NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

OFFICE OF MINORITY AND MULTICULTURAL HEALTH

THE HEALTH OF MINORITIES IN NEW JERSEY

PART III:
"ASIAN AMERICAN FORUM ON HEALTH"

SUMMIT PROCEEDINGS REPORT
and
RECOMMENDATIONS

Prepared by:
The Asian American Pacific Islander Health Coalition
Advisory Committee
And
The Office of Minority and Multicultural Health

Donald DiFrancesco
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GEORGE T. DiFERDINANDO, JR., MD, MPH
Acting Commissioner

Dear Colleague,

On behalf of the Department of Health and Senior Services I congratulate the Asian American Pacific Islander (AAPI) Health Coalition Advisory Committee on the publication of this first ever "AAPI Forum Proceedings and Recommendations Report".

This report is an important guide as we formulate a public health program that addresses the health needs of new Jersey's Asian American Pacific Islander population. We recognize that the public health community has a lot to learn about Asian American health data. Existing data indicates that the public health community faces some important challenges in addressing disparities among specific Asian and Pacific American populations. For example, we know that Vietnamese women suffer disproportionately from liver and cervical cancers. We also know that tuberculosis is another health problem that demonstrates a higher incidence in AAPIs in New Jersey.

I would like to take this opportunity to congratulate those who took the initiative of sponsoring and bringing about the August 17, 2000 Asian American Forum on Health. This forum was a fitting addition to the momentum created by the September 1999 African American Summit and the Latino Health Summit in June of 2000.

I continue to be impressed by the energy, commitment, and resources brought to the table by the AAPI Health Coalition Advisory Committee membership. We welcome the AAPI community as enthusiastic members of the expanding DHSS and minority community partnerships. We thank you for the opportunity to broaden DHSS implementation strategies through the introduction of an AAPI Forum agenda and these ensuing recommendations. With your help we will better be able to reach our goal of eliminating disparities in health care and health outcomes for all minority communities in New Jersey.

The Department of Health and Senior Services (DHSS) is pleased and proud to have contributed to the publication of this AAPI report.

George DiFerdinando, M.D., M.P.H.
Acting Commissioner

NEW JERSEY
Many Faces. One Family.

To: Acting Commissioner George T. DiFerdinando

On August 17, 2000, a historic conference "The Health of Minorities in New Jersey, Part III: Asian American Forum on Health" took place to discuss and strategize action for eliminating Asian American and Pacific Islanders health disparities in New Jersey. A primary result of the Forum is this "Summit Proceedings Report and Recommendations."

While generating a greater level of awareness regarding the health problems of Asian American and Pacific Islanders, the Forum on Health also called upon government leaders, policy makers, the healthcare industry and community based organizations to work in collaboration toward the elimination of health disparities and improved health care access for New Jersey's Asian American communities. The outcome of the Forum is included in this report, which outlines specific recommendations and action plans that should be implemented to achieve the goal of eliminating disparities and improving access.

Over 150 participants consisting of health care experts, community leaders and advocates, faith based groups, members of civic, political and volunteer organizations actively engaged in strategy planning groups, and their collective ideas are contained in these formal recommendations. These recommendations clearly focused on key areas such as access to health, data collection and Asian American representation in state and local governments. Efforts of Forum participants were focused on the development of appropriate linguistic and culturally competent services and resource allocation essential to improving understanding of the causes of health disparities and service utilization patterns among Asian American and Pacific Islanders in New Jersey.

These Forum Recommendations are intended to serve as a blueprint for action for the elimination of health disparities and the achievement of timely and measurable changes in the health status of Asian American and Pacific Islanders in the State.

On behalf of the Asian American/Pacific Islander Health Coalition Advisory Committee, I would like to thank the New Jersey Department of Health and Senior Services, Office of Minority and Multicultural Health, the Forum Planning Committee, and other community based sponsors and supporting agencies for their help in making the Forum on Health a reality and raising awareness and commitment in achieving improved health status.

Respectfully submitted

Antony Pitchai Stephen, Ph.D.
Chair: Asian American Forum on Health
Asian American/Pacific Islander Health Coalition Advisory Committee

INTRODUCTION
TO

SUMMIT PROCEEDINGS REPORT AND RECOMMENDATIONS

Introduction

The Asian American community is the fastest growing minority population in the nation and in New Jersey. As a state, New Jersey ranks fifth in Asian American/Pacific Islander population groups. New Jersey is home to Asian Indian, Chinese, Philippino, Korean, Vietnamese, Japanese, Cambodian, Hmong, Laotian, Pakistani, and many other citizens of Pacific Island and Central and East Asia origin. Almost 50% of New Jersey's AAPIs reside in Bergen, Middlesex and Hudson counties.

Executive Order 13125, was signed in 1999 and renewed in 2001, with the purpose of improving the health and well-being of Asian Americans and Pacific Islanders by increasing their participation in federal programs where they have been historically underserved. The Executive Order established the President's Advisory Commission to advise the President on the following three goals:

- Develop, monitor and coordinate federal efforts to improve Asian American and Pacific Islander participation in government programs;
- Foster research and data collection for Asian American and Pacific Islander populations and sub-populations; and
- Increase public and private sector and community involvement in improving the health and well-being of Asian Americans and Pacific Islanders

In response to the Executive Order and motivated by Healthy People 2000 which addresses racial/ethnic health disparities, the New Jersey Asian American Association for Human Services took the initiative of forming a coalition of health and civic organizations to strategize and plan an Asian American Forum on Health. The Forum, co sponsored by the New Jersey Department of Health and Senior Services and a myriad of other AAPI organizations, and with strong support from New Jersey City University (NJCU), represents a major chapter in the mission of the AAPI populations of New Jersey to advance the implementation of Executive Order 13125 and the recommendations of Healthy People 2010.

The Forum planning committee formulated the following Forum objectives and established the foundation for the Forum agenda and the Strategy Planning group sessions:

- To Mobilize and educate Asian American and Pacific Islander local community leaders, professionals, members of civic, religious and political organizations regarding health issues.
- To build a coalition of New Jersey based Asian and Pacific Islander communities of health issues.
- To strengthen the local Asian and Pacific Islander community infrastructure for participation in the formulation of effective health policy development and advocacy.

This Asian American Forum on Health was the third in a series of summits sponsored by the New Jersey Department of Health and Senior Services (DHSS) that address racial/ethnic health disparities. "The Health of Minorities in New Jersey: Part I, The Black Experience" concentrated on disparities in the African-American community. "Part II, A Call to Action for Eliminating Disparities for Latinos" focused on Latino health issues. Recommendation reports have been published as a result of the first two Summits.

The New Jersey Department of Health and Senior Services' Healthy New Jersey 2010 initiative to eliminate racial and ethnic disparities in health is supported by Executive Order 13125, and by this opportunity to join with AAPI communities across New Jersey. From the first two reports, and now this AAPI Forum Report, the Office of Minority and Multicultural Health has identified several crosscutting issues such as inadequate race/ethnic data collection, a need for strategies that increase minority access to health care, a need for cultural competency training programs for health care providers, and recruitment and training of minority health services providers. These crosscutting issues have become a baseline for the OMMH agenda and program planning for the coming years.

This report continues the "Call to Action" for partnerships among government, minority community based organizations, faith based organizations, health care professionals and civil rights groups across the State. This call for a diversity in partnerships is strengthened by this AAPI report, and the creation of partnerships is crucial to the final success of New Jersey's ultimate goal of eliminating all health disparities. Following the Health Forum, representatives from various AAPI ethnic communities in New Jersey joined to form an AAPI Health Coalition Advisory Committee that meets regularly with the DHSS Commissioner. The Advisory Committee has prioritized the report recommendations, developed this Recommendations Report and is now planning implementation strategies.

DHSS support of this third summit furthers its leadership role in addressing disparities in health care for minorities, increasing the number of minority health service providers in New Jersey and ensuring the availability of culturally competent healthcare. The DHSS and the Asian American Pacific Islander Health Coalition Advisory Committee will continue to jointly develop activities and programs to meet their mutual goals.

SELECTED FORUM PROCEEDINGS

Antony Pitchai Stephen, Ph.D.
Chair, Asian American Forum on Health

In his radio address on February 21, 1998, President Clinton committed the Nation to an ambitious goal of eliminating the disparities in six areas of health status experienced by racial and ethnic minority populations. Those six areas of health are:

1. Infant mortality
2. Cancer screening and management
3. Cardiovascular disease
4. Diabetes
5. HIV infection/AIDS
6. Immunizations

The goals within these six areas are drawn from Healthy People 2000, which is aimed at reducing the disparities in health care among minorities. The Healthy People 2010 document focuses on eliminating the disparities.

While making his remarks on Asian Pacific Heritage Day in May of this year, President Clinton stated: "Too many Asian Pacific Americans face inadequate health, lack of educational opportunity and low paying jobs."

The myth of a model minority has prevented us from getting needed assistance in health care, housing and education.

Through this forum on health, we are trying to educate ourselves about Asian Pacific American community health problems and the disparities experienced. The morning, as well as the afternoon, panel sessions, focused on those issues. The forum went beyond the Health issues. It addressed other important issues such as mental health, domestic violence and substance abuse issues facing Asian Pacific America.

There is an Asian Indian Tamil proverb, which says: in unity, there is life. Another Chinese proverb says: only when all contribute their firewood, can they build up a strong fire. Through this forum, we plan to establish a united, strong Asian Pacific American health coalition to represent Asian Pacific Americans' issues and concerns.

We will also build a strong, broad partnership and coalition with other racial and ethnic groups so that we can all build one healthy America. Finally this forum was aimed at empowering Asian Pacific Americans in our State to articulate issues and concerns in the formulation and implementation of health policies.

We have a long way to go in fully achieving a healthy Asian Pacific America. In this new millennium, this forum is the starting point. We will continue to hold this type of forum until everyone in Asian Pacific America becomes healthy. We have an arduous task in front of us. To achieve this goal, we must fight the good fight.

Ford Kuramoto, DSW
Executive Director
National Asian Pacific Association of Families
Against Substance Abuse (NAPAFASA)

As the National Director of NAPAFASA, I support the conference and all the work you are doing to improve the quality of life for AAPI populations throughout the state. I attended this Forum to literally reach across the country, from Los Angeles, California to Jersey City, New Jersey to let you know that NAPAFASA is standing with you and will work with you in the future as you plan and implement new strategies to better serve the AAPI communities here. I wish to also acknowledge the presence and support of others from outside of New Jersey who attended the Forum, including Ms. Emilie Dearing from the HORIZONS Asian American and Pacific Islanders Project, McLean, VA; Mr. David Chen from the Chinese American Planning Council in Manhattan, NY; and Dr. Jean Lau Chin a NAPAFASA Board Member from Newton, MA.

It is particularly timely that you held this conference now because the White House AAPI Initiative has just recently gotten underway and the State of New Jersey and your AAPI populations should play an active role in its implementation. One of the members of the Initiative's National Advisory Commission is on the Forum program. This was a wonderful opportunity to establish a dialogue with the Commission and the Initiative, and begin a collaborative process that will have far reaching impact for your AAPI communities in the State.

I know that culturally competent AAPI health care and related services are virtually non-existent in the State. New and enhanced services must be made a high priority for the AAPI communities and for all pertinent service providers and funding sources, in order to provide required language access to AAPI populations. In order to plan and implement needed services, appropriate data and services research must be produced. Recruitment and training must be initiated in order to provide culturally competent health care and related services. Relevant health care and related public policies must be designed to strengthen and promote the quality of life for AAPI populations in New Jersey.

NAPAFASA looks forward to our continued work together to reach the goa1s and objectives identified today at this groundbreaking conference.

Linda Holmes, Executive Director
Office of Minority and Multicultural Health

This summit was the third in a series of summits that addressed racial/ethnic health disparities. The first focused on disparities in the African-American community and the second summit focused on Latino health issues.

Based on the past two summits, the Office of Minority and Multicultural Health has identified several crosscutting issues that affect all New Jersey minorities. For example, there is a need to be more specific in data collection when focusing on race/ethnic groups. We also need to develop strategies that increase access to care for New Jersey minorities. Another crosscutting theme emerging from the summits is the need to develop and support cultural competency training programs for health care providers and to increase the numbers of minorities entering the health care professions.

Summit participants should know that a number of initiatives already exist within the Department of Health and Senior Services to address minority health issues. Some of the special programs that emanate from the Office of Minority and Multicultural Health include Minority Health Month in September, which seeks to increase statewide awareness about health disparities. In an additional effort to increase the use of culturally competent health services, the Office of Minority and Multicultural Health is co-sponsoring the development of several countywide multi-cultural health directories. The Office of Minority and Multicultural Health also provides on-going technical assistance to community based organizations, including faith based groups, interested in forming partnerships with health care providers wanting to outreach to diverse race/ethnic groups.

The Forum focused on the challenges inherent in addressing health disparities, let us not forget that each of New Jersey's race/ethnic communities also offer strengths and assets. In the Asian American community, for example, there are age-old holistic approaches to health that make the connection between mind, body, and spirit. Let us think about integrating these positive health practices, including certain dietary habits, from Asian American/Pacific Islander culture as we develop creative solutions to challenges in minority health.

Eliminating health disparities is hard work. It requires a commitment for working in partnership with government, health care professionals, academics, and community based organizations.

We also must commit to understanding how participants at the summit can partner with other race/ethnic groups in New Jersey who have identified similar needs in minority health. All minority groups must be represented as New Jersey moves forward in developing a comprehensive minority health and multi-cultural agenda.

The Office of Minority and Multicultural Health looks forward to forming long-term partnerships with the Asian American Health Forum, the sponsor of the Asian American Health Forum. The time has come to improve health care outcomes for all.

CAPT. Tuei Doong
Deputy Director
Office of Minority Health
Office of the Secretary
US Department of Health and Human Services
(Excerpts from Keynote Address)

Now is an exciting time for Asian Americans and Pacific Islanders.

- We have the White House Executive Order on AAPIs;
- We have the Presidential Advisory Commission on AAPIs.
- We have the first Asian American to head a cabinet department.
- We have the first Asian American to serve as the assistant attorney general for civil rights at the Department of Justice.
- We have the first Asian American to serve as the Deputy Surgeon General in the Department of Health and Human Services.
- We have the Department of Health and Human Services initiative to eliminate racial and ethnic disparities in health.
- We have the first Executive Order on Improving Access to Services for Persons with Limited English Proficiency, issued on August 11, 2000.

And, now we have for the first time, all around the country, Asian American and Pacific Islander communities, activists, community workers, service providers and others celebrating and rejoicing, because FINALLY, our communities' problems will be heard, and FINALLY, our communities' needs will receive attention at all levels of government. Never before has so much public policy attention been focused on AAPIs.

But in order to make sure that our communities' needs are indeed addressed, we must take advantage of the opportunities these days and times present to us. We must also continue to educate those who are not enlightened, on the issues and problems facing our diverse Asian American and Pacific Islander populations. That's why gatherings such as the Asian American Health Forum are important, they provide mechanisms by which we can all come together to share experiences, ideas and strategies and, most important, demonstrate to policy makers at the local, state, and national levels, that there are Asian American and Pacific Islander voices that will be heard.

Disparities Initiative

In 1998 the Nation was committed to an ambitious goal: to eliminate, by the year 2010, the disparities in six areas of health status experienced by racial and ethnic minority populations, while continuing the progress we have made in improving the overall health of the American people.

Health Disparities in Asian Americans and Pacific Islanders

Emerging data on AAPI subgroups show, clearly, that there are important disparities in health status, as well as unresolved problems in accessing health and social services:

- Cervical cancer occurs five times more often in Vietnamese-American women than in Caucasian women.
- The age-adjusted death rate for Native Hawaiians is nearly twice that of the general population. Native Hawaiians suffer the highest mortality rates from most cancers found in island residents, as well as having the highest rates for hypertension, obesity, smoking and binge and chronic drinking, and non-use of seatbelts.
- The infant mortality rate in the U.S. -associated Pacific Island jurisdictions, in some cases, exceeded that of the U.S. by more than two times, ranging from 9.5 per 1,000 births in Guam to an estimated high of 52 per 1, 000 in the Federated States of Micronesia as of 1994.

Immigrant Health

- Infectious diseases, particularly hepatitis and tuberculosis, are problems for more recent immigrants and refugees. It is estimated that 15 percent of Vietnamese American adults and significant numbers of Korean Americans and Chinese Americans in the United Sates are chronically infected with hepatitis B. The chances of developing liver cancer are 200 times greater if one has the hepatitis B virus.

Mental Health

- Immigrants and refugees seem to be at higher risk for both psychosocial and psycophysiological stress. Post-Traumatic Stress Disorder is seen in a large number of Asian American and Pacific Islander refugee communities. Studies have shown that most newly arrived Asian Americans and Pacific Islanders experience acculturative stress. Recent immigrants and colonized Asian Americans and Pacific Islanders have the largest rates of depression.
- Depression is the most prevalent mental health problem among the elderly, including Asian American and Pacific Islander elderly. Older Asian American and Pacific Islander women have extremely high suicide rates. At age 45, the rate for Chinese American women begins to rise and the rate for Japanese American women 75 years and older is higher than that of White women the same age.
- The major cause of disability among Asian American and Pacific Islander adolescent girls is mental disorders. Some 10-12 percent of children and adolescents are thought to suffer from mental disorders. Girls 14-18 years of age have a higher incidence of depression than among male peers. There are higher rates of eating disorders among females than males. And, in adolescents, females are two to three times more likely than males to be sexually abused.
- Study after study has shown that Asian Americans and Pacific Islanders under-utilize mental health services much more than other populations. There are a lot of reasons that Asian Americans and Pacific Islanders don't go for treatment for mental health concerns. Like in the general population, there is a stigma attached to going to receive treatment for mental health problems.

Access Barriers

Asian Americans and Pacific Islanders experience tremendous barriers in accessing the health care system, including language and cultural barriers.

- Approximately 24% of Asian American adults had no health insurance in 1998 (@ 2 million)
- 21% of Asian American adults say that they have no choice in where to go for care
- 41% of Asian American adults report that they have difficulty in paying for medical care
- A recent study in the July/August issue of Health Affairs shows that Asian Americans reported barriers to care more frequently than non-Hispanic Whites, and in some cases, more frequently than other racial/ethnic minority groups did. For example, Asian Americans were the group most likely to report dissatisfaction with the quality of care provided by their usual source of care. They also more frequently reported that they would not go to their primary care provider for new health problems, preventive care, or referrals, - suggesting that this population group may experience less continuity of care than others.

The Department of Health and Human Services is implementing an initiative to eliminate racial and ethnic disparities in health. The initiative has become the centerpiece of Healthy People 2010, the framework that enables government and community leaders, health practitioners, educators, and concerned citizens to work together to eliminate health disparities.

The Department will provide leadership through research, expanding and improving programs to purchase or deliver quality health services, programs to reduce poverty and provide children with safe and healthy environments, and expanded prevention efforts.

As part of its efforts, the Department of Health and Human Services (HHS) will broaden and strengthen its partnerships with State and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations --those who have the greatest access to and knowledge of the communities. For example, HHS has entered into a partnership with the American Public Health Association, which will ultimately include a large number of public and private sector organizations concerned with improving the health of the U.S. population.

The Department will direct attention to improvements in monitoring and developing the local and national data necessary for determining priorities and designing programs. The Department has adopted a policy that requires all HHS-sponsored data collection and reporting systems to include standard racial and ethnic categories. This inclusion policy will help monitor HHS programs to determine that Federal funds are being used in a nondiscriminatory manner and to promote the availability of standard racial and ethnic data across various agencies.

HHS policy statements are available through the OMH web page, "Data and Statistics".

According to Senator Daniel Akaka, Democrat, Hawaii, HHS is the only federal agency that has established a policy to implement OMB's newly revised standards for classifying race and ethnicity in government statistics. The recent change to 0MB standards makes it mandatory for federal data collectors to separate out data on Native Hawaiians and other Pacific Islander groups from Asian American data.

Focused improvement in the six health conditions mentioned earlier will make an important contribution to improving the health of racial and ethnic minorities as well as advance the knowledge needed to achieve the President's commitment to eliminate all disparities in the next century:

- We will do so by furthering development of existing data systems, conducting research and improving the focus and effectiveness of our health service delivery and insurance programs to better meet the needs of racial and ethnic minorities. Success in this effort will accomplish two important results: A meaningful improvement in the lives of minorities who now suffer disproportionately from the burden of disease and disability, and development of the tools and strategies that will enable the Nation to meet the far more challenging goal of eliminating these disparities by the year 2010.
- This is a long-term undertaking that will extend into the next century and requires an enduring commitment from this and future administrations.
- We acknowledge your role in this Initiative -- we are focusing on working with you and other organizations like yours --our partners. We want to strengthen existing and establish new partnerships to focus attention and efforts on addressing and eliminating racial and ethnic disparities in health. We want to involve all participants, not limit involvement to HHS.
- Secretary Shalala has committed HHS leadership and resources to these efforts. The Office of Minority Health (OMH) helped to crystallize HHS efforts for the President's Initiative on Race.

White House Initiative on AAPIs

The Department’s initiative to eliminate racial and ethnic disparities in health will also be achieved through implementation of the Executive Order for Asian Americans and Pacific Islanders and the White House Initiative. It is my firm belief that we cannot eliminate disparities in health if we do not address the issues of equitable access to services, and the cultural competency of the systems and institutions that provide these services.

Executive Order 13125 is indeed, historic and it is providing the push for all federal agencies to examine the issue of equitable access and cultural competency. Because of it, all federal agencies are now taking steps to increase the participation of AAPI communities in federal programs where they are under served. All federal agencies have prepared an inventory of AAPI participation in programs and activities. All federal agencies are preparing plans on how they can better address the issue of access to services and build community capacity. The Department of Health and Human Services had already developed its own Asian American and Pacific Islander Initiative in FY 1998 and will continue to fold our initiative into the White House Initiative.

The White House Office Executive Director and staff, and the AAPI Advisory Commission are generating great excitement and enthusiasm as they meet with numerous AAPI organizations and communities.

Shamina Singh, Executive Director of the White House Initiative, Kevin Thurm, HHS Deputy Secretary, and I, conducted site visits in California. We observed people who came to the community forums and people who we visited different service sites, who, on a day to day basis, provide much needed services at the Asian youth centers, or the Asian American senior residents

and services centers, and the after school programs. The White House initiative is a message of hope for these communities.

The Commission held its second town hall meeting on September 18 in New York City. Attendees provided testimony on the following three questions: What are actions AAPI communities can take to better access federal programs? What are actions the federal government should take to ensure AAPI issues are addressed in an appropriate and accessible manner? What types of partnerships should be developed to improve the quality of life for AAPIs?

It is hoped that the White House Initiative will drive the development of new community-based coalitions and partnerships between local, state, national, governmental and non-governmental organizations to combine resources to address the multitude of problems that confront AAPI communities. What's happening here in Jersey City today is happening all across the country?

I believe that one measure of the success of the White House Initiative will be how it has mobilized community organizations and federal agencies to form productive partnerships.

Eliminating Disparity and Inequality in Health Care

Kem B. Louie Ph.D. RN
Associate Professor – William Paterson University, Wayne, NJ
President, Asian American/Pacific Islander Nurses Association, Inc.

(Key Points of Panel Presentation)

Ethnic Diversity

- The current AAPI total population is 475,000 or 5.6% (1998).
- The state's total foreign-born population is now 17% and the national average is only 6.2%.

Data Quality Issues

- Most statistical agencies do not report health and demographic data on AAPIs by different ethnicities. One single AAPI or other classification cannot adequately describe health status of over 30 different AAPI subgroups.
- Aggregated data mask significant differences between AAPI groups and leads to false assumptions – e.g. notion of the model minority and AAPIs do not have significant health problems.

Heart Disease

- Aggregated data shows that in the US and NJ, the mortality rates are low. Yet it was noted in the Healthy People 2000 and Healthy People 2000 course review that nationally AAPIs are experiencing increased incidences of heart disease.
- When heart disease data is disaggregated, East Indians have been shown to have alarming high levels of lipodemia despite the fact that a majority of East Indians are vegetarians.

Cancer

- AAPI aggregated data in the US and NJ shows comparable rates to Hispanics. But when the national data is disaggregated, AAPI subgroups are shown to have excessive incidences of cancers e.g. Korean – stomach; Filipino, Chinese – nasopharyngeal; Japanese – lung; and Vietnamese women – cervical cancer.

Diabetes

- AAPI women have higher rates of diabetes as a medical risk factor of pregnancy than women of any other race, and the rate of increase in this rate is greater than in other races.

Stroke

- Aggregated data show that mortality rates for AAPIs in the US exceed the Healthy People 2000 target and in NJ. Stroke is the third highest incidence among the five groups. When data is disaggregated, hypertension (a risk factor) is highest for Filipinos compared to other AAPIs from national data.

Tuberculosis

- In the US, TB incidence rates are approximately five times higher than the rates for the total population. Another significant finding is TB is increasing while for the total population is decreasing.
- In NJ, AAPIs are identified as "other" and show that the rates are also nearly 5 times the total in the state.

Hepatitis B

- Hepatitis B infection among AAPI children is 2-3 times higher than for all children in the US. There is no cure for this disease and infected individuals are 300 times more at risk of developing liver cancer.

Beatriz Miranda MSN, RN, CNAA
Philippine Nurses Association of New Jersey
(Key Points of Forum Panel Presentation)

Introduction: Facts and myths about Asian Pacific American (APA) issues.

There is a pervasive myth that APAs are a model minority, with no major health problems. National data markedly under-estimates the health problems of Asian Pacific Americans (APAs) due to their frequent misclassification as Whites. A study conducted by the National Center for Health Statistics found that 32% of self-reported Asians were classified as Whites or Blacks by the interviewer. Though APAs are counted correctly when they are born in the U.S., many of them die mysteriously as Whites. These misclassification rates are as high as 33% for Chinese, 49% for Japanese, and 79% for Filipinos. This may explain why the total and CAD mortality rates of Filipino-Americans are less than one fifth that of the Whites, despite their having the worst risk factor profile among all APAs.

Dr. Moon Chen Jr., has done a phenomenal service to the APA community in launching a scientific journal solely devoted to APA health issues. Many of the data below are from this journal. The journal is not yet accessible through MEDLINE search. Although there is a wealth of misinformation in the mainstream literature perpetuating the myth that APAs are a model minority, with no health problems, the following is a partial list of diseases and risk factors facing the APAs;

1. Tuberculosis. Of all the cases of TB reported in 1990, 17% were among APAs who have a ten-fold higher rate of TB compared to the general population of the U.S. Korea has one of the highest incidence rates of TB.

2. Malaria. About 55% of malaria in the U.S. occurs among Southeast Asian refugees, and 85% of these refugees have been tested positive for at least one parasite in the stool.

3. Hepatitis B and liver cancer. Hepatitis B prevalence rates among APAs are the highest of any racial and ethnic group. About 8-15% of APAs are chronically infected with hepatitis B, compared to less then 2% of North Americans. About 50% of women who deliver hepatitis B carrier infants in the U.S. are foreign-born APAs. Ninety percent of the people in China are exposed to hepatitis virus, and 10% are carriers of hepatitis B. Similarly, 85% of males and 60% of females in Korea are exposed to hepatitis B (defined as positive for hepatitis B surface antigen (anti-HBs), or antibody to hepatitis B core antigen (anti-Hbc) by radioimmunoassay method). Hepatitis B is a major risk factor for liver cancer, and accounts for up to 80% of liver cancers. The mortality from liver cancer is five-fold higher among Chinese-Americans.

4. Cancer. Asians have the highest rates of stomach cancer in the world. Compared with Whites, Korean American men have a five-fold higher incidence of stomach cancer and an eight-fold higher incidence of liver cancer. In addition to liver cancer, the Chinese-Americans also have the highest rates of nasopharyngeal cancers. Breast cancer death rates among Japanese American, Filipino American and Native Hawaiian women are 1.5 to 2 times higher than among Caucasians. Still, very few APA women receive mammograms or Pap smears. For example, 75% of Chinese-American women and Asian Indian women and 44% of Korean women in Ohio never had a mammogram in their lifetime. Hawaii has the

highest incidence of thyroid cancer, with Chinese men (6.3 per 100,000) and Filipino women (18.2 per 100,000) leading the list.

5. Cardiovascular Diseases (CVD). CVD is the leading cause of death among APAs. However, the spectrum of CVD varies markedly between Asia and America. Stroke is the leading form of CVD in most of Asia, but coronary artery disease (CAD) is the leading form of CVD in the U.S. and Europe. For every CAD death, there are at least two stroke deaths in China and Japan, and thirteen stroke deaths in Korea Hypertension is the predominant risk factor for stroke, whereas dyslipidemia is the most powerful risk factor for CAD. Serum cholesterol levels are rapidly increasing among most APAs.

6. Stroke. Upon immigration to the U.S., there is marked decrease in stroke mortality among APAs. Rates become similar to American Indians, Whites, and Hispanics, and only one third the rates of Blacks. Thus, there is a sharp reversal of the CVD spectrum among APAs resulting in a coronary artery disease death to stroke death ratio of 3:1 compared to 1:2 ratio before immigration. Native Hawaiians have higher rates of stroke death than all other APAs (100 vs. 37 per 100,000 in 1986).

7. Coronary Artery Disease (CAD). Upon immigration and acculturation to the U.S., the relative immunity of the Asians to CAD is lost, generally in proportion to a rise in their blood cholesterol. The national statistics show a CAD mortality rate of only 41% compared to Whites. However, the incidence rate has reached the same level as in Whites. Most risk factors have a higher prevalence among APAs, and portend an emerging epidemic of CAD. Chinese having the lowest, and Asian Indians the highest rates of CAD among APAs. The Native Hawaiians have double the rate of CAD mortality compared to Whites (367 vs. 160 per 100,000 in 1986) and other APAs.

8. The Asian Indian Paradox. Despite their enormous heterogeneity in language, diet, and cultural characteristics, Asian Indians as a group, have the highest rate of CAD in the world. Compared to other racial and ethnic groups in the U.S. and elsewhere, CAD rates among Asian Indians are two to four times higher at all ages, and five to ten higher in the young. They have no excess of any of the conventional risk factors, such as high blood pressure, high cholesterol, cigarette smoking, obesity, or low socioeconomic status, and nearly half of them are life-long dedicated vegetarians. This Asian Indian paradox was recently explained by our group, as due to a genetic susceptibility, medicated by lipoprotein (a), or nature, Thus APAs offer a gold mine for cardiovascular research.

9. High Blood Pressure. The prevalence is high but the awareness, treatment, and control of high blood pressure is low among APAs. Fifty-seven percent of Cambodians refuges have high blood pressure. The prevalence of hypertension among Southeast Asian refugee children in Minnesota was significantly higher than Black and White children.

10. Smoking. Cigarette smoking is the risk factor of greatest importance to APAs. The six billion dollar tobacco advertising industry is targeting the Asian countries to maintain their market share. Sixty two percent of males in Korea and 36% of Korean Americans are cigarette smokers. In the Minhang District of China, 67% of adult males smoke an average of 17 cigarettes a day, spending an average of 60% of the personal income, and 17% of the household income. Thirty-five percent of the medical students in Japan smoke cigarettes,

compared to 20% in Europe and 3% in the U.S. An increasing number of U.S.-born APA women are smoking. Cigarette smoking rates are extremely high among APA men: Vietnamese, 65%; Cambodians, 71%; and Laotians, 92%. However, the latest official statistics show an implausible aggregate smoking rate of 18% among the APAs – a perfect example of the misleading data alluded to earlier.

11. Diabetes: Mortality from diabetes is 222% higher among Native Hawaiians compared to Whites. The 1992 age-adjusted Non-insulin Dependent Diabetes Mellitus (NIDDM) mortality was 48.1, over four times the rate of 10.1 for the continental U.S. Asian Indians also have a higher rate of diabetes.

12. Obesity: In the 1985 Molokai cardiovascular health study, 63% of women, and 66% of men were overweight by the 20% of ideal body weight criterion compared to 27% of all U.S. adults. Other studies also indicate native Hawaiians having the highest rates of obesity. Obesity (BMI>27) is also highly prevalent among Micronesians (41.8%) and Chamorros (44.3%). The mean mass is 79 kg for men and 67 kg for women among Chamorros. The corresponding figures for Micronesian men and women are 80 kg and 70 kg respectively. Anderson reported that men in non-industrialized societies consider plump women to be beautiful and preferable to slim women (44% versus 19%): this may pose a barrier to weight reduction n these women.

13. Low birth weight. Compared to Whites, the mean birth weight is lower by 115 grams for Chinese, 164 grams for Filipinos and 235 grams for Japanese, compared to 74 grams for American Indians and 120 grams for Blacks. The risk of low birth weight (<2.5 kg) associated with a two-fold risk of dying in the first year of life is 45% higher among Filipinos (and 49% higher for Blacks) as compared to Whites.

14. Mental health. Many Cambodian and Vietnamese refugees still suffer from post-traumatic stress syndrome as a result of the violence and torture they had experienced. Family violence was reported by one of every three Vietnamese American females in Atlanta. A high degree of psychological distress is reported among mothers of Amer-asian children.

15. Cultural differences. APAs have a penchant for herbal medicine, and disdain for modern medicine, even among the educated. There is a pervasive "Oriental or Asian fatalism," that militates against screening for early disease, on the mistaken belief that death and disease are predetermined before birth by divine providence, and not amenable to human intervention. For many of them, what is "dotted" cannot be "blotted". Many Hawaiians believe more in chanting or mantras than in medications, though they have very high rates of diabetes, hypertension, dyslipidemia, cigarette smoking, corpulence, CAD, and stroke.

16. Death and dying. Compared to African-Americans and Whites, fewer Mexican-Americans and Korean-Americans want their physicians to tell the diagnosis and prognosis to the patients, when faced with metastaic cancer, or other terminal illnesses. They also believe that families, rather than individual patients, should decide about the use of life-support technology. On the contrary, 60% of Japanese patients prefer to be told of the diagnosis, but only 35% of those who died of cancer were told of the diagnosis in one study. Physicians routinely do CPR on virtually all terminal patients in Japan, though they do not want CPR being performed on themselves. Only 5% of the Japanese patients participate in the decision

about their own Do-Not-Resuscitate (DNR) orders, but 36% of Japanese physicians would override the explicit request of a competent moribund cancer patient to withdraw all life support. Patients are often resuscitated to avoid death in the absence of family members. Koreans are reluctant to discontinue life support on hopelessly ill on the mistaken belief that it is disrespectful to the elderly.

17. Miscellaneous. Among the Vietnamese Americans in Atlanta, 75% had less than 8th grade education, 94% use Medicaid or Medicare, 82% had dental problems, and 57% had eye problems. Native Hawaiians have the worst health, social and economic profile of all ethnic groups in their homeland.

OFFICE OF MINORITY AND MULTICULTURAL HEALTH
FACT SHEET
SELECTED HEALTH MEASURES:
ASIAN AMERICANS AND PACIFIC ISLANDERS

- The Asian and Pacific Islander population is the fastest growing racial group in New Jersey, increasing by an estimated 63 percent between 1990 and 1998.

- New Jersey ranks fifth nationally in the number of Asian/Pacific Islander residents[1].

- In 1998, 5.6 percent of New Jersey's population was Asian and Pacific Islander. Only three western states have a higher percentage of population of Asian/Pacific Islander origin.[1]

- Almost one of every two of New Jersey's Asian Americans and Pacific Islanders resided in three counties in 1998: Bergen, Middlesex and Hudson.[1]

- More than ten percent of the total population in Bergen and Middlesex Counties is of Asian or Pacific Islander origin.[1]

- In the nation in 1993, the poverty rate of API families (14 percent) was higher than that of non-Hispanic white families (8 percent).[2]

- 16.9 percent of New Jersey's Asian/Pacific Islanders reported not having health insurance in 1998, compared to 10.8 percent of white non-Hispanics.[3]

- There were 7,116 resident New Jersey births in 1997 to Asian and Pacific Islander women. This was 6.3 percent of all resident births.[4]

- There were more New Jersey resident births to Asian Indian women than to women of any other Asian/Pacific Islander background, followed by births to Filipino, Chinese, Korean, Vietnamese and Japanese women.[4]

- In 1997, more than 90 percent of New Jersey resident Asian Indian, Vietnamese, Korean, and Filipino and over 85 percent of Chinese and Japanese women who gave birth were born outside of North America.[4]

- Asian/Pacific Islander women have higher rates of diabetes as a medical risk factor of pregnancy than women of any other race, and the rate of increase in this rate is greater than in other races.[4]

- In 1997 births, rates of chronic and pregnancy-associated hypertension were highest in black and Filipino mothers, while rates for Asian Indian mothers were relatively low.[4]

- Despite the high rates of diabetes reported during pregnancy, Asian/Pacific Islander women were more likely to have no medical risk factors during pregnancy than were women in other

racial groups: 67.8 percent of API women compared to 62.1 percent of whites, 52.6 percent of American Indians, and 49.2 percent of blacks.[4]

- Middlesex County had the highest number of births to API mothers (1,488) and also the highest percent of total resident births that were to API mothers (15.2 percent). Bergen County and Hudson County also had relatively high numbers of births to API mothers.[4]

- Almost all of the Asian Indian, Chinese, Japanese, Korean and Filipino mothers were married at conception, delivery, or sometime in between.[4]

- Asian/Pacific Islander mothers had rates of onset of prenatal care in the first trimester that were among the highest of all races; in particular, Japanese, Chinese and Asian Indian mothers all had early prenatal care rates over 80 percent [4]

- Asian American/Pacific Islander babies born in 1997 were of low birth weight at a rate that was higher than the white rate (7.2 percent vs. 6.3 percent), but lower than the black rate (13.7 percent).[4]

- Of Asian/Pacific Islanders residing in New Jersey, Asian Indian babies had the highest rate of low birth weight (9.0 percent) and Chinese babies had the lowest rate (4.7 percent).[4]

- The crude death rate among Asian/Pacific Islanders in New Jersey is much lower than the rate in the total population. However, there may be under-reporting of Asian/Pacific Islander races on the death certificate.[4]

- Age-adjusted death rates from seven states that report detailed Asian/Pacific Islander data on death certificates are lower than comparable white and black rates for Chinese, Japanese, Filipino, Asian Indian, Korean, Vietnamese, and Guamanian populations in those states.[5]

- Cancer was the leading cause of death among New Jersey's Asian/Pacific Islander population in 1997, followed by heart disease and stroke. This ranking was true for all major API groups, except Asian Indians, for whom heart disease was the leading cause.[4]

- Nationally, the highest rate of nasopharyngeal cancer has been found among Chinese Americans and very high rates of liver and cervical cancer among Vietnamese Americans.[6]

- Nationally, the rate of kidney failure due to diabetes in Asians or Pacific Islanders (156 per 1,000,000) is considerably higher than the rate in the white population (79 per 1,000,000).[7]

- The three-year average tuberculosis rate among APIs in New Jersey is 39.4 per 100,000 compared to a rate among the total population of 9.0 per 100,000.[8]

- The incidence rate of hepatitis B in Asian Americans/Pacific Islanders is higher than the rate in the total population, in the nation as a whole.[9]

- Nationally, rates of influenza and one-time pneumococcal vaccinations in Asian/Pacific Islanders aged 65 and over are lower than comparable rates in the total populations.[10]

- Nationally, only 72 percent of Asians or Pacific Islanders have a usual primary care provider, compared to 77 percent of the total population with a usual primary care provider.[11]

- In the U.S., only 63 percent of Asian or Pacific Islander women report receiving a Pap test in the past three years, while 77 percent of all women report a Pap test at this frequency.

- Just 49 percent of Asian or Pacific Islander women aged 40 and over in the U.S. report having a mammogram within the past two years, compared to 59 percent of all women.[12]

- Asian/Pacific Islanders are less likely than all U.S. adults to have had their cholesterol checked within the past five years and to have had their blood pressure measured within the past two years and know whether their blood pressure was normal or high.[12]

- In the nation, Asian American/Pacific Islander children aged two through eight have substantially higher rates of untreated dental decay than all children in this age group.[13]

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[1]Wu SY. 1998 New Jersey State and County Population Estimates by Age, Race, Sex and Hispanic Origin. New Jersey Economic Indicators. New Jersey Department of Labor, Division of Labor Market and Demographic Research. Trenton, NJ 1999.

[2]U.S. Census Bureau, 1995.

[3]Current Population Survey, U.S. Census Bureau, 1999.

[4]Center for Health Statistics, New Jersey Department of Health and Senior Services

[5]Hoyert DL and Hsiang-Ching K. Asian or Pacific Islander Mortality, Selected States, 1992. Monthly Vital Statistics Report. Vol. 46, No. 1 Supplement. Centers for Disease Control and Prevention, National Center for Health Statistics. August 14, 1997.

[6]Miller BA, Kolonel LN, et al. Racial/Ethnic Patterns of Cancer in the United States 1988-1992, Surveillance, Epidemiology and End Results (SEER), National Cancer Institute, NIH Pub. No. 96-4104. Bethesda, MD 1996.

[7]U.S. Renal Data System (USRDS), NIH, NIDDK.

[8]Communicalbe Disease Service, New Jersey Department of Health and Senior Services. Trenton, NJ. July 2000.

[9]National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Sentinel Counties Study of Viral Hepatitis, CDC, NCD.

[10]National Health Interview Survey (NHIS), CDC, NCHS-noninstitutionalized populations; National Nursing Home Survey (NNHS), CDC, NCHS-institutionalized populations.

[11]Medical Expenditure Panel Survey (MEPS), AHRQ.

[12]National Health Interview Survey (NHIS), CDC, NCHS.

[13]National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

ASIAN AMERICAN FORUM ON HEALTH

RECOMMENDATIONS

ASIAN AMERICAN FORUM ON HEALTH
August 17,2000

RECOMMENDATIONS

ADVOCACY

1. Assist in capacity building and identify linkages with other Asian American Pacific Islander (AAPI) health and human services organizations in New Jersey.

2. Build culturally and linguistically competent and affordable health care service networks for AAPI communities.

3. Formulate a political platform for affordable health care for AAPIs in New Jersey.

4. Support action for funding research, service and treatment for AAPIs,.

Action Steps:

- **Require AAPI participation in advisory and policy making committees of NJDHSS**

DATA COLLECTION

1. Establish and collect baseline data on health statistics, disaggregated by AAPI ethnic groups.

2. Develop a model for trend data analysis for AAPIs.

3. Data collection needs to be the responsibility of local, county and state health agencies.

4. Increase and improve the analyses and dissemination of data on AAPIs.

Action Steps:

- **Assess and review current data collection tools and methodologies for gathering, analyzing, and reporting of AAPI data.**
- **Develop an advisory committee to review AAPI data and make further recommendations to NJDHSS.**
- **Develop culturally and linguistically appropriate data collection tools for AAPI**

ACCESS

1. Develop, maintain and disseminate a directory of AAPI resources of health providers, institutions and consumers in New Jersey.

2. Develop culturally relevant models for community outreach for specific AAPI groups.

3. Formulate strategies to eliminate the disparities between AAPI groups.

4. Designate a lead agency for ongoing assessment of AAPI access to health services and dissemination of information on effective methods to assure access to services.

Action Steps:

- **Develop a directory of AAPI health resources and outreach efforts**
- **Disseminate effective models for community outreach for AAPI groups**

HEALTH CARE SERVICES

1. Provide resources for adequate training for health education and health services interpreters, which include quality standards and cultural competence.

2. Provide funding to sponsor a New Jersey wide Health Summit for AAPIs annually.

3. Provide funding for the following health problems and

   - Mandate collection of data/statistics on AAPI women-specific health issues (including but not limited to mental health, violence against women, cancers, diabetes, reproductive health, etc.)
   - Mandate collection of data/statistics on special needs of AAPI elderly:
   - Mandate collection of data/statistics on the following: heart disease, cancer, communicable diseases, and substance abuse.

Action Steps:

- **Disseminate best practices for addressing health problems among AAPIs.**
- **Monitor cultural competency standards among health care agencies which provide health care services to AAPIs.**

RESEARCH

1. Conduct analyses of the major health and mental health and human service related problems facing AAPI communities.

2. Develop a research agenda and solicit research proposals to increase clinical research and health care utilization information needed to reduce gaps in knowledge about AAPIs.

3. Include AAPIs in ongoing research on health and human service issues and in developing new survey instruments

4. Conduct research on sociocultural and behavioral factors essential to improving the understanding of the causes of health disparities, access and utilization among AAPls.

5. Include the AAPI in race/ethnicity category instead of classify them as "other".

Action Steps:

- **Make available funding contracts to research AAPI health outcomes and demonstration projects.**
- **Include participation of AAPI researchers in research projects**

TRAINING

1. Need to expand career awareness for all health and human services staff who can provide competent services to AAPIs.

2. Mandate training for all health providers (e.g. physicians, nurses, social workers, etc.) in cultural competency.

3. Increase availability of training opportunities that encourage health professionals and researchers to address health issues of AAPI communities.

Action Steps:

- **Develop a cultural competent training program for health care providers in providing quality care to AAPIs.**
- **Provide funding to New Jersey Asian American Association for Human Services for developing culturally and linguistically competent training curriculum for AAPI.**

ASIAN AMERICAN FORUM ON HEALTH

PLANNING COMMITTEE

2000 Asian American Forum on Health
Planning Committee

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AAPI Nurses Association

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Alcoholism and Drug Abuse
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Executive Director
Luzvimin Resource Center for Women and Families

ASIAN AMERICAN PACIFIC ISLANDER HEALTH COALITION

ADVISORY COMMITTEE

Asian American Pacific Islander Health Coalition
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Asian American Forum on Health

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- New Jersey Department of Health and Senior Services
  New Jersey Office of Minority and Multicultural Health

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- Asian American Civic Association, Inc.
- Asian American Mental Health
- Asian American Pacific Islander Nurses Association
- Bridgewater Temple
- Church of Christ, Bayonne
- Filipino Cultural Association of New Jersey City university
- Indo American Cultural Society
- Indo American Senior Citizens Association of Hudson County
- Japanese American Citizens League
- Jersey City Asian Merchant Association
- Korean American Medical Association
- Luzvimin Resource Center for Women & Family, Inc.
- MANAVI
- NJ Asian Indian Coalition for Health
- New Jersey Tamil Sangam
- Philippine American Concerned Citizens Action League
- Philippine American Seniors Coalition of Organizations, Inc.
- Philippine American Veterans Organization, Inc.
- Philippine Community Center Foundation of New Jersey, Inc.
- St. Michael's Church of Jersey City (Vietnamese)

Supporting Organizations

- Department of Sociology and Anthropology, NJCU
- Ethnic and Immigration Studies, NJCU