Health Disparities/
An Asian American & Pacific Islander Community Response

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Executive Summary

This report is a joint product and a part of the ongoing work of the Council on Asian-Pacific Minnesotans (Council) and the Minnesota Asian/American Health Coalition (MA/AHC). The Council on Asian Pacific Minnesotans is a state agency and has been actively researching and advocating on Asian American and Pacific Islander (AAPI) health and mental health issues for more than a decade. The Minnesota Asian/American Health Coalition (MA/AHC) is a nonprofit organization established in 1999 with a mission to promote and ensure the health and well-being of Asian/American communities in Minnesota. Chief among MA/AHC’s priorities is increasing the availability of disaggregated health data by AAPI ethnic community, thereby creating a better understanding of health disparities, barriers to health access, and ensuring parity in health resources.

A majority of this report is taken from the oral and written testimonies that were offered at the Asian Health Disparities Forum that took place in August 2008. The forum was organized by the Council via the Hennepin County Asian American & Pacific Islander Leadership Initiative and the US Department of Health & Human Service, Office of Minority Health and was structured as a public hearing for the community to make comments to federal officials who served as ‘listeners’. The goal was to generate solutions to health disparities and assist policymakers find ways to reduce health disparities here in Minnesota for the Asian American and Pacific Islander community.

High on the AAPI community concerns were improving medical interpreter services, a need for more health education, and increasing the availability of data on AAPI health specific to a particular sub populations. Mental health emerged as a leading health condition across Southeast Asian populations (Hmong, Lao and Karen). Testimonies provided insight into additional issues experienced by the AAPI community that are not widely known to policymakers such as obesity, domestic violence and lack of emergency preparedness plans.

Key Recommendations:

I. Identify & Address the Top Health Disparities Confronting the Community
II. Health Disparities Must Be Addressed via Good Data Sources
III. Focus on and Improve Social & Economic Determinants of Health
IV. Move Towards Universal Healthcare to Eliminate Health Disparities
V. Increase Asian American and Pacific Islander Healthcare Professionals
VI. Minnesota must create and disseminate an emergency preparedness plan for its LEP population by working with community based organizations.

Health parity is important to the AAPI community and it affects every aspect of their lives. It is desired and essential for the AAPI community to be included in and understand the health care system and decisions that are made for them and about them.
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Putting a Face on Asian Health Disparities: Five Stories

story 1
Mental Health

‘My wife is not healthy. She has mental problems. She has stress all the time. She yells and yells. I don’t know how to help her. She takes medication prescribed by doctors. The biggest problem is I don’t know how to deal with my wife. I want my wife to be calm and get out of stress.’ (Lao written testimony, Brooklyn Center)

story 2
Obesity/Diabetes

‘There is a Hmong family here with a son age twenty-one. The son weighs three hundred pounds. He works temporary jobs and has no health insurance. The mother does sewing jobs to earn money. The father’s insurance does not cover the 21 year old son. He is diabetic. The parents did not notice the diabetes until one day the mother saw the son drinking two liters of pop. “Why are you drinking (all that pop)?” asked the mother. “Because I am thirsty!” the son replied. Later he said he felt blind. “Go wash your face, your eyes!” said the mother. But he had lost his vision. He was totally blind. “Why can’t you go see the doctor?” The son ended up in a coma. His diabetes score was 800. He needed six months or more of health care. He needed bed turning. They need medical assistance. (Ly Vang, Association for the Advancement of Hmong Women in Minnesota)

story 3
Health Promotion

‘Our Karen people back home never go for regular checkups. I see a lot of difficulty in my community. Lack of regular check ups. Lack of understanding of Western systems. Lack of knowledge and education about health care. No health materials for them to read to get knowledge. Lack of knowing how to prevent health problems. Few medical interpreters. No transportation to medical appointments. Common health problems in our community are diabetes, high blood pressure, high cholesterol, liver, colds, and fever and ear infections. (PawWah Toe, Karen Interpreter/Cultural Liaison)

story 4
Diet/Nutrition

‘I want to tell about diabetes and my health. My family’s health is good because we did not smoke. The food, it is a little fat, just use oil for meals. Diet does not have any fatty food, sugar, salt, calcium. We eat small meals, rice and cereal’. (Vietnamese resident, written testimony.)

story 5
Interpretation

‘I went with my grandfather to see a cardiologist for an EKG. I was not allowed to interpret so they sent in someone else to translate. During the current health condition questions, the nurse asked whether my grandfather had a pace maker and the interpreter DID NOT interpret the question and skipped it entirely because he did not know what a pace maker was. I wanted to interject, however I did not feel comfortable and knew that my grandfather did not have a pace maker. However, if he did have one, I would have corrected the interpreter. If my grandfather did have a pacemaker and had gone to see the doctor alone, I wonder what the magnitude of the problem would have been since the interpreter neglected to interpret pace-maker?’ (Hmong, written testimony)
Part One: Introduction

This report is the convergence of many years of work by the Asian American and Pacific Islander community and healthcare professionals and the oral and written testimonies that were offered at the Asian Health Disparities Forum that took place in Minneapolis on August 2008. Historical knowledge and experience working on health issues with the community helped to formulate the analysis and recommendations of this report.

The forum was organized by the Council via the Hennepin County Asian American & Pacific Islander Leadership Initiative and Minnesota Asian/American Health Coalition (MA/AHC). The forum was also held at the request of the US Department of Health & Human Service, Office of Minority Health and thus it was structured as a public hearing for the community to make comments to federal officials who served as “listeners”. The focus of the forum was on generating solutions for policy makers to understand ways reduce health disparities here in Minnesota for the Asian American and Pacific Islander community. Thus, the forum was an opportunity to inform government officials at federal, county and city levels about the health of Minnesota’s Asia and Pacific Islander communities.

The forum was structured around seven main topics:

1. Health Care Access
2. Health Promotion
3. Health Data
4. Health Conditions (internal)
5. Health Issues (external)
6. Health Professions
7. Emergency Preparedness

The testimonies were then compiled and analyzed and grouped together within the topics and as part of the larger public health and healthcare arena. Community members were creative and responsive in identifying solutions that public officials would do well to heed.

Questions

1. If you and your family are generally healthy, what keeps you healthy?
2. If you and your family are not so healthy, what is the biggest problem for you in getting healthier?
**Methodology: Gathering Health Stories**

In preparing for the forum and this report, organizers worked with community members to collect health stories around two basic questions. People did not have to look far or hard for stories in their communities. Testimonies were drawn from extended families and or people/professionals who have experiences working with clients. Here is written testimony that sheds light on the role of a community agency in health care.

‘Our agency, United Cambodian Association of Minnesota (UCAM), functions as a cultural fitness center. Elders come here from ten a.m. to one p.m. three times a week. The elders share food and socialize together. We use these informal social times to help them understand health issues. For example, we talk to them about foods and high blood pressure, and encourage healthy eating. We have a fitness equipment room and the elders can be seen regularly enjoying the stair masters and treadmills. In winter the elders face high levels of stress. We organize fitness events. We take elders to the Mall of America for walking, and also the Roseville Mall and Maplewood Mall (three geographically different areas of the Metro Area). So now you will see Cambodians as well as Caucasian seniors exercising in winter in these indoor centers.’ (Mr. Yorn Yan, Executive Director, UCAM)

Here is a more personal story about a family member.

‘I would like to tell my personal story as a care-giver. My husband’s father died from liver cancer in Laos. He was age forty-five. An older brother died from stroke in California. Six months ago a brother died of liver cancer age 33. Plus now I have a younger sister diagnosed with breast cancer. She is in Laos. Now my husband has been diagnosed with liver cancer. He has gone for regular checkups but had not be diagnosed until in the process of switching life insurance companies they did a medical checkup and found cancer and so rejected him.’ (Bounleuth Gowing, Lao community health worker, Lao Assistance Center)

**Understanding the AAPI Demographics**

There are over forty different Asian Pacific groups residing in Minnesota that can be grouped under the umbrella term Asian American and Pacific Islander (AAPI). According to the U.S. Census Bureau 2006 American Community Survey the total API population was over 210,000. Hmong is the largest ethnic group comprising 27.3% of the API community, with Vietnamese, Asian Indian, Chinese, Korean and Lao comprising 12.4%, 12.0%, 11.2%, 9.2%, and 6.9% of the API community respectively. Eighty-five percent
of the API community lives in the Twin Cities metro area.

Unique to Minnesota is its large population of Korean adoptees, and claim to the largest Tibetan and Karen communities in the US at 2,000 each. The Karen community from Burma is one of our newest and emerging ethnic groups.

Additional factors important to understanding AAPI health disparities include:

- **AAPIs are primarily first generation refugees and immigrants to America**
  75% are foreign-born, while 60% are naturalized or citizens.

- **High rates of limited English proficiency exist among AAPIs in the Twin Cities.**
  More than one out of three Asian American children age 17 years and younger is limited English Proficiency (LEP). More than half (68%) of Asian American seniors age 65 years and older is LEP. More than one out of three Vietnamese, Cambodian, Lao, and Hmong households are linguistically isolated, while more than a quarter of Korean, Thai, and Chinese households are.

- **Families are multigenerational, often living within the same household.**
  Self-sufficiency and improved health and well-being are often the outcome when families have the ability to carry out their traditionally defined roles within a shared household.

- **AAPIs comprise great religious diversity.**
  This includes, but is not limited to Filipino & Vietnamese Catholics; Lao, Tibetan, Cambodian, and Burmese Buddhists; and Chinese Buddhists, Fulong Gongs and Confucians. The Asian Indian community alone includes Hindus, Muslims, Sikhs and Christians. The Hmong have shamanism or ancestral worship and Chao-Fa. Religious beliefs that the mainstream have yet to understand, but affect the way each community understands health.
Part Two: Voices from the Community

This section summarizes the testimonies given on the seven major topics at the August 2008 forum as well as the open public comment session. Community members were not hesitant to share their stories or to offer solutions. For many, this was the first time they had ever made comments in a public setting. While others were well versed; all were looking to make a difference and seeing change. High on people’s concerns were medical interpreter services, a need for health education and lack of health status data specific to a particular sub group within the Asian American and Pacific Islander community. Mental health emerged as a leading health concern in several Southeast Asian populations (for example Lao, Hmong and Karen). Community members identified the lack of AAPI entering the health professions as a need that must be addressed as well as the need for emergency preparedness planning. A highlight of the morning was testimony regarding cultural competency from a Hmong shaman. Speaking through an interpreter, he talked about the spiritual beliefs of the Hmong and how those beliefs are real and can be a part of the healing process.

Topic 1: Health Care Access

Health care access refers to a person’s ability to successfully utilize health services to ensure optimal health. Issues under health care access include access to affordable health care and insurance, senior access to culturally sensitive facilities, senior access to assisted living, language barriers, limited English proficiency, transportation, and affordable medication.

Medical Interpreters: The Need for Training & Standards

A major issue affecting health access is the lack of quality control over medical interpreters and medical interpreter training. Guidelines have been established nationally. In Minnesota, the Interpreter Stakeholders Group meets regularly and is looking at ways to implement and enforce standardized training.

‘One in three [AAPI] has problems accessing health care. 26% did not know how to access health care.’ (Emily Wang, City of Minneapolis, Department of Health and Family Support)

‘It is critical to have standardization. Clear and culturally sensitive communication is important in healthcare.’ (Vinodh Kutty, Hennepin County Office of Multicultural Services)

‘Interpreters are a huge problem.’ (Raj Chaudhary, SEWA: Asian Indian Family Wellness)
‘Asians have the highest rates of English Limited Language ELL and the highest cultural diversity.’ (Emily Wang)

‘I think a lot of people who need interpreters can be helped if there were better ways to train and regulate interpreters. I think some agencies hire incompetent people who may do more harm than good’ (Hmong, written testimony)

Throughout the day testifiers demonstrated the need for and the importance of quality medical interpreter services as being vital to health care access. One testifier recognized the good job and passion of most interpreters. Unfortunately, there were many more testimonies expressing the desire for greater competency and accountability from interpreters.

‘Chinese elders and adults have problems with medical interpreters.’ (YiLi You, Chinese Services Center)

‘One of my clients sat there [in reception] for hours. They were passed over. No one helped the person, no one talked to them. (Parish Nurse, Southeast Asian Ministry)

‘My community, we are refugees. Help with interpretation is important. I have a client with hemorrhoids. The doctor gave her medications. She understood him to say take and put in water for two hours, Wrong directions. She went home and sat in a bath tub for two hours. The interpreter should listen carefully. Explain how to use the meds.’ (Dung Pham, Vietnamese Social Services)

‘We worry about interpreter issues, worry about medical terminology. Many of the young interpreters have only a limited understanding and knowledge of our Hmong language and customs.’ (Ly Vang)

Ly Vang, executive director of the Association for the Advancement of Hmong Women in Minnesota (AAHWMN) spoke about the younger generation of interpreters not being culturally sensitive. She noted that while they may be fluent in English, their understanding of the native language and the culturally appropriate way in which they should interact with elders are often times lacking. She drew attention to age differences and the challenges when younger interpreters do not show respect for or understand cultural customs dictating the rules of communication and interaction with elders. If the interpreters don’t pay attention to these clues then the issues of credibility and trust can not be established. Directness is a problem:

   It is offensive to use the straight direct word. Medical language can be shameful for an elder. Concept of shame. Hmong talk in metaphors and stories, use analogies.
**With the young interpreters there is a lot of misinterpretation. The young interpreters need help using their own language. (Ly Vang)**

In addition to proficiency in medical terminology and cultural customs, ethical standards are needed. One agency testified witnessing interpreters taking clients to their preferred clinic rather than the client’s requested clinic.

**Health Insurance and Health Access**

Medical health insurance is an issue most affected by socio-economic factors such as poverty and lack of livable wage jobs that offer affordable health coverage. And while AAPI’s are often praised for their entrepreneurial spirit in opening small businesses – statistics show that employees of small businesses have the lowest amount of health coverage. Ly Vang (AAHWM) said that there are many Hmong families who do not have medical insurance and she explained how this impacts their health.

’Sо they don’t do check ups. They are not detecting disease and illness in the early stages. They wait till the last stage. Some of the medical insurance from their employers is limited. Costs of some tests go uncovered. Costs of co-payments are a problem. Today’s economy is negatively affecting health prevention. People do not have the money to pay for hospital and clinic bills for early check-ups.’ (Ly Vang)

Many AAPI experience problems navigating the healthcare system and its bureaucracy. People with English limited language (ELL) and illiterate adults need help from others to understand and complete paperwork. They cannot read their mail and often throw it away, get their younger children or literate relatives to help, or take it to a bilingual professional at a community agency. Staff at community based agencies are glad to help. They often spend many hours of uncompensated time assisting their community navigate a complicated and impersonal health system. Even the more educated and well-versed struggle with bureaucracy. Bounleuth Gowing, a Lao community health worker, noted that working with the system is hard work with lots of follow-up and not taking no for an answer.

‘I am the one who takes him to appointments, follow-up appointments, and gives him medications. We went back to our doctor then to a specialist. They did not want to treat him at first. They did not do anything. We talked to a family doctor then another specialist.’ (Bounleuth Gowing, Lao Community Health Worker)

More than half of Minnesota’s AAPI community are refugees and many are sponsored by family members who have legal status in the United States. Community members brought up the difficulty of refugees accessing healthcare due to the structure of refugee sponsorship. Under income guidelines for the state health insurance program, the sponsor’s income can be included in the income calculation for the refugee and together if their income exceed the guidelines, the refugee would be ineligible. While at the same time, the sponsors cannot buy or afford health care for the refugee. This is a no-win situation.
Religious & Cultural Practices About Health

Religious and cultural beliefs play a big part in how and when the community access western healthcare.

We Hmong know that for physical sickness we go to the doctor, but for sickness resulting from the spiritual realm, we go to the shaman. Sometimes the two can be separated, but sometimes they are intertwined and both have to be treated accordingly. The American way does not honor our Hmong way and does not allow us to heal our people especially when they are hospitalized. Then we do not get access to our people and get to do the “spiritual calling.” (Hmong Shaman or traditional healer)

The Lao wait too long before seeking help. They are suspicious of western medicine. There is a fear of treatment. At HCMC they see medical students and rarely the doctor, except with groups of students. The ‘big doctor’ examines you. They also fear doctors. There are fears in the Lao community often grounded on real incidents that hospitals are going to experiment on you, on the poor, on welfare patients. They spread rumors about incidents said to have occurred at a hospital in California. (Sunny Chantanouvong, Lao Assistance Center)

Our Eastern health and healing beliefs and practices are culturally different and are at times preferred over Western ones. Community-based data gathered by the API Community Health Center Planning Collaborative in 2006 found that of 575 respondents inclusive of 7 ethnic groups within the Twin Cities metro area, 40% utilize both Eastern and Western health practices. Furthermore, one out of three respondents who experienced barriers in accessing care “Couldn’t find care that was respectful of my culture.” (Emily Wang)

Topic 2: Health Promotion

‘Our Karen people back home never go for regular checkups. I see a lot of difficulty in my community. Lack of regular check ups. Lack of understanding of Western systems. Lack of knowledge and education about health care. No health materials for them to read to get knowledge. Lack of knowing how to prevent health problems. Few medical interpreters. No transportation to medical appointments. (PawWah Toe, KaRen Interpreter/Cultural Liaison)

Health promotion professionals define good health promotion to be a comprehensive, systematic, and coordinated approach to affecting long-term health behavior change by influencing the community (cultural) norms through education and community organization. Using this definition the AAPI community is lacking good health promotion. The community is garnering a coalition of AAPI organizations and ethnic communities around health promotion under MA/AHC. The coalition focuses on both long-term and
comprehensive action. MA/AHC just completed its first year of programming and must be supported to continue to grow and thrive in making cultural shift and changing norms.

Vietnamese Social Services has a health promotion program funded through the Minnesota Department of Health Office of Minority and Multicultural Health (MDH-OMMH). They hold health conferences for Vietnamese elders and utilize Vietnamese radio programs, cable TV, newspapers and media to disseminate health promotion messages to the Vietnamese community throughout the state. VSS develops their own culturally competent materials for distribution in their community. This is a best practice model that should be emulated.

Sometimes organizations come together to address a common concern like tobacco, gambling and chemical dependency. They pull their resources together to develop strategies and promotional materials that would change cultural norms and understanding about that specific topic. Current attempts to develop culturally competent health promotion materials and interventions are often limited to translation of existing brochures. This neglectful effort overlooks the fact that the materials were designed for and tested on non-AAPIs and are not easily adaptable or applicable to the AAPI health consumer. For example, the plan for a low cholesterol diet designed for the “American” eater relies heavily on fiber and whole grain products without consideration of AAPI culture and appropriate food alternatives.

> After my heart attack my doctor told me don’t eat rice anymore; don’t eat beef; eat vegetables and eat more turkey and bread. I don’t like bread. I eat rice and beef is a ceremonial food. So I say if I cannot eat like a Hmong man, I would rather die. (Hmong elderly man)

**Topic 3: Health Data**

A key factor in health disparities for the AAPI community is data quality. Current data collection and reporting practices either do not attempt to capture a significant sample of AAPIs on which to report, or umbrella all AAPI identities under a single “Asian” category. Three major problems result from these practices:

1. Little data is made available on AAPIs, with nominal data available on any specific ethnic subpopulation;
2. Data is generalized across the more than 40 AAPI ethnic groups and languages; and
3. The success of some AAPI communities mask the disparities experienced by other AAPI communities.

The lack of accurate, representative health data has caused the AAPI community to be overlooked by policymakers and officials. One of the main problems with any existing health
data on the AAPI communities is that the AAPI data is aggregated. Data labeled “Asian” or “Asian Pacific” is too consolidated and attempting to generalize across too much diversity. Lumping together such widely different populations as Chinese, Asian Indian, Hmong and Samoan distorts the situation for a specific population. Each one of these communities has a very different culture, history and health profile.

The Asian community is seen as a model minority but health disparities exist. Domestic violence exists. Suicides exist. HIV/AIDS exists. The Vietnamese have the highest rates of cervical cancer. The Hmong have a high incidence of kidney stones. There are low rates of immunization of children in some of the communities. Also, data on ‘Asian’ income hides the fact that 14% of Chinese are in poverty. (Xiaoying Chen, Minnesota Department of Health Office of Minority and Multicultural Health))

‘They say we all look alike, but we are all very different, culturally, languages, food, everything.’ (Doua Lee, SE Asian Community Council)

‘We are all lumped together. But each community has its sub culture. (Raj Chaudhary, SEWA)

‘The data we get is too focused on written reports and we forget the knowledge of the elders.’ (Mia Robillos, Researcher, Rainbow Research)

‘It’s very hard to make sense of the data and to find ways to address it. Asian Pacific Islanders are not the same across the different communities.’ (Emily Wang, City of Minneapolis Department of Health and Family Support)

Dr. Zha Blong Xiong, a professor in the Department of Family Social Science at the University of Minnesota, spoke about intergenerational research. He said there are challenges with health data in the Asian Pacific Islander (API) communities. In eight years of doing research, he has experienced problems such as putting all APIs in one group or generalizing findings from one Asian Pacific Islanders group to all AAPI groups. In his view, there are still limited comparative studies and data in the API community.

Emily Wang from the City of Minneapolis pointed out that researchers need to do a better job of finding a greater sample size/number and should err on over sampling with regard to minority communities especially the AAPI community and its many various ethic groups.

The challenge to obtaining a significant sample size for AAPI data can be partially attributed to insufficient attempts to adapt research methods to the AAPI community. Traditional research methods are based in Western culture. Dr. Hee Yun Lee from the University of Minnesota School of Social Work noted that traditional research methods do not work in AAPI communities, such as phone interviews used for major data surveillance studies such as the Behavioral Risk Factors Surveillance Survey.

Phone surveys are not a good way to collect data in the Asian community. Telephone interviews do not work with API and SE Asian populations. (Dr. Hee Yun Lee)
This is likely due to limited English proficiency and distrust of unknown persons by AAPI community members.

Additionally, researchers cited issues applying measurement tools and instruments developed and tested by non-AAPI populations on the AAPI community. Mental health and instruments used to measure depression have not been evaluated for use on AAPI communities; therefore there are translation problems, and lack of consideration for the refugee and immigrant experience. There is a need to develop alternative measures that are more culturally relevant.

There is a disconnect between what has been quantitatively documented via data and what the community knows and experiences.

There are six Hmong funeral homes. Hmong funerals last three days. Based on four funerals a month at each of the six funeral homes, that is a total of twenty four Hmong funerals a month. (Over 308 per year.) My staff and I estimate that only a few of these deaths are from old age, natural longevity. I estimate that 70-80% of these deaths are due to stroke, diabetes and cancer. Suicide accounts for another 10-15%. These last few months (May, June, July 2008) I heard that five deaths were from suicides. This is the mental health issue – depression, PTSD, home foreclosures, the economy. (Ly Vang, AAHWM)

While the state collects data on suicides in Minnesota and can generate a rate for the AAPI community; the community is vastly aware of what is happening within itself. The state data is aggregated, while Ms. Vang anecdotally testifies that the experience is different within the Hmong community, and is worth further study. The aggregated date of a single AAPI category often masks and hides health disparities experienced by specific AAPI subpopulations.

Without data that can accurately reflect the experiences and health status of AAPI communities, it becomes difficult to plan health promotion, prevention, and outreach programs and efforts.

How can you construct a[n] [HIV/AIDS] program when you don’t know which subpopulation is being infected. We don’t know what subpopulation they come from. We don’t know if they have language barriers, things of that nature. (Gilbert Achay, MA/AHC)

**Topic 4: Health Conditions**

Health condition refers to an illness that is chronic or acute effecting the physical, mental or spiritual well being of an individual. This topic drew the largest number of testimonies at the forum. Testifiers were quick to bring up the health conditions they witness in their community: alcoholism, asthma, breast cancer, cervical cancer, colds, diabetes, diseases of the kidneys, ear infections, fevers, heart disease, hepatitis B, high blood pressure, hypertension, HIV AIDS, liver disease, lung cancer, malnutrition, mental health (depression, PTSD), obesity, and renal failure.
The health conditions that drew the most attention were diabetes, cancer, Hepatitis B, and mental health. HIV/AIDS, kidney stones and obesity also received testimony, though previously less known as conditions affecting AAPIs. It was clear as the testimonies were presented that the testifiers knew how to identify health conditions, but many knew little about the root causes of the condition and the care, treatment, and prevention. Some testifiers created their own words or images to define and explain their condition in a manner that made sense to them.

‘Common health problems in my community are diabetes, high blood pressure, high cholesterol, liver problems, colds, fevers, ear infections both children and adults.’ (Paw Waw Toe, Karen Health Interpreter)

‘Diabetes is a problem affecting 60% of Cambodians age forty and over. These are adults who came here as refuges from the Khmer Rouge. We don’t know why diabetes is becoming such a huge issue. Depression affects over 60%. The depression stems from experiences suffered under the Pol Pot regime and also depression can result from the stresses of adjusting to life here. We see an increase in heart disease as a problem. Cancer has increase - there are 115 Cambodians diagnosed in Minnesota per annum.’ (Yorn Yarn, UCAM)

‘The biggest health problems in the Hmong community of Minnesota, which now numbers over 80,000, are number one mental health, followed by high blood pressure, diabetes, obesity, all ages, from children to elders fifty plus, cancer, strokes and deaths from suicides. Cancer includes cervical, colon, liver, pancreas, ulcer, lymph glands, sinus, and bone marrow cancer. I would say only one to two percent are breast cancer.’ (Ly Vang, AAHWM)

‘HIV-AIDs is a problem of SE Asian men getting infection from prostitutes. The visits back and forth, men going back and forth to SE Asia. Back in Laos lots of prostitution and the men get infected. They get infected in Laos but we don’t want to talk about it[in US].’ (Lao Community Member)

Diabetes: Asian Indians may be at higher risk for type two diabetes, because of the way their bodies convert fuel, according to a new Mayo Clinic study. "Asian Indians are less sensitive to insulin action, number one. Which means the same amount of insulin disposed of much less glucose in Asian Indians than Northern European Americans," explained Dr. Nair. (MPR , March 2008)

In a national study, Type 2 Diabetes Prevalence in Asian Americans, researchers found that while similar proportions of Asian and non-Hispanic white Americans report having diabetes, while after accounting for the lower BMI of Asians, the adjusted prevalence of diabetes is 60% higher in Asian Americans. (Marguerite J. McNeely, MD, MPH and Edward J. Boyko, MD)
This section could have been sub-headed by ethnic community or by health condition. We decided to format it by the latter to help highlight the conditions; however it is important to note that AAPI communities are disproportionately affected by each health condition. For example, though all AAPI communities are affected by cancer, different cancers are more prevalent in certain Asian communities.

**Cancer**

Cancer is a top killer across races; however the AAPI community is affected disproportionately by certain cancers than the general community. AAPIs experience high incidences of cervical, colorectal, lung, stomach, prostate and liver cancers; but certain ethnic communities carry a heavier burden than others for each cancer. This was brought out through testimony.

One testifier cited National Cancer Institute data, stating the incidence rate of cervical cancer among Vietnamese women is 7.4 times higher than the lowest incidence rate experienced by other populations and nearly five times higher than the general population. She also recalled another study that found only 18% of Vietnamese women over 50 have periodic breast cancer exams.

*I just wanted to share with you the concern we have in the Vietnamese community. We all know that cervical cancer is 100% preventable. And if breast cancer is detected early and with proper treatment, survival rates are very high. But our women are dying in great numbers. The reason is there is a great need for more awareness about cancer preventative care and screening and proper cancer treatment information.* (Minh Hien, Vietnamese Social Services)

**Cervical Cancer: Asian/Pacific Islander women have a cervical cancer incidence rate that is three times as high as the rate for white women. Deaths due to cervical cancer also occur at a higher rate among Asian Pacific Islanders compared with white non-Hispanics. (MDH)**

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*Indicates a rate significantly higher than white incidence rate
‘Cancer in the Asian populations includes cervical, colon, liver, and pancreas, ulcer, lymph glands, sinus and bone marrow cancer. I would say only 1-2% breast cancer. My sister in law had colon cancer, refused chemo treatment. She needed counseling to explain how surgery would improve her condition. Hmong people need our agency staff to help them explain medical practices. We need a Hmong support group with people we trust.’ (Ly Vang, AAHWMN)

‘Cancer has increased in the Cambodian community. I estimate that there are about 15 Cambodians diagnosed with cancer in Minnesota every year.’ (Yorn Yan, UCAM)

**Hepatitis B & Liver Cancer**

Hepatitis B (HBV) is a virus which can cause lifelong liver damage and even death. Not all people with chronic HBV infection will feel sick, but they carry the virus in their blood and can pass it on to others. HBV was recognized more than 40 years ago and is now preventable with a safe and efficacious vaccine; however many AAPIs are unaware of the vaccine.

Sunny Chanthanouvong, executive director of Lao Assistance Center of Minnesota, spoke about problems in the Lao community regarding HBV and the lack of understanding about HBV infection, prevention, benefits of screening, and treatment, especially for pregnant women

‘The cause of hepatitis B infection among the Lao in Minnesota goes back to practices among the Lao in Laos. When they were sick, there was only one doctor and one needle for the whole village. They knew to ‘boil the needles’ but often the doctors were lazy and just used alcohol to wipe the needles. There was never a focus on health protection. During the Vietnam War, the soldiers used tattoos to protect them. They went to the

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According to the Asian Liver Center at Stanford School of Medicine, as many as 1 out of 10 API Americans are chronically infected with HBV (ranging from 5-15% based on country of origin), compared with 1 in 1000 of Caucasian Americans.

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>2002</th>
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<tbody>
<tr>
<td>US born</td>
<td>3.7 million</td>
<td>14.4 million</td>
</tr>
<tr>
<td>Foreign-born</td>
<td>2.5 million</td>
<td>8.3 million</td>
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New estimates of chronic Hepatitis B (HBV) incidence in the United States show a four-fold increase of HBV prevalence in the API population and 3.3 fold increase in the foreign-born API population in the last 20 years. This disparate rate of HBV is a major health disparity between API and white Americans. Without this information, doctors will not routinely screen their API patients for chronic hepatitis B, nor counsel them to have their family members tested and vaccinated. (National Task Force on Hepatitis B Focus on Asian and Pacific Islander Americans, February 2005)

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Compared with all Minnesotans, the Hmong population had increased PIRs for nasopharyngeal cancer (PIR, 39.39; 95% confidence interval [95% CI], 21.01-66.86), gastric cancer (PIR, 8.70; 95% CI, 5.39-13.25), hepatic cancer (PIR, 8.08; 95% CI, 3.88-14.71), and cervical cancer (PIR, 3.72; 95% CI, 2.04-6.20) and had decreased PIRs for prostate cancer, breast cancer, Hodgkin disease, and melanoma. (Cancer in the Minnesota Hmong Population, Julie A. Ross, Ph.D., May 29, 2003)
temples for projection and blessings. Tattooists used the same needle for all the soldiers. Many of them are here now as Lao Veterans and elders.’ (Sunny Chanthanouvong)

‘My aunt was about 48 years old when she was diagnosed with liver cancer. She was so young and so healthy, we could not believe it. We did not know what to do. The cancer was so advanced, she decided on no treatment. She died. Today, many in my family know about the disease and about how it kills so fast, but they do not go for testing.’ (Hmong woman)

‘I am pregnant and my doctor just told me that I am a HBV carrier. When I found out I was shocked. I’ve never known this. I guess my mother must have passed it on to me when we were at the refugee camps. I do not want to pass it on to my child. My doctor and I have talked about immunization shots for my child at birth.’ (Pregnant woman)

Mental Health & Southeast Asian Refugees

‘We have never healed [from the refugee experience]. Most of us are illiterate. It is hard to adjust to a new life in America, especially for those not able to read or write. It takes three to five years to adjust to culture shock, learn how to write checks et cetera.’ (Wilfred Tun Baw, Karen Support Project)

Mental health is a major health concern for many Southeast Asian refugees in Minnesota due to the trauma they experienced as refugees fleeing war and persecution and as new arrivals to the United States of America. Refugees from Southeast Asian include Hmong, Lao, Vietnamese, Cambodians, Karen, Burmese, and Thai Dam.

When not treated, the ramifications become significant leading to suicide, depression, family violence, gambling, drug addictions. Tony Yang, director of Southeast Asian Services at the Wilder Foundation, a leading agency providing mental health services and counseling to Southeast Asian youth and families, said national studies found that large numbers of refugees arriving in the US are depressed. He spoke about the need for psychiatric services and estimates 36,000 Southeast Asians in Minnesota alone need mental health services but there is not enough culturally competent staff or resources available.
Between 2000 and 2005 Ramsey County Mental Health Center screened mental health needs of over 420 new Hmong refugees arriving from Thailand. They found that many of these new arrivals were clinically depressed. But only 26 received any mental health services at that time. (Tong Yang, Wilder Foundation Southeast Asian Services)

Mr. Yang went on to describe the underserved populations in Minnesota:

Sixty percent of new SE Asian refugee arrivals are clinically depressed. Many suffer from undiagnosed mental illness. In a Hmong population of 60,000 that is a lot. We estimate only three percent get services. At Wilder we see about seven hundred clients annually. The impact on the Hmong community of untreated mental illness impacts on their children. We don’t have enough staff trained from each of the SE Asian communities.

Tony Yang and his staff have been active for many years as agency host of the informal Hmong Mental Health Providers Network (HMHPN). This group is a community initiative driven by Hmong professionals to find and coordinate solutions to the problems of mental health. It was formed in response to a series of tragedies in the Hmong community where mental health services have not reached families in time to avert tragic outcomes. The tragedies pointed to the need for more crisis intervention and follow up mental health services.

The past history of refugees in war torn countries was mentioned several times as a cause of mental health problems. Many refugees suffered trauma before coming to Minnesota. Professionals from the Hmong and Karen communities testified on the need to provide more staff to address mental health in a culturally competent way. Staff from agencies serving the Karen, Hmong and Cambodian families spoke up about mental health issues:

‘Depression affects over 60% of Cambodians. Their depression stems from their experiences suffered under the Khmer Rouge during the Pol Pot Regime. And also depression can result from the stresses of adjusting to live here.’ (Yorn Yan, UCAM)

The Karen refugees from Burma are among the newest refugee communities to arrive in Minnesota after having endured decades of trauma under the Military Junta in Burma. William Tun Baw, Executive Director of the Karen Support Project, described the challenges.
The challenging adjustment to life in Minnesota is similarly experienced by the elders of the Asian community. Elders often suffer from isolation, leading to mental health issues and depression. When not treated, it may lead to suicide. Data on death by suicide often remain hidden in Asian communities.

**Obesity, Diabetes & Unhealthy Nutrition**

Sunny Chanthanouvong, Ly Vang and Doua Lee, directors of community based agencies providing direct services to the Lao and Hmong communities, shared their concerns over the increasing numbers of obese and overweight children they see at their agencies and within their communities. They cited a need for a program to address obesity in Southeast Asian children and a comprehensive strategy to educate their communities about healthy nutrition.

More testifiers spoke about an increase in incidence of diabetes, heart diseases, and kidney stones. Although research is ongoing in the diabetes field, it is believed that ‘consuming a western diet high in fat and calories, decreased physical activity and genetic makeup are all contributing factors to this serious [diabetes] epidemic in Asian American populations’. (Asian American Diabetes Initiative). There is a need to education refugee communities about maintaining healthy nutrition, physical activities, and exercise in the United States.

A Vietnamese testifier talked about her community’s concept of healthy living and commented that overall, the community has a good attitude about it, ‘78% of the Vietnamese are living a healthy life style. Physical exercise, healthy eating choices, and keeping everything in moderation.’

Obesity is linked to other health conditions such as diabetes. (In the Cambodian

‘The trauma has not healed completely. Depression is a major issue for the Karen; they don’t want to admit it because of shame.’ (Wilfred Tun Baw)
community diabetes is a problem affecting 60% of Cambodians forty years of age and older. (Cambodian Community Member)

'We need more educational materials for Hmong on healthy nutrition. I think changes in the Hmong diet in America is a cause of diabetes and stroke. Rice is the main dish. But here the people eat too much pork and beef. Once meat was for special events in the villages. But now meat is readily available from Hmong butchers.' (Ly Vang, AAHWMN)

Kidney Stones
MaiKia Moua who is a nurse and a member of MA/AHC testified to the issue of kidney stones in the Hmong community. She cited a leading report by urologist Dr. Andrew Portis that shows Hmong patients seeing a urologist were four times as likely to have a kidney stones compared to non-Hmong patients. This condition is treatable with medication that will dissolve the stones so that complications will not arise. However, compliance is a matter of outreach and education. Dr. Portis observed in the *PR Newswire* (13 Feb 2003), "Many factors may contribute to this unique health issue. Hmong people appear to be more likely to form stones and less likely to benefit from early diagnosis and treatment. A significant factor is miscommunication and misunderstanding between the Hmong and health care providers."

Tobacco & Alcohol
Through leadership and funding from BlueCross BlueShield of Minnesota, Statewide Tobacco Education and Engagement Project for the South East Asian Communities (STEEP for SEAC) received a 3-year empowerment grant to promote tobacco control. The purpose of the grant is to "Train the Trainer" utilizing a Community Based Participatory Research model. The Tobacco Educators hired by four of the six partners (Association for Advancement of Hmong Women in MN, Lao Advancement Organization of America, United Cambodian Association of MN, Inc., University of Minnesota, Vietnamese Minnesota Association and Lao Family Community) will be trained in tobacco control issues including secondhand smoke, the tobacco industry’s involvement and how to strategically recruit and train other people within the community. A testifier stated, "Asian smokers do not see tobacco as a problem. They used tobacco in Asia. They have smoked for thirty years. They do not see the harm to them or their children around them.” Since tobacco is not recognized as a health condition, STEEP members address tobacco in combination with other issues that community members do see and recognize as health-related. “We have to present tobacco as a combination, talk to them about eating, exercise and tobacco.” (STEEP Member)
Topic 5: Health Issues (External)

The United States Department of Health and Human Service (DHHS) acknowledges in the Healthy People 2010 Initiative what the community stated at the forum, "Inequalities in income and education underlie many health disparities." Under the current system, healthcare is neither accessible nor affordable for all.

*If a family is not healthy, the biggest problem to getting healthier is money.* (Case worker, Vietnamese Social Services)

‘Without health we cannot secure a job.’ (Somly Sitthisay)

Socioeconomic status, as measured either by income or level of education, is strongly correlated with health status. As noted in Healthy People 2010:

*In general, population groups that suffer the worst health status also are those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.*

Elder health care is impacted by poverty. Many Hmong, Lao and Chinese elders live in poverty and cannot afford medications.

‘One co-payment of $10 to $15 may not seem very much. But for an elder on limited income with six, ten or more medicines to buy monthly, it adds up. Costs of co-payments affect compliance and health. Elders are known to skip meds, or stretch out one month’s supply over two months.’ (Vietnamese Elder)

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Social Conditions = Health

Researchers from Vanderbilt University made a strong case for policy makers to address social conditions as a way of improving health for all Americans. First, they found job classification, a measure of socioeconomic status, was a better predictor of cardiovascular death than cholesterol level, blood pressure, and smoking combined in employed London civil servants with universal access to the National Health Service. Second, disparities in health according to socioeconomic status widened between 1970 and 1980 in the United Kingdom despite universal access (similar trends were seen in the United States). Third, in the United States, no completion of high school is a greater risk factor than biological factors for development of many diseases, an association that is explained only in part by age, ethnicity, sex, or smoking status. And fourth, the level of formal education predicted cardiovascular mortality better than random assignment to active drug or placebo over 3 years in a clinical trial that provides optimal access to care. *(Social conditions and self-management are more powerful determinants of health than access to care, Pincus T, Esther R, DeWalt DA, Callahan LF, 1998)*
‘They have their own ways of using the medications. They skip medications or try to stretch one month’s supply over two months. Why pay $100 a month if you can make the medication last for two?’ (Yorn Yan, UCAM)

**Domestic Violence**

Domestic violence is a major hidden problem shared across many AAPI communities including Asian Indian, Chinese, Hmong, Lao, Karen and Korean.

‘In my work in a non-profit agency staffed by Hmong women serving Hmong, we see family domestic violence abuse issues related to mental health.’ (Ly Vang, AAHWMN)

‘I have been with SEWA for five years. There is a problem with domestic violence in the Asian Indian and Tibetan community.’ (Raj Chaudhary, SEWA)

**Youth: Schools, Crime & Violence**

‘We hear immigrant parents despair they don’t know how to raise their children in America.’ (Lydia Lee, Minneapolis School Board)

Lydia Lee testified about gang violence as a health and public safety issue. She founded the Hmong Gang Violence Prevention Taskforce as a response to a need from students and their families. The Taskforce focus on the prevention of gang violence by working with community agencies, students, families, schools, and the police to improve policy-community relations and communication. The Taskforce is raising awareness about mental health needs of children who are entangled in the criminal justice system. In her years on the school board and working on gang prevention, Ms. Lee has seen the intersection of bad nutrition, obesity, self-esteem, and violent criminal behavior and it is not good. She sees a need to educate children about nutrition and obesity that go beyond the classroom.

‘Many in the Asian community have the unrealistic expectation that it [diabetes] can be cured after just one visit. They do not understand the need for ongoing treatments over a person’s lifetime. They think if it is controlled, it is cured, and they stop taking medication.’ (Lydia Lee, Minneapolis School Board)

‘Society has to be healthy before children can be healthy. Children are hungry and we expect them to go to school and learn. Children see violence in their home and community and they are expected to take a test. No wonder our students are not doing well.’ (Hmong Gang Violence Prevention Taskforce Member)

Mental health problems, physical health, environmental health, channel down from the adults in their families to the children. (Doua Lee)

The schools can play a bigger role in health promotion and prevention. Many barriers to medical compliance can be resolved through education.
Housing
In her testimony, Somly Sitthisay said that living in cramped housing causes depression. Multi-generational households are common among AAPI families. However for low-income families it is often difficult to find adequate housing that accommodates large households. Additionally, if families cannot afford housing on their own, families will combine households, increasing the overcrowding.

Topic 6: Professional Development

We need more health workers to educate our community how to prevent illnesses and to understand how important it is to take medicines and follow up with the doctor.’ (PawWah Toe, Karen Liaison)

The Healthcare ‘Pipeline’
There are insufficient numbers of AAPIs training for and entering in health care careers. Testimonies pointed to a shortage of Southeast Asian social workers, mental health workers, and community health workers. Issues of attraction, recruitment and retention were raised under the general topic of how to get more Asian students interested in health careers, One person testified that a major barriers is students’ perception that health-related jobs are not financially lucrative. There is often an expectation for children to support their parents and other relatives who may be unable to support themselves; therefore, pay levels are important. Many AAPIs in the medical field do not serve their community in a community-based clinic because the pay is not enough.

Professional Development
Professionals at Wilder Foundation, volunteers at the Minnesota International Health center and members of the Hmong Mental Health Network (HMHPN) help and support each other in professional development through regular meetings, conferences and workshops. The written testimony from Bounleuth Gowing is a good illustration of professional development within the API communities. She was the only Lao person at a national conference on cancer. The conference gave Bounleuth an opportunity to meet national leaders. 

I met Susan Matsuko Shinagawa, the co-founder [of Asian Pacific Islander National Cancer Survivors Network] and Ho Luong Tran MD, MPH [President/CEO of Asian & Pacific Islander American Health Forum]. I found this very helpful to me as a caregiver. I learned more about how to encourage the community on cancer.
prevention and why they should go to get regular screenings and how to support the
care-givers. (Bounleuth Growing, Lao community health worker).

Cultural Competency
Throughout the testimony listeners heard about the need for more culturally appropriate
services for Asians. In addition to efforts to attract more Asians into health care, there needs
to be an ongoing focus on the training of mainstream health professionals for increasingly
culturally diverse populations in both urban and rural areas.

Topic 7: Emergency Preparedness
In the fall of 2006, Congress revised the Stafford Act to include 42 USCS § 5196f, which is
titled Disaster Related Information Services. This provision stipulates that the Director of the
Federal Emergency Management Agency shall identify limited English proficiency (LEP)
populations and take them into account when planning for emergencies and disasters. This
change in law makes it clear that the agency’s obligations toward LEP populations is strong
and that it necessitates major and critical changes to the core structure of our nation’s
planning document to incorporate principles of language assistance and cultural competency.

This change in law resulted from lessons learned in the aftermath of Hurricane Katrina. The
Asian American Justice Center in a report entitled *Hurricane Katrina: Models for Effective
Emergency Response in the Asian American Community* found that the nation’s largest and
most well-resourced government and private relief agencies, including the American Red
Cross, Federal Emergency Management Agency (FEMA), Small Business Administration
(SBA), Department of Homeland Security (DHS) and other longstanding regional and local
agencies were completely unprepared to meet the needs of LEP populations. Completely
ignored by emergency authorities, tens of thousands of Asian Americans were forced to seek
initial relief in their own ethnic communities. There was a lack of culturally and linguistically
competent government and relief agency workers or even a plan to address different ethnic
populations in the case of an emergency or disaster. Large gaps in services and advocacy for
Asian American communities were due to limited media attention, unbalanced resource
allotment, and mistakes by governmental agencies in disaster preparedness and response.

In Minnesota, there are pockets of LEP populations that need language assistance and
information on how to respond to and recover from an emergency. A Hmong outreach
coordinator for the American Red Cross testified about how outreach efforts on Emergency
Preparedness are being hampered by language barriers and lack of resources to build good
outreach efforts and partnership with community based organizations that serve the
community. The state Office of Emergency Preparedness does not have a plan for its LEP
population.
Part Three: Recommendations to Address Health Disparities

‘[We] are here today, to share experiences of our community, to let the officials know, so we can start to reduce health disparities that affect us.’

(Nancy Pomplun, Minnesota Asian/American Health Coalition)

I. Identify & Address the Top Health Disparities Confronting the Community

Fully fund the Eliminating Health Disparities Initiative and the Office of Minority and Multicultural Health. The Initiative focuses on government-community partnerships to reduce and end health disparities that exist for Minnesota’s populations of color and establishing best practices while doing so. Health experts, professionals and workers must help the community to identify and understand the health conditions that most impact the community. We must identify the top chronic illness experienced by the community. Each health condition has its own symptoms, treatment, and course and these items must be communicated to the community in a culturally competent and caring manner in which they can learn and apply to their lives. Community members must be enlisted and empowered to be an active partner in their health care. Outreach and education must include and reach the community.

II. Health Disparities Must Be Addressed via Good Data Sources

Support funding that will enable the Behavioral Risk Factor Surveillance Survey to collect race and ethnicity data. Asian health status data and data collection methods are seriously flawed and often render the data meaningless. Our recommendation is for researchers to dig deeper into the data asking questions of racial, ethnic, and cultural influence and differences. We request that research disaggregate the data for the Asian American and Pacific Islander community where possible. Also if the source of the data set is mostly Asians from a certain ethnic group, then we ask that researchers specify the ethnic group. What is correct for Asian Indians might not be so for Hmong.

For example, in a national study, Type 2 Diabetes Prevalence in Asian Americans, researchers found that while similar proportions of Asian and non-Hispanic white Americans report having diabetes, after researchers accounted for the lower BMI of Asians, the adjusted prevalence of diabetes was 60% higher in Asian Americans.
This finding is significant and calls for immediate action. If we just looked at the primary finding, we would believe there was no health disparity.

III. Focus on and Improve Social & Economic Determinants of Health

The government and medical profession must recognize and adopt laws, rules, regulations, and policies that will address and improve upon the socio-economic conditions that create and sustain health disparities.

IV. Move Towards Universal Access to Healthcare to Eliminate Health Disparities

The state must continue to fund and protect those currently covered through Minnesota Care and Medicaid while at the same time aggressively seek legislation to expand state programs and services with the ultimate goal of all Minnesotans having access to affordable healthcare.

V. Increase Asian American and Pacific Islander Healthcare Professionals – at all levels

- Increase the number of Asian American and Pacific Islanders who are entering careers in health care such as social work, mental health workers, community health workers, nurses, technicians, across the healthcare spectrum
- Capitalize on the skills of foreign and immigrant professionals
- Create interpreter standards for quality assurance
- Work with university and colleges to recruit and train healthcare professionals
- Provide grants and forgiveness loans for students who are first generation immigrants or who are from “health disparity” areas
- Increase cultural competency for all healthcare professionals

VI. Minnesota must create and disseminate an emergency preparedness plan for its LEP population by working with community based organizations.
Appendix

Testifiers at the Forum

*Testifiers at the forum included a Hmong shaman, researchers, professors, public officials, executive directors, program managers and staff from government and community agencies. This list does not include the names from written testimonies or those who testified during public comment:

Chau Vue, Hmong/SE Asian Outreach Coordinator, American Red Cross, Twin Cities Area Chapter
Doua Lee, Executive Director, Southeast Asian Community Council
Dung Pham, Health Coordinator, Vietnamese Social Services of Minnesota
Elsa Batica, M.A., BSChE, CAN, Chair, Filipino American Women's Network-Minnesota
Emily Wang, MPH, Minneapolis Department of Health & Family Support
Gilbert Achay, Interim Board Chair, Minnesota Asian/American Health Coalition
Hee Yun Lee, PhD, MSW, Asst Professor, University of Minnesota School of Social Work
Mr. Khao Insixiengmay, Executive Director, Lao Cultural Center
Ly Yang, Executive Director, Association for the Advancement of Hmong Women in Minnesota
Lydia Lee, Board Chair, Minneapolis Public Schools
MaiKia Moua, MPH, St. Paul-Ramsey County Dept of Public Health
Marie Minh-Hien Tran, Cancer Education Program Coordinator, Vietnamese Social Services
Mia Robillos, MS, Research Associate, Rainbow Research
Myong Kang, Longterm Care Program Manager, Korean Service Center
Nancy Pomplun, Executive Director, Minnesota Asian/American Health Coalition
Narin Sihavong, Coordinator, Mpls Office of Multicultural Services
Raj Chaudhary, Executive Director, SEWA: Asian Indian Family Wellness
Somly Sitthisay, Former Coordinator, Minnesota Directors Forum
Sunny Chanthanovong, Executive Director, Lao Assistance Center of MN
Thomas Tou Yang, BA, Hmong Tobacco Prevention Educator, STEEP at Association for the Advancement of Hmong Women in Minnesota
Tony Yang, MSMFT, LMF, Director, Southeast Asian Services, Amherst H. Wilder Foundation
Vinodh Kutty, Coordinator, Hennepin County Office of Multicultural Services
Mr. Wilfred D Tun Baw, Karen Project Manager, Vietnamese Social Services of Minnesota
Xiaoying Chen, Asian American Health Coordinator, Minnesota Department of Health, Office of Minority and Multicultural Health
Xiong Pov Lee, Hmong Shaman
Yi Li You, BSW, LSW, Executive Director, Chinese Social Service Center
Zha Blong Xiong, Associate Professor, University of Minnesota
Officials present in the role of ‘Listeners’ at the Forum include:

**FEDERAL**
Mildred Hunter, Hearing Officer, Regional Minority Health Coordinator  
Office of Minority Health, Region V  
Anne Bennett, J.D., Supervisory, Civil Rights Team Leader, Office for Civil Rights - Region V,  
U.S. Department of Health and Human Services

**STATE**
Sanne Magnan, MD, PhD, Commissioner, Minnesota Department of Health (MDH)  
Mitchell Davis, Director, Minnesota Department of Health-Office of Minority & Multicultural Health  
Ilean Her, Executive Director, Council on Asian-Pacific Minnesotans (CAPM)

**LOCAL**
Gretchen Musicant, RN, MPH, Minneapolis Commissioner of Health, Minneapolis Department of Health and Family Support  
Gaoly Yang, Grants and Contracts Manager, Metropolitan Area Agency on Aging

**LEGISLATORS, LEGISLATIVE COMMISSIONS AND OFFICES**
Clara Hinkcroft, for Senator Amy Klobuchar  
Mike Siebenaler, Health Advocate for Congressman Keith Ellison  
Chao Lee, Senior District Office Representative for Congresswoman Betty McCollum  
Representative Erin Murphy  
Representative Joe Mullery  
Representative Augustine "Willie" Dominguez  
Alice Seuffert, Committee Administrator for Senator Linda Higgins  
Jamie Olson, Legislative Assistant for Senator Linda Scheid  
Gregory Gray, Legislative Commission to End Poverty in Minnesota by 2020  
Andrea Lindgren, Office on the Economic Status of Women

**CITY COUNCIL MEMBERS**
Council Member Barbara Johnson, President of Minneapolis City Council,  
Minneapolis Ward 4  
Jose Velez, Policy Aide for Council Member Don Samuels, Minneapolis Ward 5