Community Members:

<table>
<thead>
<tr>
<th>Outreach</th>
<th>Consult</th>
<th>Collaborate</th>
<th>Share Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform and Educate</td>
<td>Seek Input from Community</td>
<td>Community is a Partner at Each</td>
<td>Community makes final</td>
</tr>
<tr>
<td>Community</td>
<td>Focus groups</td>
<td>Step</td>
<td>decisions</td>
</tr>
<tr>
<td>Brochures</td>
<td>Surveys</td>
<td>Community advisory board</td>
<td>CBPR</td>
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<tr>
<td>Health Fairs</td>
<td></td>
<td>Peer employees</td>
<td>Consumer-led</td>
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<td></td>
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<td>program</td>
</tr>
</tbody>
</table>
Standard 14: Conflict Resolution Processes

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

We need to ask:

• Are the processes being used?
• Are some groups failing to use them?
• Is this because those groups are content, scared of the system, or simply don’t know how to access the process?
• How are they supported?
• Are processes well established and articulated?
Standard 15: Communication with Stakeholders

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Conclusion
Remember...

• You do not need to know everything.

• Everyone is learning and unlearning.

• Celebrate successes!

Thank You!

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